

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SUBMITTER ID	4-9	X(6)	6
3	FILE ID	10-19	X(10)	10
4	TRANS DATE	20-27	9(8)	8
5	PROD TEST CERT IND	28-31	X(4)	4
6	DDPS SYSTEM DATE	32-39	9(8)	8
7	DDPS SYSTEM TIME	40-45	9(6)	6
8	DDPS REPORT ID	46-50	X(5)	5
9	FILLER	51-1000	X(950)	950

DEFINITION / VALUES
"HDR"
Unique ID assigned by CMS.
Unique ID provided by Submitter.
Date of file transmission to PDFS.
<u>PROD, TEST, TS1K, CERT, or CT1K</u>
CCYYMMDD = DDPS file creation date
HHMMSS = DDPS file creation time
DDPS report identifier (Always '01').
Field is right-padded with spaces.
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SEQUENCE NO	4-10	9(7)	7
3	CONTRACT NO	11-15	X(5)	5
4	PBP ID	16-18	X(3)	3
5	DDPS SYSTEM DATE	19-26	9(8)	8
6	DDPS SYSTEM TIME	27-32	9(6)	6
7	DDPS REPORT ID	33-37	X(5)	5
8	FILLER	38-1000	X(963)	963

DEFINITION / VALUES
"BHD"
Must start with 0000001
Contract Number from submitted batch
Plan Benefit Package (PBP) ID from submitted batch
CCYYMMDD = DDPS file creation date
HHMMSS = DDPS file creation time
DDPS report identifier (Always '01'). Field is right-padded with spaces.
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1 - 3	X(3)	3
2	SEQUENCE NO	4 - 10	9(7)	7
3	CLAIM CONTROL NUMBER	11 - 50	X(40)	40
4	MEDICARE BENEFICIARY IDENTIFIER	51 - 70	X(20)	20
5	CARDHOLDER ID	71 - 90	X(20)	20
6	PATIENT DATE OF BIRTH (DOB)	91 - 98	9(8)	8
7	PATIENT GENDER CODE	99 - 99	9(1)	1
8	DATE OF SERVICE (DOS)	100 - 107	9(8)	8
9	PAID DATE	108 - 115	9(8)	8
10	PRESCRIPTION SERVICE REFERENCE NO	116 - 127	9(12)	12
11	PRODUCT SERVICE ID	128 - 167	X(40)	40
12	FILLER	168 - 197	X(30)	30
13	SERVICE PROVIDER ID QUALIFIER	198 - 199	X(2)	2
14	SERVICE PROVIDER ID	200 - 214	X(15)	15
15	FILL NUMBER	215 - 216	9(2)	2
16	FILLER	<u>217 - 217</u>	<u>X(1)</u>	<u>1</u>
17	COMPOUND CODE	218 - 218	9(1)	1

18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	219 - 219	X(1)	1
19	ORIGINALLY PRESCRIBED QUANTITY	220 - 229	9(7)V999	10
20	QUANTITY DISPENSED	230 - 239	9(7)V999	10
21	FILLER	240 - 242	X(3)	3
22	DAYS SUPPLY	243 - 245	9(3)	3
23	PRESCRIBER ID QUALIFIER	246 - 247	X(2)	2
24	PRESCRIBER ID	248 - 282	X(35)	35
25	DRUG COVERAGE STATUS CODE	283 - 283	X(1)	1
26	ADJUSTMENT DELETION CODE	284 - 284	X(1)	1

27	NON- STANDARD FORMAT CODE	285 - 285	X(1)	1
28	PRICING EXCEPTION CODE	286 - 286	X(1)	1
29	PART D MODEL INDICATOR	287 - 288	X(2)	2
<u>30</u>	<u>MEDICARE PRESCRIPTION PAYMENT PLAN INDICATOR</u>	<u>289 - 289</u>	<u>X(1)</u>	<u>1</u>
<u>31</u>	FILLER	<u>290 - 314</u>	<u>X(25)</u>	<u>25</u>
<u>32</u>	CATASTROPHIC COVERAGE CODE	315 - 315	X(1)	1
<u>33</u>	INGREDIENT COST PAID	316 - 326	S9(9)V99	11
<u>34</u>	DISPENSING FEE PAID	327 - 337	S9(9)V99	11
<u>35</u>	TOTAL AMOUNT ATTRIBUTED TO SALES TAX	338 - 348	S9(9)V99	11

