National Council for Prescription Drug Programs
NCPDP

This NCPDP document has been approved for direct posting to the Transaction Facilitator website.

This document was created by an NCPDP Task Group.

NCPDP provides a forum wherein their diverse membership can develop business solutions, including ANSI-accredited standards, and guidance for promoting information exchanges related to medications, supplies, and services within the healthcare system. Through a consensus-building process in collaboration with other industry organizations, NCPDP members develop these solutions to improve safety, privacy and healthcare outcomes for patients and healthcare consumers, while reducing costs in the system. For more information on NCPDP please visit http://www.ncpdp.org/

For a listing of NCPDP Task Groups, please go to http://www.ncpdp.org/Standards/Work-Group-Listing and click on the Task Groups at lower left.

To Join a Task Group

1. Go to NCPDP Collaborative Workspace http://dms.ncpdp.org/
2. Create User Account or Sign In
3. Update User Profile to Join Task Groups

NCPDP MEDICARE PART D PLANS MOVING PROCESSORS
WHITE PAPER

VERSION 4.Ø

This white paper outlines the scenarios relevant to Medicare Part D Plans changing processors and the tasks to ensure that coordination of benefits occurs for the plan years originally contracted with the prior processor.

February 2Ø14

National Council for Prescription Drug Programs
924Ø East Raintree Drive
Scottsdale, AZ 8526Ø

Phone: (48Ø) 477-1ØØØ
Fax: (48Ø) 767-1Ø42
E-mail: ncpdp@ncpdp.org
http: www.ncpdp.org

MEDICARE PART D PLANS MOVING PROCESSORS

Version 4.Ø

NCPDP recognizes the confidentiality of certain information exchanged electronically through the use of its standards. Users should be familiar with the federal, state, and local laws, regulations and codes requiring confidentiality of this information and should utilize the standards accordingly.

NOTICE: In addition, this NCPDP Standard contains certain data fields and elements that may be completed by users with the proprietary information of third parties. The use and distribution of third parties' proprietary information without such third parties' consent, or the execution of a license or other agreement with such third party, could subject the user to numerous legal claims. **All users are encouraged to contact such third parties to determine whether such information is proprietary and if necessary, to consult with legal counsel to make arrangements for the use and distribution of such proprietary information**.

Published by:
National Council for Prescription Drug Programs

Publication History:
Version 1.Ø January 2Ø13
Version 2.Ø May 2Ø13
Version 3.Ø December 2Ø13
Version 4.Ø February 2Ø14

National Council for Prescription Drug Programs
924Ø E. Raintree Drive
Scottsdale, AZ 8526Ø
(48Ø) 477-1ØØØ
ncpdp@ncpdp.org

TABLE OF CONTENTS

Disclaimer

While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice. If you require legal advice, you should consult with an attorney. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by NCPDP. The listing of an organization does not imply any sort of endorsement and the NCPDP takes no responsibility for the products or tools.

The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by the NCPDP.

The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

1. PURPOSE

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Part D Plans to coordinate benefits for 36 months. When a Part D Plan changes processors the Plan must ensure they are able to coordinate benefits for the full 36 month period and must determine how the old and/or new processor will meet these requirements.

NCPDP Work Group 1 Financial Information Reporting Task Group has developed this White Paper to provide Medicare Part D Plans with tasks required for coordination of benefits that are necessary when contemplating a change in processor. These tasks should be reviewed prior to the change. Part D Plans should ensure that the tasks outlined in this document have been included in their transition plan with the old processor and/or the new processor and available in the event of an audit. Contracts between the processors (old and new) and the Part D Plan should specify the services performed for each task.

This document outlines the scenarios relevant to Medicare Part D Plans changing processors and the tasks to ensure that coordination of benefits occurs for the plan years originally contracted with the prior processor (also referred to as "**runout**").

1.1 RESOURCES

CMS Plan Communications User Guide

http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html

2. CMS REQUIREMENTS FOR COORDINATION OF BENEFITS

In accordance with Federal regulations at 423.466(b), effective June 7, 2010 Part D sponsors are required to coordinate benefits with State Pharmaceutical Assistance Programs, other entities providing prescription drug coverage, and all other payers, including beneficiaries or other individuals or entities paying, or holding amounts for payment, on the beneficiaries' behalf, for a period of three years from the date on which the prescription for a covered Part D drug was filled. By statute, coordination of benefits relates to the following:

- Enrollment file sharing;
- Claims processing and payment;
- Claims reconciliation reports;
- Application of protection against high out-of-pocket expenditures by tracking TrOOP expenditures; and
- Other processes that CMS determines.

3. RUNOUT TRANSACTION/FILE EXCHANGE IMPACTS

When addressing coordination of benefits activities, the following transactions/file exchanges play a role in the coordination of benefits process:

- Continuing to update plan, processor, and CMS system with eligibility changes related to 4Rx, LICS, OHI for a plan year for 36 months of Financial Information Reporting (FIR transactions)
- Information Reporting (N transactions)
- Claim Billing (B transactions)
- Direct member reimbursement (DMR), paper claims, subrogation
- Claims adjustments and reconciliation
- Prescription Drug Events (PDE)
- CMS reporting (Direct Indirect Remuneration (DIR), quarterly, annual reporting)

4. SCENARIOS

The following scenarios are shown.

