MEDICARE PART D PRESCRIPTION DRUG EVENT (PDE) DATA ELEMENTS

#	Data Element	Field Description	Field Value
1	Contract Number	This field contains the unique number CMS assigns to each contract that a Part D plan has with CMS.	Contract number assigned by CMS.
2	Plan Benefit Package (PBP) Identifier	This field contains the unique number CMS assigns to identify a specific PBP within a contract.	PBP number assigned by CMS.
3	Claim Control Number	This field is an optional field, free-form field. It is intended for use by plans to identify unique events or for other plan purposes.	Optional field.
4	Health Insurance Claim Number (HICN)	This field contains the unique number identifying the primary beneficiary under the Social Security Administration and Railroad Retirement Board (RRB) programs.	Medicare HICN or RRB number.
5	Cardholder Identifier	This field contains the plan-assigned number used to identify the beneficiary.	Plan identification of the enrollee (assigned by the plan).
6	Patient Date of Birth (DOB)	This field contains the beneficiary date of birth.	CCYYMMDD
7	Patient Gender	This field identifies the gender of the beneficiary.	1=M 2=F
8	Date of Service	This field contains the date on which the prescription was filled.	CCYYMMDD
9	Paid Date	This field contains the date the plan originally paid the pharmacy for the prescription drug. If the plan subsequently adjusts payment, the plan will report the original paid date in the adjustment PDE. This field is a mandatory field for fallback plans and optional for all other plan types.	CCYYMMDD
10	Service Provider Identifier Qualifier	This field indicates the type of provider identifier used in field 11 (Service Provider Identifier).	01 = NPI 06 = UPIN 07 = NCPDP Number 08 = State License 11 = Federal Tax Identifier 99 = Other Values of '06', '08', '11' and '99' only acceptable if non-Standard format='B', 'X' or 'P'
11	Service Provider Identifier	This field identifies the pharmacy where the prescription was filled. CMS will transition to the use of the National Provider Identifier (NPI) when it is implemented. In the interim, this field typically contains the NCPDP number which all NCPDP billers are assigned. Some Part D service providers who submit in Non-Standard Format (e.g., home infusion, physicians when providing vaccines, etc.) will not have NCPDP numbers. For these providers, the Unique Provider Identification Number (UPIN), State License Number, Federal Tax Identification Number, Employer Identification Number, or the default value of 'PAPERCLAIM' will be the identifier.	For Standard Data Format, valid values are: 01 = NPI 07 = NCPDP Provider Identifier For non-Standard data format, any value in Service Provider Identifier Qualifier is valid. When Plans report Service Provider Identifier Qualifier '99' this field will contain 'PAPERCLAIM'.

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12	Prescriber Identifier Qualifier	This field indicates the type of identifier that is used in field 13 (Prescriber Identifier field).	01 = NPI 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number
13	Prescriber Identifier	This field contains the prescriber's unique identification number. CMS will transition to the use of the NPI when it is implemented. In the interim, CMS requires use of a DEA number whenever it uniquely identifies the prescriber and is allowed by State law. In other cases, the prescriber's State license number or UPIN is used.	Prescriber's unique identification number.
14	Prescription/Service Reference Number	This field contains the prescription reference number assigned by the pharmacy at the time the prescription is filled.	Prescription reference number. Field length is 9 to accommodate proposed future NCPDP standard.
15	Product/Service Identifier	This field identifies the dispensed drug using a National Drug Code (NDC). The NDC is reported in NDC11 format. In instances where a pharmacy formulates a compound containing multiple NDC drugs, the NDC of the most expensive drug is used.	NDC code in the following format: MMMMMDDDDPP followed by 8 spaces. CMS rejects the following codes: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995 and 99999999996.
16	Compound Code	This field indicates whether or not the dispensed drug was compounded or mixed.	0 = Not specified 1 = Not a compound 2 = Compound
17	Dispense as Written/Product Selection Code	This field indicates the prescriber's instruction regarding substitution of generic equivalents or order to dispense the specific product written.	0 = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed - Patient Requested Product Dispensed 3 = Substitution Allowed - Pharmacist Selected Product Dispensed 4 = Substitution Allowed - Generic Drug Not in Stock 5 = Substitution Allowed - Brand Drug Dispensed as Generic 6 = Override 7 = Substitution Not Allowed - Brand Drug Mandated by Law 8 = Substitution Allowed - Generic Drug Not Available in Marketplace 9 = Other
18	Quantity Dispensed	This field indicates how many dosage units of the medication were dispensed in the current drug event.	Number of units, grams, milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.