<u>36</u>	ESTIMATED REMUNERATION AT POS AMOUNT (ERPOSA)	349 - 359	S9(9)V99	11
<u>37</u>	PHARMACY PRICE CONCESSIONS AT POS	360 - 370	S9(9)V99	11
<u>38</u>	VACCINE ADMINISTRATION FEE OR ADDITIONAL DISPENSING FEE	371 - 381	S9(9)V99	11
<u>39</u>	FILLER	382 - 436	X(55)	55
<u>40</u>	GROSS DRUG COST BELOW OUT-OF-POCKET THRESHOLD (GDCB)	437 - 447	S9(9)V99	11
<u>41</u>	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)	448 - 458	S9(9)V99	11
<u>42</u>	PATIENT PAY AMOUNT	459 - 469	S9(9)V99	11

<u>43</u>	OTHER TROOP AMOUNT	470 - 480	S9(9)V99	11
<u>44</u>	LOW INCOME COST SHARING SUBSIDY AMOUNT (LICS)	481 - 491	S9(9)V99	11
<u>45</u>	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)	492 - 502	S9(9)V99	11
<u>46</u>	COVERED D PLAN PAID AMOUNT (CPP)	503 - 513	S9(9)V99	11
<u>47</u>	NON COVERED PLAN PAID AMOUNT (NPP)	514 - 524	S9(9)V99	11
<u>48</u>	<u>SELECTED DRUG SUBSIDY</u>	525 - 535	S9(9)V99	11
<u>49</u>	REPORTED MANUFACTURER DISCOUNT	536 - 546	S9(9)V99	11
<u>50</u>	REPORTED GAP DISCOUNT	547 - 557	S9(9)V99	11
<u>51</u>	FILLER	558 - 623	X(66)	66
<u>52</u>	TOTAL GROSS COVERED DRUG COST ACCUMULATOR	624 - 634	S9(9)V99	11
<u>53</u>	FILLER	635 - 636	X(2)	2
<u>54</u>	TRUE OUT-OF-POCKET ACCUMULATOR	637 - 647	S9(9)V99	11
<u>55</u>	FILLER	<u>648 -660</u>	<u>X(13)</u>	<u>13</u>
<u>56</u>	OTHER TROOP AMOUNT INDICATOR	661 - 661	X(1)	1
<u>57</u>	BEGINNING BENEFIT PHASE	662 - 662	X(1)	1

<u>58</u>	ENDING BENEFIT PHASE	663 - 663	X(1)	1
<u>59</u>	PRESCRIPTION ORIGIN CODE	664 - 664	X(1)	1
<u>60</u>	DATE ORIGINAL CLAIM RECEIVED	665 - 672	9(8)	8
<u>61</u>	CLAIM ADJUDICATION BEGAN TIMESTAMP	673 - 698	X(26)	26
<u>62</u>	BRAND/GENERIC CODE	699 - 699	X(1)	1
<u>63</u>	TIER	700 - 700	X(1)	1
<u>64</u>	FORMULARY CODE	701 - 701	X(1)	1

<u>65</u>	PHARMACY SERVICE TYPE	702 - 703	X(2)	2
<u>66</u>	PATIENT RESIDENCE	704 - 705	X(2)	2
<u>67</u>	SUBMISSION TYPE CODE 1	706 - 707	X(2)	2
<u>68</u>	SUBMISSION TYPE CODE 2	708 - 709	X(2)	2
<u>69</u>	SUBMISSION TYPE CODE 3	710 - 711	X(2)	2

<u>70</u>	SUBMISSION TYPE CODE 4	712 - 713	X(2)	2
<u>71</u>	SUBMISSION TYPE CODE 5	714 - 715	X(2)	2
<u>72</u>	SUBMISSION CLARIFICATION CODE 1	716 - 718	X(3)	3

<u>73</u>	SUBMISSION CLARIFICATION CODE 2	719 - 721	X(3)	3
-----------	------------------------------------	-----------	------	---

<u>74</u>	SUBMISSION CLARIFICATION CODE 3	722 - 724	X(3)	3
-----------	------------------------------------	-----------	------	---

<u>75</u>	SUBMISSION CLARIFICATION CODE 4	725 - 727	X(3)	3
-----------	------------------------------------	-----------	------	---

<u>76</u>	SUBMISSION CLARIFICATION CODE 5	728 - 730	X(3)	3
<u>77</u>	LTPAC DISPENSE FREQUENCY	731 - 732	X(2)	2

<u>78</u>	ADJUSTMENT REASON CODE QUALIFIER	733 - 733	X(1)	1
<u>79</u>	ADJUSTMENT REASON CODE	734 - 745	X(12)	12
<u>80</u>	FILLER	746 - 829	X(84)	84
<u>81</u>	CMS CALCULATED GAP DISCOUNT	830 - 840	S9(9)V99	11
<u>82</u>	CMS CALCULATED MANUFACTURER DISCOUNT	841 - 851	S9(9)V99	11
<u>83</u>	APPLICABLE DISCOUNT PERCENTAGE FOR SPECIFIED SMALL MANUFACTURER DRUGS	852 - 853	X(2)	2
<u>84</u>	APPLICABLE DISCOUNT PERCENTAGE FOR SPECIFIED MANUFACTURER DRUGS DISPENSED TO LIS BENEFICIARIES	854 - 855	X(2)	2
<u>85</u>	FILLER	856 - 895	X(40)	40
<u>86</u>	ALTERNATE SERVICE PROVIDER ID QUALIFIER	896 - 897	X(2)	2
<u>87</u>	ALTERNATE SERVICE PROVIDER ID	898 - 912	X(15)	15