1. #1a – Runout with Different BIN/PCN - Plan Changes Processors at the Beginning of a Calendar Year and has a New BIN/PCN
2. #1b – Runout with Different BIN/PCN - Plan Changes Processors any time after the Beginning of the Calendar Year
3. #2 – No Runout with Old Processor - Plan changes Processors at the Beginning of a Calendar Year with New BIN/PCN - Processes Prior Year Historical Data with Old BIN/PCN
4. #3 – Runout with Old Processor - BIN/PCN owned by Plan – Does not Change when Plan Changes Processors
5. #4 – No Runout with Old Processor - BIN/PCN owned by Plan – Does not Change when Plan Changes Processors

Each scenario includes

1. Description of the scenario
2. 4Rx changes
3. Changes needed for Health Plan Management System (HPMS)
4. Changes needed for Switches
5. Changes needed for Transaction Facilitator
6. Changes needed for Pharmacy
7. Timing discussion - estimated lead time for each of the above as appropriate
8. Benefits and Risks for each scenario

4.1 #1A – RUNOUT WITH DIFFERENT BIN/PCN - PLAN CHANGES PROCESSORS AT THE BEGINNING OF A CALENDAR YEAR AND HAS A NEW BIN/PCN

Plan has contracted to runout with the Old Processor BIN/PCN for dates of service prior to the New Processor effective date (dates of service through 12/31/2013)

1. Runout description
    a. Plan should contract for Old Processor to handle all transactions related to 2013 (the list below provides examples, but may not be all inclusive)
        i. FIRs, PDEs, N transactions, Direct Member Reimbursement (DMR), Direct and Indirect Remuneration (DIR) (for a period of 36 months due to COB requirements)
        ii. Claims for 2013 Dates of Service
            1. i.e. if your claim submission window is 90 days allow claims for 2013 Dates of Service through 03/31/2014
            2. i.e. if reversal window is 6 months then allow reversals for 2013 Dates of Service until 06/30/2014
2. 4Rx changes
    a. Report new 4Rx effective date to CMS by placing 20140101 (CCYYMMDD) in the Effective Date field in position 64-71. A single 72 transaction can be used to report these changes.
        i. Reporting the Effective Date of the new 4Rx will automatically terminate the Old Processor 4Rx one day prior to the new 4Rx Effective Date.
        ii. Note: if the plan is not sending separate 51 and 72 transactions for each beneficiary, a 51 must be sent if the beneficiary is not active with the plan at the first of the year.
        iii. Note: Plans should not send 4Rx without an Effective Date as it will default to the file process date**.**
        iv. Any FIR transaction triggered on/after the Effective Date will be sent to the new 4Rx.
3. Updates to the CMS HPMS system

a. HPMS should be updated to include the new processor information no later than the date the new processor begins processing. The old processor information should remain in HPMS until the 36 month period has expired. See section "*HPMS Screen Shots*".

4. Switch notification
   a. If BIN with New Processor is a new BIN for that processor - Plan must notify switches to add BIN
   b. If BIN is an existing BIN for the New Processor, then no action related to switches is necessary.
5. Changes for Transaction Facilitator
   a. If BIN with New Processor is a new BIN for that processor – Plan must notify the Transaction Facilitator to add BIN
      i. Transaction Facilitator needs to know what processor to contact if FIR problems, etc
   b. If BIN is an existing BIN for the New Processor, then no action related to Transaction Facilitator is necessary.
6. Changes for Pharmacy
   a. The Old Processor should update the payer sheet for the plan to indicate that it is only valid for Dates of Service for 2013.
   b. The New Processor should create a payer sheet that communicates:
      i. The new BIN/PCN is effective for Dates of Service for 2014.
      ii. All claims/reversals for Dates of Service prior to 2014 should be submitted to the old BIN/PCN.
   c. It is recommended that Old and New Processor should consider additional alternate communication (email, fax) to pharmacy.
   d. The New Processor should consider claims/reversals testing by Pharmacy.
7. Timing
   a. If new BIN for New Processor – 30-60 days for switches and Transaction Facilitator notification
   b. Transactions reporting 4Rx to CMS must have an effective date within the beneficiary's enrollment in the plan.
8. Benefits/Risks
   a. Benefits
      i. This scenario is the recommended method for plan/processor changes.
      ii. It provides clear delineation of who handles transactions based on date of service/Plan year, clear 4Rx timeframes.
   b. Risks
      i. Pharmacies may attempt to process a claim with old plan information and may not request an E1 on denial. If E1 is submitted and plan has submitted updated 4Rx data to CMS, E1 response will reflect new information.

4.2 #1B – RUNOUT WITH DIFFERENT BIN/PCN - PLAN CHANGES PROCESSORS ANY TIME AFTER THE BEGINNING OF THE CALENDAR YEAR

(Example is a non-calendar year EGWP that starts a benefit year 07/01/2013)

Plan has contracted to runout with the Old Processor BIN/PCN for dates of service prior to the New Processor effective date (date of service through 06/30/2013)

1. Runout description
   a. Plan should contract for Old Processor to handle all transactions related to dates of service through 06/30/2013 (the list below provides examples, but may not be all inclusive)
      i. FIRs, PDEs, N transactions, Direct Member Reimbursement (DMR), Direct and Indirect Remuneration (DIR) (for a period of 36 months from 06/30/2013 due to COB requirements)
      ii. Claims for 2013 Dates of Service
         1. i.e. if your claim submission window is 90 days (allow claims with Dates of Service 01/01/2013 to 06/30/2013 Dates of Service through 09/30/2013)
         2. i.e. if reversal window is 6 months then allow reversals for 2013 Dates of Service until 12/31/2013

