



Centers for Medicare & Medicaid Services

Module 12: Edits

2025 Prescription Drug Event (PDE) Participant Guide

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1. Purpose

The Centers for Medicare & Medicaid Services (CMS) designed edits to ensure the accuracy of Prescription Drug Event (PDE) data. In this module, participants will learn about the errors generated by the Prescription Drug Front-End System (PDFS) and the Drug Data Processing System (DDPS). Specifically, this module will describe the types of edits and checks performed by PDFS and DDPS and how these edits and checks are applied to the submitted data. Lastly, participants will learn about the new edit codes established to implement the provisions of the Inflation Reduction Act (IRA), specifically the Manufacturer Discount Program (MDP).

2. Objective

The information contained within this module applies to benefit years 2025 and forward. For benefit years prior to 2025, refer to the [2011 PDE Participant Guide](#) located on the Customer Service and Support Center (CSSC) website.

The information provided in this module will help participants to:

- Describe the edit logic for the PDFS and DDPS.
- Identify the edit categories in DDPS.
- Recognize and apply the resolution process to resolve errors received from PDFS and DDPS.

3. Edit Process

Plans submit PDE data to PDFS. PDFS performs format, integrity, and validity checks on the file and batch level records. PDFS performs limited edits on detail level records. Once the file passes the PDFS edits, PDFS forwards the file to DDPS at CMS. DDPS edits the detail level records for format, integrity, and validity before storing the data for future payment calculation.

Understanding the edits and edit logic allows plans to ensure the timely and accurate processing of PDE data. When programming internal systems for submitting PDEs, plans and submitters should incorporate PDFS and DDPS edits.

4. PDFS Edits

PDFS performs format, integrity, and validity checks at the file and batch level on the data submitted. Examples of edits include checking for:

- Missing data in file and batch level header and trailer records (e.g., Record ID, Submitter ID, Prod Test Cert Ind).
- Appropriate sequencing of records:
 - A batch header (BHD) record follows each file header (HDR) record.
 - A detail (DET) record follows each BHD record.
 - A DET record or a batch trailer (BTR) record follows each DET record.
 - A BHD record or a file trailer (TLR) follows each BTR record.
- File IDs that do not duplicate a File ID previously accepted within the last 12 months in production, test, or certification.
- Balance:
 - File ID and Submitter ID are the same in the HDR and TLR.

- Sequence No, Contract No, and Plan Benefit Package (PBP) ID are the same on the BHD and BTR.
- Batch and detail sequence numbers always begin with 0000001 and are assigned by incrementing the previous sequence number by one.
- Valid DET and BHD record totals.

If the file passes all PDFS edits, PDFS will forward the file to DDPS for processing. If any of the data fails PDFS editing, PDFS will reject the complete file.

4.1 PDFS Edit Logic and Ranges

When PDFS determines that there is an error, a code and associated message are generated for that error. Table 1 describes the error code logic. The series and ranges indicate whether errors occur on the file, batch, or detail level and more specifically in the header or trailer for the file and batch.

Reminder: When a file fails any PDFS edit, PDFS rejects the complete file and returns it to the submitter after all possible PDFS checks are completed.

Table 1: PDFS Edit Code Logic and Ranges

Series	Ranges	Explanation
100	126-150	File level errors on the HDR.
100	176-199	File level errors on the TLR records.
200	226-250	Batch level errors on the BHD.
200	276-299	Batch level errors on the BTR records.
600	601-602	Detail level errors on DET records.

4.2 PDFS Edit Codes

PDFS checks the format, integrity, and validity of individual fields in file level summary record types before cross-checking field to field. For example, PDFS first checks that there is a Submitter ID in the HDR and one in the TLR before cross-checking the Submitter ID between the HDR and TLR. PDFS performs edits at the file level before proceeding to perform edit checks at the batch level. PDFS validates sequence at the detail level as the last edit check performed before the file is passed to DDPS. PDFS file level, batch level, and detail level error codes are described on the [PDFS Edit Lookup](#) page on the CSSC Operations website. A complete table of the PDFS edit codes will be displayed by selecting the View All button. Individual PDFS edit codes can be entered in the Error Code search field. The edit code will be displayed with the corresponding record type, data element, and edit code description in the PDFS Edit table. Alternatively, the comprehensive PDFS Edit Spreadsheet containing all the PDFS edit codes and related information can be downloaded by selecting the Download button.