<u>88</u>	ORIGINAL SUBMITTING CONTRACT	913 - 917	X(5)	5
<u>89</u>	CORRECTED MEDICARE BENEFICIARY IDENTIFIER	918 - 937	X(20)	20
<u>90</u>	P2P CONTRACT OF RECORD	938 - 942	X(5)	5
<u>91</u>	PBP OF RECORD	943 - 945	X(3)	3
<u>92</u>	ERROR COUNT	946 - 947	9(2)	2
<u>93</u>	ERROR 1	948 - 950	X(3)	3
<u>94</u>	ERROR 2	951 - 953	X(3)	3
<u>95</u>	ERROR 3	954 - 956	X(3)	3
<u>96</u>	ERROR 4	957 - 959	X(3)	3
<u>97</u>	ERROR 5	960 - 962	X(3)	3
<u>98</u>	ERROR 6	963 - 965	X(3)	3
<u>99</u>	ERROR 7	966 - 968	X(3)	3
<u>100</u>	ERROR 8	969 - 971	X(3)	3
<u>101</u>	ERROR 9	972 - 974	X(3)	3
<u>102</u>	ERROR 10	975 - 977	X(3)	3
<u>103</u>	EXCLUSION REASON CODE	978 - 980	X(3)	3
<u>104</u>	FILLER	981 - 1000	X(20)	20

DEFINITION / VALUES
"ACC", "REJ", or "INF"
Must start with 0000001
A number assigned by the plan to identify the prescription drug event. This is an optional field. *non-numeric values should be left justified.
Medicare Health Insurance Claim Number (HICN) or Railroad Retirement Board (RRB) number or Medicare Beneficiary Identifier
Plan identification of the enrollee. Assigned by plan. *non-numeric values should be left justified.
Optional field. If populated, the format is CCYYMMDD.
Valid values are: 1 = M 2 = F
CCYYMMDD
The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans. If populated, the format is CCYYMMDD.
Applies to all PDEs with a DOS >= 01/01/2011. Field is right justified and filled with 5 leading zeros.
Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 29 spaces. Format is MMMMMDDDDPP reject the following billing codes for compounded legend and/or scheduled drugs with a value of: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, or 99999999996.
SPACES
The type of pharmacy provider identifier used in field 14. Valid values are: 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number 99 = Other (For DOS < 01/01/2025, Reported Gap Discount must = 0; for DOS >= 01/01/2025, Manufacturer Discount must = 0) Mandatory for standard format. For standard format, valid values are 01 or 07. For non-standard format any of the above values are acceptable.
When Plans report Service Provider ID Qualifier = 99, populate Service Provider ID with the default value PAPERCLAIM defined in the Facilitation Contract. When Plans report Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report dashes). * non-numeric values should be left justified.
Valid values are: 0 – 99 If unavailable, use zero.
SPACE
Valid values are: 0 = Not specified 1 = Not a Compound 2 = Compound

Valid values are:

0 = No Product Selection Indicated

1 = Substitution Not Allowed by Prescriber

2 = Substitution Allowed - Patient Requested Product Dispensed

3 = Substitution Allowed - Pharmacist Selected Product Dispensed

4 = Substitution Allowed - Generic Drug Not in Stock

5 = Substitution Allowed - Brand Drug Dispensed as Generic

6 = Override

7 = Substitution Not Allowed - Brand Drug Mandated by Law

8 = Substitution Allowed - Generic Drug Not Available in Marketplace

9 = Other

Required for Schedule II drugs that are reported as standard, electronically-submitted PDEs with a DOS $\geq$ 01/01/2025. This contain the originally prescribed quantity. Must be zero for DOS $<$ 01/01/2025, or for non-Schedule II PDEs.

Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed; quantity in the unit form of the final state of the resulting compound.

SPACES

Valid values are:

0 - 999

The type of prescriber identifier used in field 24.

For PDEs with a DOS $\geq$ 01/01/2013, the value of 01 is mandatory for all formats.

For PDEs with a DOS $<$ 01/01/2013, valid values are:

01 = National Provider Identifier (NPI)

06 = UPIN

08 = State License Number

12 = Drug Enforcement Administration (DEA) number

Mandatory for standard format.

