# NCPDP Medicare Part D Information Reporting (N) Transaction Matching to Other Health Insurance Best Practices

*This document provides NCPDP recommended best practices for matching Medicare Part D Information Reporting (N) transactions to Other Health Insurance, including the CMS SPAP/ADAP Quarterly Report.*

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**Version 10**

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The task group members, document authors, and other contributors of this paper will review and possibly update their recommendations should any significant changes occur.

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# 1. PURPOSE

NCPDP has created this overview as guidance intended for all parties involved in managing Part D benefits for Medicare beneficiaries. These parties include, but are not limited to, State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs (ADAPs), Part D Sponsors, Pharmacy Software Vendors, Pharmacy Switches, Pharmacy Benefit Managers (PBMs), Medicaid Agencies, Payers offering a supplemental benefit to Medicare beneficiaries, Providers that dispense medications to Medicare eligible beneficiaries, and Contractors (Part D Transaction Facilitator, COB contractors, etc.) that support coordination of Medicare Part D benefits.

In October 2018, Centers for Medicare and Medicaid Services (CMS) updated section 50.4 Processing Claims and Tracking TrOOP of the Chapter 14 Medicare Prescription Drug Benefit Manual to include the use of the CMS SPAP/ADAP Quarterly Report. If the sponsor receives an N transaction with a BIN/PCN on the CMS SPAP/ADAP Quarterly Report, the Information Reporting N transaction (Nx) should always be treated as a qualified transaction and reported as other TrOOP.

The purpose of this Best Practices document is to assist Medicare Part D plans in using the CMS SPAP/ADAP Quarterly Report and Other Health Insurance (OHI) information in matching to the N transactions appropriately.

The reader will note this paper is organized to first define key terms, processes, and stakeholders, and then provide detailed discussion, NCPDP recommendations and CMS regulations related to the Coordination of Benefits process. This Best Practices document should be used in conjunction with the *NCPDP Overview of the Medicare Part D Prescription Drug Coordination of Benefits Process* white paper and the *Medicare Part D Information Reporting Transaction Matching Best Practices*, both of which are available at https://www.ncpdp.org/Resources/Medicare-Part-D.

The guidance in this document applies to Version D.0 of the Telecommunication Standard, the HIPAA-adopted version at the time of publication.

All references to Information Reporting N transactions (Nx) in this Best Practices document are in reference to Information Reporting N transactions (Nx) initiated by the Part D Transaction Facilitator and identified by Software Vendor/Certification ID (110-AK) = TROOP or TROOPBATCH. The processes outlined in this document are not applicable to entities identified by other Software Vendor/Certification IDs submitting Information Reporting N transactions (Nx).

## *1.1 IMPORTANT REFERENCES*

***Medicare Prescription Drug Benefit Manual Chapter 14-Coordination of Benefits***
https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html

***Recommendations for Effective 4Rx Usage in Medicare Part D Processing***
http://www.ncpdp.org/Resources/Medicare-Part-D


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***NCPDP Medicare Part D Information Reporting (N) Transaction Matching to Other Health Insurance Best Practices***

(Click on the documents hyperlink in the second paragraph of the Recommendations for Effective 4Rx Usage in Medicare Part Processing section of the Medicare Part D Resources webpage for a zip file of information)

***NCPDP Telecommunication Standard Implementation Guide Version D.0***
Available with NCPDP membership

***Centers for Medicare and Medicaid Services (CMS) Memos***
https://hpms.cms.gov/app/login.aspx
(Note: The following CMS memo was used as guidance referenced when creating this document)

March 28, 2019 Subject: Updated Coordination of Benefits (COB) Information

***Plan Communication Users Guide (PCUG)***
https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html


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# 2. ACRONYMS AND DEFINITIONS

The definitions of various terminology used within this document are provided for the reader to reference below.

**4RX Data**

The four data elements are used to process a pharmacy claim. In Medicare Part D, these four elements uniquely identify the Medicare Part D Sponsor for the beneficiary and are identified by the sponsor during beneficiary enrollment and exchanged with CMS contracted entities. The set of four elements are exchanged via eligibility verification, claims processing, and information reporting transactions, as well as post adjudication claim reporting functions. The 4Rx data are:

| | |
|---|---|
| "RxBIN" | Bank Identification Number |
| "RxPCN" | Processor Control Number |
| "RxGRP" | Group ID |
| "RxID" | Cardholder ID defined by the plan |

It is recommended to read the NCPDP *Recommendations for Effective 4Rx Usage in Medicare Part D Processing* document for specific rules and usage for Part D Sponsors and plans supplemental to Part D.