5. DDPS Editing Rules

The DDPS editing process takes place in stages.

5.1 Stage 1: Individual Field Validity Edits

The DDPS performs format, integrity, and validity checks on all DET record fields as a first level of editing. Examples include:

- Dates in CCYYMMDD format.
- Medicare Beneficiary Identifier (MBI) field not filled with spaces.
- Fields contain valid values.

5.2 Stage 2: Enrollment/Eligibility Edits

In this stage, eligibility and Low-Income Cost-Sharing Subsidy Amount (LICS) data from the PDE are validated against CMS databases. First, DDPS looks up the MBI reported on the PDE and validates that there is a matching MBI on the Medicare Beneficiary Database (MBD) with the same gender and date of birth (DOB) (if present on the PDE). Next, DDPS cross-checks the appropriate fields against the CMS databases to verify Part D enrollment and LICS eligibility information. DDPS then confirms that beneficiary liability never exceeds the statutorily defined maximum when the beneficiary is Low-Income Subsidy (LIS) eligible.

5.3 Stage 3: Duplicate Check Edits

Prior to performing duplicate checking, DDPS looks up the reported MBI to confirm that it exists in the CMS databases. DDPS then searches for an active PDE record on file with matching data in the following five key fields: Service Provider ID, Service Provider ID Qualifier, Prescription Service Reference No, Date of Service (DOS), and Fill Number. DDPS rejects any matches identified as duplicates without an appropriate Adjustment Deletion Code.

5.4 Stage 4: Field-to-Field Edits

Following the edits to determine if a record is not a duplicate, DDPS begins logical edits which compare fields against each other. Examples include:

- Edits based on “If Then” statements e.g., if drug coverage status equals ‘E’ or ‘O’, then the Covered Plan Paid Amount (CPP) must equal zero.
- The sum of the detail cost fields must equal the sum of the payment fields within the allowable rounding error.

5.5 Stage 5: Manufacturer Discount Calculation Edits

Manufacturer Discount calculation edits are limited to PDEs that have not received rejections in any of the first four stages of PDE editing. The Total Gross Covered Drug Cost (TGDC) and True Out-of-Pocket (TrOOP) Accumulators and the Beginning and Ending Benefit Phases reported on the PDE are used along with information on the plan benefit design to allow CMS to calculate the expected Manufacturer Discount amount (The values in these fields and the relationships between one another are evaluated in previous edit stages. See Stages 1 (5.1) and 4 (5.4)). When the Reported Manufacturer Discount amount varies from the calculated Manufacturer Discount amount, DDPS issues several informational (see Section 8: Informational Edits) and reject edits.

5.6 Stage 6: Adjustment Deletion Code Edits

In the event that the PDE is submitted as an adjustment to or deletion of an original PDE, there is another stage of editing. When the Adjustment Deletion Code reports ‘A’ or ‘D’, DDPS searches for a matching current active record. If the current active record is not found, then an error message is reported on the PDE Outbound File returned to submitters. DDPS will not

assume that the plan submitted an original PDE with an Adjustment Deletion Code field incorrectly populated.

6. DDPS Edit Categories

Table 2 describes the series of edits and fourteen categories by which the DDPS edits are organized.