Mandatory for Non-Standard Format for PDEs with a DOS $\geq$ 01/01/2012

For PDEs with a DOS $<$ 01/01/2012, optional when the Non-Standard Format Code = B, C, P, or X, but must be a valid value if present

Mandatory

* non-numeric values should be left justified.

Coverage status of the drug under Part D and/or the PBP. Valid values are:

C = Covered

E = Supplemental drugs (reported by Enhanced Alternative plans only)

O = Over-the-counter drugs

Valid values are:

A = Adjustment

D = Deletion

SPACE = Original PDE

Format of claims originating in a non-standard format. Valid values are:

A = Medicaid subrogation claim

B = Beneficiary submitted claim

C = COB claim

P = Paper claim from provider

X = X12 837

SPACE = NCPDP electronic format

Valid Values are:

M= Medicare as Secondary

Payer

O = Out-of-network pharmacy (Medicare is Primary)

SPACE = In-network pharmacy (Medicare is Primary)

Plan reported value indicating the Part D Model type applied to the PDE. Valid values are:

01 = Value-based Insurance Design (VBID) Model

07 = Part D Senior Savings (PDSS) Model

SPACES = No Part D Model applied

For PDSS model eligible PDEs submitted by Plans participating in the PDSS Model, this field is required to be populated with 07 or 08 for PDEs with a DOS >= 01/01/2022 and a DOS <= 12/31/2023.

For VBID model eligible PDEs submitted by Plans participating in a VBID Model, this field is required to be populated with 01 or 02 for PDEs with a DOS >= 01/01/2023. This field is optional for VBID eligible PDEs with a DOS < 01/01/2023.

Applies to covered drugs only.

For non-model PDEs submitted by Plans participating in a Part D Model, and for PDEs submitted by Plans that are not participating in a Part D Model, this field must contain SPACES.

Required for PDEs with a DOS >= 01/01/2025 that are included in the Medicare Prescription Payment Plan. Valid values are:

Y = PDE is included in the Medicare Prescription Payment Plan

SPACE = PDE is not included in the Medicare Prescription Payment Plan

For DOS < 01/01/2025, this field must contain a SPACE.

SPACES

Optional for PDEs with a DOS >= 01/01/2011. Mandatory on PDEs with a DOS < 01/01/2011. Valid values are:

A = Attachment Point met on this event

C = Above Attachment Point

SPACE = Attachment Point not met

Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.

Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee is reported in Field 37. Dispensing Fee is reported in Field **38**.

Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.

For PDEs with a DOS $\geq$ 01/01/2025, this field contains the estimated amount of remuneration that are not pharmacy price concessions that the plan sponsor is required to apply, or has elected to apply, to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale (POS). This estimate includes the rebate or other price concession amount that the plan sponsor expects to receive from a pharmaceutical manufacturer or other non-pharmacy entity and has elected to apply to the negotiated price. This estimate does not include pharmacy price concessions applied at the point of sale, which must be reported in the "Pharmacy Price Concessions at POS" field.

For PDEs with a DOS $\geq$ 01/01/2024 and a DOS $\leq$ 12/31/2024, this estimate must reflect the maximum amount of any contingent payments or adjustments that the plan sponsor might receive from a network pharmacy that would serve to decrease the total amount that the plan sponsor pays for the drug, i.e., all pharmacy price concessions. This estimate must also reflect the rebate or other price concession that the plan sponsor expects to receive from a pharmaceutical manufacturer or other non-pharmacy entity and has elected to apply to the negotiated price.

For PDEs with a DOS $<$ 01/01/2024, this field must contain the estimated amount of rebates and/or other price concessions that the plan sponsor is required to apply, or has elected to apply, to the negotiated price as a reduction in the drug price made available to the beneficiary at the POS.

When there is no rebate or price concession made available to the beneficiary at the POS, this field may be zero dollars. This field must contain a positive dollar amount; the field may never be negative.

For PDEs with a DOS $\geq$ 01/01/2025, this field must contain the maximum amount of any contingent payments or adjustments that the plan sponsor might receive from a network pharmacy that would serve to decrease the total amount that the plan sponsor pays for the drug, i.e., all pharmacy price concessions. All other estimated remuneration applied at the POS must be reported in the "Estimated Remuneration at POS Amount (ERPOSA)" field. This field must contain a positive dollar amount, or zero dollars when there is no price concession applied at the POS; the field may never be negative. For PDEs with a DOS $<$ 01/01/2025, this field must be zero.

