FINANCIAL INFORMATION REPORTING QUESTIONS, ANSWERS AND EDITORIAL UPDATES

DOCUMENTATION

Guidance for the NCPDP Financial Information Reporting Standard Implementation Guide

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Financial Information Reporting Questions, Answers and Editorial Updates

Version 1.8

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1 PURPOSE OF THIS DOCUMENT

This document provides a consolidated reference point for questions that have been posed based on the review and implementation of the NCPDP Financial Information Reporting Standard Implementation Guide Version 1.0 and above, the Data Dictionary, and the External Code List. This document also addresses editorial changes made to these documents.

As members reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. These questions were addressed in the NCPDP Work Group 1 Financial Information Reporting Task Group calls with approval by the Work Group 1 Telecommunication during quarterly meetings.

Editorial changes include typographical errors, comments that do not match a field value, a reference pointer in error.

Any further modifications will be noted in this document. Business needs brought forward and further changes to the implementation guide will result in future versions. Editorial or clarification changes to the implementation guide, as well as format changes will be made to future versions of the Financial Information Reporting Standard. Clarifications that affect implementation of Financial Information Standard Implementation Guide will be cited in this document.

It should be noted that values may be added/changed/deleted in the External Code List on a quarterly basis. This allows the industry to adapt to business needs when values are needed.

The topics are in categories which provide a high level reference. For example, a category may be a Segment in the format, with a subcategory of a field in that segment. The question and answer is then posed for that field found in that segment. Where appropriate, the question may be the actual heading in the index for ease of research. *However, since questions may span topics, the reader is cautioned to search the entire document for other possible information.*

This document will continue to be updated as questions and answers or editorial changes are necessary.

Note: within the guide, when dollar fields and amounts are discussed, all digits may be seen for readability. When actually using the field, rules should be followed for the overpunch character, as applicable.

1.1 USE OF THIS DOCUMENT

This document should be used as a reference for the NCPDP ***Financial Information Reporting Standard Implementation Guide*** Version 1.0 and above as applicable. Questions and guidance pertain only to the use of this standard.

This document should not be confused with the NCPDP ***Telecommunication Version D and Above Questions, Answers and Editorial Updates*** which addresses questions for the NCPDP ***Telecommunication Standard Implementation Guide***.

1.1.1 HOW SOON SUPPORT THIS DOCUMENT?

Question:

Once the Financial Information Reporting Editorial document is published, how soon do implementers need to support?

Response:
When the Financial Information Reporting Editorial document is published, it is effective for use.

2 TRANSACTION FACILITATOR FUNCTIONS

Question:
What are the reasonability edits performed by the Transaction Facilitator on FIR transactions?

Response:
The industry has defined the Reject Codes that are appropriate for FIR transactions and edits have been put in place to support them. Rejected FIRs are reported on the Daily Cumulative FIR Aging Report. For more information, go to (http://medifacd.relayhealth.com/fir/reports).

Question:
If a Plan/Processor receives a FIR transaction from the Transaction Facilitator and processes it, and the response back to the Transaction Facilitator contains invalid data (syntax error, a required field missing in the response, etc.) what happens to the FIR sequence?

Response:
The FIR sequence stops and is reported on the Daily Cumulative FIR Aging Report with a T series reject code. For more information on the reject code, see
http://media.relayhealth.com/documents/FIR+Reject+Codes+Generated+by+the+Plan-Processor+or+Transaction+Facilitator.pdf

The Plan/Processor will show this transaction as being successfully processed and is not aware, except through the report, that the Transaction Facilitator received invalid information in the transaction response. The Plan should contact their Processor for resolution. Once resolved, the Plan/Processor may request a retrigger if the next scheduled sequence is not in a reasonable timeframe or the series has been concluded.

Question:
What does the Cardholder ID in the FIR Insurance Segment reflect for Medicare Part D?

Response:
Per the Transaction Facilitator Payer Sheet, the Cardholder ID is the plan's beneficiary identifier sent to CMS in the 4Rx data in the enrollment file. This may not be the HICN or the SSN or RRB. It is unique to each beneficiary.

Question:
What causes a FIR series to be initiated?

Response:
1. Any beneficiary that has a change in Contract ID during a plan year will initiate a new FIR series.
2. Any beneficiary that has a change in PBP ID with a change in either BIN, PCN or both will initiate a new FIR series.
3. Any beneficiary for which a proxy add was requested, by any plan that may have paid claims on behalf of the beneficiary, will always initiate a new series.
4. Any beneficiary for which a proxy edit was requested will trigger a FIR Sequence if a series is already under way. However if there is not an active series for the beneficiary a new series will be initiated.
5. A retrigger request, from any plan the beneficiary may have had during the plan year, will initiate a new sequence.

6. A beneficiary that has a FIR series "in flight" that also has a 4Rx or DOB change will generate a one time, on demand, FIR sequence on the day prior to the effective date of the change or the date of receipt of the change (whichever is later) if a FIR sequence is not already in queue on that day.

Question:
If I submit an inquiry or work request to the Transaction Facilitator relative to FIRs is the service level agreement of 48 hours applicable to business days or weekends?

Response:
This is 2 business days or 48 hours during business times.

Question:
Managing two benefit years in parallel - once we get into 2014, I believe that the Transaction Facilitator will provide us with transactions based on the 2014 benefit year as well as updates/changes to the 2013 benefit. For how longer into the new year/current benefit year will they continue to pass previous year updates?

Response:
The Transaction Facilitator will continue ATBT through March 31 for the prior plan year. Plans may request retriggers through May 29 to trigger on May 31. After that period no FIR transactions will be generated for the prior plan year.

Question:
How do we update information for audit off plans?

Response:
If you are a non-plan of record, you may request a proxy edit by completing the proxy edit form and submitting the form to the Transaction Facilitator. See http://medifacd.relayhealth.com/fir/non-plan-of-record

Question:
Timing of Retrigger Requests
Scenario:

- Member terminated 01/31/2013
- New plan is effective 02/01/2013
- Normal sequence process happens - FIR F1, transfer out, processed on 02/01/2013
- The remaining Transaction Facilitator's FIR F1 pings are received and posted on day 8, all the way thru day 118 (05/30/2013)
- Sometime after 05/30/2013 but before 12/01/2013 there is a claim adjustment to the beneficiary's accumulators.

Question:
Does the plan of record systematically request a retrigger of the F1 with Transaction Facilitator? If so, is it done within 45 days? Does it have to occur within 45 days? I am assuming it does since for past benefit years CMS is holding us to the 45 day rule after an adjustment. I always thought we could rely on the December 1, 2013 and January 15, 2014 auto retriggers from Transaction Facilitator but we won't be able to if there is a 45 day rule.

Response:
The current timing in the FIR process takes care of this. If it occurs after the last May manual retrigger request

or there is no subsequent scheduled automated FIR trigger or it is outside the ATBT timeframe, then the plan's policy dictates when to do the Post ATBT manual process.

Question:
How does "Pre-F" work? I have a FIR that rejected and originally the Pre-F was set to N on the Transaction Facilitator report. The most recent report has the Pre-F set to Y. Why wasn't the first report set to Y?

Response:
The cause of the reject on the first report is because the plan asking the question caused the reject.

Subsequent to the first report when the FIR was retriggered, another plan upstream caused the FIR to reject. The plan trying to fix the problem (the original N) will not be able to tell if the problem has been resolved until the upstream plan fixes their reject. (The retrigger needs to come from the upstream plan.)

