Medicare Part D Information Reporting Transaction Matching Best Practices

This document provides NCPDP recommended matching logic for Medicare Part D Information Reporting and corresponding claim transactions. This includes paid, rejected and reversed transactions.

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Disclaimer

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

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

This document is for Education and Awareness Use Only.

1. PURPOSE

NCPDP has created this overview as guidance intended for all parties involved in managing Medicare Part D benefits for Medicare beneficiaries. These parties include, but are not limited to, State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs (ADAPs), Medicare 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 (Medicare Part D Transaction Facilitator, Coordination of Benefit (COB) contractors, etc.) that support coordination of Medicare Part D benefits.

NCPDP WG1 Information Reporting Problems Task Group worked with the Centers for Medicare and Medicaid Services (CMS) and a variety of industry partners to review the N transaction (Nx) matching process. This best practices document is a result of those discussions and is intended to provide NCPDP recommendations for matching Medicare Part D N transactions (Nx) to corresponding B transactions (Bx), matching N to N transactions (Nx), and reject codes for non-matched N transactions (Nx). It is not intended to include downstream processes thereafter. 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 COB 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*. (https://www.ncpdp.org/Resources/Medicare-Part-D)

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

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

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
(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

Medicare Part D Nx Performance Reporting Materials
http://medifacd.relayhealth.com/nx

(Note: Plan-specific reports are emailed directly to the plan sponsor.)

Centers for Medicare and Medicaid Services (CMS) Memos
https://hpms.cms.gov/app/login.aspx
(Note: The following CMS memos were used as referenced guidance when creating this document; however they may not represent all CMS documentation pertaining to the processing of N Transactions.)

- Announcement Regarding Modification to the Benefit Stage Qualifier (BSQ) Filter Criteria for Supplemental Payment Information (Nx) Transactions, May 7, 2014
- Announcement Regarding Information Transaction (Nx) Reports and Reminder on Changes to Medicare Part D 4Rx Data, November 7, 2014
- Announcement Regarding Additional Details on Information Transaction (Nx) Reports, January 21, 2015
- Medicare Part D Transaction Facilitator Updates, April 7, 2017

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 Medicare Part D Sponsors and plans supplemental to Medicare Part D.

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 the American National Standards Institute (ANSI). NCPDP issues Processor ID Numbers for those entities unable to obtain a BIN from 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 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.

Claim Billing (B) Transactions

B1 – Claim Billing

This transaction is used to request payment from the processor for a specific patient for claims billed according to appropriate plan parameters. Claim Billing (B1) is a transaction request and a response.

B2 – Claim Billing Reversal

This transaction is used by the originator to cancel a claim that had been processed previously (i.e., to reverse a previously paid claim (B1)). If the reversal is processed on the same day the request for payment was processed, a single claim record showing the final outcome will be reported back to the pharmacy on remittance information. If the reversal is submitted on a day or more following the date of the original claim processing, the pharmacy will see the paid claim and an offsetting adjustment for the claim on remittance information. Billing Reversal (B2) is a transaction request and a response.

B3 – Claim Billing Rebill

This transaction is a claim submission with an implied reversal of the same Service Reference Number. It is used by the originator to cancel a claim that had been processed previously and to submit a new claim in the same transaction. A previously adjudicated claim is reversed and then the new claim is processed, using a two-step procedure in a single submitted transaction. Each part of the process works independently of the other. Claim Rebill (B3) is a transaction request and a response.

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

Information Reporting (N) Transactions for Medicare Part D
All references to N transactions (Nx) in this document are in reference to Information Reporting transactions initiated by the Medicare Part D Transaction Facilitator and identified by Software Vendor/Certification ID (110-AK) = TROOP or TROOPBATCH. (Note: This field does not imply the transaction affects accumulators. It identifies the origination and not the application thereof.)

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

1. **Transaction type**
    a. **N1 - Information Reporting**
    This transaction is used to transmit a record of supplemental coverage information related to a Medicare Part D beneficiary's liability. Information Reporting (N1) is a transaction request and a response.
    b. **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.
    c. **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 that had been processed previously and to submit a new Information Reporting in the same transaction. Information Reporting Rebill (N3) is a transaction request and a response.