**AIDS Drug Assistance Programs (ADAPs)**

The AIDS Drug Assistance Program (ADAP) is a state and territory-administered program authorized under Medicare Part B that provides FDA-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare.

**Bank Identification Number (BIN)**

This is a six-digit number (all six digits are significant) that is used for routing within the pharmacy industry. BIN values are issued by NCPDP or the American National Standards Institute (ANSI). All references to BIN in this document generically refer to either the NCPDP or ANSI issued values. When used in the Medicare Part D processing environment it is referred to as RxBIN.

It is important to note that since the publication of the Telecommunication Standard Version D.0, the term Bank Identification Number (BIN) is no longer supported. The number is now called an Issuer Identification Number (IIN). For purposes of this paper, the term BIN is still applicable.

**Benefits Coordination & Recovery Contractor (formerly named COB Contractor)**

The Benefits Coordination & Recovery Contractor (BCRC) is a federal contractor which consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment.

**Coordination Of Benefits (COB)**

In this context, Coordination of Benefits (COB) occurs when Medicare beneficiaries have a private and commercial insurer or coverage in addition to their Medicare coverage. The coordination of activities that


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result when multiple payers exist for claims to ensure the appropriate costs are paid by the responsible payer is considered coordination of benefits.

**Health Plan Management System (HPMS) SPAP/ADAP Module**
The SPAP/ADAP module in HPMS is used to assist with coordination of benefits for beneficiaries of state-based programs who are also enrolled in a Medicare Part D prescription drug plan. Part D plans are required to coordinate benefits for their enrollees with multiple sources of prescription coverage.

**Information Reporting (N) Transactions**
The Part D Transaction Facilitator transmits supplemental coverage information from payer-to-payer. The Transaction Facilitator process is triggered by the submission of a transaction by a pharmacy to a payer supplemental to a Part D Sponsor. The Information Reporting transactions Information Reporting (N1), Information Reporting Reversal (N2), and Information Reporting Rebill (N3) are used in this process. These are transactions in the NCPDP *Telecommunication Standard Implementation Guide*.

**N1 - Information Reporting**
This transaction is used to transmit a record of supplemental coverage information related to a Part D beneficiary's liability. Information Reporting (N1) is a transaction request and a response.

**N2 – Information Reporting Reversal**
This transaction is used to reverse a previously submitted N1 (Information Reporting) transaction. Information Reporting Reversal (N2) is a transaction request and a response.

**N3 – Information Reporting Rebill**
This transaction is an Information Reporting submission with an implied reversal. It is used by the Originator to cancel an Information Reporting transaction submitted that had been processed previously and submit a new Information Reporting transaction in the same transaction. Information Reporting Rebill (N3) is a transaction request and a response.

**Medicare Advantage and Prescription Drug (MARx) System**
MARx supports the beneficiary enrollment and disenrollment as well as premium, and payment functions for Medicare beneficiaries.

**Other Health Insurance (OHI)**
Other Health Insurance data provides the beneficiary's coordination of benefits detail information. CMS, through the Benefits Coordination & Recovery Center (BCRC), provides a data sharing partner with medical or prescription coverage from a beneficiary's other payer(s) and refers to this as data that identifies "other health insurance."

**Part D Sponsor**
Part D sponsors are organizations contracted with CMS to provide Medicare Part D coverage. Most are Prescription Drug Plans (PDPs) or Medicare Advantage Plans that provide qualified prescription drug coverage (MAPDs). Plans may offer the following benefits: Defined Standard (DS); Actuarially Equivalent (AE); Basic Alternative (BA); Enhanced Alternative (EA). For more information about Part D Sponsors see www.cms.gov.

**Part D Transaction Facilitator**


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The Part D Transaction Facilitator is a federal contractor which is responsible, in conjunction with CMS, for establishing procedures for facilitating eligibility queries (E1 transactions) at point of sale (POS), identifying costs reimbursed by other payers (Information Reporting (N) transactions) and alerting Part D sponsors about such transactions, and facilitating the transfer of TrOOP-related data (financial information reporting (FIR) transactions) when a beneficiary changes plan enrollment during the coverage year.