Question:
My plan is not receiving FIR transactions for newly enrolled or dis-enrolled members. Should I be requesting a FIR retrigger?

Response:
No. The automated FIR process is designed to where Plans do not need to perform any additional research. Absent a request from CMS, another Part D Plan or a beneficiary complaint, no retrigger should be requested.

3 GENERAL AUTOMATED TROOP BALANCE TRANSFER (ATBT) PROCESSING QUESTIONS

Question:
Why is my plan (Plan A) getting included in a series more than once with the same transaction identifier?

Response:
If a beneficiary is in a plan for multiple enrollment occurrences within a calendar year, each occurrence will generate a FIR sequence in a series.

Series #1- This series occurs due to change in enrollment from Plan A to Plan B. The first sequence for this series will start March 31 assuming eligibility for Plan B is received prior to that date.

First Series	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Plan A 01/01/2012 to 03/31/2012 (F1)	100	200	50								
Plan B 04/01/2012 to 07/31/2012 (F2)											

Series #2 – This series occurs due to the change in enrollment from Plan B back to Plan A. The first sequence for this series will start on July 30th assuming eligibility for Plan A is received prior to that date. Note that the Series #1 is terminated because the change in enrollment started a new series.

Second Series	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Plan A 01/01/2012 to 03/31/2012 (F1)	100	200	50								
Plan B 04/01/2012 to 07/31/2012 (F3)				75	120	180	50				
Plan A 08/01/2012 to 09/30/2012 (F2)											

In Series #2, Plan A will receive two FIRs:

- F1 for the first period that they had the beneficiary
- F2 in order to load all prior accumulators including theirs when the beneficiary has rejoined Plan A.

Series #3 - This series occurs due to the change in enrollment from Plan A to Plan C. The first sequence for this series will start on September 30th assuming eligibility for Plan C is received prior to that date. Note that series #2 is now terminated because of a new change in enrollment.

Third Series	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Plan A 01/01/2012 to 03/31/2012 (F1)	100	200	50								
Plan B 04/01/2012 to 07/31/2012 (F3)				75	120	180	50				
Plan A 08/01/2012 to 09/30/2012 (F3)								100	200		
Plan C 10/01/2012 ongoing (F2)											

Because Plan A has the beneficiary for non-concurrent periods, they will receive two FIR transactions – an F1 and F3 in order to allow them to report accumulators for both non-concurrent periods. For this last scenario there are two possible methods for Plan A to respond to the FIR transactions.

Method 1
Series January through March

- Plan A may respond with January through March accumulators (F1 response)
- Plan B would respond with April through July accumulators for their plan and Plan A January through

March accumulators (F3 response)

- Plan A may then respond with January through March and August and September accumulators for their plan and Plan B April through July accumulators (F3 response)
- Plan C would receive all the accumulators from Plan A and Plan B from January through September (F2 request)

Method 2

- Plan A may respond with January through March accumulators and August through September accumulators (F1 response)
- Plan B would respond with April through July accumulators for their plan and Plan A January through March accumulators (F3 response)
- Plan A would then respond with January through March and August and September accumulators for their plan and Plan B April through July accumulators (F3 response)
- Plan C would receive all the accumulators from Plan A and Plan B from January through September (F2 request)

A plan who receives more than **one FIR transaction type in a sequence** for a beneficiary should exercise caution that regardless of Method identified above they use, they do not double the accumulators returned in the last response.

Question:
The FIR transaction standard states that we should re-process the FIR transaction in case any of our accumulations have changed, and not to just return the financial information from the original approved FIR transaction (which may have been timed out, hence the receipt of the duplicate). By doing that, we will be processing the duplicate as if the transaction is not a duplicate.

Response:
An 'A' would be returned because a Duplicate Transaction Code is not part of the FIR Transaction. Each FIR must reflect the balances as of the receipt of that FIR. While it may be possible that the balances are the same as the last FIR, the transaction is not a duplicate.

Question:
What should we do if we receive an inquiry for a member who currently has a negative value for TrOOP in our system?

Response:
The Transaction Facilitator will reject any negative values per CMS guidance, Chapter 14 negative values should be forced to zero in the FIR response.

Question:
How would we respond when F3 or F2 is received with other plan's dollars for a member that has null coverage (effective date = termination date) resulting in no coverage with the plan receiving the F3 for the plan year. In this example, this is an audit off. Do we load the dollars? On an F3, do we return zero for the null month or only the other plan's dollars?

Response:
1. This record most likely is an audit off record. As an audit off record, if there are no balances, then a proxy delete can be requested.
2. Because this is an F3 scenario, if the month being reported already has balances from a prior plan, the plan should return the balances they received. If the month being reported does not have balances from a prior plan, then at a minimum zero dollars must be placed in the first month of the effective date.

Question:
How should we respond when TrOOP Amount > Catastrophic limit for the corresponding year?

Response:
Do not reject if you receive dollars that are over TrOOP limit. (According to CMS guidance, sponsors should not question balances.)

Question:
If we receive an F2 transaction with accumulations past the member's eligibility date, should we reject this and if so, what reject code should be used? Scenario: Member has eligibility for Feb, Mar, Apr and we receive an F2 with values for May or afterwards. What should we do?

Response:
No you should not reject. You should accept the transaction and respond and only apply accumulators that are up to and through your effective coverage period.

Question:
If we receive an F1 transaction and respond with January accumulations of $100 TrOOP/$100 Drug Spend, and then later receive an F3 that shows January accumulations of $50 TrOOP/$100 Drug Spend, are we allowed to reject the F3? If we are not allowed to reject, what kind of accumulation adjustment is needed?

Response:
No, the plan may not reject the F3. The F3 response for January should reflect the combination of your TrOOP and Drug Spend and the accumulators for the prior plan. In this example you would respond for January with $150 TrOOP and $200 Drug Spend. This example is common when a non-plan of record paid for claims for a beneficiary.

Question:
How is the processor to determine the allocation of transfer-in dollars for plans that have a brand only deductible?

Response:
CMS guidance is not specific to this scenario. The FIR process does not differentiate brand or generic.

Question:
When a FIR comes in for a month where there is no active enrollment record for that patient, our platform currently rejects this FIR as a "52 – Non-matched Cardholder ID". For example, if the member's enrollment begins on February 1 and an F1, F2, or F3 comes in for this same member but for January, we will reject this FIR as "52 – Non-matched Cardholder ID".

Response:
If the beneficiary cannot be found at all on the system, Reject Code "52 – Non-matched Cardholder ID" is appropriate.

It is expected that eligibility received on a TRR is loaded promptly so that it is accessible at least one day before the beneficiary's effective date. The plan sponsor/processor should be able to accept FIRs one day prior to eligibility (assuming it has been received prior to the effective date) to allow accumulator totals to be transferred prior to the beneficiary being effective with the new plan. If the eligibility exists, a Reject Code "52" is not appropriate. Even though the beneficiary is not effective, the FIR should process successfully.

It is possible that a plan sponsor/processor is receiving FIRs because they have become a non-plan of record (retroactive termination resulting in no coverage for the beneficiary for that 4Rx combination). In that instance the plan sponsor/processor needs to respond to FIRs if they have balances on the beneficiary even if the beneficiary is no longer active in their system. If the plan sponsor/processor doesn't have balances, there are two options:

1) Respond to the FIR with a $0 balance in the first month or
2) Request a proxy delete so the beneficiary is removed from the FIR stream.

