

# NCPDP TELECOMMUNICATION STANDARD VERSION D.Ø TRANSITION GUIDANCE

## *VERSION 1.Ø*

*This paper offers guidance to the pharmacy industry in preparing for the implementation of versioning changes to the NCPDP Telecommunication Standard Version D.Ø.*

July 2Ø11

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# **NCPDP Telecommunication Standard Version D.0**

## **Transition Guidance**

**Version 1.0**

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**Published by:**  
**National Council for Prescription Drug Programs**

**Publication History:**  
**Version 1.0 XXX 2011**  
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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**

Health care providers, health plans, health care clearinghouses as well as business associates such as pharmacy benefit managers (PBMs) and vendors that support these covered entities need adequate time to modify business processes, develop and test system software changes, and deploy for implementation of the HIPAA-named NCPDP standards.

The NCPDP Strategic National Implementation Process (SNIP) Committee developed this White Paper as guidance to the pharmacy industry as they transition from the ***NCPDP Telecommunication Standard version 5.1*** to HIPAA-named ***NCPDP Telecommunication Standard version D.Ø*** prior to the January 1, 2Ø12 compliance date.

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

## **2. SCOPE**

This document contains recommendations for implementation between trading partners during the transition from the NCPDP ***Telecommunication Standard Implementation Guide version 5.1*** to the NCPDP ***Telecommunication Standard Implementation Guide version D.Ø***. Users of this document should consult the NCPDP documents listed below for further information and clarification. These documents are referred to as “vD.Ø” and “v5.1”.

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### ***DATA DICTIONARY***

Full reference to all fields and values (contained within or reference to the *External Code List*) used in the NCPDP standard with examples.

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### ***EXTERNAL CODE LIST***

Full reference to values used in the NCPDP standard.

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### ***EMERGENCY TELECOMMUNICATION ECL VALUE ADDENDUM***

Full reference to ECL values, specific to the Telecommunication standard, which have been approved as an emergency and leverage a specific implementation timeline that is earlier than the implementation of the associated ECL publication.

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### ***ECL OVERVIEW DOCUMENT***

This document contains an overview of the ECL process, from submission of DERF to industry implementation. Please note section specific to Telecommunication.

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### ***STANDARDS MATRIX***

This document contains a high-level overview of the latest version/release and/or the most commonly used of those standards and implementation guides, as well as NCPDP’s Data Dictionary and External Code List. Additionally, this document provides version/release/publication reference charts for approved and draft NCPDP standards/implementation guides.

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### ***TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE***

The NCPDP *Telecommunication Standard Implementation Guide* (Versions 5 and above) defines the record layout for real-time transactions between providers and adjudicators. The NCPDP *Batch Standard Implementation Guide* uses the NCPDP *Telecommunication Standard* format for the Detail Record of the file.

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### ***EDITORIAL DOCUMENT***

This document contains clarifications, corrections, examples, and questions/answers that were obtained after the publication of the NCPDP *Telecommunication Standard Implementation Guide*. It must be used as a reference between official publications of the implementation guide. This document may be updated as often as quarterly and new versions should be downloaded. It is available from the Public and Members Only sections of the NCPDP website.

These documents are available to NCPDP members in the "Members" section of the website at [www.ncdpd.org](http://www.ncdpd.org). Non-members may obtain the documents with membership; please see [www.ncdpd.org](http://www.ncdpd.org) or contact the NCPDP office at 480-477-1000, or via Internet e-mail at [ncdpd@ncdpd.org](mailto:ncdpd@ncdpd.org).

### **3. PRESCRIPTION/SERVICE REFERENCE NUMBER (4Ø2-D2)**

The Prescription/Service Reference Number (4Ø2-D2) has expanded from 7 digits to 12 digits in vD.Ø to support business needs requested.

Note, it is not required that providers move to a 12 digit Prescription/Service Reference Number unless their business needs warrant. Clearinghouses, payers and entities that receive transactions must be prepared to accept up to 12-digit Prescription/Service Reference Number (4Ø2-D2).

If the provider software system is updated to support the NCPDP vD.Ø expanded field length, consideration to coordination of benefit claims processing must be made before a 12-digit Prescription/Service Reference Number is used.

For example:

- Provider submits a vD.Ø claim to a primary payer with a 12-digit Prescription/Service Reference Number (4Ø2-D2).
- Subsequent payer accepts only v5.1 claims (which only supports a 7-digit Prescription/Service Reference Number (4Ø2-D2)).
- As a result the provider cannot generate a v5.1 claim with a 12-digit Prescription/Service Reference Number (4Ø2-D2) to send to the subsequent payer.