2. **Duplicate N Transaction (Nx)**
    a. Multiple N Transactions (Nx) with the same Transaction Reference Number (880-K5).
    b. Multiple N Transactions that do not have the same Transaction Reference Number (880-K5) but contain the same values in the following fields:
        - Other Payer BIN (990-MG)
        - Other Payer PCN (991-MH)
        - Other Payer Cardholder ID (356-NU)

- Patient Paid Amount Submitted (433-DX)

Medicare Part D Sponsor
Medicare 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 Medicare Part D sponsors see www.cms.gov.

Medicare Part D Transaction Facilitator
The Medicare 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 Medicare 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.

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 Medicare 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.

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

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.

3. STAKEHOLDERS INVOLVED IN THE INFORMATION REPORTING TRANSACTION MATCHING PROCESS

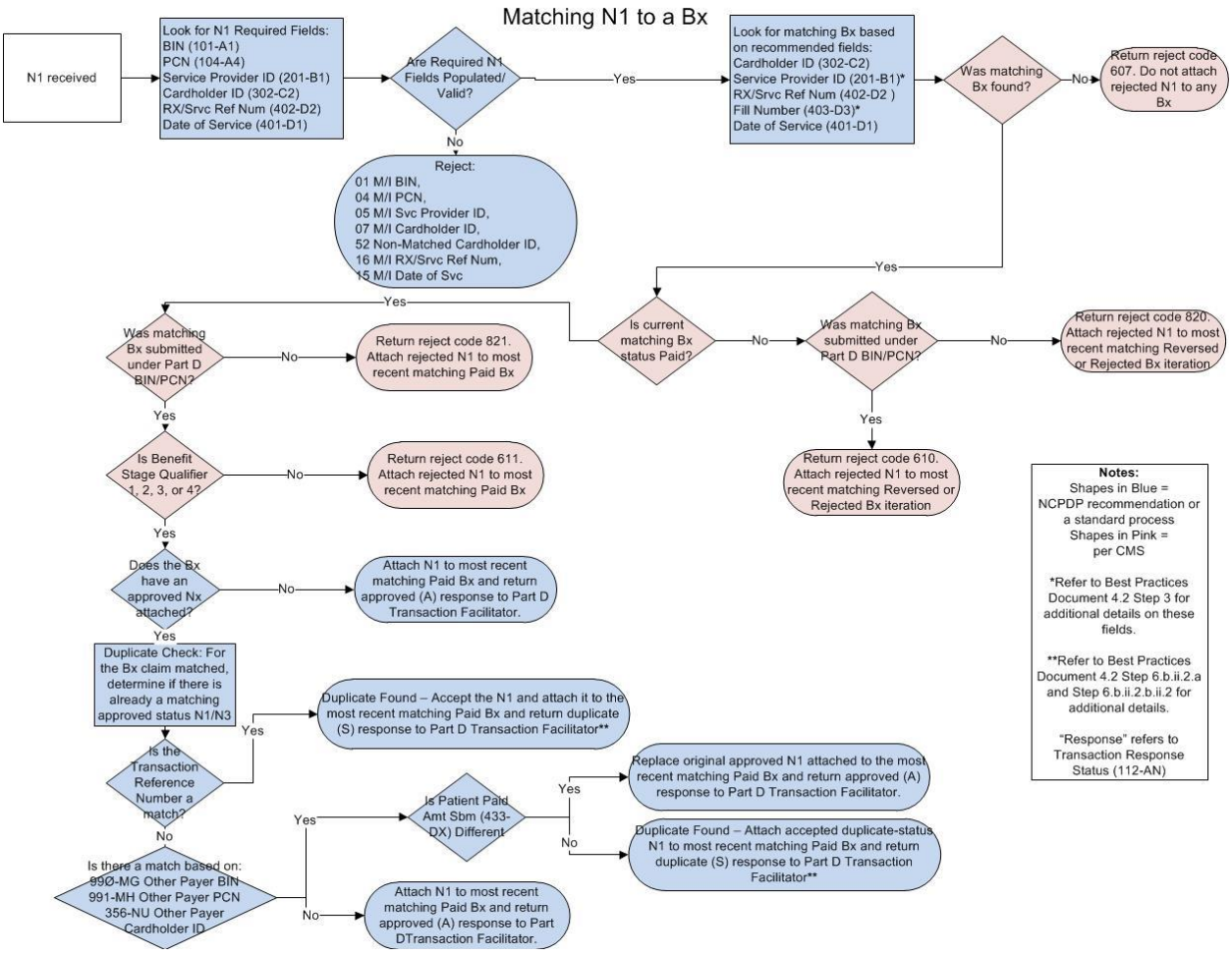
1. Beneficiaries with coverage under a Medicare Part D sponsor
2. CMS
3. CMS' contractors
    a. Benefits Coordination & Recovery Center (BCRC, formerly known as Coordination of Benefits Contractor (COBC)): A federal contractor. See section "*Acronyms and Definitions*".
    b. Medicare Part D Transaction 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 developing organization serving the pharmacy services sector.