Table 2: Categories and Descriptions

Edit Category	Description
Missing or Invalid (M/I)	Straightforward edits identifying invalid or missing values. If blank is a legal value, the missing edit does not apply.
Adjustment or Deletion (Adj/Del)	Edits in a hierarchy using eight fields (Contract No, PBP ID, MBI, Service Provider ID, Service Provider ID Qualifier, Prescription Service Reference No, DOS, and Fill Number).
Catastrophic Coverage (Cat Cov)	Edits that test the relationship between the TrOOP Accumulator and the Out-of-Pocket (OOP) Threshold and the summary cost fields for Gross Drug Cost Below Out-of-Pocket Threshold (GDCEB) and Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA), so that allowable reinsurance costs are summed correctly (Applies only to PDEs for Part D Covered Drugs).
Cost	Cost edits perform basic accounting functions to confirm that 1.) the summary cost fields and the detail cost fields balance and that 2.) the detail cost fields and payment fields balance. The summary cost field for GDCA is used to sum allowable reinsurance costs.
Eligibility (Elig)	Eligibility edits verify the MBI and the beneficiary's eligibility for Part D and enrollment in a Part D plan. Plan enrollment must be accurate because payment calculations, including Plan-to-Plan reconciliation, are summarized at the plan level.
Low-Income Cost-sharing (LICS)	LICS edits confirm that CMS documents the beneficiary's LICS status and validates that beneficiary cost-sharing never exceeds statutorily defined maximum amounts. Dollars reported in LICS are used to reconcile LICS.
National Drug Code (NDC)	NDC edits confirm that an NDC exists and that the NDC existed on the date of service (DOS). The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered drugs are excluded from True Out-of-Pocket Costs (TrOOP), LICS, and payment calculations.
Non-Covered Drug (Non Cov Drug)	Edits that test the relationship between non-covered drugs, the Beginning and Ending Benefit Phase and Accumulator fields, and other dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, Reported Manufacturer Discount, and payment calculations.
Miscellaneous (Misc)	Edits on miscellaneous data elements.
Program of the All-Inclusive Care for the Elderly (PACE)	Edits that validate the beneficiary's PACE eligibility, along with PACE PDE submission validity, population accuracy, and financial field calculations.
Plan-to-Plan (P2P) Phase III Retro Enrollment	Edits describe the Contract and/or PBP of Record changes resulting from the P2P Contract/PBP Update.
Gap Discount	Edits that confirm the Reported Gap Discount field with other data reported on the PDE.

Inflation Reduction Act (IRA)	Edits established to implement provisions of the IRA, to include covered insulin products and ACIP-recommended vaccines for 2023 and forward.
Manufacturer Discount (MDP)	Edits that confirm the Reported Manufacturer Discount field with other data reported on the PDE.

7. DDPS Edit Codes

For a complete list of the DDPS edit codes, see the [DDPS Edit Lookup](#) page on the CSSC Operations website and select the “View All” button. Individual DDPS edit codes can be entered in the Error Code search field. The edit code will be displayed with the corresponding edit code description and comments/rationale in the DDPS Edit table. Alternatively, the comprehensive DDPS Edit Spreadsheet containing all the DDPS edit codes, descriptions, and more can be downloaded by selecting the Download button. CMS expects that plans will use the information provided in the DDPS Edit table or Spreadsheet to correct errors on PDE submissions as necessary and resubmit the PDE data promptly. If you have questions about error correction, please contact the Customer Service and Support Center at 1-877-534-2772.

CMS notifies plans of updates to DDPS and communicates the addition of new edits and the modification or retirement of existing edits by releasing memorandums via the Health Plan Management System (HPMS). The DDPS Edit Spreadsheet and table will be updated accordingly to ensure current information is always available on the CSSC Operations website for reference. CMS expects that plans will be prepared to respond rapidly as DDPS, or its supporting databases are updated to facilitate PDE submission. Questions regarding updates can be submitted to the CMS PDE Operations Mailbox at PDE-Operations@cms.hhs.gov.

8. Informational Edits

DDPS has many informational edits. Informational edits either question data reported by the plan or provide additional information from CMS. Both types of informational edits may require plan action.

Informational edits such as 708 and 709 identify conditions that are usually errors. These edits are defined as informational because, infrequently, there are documented circumstances in which the condition is not an error. Plans must ensure that they submit accurate data. If the plan finds that it submitted data inappropriately, the plan must submit adjustments to correct the data whenever necessary.

CMS also uses informational edits to communicate updated information to the plan. For example, edit 710 informs the plan that CMS has updated the MBI. Plans should update their internal records and use the most current number thereafter.

Example: 1

Scenario: Greenhouse Prescription Drug Program (PDP) submitted a PDE for a beneficiary with an MBI.

Edit: While DDPS accepted this record, the system issued a 710 informational edit and provided an error message: An updated MBI is available. Use the value in the Corrected Medicare Beneficiary Identifier field from the PDE Outbound File for future submissions.

Resolution: Greenhouse PDP does not resubmit the PDE that received the 710 edit. The plan updates its system to reflect the new MBI to avoid receiving additional 710 edits on future PDEs for this beneficiary.