The plan sponsor/processor should not return a Reject Code "52". If the plan sponsor/processor did have the beneficiary at any time, the FIR should process successfully.

Question:
Med D Plan Sponsor A eligibility 1/1/12 – 2/28/12
Med D Plan Sponsor B eligibility 3/1/12 – 4/30/12
Med D Plan Sponsor A eligibility 5/1/12 – 12/31/12

During the 3/1/12 – 4/30/12 period, Sponsor B received F2 Transactions. Once the member left Sponsor B, they started receiving F3 Transactions. Sponsor B has no claims outside of their eligibility period.

It appears, that the member returned to Sponsor A, because accumulations are being returned on the F3 to Sponsor B that contain accumulations before and after the eligibility for Sponsor B.

How should the accumulations that are after the period of eligibility for Sponsor B be handled?
Should the dollars that come after the Sponsor B eligibility term date be applied towards the Sponsor B accumulations? Or should they be ignored for the Sponsor B accumulations?

Response:
The accumulators for months after Sponsor B termination should not be applied. While not applied, Sponsor B must return the values received for the subsequent months on the F3 response.

Question:
The following questions are all related to the CMS HPMS memo, "Updates regarding Automated TrOOP Balance Transfer and Plan-to-Plan Reconciliation" dated November 25, 2015.

All of members were enrolled with us in 2015, were disenrolled with a future effective date into the new plan, then retro-enrolled back into our plan with no break in coverage for the beneficiary. They were briefly enrolled with the new plan for a couple of months, incurred claims then were audited-off. The audit off disenrollment did not occur prior to the intended effective date but after the fact. Examples for purposes of illustrating scenarios for questions:

Plan A paid claims in January 2016
On February 1, 2016, Plan A retro-terms the member dating back to December 31, 2015 after the January 2016 claims were already paid.

Is it correct that Plan A must request a proxy enrollment for the member in Plan A for January 2016? Should the proxy enrollment cover only the time period for which Plan A incorrectly paid claims?

Response:
Proxy enrollment is done if the record is terminated prior to the effective date of the enrollment. If you paid and enrollment was terminated before the beneficiary was effective you need to proxy add. If there is a retroactive termination that occurs after the effective date it should be audited-off and you should not have to proxy add. If the disenrollment happened after the effective date of the record, you should not have to proxy add – there will be an audit-off. The proxy enrollment should be for the time period that you have paid claims.

Question:
Does this only apply in cases where the member's enrollment terms in a prior year? For example, if Plan A paid claims in Feb 2016, but the member's enrollment should have been terminated on Jan 31, 2016, then there is no need for the proxy enrollment? The ATBT process will work as designed?

Response:
Correct, you were active during the plan year and will receive a FIR.

Question:
Please advise what is the expectation from the plan of record plan, POR, once the audit-off spreadsheet is received from the audited-off plan?

Response:
The expectation is that the POR will negotiate payment of the plan pay amount.

Question:
Is the expectation for the POR to reimburse the plan portion to the audited-off plan for P2P reconciliation purposes in a manual fashion?

Response:
Either reimburse the plan pay amount or negotiate an amount that you'll reimburse based on your negotiated price.

Question:
If yes, how is the POR credit applied from CMS for the payment issued to the audited-off plan if it is not part of the current automated P2P reconciliation reports?

Response:
If the audited-off plan has a PDE in accepted status, it should be deleted if they receive payment from the plan. The POR can submit a PDE for the claim; if necessary, we can work with Amanda Johnson and her staff to work out the details.

Question:
If the PDE was originally accepted, however subsequent adjustments returned a 706 today the plan is unable to delete the PDE. Is there a mechanism to delete other than during the re-opening period or deadline period, i.e. during the year?

Response:
If the non-plan of record has received payment from plan of record, the claim should not be reversed it should only be deleted from reporting on the PDE. The pharmacy or beneficiary should not be impacted by this.

Question:
If FIR transactions already exist on file for the beneficiary that came from the audited-off plan, why wouldn't the automated P2P reconciliation process work via a 708?

Response:
The FIR process is completely separate from the P2P process. The P2P process requires that both plans be a POR; the audited-off plan does not meet this requirement.

Question:
If the MAPD helpdesk can provide the audit-off enrollment information from the MBD system, can the audited-off beneficiary be handled in an automated fashion via the P2P reconciliation process?

Response:
Same answer as above.

Question:
Does this new process only exist for beneficiaries who were enrolled in a new plan and then subsequently disenrolled prior to the expected effective date?

Response:
It exists for these situations, yes. However, I'm not certain that it's exclusive to these situations. Other examples where this may occur are listed in the Exceptions section of the NCPDP Medicare Part D Non-Plan of Record White Paper.

Question:
Or, should it also include any beneficiary who was audited-off after the intended effective date and the beneficiary was retro reenrolled back into their prior plan with no break in coverage?

Response:
This would generate a FIR transaction and possibly P2P recon depending on the timing of the audited off action.

Question:
If a member was audited off from a subsequent plan and the disenrollment was not timely that resulted in a 706 on the first submission verses a 708 (if this is possible) is the 706 error expected to also be part of this manual reconciliation process?

Response:
If the first PDE submission results in a 706 and it is determined the beneficiary is retroactively disenrolled the paid claim would be appropriate for the manual process.

Question:
For the manual payment requests, how far back can the request be made?

Response:
36 months from the date of request.

Question:
Per CMS guidance in the attached memo, it states plans are notified of audited-off enrollments "on the daily transaction reply report." Can you instruct me where to look for this on the TRR file? I was not able to locate information in the Plan Communication User Guide (PCUG). Is there a specific TRC I should be looking for?

Response:
TRR indicates "termed" not audited-off. A TRR termination date that is within the current plan year is not an audited-off. If the enrollment date is greater than the termination date this is an audited-off record. Additional methods for identifying an audited-off are PDE error code 706, 708 or 712 may indicate the potential for audited-off or the MARx eligibility tab or if not available in MARx request validation from MAPD Help Desk.

3.1 FIR REJECTS AND AGING

Question:
Plan A currently has FIR rejects and eligibility changes which starts a new series begins. Is the aging reset to 0?

Response:
Yes. Aging is based on the age of the rejection in a particular series. Even if an existing series never had a successful FIR transaction, the aging will be set to 0 when the new series begins.

3.2 TROOP AND GROSS DRUG SPEND

Question:
What happens if a FIR transaction response contains TrOOP greater than Gross Drug Spend?

Response:
The response accumulator values will not be passed to any subsequent plan. The Transaction Facilitator will report back to the submitter of the invalid response on their Daily Cumulative FIR Reject Report with a reject code "T*Z1" (TrOOP amount greater than gross amount).

Question:
Effective in 2014 there are scenarios where it is possible that TrOOP can exceed Gross Drug Spend. Will the edit identified above be lifted to allow these transactions to process?

Response:
Upon review with the industry and CMS, the edit will not be removed. It has been determined that the majority of these transactions that reject are due to processing errors and not actual benefit design that caused TrOOP to exceed Gross Drug Spend.