4. N TRANSACTION (NX) MATCHING

This section contains NCPDP recommended process flows and associated detail outlining the steps in matching N transactions (Nx) to B transactions (Bx) and N transactions (Nx) to N transactions (Nx). The diagrams and the verbiage should be utilized together.

4.1 N1 TRANSACTION FLOW

Below is the transaction process flow for matching the N1 transaction to a B transaction (Bx) that includes both NCPDP recommended and CMS mandated matching logic and reject codes. Please see Appendix A for information about valid and invalid reject codes.



4.2 MATCHING N1 TO A B TRANSACTION (BX) PROCESS

Steps in italicized font are mandated per CMS. Steps in non-italicized font are NCPDP recommendations or standard processes.

1. N1 is received from the Medicare Part D Transaction Facilitator

2. Validate the presence of values in the N1 Required Fields. If values are blank (spaces are considered valid), return applicable reject.

N1 Required Field	**Reject Code**
BIN (101-A1)	01 M/I BIN
PCN (104-A4)	04 M/I PCN
Service Provider ID (201-B1)	05 M/I Service Provider ID
Cardholder ID (302-C2)	07 M/I Cardholder ID 52 Non-Matched Cardholder ID
Prescription/Service Reference Number (402-D2)	16 M/I Prescription/Service Reference Number
Date of Service (401-D1)	15 M/I Date of Service

3. Once required fields have been validated, attempt to find a matching B transaction (Bx) by using the recommended fields. First, try matching with Fill Number (403-D3) and if no match is found, then try matching without Fill Number (403-D3).
   Cardholder ID (302-C2)
   Service Provider ID (201-B1)
   Prescription/Service Reference Number (402-D2)
   Fill Number (403-D3)
   Date of Service (401-D1)
   a. If Cardholder ID, Prescription/Service Reference Number, and Date of Service match but there is no match on Service Provider ID (201-B1) and the value in the Service Provider ID field on either the B or the N transaction (Nx) is PAPERCLAIM (with a Service Provider ID Qualifier (202-B2) of 99), consider a match is found and do not return reject code 607 (Information Reporting (N1/N3) Transaction Cannot Be Matched To A Claim (B1/B3)).

4. *Return reject code 607 (Information Reporting (N1/N3) Transaction Cannot Be Matched To A Claim (B1/B3)) if no match is found. Do not attach the rejected N1 to any B transaction (Bx).*

