

NCPDP D.0 and ANSI 5010 FAQs



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NCPDP D.0 and ANSI 5010 Readiness

OmniSYS is currently upgrading our product solutions to support the new NCPDP D.0 and ANSI 5010 transactions. Our EDI team is working closely with payors to understand their implementation and testing timelines in order to keep our clients informed. Please contact your Account Executive if you have questions regarding the implementation and timelines.

What is version D.0 of the NCPDP Transaction and Code Set Standards?

NCPDP Telecommunications Standard Version D.0 is an updated version of the HIPAA standard for pharmacy claims transactions. The current version of the pharmacy claim standard NCPDP is 5.1; the compliance date for NCPDP D.0 is January 1, 2012.

What is version 5010 of the X12 HIPAA Transaction and Code Set Standards?

HIPAA X12 Version 5010 is a new set of standards that regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances. Covered entities, such as health plans, healthcare clearinghouses, and healthcare providers are required to conform to HIPAA 5010 standards.

The current transaction standard is the X12 Version 4010A1 for eligibility, claims status, referrals, claims, and remittances. Use of the 5010 version of the X12 standards and the NCPDP D.0 standard is required by federal law. The compliance date for the use of these updated standards is January 1, 2012.

Who will need to upgrade to NCPDP D.0 and HIPAA 5010?

All covered entities, including entities such as those listed below, are required to upgrade to using HIPAA 5010 standards; covered entities may use a clearinghouse, such as OmniSYS, to assist them in complying with the rules.

- Physicians
- Hospitals
- Payers
- Clearinghouses
- Pharmacies
- Dentists

What transactions were named in the Final Rule that apply to Pharmacy services?

- **Retail Pharmacy Claims** – NCPDP Telecommunication Standard Version D.0 and NCPDP Batch Standards Version 1.2
- **Retail Pharmacy Supplies and Professional Services** – NCPDP Telecommunication Standard Version D.0 and NCPDP Batch Standards Version 1.2 or ASC X12N Version 5010 837 Health Care Claim Professional*
- **Medicaid Subrogation** – NCPDP Batch Standard Medicaid Subrogation Implementation Guide Version 3.0
- **Retail Pharmacy Eligibility** – NCPDP Telecommunication Standard Version D.0 and NCPDP Batch Standards Version 1.2
- **Retail Pharmacy Claims Coordination of Benefits (COB)** – NCPDP Telecommunication Standard Version D.0 and NCPDP Batch Standards Version 1.2
- **Retail Pharmacy Prior Authorization** – NCPDP Telecommunication Standard Version D.0 and NCPDP Batch Standards Version 1.2

**Please note that, based on responses received from the industry during the review period, the regulations do not dictate the use of either NCPDP or X12 to bill for supplies or for professional services; rather, this decision has been left to the*

trading partners based on their agreements. For Medicare and Medicaid claims, supplies should be submitted in the ANSI 837 5010 format.

For additional information on these requirements, please refer to the Final Rule, which can be found at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>.

Where can I obtain the Technical Reports (Implementation Guides) and NCPDP documents?

The Pharmacy industry utilizes certain transaction sets supported and maintained by NCPDP as part of their processing. The ANSI Implementation Guides, Technical Reports (TR3 documents) and the associated addenda are available for purchase in the X12 Store located at <http://store.x12.org/>.

What are the major differences between NCPDP 5.1 and D.0?