2. 4Rx changes
    a. Report new 4Rx effective date to CMS by placing 20130701 (CCYYMMDD) in the Effective Date field in position 64-71. A single 72 transaction can be used to report these changes.
        i. Reporting the Effective Date of the new 4Rx will automatically terminate the Old Processor 4Rx one day prior to the new 4Rx Effective Date.
        ii. Note: if the plan is not sending separate 51 and 72 transactions for each beneficiary, a 51 must be sent if the beneficiary is not active with the plan at the first of the year.
        iii. Note: Plans should not send 4Rx without an Effective Date as it will default to the file process date**.**
        iv. Any FIR transaction triggered on/after the Effective Date will be sent to the new 4Rx.
3. Updates to the CMS HPMS system
    a. HPMS should be updated to include the new processor information no later than the date the new processor begins processing. The old processor information should remain in HPMS until the 36 month period has expired. See section "*HPMS Screen Shots*".
4. Switch notification
    a. If BIN with New Processor is a new BIN for that processor – Plan must notify switches to add BIN
    b. If BIN is an existing BIN for the New Processor, then no action related to switches is necessary
5. Changes for Transaction Facilitator
    a. If BIN with New Processor is a new BIN for that processor - Plan must notify Transaction Facilitator to add BIN
    b. If BIN is an existing BIN for the New Processor, then no action related to Transaction Facilitator is necessary
6. Changes for Pharmacy
    a. The Old Processor should update the payer sheet for the plan to indicate that it is only valid for Dates of Service prior to 07/01/2013.
    b. The New Processor should create a payer sheet that communicates:
        i. The new BIN/PCN is effective for Dates of Service as of 07/01/2013.
        ii. All claims/reversals for Dates of Service prior to 07/01/2013 should be submitted to the old BIN/PCN.
    c. It is recommended that Old and New Processor should consider additional alternate communication (email, fax) to Pharmacy.
    d. The New Processor should consider claims/reversals testing by Pharmacy.
7. Timing
    a. If new BIN for New Processor – 30-60 days for switches and Transaction Facilitator notification
    b. Transactions reporting 4Rx to CMS must have an effective date within the beneficiary's effective date in the plan
8. Benefits/Risks
    a. Benefits
        i. This scenario is the recommended method for processor changes that occur on other than a calendar year basis. Clear delineation of who handles transactions based on date of service/Plan year, clear 4Rx timeframes.
    b. Risks
        i. The Plan is responsible for insuring beneficiary balances are transferred between the processors for purposes of TrOOP and other reporting. The Automated TrOOP Balance Transfer (ATBT) process does not apply in this scenario because there is no change in enrollment. 4Rx changes that are not accompanied by a change in Contract ID or PBP will not trigger a FIR series.
            1. If a FIR series is already "in process" any FIR sequences transmitted after the effective date of the new 4Rx will contain the new 4Rx only.
        ii. The Plan must ensure that balances for beneficiaries terminated prior to the effective date of the New Processor 4Rx will be appropriately transferred if a FIR is received.
        iii. If the Plan manually transfers balances between the Old and New Processors, and a FIR is received by the Old Processor (for a beneficiary whose balances were manually transferred), the plan must ensure that the beneficiary's balances are not doubled. This

may be avoided by requiring the Old Processor to zero out the balances they would normally provide. For example, an F1 response would return $0.00.

iv. The Plan will receive only one Daily Cumulative FIR Aging Report regardless of processor. In this scenario, if the plan has updated its email distribution for the reports to transmit to the New Processor, this processor will see all rejects including those rejected by the Old Processor. Separate reports specific to the processor cannot be generated, because the reports are at the contract level. The plan would be responsible for notifying the Old Processor of their rejects.

v. Pharmacies may not request an E1 because they are not expecting a non-calendar year change and may attempt to process claim with old plan information. If plan has submitted updated 4Rx data to CMS, E1 response will reflect new information.

vi. If calendar-year plan changes processors anytime other than the first of the year, this may impact beneficiaries. It would require beneficiary recarding mid-year as well as affect DIR and other reporting.

4.3 #2 – No Runout with Old Processor - Plan changes Processors at the Beginning of a Calendar Year with New BIN/PCN - Processes Prior Year Historical Data with Old BIN/PCN

The New Processor has contracted to process the prior year(s) BIN/PCN and handles the new BIN/PCN for 2014. It doesn't really matter when the change occurs as the New Processor is taking on the historical data.