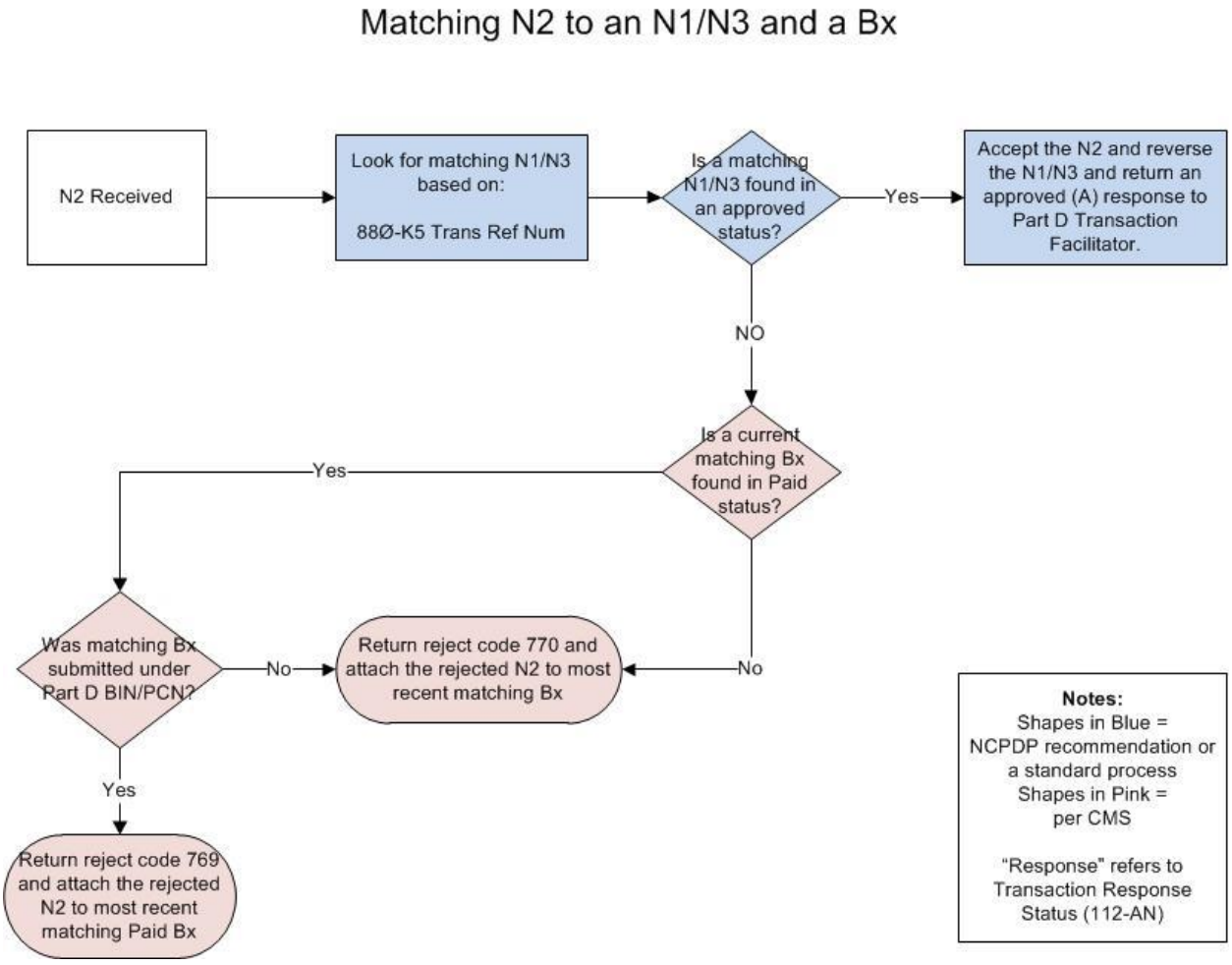
5. *If matching B transaction (Bx) was found in Reversed or Rejected status, determine if B transaction (Bx) was submitted under Medicare Part D BIN/PCN.*
   a. If not submitted under Medicare Part D BIN/PCN, return reject code 820 (Information Reporting Transaction (N1/N3) Matched To Reversed Or Rejected Claim Not Submitted Under Medicare Part D IIN PCN). Attach rejected N1 to most recent matching Reversed or Rejected B transaction (Bx) iteration.
   b. If submitted under Medicare Part D BIN/PCN, return reject code 610 (Information Reporting Transaction (N1/N3) Matched To Reversed Or Rejected Claim Submitted Under Medicare Part D IIN PCN). Attach rejected N1 to most recent matching Reversed or Rejected B transaction (Bx) iteration.