When different claim versions are supported in the same business case, inconsistencies in the Prescription/Service Reference Number (4Ø2-D2) field length will result in transactions not processing correctly.

**Recommendation:** Prior to January 1, 2Ø12, providers sending vD.Ø claims should continue to submit the Prescription/Service Reference Number (4Ø2-D2) as currently submitted in a v5.1 transaction. Since all entities will not be accepting vD.Ø claims prior to January 1, 2Ø12, it is strongly recommended that the Prescription/Service Reference Number (4Ø2-D2) not be greater than 7-digits during this transition period.

## 4. COORDINATION OF BENEFITS (COB)

The following information is specific to v5.1 to vD.Ø transition issues. Additional vD.Ø Coordination of Benefit (COB) processing questions unrelated to transition have also been addressed in the vD.Ø Editorial Document found at the following link:

[http://www.ncdp.org/public\\_documents.aspx#vDed](http://www.ncdp.org/public_documents.aspx#vDed)

### 4.1 OTHER PAYER COVERAGE TYPE (338-5C) VALUES 98 (COUPON) AND 99 (OTHER)

Other Payer Coverage Type (338-5C) values “98” (Coupon) and “99” (Other) were valid in v5.1 but are obsolete in vD.Ø. When the same processor administers more than one benefit, to ensure the appropriate processing order applies, the Other Payer Coverage Type (338-5C) field is required for vD.Ø coordination of benefit claim reversals. If the v5.1 COB claim was processed using Other Payer Coverage Type “99” or “98”, the vD.Ø claim reversal cannot be submitted with these values.

**Recommendation:** When submitting the Other Payer Coverage Type (338-5C) on a vD.Ø claim reversal, where the v5.1 claim value was “98” (Coupon) or “99” (Other) it is recommended to use the Other Payer Coverage Type value “ ” (blank).

### 4.2 REVERSALS

When submitting a vD.Ø Claim Reversal (B2) to a subsequent payer, where the Claim Billing (B1) was submitted as v5.1 it will be necessary to submit the Other Coverage Code (3Ø8-C8) as part of the Reversal.

### 4.3 OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT (352-NP)

When either Other Payer-Patient Responsibility Amount or Government COB is the selected coordination of benefit method, the NCPDP Telecommunication vD.Ø Implementation Guide recommends that the components of patient pay be reported using all applicable and specific Other-Payer Patient Responsibility Amount Qualifier(s) (351-NP) other than “Ø6” (Patient Pay Amount (5Ø5-F5) as reported by previous payer). However the following transitional situations may present incomplete reporting of the components of patient pay and result in inconsistencies with coordination of benefit claims processing.

- o The response from the previous payer does not balance where the sum of the components of patient pay do not equal Patient Pay Amount (5Ø5-F5).
- o The response pricing components cannot be mapped to the detailed vD.Ø Other Payer-Patient Responsibility Amount qualifiers, for example:
  - The provider cannot determine if the value returned in the Amount of Copay/Coinsurance (518-FI) field of a v5.1 claim response should be reported as the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of “Ø5” (Amount of Copay) or “Ø7” (Amount of Co-insurance) on the vD.Ø coordination of benefit claim.

**Recommendation:** For the above situations, the Other Payer-Patient Responsibility Qualifier (351-NP) value of “Ø6” (Patient Pay Amount (5Ø5-F5) as reported by previous payer) should be used alone to report the patient pay on vD.Ø coordination of benefit claims. The Coordination of Benefits/Other Payments segment’s fields should be used in the following manner in the claim submission:

vD.Ø Field ID	vD.Ø Field Name	vD.Ø Value
353-NR	Other Payer-Patient Responsibility Count	1

vD.Ø Field ID	vD.Ø Field Name	vD.Ø Value
351-NP	Other Payer-Patient Responsibility Amount Qualifier	“Ø6” (Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient’s responsibility.)
352-NP	Other Payer-Patient Responsibility Amount	Patient Pay Amount (5Ø5-F5) as received from previous payer

#### 4.4 REJECT CODE (511-FB) & OTHER PAYER REJECT CODE (472-6E)

New vD.Ø Reject Codes offer distinct messaging associated to specific reject scenarios. In the situation where the primary payer returns new vD.Ø Reject Code values and the non-primary payer does not recognize/accept these new Reject Code values, coordination of benefit claims processing issues may occur. Situations may occur when the non-primary payer is still processing v5.1 transactions or, when processing vD.Ø transactions but supporting an earlier version of the External Code List (ECL).