1. Handling of transactions for prior years
    a. Plan should contract for New Processor to handle all transactions for years prior to 2014 that include the old BIN/PCN (the list below provides examples, but may not be all inclusive).
        i. FIRs, PDEs, N transactions, Direct Member Reimbursement (DMR), Direct and Indirect Remuneration (DIR) (for a period of 36 months due to COB requirements)
        ii. Claims for 2013 Dates of Service
            1. i.e. if your claim submission window is 90 days allow claims for 2013 Dates of Service through 03/31/2014
            2. i.e. if reversal window is 6 months then allow reversals for 2013 Dates of Service until 06/30/2014
    b. Plan must ensure that all historical information from the Old Processor is transferred and imported into the New Processor system (e.g. eligibility, benefit set up and design, prior authorization, claims history, formulary, FIR, N, etc.
        i. The New Processor is processing in the same manner as the Old Processor. The change in processor should be transparent.
2. 4Rx changes
    a. Report new 4Rx effective date to CMS by placing 20140101 (CCYYMMDD) in the Effective Date field in position 64-71. A single 72 transaction can be used to report these changes.
        i. Reporting the Effective Date of the new 4Rx will automatically terminate the Old Processor 4Rx one day prior to the new 4Rx Effective Date.
        ii. Note: if the plan is not sending separate 51 and 72 transactions for each beneficiary, a 51 must be sent if the beneficiary is not active with the plan at the first of the year.
        iii. Note: Plans should not send 4Rx without an Effective Date as it will default to the file process date**.**
        iv. Any FIR transaction triggered on/after the Effective Date will be sent to the new 4Rx.
3. Updates to the CMS HPMS system
    a. HPMS should be updated with the new processor information no later than the date the new processor begins processing. The old processor information should be removed as of the date the old processor ceases processing for the plan. See section "*HPMS Screen Shots*".
4. Switch notification

a. The old BIN/PCN has moved to the New Processor as of 01/01/2014 regardless of the Date of Service
b. If the new BIN/PCN for 2014 is a new BIN for that processor - Plan must notify switches to add BIN
c. If the new BIN/PCN for 2014 is an existing BIN for the New Processor, then no action related to switches is necessary

5. Changes for Transaction Facilitator
    a. The old BIN/PCN has moved to the New Processor as of 01/01/2014 regardless of the Date of Service
    b. If the new BIN/PCN for 2014 is a new BIN for that processor - Plan must notify Transaction Facilitator to add BIN
        i. Needs to know what processor to contact if FIR problems, etc
    c. If the new BIN/PCN for 2014 is an existing BIN for the New Processor, then no action related to Transaction Facilitator is necessary
6. Changes for Pharmacy
    a. The Old Processor should update the payer sheet for the plan to indicate the last date they will accept claims/reversals is 12/31/2013 and only for Dates of Service prior to 12/31/2013.
    b. The New Processor should create a payer sheet that communicates:
        i. The new BIN/PCN is effective for all claims/reversals submitted as of 01/01/2014 based on Dates of Service rules below.
        ii. Prior year rules for reversals and claims. (For example: the plan only allows claims to be submitted for 90 days from Date of Service.) Note: Need to clearly indicate the run out period for prior year so Pharmacy can update beneficiary's profiles appropriately.
    c. It is recommended that Old and New Processor should consider additional alternate communication (email, fax) to Pharmacy.
    d. The New Processor should consider claims/reversals testing by Pharmacy.
7. Timing
    a. The old BIN/PCN has moved to the New Processor as of 01/01/2014 - 30 days for switches and Transaction Facilitator notification
        i. This assumes the Old Processor was processing electronic transactions.
    b. If new BIN/PCN for 2014 is a new BIN for that processor – 30-60 days for switches and Transaction Facilitator notification
    c. Transactions reporting 4Rx to CMS must have an effective date within the beneficiary's effective date in the plan
8. Benefits/Risks
    a. Benefits
        i. This offers a clear delineation of who handles transactions based on date of service/Plan year, clear 4Rx timeframes.
        ii. The beneficiary deals one entity regardless of the year.
        iii. The Plan only deals with one processor.
        iv. Plan receives one set of reports.
    b. Risks
        i. This scenario of the four scenarios has the highest risk.
        ii. It is unlikely the New Processor would be able to handle historical transactions exactly the same as the Old Processor.
        iii. There may be some beneficiary disruption due to the new BIN/PCN created for 2014.

4.4 #3 – RUNOUT WITH OLD PROCESSOR - BIN/PCN OWNED BY PLAN – DOES NOT CHANGE WHEN PLAN CHANGES PROCESSORS

In this scenario both processors will be processing for the same BIN/PCN with differentiation of the Dates of Service. Old Processor processes for dates of service prior to 2014. New Processor will be processing for 2014 and beyond. It does not really make a difference when this changes (calendar or plan year) because the BIN/PCN is moving to the New Processor and is Date of Service driven.

Plan has contracted to runout with the Old Processor with the same BIN/PCN for dates of service prior to the New Processor effective date (Dates of Service through 12/31/2013)