If a plan determines that they have received the "T*Z1" reject due to a benefit design that causes TrOOP to exceed Gross Drug Spend, the plan will need to use the Post ATBT process to manually transfer these balances. CMS will not include this reject code in their FIR transaction compliance monitoring, unless a change is warranted, because there is no way to resolve this in the case where TrOOP exceeding Gross Drug Spend is valid. See example 16 "EGWP plan in the ICP and the OHI benefit charges a higher copay than the defined standard benefit" in 12/13/2013 Prescription Drug Event Reporting Examples for Benefit Year 2014.
http://www.csscoperations.com/internet/cssc3.nsf/files/2014%20PDE%20Reporting%20Guidance%2012-13-2013.pdf/%24FIle/2014%20PDE%20Reporting%20Guidance%2012-13-2013.pdf

4 CLAIMS PAID AS NON-PLAN OF RECORD

Question:
A non-plan of record has received reimbursement from the plan of record. Does the non-plan of record still need to continue responding to FIR transactions?

Response:
All accumulators need to be transferred via the automated FIR process. The downstream payers still need to know the accumulator updates. The reimbursement from the plan of record only reflects a portion of the total claim cost (plan paid portion). The plan of record does not receive accumulator information on the P2P payable report therefore does not know the beneficiary's balances from the non-plan of record.

Question:
If a plan had the beneficiary and becomes the non-plan of record and has no accumulator dollars, how does the non-plan of record handle FIRs?

Response:
The non-plan of record should either:

1. Reject the FIR with a "65 " and request a proxy delete, or
2. Respond to the FIR with zero dollar accumulators.

See NCPDP *Post Automated TrOOP BalanceTransfer (ATBT) Process White Paper* at
http://www.ncpdp.org/Resources/Medicare-Part-D

Question:
If a member accumulated TrOOP and Drug spend in a Plan and then that Plan becomes Non POR (member retro termed), how does the Non-Plan of Record report those accumulators to the next Plan?

Response:
There are two Non-Plan of Record scenarios, one where a FIR is automatically generated and the second scenario is when the plan must request a Proxy Add in order to initiate the FIR. Both are covered in the Non-Plan of Record white paper. The white paper, labeled ***Medicare Part D Non-Plan of Record***, may be found at
http://www.ncpdp.org/Resources/Medicare-Part-D

5 GENERAL POST ATBT PROCESSING QUESTIONS

Question:
How do you handle transferring of TrOOP balances that need to occur after Automated TrOOP Balance Transfer Process has ended for a plan year?

Response:
See NCPDP ***Post Automated TrOOP Balance Transfer (ATBT) Process White Paper*** at
http://www.ncpdp.org/Resources/Medicare-Part-D

Question:
How long are Part D Plans responsible for transferring beneficiary's accumulators outside of the ATBT process?

Response:
The Part D Plan should have a policy of when the balances should be transferred. This policy should incorporate the 36 month timeframe. The Part D Plan does not need to transfer balances for more than 36 months.

Example: Currently July 2014 transferring balances as far back as January 1, 2011
3 plan years prior to the current plan year

Question:
I am outside of the ATBT process and need to transfer balances manually. Do I need to transfer balances for beneficiaries that only had FIR records (post ATBT)?

Response:
The Post ATBT transfer of beneficiary balances for only those beneficiaries for whom a FIR transaction has been received is consistent with the current intent and process.

6 APPEAL PROCESS RELATED TO ELIGIBILITY

6.1 RETROACTIVE DISENROLLMENT WHERE CMS ELIGIBILITY IS NOT UPDATED

Question:

How does a plan handle retroactive disenrollments that require CMS' vendor (i.e. Reed & Associates, etc.) to drop the record from MARx? These are retroactive disenrollments that are received after the beneficiary was active and eligible in the plan. This was not caused by a new plan taking over the enrollment period. It was most likely caused by the beneficiary notifying the plan that they did not want to enroll. When this occurs the plan disenrolls the beneficiary in their system and notifies the CMS' vendor to drop the record from MARx.

Response:

1. Until CMS receives and processes the Plan B retroactive disenrollment, Plan B is still the plan of record and must not reject the FIR.
2. Once CMS processes the Plan B retroactive disenrollment, then Plan B becomes an audit off record. Plan B can choose one of the following options for the audit off record.
    a. If there are no paid claims by Plan B, they can request a proxy delete of the audit off record or they can continue to process FIRs if their system is set up to handle FIRs regardless of effective period.
    b. If there are paid claims by Plan B, they must respond to the FIRs.

7 NON-CALENDAR YEAR PLAN QUESTIONS

Question:
Is there a requirement for plans to be calendar year based? Many employer group waiver plans (EGWP) are not calendar year.

Response:
No, there is no requirement for plans to be calendar year. FIRs are always calendar year. See CMS Chapter 14 for more information.

Question:
Since FIRs are only transmitted based on calendar year basis, are non-calendar year plans required to get TrOOP and gross drug spend information necessary from a prior year (that spans their benefit year). How is this done?

CMS Response: Non-calendar year EGWPs should apply TrOOP and gross covered drug costs from prior plans for months in a prior calendar year that are within the plan's coverage year in order to ensure the beneficiary gets credit for these amounts in the EGWP's administration of its benefit. EGWPs should request accumulator data from these prior plans on a periodic basis to ensure they have the most current data, rather than rely on EOB data which are not updated after the end of the calendar year. The Post ATBT spreadsheet can be used for this process.

Question:
Is there a situation where no FIR is generated when a beneficiary transfers from a non-calendar year plan into a calendar year plan?

Response:
Yes, provided the move between the non-calendar year plan and the calendar year plan is not January 1. January 1 is considered CMS' beginning of a plan year and changes at the beginning of a plan year do not initiate a FIR series.

For example:

> Beneficiary enrolled in Plan A (non-calendar year plan) July 1, 2011 – June 30, 2012. On January 1, 2012 the beneficiary enrolls in Plan B. Plan B is a calendar year plan with the benefit period starting January 1, 2012. Although the beneficiary was enrolled in a non-calendar year plan (Plan A) and had claims from July 1, 2011 – December 31, 2011, the claims would not apply to the 2012 calendar year plan (Plan B). Since this is the beginning of the calendar year and the new plan is a calendar year plan, the beneficiary is starting over; no FIR transactions would be necessary because there are no accumulators to transfer to Plan B.

Question:
If a beneficiary enrolls in a non-calendar year plan after the beginning of that plan's benefit period, how does the non-calendar year plan receive balances from the previous plan?

Response:
If the beneficiary enrolls in a non-calendar year plan before January 1, a FIR will be automatically generated for each plan that the beneficiary was enrolled in during the calendar year.

For example:

> Beneficiary enrolled in Plan A (calendar year plan) January 1 – November 30, 2012. On December 1, 2012 the beneficiary enrolls in Plan B. Plan B is a non-calendar year plan with the benefit period starting July 1, 2013. The beneficiary is enrolling five months into Plan B's benefit period. This is the same calendar year for FIRs. In this situation a FIR will be generated for Plan A. Plan B will receive balances for January through November, 2012. Those balances

include months that are prior to Plan B's benefit period (started in July, 2012). Plan B will need to handle this.

If the beneficiary enrolls in a non-calendar year plan on January 1, a FIR will not be automatically generated for any plan that the beneficiary was enrolled. Plan B would need to request balances from Plan A manually for the prior months covered by Plan A during Plan B's plan year.

For example:

Beneficiary enrolled in Plan A (calendar year plan) January 1 – December 31, 2012. On January 1, 2013, the beneficiary enrolls in Plan B. Plan B is a non-calendar year plan with the benefit period starting July 1, 2012. The beneficiary is enrolling six months into Plan B's non- calendar year 2012 benefit period. FIRs are based on a calendar year. In this instance, the January 1, 2013 enrollment is at the beginning of a new calendar year and even though the enrollment is six months into Plan B's non-calendar year 2012 benefit period, a FIR will not be generated because the calendar year for accumulators is January 1, 2013 in this example. Plan B should request the accumulators for July through December 2012 manually from Plan A for purposes of updating Plan B's benefit accordingly.

