Centers for Medicare & Medicaid Services
HIPAA Version 5010: Fourth National Provider Call
Moderator: Mary Loane
March 24, 2010
2:00 p.m. ET

Welcome

Operator: Ms. Loane, you may begin.

Mary Loane: Well, thank you. Good afternoon, this is Mary Loane from the Provider Communications Group here at CMS and I would like to welcome you to this HIPAA 5010 conference call. CMS appreciates your participation in today's call and we are looking forward to an informative session. The purpose of today's call is to give an overview of CMS' approach for new error handling transactions 999 and 277CA. There will be a Q&A session at the end of the presentation enabling participants to ask questions of CMS subject matter experts. There will also be a transcript of today's call that will be posted on the CMS website within two weeks of today's call. So without further delay I'd like to introduce our speaker for today Chris Stahlecker, who is the Director of the Division of Medicare Billing Procedures in the Office of Information Services here at CMS.

Slides 2 through 26

Chris Stahlecker Thank you Mary and welcome everyone, we appreciate your participation today, this is our forth national call and we have covered some of this material before but it’s been a little bit of time and we're into a new calendar and fiscal year since the last time we chatted so we thought we would hit a couple of the preliminary pieces of information. I'm going to go to slide 2 and re-emphasize the purpose of today's call. It’s to give an update on our CMS activities related to our implementation here for Medicare Fee-For-Service of the HIPAA upgrade to the 5010 and NCPDP D.0 version.

We also have some enhancements that we're going to talk about in a moment. One of those enhancements is the purpose number two on this page and that will be to emphasize the 277 Claims Acknowledgement and 999 Functional Acknowledgement in terms of their use for error handling. And finally our third but maybe our most important objective today is to actually listen to you and at the end of our 30 minute presentation we'll have a Q&A listening session so we could become up to speed on where you are with your

implementations and any questions, issues or concerns you might have meeting the Medicare Fee-For-Service schedule.

On slide 3 again, to reiterate our agenda we're going to have a general overview hitting the requirements of the upgrade for the specific changes of Medicare Fee-For-Service, a review of our time line and state, some suggestions about what you could be doing now to prepare, and then some emphasis on the 999 and 277CA transactions. And we've added – just a quick update on two hot topics that seem to be getting general interest and that's with some technical changes in the transactions and so on to slide 4, the general overview.

What was changed under the HIPAA modifications rule? Well, it selected version 5010 of the X12 administrative transaction; it selected D.0 for the NCPDP suite for pharmacy transactions; and it selected 3.0 for the NCPDP transaction for Medicaid pharmacy subrogation. It also points out in this rule that either D.0 or version 5010 can be used for retail pharmacy supplies and services billing.

On slide 5, is an emphasis on some of the benefits. There's less ambiguity in the TR3 or Technical Report 3, also known as implementation guides. And it does tighten up the language for usability and usefulness of certain transactions, hopefully improving the utility of the NCPDP standards. The rule is direction to standardize companion guides and increase the use of EDI between covered entities. The final bullet on this slide is not part of the Fee-For-Service program but we did want to emphasize Version 3 for use in state Medicaid subrogation recollections.

On slide number 6, continuing with a general overview. The legislation mandates that standards are used for electronic claim and related transaction exchange. And the HIPAA 5010 project what we're calling this project within Medicare Fee-For-Service, it does include both the 5010 upgrade and the National Council for Prescription Drug Program or NCPDP upgrade to D.0. Medicare Fee-For-Service is, however, doing some additional implementations. We're enhancing the infrastructure of our Medicare Fee-For-Service suite of programs and that is in preparation for ICD-10. We'll

also introduce the new standard acknowledgement and rejection transactions that were mentioned. In terms of preparing Medicare Fee-For-Service for the future, this preliminary work, will take us toward that modernization effort.