1. Runout description
    a. Plan should contract for Old Processor to handle all transactions related to 2013 eligibility (the list below provides examples, but may not be all inclusive)
        i. FIRs, PDEs, N transactions, Direct Member Reimbursement (DMR), Direct and Indirect Remuneration (DIR) (for a period of 36 months due to COB requirements)
        ii. Claims for 2013 Dates of Service
            1. i.e. if your claim submission window is 90 days allow claims for 2013 Dates of Service through 03/31/2014
            2. i.e. if reversal window is 6 months then allow reversals for 2013 Dates of Service until 06/30/2014
2. 4Rx changes
    a. No reporting to CMS because 4Rx has not changed.
3. Updates to the CMS HPMS system
    a. HPMS should be updated to include the new processor information no later than the date the new processor begins processing. The old processor information should remain in HPMS until the 36 month period has expired. See section "*HPMS Screen Shots*".
4. Switch notification
    a. Requires custom contracting with the switches to route to the appropriate processor based on Date of Service.
5. Changes for Transaction Facilitator
    a. Requires custom contracting with the Transaction Facilitator to route to the appropriate processor based on Date of Service.
6. Changes for Pharmacy
    a. If Pharmacy uses a switch/intermediary to process claims and other transactions, no action is needed by the Pharmacy as the switch will route claims and other transactions appropriately.
    b. If the Pharmacy has a direct connection to the processor, requires custom contracting with the Pharmacy to route to the appropriate processor based on Date of Service.
    c. The Old Processor should update the payer sheet to communicate that it will be based on Dates of Service only.
    d. The New Processor should create a payer sheet that communicates:
        i. The new BIN/PCN is effective for all claims/reversals submitted as of 01/01/2014 based on Dates of Service.
    e. It is recommended that Old and New Processor should consider additional alternate communication (email, fax) to Pharmacy.
    f. The Old Processor and the New Processor should consider claims/reversals testing by Pharmacy.
7. Timing
    a. The Transaction Facilitator should be notified 90 days prior to effective date to allow time for contracting and development work.
    b. The switches should be notified 60-90 days prior to effective date to allow time for contracting and development work.
    c. HPMS update should follow normal CMS rules. This information can be entered at any time, however no later than when the New Processor is effective.
8. Benefits/Risks
    a. Benefits
        i. Minimizes beneficiary disruption with 4Rx not changing.
        ii. May not need to recard if support contact or other information does not change.
        iii. It provides clear delineation of who handles transactions based on date of service.
    b. Risks
        i. If not coordinated well with all entities involved, the routing of transactions may be incorrect, causing rejections which may impact beneficiary access.
        ii. May need to recard (or send stickers) if support contact or other information changes on the card.
        iii. The beneficiary deals with two entities based on Date of Service.

iv. The Plan deals with two processors based on Date of Service.
v. Plan receives two sets of reports based on Date of Service.

4.5 #4 – NO RUNOUT WITH OLD PROCESSOR - BIN/PCN OWNED BY PLAN – DOES NOT CHANGE WHEN PLAN CHANGES PROCESSORS

In this scenario only one processor will be processing for the BIN/PCN as of a specific date, regardless of Date of Service.

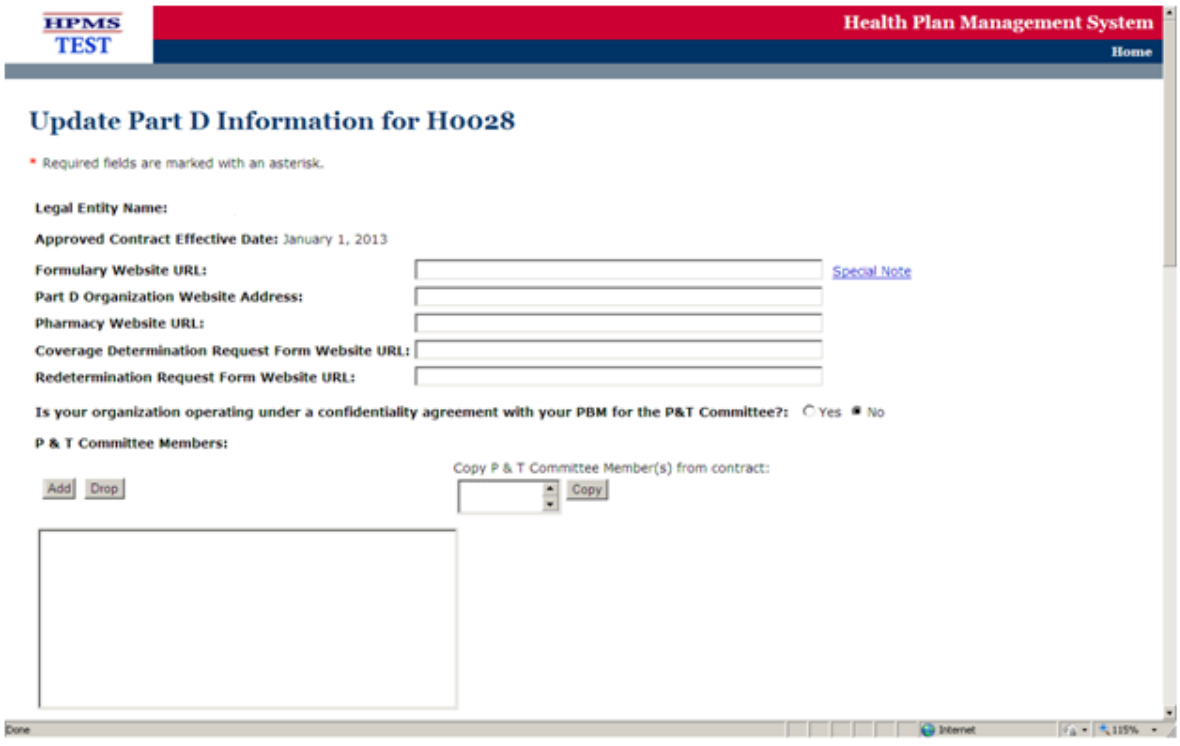
The New Processor has contracted to process the prior year(s) BIN/PCN and handles the new BIN/PCN for 2014. It doesn't really matter when the change occurs as the New Processor is taking on the historical data.