**Recommendation:** A mapping of the vD.Ø Reject Code values back to the comparable less descriptive v5.1 Reject Code values, allowing the COB claim to process as normal must be supported. This mapping can be implemented by either the processor or the provider. Please refer to the Reject Code Mapping table below.

##### Reject Code Mapping

##### HIGH RISK: Most Commonly Used Reject Codes

D.Ø Reject Code	Explanation	5.1 Reject Code	5.1 Reject Code Description
N1	No patient match found	52	Non-Matched Cardholder ID
569	Provide Beneficiary with CMS Notice of Appeal Rights	7Ø	Product/ Service Not Covered
7Y	Compounds Not Covered,	7Ø	Product/ Service Not Covered
A5	Not Covered Under Part D Law	7Ø	Product/ Service Not Covered
A6	This Medication May Be Covered Under Part B	7Ø	Product/ Service Not Covered
MR	Product Not On Formulary	7Ø	Product/ Service Not Covered
7X	Days Supply Exceeds Plan Limitation	76	Plan Limitations Exceeded

##### MODERATE RISK:

D.Ø Reject Code	Explanation	5.1 Reject Code	5.1 Reject Code Description
582	M/I Fill Number	17	M/I Fill Number
585	Fill Number Value Not Supported	17	M/I Fill Number
7W	Refills Exceed allowable Refills	17	M/I Fill Number
512	Compound Code Value Not Supported	2Ø	M/I Compound Code
8K	DAW Code Value Not Supported	22	M/I (DAW)/ Product Selection Code
556	Unit Of Measure Value Not Supported	26	M/I Unit Of Measure
8R	Submission Clarification Code Value Not Supported	34	M/I Submission Clarification Code
56Ø	Pharmacy Not Contracted in Retail Network	4Ø	Pharmacy Not Contracted With Plan DOS
561	Pharmacy Not Contracted in Mail Order Network	4Ø	Pharmacy Not Contracted With Plan DOS
562	Pharmacy Not Contracted in Hospice Network	4Ø	Pharmacy Not Contracted With Plan DOS
563	Pharmacy Not Contracted in Veterans Administration Network	4Ø	Pharmacy Not Contracted With Plan DOS
564	Pharmacy Not Contracted in Military Network	4Ø	Pharmacy Not Contracted With Plan DOS

G6	Pharmacy Not Contracted in Specialty Network	4Ø	Pharmacy Not Contracted With Plan DOS
G7	Pharmacy Not Contracted in Home Infusion Network	4Ø	Pharmacy Not Contracted With Plan DOS
G8	Pharmacy Not Contracted in Long Term Care Network	4Ø	Pharmacy Not Contracted With Plan DOS
G9	Pharmacy Not Contracted in 9Ø Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø days supply of drugs)	4Ø	Pharmacy Not Contracted With Plan DOS
MS	More than 1 Cardholder Found – Narrow Search Criteria	52	Non-Matched Cardholder ID
9G	Quantity Dispensed Exceeds Maximum Allowed	76	Plan Limitations Exceeded
59Ø	Compound Dosage Form Not Covered	EG	M/I Compound Dispensing Unit Form Indicator
547	Prior Authorization Type Code Value Not Supported	EU	M/I Prior Authorization Type Code
9T	Prior Authorization Type Code Submitted Not Covered	EU	M/I Prior Authorization Type Code
N9	Use Prior Authorization Code Provided For Level of Care Change	EV	M/I Prior Authorization Number Submitted
516	Compound Type Value Not Supported	7Ø	Product/ Service Not Covered
552	Route of Administration Value Not Supported	7Ø	Product/ Service Not Covered
9Q	Route Of Administration Submitted Not Covered	7Ø	Product/ Service Not Covered

NOTE: All Reject Code values are strings and trailing spaces are generally, but not always, truncated. When mapping is performed, care must be taken by the mapping system to properly replace the new mapped value in a manner that does not retain any remnant character(s) of the old value. For example, the truncated value of “EG” must fully replace “59Ø” and not allow a result of either “5EG” or “EGØ” to be used in the processing of the COB claim.

