Monday, May 6, 2013

I. Welcome and Call to Order
A meeting of WG1 Telecommunication was held in Phoenix, AZ on May 6, 2013. Co-Chairs Roger Pinsonneault, R.Ph. of RelayHealth, Amy Harvey of Rite Aid and Damon Tressler of CVS|Caremark were present to conduct the meeting. Roger Pinsonneault called the meeting to order at 8:01 a.m.

II. Reading of the Antitrust Statement
Amy Harvey read NCPDP’s Antitrust Statement.

III. Housekeeping Items and Announcements
Amy Harvey noted the following:
1. Badges must be worn at all times.
2. The CMS Discussion will not take place during May work group meetings. The Sunday work group meetings will begin at 8:00 a.m.
3. The Co-Chairs will be announced on Monday, May 6, 2013 during MC Maintenance and Control.
4. Most Valuable Participant (MVP) Awards will be announced during MC on Monday, May 6, 2013.
5. All are encouraged to attend the General Business Session
   a. Monday, May 6, 2013 at 5:15 pm in Mesa/Flagstaff
   b. Even if you are not attending Annual Conference, you can still attend the General Business Session.
   c. General Business Session Agenda and General Business Session Minutes are available on the MC page of the website (http://www.ncpdp.org/members/members_wg_info.aspx?wgid=wgmc) as well as on the mobile application. Handouts will not be distributed.
6. Handouts are available for:
   a. May Work Group meeting schedule (sent via email; also available online)
   b. Work Group Attendee Roster
   c. Task Group Listing
   d. Calendar of Events (available online)
7. For Annual Conference Attendees (in handout bag):
   a. Welcome Letter from Lee Ann Stember, President
   b. Annual Conference Continuing Education Credit information is available at the registration desk upon request.

IV. Agenda
Amy Harvey asked if there were any modifications to the agenda. The webinars were added. A request to discuss a new task group on Transition Fill Claims Transfers was added. A motion was made to approve the agenda as modified. The motion was seconded and carried.

V. Minutes
Amy Harvey requested a motion to approve the minutes of the February 2013 meeting. The motion was made, seconded and carried.
VI. Old Business

A. Year in Review
Amy Harvey presented. See presentation.

B. Pended DERF
See Task Group discussion.

C. Ballot
Roger Pinsonneault led discussion.
WG010058 Telecom E.3 (DERFs 001080). The ballot was valid at 66.39% of the consensus group voting. There was a negative with reason vote. There was one negative public comment. See the ballot spreadsheet. Depending on the outcome of negative with reason vote, the ballot will either proceed to the Board of Trustees for approval after the required appeal period or be recirculated.

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/events.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 Name:</th>
<th>COB Task Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Task Group Formed:</td>
<td>Long time ago</td>
</tr>
<tr>
<td>Task Group Leader(s):</td>
<td>Cookie Orescanin – MedImpact; Sharon Gruttadauria – CVS/Caremark Pharmacy</td>
</tr>
<tr>
<td>Parent Work Group:</td>
<td>WG 1 – Telecommunication</td>
</tr>
<tr>
<td>Goal of Task Group:</td>
<td>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.</td>
</tr>
<tr>
<td>Generally meets every other Thursday at 1:00 Eastern</td>
<td></td>
</tr>
<tr>
<td>Business Cases Reviewed:</td>
<td>1) Medicare D versus Hospice, Medicare D versus ESRD Reject Codes 2) #36: Reversal on COB Claim 3) #37: Benefit Stage Qualifier and EGWP Wrap 4) #38: Negative Total Amount Paid, Click Fees a. Reject Code 8V Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field 5) #39: Medicare D Sponsor Names 6) #40: COB and Non-Balanced Primary Claim Responses 7) #41: Pricing Segment is Sent Contain Values as if Payer is Primary</td>
</tr>
<tr>
<td>Task Group Decisions (bullets or text):</td>
<td></td>
</tr>
<tr>
<td>Task Group Reportables (bullets or text):</td>
<td>1) Revised Task Group Goals 2) Submitted 2 DERFS / ECL a. DERF 001111/ECL 000135 – Sunset Reject Code 8V - Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field i. This DERF is the result of FAQ #38 – Click Fees. FAQ response was modified and approved for the vD Editorial Document at the February 2013 Work Group. See section 4.3.5 TOTAL AMOUNT PAID (009-F9) NEGATIVE? a. DERF 001113 / ECL 000136 - Requesting 2 new reject codes to be used when the prescription claim meets the MEDICARE D VERSUS HOSPICE, or MEDICARE D VERSUS ESRD situations. These reject codes would be in combination with reject code 75 – PRIOR AUTHORIZATION REQUIRED, when the claim meets the situations as defined in the 2014 Medicare D Draft Call Letter 3) Completed Response to 2 Questions a. #41: Pricing Segment is Sent Contain Values as if Payer is Primary</td>
</tr>
</tbody>
</table>
i. Response provided to submitter
b. #36: Reversal on COB Claim
   i. Request WG approval to add response to Editorial Guide / Imp Guide

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

1) Review / Respond to pending questions:
   a. #21: Patient Paid Amount Submitted
   b. #39: Medicare D Sponsor Names – Coordinate with WG1 Information Reporting
   c. #40: COB and Non-Balanced Primary Claim Responses
2) Work with WG1 Information reporting and WG9 Medicare D Task Groups to finalize question #37 - Benefit Stage Qualifier and EGWP Wrap
3) Work with Vaccines Services Task Group in validating COB pricing scenarios

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

Request to add the following to the Version D Editorial Guide

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

DERF 001111/ECL 000135 requests "COB Task Group requests that Reject Code 8V be sunsetted. 8V - Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field. The request for removal of reject code 8V follows a vD.Ø Editorial recommendation from the COB Task group which outlined valid scenarios in which a downstream payer can receive a negative Other Payer Amount Paid (431-DV) in a claim billing request." A motion was made to approve the DERF/ECL to MC. It was seconded. The motion carried with no opposition.

2. **REMS Task Group**

   Roger Pinsonneault of RelayHealth, Task Group lead provided a report.

   Task Group Recap Report
   Date: May 2013

   **Task Group Name:** WG1 Safe Use Processing (REMS)
   **Date Task Group Formed:** Q1 2009
   **Task Group Leader(s):** Roger Pinsonneault, R.Ph.
   **Parent Work Group:** Work Group 1 (Telecommunication)

   **Goals of Task Group:**
   1. To assess the FDA Amendments Act of 2007 to determine if there is an opportunity for NCPDP to define data communication standards for any of the identified professional activities or processes.
   2. To positively guide and influence the Food & Drug Administration and their REMS recommendations and their impact on the pharmacy, physician, and pharmaceutical manufacturing segments of healthcare.
   3. To develop data communication and process standards supporting the REMS guidelines of the FDA Amendments Act of 2007.