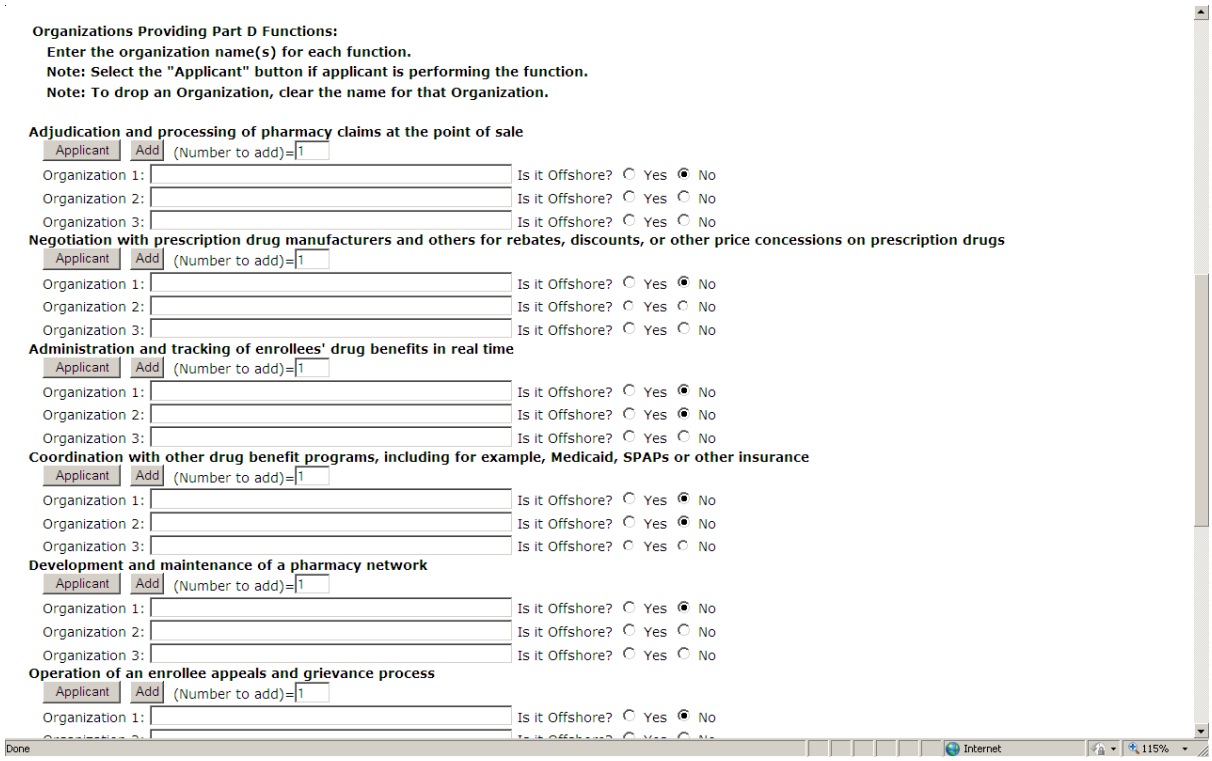
Plan has contracted with the New Processor for all Dates of Service including transactions that were previously processed by the Old Processor.

