Thursday, August 8, 2013

I. Welcome and Call to Order
A meeting of WG1 Telecommunication was held in Fort Worth, TX on August 8, 2013. Co-Chairs Roger Pinsonneault, R.Ph. of RelayHealth, Amy Harvey of Rite Aid and Trish Brown of CVS|Caremark were present to conduct the meeting. Trish Brown called the meeting to order at 8:40 a.m.

II. Reading of the Antitrust Statement
Trish Brown read NCPDP’s Antitrust Statement.

III. Housekeeping Items and Announcements
Trish Brown noted the following:
1. Badges must be worn at all times.
2. The CMS Medicare Part D and General Medicaid Discussion will take place on Thursday August 8, 2013 at 7:30 a.m. – 8:30 a.m. in Fort Worth Ballrooms 1-4.
3. An update for the membership from the Board of Trustees will take place on Friday, August 9, 2013 from 7:30 – 8:00 a.m. (30 minutes) in Fort Worth Ballrooms 1-4.
4. Information is available for:
   a. August Work Group meeting schedule (sent via email; also available online)
   b. Work Group Attendee Roster (sent via email)
   c. Task Group Listing
   d. Calendar of Events (available online)

IV. Agenda
Trish Brown asked if there were any modifications to the agenda. A request to discuss the SPC Deliverable was added. A request to form a Benefit Integration Task Group was requested. A motion was made to approve the agenda as modified. The motion was seconded and carried.

V. Minutes
Trish Brown requested a motion to approve the minutes of the May 2013 meeting. The motion was made, seconded and carried.

VI. Old Business
A. Pended DERF
   See Task Group discussion.

B. Ballot
   There were none.

C. Recirculation Ballot
   Recirculation Ballot WG010058R Telecom E.3 (DERFs 001080) was valid at 78.26% of the consensus group voting and 75% approval rating. The ballot will be sent to NCPDP Board of Trustees for approval after a 30-day appeal period.

D. Task Group Reports
   The Work Group Co-Chairs led discussion. A list of task groups is available on the website at http://www.ncpdp.org/Get-Involved.aspx under
“NCPDP’s Task Groups”.

1. **Coordination of Benefits Task Group**

Cookie Orescanin, MedImpact and Sharon Gruttadauria, CVS Pharmacy, Task Group leads provided the report of the task group.

<table>
<thead>
<tr>
<th>Task Group Recap Report</th>
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<tbody>
<tr>
<td><strong>Task Group Name:</strong> COB Task Group</td>
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<tr>
<td><strong>Date Task Group Formed:</strong> Long time ago</td>
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<tr>
<td><strong>Task Group Leader(s):</strong> Cookie Orescanin – MedImpact; Sharon Gruttadauria – CVS/Caremark Pharmacy</td>
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**Parent Work Group:** WG 1 – Telecommunication

**Goal of Task Group:**

Answers questions and provides clarification and guidance for coordination of benefits claims processing under the current named HIPAA Telecommunication Standard. Develops solutions for future versions of the Standard to address business cases presented.

**Task Group Meeting Dates (This Period):** (5 calls)


Generally meets every other Thursday at 11:00am EST

**Business Cases Reviewed:**

1) COB Claim Pricing Segment - Contain Values as if Payer is Primary
2) Brand Medically Necessary and Patient Pay Amount Coverage Rules
3) Military Treatment Facilities – Medicare D Primary – COB payer
4) Response to Non-Mail Order Pharmacy
5) OIG Inquiry on Coupon/Copay Assistance Programs

**Task Group Reportables (bullets or text):**

1) **#41: COB Claim Pricing Segment – Contain values as if Payer Is Primary**
   a. Request WG approval to add clarification to the Pricing Segment section of the Editorial Guide

2) **#42: Brand Medically Necessary and Other Payer Patient Responsibility Qualifiers 02, 08, and 11**
   a. Request WG approval to add FAQ to COB section of the Editorial Guide.

3) **#43: Military Treatment Facilities – Medicare D Primary – COB payer**
   a. Request WG approval to add FAQ to COB section of the Editorial Guide.
   b. Request an RFP to add FAQ to COB section of the Editorial Guide.
   c. Request an RFP to add FAQ to COB section of the Editorial Guide.

4) **#44: Primary Response to Non-Mail Order Pharmacy**
   a. Task Group Response was provided to the submitter
   b. Question: Is there NCPDP guidance as to how the primary payer should return the response to the non-mail order pharmacy when the primary requires the fill to be processed under the mail order benefit?
   c. Response: There are multiple ways that a claim could be processed and still be compliant with the Standard. Plan benefit designs would dictate how these types of claims are processed. Some payers may choose to return 100% patient pay amount ideally specifying the Amount Attributed to Provider Network Selection (133-UJ) while others may choose to reject the claim

5) **Coupon/ Copay Assistance Claims Processing Inquiry from OIG**
   a. Task Group Response was provided to the submitter
   b. Inquiry: The OIG section out of Chicago that works on studies had a general fact finding call several months ago with the Standards Development Staff about several different things, Medical Rebate, Pedigree and Coupons. They came back with additional questions related to coupons and it was felt that the COB Task Group would be the first place for them to start with.
   c. Response: The COB Task Group could only speak to what the NCPDP Standard supports for COB claims processing and could not speak to program administration processes.

**Task Group Action Items/Next Steps (bullets or text):**

Review / Respond to pending questions:

1) **#21: Patient Paid Amount Submitted 433-DX**
2) **#39: Medicare D Sponsor Names and #37: Benefit Stage Qualifier and EGWP Wrap**
   a. Coordinate with other task groups with similar discussions
   b. WG1 Information Reporting – SPAPs, ADAPs need additional information submitted in the COB segment to identify the primary Medicare D plan (e.g.: 4-RX)
   c. WG 9 Medicare D – downstream payers not eligible to receive the benefit stage amount require access to the benefit stage qualifier
3) **#40: COB and Non-Balanced Primary Claim Responses (OPPRA Qualifier 06 versus component qualifiers 01 – 05, 07-12)**
4) Work with Vaccines Services Task Group in validating COB pricing scenarios
5) Work with Appendix G Task Group in developing COB reject Code Guidance

See Recommendations for the Version D Editorial section.

2. Financial Information Reporting Task Group

Monique Irmen, RelayHealth and Annette Gabel of Express Scripts, Inc., Task Group leads provided the report.

Task Group Recap Report
Date: 7/26/2013

Task Group Name: WG1 Financial Information Reporting Task Group
Date Task Group Formed:
Task Group Leader(s): Annette Gabel, Monique Irmen
Parent Work Group: WG1
Goal of Task Group: The task group will review questions that warrant consistent application of FIR transactions and reject resolution across the industry

Task Group Meeting Dates (This Period): Almost Every Monday and Friday- WE HAVE DIEHARDS IN THIS GROUP!

Business Cases Reviewed:
- Non Plan of Record White Paper
- Post ATBT Process White Paper
- FAQs for formal published document

Task Group Questions to the Work Group (bullets or text):
Please approve the creation of a specific FAQ document for FIR so that questions can be added to the editorial document

Task Group Action Items/Next Steps (bullets or text):
- Continued work on FAQs
- Continued work on whitepaper for Part D Non-Plan of Record
- Post ATBT process white paper (get approval from standardization to publish)
- Justification to allow POST ATBT electronic requests after May 31st. Plans/processors have been requested to submit data related to the volume of Balance changes that need to be communicated after the Automated TrOOP Balance Transfer has closed (May 31)

A heading of XXX was modified to Appeal Process Related to Eligibility. A motion was made to approve with modifications the FIR Editorial document for FIR questions. It was seconded. It is a standalone document just for FIR questions. The motion carried with no opposition.

3. Information Reporting Problems Task Group

Melanie Merlino of CVS/Caremark, Task Group and Mary Perez, Catamaran Task Group leads provided the report. Melanie will be unable to continue as task group lead. Yvette Zawisza, Argus Health Systems volunteered to be a new co-lead.

Task Group Recap Report
Date: July 9, 2013

Task Group Name: Information Reporting (Nx) Problems Task Group
Date Task Group Formed: 11/07/08
Task Group Leader(s): Melanie Merlino and Mary Perez
Parent Work Group: Work Group 1 - Telecommunication

Goal of Task Group: Review key components of the COB process (N transactions, COB file loads, plan enrollment, SPAP file loads to GHI, etc.). Prepare a white paper for industry usage that explains how the components of the COB process work together to manage the Part D plan for Medicare beneficiaries including recommendations for optimal results. Continue to coordinate discussions with SPAPs to enhance the COB process.