9. Error Resolution

Error correction/resolution is a central component in ensuring the acceptance, accuracy, and completeness of plans' PDE data submissions. As plans correct individual errors, they must assess the factors that caused the error. Plans should also measure and improve their own performance in reducing errors over time.

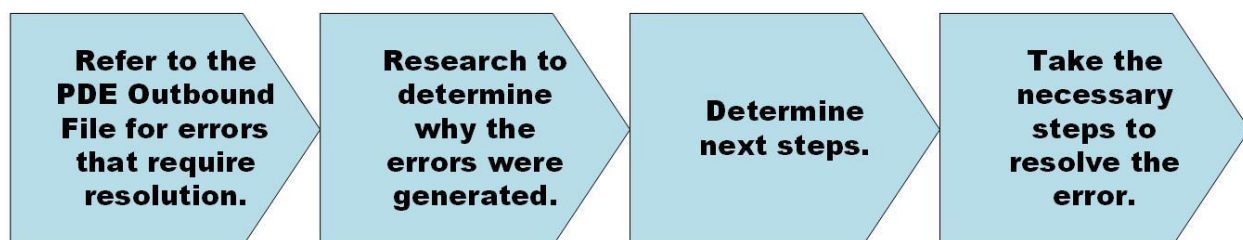
To assist plans with working through the error resolution process, this section provides plans with an explanation of the basic framework of the error resolution process and offers plans different types of error resolution strategies with examples of the types of situations in which these strategies should be used.

9.1 The Basic Framework to Error Resolution Process

CMS expects plans to have an active and considered approach to correct errors as a part of their PDE submission strategy. Error resolution has two parallel paths. Plans should have processes in place to respond quickly and effectively to errors that they receive on the PDE Outbound File returned from CMS. In addition, plans should also have measures in place internally to help identify potential or current errors that require fixes.

Figure 1 describes the steps to resolve errors within DDPS. These steps are essentially the same for each error resolution, though different types of errors may require additional steps to facilitate resolution. Those additional strategies are outlined later in this section.

Figure 1: Error Resolution Process



- **Refer to the PDE Outbound File for errors that require resolution.** Edit resolution is a process that should commence with the receipt of every PDE Outbound File from DDPS. The PDE Outbound File uniquely identifies and gives details for up to ten errors. This detail information gives the plan sufficient information to correct the majority of errors in a record and resubmit data accordingly. Note that the maximum error count returned in the PDE Outbound File is ten. If the error count is ten, plans can conclude that the record most likely contained additional error conditions for which no error detail could be reported.
- **Research to determine why the errors were generated.** Plans should identify the field or fields that triggered the error, assess the factors that could have caused the error, and determine the root cause of the error.
- **Determine next steps.** Plans should assess the errors received and determine whether the plan is capable of correcting the data or whether CMS needs to be involved in the resolution of the error. Note that most errors can be resolved through action on the part of the plan, while some errors require CMS intervention to resolve.

- **Take the necessary steps to resolve the error.** For errors that are within a plan's control to correct, plans should research the error, and if appropriate, correct the data and resubmit. For errors that require CMS intervention, the plan should submit an inquiry to CMS via the CMS PDE Operations Mailbox at PDE-Operations@cms.hhs.gov.

Individual Field Error Resolution

1. Error resolution for missing and invalid edits on an individual field is straightforward. Once the plan has received the edit indicating a missing or invalid value, the plan should determine the exact nature of the error, i.e., whether the data is missing or invalid, and then determine how to correct the data.
2. If the data is missing, and it is a required field, the plan should resubmit with the required data.
3. If the data is invalid because it was submitted in an incorrect format, the plan should determine the correct format and resubmit the data.
4. If the data is invalid because an invalid value was submitted, the plan should determine what the appropriate value is and resubmit the data.
5. If the plan receives a missing/invalid edit for an optional field, such as DOB, because the data is invalid the plan could also choose to omit the data that caused the reject.

Example: 2

Determining if the error occurred because the format is invalid.

Scenario: Park PDP submitted a PDE record with the Prescription Service Reference No populated using an alphanumeric format instead of numeric.

Edit: Park PDP receives edit 612, which indicates the Prescription Service Reference No is missing or invalid. The Prescription Service Reference No must be numeric.

Resolution: Park PDP corrects the invalid format and resubmits with the corrected data.