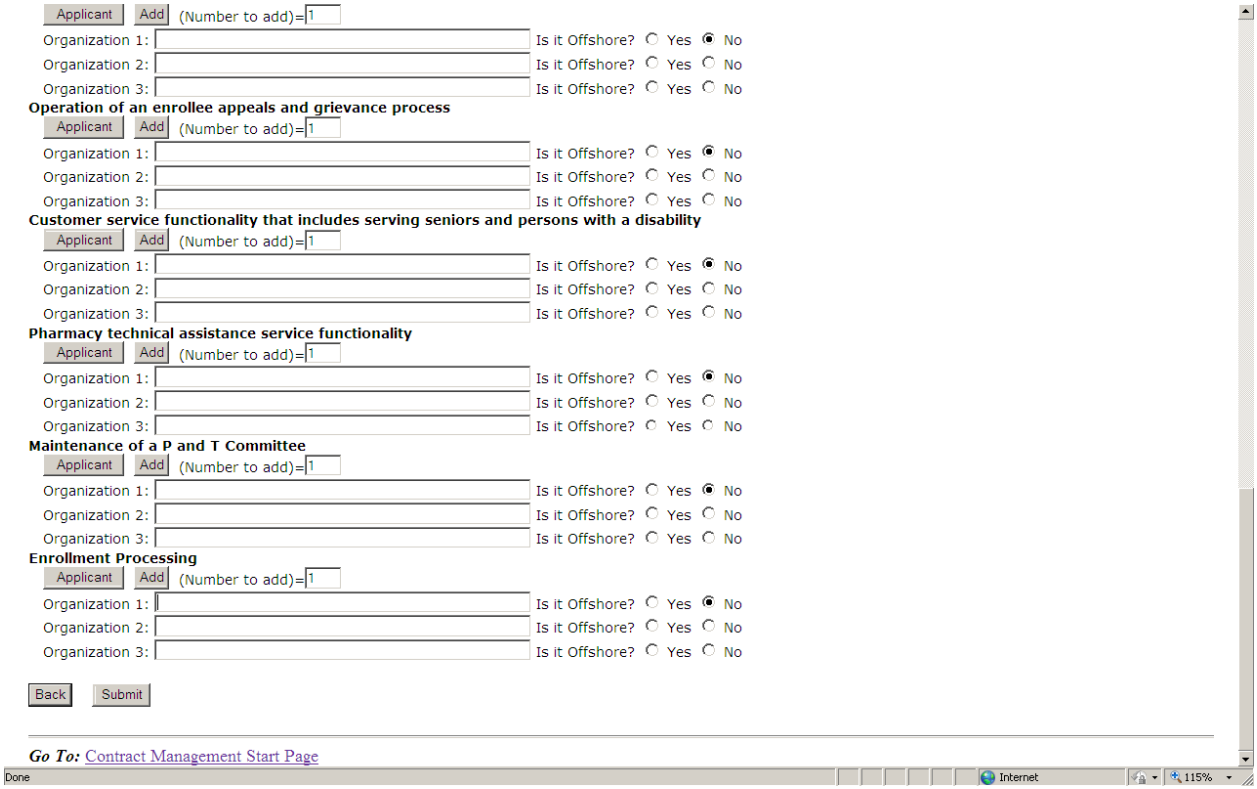
1. Handling of transactions for prior years
    a. Plan should contract for New Processor to handle all transactions for years prior to 2014 that includes the same BIN/PCN (the list below provides examples, but may not be all inclusive).
        i. FIRs, PDEs, N transactions, Direct Member Reimbursement (DMR), Direct and Indirect Remuneration (DIR) (for a period of 36 months due to COB requirements)
        ii. Claims for 2013 Dates of Service
            1. i.e. if your claim submission window is 90 days allow claims for 2013 Dates of Service through 03/31/2014
            2. i.e. if reversal window is 6 months then allow reversals for 2013 Dates of Service until 06/30/2014
    b. Plan must ensure that all historical information from the Old Processor is transferred and imported into the New Processor system (e.g. eligibility, benefit set up and design, prior authorization, claims history, formulary, FIR, N, etc.
        i. The New Processor is processing in the same manner as the Old Processor. The change in processor should be transparent.
2. 4Rx change
    a. No reporting to CMS because 4Rx has not changed.
3. Updates to the CMS HPMS system
    a. HPMS should be updated with the new processor information no later than the date the new processor begins processing. The old processor information should be removed as of the date the old processor ceases processing for the plan. See section "*HPMS Screen Shots*".
4. Switch notification
    a. Notify the switches of the effective date of the routing change.
5. Changes for Transaction Facilitator
    a. Notify the Transaction Facilitator of the effective date of the routing change.
6. Changes for Pharmacy
    a. The Old Processor should update the payer sheet for the plan to indicate the last date they will accept claims/reversals is 12/31/2013 and only for Date of Service prior to 12/31/2013.
    b. The New Processor should create a payer sheet that communicates:
        i. They are processing the BIN/PCN that is effective for all claims/reversals submitted as of 01/01/2014 based on Dates of Service rules below.
        ii. Prior year rules for reversals and claims. (For example: the plan only allows claims to be submitted for 90 days from Date of Service.)
            1. Note: The New Processor's payer sheet should clearly indicate the runout period for the prior year so Pharmacy can update beneficiary's profiles appropriately.
    c. It is recommended that Old and New Processor should consider additional alternate communication (email, fax) to Pharmacy.
    d. The New Processor should consider claims/reversals testing by Pharmacy including historical claims within Dates of Service rules.

7. Timing
    a. The Transaction Facilitator and the switches should be notified 30 days prior to effective date to ensure transactions are routed to the New Processor.
    b. HPMS update should follow normal CMS rules. This information can be entered at any time, however no later than when the New Processor is effective.
8. Benefits/Risks
    a. Benefits
        i. Minimizes beneficiary disruption with 4Rx not changing.
        ii. May not need to recard if support contact or other information does not change.
        iii. It provides clear delineation of who handles transactions based on date of service.
        iv. This offers a clear delineation of who handles transactions based on date of service/Plan year, clear 4Rx timeframes.
        v. The beneficiary deals with one entity regardless of the year.
        vi. The Plan only deals with one processor.
        vii. Plan receives one set of reports.
    b. Risks
        i. If not coordinated well with all entities involved, the routing of transactions may be incorrect, causing rejections which may impact beneficiary access.
        ii. May need to recard (or send stickers) if support contact or other information changes on the card.
        iii. It is unlikely the New Processor would be able to handle historical transactions exactly the same as the Old Processor.

4.6 HPMS SCREEN SHOTS







5. CMS GUIDANCE TO ALTERNATIVE ROUTING SCENARIOS

This information is also found in the NCPDP *Recommendations for Effective 4Rx Usage in Medicare Part D Processing* document.

Per CMS, identified below are scenarios that route the claim to a different payer or processor behind the scenes and are **NOT** consistent with CMS policy requiring that claims be routed to the 4Rx submitted to CMS and returned in an NCPDP Eligibility Verification (E1) transaction for that date of service.

- In scenario #1, the claim is being submitted with 4Rx that is not active in the CMS system for the date of service.
- In scenario #2, the claim is being initially routed to a BIN/PCN that is not a Part D BIN/PCN and behind the scenes is being rerouted to the Part D BIN/PCN; therefore the claim submitted by the pharmacy does not contain the Part D 4Rx and does not match the E1.

The scenarios outlined above are inconsistent with the CMS and NCPDP jointly developed COB process which **requires** consistent use of the same unique identifiers by all participants in the COB process. However, the scenarios above are not applicable to claims submitted under the Part D 4Rx but paid under an alternate benefit in which the appropriate Benefit Stage Qualifier is returned.