   **Task Group Meeting Dates (This Period):** N/A

   **Business Cases Reviewed:** N/A

   **Task Group Decisions (bullets or text):** N/A

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

   **Task Group Questions to the Work Group (bullets or text):**
   - Awaiting outcome of ballot at the May 2013 Work Group meetings

3. **Definition of a Valid Prescriber Task Group**

   Jenn Ausbrook of Walgreens and Sharon Gruttadauria, CVS Pharmacy, Task Group leads provided the report.

   Task Group Recap Report
   Date Revised: 4/26/2013

   **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):** Eleven – 90 minute calls
02/18/2012; 02/25/2012; 03/04/2013; 03/11/2013; 03/18/2013; 03/25/2013; 04/01/2013; 04/08/2013; 04/15/2013; 04/22/2013; 04/29/2013

**Business Cases Reviewed:**

1. Texas regulation and DERF 001091 – Supervising Physician Identifiers
   - Texas regulation and DERF 001091 – Supervising Physician Identifiers

2. Guest Speaker provided current statistics on Prescriber Type 1 enumeration
   - Daniel Schofield
   - Director, Provider Verification Solutions
   - Health Market Science

3. Prescriber Type 1 NPI outreach
   - Statistics:
     - 11/2012 – 102,000 prescribers w/o NPI
     - 02/2013 – 100,000 prescribers w/o NPI
     - 04/2013 – 94,000 prescribers w/o NPI
   - Can CMS assist with the prescriber Type 1 NPI outreach
   - Potential conflict between NPI final rule and Part D regulation, when the prescriber is not covered under HIPAA and he/she refuses to obtain an NPI
   - Task Group drafted Prescriber NPI Outreach Letter

4. Narcotic / Non-Narcotic Identifiers:
   - Conflict in DEA schedule identifiers between prescriber DEA registrations and drug DEA schedules, specifically as it relates to narcotic and non-narcotic.
   - Is there a standard narcotic identifier that will allow for interoperability across drug and prescriber data files?

5. Hospital DEA’s
   - How should plan sponsors handle controlled substance prescriptions where the individual prescriber is authorized to use DEA of affiliated organization?
   - How will CMS determine the controlled prescriptive authority of the prescriber?
   - Is there an industry solution, to prevent the repeated POS rejects for a single prescriber as the current prescriber data files do not disseminate the prescriber to hospital DEA affiliations?

6. Acumen Reports of invalid prescriber IDs, deceased prescriber

7. Medicare Exclusion Database – how can processor and providers obtain access (open)

8. Standardize the Post Adjudication Audit process, for POS claims submitted with a SCC and plan is unable to validate prescriber at time of PDE submission (open).
   - File layout
   - Standardize code values
   - (Note, Audit TG submitted DERFs based on this TG)
   - Will discuss 2014 call letter for audit topics

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

1. Evaluated DERF 001091, provided task group recommendation

   **Due to the following concerns it is recommended DERF 1091 be denied at this time.**
   1) Was the original intent of this regulation for medical processes, where the relationship between the prescriber and the supervising physician is known and readily available?
      a. If yes, this requirement should be limited to the medical side as the medical side maintains and has direct knowledge of this relationship and the required attributes.
      b. If no, the pharmacy is downstream of this relationship and can only report the information provided to them.
         i. For pharmacy claims, the relationship may be known however the required attributes may not be readily available or clearly communicated with the prescription.
         ii. There are no means to consistently require this information on a paper, fax, telephone, electronic prescription.
         1. The lack of the required information in the pharmacy will cause rejects, delays, and will compromise patient care.
         iii. The lack of real-time relationship information in the Texas enrollment files will cause rejects, delays, and will compromise patient care.
   2) Regulation is narrow in scope and imposes operational difficulties:
      a. Texas only
      b. Only Medicaid (Fee For Service, Managed Medicaid) claims
3) It is unclear how the Texas enrollment processes will support this regulation
   a. The Texas Managed Medicaid programs are not required to support enrollment of prescribers, so it is unclear how the non-enrolled relationships will be captured and then be used for validation
   b. The Texas enrollment processes will need to support the multiple relationships that exist
   c. The Texas enrollment processes will need timely updates of modifications to the relationship changes
   d. The Texas enrollment processes will need to support dissemination and access to industry of the relationships for validation

4) Due to the above unknowns, it is unclear what modifications would need to be made to the pharmacy claims standard to support the supervising physician in claims adjudication for Texas Medicaid.

2. Drafted Prescriber NPI Outreach letter
   a. http://www.ncpdp.org/pdf/PrescriberType1NPIOutreachTemplate.doc

3. Definition of a Valid Prescriber FAQs – Completed 5 Questions
   a. R1 – DERF 001091 TX House Bill – Supervising Physician
      i. WG to adjudicate DERF
   b. D25 – Special DEA / DATA Waiver Prescribers
      i. Response provided to submitter
   c. D24 - ARCOS and DEA Schedules
      i. Requesting WG approval to add to vD Editorial
   d. D2 – Can CMS Assist With Industry Outreach for Type 1 NPI Requirements
      i. Requesting WG approval to add to vD Editorial
   e. D11 - HOW SHOULD PLAN SPONSORS HANDLE CONTROLLED SUBSTANCE PRESCRIPTION CLAIMS WHERE THE ASSOCIATED DEA IS AN ORGANIZATIONAL DEA
      i. Requesting WG approval to add to vD Editorial

Task Group Action Items/Next Steps (bullets or text):
- Complete FAQs
- Complete White Paper

DERF 001091 requests “Texas House Bill 172Ø, 82nd Legislature, Regular Session (Section 531.024161) requires that the National Provider Identification (NPI) number for both the referring/ordering prescriber and the supervising prescriber be on Medicaid claims when the referring prescriber is supervised or directed by another prescriber. This is effective September 2012, but currently the NCPDP D.Ø format does not allow for the inclusion of two prescriber NPIs.” In November, the DERF was pending for WG1 Definition of a Valid Prescriber Task Group to work through fields needed, situations, rejects, and matrix needs.

A motion was made to deny the DERF due to concerns the WG1 Definition of a Valid Prescriber Task Group brought forward. It was seconded. The motion carried with no opposition.

See Recommendations for the Version D Editorial section.