Example: 3

Determining if the data value is invalid.

Scenario: Lighthouse Health submitted a PDE record with 'D' in the Drug Coverage Status Code.

Edit: Lighthouse Health received edit 625, which indicates the Drug Coverage Status Code is missing or invalid. The only valid values for this field are 'C', 'E' or 'O'.

Resolution: Lighthouse Health corrects the invalid data and resubmits with a valid value for this field.

Field-to-Field Error Resolution

The process for resolving errors associated with field-to-field edits is similar but involves several additional steps.

1. Identify the relationships between the multiple fields that triggered the error.
2. Determine which fields had incorrect values that caused the error.

Because field-to-field errors could indicate a system issue, plans may need to make internal systems changes prior to resubmitting data.

When resolving errors and implementing prevention mechanisms in internal systems, plans can ask the following questions:

- Are plan system's field definitions and values consistent with PDE definitions and values?
- Are plan system's edits compatible with DDPS edits?
- Did system deficiencies contribute to the error?
- Could system enhancements, such as better user prompts, minimize recurring errors?

Note: Cost Edits, NDC Edits, and Drug Coverage Status Code Edits are examples of field-to-field edits.

Example: 4

Scenario: Red Farm Health submitted a PDE record in which the detail cost fields do not equal the summary cost fields.

Edit: Red Farm Health received edit 691, which indicates that the sum of GDCB and GDCA is not equal to the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee.

Resolution: Red Farm Health should:

- Determine if the system populated and summed the detail cost fields correctly.
- Determine if the system populated and summed the GDCB and the GDCA correctly.
- If appropriate, make systems changes to correct the error.

Some field-to-field edits require additional problem-solving steps to resolve the error. For some field-to-field edits, correcting the data or the source of the data issue and resubmitting may not be appropriate to resolve the error. For these edits, additional problem-solving steps such as contacting CSSC, are required to resolve the error. These steps are described in the section on Error Resolution Process.

Eligibility and LICS edits are examples of field-to-field edits with specific problem-solving steps.

Example: 5

Eligibility Edits:

Scenario: Yellow Ridge PBP submitted a PDE record for a beneficiary on 05/13/2025.

Edit: Yellow Ridge PBP received edit 707 indicating that the beneficiary was not enrolled in the Part D plan benefit package (PBP ID) on the DOS. The beneficiary must be enrolled in this PBP ID on the DOS to receive coverage.

Resolution: Yellow Ridge PBP should:

- Determine if the DOS is accurate.
- Determine if the plan's enrollment file shows that the beneficiary was enrolled in the plan and if the enrollment date is on or before the DOS. There may be enrollment date discrepancies when a beneficiary transfers from one plan to another.

- Determine if the Medicare Advantage Prescription Drug System (MARx) shows that the beneficiary was enrolled in the plan and if the enrollment date is on or before the DOS and if the disenrollment date (if applicable) is after the DOS.
- If the plan cannot resolve enrollment discrepancies, the last step is to contact the CMS PDE Operations mailbox for assistance at PDE-Operations@cms.hhs.gov.

Example: 6

LICS Edits:

Scenario: Green Fan PDP submitted a PDE record for a non-Low-Income Subsidy (non-LIS) beneficiary and included \$10 in the LICS field.

Edit: Green Fan PDP received edit 715 indicating that the beneficiary is not eligible for LICS on the DOS.

Resolution: Since the beneficiary is not eligible for LICS subsidy because the beneficiary is not low-income-eligible, Green Fan PDP should:

- Determine if the DOS is accurate.
- Determine if the plan's enrollment file shows that the beneficiary was LIS-eligible on the DOS.
- There may be eligibility date discrepancies when a beneficiary first becomes LIS-eligible due to retroactive LIS eligibility.
- Determine if MARx shows that the beneficiary was LIS-eligible on the DOS. There may be timing lags between MARx and plan data for LIS status.
- If the plan cannot resolve LIS discrepancies, the last step is to contact CSSC at 1-877-534-2772.

Plans have financial incentive to resolve LICS edits because plans will not receive payment for LICS amounts that plans advanced to beneficiaries who are not listed as LIS-eligible on MARx.

Plans must also monitor Transaction Reply Reports (TRRs) for retroactive LIS status.