Task Group Meeting Dates (This Period):
5/22, 6/5, 6/19, and 7/3

Business Cases Reviewed:
SPAP/ADAP BIN/PCN list used now by plans to identify qualified plans is being reviewed to add a column for an attestation from the qualified payer (SPAP/ADAP) that their BIN/PCN reported on the spreadsheet is “unique” to that business. A process for this attestation will be created and presented to the task group next quarter. The purpose of this attestation is to define without question qualified plans in order for Part D plans to apply TrOOP and PLRO accurately per CMS guidance. The task group will continue next quarter to work on this process to improve upon what is used currently.

Task Group Decisions (bullets or text):
- Contracted business associate access to MARx. CMS is working with Enrollment to gather the boundaries of access to MARx requirements. A response is expected for next quarter.
Task Group Reportables (bullets or text):

- The chart of the COB White Paper in section 6.1 has been revised by CMS. The Standardization Committee is doing a final review of the COB White Paper. When done, notification will be sent out and white paper posted.

Task Group Questions to the Work Group (bullets or text):

Question: What are the situations where a beneficiary’s Benefit Stage Qualifiers (Field 393-MV) might be returned with a gap between values (e.g. claim with non-adjacent Benefit Stage Qualifier 1 and 3, or 1 and 4, or 2 and 4)?

Response (Sent to & received from WG9 Medicare FAQ Task Group):
This happens in two situations:
1. When a claim is reversed by the pharmacy that is in a prior phase. The next claim submitted will fill the hole left by the reversed claim first and continue to process under the next open phase once the prior phase is satisfied.
2. When the processor is restacking claims (reconciliation) and a claim is submitted that fills in the phase amount.

Task Group Action Items/Next Steps (bullets or text):

- A process for the attestation (Unique BIN/PCN) added column to the SPAP/ADAP BIN/PCN list.
- COB Task Group Question 39 – Review of spreadsheet of potential new fields that could be used to identify the previous payer(s).
- Follow-up with CMS on MARx access requirements.

4. Post Adjudication Task Group

Annette Gabel of Express Scripts, Inc., Task Group lead, provided the report. The task group discussed a request for Transition Fill Claims Transfers process. They are looking at the use of the Information Reporting (Nx) transactions. A CMS representative noted that as this was transferring Medicare data, a request must first be made for the transfer of data per HIPAA; it is not just given. The privacy regulations and minimum necessary exchange are in effect.

5. Audit Task Group

Patrick Harris of RelayHealth and Charlie Oltman of Target, Task Group leads provided a report.

Task Group Recap Report
Date: 08/2013

Task Group Name: Audit
Date Task Group Formed: 11/2009
Task Group Leader(s): Patrick Harris & Charlie Oltman
Parent Work Group: WG1 Telecommunication

Goal of Task Group:
Create an electronic audit transaction with request, response and final outcomes transactions for both ‘desk-top’ and ‘in-store’ audit requests.

Task Group Meeting Dates (This Period):
July 25, 2013

Business Cases Reviewed: N/A

Task Group Decisions (bullets or text): TBD

Task Group Reportables (bullets or text):
- TG developing reject codes within header and detail record to support Audit Transaction Standard.

Task Group Questions to the Work Group (bullets or text): N/A

Task Group Action Items/Next Steps (bullets or text):
- Determine reject codes for Header and Detail records.
- Submit updates to Audit Transaction Standard for Nov WG meeting

6. REMS Task Group

Roger Pinsonneault of RelayHealth, Task Group lead provided a report. The task group has not met, but was monitoring the ballot. They will remain active to see if there is any response from the Office of the National Coordinator on the REMS white paper, or any action on the federal PDMP focus.

7. Definition of a Valid Prescriber Task Group

Jenn Ausbrook of Walgreens and Sharon Gruttadauria, CVS Pharmacy, Task Group leads provided the report. This task group had a couple reportable questions, but they did not feel they were needed in the Version D Editorial document. There was initial discussion whether there were any FAQs out of various task groups that might go into a WG9 Part D FAQ document. There was no follow up action at this time.
Task Group Recap Report  
Date: 7/29/2013

Task Group Name: Definition of a Valid Prescriber  
Date Task Group Formed: November 2011  
Task Group Leader(s): Jenn Ausbrook, Sharon Gruttadauria  
Parent Work Group: WG1

GOAL OF TASK GROUP:

- Create a white paper to address the following areas:  
  (Ongoing)
  - Walk through the prescription process describing what identifier(s) are available to determine the prescriber information submitted on the prescription claim is valid
  - Identify gaps and recommendations related to this process.
  - Identify the roles of each entity (prescriber/pharmacy/plan/database entities).
- Create POS edit matrix (Complete)
- Review and respond to FAQs related to prescriber validation (Ongoing)
- Submit DERFs for new code values needed to complete POS edit process  
  (Complete)

TASK GROUP MEETING DATES (THIS PERIOD): Met 9 times
90 minute call every Monday, 11am – 12:30pm EST

BUSINESS CASES REVIEWED:
1. Guest Speaker provided current statistics on Prescriber Type 1 enumeration  
   Daniel Schofield  
   Director, Provider Verification Solutions  
   Health Market Science  
   - Statistics:

   ![Statistics Table]

2. NCPDP Prescriber NPI outreach letters sent to ADA and NDEDIC.  
   - NDEDIC will outreach to their members, who will reach out to their network of dentists
3. Substance Abuse Treatment Data Waivers and DEA BAC and BACSC identifiers when prescriber has multiple DEAs.  
   - Question to be submitted to the DEA.
4. May 2013 CMS Memo regarding hospital DEAs – should plan sponsors leverage the point of service reject and submission clarification code process as outlined in the Editorial Guide.  
   - Requested clarification from CMS
5. Will CMS consider adjusting PDE death date rules due to the Death Dates within protected state records that are no longer publically available  
   - Question submitted to CMS
6. Can processors and pharmacy providers obtain access to the Medicare Exclusion Data (MED)  
   - Question submitted to CMS
7. When the prescriber is a sole proprietor, is CMS leveraging the Type 1 NPI indicator or the organizational taxonomy to determine individual prescriptive authority?  
   - Question submitted to CMS
8. Star ratings and the volume of point of service rejects with submission clarification code overrides  
   - Task Group response – reportable only
9. Resubmitted Claims and Audit processes. Medicare Part D Post Adjudication administrative errors related to the submitted prescriber ID.
10. State-Specific Controlled Substance Schedules
   - Task Group response – reportable only

11. Type 1 vs. Type 2 NPIs / ACA Ordering Referring Provider vs. CMS-0040
    - Task Group response – reportable only

12. Use of submission clarification codes when plan sponsor has determined the prescriber’s DEA registration does not align with the drug DEA schedule
    - Task Group response – requesting WG approval for Editorial Guide

**TASK GROUP REPORTABLES:**

**Definition of a Valid Prescriber FAQs –**

1. **D13 – Star Rating**
   - Reportable Only
   - **Question:** How will the PDE process align with the POS process? Scenario: In the situation where the Pharmacy has a valid ID on file. The Plan does not have the valid ID on file. CMS does not have the valid ID on file. The pharmacy submits the claim with the applicable Submission Clarification Code. The Plan pays the claim. The paid claim with an “invalid” ID is sent on the PDE;
     - Will CMS put this PDE record “on hold”? How will this process affect the plan’s STAR rating?
     - Is there a difference in the PDE process during the time SCC is not reported on the PDE file? Then when the SCC is on the PDE file? (Timing issues?) SCC submitted for ID situations? Multiple SCC submitted on PDE?
   - **CMS Response**
     - The sponsor will have to re-submit the PDE
     - This will not affect the plan’s star ratings. The claim is paid. DEA Schedule registration information is not submitted on the PDE. In this instance, sponsors can assume prescription was dispensed in accordance with applicable controlled substances law, as our policy does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substance Act and DEA rules.