4. Service Billing Task Group
Roger Pinsonneault of RelayHealth, Task Group lead provided a report.

Task Group Recap Report
May 2013

Task Group Name: Service Billing
Date Task Group Formed: August, 2012
Task Group Leader(s): Roger Pinsonneault, RelayHealth
Parent Work Group: Work Group 1 - Telecommunication

Goal of Task Group:
- To facilitate pharmacy provider billing and reversal of claims in which there is a product and service component,
- To facilitate pharmacy benefit processing of claims in which there is a product and service component,
- With the overriding goals of maintaining current billing capabilities (i.e. product billing and service billing), and
- To expand sales tax documentation capabilities

Task Group Meeting Dates (This Period):
- N/A this quarter

Business Cases Reviewed:
- N/A this quarter, awaiting outcome of discussions within the Vaccine Services Task Group

Task Group Decisions-Discussion Points (bullets or text):
Proposed Approach:
- Prescription/Service Reference Number Qualifier (455-EM)
  - 1 = Product Billing
  - 2 = Service Billing
  - 3 = Product with Associated Service Billing
- Transaction Code
  - B1 – Billing
  - B2 – Reversal
  - B3 – Rebill
- Other Amount Claimed Submitted Qualifier (479-H8)
  - 01 - Delivery
  - 02 - Shipping
  - 03 - Postage
  - 04 – Administrative
  - XX – Service Administration
  - 99 - Other

Proposed Additional Fields:
- + Flat Sales Tax Amount Submitted (481-HA)
  - Flat Sales Tax Amount Count (XXX-XX)
  - Flat Sales Tax Amount Qualifier (XXX-XX)
- + Percentage Sales Tax Amount Submitted (482-GE)
  - Percentage Sales Tax Amount Count (XXX-XX)
  - Percentage Sales Tax Basis Submitted (484-JE)
  - Percentage Sales Tax Amount Qualifier (XXX-XX)

Proposed Product with Associated Service Billing Formula:
- Ingredient Cost Submitted (409-D9)
- Professional Service Fee Submitted (477-BE)
  - + Dispensing Fee Submitted (412-DC)
  - + Other Amount Claimed Submitted (480-H9)
    - Other Amount Claimed Submitted Count (478-H7)
    - Other Amount Claimed Submitted Qualifier (479-H8)
      - 01 - Delivery
      - 02 - Shipping
      - 03 - Postage
      - 04 – Administrative
      - XX – Service Administration
      - 99 - Other
- + Flat Sales Tax Amount Submitted (481-HA)
  - Flat Sales Tax Amount Count (XXX-XX)
  - Flat Sales Tax Amount Qualifier (XXX-XX)
- + Percentage Sales Tax Amount Submitted (482-GE)
  - Percentage Sales Tax Amount Count (XXX-XX)
  - Percentage Sales Tax Basis Submitted (484-JE)
  - Percentage Sales Tax Amount Qualifier (XXX-XX)
- Gross Amount Due
  - Patient Paid Amount Submitted (433-DX)
  - Other Payer Amount Paid (431-DV)
  - (Net Amount Due)

Transaction Count – Transaction Count must equal “1” if Prescription/Service Reference Number Qualifier = “3” (i.e. Limit Product with Associated Service Billing transmissions to a single transaction)

Reject Codes – If a processor receives a request for a Product with Associated Service Billing (i.e. Prescription/Service Reference Number Qualifier = “3”) there are multiple reject scenarios:
- “XXX” to indicate a processor does not support “Product with Associated Service Billing transactions,
- “XXX” to indicate Product Rejected and Service is eligible,
- “XXX” to indicate that Service is rejected and Product is eligible, and
- “XXX” to indicate that Product and Service are rejected

Task Group Reportables (bullets or text):
- See Vaccine Services Task Group Recap

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

Task Group Action Items/Next Steps (bullets or text):
- Await outcome of Vaccine Services Task Group and discussion on combining the billing of product and services into a single transaction

5. Telecom FAQ Task Group

Mike Day of DayTech, Task Group lead provided the report.

Task Group Recap Report
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: NONE  
Business Cases Reviewed:  
One question was received by email, reviewed by Lynne and myself and answered based on current documented guidance. No meeting was required.  
Reportable questions are: NONE  
Question still in open discussion: NONE  
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  

6. Financial Information Reporting Task Group  
Monique Irmen, RelayHealth and Annette Gabel of Express Scripts, Inc., Task Group leads provided the report. The task group has been meeting on Mondays and Fridays. On April 1, there was an implementation of a new FIR report. The task group has reviewed and answered questions. They are going through the list of FAQs to create a FIR Editorial document. They updated a published white paper on plans moving processors to version 2 now that the industry has real life experience. They are working on a new white paper for the nonplan of record.  

7. Information Reporting Problems Task Group  
Melanie Merlino of CVS/Caremark, Task Group lead provided the report.  
NCPDP Task Group Recap Report  
Date: 2/06/2013  
Task Group Name: Information Reporting Problems Task Group  
Date Task Group Formed: 11/07/08  
Task Group Leader(s): Melanie Merlino, Lisa Chernov  
Parent Work Group: WC1  
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):  
3/6, 3/20, 4/3, 4/17, 5/1  
Business Cases Reviewed:  
Monique Irmen reviewed the beta website that RelayHealth was preparing for launch and asked for SPAP feedback. The new website design offers a section for "Nx" and reorganizes helpful information for payers that supplement Medicare Part D coverage. NCPDP distributed the beta website link for membership review. The website is now operational.  
The task group discussed how the SPAPs use the claim fields available on the D.0 supplemental claim (post Part D coverage) to assist with administering the SPAP benefit. During the initial implementation of Part D, the SPAPs raised the business need have visibility to the Part D benefit stage (ICL, GAP, etc.) that was applicable at the time that the Part D plan processed the claim. As a result, benefit stage fields were created for use in the D.0 claim format. This task group is revisiting the SPAP business requirements as they have evolved over time. The task group will prepare recommendations to the existing D.0 standard, and to a future claim standard based on the SPAP business needs. These recommendations will be presented to WG1 and WG9 for further discussion.  
Task Group Decisions (bullets or text):  
Approval of the COB white paper. See the WG1 zip for the COB white paper.
Task Group Reportables (bullets or text):
Requesting the COB White Paper by WG1.

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

Task Group Action Items/Next Steps (bullets or text):
Upon approval of the COB white paper, work with NCPDP to disseminate the information.
Continue discussions related to potential changes to the existing or new NCPDP pharmacy claim standard to support evolving SPAP business needs.

A motion was made to approve the COB white paper. It was seconded. The motion carried with no opposition. After the meeting, Mary Perez of Catamaran agreed to be co-lead.

8. Post Adjudication Task Group
Annette Gabel of Express Scripts, Inc., Task Group lead, provided the report. The task group did not need to meet. It was recommended to keep the task group open in case there are questions from the exchanges. See the New Business request for Transition Fill Claims Transfers Task Group. This work will be discussed in the Post Adjudication Task Group rather than forming a new task group.