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19	Days Supply	This field indicates the number of days' supply of medication dispensed by the pharmacy and will consist of the amount the pharmacy enters for the prescription.	0 - 999
20	Fill Number	This field indicates the number fill of the current dispensed supply.	0 - 99; if unavailable, 0 will be populated.
21	Dispensing Status	This field indicates how the pharmacy dispensed the complete quantity of the prescription. When the pharmacy partially fills a prescription, this field indicates a partial fill. When the full quantity is dispensed at one time, this field is blank.	Blank = Not specified or full quantity P = Partial Fill C = Completion of Partial Fill
22	Drug Coverage Status Code	This field indicates whether or not the drug is covered under the Medicare Part D benefit and/or a specific PBP.	C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
23	Adjustment/Deletion Code	This field distinguishes original from adjusted or deleted PDE records so CMS can adjust claims and make accurate payment for revised PDE records.	A = Adjustment D = Deletion Blank = Original PDE
24	Non-Standard Format Code	This data element is used by CMS to identify PDE records that are compiled from non-standard sources. NCPDP is the standard format in which plans receive data from pharmacies.	X = X12 837 B = Beneficiary submitted claim P = Paper claim from provider Blank = NCPDP electronic format
25	Pricing Exception Code	This field indicates that the PDE reports an out-of-network or Medicare as Secondary Payer (MSP) service that is subject to unique pricing rules.	M = Medicare as Secondary Payer O = Out-of-Network pharmacy Blank = In-Network pharmacy and Medicare Primary
26	Catastrophic Coverage Code	This field indicates that a beneficiary has reached the out-of-pocket threshold or attachment point. At this point, catastrophic coverage provisions begin, namely reinsurance and reduced beneficiary cost sharing.	A = Attachment point met on this event C = Above Attachment point Blank = Attachment point not met
27	Ingredient Cost Paid	This field contains the amount paid to the pharmacy for the drug itself. Dispensing fees or other costs are not to be included in this amount except as allowed on non-standard format claims.	Amount paid to pharmacy for drug.
28	Dispensing Fee Paid	This field contains amounts paid to the pharmacy for dispensing the medication. This field should only contain the activities related to the transfer of possession of the drug from the pharmacy to the beneficiary, including charges associated with mixing drugs, delivery, and overhead as delineated in the final rule and the preamble to the rule. No other costs shall be included in this field. The fee may be negotiated with pharmacies at the plan or PBP level.	Amounts paid to pharmacy for dispensing medication.
29	Total Amount Attributed to Sales Tax	This field contains the sum of all amounts paid to the pharmacy to cover sales tax.	Amounts paid to pharmacy to cover sales tax.

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#	Data Element	Field Description	Field Value
30	Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)	This field represents the gross drug cost paid to the pharmacy below the Out-of-Pocket threshold for a given PDE for a covered drug. For claims received prior to a beneficiary reaching the attachment point, this field will contain a positive dollar amount. For claims above the attachment point, this field will contain a zero dollar value. For a claim on which the attachment point is reached, there is likely to be a positive dollar amount in this field and there will be a positive dollar amount in field 31 (GDCA).	When the Catastrophic Coverage Code = 'Blank', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax falling at or below the Out-of-Pocket threshold. The remaining portion is reported in GDCA.
31	Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	This field represents the gross drug cost paid to the pharmacy above the Out-of-Pocket threshold for a given PDE for a covered drug. For claims received prior to a beneficiary reaching the attachment point, this field will contain a zero dollar amount. For claims above the attachment point, this field will contain a positive dollar value. For a claim on which the attachment point is reached, there is likely to be a positive dollar amount in this field and there will be a positive dollar amount in field 30 (GDCB).	When the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax above the Out-of-Pocket threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax falling above the Out-of-Pocket threshold. The remaining portion is reported in GDCB.
32	Patient Pay Amount	This field lists the dollar amount the beneficiary paid that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts). This amount contributes to a beneficiary's TrOOP only when it is payment for a covered drug. Payments made by the beneficiary or family and friends shall also be reported in this field. Other third party payments made on behalf of a beneficiary that contribute to TrOOP shall be reported in field 33 (Other TrOOP Amount) or field 34 (Low-Income Cost-Sharing Amount) and payments that do not contribute shall be reported in field 35 (Patient Liability Reduction due to Other Payer Amount).	Amount beneficiary paid that is not reimbursed by a third party.
33	Other True Out-of-Pocket (TrOOP) Amount	This field records all qualified third party payments that contribute to a beneficiary's TrOOP, except for LICS and Patient Pay Amount. Examples include payments made on behalf of a beneficiary by a qualified State Pharmacy Assistance Program, charities, or other TrOOP-eligible parties.	Amount of qualified third party payments that contribute to a beneficiary's TrOOP.
34	Low-Income Cost-Sharing Subsidy Amount (LICS)	This field contains plan-reported LICS amounts per drug event so that CMS systems can reconcile prospective LICS payments made to plans with actual LICS amounts incurred by the plan at Point of Sale.	Amount the plan reduced patient liability due to a beneficiary's LICS status.

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35	Patient Liability Reduction due to Other Payer Amount (PLPRO)	This field takes into account coordination of benefits that results in reduced patient liability, excluding any TrOOP-eligible payers.	Amounts by which patient liability is reduced due to payments by other payers that do not participate in Part D and are not TrOOP-eligible. Examples of non-TrOOP-eligible payers are group health plans, Worker's Compensation and governmental programs (e.g. VA, TRICARE).
36	Covered D Plan Paid Amount (CPP)	This field contains the net amount the plan paid for standard benefits (covered Part D drugs).	Net amount the plan has paid for a Part D covered drug (where Drug Coverage Code = 'C'). If Drug Coverage Code = 'E' or 'O', the CPP field is zero.
37	Non-covered Plan Paid Amount (NPP)	This field contains the net amount paid by the plan for benefits beyond the standard benefit.	Net amount the plan has paid for all over-the-counter drugs, enhanced alternative drugs, and enhanced alternative cost-sharing amounts.