

TRANSITION TO NCPDP TELECOMMUNICATION STANDARD VERSION D.0 - LESSONS LEARNED

VERSION 1.0

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Transition to NCPDP Telecommunication Standard Version D.Ø - Lessons Learned Version 1.Ø

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The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

1. PURPOSE

The NCPDP Strategic National Implementation Process (SNIP) Committee developed this White Paper as guidance to the pharmacy industry as they transition to future HIPAA transaction standards.

For the purpose of this document, the term “provider” refers to pharmacies or dispensing entities.

2. SCOPE

This document contains lessons learned and recommendations for improvements as the industry begins to prepare for future HIPAA transaction standards.

3. LESSON LEARNED

3.1 PAYER SHEETS

A more detailed Payer Sheet Template was created in order to help processors communicate the NCPDP Telecommunication Standard vD.0 requirements for adjudication to their providers. During the transition to vD.0, the industry learned the following:

- The Payer Sheet Template should have included more detailed instructions on how to create and use a payer sheet.
 - Implementers must pay closer attention to published payer sheets.
 - Payer sheets must be issued in a timely manner. During the transition to vD.0, payer sheets were being released all the way up to the compliance date of January 1, 2012.
 - It is extremely important that the payer sheet be accurate when issued to ensure a smooth transition.
 - Information provided for Coordination of Benefit claims was confusing and more specific information should have been provided.
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- Recommendations for the payer sheet template include:
 - Addition of a payer/plan specific version and release date
 - Creation of a Plan specific profile sheet template
 - Add a section for revisions/change logs
 - Make sure directions for completing the payer sheets are clear using the questions that arose during the transition.
 - Recommendation for payer sheets
 - Creation of a central repository for payer sheets that would be accessed with a user name and password. The repository would also validate the payer sheets against the standard to ensure that all rules of the payer sheet template and Standard are followed and the payer sheet is clear to choices prior to posting.

3.2 REPURPOSING FIELDS

The lesson learned during transition was not to repurpose field tags in future versions but instead create entirely new fields and retire the old tag. The repurposing of the field tag with a new field name, definition and code list caused confusion in the industry.

For example, In the Telecommunication Standard v5.1 the field Patient Location Code (307-C7) existed and contained values for both places of service and patient residence. In the Telecommunication Standard vD.0 the code list value for Patient Location Code (307-C7) was primarily patient residences so the decision was made to split into two fields.

- Place of Service (307-C7)
- Patient Residence (384-4X)

The field tag 307-C7 was repurposed to become the Place of Service field with a new code list. Place of Service (307-C7) uses the Center for Medicare and Medicaid Services (CMS) place of service code list values.

3.3 COMPOUNDS

During transition it was determined that a better understanding of the implications of providing each ingredient in a compound claim would have been helpful.

The Telecommunication Standard v5.1 allowed three different approaches for the billing of compounds which included:

- Billing using the NDC of the highest priced ingredient

- Billing using a dummy NDC number and an ingredient cost representing the total ingredient cost of the components of the compound
- Billing using the Compound Segment

The most popular methods were to bill the claim using the NDC of the highest priced compound ingredient or the use of the dummy NDC number. The use of the Compound Segment was extremely limited. With the Telecommunication Standard vD.Ø the only method to bill a compound is to use the Compound Segment and report all the ingredients that make up the compound.

Many issues arose during the transition period for both processors and providers. Some of the issues included:

- Lack of standardized level of effort
- Inability to report trace amounts of active ingredients
- Not all items used in compounds have NDC numbers
- Formulary issues with ingredients such as OTC items
- Improper use by processors of the Product/Service ID field in the Claim Segment
- Coverage issues for individual ingredients

The first lesson learned was that compounds should have been addressed earlier in the development and testing process. NCPDP should also have solicited participation from the entities with the most subject matter expertise in compounding. These experts should have had knowledge of compound prep as well as experience with compound claim submission and processing.

3.4 COORDINATION OF BENEFITS PROCESSING

Even with all the outreach that was done by NCPDP prior to implementation, the coordination of benefits changes within the Telecommunication Standard vD.Ø were more extensive than the industry recognized. The Implementation Guide provided examples for primary and secondary billing, however as questions arose regarding tertiary and further billing, it was realized that providers needed standard formulas for determining the delta amounts paid by subsequent payers so the amount could be reported properly in the Coordination of Benefits/Other Payments Segment. Processors also needed to understand the formulas for purposes of payment and auditing. As a result of the questions received, further education took place in the form of Webinars and guidance via the Editorial guide.