When a beneficiary receives a LIS status retroactively, the plan must:

1. Reimburse the beneficiary for cost-sharing greater than the LIS cost-sharing limit for claims occurring during the timeframe covered by the retroactive LIS status and;
2. Submit an adjustment for every previously accepted PDE to report LICS accurately.

Example: 7

NDC Edits:

Scenario: Blue Bird PDP submitted a PDE record for a covered Part D drug on 1/15/2025.

Edit: Blue Bird PDP received edit 746 indicating that the NDC was not found on the current FDA NDC SPL Data Element (NSDE) file.

Resolution: Blue Bird PDP should:

- Determine whether the NDC represents a covered Part D drug.

- Determine whether the NDC is a new drug product on the market and has recently been added to the NSDE file. Timing may be an issue between the dates of PDE submissions and updates to the NSDE file used for PDE editing. If the NDC is identified as a new addition to the NSDE file, then Blue Bird PDP should resubmit the PDE the following month.
- If a plan believes that information on the NSDE file is incorrect, the plan should notify the Food and Drug Administration (FDA) at SPL@fda.hhs.gov and contact the manufacturer to update the NDC information provided on the NSDE file. Once the information is updated on the NSDE file, the plan should resubmit rejected PDEs.

Example: 8

NDC Edits:

Scenario: Five Star PDP submitted a PDE record for a covered Part D drug on 9/15/2025 with a DOS = 9/5/2025.

Edit: Five Star PDP received edit 747 indicating that the NDC was found on the current FDA NDC SPL Data Element file but is not effective for the given DOS.

Resolution: Five Star PDP should:

- Determine whether the Marketing End Date for the NDC has recently changed on the NSDE file. Timing may be an issue between the dates of PDE submissions and updates to the NSDE file used for PDE editing. If the NDC is identified as a drug product where the Marketing End Date has been extended on the NSDE file, then Five Star PDP should resubmit the PDE the following month.
- If a plan believes that information on the NSDE file is incorrect, the plan should notify the FDA at SPL@fda.hhs.gov and contact the manufacturer to update the NDC information provided on the NSDE file. Once the information is updated on the NSDE file, the plan should resubmit rejected PDEs.

Example: 9

NDC Edits:

Scenario: Silver Lake PDP submitted a PDE record.

Edit: Silver Lake PDP received edit 738 indicating that the NDC was not covered by Part D.

Resolution: Silver Lake PDP should refer to the subcategory reject code returned in the Exclusion Reason Code field on the PDE Outbound File for more information. If a plan thinks that the NDC should be accepted, then they should contact the CMS PDE Operations mailbox for assistance at PDE-Operations@cms.hhs.gov.

Appendix A: Acronyms

Table 3: Acronyms

Acronym	Literal Translation
ACIP	Advisory Committee on Immunization Practices
BHD	Batch Header
BTR	Batch Trailer
CMS	Centers for Medicare & Medicaid Services
CPP	Covered D Plan Paid Amount
CSSC	Customer Service and Support Center
DDPS	Drug Data Processing System
DET	Detail
DOB	Date of Birth
DOS	Date of Service
FDA	Food and Drug Administration
GDCA	Gross Drug Cost Above Out-of-Pocket Threshold
GDCB	Gross Drug Cost Below Out-of-Pocket Threshold
HDR	File Header
HPMS	Health Plan Management System
IRA	Inflation Reduction Act
LICS	Low-Income Cost-Sharing Subsidy Amount
LIS	Low-Income Subsidy
MARx	Medicare Advantage Prescription Drug System
MBI	Medicare Beneficiary Identifier
MDP	Manufacturer Discount Program
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NSDE	NDC SPL Data Elements File
OOP	Out-of-Pocket
OTC	Over-the-Counter
P2P	Plan-to-Plan
PACE	Program of the All-Inclusive Care for the Elderly
PBP	Plan Benefit Package
PDE	Prescription Drug Event
PDFS	Prescription Drug Front-End System
PDP	Prescription Drug Program
PLRO	Patient Liability Reduction due to Other Payer Amount
SPL	Structured Product Labeling
TGCDC	Total Gross Covered Drug Cost

Acronym	Literal Translation
TLR	File Trailer
TrOOP	True Out-of-Pocket Costs
TRRs	Transaction Reply Reports