On slide 7, are some additional enhancements that were mentioned. These are to improve the claims receipt, control, and balancing procedures in place at the Medicare Administrative Contractors and will increase the consistency of claim editing and the error handling that they will perform. The MAC, the Medicare Administrative Contractors, will return claims that may need correction much earlier in the process. And for those claims that are accepted, the claim number will be sent back to the billing agent or provider in the claims acknowledgement transaction so you'll have that claim number much earlier than the current process.

On slide 8, the ASC X12 standard, is introduced. The Functional Acknowledgement 999 is going to replace the current 997 transaction, and the Claims Acknowledgement 277CA will be used to replace current proprietary error reporting.

On slide number 9, we're starting to introduce our timelines and deadlines. For 5010 and D.0, the rule specifies that mandatory compliance must begin on January 1, 2012 for all covered entities. What does that really mean? It means that internal testing, aimed at a payer such as Medicare Fee-For-Service, , is to begin on or after January 1, 2010 and continue through the calendar year ending on December 31, 2010 and that we need to be prepared to support external testing on or after January 1, 2011 A little bit more about that on the next slide. The mandatory compliance dates, according to the rule, for NCPDP Version 3.0 for Medicaid subrogation is January 1, 2012 for all covered entities except small health plans, which have until January 1, 2013.

Within the Medicare Fee-For-Service program on slide 10, we've outlined the timeline and when we expect to be having the particular deliverables that were mentioned in the rules. Our development had heavy emphasis during the calendar year of 2009 and now that we're into 2010 we are in effect doing heavy systems testing. And that's all in preparation for Medicare Fee-For-Service being ready to accept productionally January 1, 2011; we'll be able to

accept production claims and exchange the other transaction. That will give providers the entire calendar year of 2011 to complete their transition. So Medicare Fee-For-Service will be productionally ready January 1, 2011.

On slide number 11, there is currently an incremental approach being used within Medicare Fee-For-Service to promote certain developed items into production knowing that they're not being used for 5010 work until January 1, 2011. So, at this point we're performing very limited 5010 testing and as the software components are put into production we will do more and more intensive testing throughout the remainder of 2010. So we're emphasizing our regression testing at this time and planning an intensive system and integration test for later this year.

As a reminder, the first two indented bullets on slide 11 states that we're going to be supporting the current 4010 path for the entire calendar year of 2011 while providers are coming up on the new 5010 path. So, once a provider is ready to submit their 5010, they can submit only 5010 if they so chose but Medicare Fee-For-Service is planning on disengaging the 4010 path on January 1, 2012.

On slide number 12, “So when are you required to have your systems changes implemented?” As I've mentioned, Medicare will be ready to begin transitioning provider workload into production on the 5010 format on January 1, 2011 and then Medicare is planning on disengaging the 4010A1 format, on January 1, 2012 along with the NCPDP 5.1 format. That means there's less than 12 months left to this total implementation plan for Medicare Fee-For-Service to be ready.

On slide number 13, “What do you need to do now to prepare?” Well, first you should know the formats that you're currently using and which ones are changing. We've emphasized that in this presentation thus far that it's the X12 administrative transactions for the claim- that's institutional 837, professional 837, the 276 Claim Status Inquiry, , the 277 Claims Status Response, the 270 Eligibility Inquiry , and the 271 Eligibility Response along with the 835 Remittance Transaction , as well as the NCPDP 5.1 version upgraded to D.0. Systems that submit claims or receive remittances will also need to change.

So, your systems that actually create the Medicare billing, receive and process remittances posted into your accounts receivable systems, or exchange the claims status eligibility transactions, will all need to change.

Some of these new versions have new data element requirements, so you should be studying up on these changes and understanding what business processes you may need to modify to use different data elements as the transactions have changed, or to capture new data content in order to complete the enhanced 837. To support that educational awareness, Medicare has performed a comparison of the current and the new formats and you'll see the location posted on slide 13. The software that you're using to produce these transactions or exchange them will also need to be modified. Your business processes may need to be enhanced to capture the additional data elements, and fundamentally you'll need to manage your transition with all of your payers, not just Medicare Fee-For-Service, but all of the payers that you exchange these transactions with and decide how you are going to come up during the calendar year of 2011 with which payer first.