Since coordination of benefit claims represents a small percentage of overall transaction volume both development and testing were addressed later in the timeline. This resulted in issues being identified with the processing of COB claims during transition. This did not leave adequate time for additional development changes and testing. NCPDP created a COB Task Group to look at issues as they arose and provided guidance to the industry.

Additionally, while it made sense to generalize PBM payer sheets at a BIN/PCN and COB method level; this made it difficult for providers to determine which COB methods applied to the multiple third party plans associated to the PBM. Examples for supplying COB methods per PBM via payer sheet could have been supplied to clarify the process.

Furthermore, there were challenges with the interpretations of various COB terms (e.g. Government COB) and naming conventions (e.g. Medicare D Supplemental versus MSP) which caused confusion with the appropriate COB method that should apply. The use of the Other Payer-Patient Responsibility Amount and Qualifier fields to report what the member was to pay based on the primary claim changed significantly between v5.1 and D.Ø. Detail definitions of COB terms and methods should be supplied.

The lesson learned was that COB should have been addressed earlier in the development and testing process. When creating educational materials and webinars, they should be presented not only at NCPDP but also at industry groups/events such as NMEH.

3.5 EXTERNAL CODE LIST IMPLEMENTATION

The External Code List (ECL) was created to allow new values to be used in existing fields without waiting for an updated HIPAA version. Without a standard approach, each processor and provider determined when to implement a new version of the ECL. In order to standardize the implementation process, a recommended standard timeline for the implementation of ECL changes was created. An industry recommendation was released related to the ECL versions the industry should be using on the compliance date.

Recommendation for ECL Implementation timeline should be included in the front matter of the Implementation Guide.

3.6 TRANSITION

The implementation of NCPDP D.Ø showed many entities did not read the detail contained in the Telecommunication Implementation Guide and the associated vD.Ø Editorial Guide. There was a presumption that the information previously used in submissions and responses in v5.1 could continue to be used in vD.Ø. Some examples are:

- 1) 433-DX requirement to contain the Patient Pay Amount.
- 2) In v5.1 Additional Message Information (526-FQ) was a single 200 character field. In vD.Ø the Additional Message Information field was changed to a repeating field and an Additional Message Information Count (130-UF), Additional Message Information Qualifier (132-UH) and an Additional Message Information Continuity Indicator (131-UG) were added allowing up to nine iterations of the Additional Message field. Numerous cases were reported where the count and the qualifier were NOT provided and where the Additional Message field contained more than 40 characters.
- 3) Patient Location (307-C7) and Patient Residence (384-4X).
- 4) Claims for Compound Prescriptions were changed to use a single submission type.
- 5) Copay Only Billing replaced with the Other Payer-Patient Responsibility Amounts fields.
- 6) Prescription/Service Reference Number changed from 9(7) in v5.1 to 9(12) in vD.Ø and some entities required that 12-digits be submitted on a claim.
- 7) Route of Administration (995-E2) was added as an Override for the default route of administration although some entities asked for this field on ALL Claims.
- 8) Removal of the Response Insurance Segment "AM25" from the Claim Reversal Response in D.Ø which was included in v5.1.
- 9) Misunderstanding around "Not Used" fields.
 - a. Reversals
 - i. Pricing Segment fields on a Claim Reversal (B2) submission in vD.Ø are limited to Incentive Amount Submitted (438-E3) and Gross Amount Due (430-DU). Some Payers were requesting additional "Not Used" fields to be submitted on a Reversal.
 - ii. Additionally many "Not Used" fields were submitted on Claim Reversals (B2) causing syntax errors.
 - iii. Fields marked as "Not Used" were returned in Claim Reversal Responses causing issues with some systems.
- 10) Balancing issues with the Patient Pay Amount to the component fields.
- 11) The use of Other Amount Claim Submitted Qualifier (480-H8) value of "09" (Compound Prep Fee) was not used consistently.
- 12) External Code List (ECL) changes had removed many of the blank code values, yet entities continued to use these causing syntax errors on both requests and responses.

In order to address this issue in future versions, a section will be added to the Implementation Guide to instruct entities on which sections are relevant for their business functions and use.