**Pharmacy Benefit Manager (PBM)**
Typically a third-party administrator of prescription drug programs, PBMs can assist a plan sponsor to achieve the most effective utilization of prescription drug expenditures through benefit design, formulary management, rebate contracting, retrospective Drug Utilization Review (DUR), prospective DUR, network administration, and disease management. The PBM may also be a payer/processor or other entity that receives prescription drug claims, makes a decision regarding the level of reimbursement and sends the appropriate message or reject code back to the pharmacy/provider for action.

**Pharmacies**
Providers such as retail, mail, home infusion, specialty, long term care, post-acute care, Indian Tribal Unit, etc.

**Patient Liability Reduction Due To Other Payer Amount (PLRO)**
The amount by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D is reported to the CMS in defined fields of PLRO on the Prescription Drug Event (PDE). These dollars are to be deducted from TrOOP. Examples of such non-TrOOP eligible payers include group health plans, non-Part D government-funded programs (e.g., VA and TRICARE), and liability insurances (e.g., workers' compensation, home and auto).

**Processor**
A Processor may be an insurer, a governmental program or another financially responsible entity or a third-party administrator or intermediary contracted on behalf of those entities which receives prescription drug claims, makes a decision regarding the level of reimbursement to the provider, and transmits a response to the provider submitting a claim.

**Processor Control Number (PCN)**
This is a 10-character value that is typically assigned by the Part D Sponsor's processor and is also used for routing. When used in the Medicare Part D processing environment it is referred to as RxPCN.

**State Pharmaceutical Assistance Programs (SPAPs)**
A state pharmaceutical assistance program (SPAP) to help their residents pay for prescription drugs. Each program works differently. Some states offer programs that can help people with certain illnesses pay for their prescription drugs. The states that offer SPAPs often coordinate their SPAPs with Medicare's drug benefit (Part D).

**Supplemental Payers (Other Payer)**
A payer that is supplemental to Part D offers benefits or coverage after Part D benefits have been determined. These benefits are usually in the form of copay/coinsurance reduction.


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**Switch/Service Intermediary**

A switch/service intermediary is an entity that connects pharmacies to processors in a standard manner in order to transmit transactions or files. The switch accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity. A switch/intermediary may perform value added services including detailed editing/messaging of input/output data for validity and accuracy and translating data from one format to another.


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# 3. STAKEHOLDERS INVOLVED IN THE INFORMATION REPORTING TRANSACTION MATCHING PROCESS

1. Beneficiaries with coverage under a Medicare Part D Sponsor
2. Centers for Medicare and Medicaid Services (CMS)
3. CMS' contractors
    a. Benefits Coordination & Recovery Center (BCRC, formerly known as Coordination of Benefits Contractor (COBC)): A federal contractor, currently, Group Health Inc. (GHI) an EmblemHealth Company. See section "*Acronyms and Definitions*".
    b. Part D Transaction Facilitator (formerly TrOOP Facilitator): RelayHealth
4. Medicare Part D Sponsors: See section "*Acronyms and Definitions*".
5. Supplemental Payers (Other Payer): See section "*Acronyms and Definitions*".
6. Pharmacies: See section "*Acronyms and Definitions*".
7. Switch/Service Intermediary: See section "*Acronyms and Definitions*".
8. Pharmacy Benefit Managers (PBMs). See section "*Acronyms and Definitions*".
9. Processor: See section "*Acronyms and Definitions*".
10. National Council for Prescription Drug Programs (NCPDP): An ANSI-accredited standards development organization serving the pharmacy services sector.


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# 4. OTHER HEALTH INSURANCE COORDINATION OF BENEFITS RECORDS

Medicare Part D sponsors periodically receive new and updated OHI information for their beneficiaries in a daily COB-OHI file. This file contains coverage other than Medicare Part D for the plan's beneficiaries who may have coverage through one or more insurance plans, including those that may pay primary to Medicare Part D and those that are supplemental to Medicare Part D.

Records are submitted to CMS through the CMS BCRC/COB contractor using over 35,000 data exchanges including those with Data Sharing Agreements (DSAs), Voluntary Data Sharing Agreements (VDSAs), Section 111 Reporting Entities, State reporting, Pharmacy Benefit Manager reporting, Employer Group Health Plans (EGHPs), 1-800-Medicare, CMS Regional Offices, beneficiaries, and others on behalf of the beneficiaries.

MARx forwards this COB-OHI file whenever a plan's enrollees are affected, which may occur as often as daily. The enrollees included on the file are those newly enrolled who have known OHI and those plan enrollees with changes to their OHI.