On slide number 14, continuing -"What you can do now to prepare." Be very familiar with the resources that are available to you. CMS is a good source of information, but not the only source, but what we're pointing you to today is the Medicare Fee-For-Service 5010 pages. It will provide technical assistance and forms, such as today's outreach call and the products that we have posted on our websites which are listed here. We will ask you to pay attention to new announcements and news flashes and posting the frequently asked questions list. I believe that's up on our web page already even though the slide happens to say coming soon, it's there now.

On slide 15, just to let you know, the plan is for Medicare Fee-For-Service is to hold monthly provider calls and here is a schedule of the topics that we believe we will be addressing and the dates. More to come on this as these tentative dates are firmed up but for planning purposes you might want to recognize these dates and put a hold on your calendar.

On slide number 16, again knowing what resources are available to you, you're going to be required to obtain your own implementation guide or technical reference documents, the TR3. You'll need to purchase them from the X12 organization the information on where you can go to obtain them is listed here on slide 16. You may also want to review the comments that are being exchanged among industry representatives and we have a location here on our CMS website where information is exchanged on the transactions codes, code sets, and standards. And other industry points of reference the DSMO, is often pronounced dismo, the Designated Standards Maintenance Organizations do review and log requests for change; you may look at this website and observe what changes industry is asking for in the transactions.

On slide number 17, “What other actions may you take now?” One step you might want to consider taking now would be to contact your system vendors. Find out whether or not your current software license or contract includes a regulatory update or if you will be asked to give additional funding to them in order for them to perform that upgrade. Find out if your upgrade will include these acknowledgement transactions that Medicare Fee-For-Service is implementing and I would point out that these are not HIPAA standards, these are EDI standards that are accepted, but not required, under HIPAA. But Medicare Fee-For-Service believes that it is an appropriate action to take to implement these standards since they do exist and it’s in a package suite with the HIPAA standard upgrade. But that would mean, as the last bullet here in the first section on slide 17 states, that the human readable error report that is currently returned to you is being replaced by a EDI transaction. So you're encouraged to find out from your vendor, or your information services provider, that’s either internal to your organization or a service provider that you have engaged under contract, if they will be taking this 277CA and preparing a human readable error report for you in those business areas that will require it; Medicare Fee-For-Service will only return a standard electronic error transaction. This applies to the 999 transaction as well.

You may also be interested in finding out when you're vendor is planning your individual system upgrade. Then you would be in a position to assess whether or not your upgrade is going to dovetail well in advance of the January 1,

2012 cutoff or if your business practices might be at risk, necessitating looking for a replacement vendor. We're not encouraging that, we're just saying please be prudent with your planning exercises to make sure your business practices will be well taken care of. And finally, to evaluate the impact to your routine operations, begin planning for the training effort that you would likely need to accommodate the new data elements and the transactions, and to complete your entire transition. You may be interested in transitioning Medicare Fee-For-Service first, but you have a complete book of business to transition, because all payers are required to terminate the 4010 formats on the same date.

On slide number 18 we wanted to emphasize and share with you a little bit about some of our infrastructure enhancements and how Medicare Fee-For-Service is implementing common edits and error handling in order to have consistent error responses or consistent business transaction processing with each of the providers across the country through each of the Medicare Administrative Contractors. So, the Common Edits and Enhancements Module, or CEM software, will perform Medicare-specific edits. CMS has selected implementation guide edits and incorporated these as requirements into the CEM software. The CEM software is going to be delivered to each MAC for incorporation in their front-end systems and it will produce accepted transactions that will contain claim numbers that will be returned to you on the 277 Claims Acknowledgement.