6. *If matching B transaction (Bx) was found in Paid status, determine if B transaction (Bx) was paid under Medicare Part D BIN/PCN.*
    a. *If not paid under Medicare Part D BIN/PCN, return reject code 821 (Information Reporting (N1/N3) Transaction Matched To Paid Claim Not Submitted Under Medicare Part D IIN PCN). Attach rejected N1 to most recent matching paid B transaction (Bx).*
    b. *If paid under Medicare Part D BIN/PCN, determine if the Benefit Stage Qualifier (393-MV) is 01, 02, 03, or 04.*
        i. *If Benefit Stage Qualifier is not 01, 02, 03, or 04, return reject code 611 (Information Reporting Transaction (N1/N3) Was Matched To A Claim Submitted Under The Medicare Part D IIN/PCN Paid As Enhanced Or OTC Or By A Benefit Other Than Medicare Part D). Attach rejected N1 to most recent matching paid B transaction (Bx).*
        ii. If Benefit Stage Qualifier is 01, 02, 03, or 04, determine if Bx has an approved N transaction (Nx) attached.
            1. If no N transaction (Nx) is found or a denied N transaction (Nx) is attached, attach the N1 to the most recent matching paid Bx and return Approved(A) response to Medicare Part D Transaction Facilitator.
            2. If an approved N transaction (Nx) is attached, perform a duplicate check by using the Transaction Reference Number (880-K5) to determine if there is already a matching Accepted status N1/N3.
                a. If match is found with Transaction Reference Number, accept the N1 and attach it to the most recent matching paid B transaction (Bx) and return a Header Response Status (501-F1) of "A" (Accepted) and a Transaction Response Status (112-AN) of "S" (Duplicate of Approved) to the Medicare Part D Transaction Facilitator. It is at the plan/processor's discretion as to how to handle the prior N transaction (Nx) in conjunction with the new accepted duplicate N transaction (Nx) and the impact on any downstream processes.
                b. If match is not found with Transaction Reference Number, look for another matching N1/N3 transaction based on Other Payer BIN (990-MG), Other Payer PCN (991-MH), Other Payer Cardholder ID (356-NU).
                    i. If match is not found using the Other Payer fields, attach N1 to most recent matching paid B transaction (Bx) and return approved (A) response to the Medicare Part D Transaction Facilitator. It is at the plan/processor's discretion as to how to handle the application of multiple accepted N transactions.
                    ii. If match is found using the Other Payer fields, determine if the Patient Paid Amount Submitted (433-DX) is different.

1. If Patient Paid Amount Submitted is different, replace original approved N1 attached to the most recent matching paid B transaction (Bx) and return approved (A) response to the Medicare Part D Transaction Facilitator. (Note: An assumption is made that an N2 was not received in this situation. The method used to replace the original accepted N1 is at the discretion of each plan/processor. The intent behind replacing the original transaction is to provide an audit history).
2. If Patient Paid Amount Submitted is not different, consider the N1 a duplicate and attach it as accepted to the most recent matching paid B transaction (Bx) and return a Header Response Status (501-F1) of "A" (Accepted) and a Transaction Response Status (112-AN) of "S" (Duplicate of Approved) to the Medicare Part D Transaction Facilitator.

4.3 N2 TRANSACTION FLOW

Below is the transaction process flow for matching the N2 transaction to a N1/N3 transaction that includes both recommended and CMS mandated matching logic and reject codes. Please see Appendix A for information about valid and invalid reject codes.



4.4 MATCHING N2 TO A N1/N3 TRANSACTION PROCESS

Steps in italicized font are mandated per CMS. Steps in non-italicized font are NCPDP recommendations or standard processes.

1. N2 is received from the Medicare Part D Transaction Facilitator.

2. Attempt to find a matching N1/N3 transaction based on the value in Transaction Reference Number (880-K5).

3. If a matching N1/N3 was found in approved status, accept the N2 and reverse the N1/N3 and return approved (A) response to the Medicare Part D Transaction Facilitator.