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

Task Group Recap Report
Date: 05/2013

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):
February 28, 2013, March 14, 2013

Business Cases Reviewed: N/A

Task Group Decisions (bullets or text):
- DERF additional values to support WG1’s Definition of a Valid Prescriber TG’s identified prescriber related audits.

Task Group Reportables (bullets or text):
- DERFs (Appendix A)

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

Task Group Action Items/Next Steps (bullets or text):
- Finalize changes based on pilot outcomes and member requests
- Determine the best way to support rejects (files and detail records)
- Submit updates to Audit Transaction Standard for August WG meeting

Appendix A – DERFs
New Audit Element Type 1-5 values:

<table>
<thead>
<tr>
<th>Value Suggested</th>
<th>Value Description (required)</th>
<th>Value Description Definition (required)</th>
<th>Value Limitations (not required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2X</td>
<td>NPI Required</td>
<td>Claim billed without Prescriber NPI, submit proof of valid Prescriber NPI.</td>
<td></td>
</tr>
<tr>
<td>2Y</td>
<td>NPI De-activated</td>
<td>Claim billed with Inactive Prescriber NPI, submit proof that Prescriber NPI is active.</td>
<td></td>
</tr>
<tr>
<td>2Z</td>
<td>NPI Not Found</td>
<td>Claim billed with unidentified NPI, submit proof of Prescriber’s NPI validity.</td>
<td></td>
</tr>
<tr>
<td>3A</td>
<td>Type 2 NPI Not Allowed</td>
<td>Claim billed with Organizational NPI, submit Prescriber’s Individual NPI.</td>
<td></td>
</tr>
<tr>
<td>3B</td>
<td>DEA Expired</td>
<td>Claim billed with Expired Prescriber DEA Number, submit proof that Prescriber DEA is re-activated.</td>
<td></td>
</tr>
<tr>
<td>3C</td>
<td>DEA Inactive</td>
<td>Claim billed with Inactive Prescriber DEA Number, submit proof that Prescriber DEA is active.</td>
<td></td>
</tr>
</tbody>
</table>
3D  Prescriber DEA Schedule not Authorized for Drug  Claim billed with Prescriber not authorized to write for drug. submit proof that Prescriber has authority to write for drug.

New Audit Element Response 1-5 values:

<table>
<thead>
<tr>
<th>Value Suggested</th>
<th>Value Description (required)</th>
<th>Value Description Definition (required)</th>
<th>Value Limitations (not required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Submitted ID is Valid in NPPES.</td>
<td>According to NPPES, the Prescriber NPI submitted is valid.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Resubmitted</td>
<td>Claim has been reversed and resubmitted.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Date of Service Outside Billing Window.</td>
<td>Claim has been reversed, cancel audit.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Claim Reversed</td>
<td>Claim has been reversed, cancel audit.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Unable to Resolve</td>
<td>Documentation for Audit Element Type requested not available.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Date Written prior to NPI Deactivation Date.</td>
<td>The date the prescription was written by the prescriber was prior to the NPI deactivation date.</td>
<td></td>
</tr>
</tbody>
</table>

DERF 001114/ECL 000138 “Request additional values are added to the Audit Element Response Type 1 (A62). Note: Audit Element Response Type 2 (A63), Audit Element Response Type 3 (A64), Audit Element Response Type 4 (A65) and Audit Element Response Type 5 (A66) all reference the code list found in Audit Element Response Type 1.” The description was changed from PDE to claim. A motion was made to recommend the DERF/ECL be approved at MC with modifications. It was seconded. The motion carried with no opposition.

DERF 001115/ECL 000139 requests “Request additional values are added to the Audit Element Type 1 (A57). Note: Audit Element Type 2 (A58), Audit Element Type 3 (A59), Audit Element Type 4 (A60) and Audit Element Type 5 (A61) all reference the code list found in Audit Element Type 1.” A motion was made to recommend the DERF/ECL be approved at MC. It was seconded. The motion carried with no opposition.

10. Supplemental Payer Reporting

Monique Irmen of RelayHealth, Task Group lead provided the report. The task group is working through reports from the Transaction Facilitator that will assist the supplemental payers in researching claims to Information Reporting transactions and failure situations.

Task Group Recap Report
Date: 4/23.2013

Task Group Name: WG1 Supplemental Payer Reporting Task Group
Date Task Group Formed: 02/2012
Task Group Leader(s): Monique Irmen, NEED a new co-lead
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):
4/3/2013

Business Cases Reviewed:
Data elements for reports for supplemental payers confirmed with end users

Task Group Decisions (bullets or text):

Task Group Reportables (bullets or text):
Reports and data elements have been finalized.

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

The task group is looking for a new co-lead. It was noted that SPAPs and ADAPs have unique BIN/PCNs. Commercial plans do not have to separate. A question was received by the WG1 Telecom FAQ Task Group that will be discussed at their next call.
11. **Eligibility Verification Enhancements Task Group**  
Mary Perez of RelayHealth and Nancy Bridgman of Omnicare, Task Group leads provided the report.

**Task Group Recap Report**  
Date: 04/29/2013

**Task Group Name:** Eligibility Verification Enhancements Task Group  
**Date Task Group Formed:** February 2012  
**Task Group Leader(s):** Nancy Bridgman - Omnicare and Mary Perez - Catamaran  
**Parent Work Group:** Work Group 1 Telecommunication

**Goal of Task Group:** This task group will explore enhancements to the Eligibility Verification Transaction, specifically for Medicare Part D needs.

**Task Group Meeting Dates (This Period):**  
3/12/13, 3/26/13, 4/10, & 4/23

**Business Cases Reviewed:**
1. Continued review of a new Pharmacy Scenario for E1 Transaction where pharmacy can submit last known Part D information from last successful claim processed requesting current Part D coverage.
3. Testing for E1 Structured Messaging Enhancement that is being implemented 5/23/2013.
   a. There will be test cases available in the updated payer sheets that is scheduled to be distributed in May.
   b. Test cases can be submitted before May 23, however, they will not have a response in the test case that will include the new data. That will not be available, until May 23.

**Task Group Decisions (bullets or text):**
- DERF 001116 submitted for Eligibility Verification Information revisions for the Implementation Guide.

**Task Group Reportables (bullets or text):**
- Question to OESS to address if any interim process can be followed until new E1 Segment “Last Known Plan Segment” is introduced for the next HIPAA adoption.
  - From the discussion it appears the options are:
    - Request a pilot
    - Develop a separate transaction that could be used optionally by the industry, and not an adopted standard
    - Develop a separate standard transaction (similarly to the Medicaid subrogation standard that is only used by Medicaid) and request HIPAA adoption
    - Enhance D.0 for the next adopted version

**Task Group Questions to the Work Group (bullets or text):**
- Commercial E1 activity – are there any recommendations we as a task group can provide to help improve these transaction types – data received?
  - Response: submitter of the question is working with an industry entity; no further action of the task group.