You will get a Claims Acknowledgement for each claim you submit. The acknowledgement will convey whether or not that claim was accepted or rejected. If it was accepted, it will contain a claim number. If it was rejected it will contain the detail information about that rejection expressed to you in terms of code values. So, this will enable Medicare systems, all the MACs, to return individual claims as opposed to returning an entire transaction set when an error is discovered that may be more of a tactical or a structural problem.

On slide number 19, we wanted to emphasize that our MACs have been instructed by CMS to use COTS, commercial off- the-shelf software, translators, in conjunction with the Common Edit Modules that will be

supplied to them from Medicare. It is the translators that will perform all of the X12 syntax edits, prepare the TA1 for rejected interchanges, the 999 for rejected functional groups, or the 999 for functional groups that were accepted but contain errors subsequently to be communicated to you in the 277 format. So, I just want to point out, as I know we've had questions in the past about the TA1, if the submitter is requesting the use of the TA1 by conveying that in the ISA, the outer envelope, data element 14 would be coded with a one, prompting the return of the TA1. Absent that code, the TA1 will not be returned.

On slide 20, we provide a link to the Medicare Fee-For-Service edit documentation that has been prepared. We have made available a spreadsheet compares how 4010A1 is being changed to 5010; I mentioned the side by side comparisons earlier. We also have additional editing documentation that describes the requirements that are contained in the common edits module. This slide 20 works in conjunction with slide 21 and I did want to use the sample extract on slide 21 to explain a bit about how to use the spreadsheet. And if you take a moment and number the columns one through seven and number the rows one through 13, I would draw your attention to what would be column number four. That would be your primary indication of the type of transaction that will be returned to you from Medicare when an error is encountered on a data element specified in this particular row. So, for example, on row one, we have the billing provider city, state, and zip. If it is missing, you will get a 999 rejection. Column number five indicates that it is a rejected transaction, and column 6 indicates that it is a syntactical error, specifically stating that the required segment is missing.

If you look down this page just a little bit on row number five where the edit is performed on the N401 that contains address data. This particular 999E conveys whether the element is too short or too long. If it's too short, the IK403 will contain a four, if it's too long it'll contain a five, but regardless you will receive back a 999E transaction. In addition to that, it is conveying to you that the transaction is not able to be completely accepted, so you will also get the error handling transaction on row six in the format of a 277 Claims Acknowledgement. It will convey to you through the use of the CSC CA

segment, a code value of seven, which conveys to you that an acknowledgement is rejected because it had invalid information, a CSC code value of 512 that means there was an invalid link, a CSC code value of 502 that tells you that the error was in the city information, and an EIC segment with a code value of 85 conveying to you that it was in reference to address information related to the billing provider.

So the use of the spreadsheet indicates to you for this one particular error you will receive back both a 999 transaction and a 277 transaction. That'll be different timing and the delivery of these two transactions. Upon translation the 999 should be returned to you while that input file continues to be processed by the MAC to determine each and every error within it that will be conveyed back to you and the 277 transaction. So we're expecting that there may be a bit of a difference in the delivery and we're not talking days, we're talking minutes or hours but there would be a difference in the delivery timing.

Onto slide number 22, the special situations related to how we decided where the edit would be processed. We decided that the business errors would be performed in the Common Edit Module, so that when a business error is encountered, a claim will continue to be edited so that all the front-end system errors are identified and returned to the submitter. However, when a syntactical or a fatal error is encountered, especially at a provider level, since that begins a lot of data in the transaction the detailed claim editing will not be performed. - The error will only point to the invalid situation of the provider, but the subsequent detailed claim editing on all the claims that came from that provider will not be performed.

On slide 23, how are we going to use these TA1s, 999s, and 277CAs. As the TA1 and 999 reflect technical problems discovered in the translator, they would likely need to be addressed by technicians who would open up trouble tickets and do some technical troubleshooting related to the EDI transmission. However, the 277CA will reflect business problems in the data relationships, so the billing staff would likely be involved, in which case you will need that human readable 277 claims acknowledgement report created by your vendor

or your internal staff to troubleshoot and understand the error. Clearinghouses and vendors may also be entities that would perform the development of the human readable 277 equivalent.