This field reports the amount the plan paid the pharmacy for administering a vaccination. For PDEs with a DOS $\geq$ 01/01/2008, a value must be reported if there is a vaccine administration fee or additional Emergency Use Authorization (EUA) dispensing fee charged. For PDEs with a DOS $<$ 01/01/2008, this field must be zero. This field may also include amounts of additional dispensing fees paid for EUA oral antiviral medications procured by the U.S. Government, over and above what was reported in the "Dispensing Fee Paid" field.

SPACES

Reports covered drug cost at or below the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCA. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee.

For PDEs with a DOS $<$ 01/01/2011, when the Catastrophic Coverage Code = SPACE, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee. When the Catastrophic Coverage Code = A, this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee falling at or below the OOP threshold. Any remaining portion is reported in GDCA. This amount increments the Total Gross Covered Drug Cost Accumulator amount.

Reports covered drug cost above the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCE. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee.

For PDEs with a DOS $<$ 01/01/2011, when the Catastrophic Coverage Code = C, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee above the OOP threshold. When the Catastrophic Coverage Code = A, this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee falling above the OOP threshold. Any remaining portion is reported in GDCE. This amount increments the Total Gross Covered Drug Cost Accumulator amount.

Payments made by the beneficiary or by family or friends at point of sale. This amount increments the True Out-of-Pocket (TROOP) Accumulator amount.

Other health insurance payments by TrOOP-eligible other payers (e.g., SPAPs). **This field records all third-party payments that a beneficiary's TrOOP except LICs, Patient Pay Amount, and the Reported Gap Discount (for PDEs with a DOS < 01/01/2025)** increments the True Out-of-Pocket Accumulator amount. For PDEs with a DOS >= 01/01/2023 and DOS <= 12/31/2023, this field includes the Inflation Reduction Act Subsidy Amount (IRASA). When this field contains IRASA, the Other TrOOP Amount Indicator field must be reported with a value of S or B.

Amount the plan advanced at point-of-sale due to a beneficiary's LI status. This amount increments the True Out-of-Pocket Accumulator amount.

Amount by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in the plan.

The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and Over-the-Counter drugs are excluded from this field.

The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is used in risk corridor calculations.

Required for PDEs with a DOS >= 01/01/2026. The reported subsidy amount that the plan sponsor advanced at point of sale for the drug in the Initial Coverage Period. This field must contain a positive dollar amount, or zero dollars when there is no Selective Drug Exemption applied at the POS; the field may never be negative. On PDEs with a DOS < 01/01/2026, must be zero. This amount will not increment the True Out-of-Pocket Accumulator amount.

Required for PDEs with a DOS >= 01/01/2025. The reported amount that the plan sponsor advanced at point of sale for the Medicare Part D Discount for applicable drugs. On PDEs with a DOS < 01/01/2025, must be zero. This amount will not increment the True Out-of-Pocket Accumulator amount.

The reported amount that the plan sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024. On PDEs with a DOS < 01/01/2011 or PDEs with a DOS >= 01/01/2025, must be zero. This amount increments the True Out-of-Pocket Accumulator amount.

SPACES

Sum of the beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be zero.

SPACES

Sum of the beneficiary's incurred costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be zero.

SPACES

This code is used for PDEs with a DOS >= 01/01/2023 and a DOS <= 12/31/2023, when the Other TrOOP Amount includes Inflation Reduction Act Subsidy Amount (IRASA) dollars for benefit year 2023.

Valid values are:

B = indicates the amount reported in Other TrOOP field contains both IRASA and non-IRASA Other TrOOP amounts.

S = indicates the amount reported in Other TrOOP field contains only IRASA Other TrOOP amount.

SPACE = indicates amount reported in Other TrOOP field contains only non-IRASA Other TrOOP amount, if any; and for PDEs with a DOS < 01/01/2023 or for PDEs with a DOS >= 01/01/2024.

Required on PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024. Plan-defined benefit phase in effect immediately prior to the sponsor began adjudicating the individual claim being reported. Valid values are:

D = Deductible

N = Initial Coverage Period

G = Coverage Gap

C = Catastrophic

For PDEs with a DOS < 01/01/2011, must be SPACE. For PDEs with a DOS >= 01/01/2025, the value of G no longer applies, and must be reported as C. Applies to covered drugs only.

Required on PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024. Plan-defined benefit phase in effect upon the sponsor adjudication of the individual claim being reported. Valid values are:

D = Deductible

N = Initial Coverage Period

G = Coverage Gap

C = Catastrophic

For PDEs with a DOS < 01/01/2011, must be SPACE. For PDEs with a DOS >= 01/01/2025, the value of G no longer applies, and accepted. Applies to covered drugs only.