If the beneficiary enrolls in a non-calendar year plan on February 1, a FIR will be automatically generated for the new calendar year period (Plan A has coverage in January, Plan B has coverage in February). The FIR will only contain the month of January. For the prior calendar year months that Plan B's plan year (July – December) Plan B would need to request balances from Plan A manually for the prior months covered by Plan A during Plan B's plan year.

For example:

Beneficiary enrolled in Plan A (calendar year plan) January 1, 2012 – January 31, 2013. On February 1, 2013, the beneficiary enrolls in Plan B. Plan B is a non-calendar year plan with the benefit period starting July 1, 2012. The beneficiary is enrolling seven months into Plan B's non-calendar year 2012 benefit period. FIRs are based on a calendar year. In this instance, the February 1, 2013 enrollment is at the beginning of a new calendar year and will trigger a 2013 FIR. This FIR will only cover 2013 accumulators (the month of January) in this example. Plan B should request the accumulators for July through December 2012 manually from Plan A for purposes of updating Plan B's benefit accordingly.

This scenario would be the same for any enrollment between February and June 2013. The FIR will report all 2013 months accumulators prior to the new enrollment. Example, if new enrollment is May 2013, the FIR will contain accumulators of January through April 2013. Plan B will still need to request the accumulators from 2012 manually from Plan A.

8 FINANCIAL INFORMATION REPORTING STANDARD QUESTIONS

8.1 TRANSACTION ID UNIQUE

Question:
Is FIR Transaction ID unique on a per patient basis or just plain unique?

Response:
The Transaction ID (651-S2) is unique to a sequence. A sequence is all FIRs initiated on a particular date for a beneficiary.

A FIR sequence is initiated on 06/06/2013 and is sent to 3 plans. The sequence contains an F1, F3, and then an F2. All three FIR transactions will contain the same Transaction ID. The Transaction Facilitator embeds the date (YYYYMMDD) in the first eight bytes of the Transaction ID.

8.2 CANNOT PARSE FIR TRANSACTION REQUEST

Question:
If we receive a FIR transaction request that we cannot parse, how should we respond?

Response:
When rejecting in a scenario when you cannot parse the FIR transaction request appropriately, you should return a correctly formatted FIR response in the current version.

8.3 PROCESSING FIR TRANSACTIONS

Question:
Beneficiary turns 65 in February. He/she had no Part D benefit in January. He/she in Plan A in February and moves to Plan B in March. While enrolled in Plan A, no claims were processed. When Plan A receives the F1, should the response contain $0 TrOOP/$0 Drug Spend for February? Is it ok to report it for January?

Response:
You must report $0 TrOOP and Drug Spend for February. If you report $0 in January, the FIR will reject because the beneficiary had no Part D coverage. The guidance has always been that they send a $0 for the FIRST month of coverage in their plan if they had no paid claims. This avoids zeroing out someone else's balances if they are downstream from another plan.

Question:
If patient moves yet again (A-B-C scenario), can we confirm that when Plan B reports accumulations on the F3 response (F1 reported 0), the $0 January or February accumulations (dependent upon answer above) should not be reported when Plan B has $100/$100 to report for March, correct? (B should remove the $0 month and only submit the non-$0 months)

Response:
Plan B should report $0 in February and report $100/$100 in March.

Question:
Scenario:
Claim A has a date of service of 02/01/2013 and is processed on 02/02/2013.
Claim A is reversed on 12/30/2013.
Replacement Claim B still has a date of service (fill date) of 02/01/2013, but is processed on 01/20/2014. (Many PBMs do not match up replacement claims with the original claim)

Since the industry and CMS recognizes that we process claims in the order they are received and not by date of service, for which month would Claim B be accumulated in for a FIR transaction? Another way to put the question is whether we accumulate on fill date or processing date?

Response:

Per CMS, CMS has no specific guidance on this issue. Sponsors should develop and follow a process that they can provide, along with their rationale, to any auditors.

Plans apply accumulators either based on date of receipt *or* date of service of the claim.

- If the plan uses the date of service of the claim method, the accumulators must be applied in the month of date of service on the FIR.
- In the instance where the date of receipt is outside of the plan year of the date of service and the plan uses the date of receipt method, the accumulators must be applied in the month of December on the FIR.

Question:

It seems as though the point-in-time nature of the accumulation values passed out by the processor in a FIR transaction response would have limited value for long-term auditing and record keeping purposes. If plans and their processors retain records of the net adjustments to TrOOP and drug spend accumulations that are applied in their systems as the result of the FIR transaction requests, are the FIR transactions themselves necessary to maintain in archives like claims are? If so, for what period of time?

Response:

See CMS Guidance, Chapter 14, Appendix C. Record Retention.

Question:

Is Person Code used in FIR transactions?

Response:

No. CMS requires a beneficiary to be unique based on their Cardholder ID. Person Code and Patient Relationship Code are not used to identify a beneficiary.

Question:

If a plan receives an F1 but am aware there is a prior plan, should the plan reject the F1?

Response:

No, it should not be rejected. Eventually the eligibility will catch up and the F1 will be converted to an F3 once the non-plan of record requests a proxy add of the Transaction Facilitator or CMS eligibility for the actual plan of record catches up.

Question:

How do PACE plans transfer balances? CMS has stated that PACE plans are not required to participate in the FIR process but must have a manual process in place should the beneficiary move to a non-PACE Part D plan during a plan year.

Response:

PACE programs are automatically excluded from FIR transactions unless the Transaction Facilitator is notified to include the Contract ID in FIR processing. For those PACE programs who are not included in the ATBT process they are required to manually transfer the balances when a beneficiary moves to a non-PACE Part D plan during a plan year. Manually transfers should be done using the published Post ATBT process.

For PACE programs that participate in the ATBT process, FIR transaction processing is the same as for any other program.

Question:

"Beneficiary not found" rejects by audited off plans. If a plan has been audited off in MBD (i.e., is a non-plan of record), and returns a beneficiary not found type of FIR reject code (e.g., a "52" or other Handling Type 2 code on the attached spreadsheet), we believe the likely reason is that the beneficiary was never added to the payer's adjudication system, and therefore will never have any financial activity. In such cases, we don't believe it will be useful to continue to include that audited off plan in FIR sequences, since the same response will continue to occur. It is also important that the beneficiary not be suspended in such cases.

Response:

If you are not the plan of record and you do not have paid claims for the audited off beneficiary you can request a proxy delete which will remove the plan from the FIR sequence. If you have paid claims you must report them whether or not you are the plan of record.

Question:

If a beneficiary is retroactively terminated so there is no coverage for the beneficiary in a plan year and our plan has paid for claims for that beneficiary, are we still responsible for providing balances relative to those claim payments?
For example,

- The beneficiary was retroactively termed from our plan (H####) on 04/01/2013, effective date of term back to 11/30/2012, due to loss of Part B.
- Beneficiary currently enrolled in contract S####, effective 04/01/2013.
- Beneficiary effectively had no Part D coverage from 12/01/2012 to 03/312013.
- However, because we had not yet received the term date as it was a retroactive disenrollment, there are 2 claims on record for CY13, processed under our contract, and with a total member Part D TrOOP incurred of $5.30. These claims were on January 10, during the time when beneficiary effectively had no Part D coverage, but prior to receipt of the retroactive disenrollment notice, thus they processed.