There are changes across all of the transactions, some of which include:

- The ability to support new-use cases brought forward by the industry
- Clarification of usage to remove ambiguity
 - Fields and segments displayed as optional within the Implementation Guide were reviewed and determined, according to the transaction type and its associated response, to be “Not Used”, “Required if”, “Required”, or “Optional”. Fields and segments cannot be used in a manner other than as stated in the situations. This action was taken to address the situational versus optional data requirements discussed in the HIPAA Privacy Regulations.
- Consistency across transactions
 - The industry expanded the segment usage matrices to help clarify which segments and fields are sent for each transaction type. The segments and the fields within each transaction type have been very specifically defined.
- Removal of data content that is no longer used
- Medicare Part D enhancements
 - Eligibility Transaction enhanced for the Facilitator to provide patient eligibility information for Medicare Part D and other insurance coverage,
 - Long Term Care Pharmacy claim processing enhancements to appropriately identify and process Medicare Part D claims.
- Medicare Part B enhancements
 - Three segments were added to allow for the processing of Medicare certificates of medical necessity, facility and narrative information.
 - New data elements were added to allow for the items needed to process Medicare Part B transactions and assist in the crossover of claims from Medicare to Medicaid.
- Compounds
 - The only method for billing of compounds is by the use of the Compound Segment. The two alternatives supported in previous versions for compounded claim processing were removed.
- Clarification for pricing guidelines
 - New fields were added and existing fields redefined to further clarify/correct the financial balancing of transactions.
- Coordination of Benefits (COB)
 - Extensive clarification was made to the Implementation Guide for Coordination of Benefits processing. COB is more complicated with more complex rules than in the past. Specificity was given to the COB process by including new data elements such as patient responsibility and benefit stage fields as well as refining the use of the Other Coverage Code field.
- Prior Authorization

- Additional guidance was given for the Prior Authorization transactions with the addition of a new section to the implementation guide.
- Prescription/Service Reference Number (402-D2)
 - Increased to 12 digits.
- Payer to Payer processing
 - The business needs of crossover and subrogation transactions and Information Reporting have been addressed.
- Service Billings
 - Now have their own Transaction Code (S1, S2, S3).

The following fields with attribute changes in NCPDP D.0 may need close review. Changes to the length of these fields could impact current submitters of NCPDP 5.1, causing possible truncation of data, rejections, or system issues related to these reference numbers:

- **402-D2** – Prescription/Service Reference Number
- **456-EN** – Associated Prescription/Service Reference Number

Will OmniSYS utilize the new D.0 documentation segments for Medicare Part B on January 1, 2012?

OmniSYS is discussing D.0 documentation segments for Medicare Part B individually with each client to determine if clients prefer to use existing processes in 2012 to allow resources to focus on the D.0 transition for other payers. OmniSYS will support the use of the D.0 documentation segments for Medicare Part B as requested by our clients. Please contact your Account Manager to discuss your needs and preferences.

Which format and transaction types will OmniSYS support?

OmniSYS will support NCPDP D.0 and the following healthcare ANSI X12 standard transactions:

270	Eligibility Inquiry
271	Eligibility Response
837P	Professional Claims
835	Remittance Advice
999	Functional Acknowledgement
277CA	Claim Acknowledgement

When will OmniSYS publish D.0 payer sheets?

Our preliminary D.0 payer sheets will be available very soon on our Extranet site for our clients to start preparing for the transition. Final versions will be published once payors have published their companion guides. At that time, a full analysis of their implementation changes will be completed and minor modifications may be required.

When will OmniSYS be ready for D.0 testing with vendors and clients?

Testing will begin in January 2011. Please contact our testing team at testing_support@omnisys-llc.com to be added to our testing schedule and she will provide you with the testing information you need to get started. If you currently use a third party software vendor, please contact your vendor to confirm when they plan to test with OmniSYS.

When will OmniSYS begin testing with CMS?

Medicare plans to begin testing with vendors in January 2011. Currently, they are not scheduling testing appointments. OmniSYS has offered to perform pilot testing prior to January 2011 if CMS decides to allow that option.

Most State Medicaid are still working on the changes needed for their implementation and have stated that their Payor specs and Companion Guides will not be published until the 2nd or 3rd Quarter of 2011. The majority of the Medicaid have not confirmed their testing dates at this time.

Who should I contact if I have additional questions?

OmniSYS will continue to provide updates on our extranet site. Be sure to check the site frequently for new updates. For additional questions, please contact your Account Executive who will work with our implementation teams to provide the answers you need.