Valid values are:

1 = Written

2 = Telephone

3 = Electronic

4 = Facsimile

5 = Pharmacy

0 = Not Specified

SPACE = Unknown

For PDEs with a DOS >= 01/01/2010, only the values of 1, 2, 3, 4 or 5 are valid for the following scenarios:

1. PDEs that are standard claims (excluding Medicaid Subrogation) and Fill Number = 00

2. PACE claims with non-standard format code not in X, B, P or C and Fill Number = 00

Date sponsor received original claim. Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be SPACE. Required for all LI NET PDEs submitted on and after 01/01/2011, regardless of the DOS.

Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be SPACES or zero.

Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. Valid values are:

B = Brand

G = Generic

Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be a SPACE. Applies to covered drugs only.

Formulary tier in which the sponsor adjudicated the claim. Required on PDEs with a DOS >= 01/01/2011.

On PDEs with a DOS >= 01/01/2022, values must be 1-7 or a SPACE.

On PDEs with a DOS >= 01/01/2011 and DOS <= 12/31/2021, values must be 1-6 or a SPACE.

On PDEs with a DOS < 01/01/2011, must be a SPACE.

Applies to covered drugs only.

Indicates if the drug is on the plan's formulary. Valid values are:

F = Formulary

N = Non-Formulary

Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be a SPACE. Applies to covered drugs only.

Required on PDEs with a DOS >= 02/28/2013. Valid values are:

01 = Community/Retail Pharmacy Services
02 = Compounding Pharmacy Services
03 = Home Infusion Therapy Provider Services
04 = Institutional Pharmacy Services
05 = Long Term Care Pharmacy Services
06 = Mail Order Pharmacy Services
07 = Managed Care Organization Pharmacy Services
08 = Specialty Care Pharmacy Services
99 = Other

For PDEs with a DOS < 02/28/2013, valid values are SPACES or any of the valid values listed above.

For COB **or Medicaid Subrogation PDEs**, valid values are SPACES or any of the valid values listed above.

Required on PDEs with a DOS >= 02/28/2013. Valid values are:

00 = Not specified, other patient residence not identified below
01 = Home
03 = Nursing Facility
04 = Assisted Living Facility
06 = Group Home
09 = Intermediate Care Facility/Intellectual Disability
11 = Hospice

For DOS < 02/28/2013, valid values are SPACES or any of the valid values listed above.

For COB or **Medicaid Subrogation PDEs**, valid values are SPACES or any of the valid values listed above.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES

AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill

For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES

AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill

For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES

AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill

For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:

SPACES

AA = 340B Claims

AB = Split Billing

AD = Nominal Price

AF = Synchronization Fill

AG = Trial Fill

For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:

SPACES

AA = 340B Claims

AB = Split Billing

AD = Nominal Price

AF = Synchronization Fill

AG = Trial Fill

For PDEs with a DOS < 01/01/2025, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value is reported, Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:

SPACES

16 = Long Term Care (LTC) emergency box (kit) or automated dispensing machine

21 = LTC dispensing: 14 days or less not applicable

22 = LTC dispensing: 7 days

23 = LTC dispensing: 4 days

24 = LTC dispensing: 3 days

25 = LTC dispensing: 2 days

26 = LTC dispensing: 1 day

27 = LTC dispensing: 4-3 days

28 = LTC dispensing: 2-2-3 days

29 = LTC dispensing: daily and 3-day weekend

30 = LTC dispensing: Per shift dispensing

31 = LTC dispensing: Per med pass dispensing

32 = LTC dispensing: PRN on demand

33 = LTC dispensing: 7 day or less cycle not otherwise represented

34 = LTC dispensing: 14 days dispensing

35 = LTC dispensing: 8-14 day dispensing method not listed above

36 = LTC dispensing: dispensed outside short cycle, determined to be Medicare Part D after originally submitted to another payor

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACES with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value is reported, Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:
SPACES

16 = Long Term Care (LTC) emergency box (kit) or automated dispensing machine

21 = LTC dispensing: 14 days or less not applicable

22 = LTC dispensing: 7 days

23 = LTC dispensing: 4 days

24 = LTC dispensing: 3 days

25 = LTC dispensing: 2 days

26 = LTC dispensing: 1 day

27 = LTC dispensing: 4-3 days

28 = LTC dispensing: 2-2-3 days

29 = LTC dispensing: daily and 3-day weekend

30 = LTC dispensing: Per shift dispensing

31 = LTC dispensing: Per med pass dispensing

32 = LTC dispensing: PRN on demand

33 = LTC dispensing: 7 day or less cycle not otherwise represented

34 = LTC dispensing: 14 days dispensing

35 = LTC dispensing: 8-14 day dispensing method not listed above

36 = LTC dispensing: dispensed outside short cycle, determined to be Medicare Part D after originally submitted to another payor