Slide 24. Currently each of our Medicare Administrative Contractors is performing a proprietary error handling report, and by moving to the use of a standardized error handling report, Medicare is positioning itself to be able to standardize the types of edits that are performed and the way that errors are conveyed to you. So, these standard transactions can be used by clearinghouses and software vendors to produce customized reports for you.

On slide 25, we do want to talk a little bit or at least introduce two hot topics that you might be hearing about in today's industry and discussion. One is the valid use of the address information in the billing provider loop and the transaction. Please note that the Post Office Boxes are no longer permitted in a billing provider address in the 837 transaction.

The second hot topic that we wanted to introduce today is a discussion about errata in the X12 transactions. We want to simply say that Medicare has looked at all of the proposed errata and there are two flavors of errata. One is the simple typographical situation; Medicare does not object to corrections being made to typos in the TR3 documents.

The second type of change may be more significant to the transactions however; the scope of changes being addressed right now has been reviewed by Medicare and has been determined to be insignificant to the Medicare Fee-For-Service program. So, we're not seeing any proposed changes at this time that would cause Medicare to need or want to implement any of these changes. So, we're waiting to see how the Standards Development Organization X12 is going to accommodate the industry request for change. But I wanted to assure folks that Medicare Fee-For-Service does not need to address any of the proposed changes at this time.

On slide number 26, I want to say that now is our turn to listen to your issues. So, I would suggest that if you have any issues or concerns to please share them. Everything I've mentioned so far has been an attempt to kind of level

set. Most of this material you've heard before. We wanted to re-energize our activities at this time and listen to see what your issues and concerns are with either the transactions, your implementation schedule, meeting our implementation schedule, or just general feedback. So I'll go to our facilitator and ask that they now open the line for questions.

Question and Answer Session

Operator: We will now open the lines for a question and answer session. To ask a question please press star followed by the number one on your touchtone phone. To remove yourself from the queue please press the pound key. Please state your name and organization prior to asking your question and please pick up your handset before asking your question to ensure clarity. Please note, your line will remain open during the time you are asking a question so anything you say or any background noise will be heard in the conference and your first question comes from Elle Marchese. Your line is now open.

Elle Marchese: Thank you. It's actually Elle Marchese from Suffolk Anesthesiology Associates and unfortunately I dialed in very late to this conference call and was not finding the slides that you were going over so I was unable to follow along. Could I get that link now so I could at least review it for myself?

Chris Stahlecker: Just wait one minute till we come back to you with an answer while we try to locate that link.

Elle Marchese: OK, thanks. I appreciate it.

Chris Stahlecker: If we could take the next question, we will come back with an answer for this one.

Male: Can we maybe just get her e-mail address?

Chris Stahlecker: We would send it to you after your Q&A session is over, after our conference call is over.

Elle Marchese: That's fine.

Chris Stahlecker: You want to give us your e-mail address?

Elle Marchese: Sure, it's xxx@xxxx.

Chris Stahlecker: OK.

Elle Marchese: Thank you so much.

Chris Stahlecker: Alrighty, thank you.

Operator: Your next question comes from Patrice Coupe. Your line is now open.

Patrice Coupe: Hi, it's Patrice from (inaudible) and we really appreciate your schedule that you actually have one and we can work with our vendors. Not able to report to you on when exactly we'll start testing. I do have two questions with the slide 21, you mentioned we would get the error report twice or the error reported in both the 999 and a 277.

Chris Stahlecker: Yes. There are two pieces...

Patrice Coupe: Well...

Chris Stahlecker: Yes go ahead.