4. *If matching N transaction (Nx) was not found or found but not in approved status, determine if there is a current matching B transaction (Bx) in Paid status.*

a. *If current matching B transaction (Bx) is not found or is found with a status other than Paid, then return reject code 770 (Paid Billing Transaction (B1/B3) Submitted Under The Medicare Part D IIN PCN Not Found And Information Reporting Reversal (N2) Cannot Be Matched To An Information Reporting Transaction (N1/N3) In Approved Status; Reversal (N2) Not Processed) and attach the rejected N2 to the most recent matching B transaction (Bx).*

b. *If current matching B transaction (Bx) is found in Paid status, then determine if the B transaction (Bx) was submitted under Medicare Part D BIN/PCN.*

   If a previous N1/N3 transaction has been rejected with 610 (Information Reporting Transaction (N1/N3) Matched To Reversed Or Rejected Claim Submitted Under Medicare Part D IIN PCN) or 611 (Information Reporting Transaction (N1/N3) Was Matched To A Claim Submitted Under The Medicare Part D IIN/PCN Paid As Enhanced Or OTC Or By A Benefit Other Than Medicare Part D) and is attached to the most recent B transaction, the N2 should imply a reversal of the rejected N1/N3 and not eligible to be included in future adjustments.

   i. *If the matching B transaction (Bx) was submitted under the Medicare Part D BIN/PCN, then return reject code 769 (Paid Billing Transaction (B1/B3) Submitted Under The Medicare Part D IIN PCN Found But Information Reporting Reversal (N2) Cannot Be Matched To An Information Reporting Transaction (N1/N3) In An Approved Status; Reversal (N2) Not Processed) and attach the rejected N2 to the most recent matching paid B transaction (Bx).*

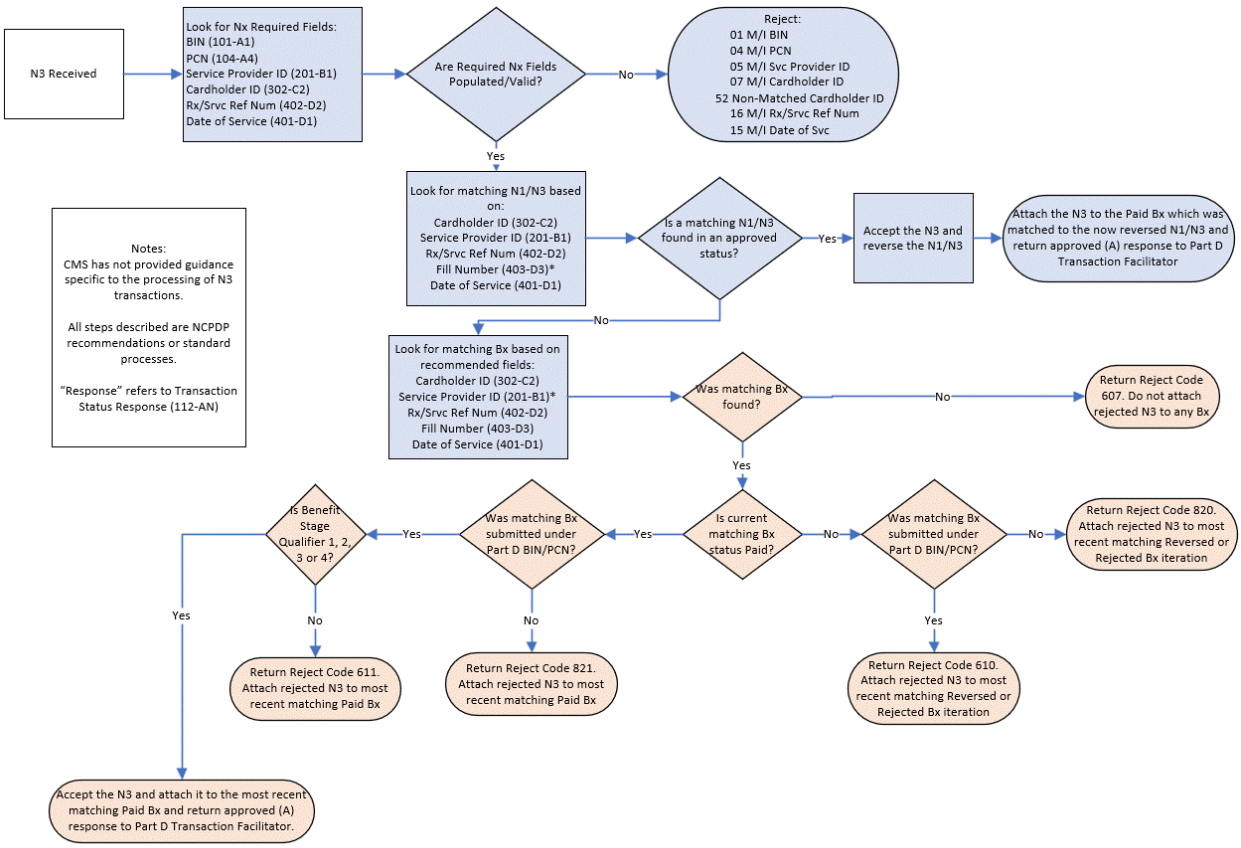
   ii. *If the matching B transaction (Bx) was not submitted under the Medicare Part D BIN/PCN, then return reject code 770 (Paid Billing Transaction (B1/B3) Submitted Under The Medicare Part D IIN PCN Not Found And Information Reporting Reversal (N2) Cannot Be Matched To An Information Reporting Transaction (N1/N3) In Approved Status; Reversal (N2) Not Processed) and attach the rejected N2 to the most recent matching paid B transaction (Bx).*