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACES. For PDEs with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value is reported, Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:
SPACES

16 = Long Term Care (LTC) emergency box (kit) or automated dispensing machine

21 = LTC dispensing: 14 days or less not applicable

22 = LTC dispensing: 7 days

23 = LTC dispensing: 4 days

24 = LTC dispensing: 3 days

25 = LTC dispensing: 2 days

26 = LTC dispensing: 1 day

27 = LTC dispensing: 4-3 days

28 = LTC dispensing: 2-2-3 days

29 = LTC dispensing: daily and 3-day weekend

30 = LTC dispensing: Per shift dispensing

31 = LTC dispensing: Per med pass dispensing

32 = LTC dispensing: PRN on demand

33 = LTC dispensing: 7 day or less cycle not otherwise represented

34 = LTC dispensing: 14 days dispensing

35 = LTC dispensing: 8-14 day dispensing method not listed above

36 = LTC dispensing: dispensed outside short cycle, determined to be Medicare Part D after originally submitted to another payor

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACES.
with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value is reported, Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:
SPACES

16 = Long Term Care (LTC) emergency box (kit) or automated dispensing machine

21 = LTC dispensing: 14 days or less not applicable

22 = LTC dispensing: 7 days

23 = LTC dispensing: 4 days

24 = LTC dispensing: 3 days

25 = LTC dispensing: 2 days

26 = LTC dispensing: 1 day

27 = LTC dispensing: 4-3 days

28 = LTC dispensing: 2-2-3 days

29 = LTC dispensing: daily and 3-day weekend

30 = LTC dispensing: Per shift dispensing

31 = LTC dispensing: Per med pass dispensing

32 = LTC dispensing: PRN on demand

33 = LTC dispensing: 7 day or less cycle not otherwise represented

34 = LTC dispensing: 14 days dispensing

35 = LTC dispensing: 8-14 day dispensing method not listed above

36 = LTC dispensing: dispensed outside short cycle, determined to be Medicare Part D after originally submitted to another payor

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACES with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:
SPACES

16 = Long Term Care (LTC) emergency box (kit) or automated dispensing machine

21 = LTC dispensing: 14 days or less not applicable

22 = LTC dispensing: 7 days

23 = LTC dispensing: 4 days

24 = LTC dispensing: 3 days

25 = LTC dispensing: 2 days

26 = LTC dispensing: 1 day

27 = LTC dispensing: 4-3 days

28 = LTC dispensing: 2-2-3 days

29 = LTC dispensing: daily and 3-day weekend

30 = LTC dispensing: Per shift dispensing

31 = LTC dispensing: Per med pass dispensing

32 = LTC dispensing: PRN on demand

33 = LTC dispensing: 7 day or less cycle not otherwise represented

34 = LTC dispensing: 14 days dispensing

35 = LTC dispensing: 8-14 day dispensing method not listed above

36 = LTC dispensing: dispensed outside short cycle, determined to be Medicare Part D after originally submitted to another payor

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACES with a DOS < 02/28/2013, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. **Used** for long-term and post-acute care short-cycle (LTPAC) dispensing. Valid values are:
SPACES

1 = Medication dispensed in a day-supply increment equal to the billed days supply (for example: medication dispensed for a 30-day supply and billed for a 30-day supply).

2 = 7 days - dispenses medication in 7-day supplies.

3 = 4 days - dispenses medication in 4-day supplies.

4 = 3 days - dispenses medication in 3-day supplies.

5 = 2 days - dispenses medication in 2-day supplies.

6 = 1 day - dispenses medication in 1-day supplies.

7 = 4-3 days - dispenses medication in 4-day, then 3-day supplies.

8 = 2-2-3 days - dispenses medication in 2-day, then 2-day, then 3-day supplies.

9 = Daily and 3-day weekend - dispensed daily during the week and combines multiple days dispensing for weekends.

10 = Per shift dispensing (multiple med passes).

11 = Per med pass dispensing.

12 = PRN on demand.

13 = 7-day or less cycle not otherwise represented.

14 = 14 days dispensing - dispenses medication in 14-day supplies.

15 = 8-14-Day dispensing cycle not otherwise represented.

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS < 01/01/2025, must be SPACES.

For PDEs with a DOS >= 11/13/2016 and a DOS <= 12/31/2024, the type of Adjustment Reason Code used in field 79. Valid values are:

- 2 = CMS Audit
- 3 = CMS Identified Overpayment (CIO)
- 4 = CGDP Dispute or Appeal
- 9 = Other
- SPACE = Not Applicable

The Adjustment Reason Code Qualifier of 1 has been removed from the list of valid values for PDEs with a DOS >= 11/13/2016 and will not be accepted.