2. **D22 – RESUBMIT CLAIM AND AUDIT – DIR Topic REPORTABLE TO AUG WG; WORKING WITH TGS**
   - Reportable Only
   - **Question:** Will all sponsors provide a post adjudication audit, or will the pharmacy be responsible for identifying the paid claims with the approved message code and resubmit? If sponsor does not provide audit file and pharmacy does not pro-actively report and re-submit, will claim be at risk for automatic reversal? How does this relate to the DIR guidance?
   - **Task Group Response:**
     - For any administrative error (2012 and the future) – The references to the pharmacy “amending the claim” – can this refer to the pharmacy providing amended data via an offline audit process? An offline audit process would negate financial accumulator changes caused by re-adjudicating the claim.
       - WG1 Audit TG, WG9 Medicare Part D FAQ TG and WG1 Definition of a Valid Prescriber TG will evaluate solutions to standardizing the correction of administrative errors that do not incur a financial impact to the accumulators.
     - Will CMS support an extension for 2012 claims?
       - Per CMS, the 2012 reconciliation period ended June 30, 2013 there was no extension to the deadline. As CMS communicated to Pharmaceutical Care Management Association (PCMA) group, reopening of the reconciliation period is unlikely to happen before 2015.
     - Excluded provider is noted on the chart within the 2014 Call Letter as administrative error (row 12). When would this situation occur if the plan sponsor is required to reject at POS? Is CMS comparing the claim DOS to the excluded provider file effective date where retrospective suspensions would not cause the PDE reject?
       - Per CMS, occasionally there are retrospective exclusions, often related to appeals. There are regulatory requirements that prohibit paying for anything that involves an excluded provider.
     - What data source is being used to determine prescriber is deceased? Conflicts have been found with 2012 PDE Audit data rejects, where the prescriber is not deceased.
       - Per discussion with CMS:
         - 2012 PDEs leveraged logic that allowed claims where Date of Service was inside the one year window.
         - Acumen logic did not support the one year window until 2013.
         - CMS stated that any 2012 claims on the report from Acumen that indicated they were inside the one year window were not accurately reported, therefore the PDE does not have to be resubmitted for this reason.
If entities are finding conflicts with prescriber date of death information, they should report the situation to CMS (Deb Larwood).

What data source is being used to determine prescriber controlled substance prescriptive authority? Conflicts have been found with 2012 PDE Audit data rejects, where the prescriber is registered with all DEA schedules.

Per discussion with CMS, if entities are finding conflicts with prescriber controlled substance prescriptive authority information, they should report the situation to CMS (Deb Larwood).

3. **D26 - State-Specific Controlled Substance Schedules**
   - **Reportable Only**
   - **Question:** How should the processor/plan handle state-specific controlled substance schedules (i.e., when the state specifies a different schedule for a particular product than what is specified at a federal level by the DEA, such as New York treating hydrocodone as a CII) when assessing whether the prescriber has proper prescriptive authority?
   - **Task Group Response:**
     - The processor/plan needs to operate under whatever business rules or state or federal regulations apply to such entities. Products are available to determine the state versus federal DEA schedule of a drug.

4. **Prescriber Individual Type 1 versus Type 2 Organizational NPIs or Supervising Physician Type 1 NPI**
   - **Reportable Only**
   - **Question:** Is there a conflict with the use of the Type 2 organizational NPI or the use of the Supervising Physician’s Type 1 NPI, between the ACA Ordering Referring Provider requirements for State Medicaid programs and the CMS 0040 NPI final rule?
   - **Task Group Response**
     - Reference the final rule CMS 0040 which has further relevance to the ACA with regards to prescriber identifiers:
       - Final Rule, September 2012 CMS 0040 with a compliance date of May 6, 2013 - An organization covered health care provider must require certain non-covered individual health care providers who are prescribers to obtain and disclose an NPI.

5. **D29 - Submission Clarification Codes and Prescriber Validation Error Scenario**
   - **Request to add Task Group response to vD Editorial Guide.** Refer to below section “Task Group Questions to the Work Group”

**TASK GROUP ACTION ITEMS/NEXT STEPS:**
- Complete FAQs
- Complete White Paper

**TASK GROUP QUESTIONS TO THE WORK GROUP:**
The task group requests the following FAQ be approved to be added to the vD.0 Editorial Document.

See [Recommendations for the Version D Editorial section.](#)

8. **Supplemental Payer Reporting**

Monique Irmen of RelayHealth, Task Group lead provided the report.

**Task Group Recap Report**
Date: 7/26/2013

**Task Group Name:** WG1 Supplemental Payer Reporting Task Group
**Date Task Group Formed:** 02/2012
**Task Group Leader(s):** Monique Irmen
**Parent Work Group:** WG1

**Goal of Task Group:** This task group is for supplemental payers to track Information Reporting transaction effectiveness. The goal of this group is to design reports that provide necessary information for supplemental payers and Part D plans.

**Task Group Meeting Dates (This Period):**
None – in a holding pattern until CMS approves project

**Business Cases Reviewed:**

**Task Group Decisions (bullets or text):**

**Task Group Reportables (bullets or text):**

**Task Group Questions to the Work Group (bullets or text):**

**Task Group Action Items/Next Steps (bullets or text):**
Work on the Guide that accompanies the reports

9. **Eligibility Verification Enhancements Task Group**

Mary Perez of RelayHealth and Nancy Bridgman of Omnicare, Task Group leads provided the report. The task group worked on DERF 001116.

DERF 001116 requests "Revision of the Telecommunication Implementation Guide Section 6 “Eligibility Verification Information” removing “Future Coverage” verbiage and adding information regarding new enhancements. The revisions are attached in a separate document. This would be added to a future version of the Telecommunication Implementation Guide." A concern was raised about the implementation guide having the 9 months and 4 months verbiage, which could be changed again. Eligibility changes might be fluid. This information could move to the Version D Editorial. As of May 23, 2013, the 9 months and 4 months goes into effect, but the version of the Telecom Imp Guide this would change is farther out. The DERF was pended in May so the task group could look at moving the changes out of Telecom and into the Version D Editorial and include the effective dates. The task group has reviewed the Telecom Imp Guide and made recommendations to move information into the Version D Editorial. A motion was made to approve the recommendations as modified. It was seconded. The motion carried with no opposition.

They are also working on a new segment to be used for Eligibility Verification between the pharmacy and the Transaction Facilitator for Medicare Part D. They have begun exploring how to implement this. The enhancements would be part of a new version of Telecom.

1. They have examined the function of a "demonstration project" under HIPAA, which is intended to be for testing an enhancement, with a limited number of entities and a limited timeframe. However the task group would like to open up the enhanced E1 to anyone. This may not be appropriate for a demonstration project.

2. An alternative route is to start the process for a new version of Telecom to be named under HIPAA. This would be for the future. Consideration could be for only requesting a new version of the Eligibility Verification (E1), to proceed forward so that entities that want to use the enhanced eligibility can, and not cause changes to the other Telecom transactions (billing, PA, controlled substance, etc.).

3. Or the industry could decide the timeframe is such to plan for all transactions to proceed to a new version under HIPAA.

It was recommended the task group create a survey to the industry on these questions.

10. **Service Billing Task Group**

Roger Pinsonneault of RelayHealth, Task Group lead provided a report. The task group did not meet this quarter. The task group will remain on hiatus pending information from the Vaccine Services Task Group.

11. **Appendix G Task Group**

Roger Pinsonneault of RelayHealth and Terry Fortin of PharMerica, Task Group leads provided the report.

**Task Group Recap Report**

Date: 7/18/13

Task Group Name: WG1 Appendix G (Two Way Communication To Increase The Value of On-Line Messaging)

Date Task Group Formed: August 2012

Task Group Leader(s):
- Terry Fortin / PharMerica Corporation
- Roger Pinsonneault, R.Ph. / RelayHealth

Parent Work Group:
- Work Group 1 (Telecommunication)
- Work Group 14 (Long Term Post Acute Care)

Goal of Task Group:
1. To **assess** Appendix G of the Telecommunication Standard for guidance currency;
2. To **recommend** the frequency in which Appendix G content is reviewed and updated;
3. To **ensure** that Appendix G guidance is not duplicative of other NCPDP reject code guidance; and
4. To **develop** enhancement recommendations for Appendix G

Task Group Meeting Dates (This Period):
- 6/7/13, 6/21/13, 7/12/13, 7/26/13 (scheduled)
Business Cases Reviewed:
- Reviewed recommended changes to the Long Term Care Transition, Emergency Fill and Change in Level Of Care Messaging for Rejected and Paid Claims section
- Reviewed sections of E.0 Implementation Guide where reject codes are mentioned
- Reviewed mention of “should”, “could” and “may” in Appendix G for possible re-wording

Task Group Decisions/Recommendations (bullets or text):
- Incorporated changes to the Long Term Care section
- Recommended that in the future when new reject codes are added to the ECL that any guidance related to additional messaging that would be beneficial to accompany the reject code should be added to Appendix G (in its new “home” of the Editorial Guide).
- Reject Code 87 and 9G were added to Appendix G

Task Group Reportables (bullets or text): N/A

Task Group Questions to the Work Group (bullets or text): N/A

Task Group Action Items/Next Steps (bullets or text):
- Review and incorporate any additions recommended by the COB task group
- Finalize document and prepare what we want to suggest goes into the Version D.0 Editorial Guide.
- Prepare DERF to have Appendix G removed from future Telecom Guides

VII. Motion to Suspend
Trish Brown asked for a motion to suspend the meeting. The motion was moved and seconded. The motion carried. The meeting suspended at 11:57 a.m.