Note: It is at the plan/processor's discretion as to how to handle the prior N1/N3 transaction in conjunction with the N2 transaction and the impact on any downstream processes.

4.5 N3 TRANSACTION FLOW

Below is the transaction process flow for matching the N3 transaction to a N1/N3 transaction that includes both recommended and CMS mandated matching logic and reject codes. Please see Appendix A for information about valid and invalid reject codes.

Matching N3 to an N1/N3



4.6 MATCHING N3 TO N1/N3 TRANSACTION PROCESS

CMS has not provided guidance specific to the processing of N3 transactions. All steps described below are NCPDP recommendations or standard processes.

1. N3 is received from the Medicare Part D Transaction Facilitator.

2. Validate the presence of values in the N3 Required Fields. If values are blank (spaces are considered valid), return applicable reject.

N3 Required Field	**Reject Code**
BIN (101-A1)	01 M/I BIN
PCN (104-A4)	04 M/I PCN
Service Provider ID (201-B1)	05 M/I Service Provider ID
Cardholder ID (302-C2)	07 M/I Cardholder ID 52 Non-Matched Cardholder ID
Prescription/Service Reference Number (402-D2)	16 M/I Prescription/Service Reference Number
Date of Service (401-D1)	15 M/I Date of Service

3. Once required fields have been validated, attempt to find a matching N1/N3 transaction by using the recommended fields. First try matching with Fill Number (403-D3) and if no match is found, then try matching without Fill Number (403-D3).
   Cardholder ID (302-C2)
   Service Provider ID (201-B1)
   Prescription/Service Reference Number (402-D2)
   Fill Number (403-D3)*
   Date of Service (401-D1)

4. If a matching N1/N3 was found in approved status, accept the N3 and reverse the matching N1/N3.

5. Attach the N3 to the Paid B transaction (Bx) which was matched to the now reversed N1/N3 and return approved (A) response to the Medicare Part D Transaction Facilitator. If a matching N1/N3 was not found or found but not in approved status, then continue trying to match the N3 to the B transaction using the below steps (Same process as N1 transaction).

6. If no matching B transaction (Bx) was found return reject 607 (Information Reporting (N1/N3) Transaction Cannot Be Matched To A Claim (B1/B3)).

7. If matching B transaction (Bx) was found in Reversed or Rejected status, determine if B transaction (Bx) was submitted under Medicare Part D BIN/PCN.
   a. If not submitted under Medicare Part D BIN/PCN, return reject code 820 (Information Reporting Transaction (N1/N3) Matched To Reversed Or Rejected Claim Not Submitted Under Medicare Part D IIN PCN). Attach rejected N3 to most recent matching Reversed or Rejected B transaction (Bx) iteration.
   b. If submitted under Medicare Part D BIN/PCN, return reject code 610 (Information Reporting Transaction (N1/N3) Matched To Reversed Or Rejected Claim Submitted Under Medicare Part D IIN PCN). Attach rejected N3 to most recent matching Reversed or Rejected B transaction (Bx) iteration.