**Task Group Action Items/Next Steps (bullets or text):**
- Work on request for a Pilot for the new E1 Segment “Last Known Plan Segment”.
- Respond to any questions related to the E1 Structured Messaging Enhancement that is being implemented 5/23/2013.
- Phase II of the E1 Structured Messaging Enhancement in relation to the 2014 Call Letter “Pay & Chase” for Hospice & ESRD – Keeping as a task group follow-up with CMS & Relay Health.

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 Telecommunication Implementation Guide to support this change is farther out. A motion was made to pend the DERF so the task group could look at moving the changes out of Telecom and into the Version D Editorial and include the effective dates. It was seconded. The motion carried with no opposition.

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

**Task Group Recap Report**  
Date: 4/24/13

**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):**
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):
2/22/13, 3/8/13, 3/22/13, 4/12/13, 4/19/13, 4/26/13

Business Cases Reviewed:
- Reviewed recommended changes to the DUR section
- Reviewed updated reject code analysis (4/12/13)
- Reviewed sections of Editorial Guide where reject codes are mentioned

Task Group Decisions/Recommendations (bullets or text):
- Recommendation to move Appendix G to Editorial Document
- Incorporated changes to the DUR section
- Reject Code 7X and 85 were added to Appendix G since they were new to the top 25 reject codes
- Reject Codes 597, 612, and 613 were added to Appendix G and LTC Billing Issues Task Group was asked to review.
- Reject Codes 620, 621, A5 and A6 were added to Appendix G.
- Request submitted to COB Task Group to review Section 9.18 of the Editorial Guide to determine if still necessary and whether there are any COB related reject codes that should be 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 E.0 Implementation Guide references to reject codes
- Review mention of “should” and “must” in Appendix G for possible re-wording (recommendations could potentially become enforceable in the future as operating rules).
- Identify questions to ask the other WG’s to identify pain points with current rejects where additional messaging would be beneficial.
- Incorporate recommended changes to the LTC section
- Determine how we organize Appendix G & Reject Code guidance in Editorial Document

It was suggested the task group look at any ECL guidance as well. It was asked if we could republish a new version of Telecom D.0 with sections removed. No, this requires a version change. It was suggested to move Appendix G information to the Version D Editorial to allow more fluidity. The task group needs more participants.

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

Task Group Recap Report
Date: 4/3/2013

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.
- Third area made for review of DUPLICATE LOGIC to refine criteria for future as well.

Task Group Meeting Dates (This Period): (Every other Thursday at 1:00 Eastern)
**Business Cases Reviewed:**

**WHO creates the Transaction Id?**
- Initial thought was for processor to assign however in review of DUPLICATES, a txn id from provider software could be a 'flag' to processor that while THEY have determined this to be a duplicate, the pharmacy views this as a unique and different claim.
- Group is leaning towards having provider software create the id.

**Concerns:**
- Since issues exist today where processor or provider software is not creating 'clean' transactions and responses – does adding a new value really help?
- With provider software creating a Txn ID, the id of the provider must be embedded within this or the provider id or we are back to having to use multiple fields for matching.
- Similar issue exists if processor creates the Txn ID then a merger occurs whereby the new processing entity ends up with multiple Txn Ids within their system for completely different claims.
- Perhaps best approach is to review and document existing issues to provide better guidance in the Implementation Guide for match criteria for Reversals and Duplicates.
- Continuing to review reversal issues to see where a Txn Id would correct a non-match issue (i.e. submission of Transaction Date instead of Date of Service)
- The use of a Txn Id for 'editing' a claim to allow update of non-financial criteria is still to be reviewed to determine what fields can be considered non-financial.

**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):**

14. **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: 4/17/2013

**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):**

**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.

Topic 3 recommendations 1-3 are requested to be approved for inclusion in the Version D Editorial document. See below.

**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. There is an NDC code for the product, but it is not in the pharmacy or the processor's drug file.
3. There is a UPC code for the product; the product does not have an NDC. It is not in the drug file.
4. The product is not identified by an NDC or an UPC. It could be identified with an HRI.
5. The product is not identified with a "valid" identifier

**Task Group Questions to the Work Group (bullets or text):**
When using the Telecommunication Standard version D.0 multi-ingredient claim, should we leave off ingredients that are not paid for, like cream bases, empty capsules and fillers which are necessary to prepare the compounds, etc.? This example assumes that not all ingredients in the compound are identifiable by the pharmacy and the payer but they are valid products.

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

Task Group Action Items/Next Steps (bullets or text):
- Continue reviewing the use of identifiable ingredients with other types of qualifiers (UPC, HRI, etc.) that are not recognized by the payer/processor.
- Continue reviewing the use of non-NDC ingredient identifiers (HCPCS, UPC, UPIN, etc.)
  - Active ingredients
  - In-active ingredients
- Review the use of non-ingredient supplies

See Recommendations for the Version D Editorial section.

15. Vaccine Services Task Group

Roger Pinsonneault, RelayHealth, Task Group lead provided the report.

Task Group Recap Report
Date: May 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, March 22, 2013
- Friday, April 5, 2013
- Friday, April 19, 2013

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 Benefits – 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):
- Scope - Task Group focus extends beyond influenza vaccines
- Task Group Priorities:
  - Pharmacy Billing & Reconciliation – Primary / Concurrent Sub Task Group
  - Medical Eligibility & Billing Coordination – Primary / Concurrent Sub Task Group
  - Electronic Prescribing – First
- Electronic Prescribing - Future
- Registry Reporting – Future
- Primary Care Provider Notifications - Future
- Pharmacist Credentialing – Future

**Recommendations (Pharmacy Sub Task Group):**

- To assign specific reject codes for specific billing scenarios,
  - To indicate the vaccine is a covered pharmacy benefit, the service fee is not a covered benefit, and the pharmacy must remove the service fee
  - To indicate a Professional Service Code submission requirement if the service fee (i.e. Incentive Amount Submitted) is to be recognized,
  - To indicate that vaccine coverage is known by the pharmacy benefit and available under the patient’s medical benefit

- To standardize on a single vaccine, product and administration, billing process to the pharmacy benefit:
  - Product and service fees within a single transaction (e.g. Medicare Part D recommendations),
  - To identify the service fee in the Incentive Amount Submitted field on a request,
  - To reject the vaccine billing request when the requests payment for the administration of the vaccine

- To standardize on a vaccine, product and administration, payment response from the pharmacy benefit:
  - To identify the reimbursed service fee component as follows:
    - In the Ingredient Cost Paid field on a paid claim response, when the vaccine product and service is reimbursed at a contracted flat rate
    - In the Incentive Amount Paid field on a paid claim response, when the vaccine product and service is not reimbursed at a contracted flat rate