Response:

If the timeframe is still within the Post Automated TrOOP Balance Transfer (ATBT) period the plan should request a proxy add to ensure that the balance is transferred.

If the timeframe is outside the Post ATBT period the plan's policy will dictate whether a manual Post ATBT is required or non-plan of record payments should be treated in the same manner as plan of record Post ATBT.

Question:

My processor is rejecting FIRs for enrollment related reject codes (such as "01", 04", 06", 07", "09" "10" "51", "52", "7D", "7H", "ZX", "ZY"). How do I know what is wrong?

Response:

The Part D processor should send all Reject Codes applicable. The plan should compare the BIN/PCN/Group/Cardholder ID/Date of Birth/Contract ID/PBP ID reported on the Daily Cumulative Reject Report to determine which field is not matching between the processor, the plan, and CMS. All fields must match what the plan put on the CMS MARx transaction exchanges that utilize those fields and at minimum including 61 and 72.

Question:
My plan is the plan of record and received a 784 error on the PDE. The non-plan of record has an informational edit of 708/712 for the same claim. How do I resolve this issue as we should be the only one with the actual claim and accepted PDE? Here is an example of an actual case (with de-identified data).

Claim #114162818631 submitted on 2/3/2014 rejected as they indicated with edits 708, 712 and 784. The claim rejected because the exact same PDE was previously submitted by R6801/012 (the contract/plan of record). The specifics of both PDEs matched:

HICN	DOS	Rx Ref	srvc prvdr qual	service prvdr	fill	NDC
*****0980A	20140116	000001647201	01	1396714903	00	55111012705

Claim #144601940351 submitted on 5/2/2014 also rejected as they indicated with edits 708, 712 and 784. The claim rejected because the exact same PDE was previously submitted by H3404/001 (the contract/plan of record). The specifics of both PDEs matched:

HICN	DOS	Rx Ref	srvc prvdr qual	service prvdr	fill	NDC
*****1013A	20140301	000000277634	01	1548369770	02	00185010201

It would appear that in each case, the pharmacy submitted the same claim to two different plans.

Response:
If this situation is identified the plan of record should work with the non-plan of record outlined in the steps below:

1. Both plans should work together to assure the non-plan of record received payment. If no payment was received, work out a plan-to-plan payment. For examples when the automated P2P process may not occur see: Medicare Part D Non-Plan of Record White Paper http://www.ncpdp.org/Resources/Medicare-Part-D
2. Non-plan of record needs to determine if reversal was received and processed. If processed, go to step 3. If not received/processed the non-plan of record needs to request the pharmacy resubmit the reversal and work to ensure the reversal is processed.
3. Once the reversal is processed the non-plan of record needs to delete the PDE and confirm to the plan of record they can submit the PDE.
4. Plan of record to resubmits PDE.

Question:
As I understand it, if you previously received a transaction with values in a given month and later transactions no longer have values you are zeroing out those months regardless of the eligibility period of the transaction being received.

Response:
Yes, you are correct. For months that are outside of your enrollment period, you would zero out any previous accumulators sent. For months inside your enrollment period if the FIR does not contain any values, if previous values existed, you would zero those values out and return your values.

Question:
What happens if I receive amounts for months that are after my plan's enrollment period? Should I zero them out on the response because they don't impact me?

Response:
No, you should return amounts outside of your enrollment period exactly as they were provided to you. Apply dollars to your member's accumulators up to your termination date. However, you must respond with all dollars sent to you in the F3 plus any dollars the member accumulated while in your plan.

Although you may not be expecting values on the F3 for months after your enrollment period, if the values are present, they must be returned on the FIR response transaction, even if they are after your enrollment period. Returning the same values rather than changing or wiping them out will prevent the facilitator from rejecting the claim with T*Z2 because the amount on the response is less than the amount on the request.

Please see the following examples.

Example 1:
Plan A- January and February
Plan B (you) March –open ended

As of March you will receive a F2 that will contain January and February dollars from the prior plan. If subsequent F2s no longer have values for January and February, it is correct to zero out the values.

Transaction 1				
Transaction Date	**Transaction type**	**Plan A**	**TrOOP**	**Drug Spend**
3/1/2015	F1	Jan	$700.00	$700.00
		Feb	$1,200.00	$1,400.00
Plan A returns			**$1,900.00**	**$2,100.00**
Transaction Date	**Transaction type**	**Plan B**	**TrOOP**	**Drug Spend**
3/1/2015	F2	Jan	$700.00	$700.00
		Feb	$1,200.00	$1,400.00
Plan B applies			**$1,900.00**	**$2,100.00**

However later on the following happens:
Plan A January-February
Plan B (you) March- June (termination in June)
Plan C- July
You will now receive an F3. Again, if you were receiving values from January-February, but no longer receive them, then you should be zeroing them out (overlaying with the most current value which is zero) because they are still before your termination date.

Transaction 2				
Transaction Date	**Transaction type**	**Plan A**	**TrOOP**	**Drug Spend**
7/1/2015	F1	Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
Plan A returns			**$1,200.00**	**$1,400.00**
Transaction Date	**Transaction type**	**Plan B**	**TrOOP**	**Drug Spend**
7/1/2015	F3	Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
Plan B applies			**$1,200.00**	**$1,400.00**
		Mar	$500.00	$500.00
		April	$200.00	$250.00
		May	$800.00	$800.00
		June	$1,000.00	$1,200.00
Plan B accumulates			**$2,500.00**	**$2,750.00**
		Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
		Mar	$500.00	$500.00
		April	$200.00	$250.00
		May	$800.00	$800.00
		June	$1,000.00	$1,200.00
Plan B Returns			**$3,700.00**	**$4,150.00**
Transaction Date	**Transaction type**	**Plan C**	**TrOOP**	**Drug Spend**
7/1/2015	F2	Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
		Mar	$500.00	$500.00
		Apr	$200.00	$250.00
		May	$800.00	$800.00
		June	$1,000.00	$1,200.00
Plan C Applies			**$3,700.00**	**$4,150.00**

Overrides prior amount or adds a adjustment to accumulators

Then this happens
Plan A January-February
Plan B (you) March- June (June termination)

Plan C- July-October (October termination)
Plan B (you) November-December

You will now receive an F3 for the period of January-February AND an F2 for the period of November-December. If you received values for July-October on the F2 and no longer receive values for those dates on subsequent F2, they should be zeroed out or overlaid with zero.