At a high level there are instances where a processor has knowledge on file that a claim should be processed under different 4Rx for the date of service. The processor suspends in real-time the pharmacy-submitted claim request, creates a separate claim request using the other 4Rx data that they have knowledge of and sends the claim request, via a switch/intermediary, to the other 4Rx processor. When the other 4Rx processor responds to the rerouted claim, the processor that received the claim from the pharmacy uses this response information completes the processing of the pharmacy submitted claim and responds to the pharmacy.

Process flow:

- Pharmacy submits an NCPDP claim request to a Processor
- Processor to whom the claim was submitted has information on file that the cardholder has primary coverage (either commercial or Part D)
- Processor to whom the claim was submitted holds that original claim request in a real time suspended mode and creates a new NCPDP claim request using the 4Rx data for the primary Processor that they have on file for the member
- Processor to whom the claim was submitted submits the newly created claim to a switch
- Switch routes newly created claim to the primary Processor
- Primary Processor responds
- Switch returns primary Processor response to Processor to whom the claim was submitted
- Processor to whom the claim was submitted completes processing of the original claim submitted based on the information returned from the primary Processor and responds to the Pharmacy

The end result is that the pharmacy does not realize that the claim was paid by a different entity than to whom they sent the claim. Additionally, the claim does not match the eligibility data on file at CMS. The processor **must reject** the claim, and it is recommended that they provide the correct 4Rx for the date of service in the response so the pharmacy can submit to the correct primary payer that matches the 4Rx on the CMS eligibility file.

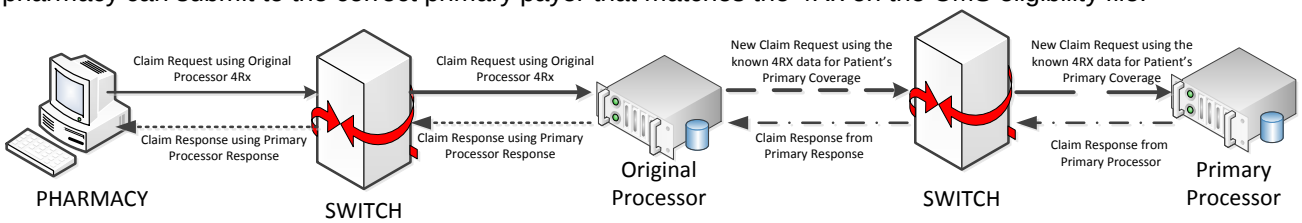


Figure 1. Alternative Routing Flow Diagram

There are two business cases identified to date that use the flow above where this is or has been coded to happen, that do not meet CMS requirements:

1. The plan has changed processors and the pharmacy is submitting the claim to the new processor using the 4Rx, but the claim is being paid under and by the old processor. This is being done to reduce rejects at POS.
2. The pharmacy is submitting the claim to a 340B processor, who determines that they should bill the Part D plan first and does so in a similar manner described above.

In these examples, the pharmacy is not aware that a different BIN/PCN has paid; the 4Rx on pharmacy claim transaction does not match what would be returned for the date of service on an E1 transaction. The ASC X12 835 payment will contain information from the processor to whom the claim was rerouted, yet the submitted claim transaction contains the new processor information.

6. APPENDIX A. HISTORY OF CHANGES

6.1 VERSION 1.Ø

The initial release of the paper.

6.2 VERSION 2.Ø

Updated the document with plans changing throughout the year.
Clarification was made to state "eligibility changes related to 4Rx, LICS, OHI" rather than general "eligibility". "Changes for eligibility" was clarified to "4Rx changes" in scenarios.
Scenario #1A and #1B "4Rx changes" and "Timing" sections were modified. Scenario #1B Risks was updated.
Scenario #2 "4Rx changes" and "Timing" sections were modified.
Scenario #4 "4Rx changes" was modified.

Member was changed to beneficiary for consistency.

6.3 VERSION 3.Ø

A reference to Plan Communications User Guide was added in section "*Resources*".

The "4Rx changes" were clarified in Scenario #1A, #1B, and #2.
From

1. 4Rx changes
    a. Terminate the Old Processor's 4Rx as of 12/31/2013 with CMS
    b. Report new 4Rx to CMS effective 01/01/2014. (A single 72 transaction can be used to report these changes. Reporting the effective date of the new 4Rx will automatically terminate the Old Processor 4Rx one day prior to the new 4Rx effective. Note: if the plan is not sending separate 51 and 72 transactions for each beneficiary, a 51 must be sent if the beneficiary is not active with the plan at the first of the year.)

To

1. 4Rx changes
    a. Report new 4Rx effective date to CMS by placing 20140101 (CCYYMMDD) in the Effective Date field in position 64-71. A single 72 transaction can be used to report these changes.
        i. Reporting the Effective Date of the new 4Rx will automatically terminate the Old Processor 4Rx one day prior to the new 4Rx Effective Date.
        ii. Note: if the plan is not sending separate 51 and 72 transactions for each beneficiary, a 51 must be sent if the beneficiary is not active with the plan at the first of the year.
        iii. Note: Plans should not send 4Rx without an Effective Date as it will default to the file process date**.**
        iv. Any FIR transaction triggered on/after the Effective Date will be sent to the new 4Rx.

6.4 VERSION 4.Ø

Section "*CMS Guidance to Alternative Routing Scenarios*" has been added.