Friday, August 9, 2013

I. Welcome and Call to Order
A meeting of WG1 Telecommunication was held in Fort Worth, TX on August 9, 2013. Co-Chairs Roger Pinsonneault, R.Ph. of RelayHealth, Amy Harvey of Rite Aid and Trish Brown of CVS|Caremark were present to conduct the meeting. Roger Pinsonneault called the meeting to order at 8:01 a.m.

A. Task Group Reports
1. Transaction ID Task Group
Cookie Orescanin of MedImpact and Sharon Gruttadauria, CVS Pharmacy, Task Group leads provided the report.

Task Group Recap Report
Date: 7/26/2013

Task Group Name: Transaction ID Task Group
Date Task Group Formed: November 2012
Task Group Leader(s): Cookie Orescanin – MedImpact; Sharon Gruttadauria – CVS/Caremark Pharmacy
Parent Work Group: WG 1 – Telecommunications

Goal of Task Group:
For a future version
- Provide a Transaction Id for submission on a Reversal Request to provide exact match for Reversal purposes.
- Determine if a Transaction id could be used for a CLAIM EDIT process whereby updates to fields not affecting financial payment could be made without reversal and reprocessing which today often provides different results.
- Determine if Transaction id is of use for DUPLICATE CLAIM LOGIC.
For current D.0 version
- Identify match criteria and pain points related to Reversals today and develop ‘best practice’ recommendations that may lead to industry defined Operating Rules.
- Review of DUPLICATE LOGIC to refine match criteria in order to provide further Editorial guidance for D.0 usage.

Task Group Meeting Dates (This Period): (Every other Thursday at 1:00 Eastern) 5 meetings
5/30, 6/13, 6/27, 7/11, 7/25

Business Cases Reviewed:
1) Transaction Id – Who assigns – provider or processor?
Group has worked on a flow where Id was assigned by processor.
Concept:
- F3 – Authorization Id could continue to be used as it is today. Some processors respond with a new Auth ID for every claim or reversal transaction.
- An APPROVAL ID is ONLY assigned to PAID, CAPTURED, or DUPLICATE PAID claim responses.
  - “P” PAID or “C” Captured claims – processor to return unique APPROVAL ID.
  - “D” Duplicate Paid claims – processor to return APPROVAL ID for the PAID CLAIM that is generating the “D” response.
  - B2/B3 transaction to include APPROVAL ID to allowing matching to original paid claim – no need to drill down into COB criteria.

Next step is to do similar flow grid where provider software creates an ID for transaction processing.
- A re-submission of a claim when they did not receive a response would carry the same ID and processor would need to act on this.
- A COB claim for the same Pharmacy, Service Provider Id and Date of Service would carry a different transaction id.

CONCERNS:
1. Either method requires software development to understand and adhere to the guidelines associated to new fields developed.
2. Since many of the concepts are fairly clearly stated in the current Implementation Guide – yet don’t seem to be understood thus not adhered to – will new fields make this any better? Or only lead further misunderstanding?
3. Further discussion to occur

2) WHY are REVERSALS being Rejected?
   a. Time limits:
      i. Pharmacies finding anything from 3 days to 90 days.
      ii. Payer Sheets should define this but many do not.
      iii. Believe Part D allows for 90 days.
      iv. Understand that some processors may ‘move’ approved claims to history claim files making reversal problematic.
      v. Reversal may be rejected at time of adjudication yet payment recouped via remit so appears Rejected Reversal is ‘pended’ and then back end review of history claims finds and reverses claim.
      vi. Basis for dates associated with
      vii. No standard Reject Code for this today (81 – CLAIM TOO OLD often used) however in case of a plan to submit a DERF in November for
   b. Syntax Errors
      i. While the formatting of the reversal is found to be in error, processors may be making allowance to accept the Reversal when matching to an APPROVED claim is possible since Reversal errors do not seem to receive the pharmacy attention resulting in correction and resubmission as often occurs when a claim rejects.
      ii. Often, syntax errors often need to be addressed outside of the individual pharmacy (by corporate, software vendor, selected person within pharmacy etc.)
      iii. when they are able to determine the claim/reversal match information and have that as an approved claim on their database.
   c. Identifying IF a Transaction ID on the submitted Reversal addresses the concern.

3) DEVELOPMENT OF BEST PRACTICE SCENARIOS
   a. Review of current Implementation Guide criteria for Duplicate determination (noted below) which also may be used for Reversal match (but is not firmly stated)
      i. In this have learned that Providers and Pharmacy view CLAIMS somewhat differently which may be:
         1. Pharmacy tends to view by Pharmacy Id, Rx and Date of Service, then Fill Number and COB criteria.
         2. Processors tend to view by Member, Product, and Date of Service then some level of use for Pharmacy Id, Fill Number and COB criteria
      b. Per Lynn, with the ACA, industry agreement on “Operating Rules” is coming into play. “Best Practice” agreement, so coming up with our OWN agreed upon industry practice is recommended.
         i. Identify recommendations for Best Practices for REVERSAL Processing for addition to Editorial Guide and future version (which may include Transaction Id).
         ii. Identify recommendations for Best Practices for DUPLICATE CLAIM processing that for addition to Editorial Guide and future version (which may include Transaction Id).

26.3.1 DUPLICATE TRANSMISSION FOR A PRIMARY PAYER
A duplicate transmission for a primary payer is based on the following criteria:
- Same patient/member
- Same Service Provider ID
- Same Date of Service
- Same Product/Service ID
- Same Prescription/Service Reference Number
26.3.2 DUPLICATE TRANSMISSION FOR A DOWNSTREAM PAYER

A duplicate transmission for a downstream payer is based on the following criteria:

- Same patient/member
- Same Service Provider ID
- Same Date of Service
- Same Product/Service ID
- Same Prescription/Service Reference Number
- Same Fill Number (required if Claim Billing/Claim Rebill/Encounters; situational on Service Billing/Service Rebill)
- Same Other Coverage Code
- Same Other Payer Coverage Type (the highest coverage type value)

Task Group Decisions (bullets or text): None at this time

Task Group Reportables (bullets or text):

- Discussion only

Task Group Questions to the Work Group (bullets or text): None at this time

Task Group Action Items/Next Steps (bullets or text):

- Develop Best Practice Scenarios as noted above.

2. Compound Billing Solutions Task Group

Stephanie Russell of Express Scripts, Jenn Ausbrook of Walgreens, and Nick Calla of Community Specialty Pharmacy Network, Task Group leads provided the report. They are working jointly with WG10 Specialty and Compound Task Group.

Task Group Recap Report

Date: 7/26/2013

Task Group Name: WG1 Compound Billing Solutions Task Group
Date Task Group Formed: 11/8/2012
Task Group Leader(s): Stephanie Russell, Jenn Ausbrook, Nick Calla
Parent Work Group: WG1 and WG10 Joint Task Group

Goal of Task Group:
This task group will seek to develop solutions and recommendations for the correct billing and adjudication of compound claims. TG began with questions submitted to the WG1 Telecom FAQ Task Group and from WG10 Specialty and Compound Services Task Group.

Task Group Meeting Dates (This Period):
5/29/13, 6/12/13, 6/26/13, 7/10/13, 7/24/13

Business Cases Reviewed: N/A

Task Group Decisions (bullets or text):
Will review questions submitted to the WG1 FAQ TG related to compound billing and provide responses to submitters. Responses may be published in Version D Editorial document when appropriate.