Transaction 3				
Transaction Date	**Transaction type**	**Plan A**	**TrOOP**	**Drug Spend**
12/31/2015	F1	Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
Plan A returns			**$1,200.00**	**$1,400.00**
Transaction Date	**Transaction type**	**Plan B**	**TrOOP**	**Drug Spend**
12/31/2015	F3	Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
Plan B applies			**$1,200.00**	**$1,400.00**
		Mar	$500.00	$500.00
		April	$200.00	$250.00
		May	$800.00	$800.00
		June	$1,000.00	$1,200.00
Plan B Accumulates			**$2,500.00**	**$2,750.00**
		Jan	$0.00	$0.00
		Feb	$1,200.00	$1,400.00
		Mar	$500.00	$500.00
		April	$200.00	$250.00
		May	$800.00	$800.00
		June	$1,000.00	$1,200.00
		November	$100.00	$100.00
		December	$100.00	$100.00
Plan B Returns			**$3,900.00**	**$4,350.00**
Transaction Date	**Transaction type**	**Plan C**	**TrOOP**	**Drug Spend**
12/31/2015	F3	Jan	$0.00	$0.00

		Feb	$1,200.00	$1,400.00	
		Mar	$500.00	$500.00	
		Apr	$200.00	$250.00	
		May	$800.00	$800.00	
		June	$1,000.00	$1,200.00	
		November	$100.00	$100.00	Plan C does not apply member terminated
		December	$100.00	$100.00	Plan C does not apply member terminated
Plan C Applies			**$3,700.00**	**$4,150.00**	
		July	$55.00	$55.00	
		August	$20.00	$20.00	
		September	$100.00	$120.00	
		October	$75.00	$100.00	
Plan C Accumulates			**$250.00**	**$295.00**	
		Jan	$0.00	$0.00	
		Feb	$1,200.00	$1,400.00	
		Mar	$500.00	$500.00	
		Apr	$200.00	$250.00	
		May	$800.00	$800.00	
		June	$1,000.00	$1,200.00	
		July	$55.00	$55.00	
		August	$20.00	$20.00	
		September	$100.00	$120.00	
		October	$75.00	$100.00	
		November	$100.00	$100.00	
		December	$100.00	$100.00	
Plan C Returns			**$4,150.00**	**$4,645.00**	
Transaction Date	**Transaction type**	**Plan B**	**TrOOP**	**Drug Spend**	
12/31/2015	F2	Jan	$0.00	$0.00	already applied in original F3
		Feb	$1,200.00	$1,400.00	already applied in original F3
		Mar	$500.00	$500.00	Their dollars
		Apr	$200.00	$250.00	Their dollars
		May	$800.00	$800.00	Their dollars
		June	$1,000.00	$1,200.00	Their dollars
		July	$55.00	$55.00	applies
		August	$20.00	$20.00	applies
		September	$100.00	$120.00	applies

		October	$75.00	$100.00	applies
		November	$100.00	$100.00	Their dollars
		December	$100.00	$100.00	Their dollars
Plan B Applies			**$250.00**	**$295.00**	

Response:
Although Plan B would not be expecting values on the F3 for months after June (end of enrollment period), if the values are present, Plan B must return the values received for months outside of their effective period. Returning the same values rather than changing or wiping them out will prevent the facilitator from rejecting the claim with T*Z2 because the amount on the response is less than the amount on the request.

Reminder: Software should be coded to know what months of the FIR transaction are applicable to the months of your effective period. Other months do not require any action other than returning them on the FIR transaction.

Question:
A plan updates its termed beneficiaries' cardholder IDs in its eligibility system, but the cardholder IDs (of the 4Rx data) are not updated in MARx.

For example –
A termed beneficiary's cardholder ID was updated in the plan's eligibility system on 1/1/2016. The beneficiary was termed from the plan effective 6/30/2015, which is too old to update the 4Rx data via a 72 transaction. Will the plan use the Updating/editing a Non Plan of Record (Proxy Edit) form to update the 4Rx data to ensure that the transactions are accepted by the plan? If not, will you please provide the process to update 4Rx data for termed beneficiaries to ensure FIR transactions are processed successfully?

	HICN	**Name**	**Cardholder ID (4Rx)**	**Effective Dates**
Plan's Eligibility System	123456789A	John Doe	ABCX98765432	1/1/2016 –
CMS (MARx)	123456789A	John Doe	ABCX01234567	1/1/2015 – 12/31/2015

Response:
Regarding eligibility updates: From Section 8.1.1 of the PCUG (available on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html)

Plans may submit multiple change transactions for the same beneficiary in the same transmission file. The current requirement for effective dates submitted with Plan change TC 72s are within a date range of the Current Calendar Month (CCM) minus one month (CCM-1) through CCM plus three months (CCM+3). This is referred to as the allowable range.

However, editing for allowable date range is not performed on Plan change TC 72s submitted with 4Rx data, since auto-enrollments can have a retroactive effective date of several months and facilitated enrollments can have a prospective effective date of several months. Any Plan change TC 72 submitted with 4Rx data is accepted as long as the effective date in the transaction falls within the Plan's enrollment period.

Additionally, one cannot proxy edit a plan of record, only non-plan of records can be proxy edited. A plan must fix the 4Rx with CMS via a TC 72 for plans of record.

Question:
If the plan failed to provide their email information, would they just follow the process to complete the form on

RH's site (Annual ATBT and NX Report Distribution Email List for 2014-2016) and submit to TBTSupport@relayhealth.com?

Response:
If requestor is looking for email information related to the HPMS memo which means the P2P contact, this must be done in HPMS. If the requestor wants to update email information for the FIR report, complete the form on RH's site (Annual ATBT and NX Report Distribution Email List for 2014-2016 and submit to TBTSupport@relayhealth.com).

Question:
In reviewing the list of FIR rejections from the RH website, is there a recommended reject code to use if the FIR cannot be processed due to a lock on the member record (i.e. we cannot update because it's currently in use). Though it's a rare scenario, we currently send back the 85 (Claim Not Processed), but in an effort to provide a more specific reject, I am considering using the 91 (Host Response Error).

Response:
Use 97-Payer Unavailable to insure FIR is retried.

9 EDITORIAL CORRECTIONS CITED IN FINANCIAL INFORMATION REPORTING STANDARD

February 2016 - Corrected Sections 8.1.2 and 8.2.2 Headings - changed “Transaction” Level to “Transmission” Level and republished v1.2

10 TYPOGRAPHICAL ERRORS

(This section is blank.)

11 GENERAL QUESTIONS

11.1 HOW SOON DO IMPLEMENTERS SUPPORT THIS DOCUMENT

Question:
Once the Financial Information Reporting Editorial document is published, how soon do implementers need to support?

Response: When the Financial Information Reporting Editorial document is published, it is effective for use.

11.2 REJECT CODE GUIDANCE

See "*Appendix A – Reject Codes for 511-FB"* in the NCPDP *External Code List* for guidance on the use of reject codes.

11.3 SYNTAX ERROR

Question:
What constitutes a syntax error?

Response:
Syntax errors encompass all errors that are associated with the parsing of the transmission. The purpose of a syntax error in the standard is to call out an error in the structure of the transmission as opposed to an error in the data associated with the transmission. Best practice for handling a syntax error is to recognize that it applies only to structural errors within a transmission and must be accompanied if possible by the location (e.g. byte count, the last parsable field) within the transmission at which the syntax error was encountered. Syntax error does not apply to the data content of a properly parsable field. In this case an M/I or more specific reject code should be returned.

11.4 NOT USED DATA ELEMENT

Question:
For a Financial Information Reporting transaction, if a data element is defined as "not used" in the implementation guide and on the "Request" transaction a "not used" data element is present; then the receiver of the transaction is required to reject the transaction?

Response:
Yes. See also the NCPDP ***External Code List*** (ECL), section "*Appendix A – Reject Codes for 511-FB*".

12 APPENDIX A. WHERE DO I FIND

12.1 ANSWERS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

- NCPDP Financial Information Standard Implementation Guide Version 1.0 and above
- NCPDP Data Dictionary
- NCPDP External Code List
- This document

Other resources:

- NCPDP standards process http://www.ncpdp.org/Standards/Standards-Development-Process
- Obtaining standards (with membership) http://www.ncpdp.org/Membership
- Member to obtain standards http://www.ncpdp.org/Members/Standards-Lookup

12.1.1 WHAT FIELDS CHANGED?

NCPDP Data Dictionary

- section Appendix "*Publication Modifications*"

NCPDP Financial Information Standard Implementation Guide

- section "*Appendix A. History of Document Changes*"

12.1.2 DOCUMENTATION DATES

Question: Where do I obtain publication date information of the various version/releases of the Financial Information Standard Implementation Guide?