3.6.1 NEW FIELDS AND FUNCTIONALITY

The NCPDP Telecommunication Standard vD.Ø introduced extensive changes and new fields and functionality were added. It became evident during testing and even in production that the use of new fields and enhanced functionality was not embraced consistently throughout the industry. As a result we identified the following:

- 1) The Benefit Stage fields (Benefit Stage Count (392-MU), Benefit Stage Qualifier (393-MV) and Benefit Stage Amount (394-MW)) were not provided consistently by Part D Plans and were often required by supplemental payers when the fields were not necessary for the submission of the claim.
- 2) Pharmacies were submitting COB claims to Part D supplemental payers for beneficiaries that were not covered by Part D. Because the supplemental payers were only expecting Medicare Secondary Payer claims, Reject Codes (511-FB) of MU=M/I Benefit Stage Count, MV=M/I Benefit Stage Qualifier and MW=M/I Benefit Stage Amount were returned which was confusing to pharmacies.

More thought needs to be given to education that can be provided for issues that might occur because of a transition period. Some payers were on the new Standard while others were on the old Standard which created issues for providers who were doing coordination of benefits with those payers.

The lesson learned during transition was the entities that participated consistently in NCPDP meetings, Task Groups and attended the webinars had a higher level of success at installing the revisions required for vD.Ø. Those that participated in the development had a much broader knowledge of why the changes were made and what was required for implementation. Lack of participation in the standards process resulted in incorrect implementation of the Standard.

4. RECOMMENDATIONS

Even though there was an extensive effort to make the transition from the NCPDP Telecommunication Standard V5.1 to vD.0, there are areas where improvement could be made. The following is a list of recommendations based on the lessons learned during transition.

- Due to the massive amount of plan changes that take place in January and July of each year, it is recommended that the compliance date not be in January or July.
- Better communication dealing with transition (i.e. Payer Sheet, Contacts, Implementation Date) between Payers and Switches.
- Switches act as a central repository for all Payer Sheets
- Testing and certification is highly encouraged to ensure a smooth transition to the next named HIPAA Standard.
- Share certification/testing documents and results early in the transition allowing adequate time for testing and software modification if issues are found.
- Every processor allows testing even if certification is not required.
- A centralized tracking authority is created to track testing/certification requirements. This would allow for better tracking of who is ready to begin testing/certification/accepting production claims.
- All testing/certification be complete a minimum of 90 days prior to the compliance date for the new Standard.
- Test cases between trading partners should not violate the Standard in terms of format and syntax. Errors in format and syntax should be tested internally.
- When testing COB claim submission, if specific data is being required for secondary or downstream claim submission, then the specific information should be available from the processor in the response from a primary or upstream claim so the information can be available.
- Trading partners should test as many iterations of COB as they plan to support.
- NCPDP University and the SNIP Implementation White Paper include information on the major changes since the last HIPAA version.
- Establish additional communication methods to keep the industry informed when Editorial Guide updates are published so the industry can synchronize their development.
- Covered entities should work together proactively to ensure all entities will adhere to the timelines established by NCPDP SNIP and CMS.

5. GENERAL INFORMATION

5.1 EXTERNAL CODE LIST (ECL) IMPLEMENTATION GUIDANCE

The NCPDP ECL Task Group developed an External Code List (ECL) implementation process that applies to all versions of the Telecommunication Standard, beginning with vD.Ø. This process facilitates consistent adoption of the approved ECL versions within a reasonable and workable timeframe, and it applies to all industry participants.

The implementation process may be found on the Standards Lookup web page by selecting the *Understanding the External Code List Process* on the left menu bar at the following link

<http://www.ncdp.org/members/Standards-Lookup.aspx>

5.1.1 EMERGENCY ECL VALUE IMPACT

For expedited implementation of values added to the ECL that are specific to regulatory requirements, an Emergency ECL Value Exception process is allowed. While the normal quarterly ECL publication process will be followed, these “emergency approved” values will also be published and tracked in a separate document referred to as the Emergency Telecommunication ECL Value Addendum. This document is found with the External Code Lists in the member only section of the website under Standards Download

<http://www.ncdp.org/members/Standards-Lookup.aspx>

5.2 VERSION D.Ø EDITORIAL GUIDE

Additional guidance for the implementation of vD.Ø is found in the Version D.Ø Editorial Guide by expanding the Telecommunication VD.0 banner located at the following link:

<http://www.ncdp.org/Hipaa.aspx>

5.3 HIPAA RESOURCES

For more information please see the following web pages <http://www.ncdp.org/Hipaa.aspx> and <http://www.ncdp.org/Guidance-Documents.aspx> by expanding on the NCPDP Strategic National Implementation Process (SNIP) banner.

6. FREQUENTLY ASKED QUESTIONS

7. APPENDIX A. HISTORY OF CHANGES

- September 2013 – update links to websites