Task Group Reportables (bullets or text):
The task group is working on recommendations (draft headings)

1. It is recommended that the correct Product/Service ID Qualifier (436-E1) value be supported for the Product/Service ID (407-D7).
2. The product is not identified by an NDC or an UPC. It could be identified with an HRI.
3. The product is not identified with a “valid” identifier

Task Group Questions to the Work Group (bullets or text):

Task Group Recommendation: No recommendations completed for review during WG.

Task Group Action Items/Next Steps (bullets or text):

- Add example claims with reject code recommendations for recent FAQs added to vD.0 Editorial document – completion expected for November WG
- Develop recommendation for products not identified by NDC or UPC (Qualifier exists – For Example - HRI, HCPCS and is supported by Compendia)
- Develop recommendation for new use of Submission Clarification Code ‘08’ (Process Compound for Approved Ingredient)

See Recommendations for the Version D Editorial section.

3. Vaccine Services Task Group

Roger Pinsonneault, RelayHealth, Task Group lead provided the report. More payer/processor participation is needed for discussion of product versus service billing. The task group is discussing “bundled” when vaccines and services are billed together. Input is needed from the industry of what to call this if not bundled.

Task Group Recap Report
Date: August 2013

Task Group Name: WG1 Vaccine Services
Date Task Group Formed: Q1 2013
Task Group Leader(s): Craig Bentley, Amanda Daniels, & Roger Pinsonneault, R.Ph.
Parent Work Group: Work Group 1 (Telecommunication)

Goals of Task Group:
1. To identify the barriers slowing the adoption and expansion of vaccine administration services in pharmacy.
2. To develop “best practice” recommendations for vaccine administration services, including pharmacy benefit billing & processing, medical benefit eligibility verification and billing, registry reporting, pharmacy certification, and provider communications in pharmacy and health departments.
3. To assess the impact of vaccine regulatory requirements on pharmacy operations and services, and
4. To develop data communication and process standards supporting the advancement of vaccine administration services by pharmacies and health departments.

Task Group Meeting Dates (This Period):
- Friday, May 24, 2013
- Friday, June 7, 2013
- Friday, June 21, 2013
- Friday, July 12, 2013
- Friday, July 26, 2013 (Scheduled)

Business Cases Reviewed:
- **Awareness** – Are there education, standards development, or process improvement activities that NCPDP should pursue?
  - White Paper?
  - Version D.0 Editorial Document?
- **Pharmacy Benefit** – Are there NCPDP Telecommunication Standard enhancements needed to facilitate the billing of vaccines?
  - Challenge of Medicaid billing by pharmacies; pharmacists not always a provider.
  - Product and service billings.
  - Matching the reconciliation to the billing.
- **Medical Benefit Eligibility** – Can NCPDP develop standard operating rules for eligibility verification benefits for vaccines?
  - Levels of eligibility between payers are different; information returned is variable.
  - Includes medical bill submission
  - The use of the X12 270/271 by the pharmacy to obtain medical eligibility information for vaccine coverage; standardization of response.
  - There are mapping services offered today.
  - Is there a patient copay/deductible?
- **Prescriber Orders** – Are there unmet business needs relative to electronic prescribing of vaccinations?
  - N/A

Task Group Decisions (bullets or text):
- Guidance Document / Pharmacy / Responsibilities
- Guidance Document / Pharmacy / Usual & Customary scenarios
- Guidance Document / Pharmacy / Rejected Claims scenarios
- Guidance Document / Pharmacy / Date of Service scenarios
- Guidance Document / Pharmacy / Three Examples
- Guidance Document / Pharmacy / Days Supply
- Guidance Document / Processor / Responsibilities
- Guidance Document / Processor / Days Supply
- Guidance Document / Processor / Professional Amount Submitted & Professional Service Code Reject Scenarios
- Guidance Document / Processor / Definition of “Bundled Reimbursement” and “Separate Reimbursement"
Task Group Reportables (bullets or text):
- Initiated development of the guidance document – questions and answers

Task Group Questions to the Work Group (bullets or text):
- Medical Benefits Status & Messaging – Identification of Medical Benefits?
- Dispensing Fee – Billing for “Dispensing Fee” only
- Service Transactions – Billing for “Service Fee” only

Task Group Action Items/Next Steps (bullets or text):
- Continue Pharmacy Billing & Reconciliation Sub-Task Group activities
  - Current Situation
  - Recommendations
  - Output
- Continue Medical Eligibility & Billing Coordination Sub-Task Group activities
  - Current Situation
  - Recommendations
  - Output

Pharmacy Sub-Task Group

Goals:
- Identify the current situation for pharmacy billing (only)
- Identify the challenges of billing a vaccine to the pharmacy benefit
- Document pharmacy billing questions for Task Group review

Current Situation:
- Pharmacy receives an immunization request
- Pharmacy associates patient to a pharmacy benefit
- Pharmacy inputs immunization details into pharmacy practice management system (i.e. like a prescription order)
- Pharmacy submits billing request to pharmacy benefit and awaits response
- Pharmacy receives billing request response
- Pharmacy determines next steps (i.e. administration, additional transaction processing, or administration)

Challenges:
1. Some pharmacy benefit processors do not reimburse for vaccines
2. Some pharmacy benefit processors support billing for the combined product and service, others do not
3. Some pharmacy benefit processors reimburse for the product only
4. There are inconsistencies in the manner in which pharmacy benefit processors report the financials on a response
5. There are inconsistencies in the manner in which pharmacy benefit processors report the financials on claim advice
6. There are inconsistencies in the manner in which pharmacy benefit processors report the financials on claim advice
7. Situations where the pharmacy dispenses and bills the vaccine, but does not administer the vaccine.
8. Situations where the pharmacy benefit processor recognizes the vaccine as a brand and reimburses at “unacceptable” level.
9. Inconsistency between states in what services the pharmacist can provide.
10. Inconsistencies between what the state Boards of Pharmacy allow and what the health plans (esp. state programs) support.
11. Inconsistency in what vaccines can be billed and how the products are identified.
12. Inconsistency in the administration fee/reimbursement fee. (The fee criteria is out of scope for NCPDP discussion. Processing the transactions consistently is in scope.)
13. Inconsistencies in methods used by pharmacy to document vaccine administration in the patient’s medical record. (may be out of scope).
14. There are some challenges we may not be able to solve.....

Additional Information:
- Telecommunication Version D and Above Questions, Answers, and Editorial Updates – References to Vaccines
  - 9.5 Other Amount Paid (565-J4) and COB
  - 9.7 Other Payer Amount Paid Qualifier (342-HC) Value 99?
  - 9.9 Like Amounts Submitted as Incentive Fee
  - 15.16 Vaccine Administration (Guidance on Usual & Customary)
  - 15.20.4 Prescriber ID and PDE Questions

Task Group Questions:
1. Overall, have we captured all the pharmacy benefit billing of vaccine challenges? **Status:** Pharmacy benefit billing challenges expanded on 03/22.
2. Regarding challenge # 1 (i.e. no coverage), do we need to make any recommendations relative to standard reject codes/ messaging? **Status:** Recommendations: (i.) to assign specific reject codes for specific billing scenarios, and (ii.) to assign a specific reject code that indicates coverage is known and available under medical benefit.
3. Regarding challenge # 2 (i.e. billing process), do we need to standardize on a single billing process (i.e. product & service like Medicare Part D) or support multiple billing processes (i.e. combined product and service billing
transaction and/or separate product and service billing)? Status: Recommendation to standardize on a single billing process (i.e. product and service within a single transaction e.g. Medicare Part D

4. Regarding challenge # 2 (i.e. billing process), do we need to make any recommendations relative to coordination of benefit transactions involving the billing of a product and a service? Status: Recommendation to: (i.) Review COB scenarios, and (ii.) Seek assistance from the COB Task Group

5. Regarding challenge # 3 (i.e. reimbursement for product and not service), do we want the pharmacy benefit processor to reject the pharmacy billing request when reimbursement does not include reimbursement the administration fee? If “yes”, do we want to propose standard reject codes/messaging for this scenario? Status: Yes, we want to reject the billing request when submitted with an Incentive Amount Submitted

6. Regarding challenge # 4 (i.e. pharmacy financials), do we want to document a specific recommendation or guidance on how the financials are returned for a vaccine billing when the response includes product and service fees? Status: Yes, To standardize how financials are returned on a response

7. Regarding challenge # 5 (i.e. claim advice), are there any Task Group recommendations? Status: Yes, we want them to align with the financial response fields.