### **4.5 OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER (479-H8) AND OTHER AMOUNT PAID QUALIFIER (564-J3) AND OTHER PAYER AMOUNT PAID QUALIFIER (339-6C)**

Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) values of “99” (Other) are valid values for v5.1 claims. The value of “99” however, cannot be used to report the Other Payer Amount Paid value on vD.Ø coordination of benefit claims. If an appropriate Other Payer Amount Paid (431-DV) value is not reported in the claim, the categorization of the amount may be Drug Benefit “Ø7” or Cognitive Service “Ø6”, which may negatively impact the provider or patient. This may not reflect the original intent of the Other Payer Amount Paid (431-DV) dollar amount.

**Recommendation:** Beginning immediately and until the implementation date of the ECL when the value of “99” is removed from Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) claim responses should not include the value “99” in these fields.

Replacing the Other Amount Paid Qualifier (564-J3) value of “99” with the specific value, such as those for Delivery Cost “Ø1”, Administrative Cost “Ø4”, etc. will allow the proper identification of prior payer amounts paid in the Other Payer Amount Paid Qualifier (342-HC) field in a vD.Ø COB claim.

This information is also noted in the section titled “[Pricing](#)”.

### **4.6 BENEFIT STAGE FIELDS**

The new vD.Ø Benefit Stage Count (392-MU), Benefit Stage Qualifier (393-MV) and Benefit Stage Amount (394-MW) fields are applicable to Medicare Part D claim responses and coordination of benefit claims to supplemental payers. If the Medicare Part D primary claim is processed as v5.1, then Benefit Stage fields are not available for the vD.Ø coordination of benefit claim to the supplemental payer.

**Recommendation:** Medicare Part D supplemental payers accepting vD.Ø transactions prior to January 1, 2Ø12 should not reject claims that do not contain the Benefit Stage fields in Coordination of Benefits (COB)/Other Payments Segment until January 1, 2Ø12 or later.

## 5. COMPOUNDS

Multi-ingredient compound processing was available in v5.1 and was the recommended method of the three that were allowed but was not widely adopted. Multi-ingredient compound processing is the **only** compound processing method allowed in vD.Ø. When the Compound Segment is transmitted on the Claim Billing (B1), the Product Service ID (4Ø7-D7) is submitted as “Ø” (Zero means “Ø”) and the Product Service ID Qualifier (436-E1) is submitted as “ØØ” (Zero means “ØØ”).

### V5.1 and Most Expensive Legend Drug and vD.Ø Reversals:

In the alternate v5.1 compound processing method of submitting the NDC of the most expensive legend drug, product specific values were transmitted in the Product Service ID (4Ø7-D7) and Product Service ID Qualifier (436-E1) fields and the Compound Segment was not sent.

Both v5.1 and vD.Ø reversal transactions (B2), require the Product Service ID (4Ø7-D7) and the Product Service ID Qualifier (436-E1). If this claim is being reversed as vD.Ø, identifying the Product Service ID (4Ø7-D7) as “Ø” and the Product Service ID Qualifier (436-E1) as “ØØ” may result in a reversal rejection, as the processor cannot match the reversal to the claim.

**Recommendation:** When a provider submits a v5.1 claim using the most expensive legend drug option and uses vD.Ø to reverse the original claim, the provider must include the Product/Service ID (4Ø7-D7) and Product/Service ID Qualifier (436-E1) from the original (v5.1) claim in the reversal (vD.Ø).

### V5.1 and Use of Billing Codes and vD.Ø Reversals:

In the alternate v5.1 compound processing method of submitting a compound billing code, specific values were transmitted as the Product Service ID (4Ø7-D7) and the Compound Segment was not sent.

Compound Schedule	Billing Code
Legend, non-scheduled	“9999999999”
Schedule II	“9999999992”
Schedule III	“9999999993”
Schedule IV	“9999999994”
Schedule V	“9999999995”
Miscellaneous compounds	“9999999996”

Both v5.1 and vD.Ø reversal transactions (B2) require the Product Service ID (4Ø7-D7) and the Product Service ID Qualifier (436-E1) fields to be submitted. If this claim is being reversed using vD.Ø, identifying the Product Service ID (4Ø7-D7) as “Ø” and the Product Service ID Qualifier (436-E1) as “ØØ” may result in a reversal rejection, as the processor cannot match the reversal to the claim.

**Recommendation:** When a provider submits a v5.1 claim using the billing code option and uses vD.Ø to reverse the original claim, the provider must include the Product/Service ID (4Ø7-D7) and Product/Service ID Qualifier (436-E1) from the original (v5.1) claim in the reversal (vD.Ø).