- To seek assistance from the COB Task Group,
  - To review the preceding recommendations for appropriateness relative to coordination of benefit transactions,
  - To provide examples of the following coordination of benefit scenarios:
    - Product & Service Fees Paid
    - Product & Service Fees Rejected
    - Product Paid & Service Fee Rejected

- To ensure consistency between the pharmacy financial response and the corresponding fields on the X12 835 (Health Care Claim Payment/Advice)

**Task Group Reportables (bullets or text):**
- Task Group Formation Approval – February, 2013
- Task Group Goals Established – Q1, 2013
- Task Group Scope Established – Q2, 2013
- Task Group Decisions & Recommendations – Q2, 2013

**Task Group Questions to the Work Group (bullets or text):**
- To standardize on a vaccine, product and administration, payment response from the pharmacy benefit. Specifically, to identify the reimbursed service fee component as follows:
  - In the Ingredient Cost Paid field on a paid claim response, when the vaccine product and service is reimbursed at a contracted flat rate
  - In the Incentive Amount Paid field on a paid claim response, when the vaccine product and service is not reimbursed at a contracted flat rate

**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 (56S-J4) and COB
  - 9.7 Other Payer Amount Paid Qualifier (342-HC) Value 99?
  - 9.8 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.

The work group discussed that the Telecommunication Implementation Guide says when a pricing field is submitted, the paired response field is sent back. What about a flat dollar amount? On the medical side there are procedure codes that may be grouped together. What are the rules for COB downstream? The pharmacy may lose the administration fee because it is bundled under a drug benefit. The Vaccine Services Task Group needs to write up the scenarios before the COB Task Group can help discuss.

**E. HIPAA Update**

Amy Harvey provided input from Margaret Weiker, The Weiker Group, Standardization Committee.

- Important: Approved at Nov WG: We are recommending that an existing field, Quantity Prescribed (46Ø) 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 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. A federal notice will be published (“soon”).

ii. **Industry implementation January 1, 2014.**

- 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—not 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 Health Plan and Other Entity System (HPOES) is available for obtaining an HPID or OEID. For more information see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

  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.

Meaningful Use:
http://www.healthit.gov/

F. Strategic National Implementation Process (SNIP) Update

Annette Gabel, Committee Chair noted the NCPDP SNIP Committee completed industry lessons learned of this round of HIPAA. The committee will work 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.

VII. 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

Amy Harvey led discussion.

DERF 001117/Emergency ECL 000140 requests “CMS has issued a Final Rule reminding Part D sponsors that they must establish and apply a daily cost sharing rate whenever certain prescriptions are dispensed by a network pharmacy for less than a 30 days’ supply. Situations that require the proration of copay typically involve Synchronization or trial fill which may trigger a refill too soon edit. Two new Submission Clarification Codes (47 and 48) were approved for October ECL and indicate shortened day supplies. Current: 47 = Shortened Days’ Supply Fill - only used to request an override to plan limitations when a shortened days’ supply is being dispensed. 48 = Fill Subsequent to a Shortened Days’ Supply Fill - only used to request an override to plan limitations when a fill subsequent to a shortened days’ supply is being dispensed. We are proposing two additional codes. These two new codes will allow for identification of the claim types and then two existing codes for override in the event a plan rejects for refill too soon.” The submitter withdraw the DERF, but wondered if anyone else had a business need. No one requested.

C. Recommendations for the Version D Editorial

Amy Harvey led discussion.
1. **Telecommunication FAQ Task Group**

There were none.

2. **COB Task Group**

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

1) #36: Reversal on COB Claim

**Question:**
Please clarify the “appropriate back-out order” for COB reversals.

**Task Group Recommendation:**

Coordination of Benefit reversals: Reversal requests for COB claims should be submitted in the reverse order of the claim billing request (example: claim billing occurred as Primary, Secondary then Tertiary, reversal order should be Tertiary, Secondary, Primary). COB claim reversals must contain the Coordination Of Benefits/Other Payments Segment and include the Other Payer Coverage Type in order to facilitate the proper order especially in instances where one processor is the payer for multiple levels of coverage.

A rejected reversal for a COB claim may need to be addressed by alternative processes in order to maintain financial integrity for the claim associated to each payer (Tertiary, Secondary, Primary).

It is also recommended that the next version of the Implementation Guide be updated as follows:

**10. REVERSAL INFORMATION**

The reversal transaction is used to “back out” a previously captured or paid prescription, service billing, information or controlled substance reporting. Up to four reversal transactions per transmission are permitted. Reversal Transaction Codes are “B2”, “S2”, “N2”, or “C2”.

It is recommended that the pharmacy not allow a reversed prescription to be deleted from their pharmacy system without first receiving a response from the processor related to the reversal. A rejected reversal may require alternative processes to maintain financial integrity of the claim.

**10.1 Coordination of Benefit Reversals**

Reversal requests for COB claims should be submitted in the reverse order of the claim billing request (example: claim billing occurred as Primary, Secondary then Tertiary, reversal order should be Tertiary, Secondary, Primary). COB claim reversals must contain the Coordination Of Benefits/Other Payments Segment and include the Other Payer Coverage Type in order to facilitate the proper order especially in instances where one processor is the payer for multiple levels of coverage.

A rejected reversal for a COB claim may need to be addressed by alternative processes in order to maintain financial integrity for the claim associated to each payer (Tertiary, Secondary, Primary).

**10.2 Transmission with Multiple Reversal Transactions**

To correctly build a multi-reversal transmission, the reversal transaction(s) in this transmission must be:

- In the same format (Version/Release Number) and
- Sent to the same entity (processor or PBM using the BIN Number and Processor Control Number) and
- For the same pharmacy (Service Provider ID and Qualifier) and
- For the same date (Date of Service).

Situational segments such as the Insurance Segment may be supported. If a processor/PBM needs this information to process a reversal, this segment can be used. Only one Insurance Segment must be submitted per transmission.

If a processor/PBM does not need the Insurance Segment, but the pharmacy wishes to send it, the processor/PBM must ignore the valid optional and/or situational information.

Date of Service (4Ø1-D1) is defined as “identifies date the prescription was filled or professional service rendered”. Therefore, since the date is in the Transaction Header segment that occurs once (at the transmission level), one to four transactions (at the transaction level) must be for the same date.

Multiple claim or service reversal transactions in a transmission must be for the same patient.