4. Telecom FAQ Task Group
Mike Day of DayTech, Task Group leader provided the report.

Task Group Recap Report
Date: 07/12/13

Task Group Name: Telecom FAQ
Date Task Group Formed: long-long ago
Task Group Leader(s): Mike Day, DayTech Corp.
Parent Work Group: WG I

Goal of Task Group: Analyze and propose answers to questions submitted regarding the NCPDP Telecommunications Standard to Work Group I for approval and possible inclusion in the Telecom Editorial Document

Task Group Meeting Dates This Period:
05/28, 06/10, 06/26, 07/13

Business Cases Reviewed:
Three questions were received and discussed this quarter.

Reportable questions are:
105 – Financial reporting of a 100% patient pay amount on an Exchange Program Grace Period claim as defined under the ACA.
107 – Allowable formatting of data in field 462 (Prior Authorization Number)

Question still in open discussion:
106 – Identifying Medicaid Beneficiaries at POS to avoid improper COB processing

Dropped from Monitor Status: NONE

Task Group Decisions (bullets or text): NONE

Task Group Action Items/Next Steps (bullets or text):
Remain available to handle future questions as they arise

See Recommendations for the Version D Editorial section.

B. HIPAA Update
Margaret Weiker, The Weiker Group, Standardization Committee provided the information.

- Important: Approved at November WG: We are recommending that an existing field, Quantity Prescribed (46Ø ET) which is currently not used in the Telecommunication Standard be reactivated with approval from the Office of e-Health Standards and Services. Note this field would be required for Part D Schedule II Controlled Substance claims; however the use of this field is not limited to Part D claims only. Refer to DERF 1097 for additional information. CMS requested this modification due to an OIG audit of 2009 PDEs and determined that 400,000 Schedule II Controlled Substance prescriptions were wrongly refilled, or about 2 percent of all Schedule II prescriptions billed under Medicare Part D in 2009. A request was sent to OESS to issue an updated regulatory notice about the new version of Telecom D.0. In order to remain HIPAA compliant, the new version must be used 180 days from the notice. This was discussed at length during November WG meetings.
  a. Telecom D.0 and all versions from that point have been updated (November 2012).
  b. DSMO Change Request filed (and approved).
  c. OESS and NCVHS have been sent information.
     i. OESS has responded approving the request to proceed (see http://www.ncpdp.org/Hipaa.aspx under Implementation Guide Corrections banner section.
     ii. From their initial response OESS thought they could publish a Federal Register notice only. Office of General Counsel (OGC) advised that OESS could not.
iii. OESS thought they could publish an Interim Final Rule (IFR) per ACA section 1104. Office of General Counsel (OGC) advised that OESS could not.

iv. Office of General Counsel (OGC) advised that OESS will need to publish a Notice of Proposed Rule Making (NPRM).

1. NCPDP SNIP Committee discussion follow up:
   a. Is there a way to request an official answer of why an Interim Final Rule with Comments (IFC) cannot be done? How do I do that? Concern with ACA intent - when naming a new standard (EFT, attachments) – this is a large implementation impact but because of ACA it can now be considered an IFC (shortened regulatory timeframe). However a modification to an existing HIPAA transaction still is forced into the full regulatory process. It is hoped that the ACA writers intended the entire Administrative Simplification section to be an improvement for all HIPAA transactions, not a contradiction, but the opinion supports it was written pretty prescriptive to certain transactions and processes, and not to consistency in the overall HIPAA processes.
      i. OESS: The IFC never cleared legal counsel (OGC) because OGC determined that the enhancement was a modification, and required the full regulatory process. OESS will inquire about a formal response.
      ii. OESS suggested NCPDP write a letter to the Secretary of HHS requesting clarification and a response. It may require a second opinion.

b. Lynne requested a timeline of the process and where regulatory steps could be shortened because the industry was planning for early 2014 and now because of the regulatory steps, budgets and resources have to be reallocated for 2015, or possibly later?
   i. OESS …will see what options we have. A lot will depend on whether this reg is stand-alone or combined with something else.

v. The original industry requested implementation timeframe was 01/2014. THIS IS ON HOLD PENDING REGULATORY PROCESSES. The Telecommunication Standard Version D.0 of 08/2010 is still in place.

vi. The WG noted that the August 2010 Telecom D.0 would need to be reshown on the website as the official HIPAA version still in effect since we do not know when the regulatory processes will be published. The November 2012 Telecom D.0 version is displayed as yet to be named HIPAA. A front page has been added to the imp guide to alert the reader that the Quantity Prescribed change cannot be implemented yet until the regulatory processes are done. Other documents and website pages have been updated. This has been done. Notifications will go out to NCPDP, NMEH, WEDI, and other organizations to let them know of the status.

**Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act:**
Other Modifications to the HIPAA Rules was published in the Federal Register on January 25, 2013. Covered entities and business associates must comply with the applicable requirements of this final rule by September 23, 2013.

   a. The final rule significantly strengthens the chain of responsibility to protect health information among covered entities, business associates and subcontractors. The rule makes business associates and subcontractors comply with HIPAA rules in the same manner covered entities must; making BAs and subcontractors directly liable for HIPAA violations— even if a BA failed to enter into a formal contract with a subcontractor—and making covered entities and business associates legally liable for the acts of their business associates. The BA for a business associate would be a subcontractor. The BA—which the covered entity—is responsible for having a subcontractor appropriately safeguard information, but the covered entity is responsible for the BA’s actions.

   b. Another major change is in the breach notification rule, where the “harm threshold,” a subjective measure of determining whether a breach has or could cause significant harm to one or more individuals, has been replaced with a more objective risk assessment process to determine if protected information has been compromised.

   c. Other provisions in the final rule include:
      i. Setting four-tier financial penalty structure for breaches deemed serious enough to warrant a federal-imposed penalty. Based on culpability, fines range from $100 to $50,000 per violation with a $1.5 million cap on violations of an identical provision within a calendar year.
      ii. Expanding the definition of business associates to include patient safety organizations, health information organizations, e-prescribing gateways, providers of data transmission services for protected health information to a covered entity and requiring routine access to PHI, or personal health record vendors offering PHRs to individuals on behalf of a covered entity. PHRs offered directly only to individuals are not covered.
iii. Clarifying that PHI stored in photocopiers, faxes and other office equipment that retain data, whether intentionally or not, is subject to the privacy and security rules, and PHI should be wiped before a device is removed from the office.

iv. Applying to business associates the minimum necessary standard when using or disclosing PHI, or when requesting PHI from another covered entity or business associate.

v. Enabling patients to ask for a copy of their electronic medical record in an electronic form, with fees charged not greater than labor costs.

vi. Enabling patients paying with cash to instruct providers to not make information about their treatment available to insurers. Separate or segregated records are not required, but some type of flag or other notification of restrictions in the record are necessary.

vii. Enabling patients to easily opt out of receiving fundraising and marketing solicitations.

viii. Prohibiting the sale of an individuals' health information without their express consent, with exemptions when the information is used for public health activities or research purposes.

• Health Plan ID Final Rule was released September 5, 2012. Final rule with corrections was issued October 4, 2012.
  a. Compliance Date for all health plans (to obtain HPID) except small health plans: November 5, 2014
  b. Compliance Date for small health plans (to obtain HPID): November 5, 2015
  c. Use of HPIDs in standard transactions on or after: November 7, 2016


The WG3 HPID Task Group has been actively evaluating standards for use of fields that this regulation may affect. They plan to submit a DERF for November WG to sunset Home Plan (314-CE) as industry review is showing this field is no longer used in Telecom D.0. They plan to submit a DERF for the modifications to the data dictionary and standards that are affected by HPID.

• The Health Plan Certification (CMS-0037-P) dates have been pushed back from December 31, 2013. An NPRM will be issued to solicit industry feedback.

• ICD-10 released with HPID Final Rule – compliance October 1, 2014.
  a. OESS staff will work with the industry to develop more extensive outreach programs for ICD-10 including a definition of End-to-End testing. The definition is expected to include phases of testing, planned activities and deliverables for each phase, and best practices so that, upon completion, entities will be positioned for the transition. The End-to-End testing protocols and procedures are planned to be reused beyond ICD-10 for example when implementing future e-Health initiatives found in the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act (HIPAA). For more information on End-to-End testing, see [http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/End-to-End-Testing.html](http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/End-to-End-Testing.html).