Response: The Standards Matrix document should be referenced. The document can be found at http://www.ncpdp.org/pdf/StandardsMatrix.pdf

This document lists all of the NCPDP standard implementation guides, their status, and the appropriate Data Dictionary and External Code Lists to use.

12.1.3 WHAT IF I HAVE A NEW QUESTION

Send the question to NCPDP Council Office at ncpdp@ncpdp.org or join the **WG1 Financial Information Reporting Task Group**. See http://www.ncpdp.org/PDF/Task_Groups_List.pdf.

13 APPENDIX B. MODIFICATIONS TO THIS DOCUMENT

13.1 Version 1.1

Added to section "*General Automated TrOOP Balance Transfer (ATBT) Processing Questions*":

- **Question:**
  If we receive an F1 transaction and respond with January accumulations of $100 TrOOP/$100 Drug Spend, and then later receive an F3 that shows January accumulations of $50 TrOOP/$100 Drug Spend, are we allowed to reject the F3? If we are not allowed to reject, what kind of accumulation adjustment is needed?
- **Question:**
  How is the processor to determine the allocation of transfer-in dollars for plans that have a brand only deductible?

13.2 Version 1.2

Section "*Processing FIR Transactions*" was added.
Questions "If I submit an inquiry or work request…" through "How do we update information for audit off plans?" were added to section "*Transaction Facilitator Functions*".

13.3 Version 1.3

Section "*Non-Calendar Year Plan Questions*" was added.

Question "Timing of Retrigger Requests" was added to section "*Transaction Facilitator Functions*".

Questions "How long are Part D Plans responsible for transferring beneficiary's accumulators outside of the ATBT process?" and "I am outside of the ATBT process and need to transfer balances manually. Do I need to transfer balances for beneficiaries that only had FIR records (post ATBT)?" were added to section "*General Post ATBT Processing Questions*".

13.4 Version 1.4

To section "*General Automated TrOOP Balance Transfer (ATBT) Processing Questions*":

- Subsection "*TrOOP and Gross Drug Spend*" has been added.
- Question "When a FIR comes in for a month where there is no active enrollment record for that patient, our platform currently rejects this FIR as a "52 – Non-matched Cardholder ID"" has been added.

Question "How does "Pre-F" work?" has been added to section "*Transaction Facilitator Functions*".

13.5 Version 1.5

To section "*Claims Paid as Non-Plan of Record*":

- Question "If a member accumulated TrOOP and Drug spend in a Plan and then that Plan becomes Non POR (member retro termed), how does the Non-Plan of Record report those accumulators to the next Plan?" has been added.

To section "*General Automated TrOOP Balance Transfer (ATBT) Processing Questions*":

- Questions "How should the accumulations that are after the period of eligibility for Sponsor B be handled? Should the dollars that come after the Sponsor B eligibility term date be applied towards the Sponsor B accumulations? Or should they be ignored for the Sponsor B accumulations?" has been added.

13.6 Version 1.6

To section "*Transaction Facilitator Functions*":

- Question "My plan is not receiving FIR transactions for newly enrolled or dis-enrolled members. Should I be requesting a FIR retrigger?" has been added.

13.7 Version 1.7

To section "*Processing FIR Transactions*":

- Question "My plan is the plan of record and received a 784 error on the PDE. The non-plan of record has an informational edit of 708/712 for the same claim. How do I resolve this issue as we should be the only one with the actual claim and accepted PDE?" has been added.
- Question "As I understand it, if you previously received a transaction with values in a given month and later transactions no longer have values you are zeroing out those months regardless of the eligibility period of the transaction being received" has been added.
- Question "What happens if I receive amounts for months that are after my plan's enrollment period? Should I zero them out on the response because they don't impact me?" has been added.
- Question "A plan updates its termed beneficiaries' cardholder IDs in its eligibility system, but the cardholder IDs (of the 4Rx data) are not updated in MARx" has been added.

To section "*General Automated TrOOP Balance Transfer (ATBT) Processing Questions*":

- Question "Is it correct that Plan A must request a proxy enrollment for the member in Plan A for January 2016? Should the proxy enrollment cover only the time period for which Plan A incorrectly paid claims?" has been added.
- Question "Does this only apply in cases where the member's enrollment terms in a prior year? For example, if Plan A paid claims in Feb 2016, but the member's enrollment should have been terminated on Jan 31, 2016, then there is no need for the proxy enrollment? The ATBT process will work as designed?" has been added.
- Question "Please advise what is the expectation from the plan of record plan, POR, once the audit-off spreadsheet is received from the audited-off plan?" has been added.
- Question "Is the expectation for the POR to reimburse the plan portion to the audited-off plan for P2P reconciliation purposes in a manual fashion?" has been added.
- Question "If yes, how is the POR credit applied from CMS for the payment issued to the audited-off plan if it is not part of the current automated P2P reconciliation reports?" has been added
- Question "If the PDE was originally accepted, however subsequent adjustments returned a 706 today the plan is unable to delete the PDE. Is there a mechanism to delete other than during the re-opening period or deadline period, i.e. during the year?" has been added.
- Question "If the PDE was originally accepted, however subsequent adjustments returned a 706 today the plan is unable to delete the PDE. Is there a mechanism to delete other than during the re-opening period or deadline period, i.e. during the year?" has been added.
- Question "If the MAPD helpdesk can provide the audit-off enrollment information from the MBD system, can the audited-off beneficiary be handled in an automated fashion via the P2P reconciliation process?" has been added.
- Question "Does this new process only exist for beneficiaries who were enrolled in a new plan and then subsequently disenrolled prior to the expected effective date?" has been added.
- Question "Or, should it also include any beneficiary who was audited-off after the intended effective date and the beneficiary was retro reenrolled back into their prior plan with no break in coverage?" has been added.
- Question "If a member was audited off from a subsequent plan and the disenrollment was not timely that resulted in a 706 on the first submission verses a 708 (if this is possible) is the 706 error expected to also be part of this manual reconciliation process?" has been added.
- Question "For the manual payment requests, how far back can the request be made?" has been added.

13.8 Version 1.8

To section *General Automated TrOOP Balance Transfer (ATBT) Processing Questions*

- Question "Per CMS guidance in the attached memo, it states plans are notified of audited-off enrollments "on the daily transaction reply report." Can you instruct me where to look for this on the TRR file? I was not able to locate information in the Plan Communication User Guide (PCUG). Is there a specific TRC I should be looking for?" has been added.

To section *Processing FIR Transactions*

- Question "If the plan failed to provide their email information, would they just follow the process to complete the form on RH's site (Annual ATBT and NX Report Distribution Email List for 2014-2016) and submit to TBTSupport@relayhealth.com?" has been added.
- Question "In reviewing the list of FIR rejections from the RH website, is there a recommended reject code to use if the FIR cannot be processed due to a lock on the member record (i.e. we cannot update because it's currently in use). Though it's a rare scenario, we currently send back the 85 (Claim Not Processed), but in an effort to provide a more specific reject, I am considering using the 91 (Host Response Error)." has been added.