8. If matching B transaction (Bx) was found in Paid status, determine if B transaction (Bx) was paid under Medicare Part D BIN/PCN.
   a. If not paid under Medicare Part D BIN/PCN, return reject code 821 (Information Reporting (N1/N3) Transaction Matched To Paid Claim Not Submitted Under Medicare Part D IIN PCN). Attach rejected N3 to most recent matching paid B transaction (Bx).
   b. If paid under Medicare Part D BIN/PCN, determine if the Benefit Stage Qualifier (393-MV) is 01, 02, 03, or 04.
      i. If Benefit Stage Qualifier is not 01, 02, 03 or 04, return reject code 611 (Information Reporting Transaction (N1/N3) Was Matched To A Claim Submitted Under The Medicare Part D IIN/PCN Paid As Enhanced Or OTC Or By A Benefit Other Than Medicare Part D). Attach rejected N3 to most recent matching paid B transaction (Bx).

ii. If Benefit Stage Qualifier is 01, 02, 03 or 04, accept the N3 to the most recent matching paid B transaction (Bx) and return approved (A) response to the Medicare Part D Transaction Facilitator.

N3 transactions are not expected to have duplicates as each would simply reverse and resubmit the N information.

5. APPENDIX A: OVERVIEW OF VALID AND INVALID REJECT CODES FOR MEDICARE PART D RECORD OF SUPPLEMENTAL PAYMENT N TRANSACTIONS (NX)

The ***Valid and Invalid Reject Codes for Medicare Part D Record of Supplemental Payment N Transactions (Nx)*** document represents a list of reject codes which are recommended as valid (applicable) or invalid (non-applicable) as they apply to processing N transactions (Nx) generated by the Medicare Part D Transaction Facilitator. The document may be found on the Medicare Part D Transaction Facilitator website at http://medifacd.relayhealth.com/nx/part-d-plans/nx-reject-reports.

There are three tabs in the document:

1) Overview tab-identifies the purpose of the document and provides an overview of the other tabs.

2) Valid Rejects tab – list of recommended reject codes to be returned to the Medicare Part D Transaction Facilitator when unable to successfully process an N transaction (Nx) initiated by the Medicare Part D Transaction Facilitator (Software Vendor/Certification ID (110-AK) = TROOP or TROOPBATCH).

3) Invalid Rejects tab – list of recommended reject codes that should not be returned to the Medicare Part D Transaction Facilitator when unable to successfully process an N transaction (Nx) initiated by the Medicare Part D Transaction Facilitator (Software Vendor/Certification ID (110-AK) = TROOP or TROOPBATCH). Note these reject codes may be valid for N transactions from other entities, therefore it is recommended to segregate coding based on 110-AK.

This document has been created through industry collaboration on the NCPDP WG1 Medicare Part D Supplemental Payment Reporting Task Group. Questions related to these reject codes can be submitted to NCPDP at *standards@ncpdp.org* with a subject line of "Supplemental Payment Reject Codes" for discussion on a task group call.

6. APPENDIX B: HISTORY OF CHANGES

6.1 VERSION 1.0

Original Publication

6.2 VERSION 2.0

- Section 1 – Removed reference to white paper since this is a guidance document
- Section 2 – Clarified issuer of BIN and updated explanation of N3 – Information Reporting Rebill transaction
- Section 3 – Removed reference to Coordination of Benefits Contractor and Group Health Inc.
- Section 4.5 - Update Matching N3 to an N1/N3 diagram adding additional steps if matching N1/N3 is not found in an approved status
- Section 4.6 – Updated steps 4 – 6 and added steps 7 – 8
- Section 5 – Updated contact email address for NCPDP Standards Department
- Standardized reference to Medicare Part D
- Added reject code definitions and field reference numbers
- Grammar, punctuation and administrative corrections throughout