Meaningful Use:

C. Strategic National Implementation Process (SNIP) Update

Annette Gabel, Committee Chair noted the NCPDP SNIP Committee is working on outreach to the industry for the use of Quantity Prescribed. The committee will also work on educational materials that were recommended from the NCPDP Compounding/Specialty Pharmacy Focus Group. They will be working on a HPID white paper.

II. New Business

A. New DSMO Change Requests

There were none, but see the HIPAA reportable above for DSMO Change Request 1182 submitted by NCPDP.

B. New DERFs

Trish Brown led discussion.

DERF 001143/ECL 000144 requests "Since TRICARE has replaced CHAMPUS as the official name for the Civilian Care Component of US Military Health System, recommend updating ECL values to reflect the TRICARE name." A motion was made to recommend approval of the DERF/ECL to MC. It was seconded. The motion carried with no opposition.
C. Recommendations for the Version D Editorial
Amy Harvey led discussion.

1. Telecommunication FAQ Task Group
There were none.

2. COB Task Group

#41: CLARIFICATION REQUESTED FOR COB CLAIMS RELATED TO THE FOLLOWING STATEMENT FROM VD.0 EDITORIAL GUIDE SECTION 9.1: “PRICING SEGMENT CONTAINS VALUES ‘AS IF’ THE CLAIM WAS PRIMARY”

TASK GROUP RESPONSE
REQUESTING BELOW CLARIFICATION BE ADDED TO THE PRICING SECTION (3.6) OF THE EDITORIAL GUIDE

Section 9.1 of this Editorial Document states:
The purpose of the formulae is to provide clarification on how providers should balance the claim submission and how processor/payers should determine the ‘net’ value that is being billed. This is critical in coordination of benefits (COB) scenarios since the Pricing Segment contains values ‘as if’ the claim was primary and the Other Payer values are contained in the Coordination of Benefits/Other Payments Segment.

Contractual agreements would determine the required elements within the pricing segment for each payer. This means the pricing segments could be the same or may be different between the primary and subsequent payer submissions. Refer to Section 9.1 Clarification of Net Amount Due In Coordination of Benefits and examples in Section 34.6 Billing Transaction Code B1 Coordination of Benefits in the NCPDP Telecommunication Implementation Guide VD.Ø.

Work Group Recommendation: A motion was made to approve the response and add this to the Pricing Segment section and the COB section of to the Version D Editorial document only. It was seconded. The motion carried with no opposition.

#42 – BRAND MEDICALLY NECESSARY

QUESTION
We believe that the NCPDP standard (Dictionary / Implementation Guide) has already determined that the amount is populated when the penalty is due to patient selection of the product and not because the prescriber has indicated medical necessary. We question the use of ‘02’ qualifier from the upstream payer when it was the prescribers decision to write for the brand name, based upon medical necessary. This dual use of the qualifier causes interruption issues for downstream payers. Our state Medicaid regulation limits the decision of brand verses generic to the prescriber, and not the patient.

If the prescription is written as Brand Medically Necessary (DAW 1), or based on state regulations the brand must be dispensed (DAW 7), and all payers billed support the applicable DAW code (allowed under benefit, or approved through PA):

1. What defines when a Brand (134-UK) penalty would apply to the patient liability amount?
2. If the COB payer’s coverage policy is limited to copay (05), co-insurance (07), Deductible (01), benefit max (04), coverage gap (12) and health plan funded amount (09), how should the COB payer treat the Brand (02) Other Payer Patient Responsibility Amount that was returned by the previous payer?

TASK GROUP RESPONSE
1. What defines when a Brand (134-UK) penalty would apply to the patient liability amount?

Plan benefit designs, while they allow a Dispense As Written (DAW)/ Product Selection Code (408-D8) value of “1” (Substitution Not Allowed by Prescriber), may still pass on the cost difference between the brand and generic to the patient. This cost differential would be represented in the appropriate field:

- Amount Attributed to Product Selection/Brand Drug (134-UK), or
- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) or
- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN).

This allows the pharmacy to dispense the prescription as written per regulatory agency requirements.
2. If the COB payer’s coverage policy is limited to copay (05), co-insurance (07), Deductible (01), benefit max (04), coverage gap (12) and health plan funded amount (09) how should the COB payer treat the Brand (02) Other Payer Patient Responsibility Amount that was returned by the previous payer?

If the COB payer is a government entity requiring full disclosure, restricted by regulation to only support specific Other Payer-Patient Responsibility Amount Qualifier (351-NP) values and cannot pass the cost on to the patient and cannot reject the claim; they may default to their Other Payer Amount Paid (OPAP) logic. This would enable the claim to be paid using the difference between the COB payer’s allowed amount/contracted amount and the Other Payer Amount Recognized (566-J5).

Alternatively the COB payer could include coverage through the DAW Prior Authorization process for the Other Payer-Patient Responsibility Amount Qualifier (351-NP) values “02” (Amount Attributed to Product Selection / Brand Drug), “08” (Amount Attributed to Product Selection / Brand Non-Preferred Formulary Selection) and “11” (Amount Attributed to Product Selection / Brand Non-Preferred Formulary Selection).

For a long term solution, review regulations to align with current benefit designs within the pharmacy industry.

Work Group Recommendation: A motion was made to approve the response and add to the Version D Editorial document. It was seconded. The motion carried with no opposition.

#43 – MILITARY TREATMENT FACILITIES – GOVERNMENT BILLING THE GOVERNMENT

QUESTION
A Part D member who has commercial coverage as secondary was visiting someone at a military base. For some reason this person went to the base for a prescription.

The military base pharmacy is telling us that they cannot bill Medicare Part D as ‘government’ doesn’t bill ‘government’. So military base pharmacy is billing the commercial coverage who is rejecting for 41 – Bill Other Payer since the commercial coverage is a secondary benefit and the claim submitted is for a primary benefit.

Processor for commercial coverage expects a COB claim as they ‘need to see’ that billing to the other payer, who is primary, was attempted. But military base pharmacy says they can’t do this and are unable to submit a COB claim.

Typical thought would be that pharmacy would require member to pay 100% since the pharmacy is out of network and then member would submit the claim for reimbursement. But that did not seem to happen in this case. The military base pharmacy wants the commercial coverage to have override capability to allow non-COB claim to process under the commercial secondary benefit. How should this situation be addressed?

TASK GROUP RESPONSE (Based on information provided by CMS)
Per CMS information: The VA and Military Treatment Facility (MTF), by law, cannot bill Medicare. The VA or MTF pharmacy should direct the member to an in-network pharmacy or require the member to pay cash and seek reimbursement from Medicare Part D and the supplemental payer. If the claim is submitted to the supplemental payer, they are under no obligation to pay as primary to accommodate the pharmacy or member.

If the member chooses to pay cash, the claim would be submitted by the member for reimbursement and the Medicare Part D plan would determine if the member met the plan’s out-of-network access requirements. The Medicare Part D sponsor may deny the direct member reimbursement (DMR) claim because it’s not a covered Medicare Part D drug unless it’s accessed from a network pharmacy or meets the out-of-network access requirements.

Work Group Recommendation: The work group modified the verbiage.

If the claim is submitted to the supplemental payer, the supplemental payer is under no obligation to pay as primary to accommodate the pharmacy or member.

Per CMS information: The VA and Military Treatment Facility (MTF), by law, cannot bill Medicare. The VA or MTF pharmacy should direct the member to an in-network pharmacy or require the member to pay cash.
If the member is unable to reasonably access a network pharmacy and elects to pay cash, the claim could be submitted by the member for reimbursement and the Medicare Part D plan would determine if the member met the plan’s out-of-network access requirements. The Medicare Part D sponsor may deny the direct member reimbursement (DMR) claim because it’s not a covered Medicare Part D drug unless it’s accessed from a network pharmacy or meets the out-of-network access requirements.

A motion was made to approve the response with modifications and add to the Version D Editorial document. It was seconded. The motion carried with no opposition.

3. Definition of a Valid Prescriber Task Group

Requesting Work Group Approval for Following FAQs to be added to the vD Editorial Document

**D29 – Submission Clarification Codes and Prescriber Validation Error Scenario**

**Question:**
A prescriber’s DEA registration is expired and can only write scripts for schedules III – V in the plan’s data base. The claim is for a schedule II medication. The claim rejects for 43 Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired. After the pharmacy enters an SCC of 43 should the claim pay and allow the schedule II medication or should the claim also have rejected 46 Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA class? This would mean the pharmacy would have to submit two SCCs on the claim 43 and 46 to get the claim to pay?