The structure does support multiple claim or service reversals for the same processor/PBM, for the same pharmacy, for the same Date of Service, but for multiple patients. However, it is recommended that a transmission containing multiple reversals for multiple patients not be supported. Even though the structure supports reversals for multiple patients, the recommendation is that this not be supported. If, during the transmission of a reversal, the communication or procedure is interrupted, a provider may not receive notification that the processor has reversed the transaction. If the provider retransmits the reversal, the processor must not apply the reversal more than once for a given transaction. A “Reversal” resubmission must prompt the processor to reply with the same information returned on the original reversal response, and use an “S” (Duplicate of Approved) status. The message field may be used to inform the submitter of the reason for the duplicate status, e.g. reversal previously accepted. See section “Response Processing Guidelines”, “Duplicate Transactions”. 
Work Group Recommendation: 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

Task Group Questions to the Work Group (bullets or text):
The task group requests the following FAQs be approved to be added to the vD.0 Editorial Document.

1. D24 - ARCOS and DEA Schedules
   Modify Question currently in Version D Editorial (15.20.2):
   Question:
   Does CMS expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level? Situation: A prescriber's DEA license is associated to the applicable DEA schedules (2, 3, 4, 5). The DEA further delineates the schedules as Narcotic and Non-Narcotic, where Non-Narcotic is listed as 2N, or 3N. Not all The drug compendia however do not may provide a Narcotic or Non-Narcotic classification. Based on the lack of standardization of a narcotic identifier on the drug files, does CMS expect sponsors to be editing to that level?

   CMS Response:
   As noted in the CY 2012 Call Letter, the DEA Schedule policy does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substances Act and DEA rules.

   TASK Group Recommendation
   No. Sponsors are not expected to edit the drug DEA schedule to the prescriber's DEA schedule down to the narcotic and non-narcotic level, as there is not an attribute currently available to perform this validation.

   CMS does not expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level.

   No. However, systematic validation may be available based on data elements on the drug compendia files. (Note: The DEA schedule and a narcotic box will eventually be on the HDMA form used by the wholesalers to send info to the compendia. As an additional resource, WG2 Structured Product Label Task Group will ask FDA to generate an Index of Narcotics on the Dailymed website.)

   The industry uses the CFR - Code of Federal Regulations Title 21 for the definition of a narcotic.


   Narcotic drug means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:
   (1) Opium, opiates, derivatives of opium and opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation. Such term does not include the isoquinoline alkaloids of opium.
   (2) Poppy straw and concentrate of poppy straw.
   (3) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine and derivatives of ecgonine or their salts have been removed.
   (4) Cocaine, its salts, optical and geometric isomers, and salts of isomers.
   (5) Ecgonine, its derivatives, their salts, isomers and salts of isomers.
   (6) Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in paragraphs (1) through (5) of this definition.

   Validation rules:
   - If the Prescriber has DEA schedule of 2, 2N, 3, 3N it must be an exact match to the drug DEA schedule of 2, 2N, 3, 3N.
   - If the Prescriber has DEA schedule of 4, the match to drug DEA schedule of 4 or 4N is valid.
   - If the Prescriber has DEA schedule of 5, the match to drug DEA schedule of 5 or 5N is valid.
### Examples:

1. Prescriber has a DEA schedule of 2 and does not have 2N, and the drug DEA schedule is 2N
   a. Check is not valid since the match of 2N must be exact.

2. Prescriber has a DEA schedule of 3N and does not have 3, and the drug DEA schedule is 3.
   a. Check is not valid since the match of 3 must be exact.

3. Prescriber has a DEA schedule of 4 and the drug DEA schedule is 4N
   a. Check is valid since the match for 4 is 4 or 4N.

### Work Group Recommendation: 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.

2. **D2 – Can CMS Assist with Industry Outreach for Type 1 NPI Requirements**
   a. Question: Can CMS assist with industry outreach for entities that need Type 1 NPIs? (FAQ already in Version D Editorial; modify)
      i. Answer: **Work Group modification in yellow:** Please refer to the October 19, 2012 CMS Transmittal R2567CP which was directed to physicians. Refer to page 14 “Announcement About Medicare Participation for Calendar Year 2013”

         NCPDP has also drafted a Prescriber NPI Outreach Letter Template that is available at http://www.ncpdp.org/news_npi_info.aspx#NPIEx

   b. Question: How should the Medicare Part D prescription claim and PDE be processed in the situation where the prescriber is not a HIPAA covered entity and refuses to obtain a Type 1 NPI?
      i. Answer:
         i. CMS response: The vast majority of prescribers are either HIPAA covered entities themselves, or even more commonly, have a member, employment, or contractual relationship with an organization covered health care provider. In both instances, the prescribers must obtain an NPI. For the very limited instances when a Part D sponsor has verified that a prescriber does not have an NPI and the sponsor has been unable to persuade the prescriber to obtain one, the sponsor may report this instance to HHS/CMS/OESS as a possible violation of HIPAA Administrative Simplification requirements by an organization covered health care provider or covered entity. Please see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Enforcement/index.html to learn more about the HIPAA Enforcement process and how to file a complaint.

         In the event that the prescriber does not obtain an individual Type 1 NPI, the Part D Sponsor will not be able to submit the PDE. There is not a PDE exception process for this situation. The sponsor must administer the benefit and update the accumulators correctly.

   c. Question: How should the Medicare Part D prescription claim and PDE be processed in the situation with a deceased prescriber who did not obtain an NPI (where state law allows subsequent fills to process after a prescriber’s death)?
      i. Answer:
         a. CMS Response: In this situation, which we believe will be extremely rare; the Part D sponsor will not be able to submit the PDE. There is not a PDE exception process for this situation. The sponsor must administer the benefit and update the accumulators correctly. (It is understood that this situation will eventually resolve itself in time.)

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</table>
Work Group Recommendation: A motion was made to approve the response with modifications and add/updated the Version D Editorial document. It was seconded. The motion carried with no opposition. Monique Irmen volunteered to follow up on possible dentist outreach.

3. **D11. HOW SHOULD PLAN SPONSORS HANDLE CONTROLLED SUBSTANCE PRESCRIPTION CLAIMS WHERE THE ASSOCIATED DEA IS AN ORGANIZATIONAL DEA**

Task Group Recommendation: To be put in the Version D Editorial.

**Question:** How should plan sponsors handle a controlled substance prescription claim where the prescriber’s individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan’s prescriber data base?

**Response:** In the situation where the processor is not able to identify a DEA number to be associated to the submitted individual prescriber NPI, the claim would reject as Reject Code “44” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is not found). After validation, the pharmacy would resubmit the claim with the Submission Clarification Code 45 (Prescriber’s DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule). Note: pharmacy systems may be able to proactively recognize the prescriber relationship to a hospital and could submit the Submission Clarification Code 45 on the initial submission prior to any reject. The elimination of the reject will mitigate patient care delays and improve beneficiary experience. Per CMS, the DEA Schedule registration information is not submitted on the PDE. In this instance, sponsors can assume the 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. From the Part D perspective, the process is completed when the pharmacy submits the Submission Clarification Code 45.