The Adjustment Reason Code Qualifiers of 3, 4, and 9 have been removed from the list of valid values for PDEs with a DOS >= 11/13/2016 and will not be accepted.

For PDEs with a DOS >= 11/13/2016 and a DOS <= 12/31/2024, this code will assist CMS to track the reason for an adjustment. Accepted values are dependent upon the adjustment reason code qualifier submitted in field 78. Valid values are:

- If the qualifier = 2, the valid value is: OFM, RAC, or MEDIC
- If the qualifier = 3, the valid value is: CIO
- If the qualifier = 4, the valid value is: DISPUTE or APPEAL
- If the qualifier = 9, the valid value is: For future use at CMS' direction
- If the qualifier = SPACES, the valid value is: SPACES

* Non-numeric values should be left justified

The Adjustment Reason Code Qualifier of 1 has been removed from the list of valid values for PDEs with a DOS >= 11/13/2016 and will not be accepted.

The Adjustment Reason Codes of CIO, DISPUTE or APPEAL, and For Future use at CMS' direction have been removed from the list of valid values for PDEs with a DOS >= 01/01/2025, and will not be accepted.

SPACES

For PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024, the Gap Discount Amount calculated by CMS during on-line PDE editing based on data reported in the PDE.

For PDEs with a DOS >= 01/01/2025, the Manufacturer Discount Amount calculated by CMS during on-line PDE editing based on data reported on the PDE.

For PDEs with a DOS >= 01/01/2025, the phased-in Manufacturer Discount percentage that applies for the benefit year of the specified small manufacturer drugs, as provided by the statute.

For PDEs with a DOS >= 01/01/2025, the phased-in Manufacturer Discount percentage that applies for the benefit year of the specified manufacturer drugs dispensed to Low Income Subsidy (LIS) eligible beneficiaries, as provided by the statute.

SPACES

The Alternate Service Provider ID Qualifier cross-referenced by CMS to the Service Provider ID submitted on the PDE. Valid values are:

- 01 = NPI (if the Service Provider ID Qualifier submitted on PDE = 07)
- 07 = NCPDP Provider ID (if the Service Provider ID Qualifier submitted on PDE = 01)

The Alternate Service Provider ID cross-referenced by CMS to the Service Provider ID submitted on the PDE. Corresponds to the Service Provider ID Qualifier.

Contract that submitted the previously accepted PDE (in conjunction with edit 784).

Populated with Medicare Beneficiary Identifier (MBI) if HICN was received on PDE submission file or the beneficiary MBI has changed according to CMS records.

Contract of Record for accepted P2P PDEs

PBP of Record assigned by CMS during P2P Update Process. Returned only when the PBP of Record changes from the time the contract was processed and accepted by CMS.

Count of errors encountered during processing

First error encountered during processing

Second error encountered during processing

Third error encountered during processing

Fourth error encountered during processing

Fifth error encountered during processing

Sixth error encountered during processing

Seventh error encountered during processing

Eighth error encountered during processing

Ninth error encountered during processing

Tenth error encountered during processing

Subcategory reject code for an NDC Error Code of 738 identified in Errors 1-10.

SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SUBMITTER ID	4-9	X(6)	6
3	FILE ID	10-19	X(10)	10
4	TLR BHD RECORD TOTAL	20-28	9(9)	9
5	TLR DET RECORD TOTAL	29-37	9(9)	9
6	TLR DET ACCEPTED RECORD TOTAL	38-46	9(9)	9
7	TLR DET INFORMATIONAL RECORD TOTAL	47-55	9(9)	9
8	TLR DET REJECTED RECORD TOTAL	56-64	9(9)	9
9	FILLER	65-1000	X(936)	936

DEFINITION / VALUES
"TLR"
Must match HDR
Must match HDR
Total count of BHD records
Total count of DET records
Total count of ACC records as determined by DDPS processing
Total count of INF records as determined by DDPS processing
Total count of REJ records as determined by DDPS processing
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SEQUENCE NO	4-10	9(7)	7
3	CONTRACT NO	11-15	X(5)	5
4	PBP ID	16-18	X(3)	3
5	DET RECORD TOTAL	19-25	9(7)	7
6	DET ACCEPTED RECORD TOTAL	26-32	9(7)	7
7	DET INFORMATIONAL RECORD TOTAL	33-39	9(7)	7
8	DET REJECTED RECORD TOTAL	40-46	9(7)	7
9	FILLER	47-1000	X(954)	954

DEFINITION / VALUES
"BTR"
Must match BHD. Must start with 0000001.
Must match BHD
Must match BHD
Total count of DET records
Total count of ACC records as determined by DDPS processing
Total count of INF records as determined by DDPS processing
Total count of REJ records as determined by DDPS processing
SPACES