For specific information on this COB-OHI File, please refer to the Plan Communication User Guide (PCUG) at *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-technology/mapdhelpdesk/Plan_Communications_User_Guide.html.*


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# 5. CMS SPAP/ADAP QUARTERLY REPORT

A new source of information was published by CMS in April 2019 for Part D plans to use when coordinating with SPAPs and ADAPs. Medicare Part D plans are required to coordinate prescription drug coverage with SPAPs and ADAPs. Several years ago CMS received comments indicating that Medicare Part D plans needed more reliable information about SPAP and ADAP plans. Based on this feedback CMS began an initiative to verify SPAP/ADAP data and agreements electronically within the Health Plan Management System (HPMS). An extract of the HPMS SPAP and ADAP data will be available quarterly for use by Medicare Part D plans. This list will be referred to going forward as the CMS SPAP/ADAP Quarterly Report.

This report will include SPAPs and ADAPs that have registered in HPMS. It is recommended that plans/PBMs maintain their internal processes to use the information from the CMS SPAP/ADAP Quarterly Report cumulatively. If a SPAP/ADAP has not registered for the upcoming plan year and their BIN/PCN is not included on the CMS SPAP/ADAP Quarterly Report, plans/PBMs should not remove that BIN/PCN from their internal process and continue to apply N transactions for those BIN/PCNs as qualified. If the CMS SPAP/ADAP Quarterly Report has a new BIN/PCN combination, plans/PBMs should add that BIN/PCN to their internal process.

The CMS SPAP/ADAP Quarterly Report may be found at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Coordination_of_Benefits.html

*NOTE:* It is recommended this file be opened in text format so leading zeroes are included and not truncated.


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# 6. INFORMATION REPORTING TRANSACTION (NX)

N transactions contain supplemental claim information, including the other payer 4Rx information and how much the member paid on the claim after the supplemental payer processed the claim.

An N transaction can be qualified or non-qualified.

If a qualified SPAP or ADAP pays the supplemental dollars, the beneficiary's TrOOP accumulators should include the amount paid by the qualified supplemental payer. These are reported under the "Other TrOOP" field on the PDE.

If a non-qualified payer pays the supplemental dollars, the beneficiary's TrOOP will be reduced from TrOOP and reported in the PLRO field on the PDE.


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# 7. STEPS TO DETERMINE HOW TO APPLY AN N TRANSACTION AS QUALIFIED OR NON-QUALIFIED

These recommended steps do not have to be executed in any specific order.

- Compare the 4Rx fields in the N transaction to the 4Rx fields in the OHI record (any combination of the 4Rx fields as determined by your processor).
    - If the N transaction matches to the OHI record and the Supplemental Type Code on the OHI record is recognized as qualified[1], apply the calculated amount contributed by the other payer to TrOOP and report as Other TrOOP on the PDE.
    - If the N transaction matches to the OHI record and the Supplemental Type Code on the OHI record is **not** recognized as qualified, reduce TrOOP by the calculated amount the other payer contributed and report as PLRO on the PDE.
- Compare the BIN/PCN on N transaction with BINs/PCNs on the CMS SPAP/ADAP Quarterly Report (the BIN/PCNs on this list are considered qualified and any calculated amount contributed by the other payer are considered TrOOPable as per Chapter 14).
    - If the BIN/PCN on the N Transaction matches the BIN/PCN on the CMS SPAP/ADAP Quarterly Report, apply the calculated amount contributed by the other payer to TrOOP and report as Other TrOOP on the PDE.
- If the N Transaction does not match either the OHI record or the CMS SPAP/ADAP Quarterly Report, consider as non-qualified and reduce TrOOP by the calculated amount the other payer contributed and report as PLRO on the PDE.
- Processors should provide to their plans reporting when a N Transaction matches the CMS SPAP/ADAP Quarterly Report but does not match the member's OHI record or there is no OHI record for the member. Per Chapter 14, "CMS encourages sponsors to subsequently follow up by contacting the beneficiary to identify the supplemental payer. Once the sponsor receives this information, except for SPAP/ADAP coverage, it should be transmitted to the BCRC for verification of the secondary coverage."

[1] Refer to the Other Payers Supplemental to Part D and Applicability to TrOOP table in *Medicare Prescription Drug Benefit Manual Chapter 14-Coordination of Benefits* for the list of qualified supplemental type code values.


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# 8. APPENDIX A: DOCUMENT REVISIONS

## Version 10

- Original Publication


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