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

4. **Compound Billing Solutions Task Group**

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

**Topic 3: Submission of identifiable Ingredients that are not recognized by the Payer?** - Items 1-3 to May WG

**Submission of Identifiable Ingredients that are not Recognized by the Payer**

1. It is recommended that the correct Product/Service ID Qualifier (436-E1) value be supported for the Product/Service ID (407-D7).
   a. It has been identified that entities may not be supporting the valid qualifier values for the types of products exchanged in compounds. This may be a long term implementation modification. However the industry needs to move to use the correct ID and Qualifier pair.
   b. **Recommendation if the processor does not support the code list (does not support the value for the Product/Service ID Qualifier):**
      i. It is recommended the processor identify on the payer sheets which Product/Service ID Qualifiers are supported. If an ingredient has a qualifier value that is not supported by the processor, it is recommended that procedures for how the pharmacy is to be able to submit the claim and be reimbursed for ingredients that are covered be handled between trading partners.

2. **There is an NDC code for the product, but it is not in the pharmacy or the processor’s drug file.**
   a. Someone in the supply chain should insure that the identifier is loaded timely into the drug file.
   b. May be payer-specific or drug compendia-specific and is time-consuming to update the drug file(s).
   c. **Recommendation for identification of product:**
      i. The processor may not know enough about the product to contact their compendia. The pharmacy has the product in hand to contact the manufacturer. The pharmacy could provide information about the product to the processor so the processor could follow up with their compendia.
      ii. The pharmacy or the processor should contact the manufacturer and their compendium.
      iii. The manufacturer should share their information with the compendia to update all drug file(s).

3. **There is a UPC code for the product; the product does not have an NDC. It is not in the drug file.**
   a. Compendia list products that only have UPCs on their files.
   b. Private label product identifiers have to be shared with entities in the entire supply chain. Whether private label or not, there is a distributor. The distributor (pharmacy chain, buying group) should have relationships with the compendia.
   c. **Recommendation for identification of product:**
      i. For this recommendation, manufacturer or distributor is the entity that applies for the UPC. Repackaged products are not included in this recommendation.
      ii. The processor may not know enough about the product to contact their compendia. The pharmacy has the product in hand to contact the manufacturer or distributor. The pharmacy could provide information about the product to the processor so the processor could follow up with their compendia.
      iii. The pharmacy or the processor should contact the manufacturer or distributor and their compendium.
      iv. The manufacturer or distributor should share their information with the compendia to update all drug file(s).
Work Group Recommendation: There was discussion of whether Reject Codes should be recommended? There was more discussion at the task group on the use of the ID and Qualifier. The Submission Clarification Code value 8 can be used for billing overrides, but there are problems with the identification of the product. The task group is focused on how to resolve, not more clarifying reject codes. But resolution is not in the standards, it is in operational use and business practices. A motion was made to approve the response and add to the Version D Editorial document and work on further guidance. It was seconded. The motion carried with no opposition.

D. Request for Task Group
Transition Fill Claims Transfers - The intent is to collaborate with PBM industry partners to exchange claims data for clients that are changing PBM vendors in a more standardized and timely manner (Peggy Gedzyk) – this was discussed between the submitter and the Post Adjudication Task Group lead and the work will be discussed there. See document in WG1 zip file.

E. WG14 Updates to Version D Editorial
A motion was made to modify the agenda to include this topic. It was seconded. The motion carried with no opposition. See document in WG1 zip file. The modifications were made as a result of guidance but did not change the intent. ICF/MR or IMD use was at the bottom; it was added throughout to call to attention. It was noted that there was discussion of Part D plans or their processors who were receiving PDE rejects on compounds because the Submission Clarification Code value 8 was submitted. Compounds are excluded from CMS short cycle dispensing requirement because they are not considered a brand name drug. CMS edits the Submission Clarification Code on the PDE; the short cycle Submission Clarification Code values are the only values to send. The updated guidance clarifies these are the values to be sent. It was requested to pend the changes for more review; an entity was concerned this was being rushed; they weren't concerned about ICF/MR or IMD use; but had concern about the rest. A respondent noted that this is information that is known, WG14 clarified existing guidance that should be known; the updates were based on questions. The PDE record edits or other changes may be more sweeping. It was asked if all were familiar with the subjects of the changes. It was asked if there were concerns. No one stated any concerns. It was noted that it is difficult to be on all task groups, but companies do need representation and review to share within a company. These are points of clarification, items already being done; these are questions. On the billing of generics section – there was a question about the statement (shown in italics) -

Note, although the CMS mandate applies to Brand Oral Solid Drugs as defined above, if a pharmacy chooses to short cycle dispense generic medications, they may choose to submit (but are not required to submit) the same Submission Clarification Codes developed for short cycle brand oral solid drugs. Claims should not reject based solely on the inclusion of these codes, instead the payer should ignore.

It was felt the italicized section is a trading partner agreement. This is in the CMS call letter where they encourage the pharmacy to dispense less for waste, even though they are not required. Another participant said this information is not new; it has been known for the last two years; it is based on CMS guidance.

A motion was made to approve as modified. It was seconded. The motion was withdrawn because it was asked to review the modifications with WG1. The modifications were reviewed. It was asked if there are payers rejecting based on the SCC values submitted today. It was not believed so, and noted that if the pharmacy chooses to send but the payer does not need, they can ignore the values. A motion was made to approve as submitted by WG14. It was seconded. The motion carried with no opposition.

F. Webinars
- May 16, 2013 at 12 pm EST “Medicare Part D Opioid Overutilization Data Sharing Between Sponsors”.
- SNOMED – June TBD

G. Next Quarterly Work Group Meeting
The next NCPDP quarterly work group meeting will be held on August 7-9, 2013 at the Omni Fort Worth, Fort Worth, TX.

Agenda items include:
Old Business

- Year in Review
- 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
- HIPAA
- SNIP

New Business

- New DERFs
- New DSMO CRS
- Work Group Scope and Goals

WG1 plans to meet for 1 day, not across from WG9 or WG45 or WG17.

H. Submission of new DERFs and New Project Development Forms
Submission of new DERFs and Project Development Forms are due Monday, July 8, 2013 to Kittye Krempin.

VIII. Motion to Adjourn
Damon Tressler asked for a motion to adjourn the meeting. The motion was moved and seconded. The motion carried. The meeting adjourned at 2:18 p.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)
- Year in Review

Lynne Gilbertson
Lynne Gilbertson
Staff Liaison
WG1 Telecommunication