**Task Group Response**
This example is a scenario of a timing issue. The plan’s database differs from what the pharmacy has actually validated with the prescriber. The prescriber has updated their DEA registration and Schedule II-V are now included. This information may take time to funnel through the industry.

The plan should return all applicable Reject Codes on the initial response (Reject Code 43 and 46). The pharmacy will validate the active status and prescriptive authority of the prescriber. When validated, the claim can be resubmitted with the Submission Clarification Code 43 (Prescriber’s DEA is active with DEA Authorized Prescriptive Right.)

While not recommended, in the event the plan only returns a single Reject Code when multiple errors are evident, the pharmacy would have to resubmit the claim with the applicable Submission Clarification Code for the initial Reject Code and then respond to any subsequent rejects.

**Work Group Recommendation:** A motion was made to approve the response and add to the Version D Editorial document. It was seconded. The motion carried with no opposition.

4. Compound Billing Solutions Task Group

There were none.

D. Work Group Scope and Goals

Roger Pinsonneault led discussion. There were no further changes from what had originally been suggested by the WG1 Co-Chairs.

**WG1 Telecommunication**

WG1 Telecommunication develops and maintains standards and guidelines to accommodate the collection, transmission, and processing of electronic pharmacy claim information, i.e. administering and certifying eligibility, prior authorization, and prescribing drug benefits for traditional, managed care, and government programs; billing; payment or denial of compensation with explanations, and concurrent drug use review.

**Goals:**
1. Promote NCPDP membership attendance and active participation in Work Group 1 Telecommunication meetings and task groups.
3. Review Data Element Request Forms (DERFs) and ballots pertaining to standards for which this work group is responsible.
4. Promote the use of the other transactions in the Telecommunication Standard for predetermination of benefits, information reporting, controlled substance reporting, and prior authorizations.

5. Continue support of the Universal Claim Form (UCF), Workers’ Compensation/Property and Casualty UCF, and supporting Reference Implementation Guide for enhancements to the Telecommunication Standard.

6. Provide Health Insurance Portability and Accountability Act (HIPAA) updates.
   a. Provide responses to technical questions that may be sent to NCPDP as a result of a Notice of Proposed Rule Making (NPRM) for new transactions or enhancements in HIPAA.

7. Review Designated Standards Maintenance Organizations Change Request System (DSMO CRS) requests as needed.

8. Provide Workgroup for Electronic Data Interchange - Strategic National Implementation Process (WEDI SNIP) and NCPDP SNIP updates.

9. Support the MC Education, Legislation and Regulation Task Group when new legislation is being introduced regarding issues relevant to the work group.

10. Support a forum for the discussion of CMS Medicaid and Medicare pharmacy issues as appropriate to WG1 standards.

11. Monitor WG1 task groups to ensure they are tracking to scope, goals, and deliverables. Disband task groups that have completed their work.

12. Continue support for task groups, assigned to other work groups that may impact the Telecommunication Standard or other WG1 standards.

For a list of acronyms, please see http://www.ncpdp.org/news_acro.asp

E. Strategic Planning Committee Deliverable

Roger Pinsonneault led discussion. The work group discussed the Strategic Planning Committee request to document and track work group activities and initiatives that provide opportunities to show how the work of NCPDP leads to improved health outcomes, increased patient safety and reduced cost. The WG added the following:

<table>
<thead>
<tr>
<th>TOP 5 WG CONCERNS (WHAT IS KEEPING YOU UP AT NIGHT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possibly decoupling the naming/implementation timeframe of Telecom transactions in HIPAA regulations.</td>
</tr>
<tr>
<td>Status of industry adoption of other Telecom transactions (controlled substance, PDMP, service billing, prior auth, predetermination of benefits)</td>
</tr>
<tr>
<td>Determining the trigger for requesting the naming of the next version of Telecom under HIPAA</td>
</tr>
<tr>
<td>Publication options for Telecom (NCPDP staff has a project for tools for this to be scheduled). Also recommendation from SNIP to include front matter information.</td>
</tr>
<tr>
<td>Availability, lack of standardization, use of NCPDP Payer Sheet Guide, certification. Operating rule for use of payer sheet?</td>
</tr>
<tr>
<td>Use of the Standards Compliance Process when suspected misapplications are identified. (More education?)</td>
</tr>
<tr>
<td>Consideration of removal of overpunch use but continue support of negative numbers (increase 1 digit and use sign)</td>
</tr>
</tbody>
</table>

F. Request to form a Benefit Integration Task Group

Annette Gabel provided: There is a need in the industry for plans to share information on deductible, copay and Out of Pocket (OOP) to correctly maintain the Maximum out of pockets as described in the ACA. These accumulators must reflect the total amounts paid by a family or individual for all of their benefits, medical, drug, etc. A task group was formed years ago and a file format was created that some Entities in the industry are already using to pass data back and forth between the Health Insurance Carrier for their Medical claims and their Vendor/Processor/PBM for their drug claims. Now, due to the ACA requirements for a Maximum Deductible on Small Group business and a Maximum Out of pocket on all Heath Insurance, the Industry is asking for a standard. Since NCPDP already has a standard developed it would be in their best interest to promote this standard. NCPDP should bring the right parties together to review the existing standard to ensure it meets the need and modify if necessary.
Task Group Leaders: Annette Gabel, Express Scripts and Harry Ram, Express Scripts agreed to be task group leaders. If a representative from another company would like to co-lead; please let Teresa Strickland (tstrickland@ncpdp.org) know. A motion was made to approve the task group formation. It was seconded. During discussion it was noted that this is from pharmacy claim data, but medical accumulators are reported. PCMA and BCBSA are interested in participating. It was requested that the task group consider COB (coupons, Medicaid). Analysis includes adjustments, reversal, and reconciliation use. This is a real-time transaction flow. The first priority is the transfer of medical and pharmacy accumulators. Consideration is to let the pharmacy know if paid amounts changed. The task group will reanalyze the goals and the flows from the original “Tax Advantage” task group work. These are transactions between the pharmacy and the medical processors and vice versa. The motion carried with no opposition.

G. Educational Program
An Educational Program will be held November 5, 2013 at the Portland Marriott Downtown, Portland, OR. The topic: “Aligning Healthcare to Improve Patient Safety - NCPDP is more than claims and billing!”

H. Next Quarterly Work Group Meeting
The next NCPDP quarterly work group meeting will be held on November 6-8, 2013 at the Portland Marriott Downtown, Portland, OR.

Agenda items include:

Old Business
- Reportable of Scope and Goals
- SPC Deliverable reportable
- Ballots (if applicable)
- Pended DERFs (if applicable)
- Task Groups
  - Telecomm FAQ TG
  - COB TG
  - FIR TG
  - Info Rpt Problems TG
  - Post Adjudication TG
  - Audit TG
  - REMS TG
  - Definition of Valid Prescriber TG
  - Supplemental Payer Reporting TG
  - Eligibility Verification Enhancement TG
  - Compound Billing Solutions TG
  - Service Billing TG
  - Transaction ID TG
  - Appendix G TG
  - Vaccine Services TG
  - Benefit Integration TG
- HIPAA
- SNIP

New Business
- New DERFs
- New DSMO CRS

WG1 plans to meet for 1 day, not across from WG9 or WG45.

I. Submission of new DERFs and New Project Development Forms
Submission of new DERFs and Project Development Forms are due Monday, October 7, 2013 to Kittye Krempin.
III. Motion to Adjourn

Amy Harvey asked for a motion to adjourn the meeting. The motion was moved and seconded. The motion carried. The meeting adjourned at 9:39 a.m.

Action Items:

- Task group calls and deliverables
- Prepare ballots (as appropriate)
- Task Group Leaders/Lynne Gilbertson
- Standards Development Staff

Attachment (available by contacting the Council office or on the website):

- Attendee Roster
- Any Task Group FAQs – WG1 web page
- Task Group reports and any associated documents - WG1 web page
- Ballot Spreadsheet(s)
- WG1 Scope and Goals
- SPC Deliverable information

Lynne Gilbertson
Lynne Gilbertson
Staff Liaison
WG1 Telecommunication