## **6. REBILL TRANSACTIONS**

All recommendations in this document that refer to claims processing and reversal processing must be considered for impact to rebill processing.

## **7. REVERSAL TRANSACTIONS**

If trading partners have agreed to the completion of the vD.Ø transition prior to January 1, 2012, it is recommended that the Claim Reversal (B2) transaction be submitted using vD.Ø, regardless of the version of the Claim Billing (B1).

When submitting a vD.Ø Claim Reversal (B2) to a subsequent payer, where the Claim Billing (B1) was submitted as v5.1 it will be necessary to submit the Other Coverage Code (308-C8) as part of the Reversal.

See section "[Other Payer Coverage Type \(338-5C\) values "98" \(Coupon\) and "99" \(Other\)](#)".

## **8. PRICING**

Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) values of "99" (Other) are valid values for v5.1 claims. The value of "99" however, cannot be used to report the Other Payer Amount Paid value in vD.Ø coordination of benefit claims. If an appropriate Other Payer Amount Paid (431-DV) value is not reported in the claim, the categorization of the amount may be "Ø7" (Drug Benefit) or "Ø6" (Cognitive Service), which may negatively impact the provider or patient. This may not reflect the original intent of the Other Payer Amount Paid (431-DV) dollar amount.

**Recommendation:** Beginning immediately and until the implementation date of the ECL from which the value of "99" is removed from Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3), claim responses should not include the value "99" in these fields.

Replacing the Other Amount Paid Qualifier (564-J3) value of "99" with the specific value, such as those for Delivery Cost "Ø1", Administrative Cost "Ø4", etc. will allow the proper identification of prior payer amounts paid in the Other Payer Amount Paid Qualifier (342-HC) field in a vD.Ø COB claim.

This information is also noted in the section titled "[Coordination of Benefits \(COB\)](#)".

## **9. INFORMATION REPORTING TRANSACTIONS**

It is recommended that providers coordinate with trading partners and mutually agree on when to convert from Telecommunication Standard version vC.1 to vD.Ø. These transactions are not currently subject to HIPAA regulations and HIPAA-mandated implementation timelines.

## **10. GENERAL INFORMATION**

### ***10.1 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 MC Maintenance and Control Work Group web page at the following link:

[http://www.ncdp.org/members/members\\_wg\\_info.aspx?wgid=wgmc](http://www.ncdp.org/members/members_wg_info.aspx?wgid=wgmc)

#### **10.1.1 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/members\\_download.aspx](http://www.ncdp.org/members/members_download.aspx)

### ***10.2 VERSION D.Ø EDITORIAL GUIDE***

Additional guidance for the implementation of vD.Ø is found in the Version D.Ø Editorial Guide located at the following link:

[http://www.ncdp.org/public\\_documents.aspx#vDed](http://www.ncdp.org/public_documents.aspx#vDed)

### ***10.3 HIPAA RESOURCES***

Please see [http://www.ncdp.org/news\\_hipaa\\_trans\\_current.aspx](http://www.ncdp.org/news_hipaa_trans_current.aspx) and [http://www.ncdp.org/news\\_hipaa\\_snip.aspx](http://www.ncdp.org/news_hipaa_snip.aspx) for information.

## 11. FREQUENTLY ASKED QUESTIONS

### 11.1 NOT ACCEPTED VERSION/RELEASE

**Question:**

Has the industry agreed upon the Reject Code (511-FB) to be returned when a not-accepted Version/Release of the Standard is submitted?

“Ø2” - M/I Version/Release Number or

“1R” - Version/Release Value Not Supported

**Response:**

NCPDP v5.1 transactions are restricted to use the September 1999 Data Dictionary. Reject Code (511-FB) value “1R”, became available with the May 2ØØ5 ECL publication and therefore cannot be returned on a v5.1 response. Refer to the chart below for applicable scenarios.

Pharmacy sends	Payer supports	Reject Code
v5.1	v5.1 only	N/A
v5.1	vD.Ø only	“Ø2”
v5.1	Both v5.1 and vD.Ø	N/A
vD.Ø	v5.1 only	“Ø2”
vD.Ø	vD.Ø only	N/A
vD.Ø	Both v5.1 and vD.Ø	N/A
vD.1	Both v5.1 and D.Ø	“1R”

## **12. APPENDIX A. HISTORY OF CHANGES**