Patrice Coupe: It's the same error basically, something looks like was wrong with the city or something but do we just ignore 999s; I'm trying to think of my business flow. I don't want people duplicating work and I'm trying to figure out which one is going to make the most meaning to get the people that need to make the fix.

Chris Stahlecker: This is an excellent question, Patrice. Thanks for asking it. The 999 transactions we believe will most likely be able to be interpreted by a technician and so it is going to give a byte location of where within the entire file the problem occurred. It's kind of difficult for a human, a non-technician, a business person to actually interpret so that's why Medicare does not object to the fact that in this design two types of error reports are being generated. The 999 and TA1 we believe should go to a technical resource and the 277

would likely go to a piece of software to be interpreted and a human readable report generated on behalf of your customers.

Patrice Coupe: And we're the provider. we're the ultimate receiver of this and we do have translators but I get sort of what your concept is and I don't remember the 999 of the top of my head but a 999 could report things that you would not see in a 277, would that be correct.

Chris Stahlecker: Absolutely.

Patrice Coupe: OK.

Chris Stahlecker: Many of the outer enveloping...

Patrice Coupe: Yes, the X12 stuff.

Chris Stahlecker: The X12 wrappers, yes, are conveyed in the 999.

Patrice Coupe: And then will the COB contractor have to use acknowledgements back to the claims you cross over?

Chris Stahlecker: Absolutely.

Patrice Coupe: Because there's sort of a black hole there.

Chris Stahlecker: Actually no, they're not going to be producing the 999 and the 277CA. The COB contractor is sending 837s to their trading partner recipients.

Patrice Coupe: Well, when you send them the 837 file, I would hope that they could use these to, you know, if something gets broken and then when they send to the COB payer. I would hope they'd have to use it.

Chris Stahlecker: Let me just correct an understanding here. When the shared systems, the Medicare Fee-For-Service shared systems, send the COB file to the COBC contractor, it is not in an X12 format. It is in a flat file format so it is not expected that these would be useful in that workflow. That's an internal Medicare Fee-For-Service system, one system talking to the next system so it's not required under HIPAA to be in the 837 format. When the COBC

contractor does deliver the claim to the trading partner it is of course in the 837 format.

Patrice Coupe: Thank you for your time.

Operator: Your next question comes from Pat Travis. Your line is now open.

Pat Travis: Hello. My question is at what time will the P.O. Boxes no longer be permitted in the billing provider address?

Chris Stahlecker: That's upon use of the 5010 transaction format, so if you wanted to begin your transition early in 2011, it would be as soon as you started to submit that format.

Pat Travis: OK, so it can be used as early as January 2011 but mandatory in 2012 or 2013.

Chris Stahlecker: That's one way of looking at it. It's mandatory when you stop using the 4010 format.

Pat Travis: OK, thank you.

Operator: Your next question comes from Karen Fox. Your line is now open.

Karen Fox: Hi, I'm Karen Fox from Dr. John McCrillis' office and I'm fairly new to all of this so I'm trying to plug along and understand.

Chris Stahlecker: Oh, you're welcome.

Karen Fox: We use Express Plus and the Pro 32 so would there be a problem – what implementations do I need with that or is that something that Medicare is taking care of?

Chris Stahlecker: Medicare is arranging for the Pro32 also some people call it PCAce.

Karen Fox: PCAce. Yes, that's what we're using.

Chris Stahlecker: And that will have a new version for 5010 so that will be upgraded and if that's what you're using then you would contact your carrier or your Medicare

Administrative Contractor and request to have the new version of that software made available to you.

Karen Fox: OK and then what about the Express Plus?

Chris Stahlecker: Express Plus, we believe, is not being upgraded at this time.

Karen Fox: OK.

Chris Stahlecker: So we would need to encourage you to transition but that information should be coming to you from your MAC, your contractor.

Karen Fox: Right. We've already upgraded the PCAce for the DME that's only affecting the DME or is it affecting jurisdiction B as well?

Chris Stahlecker: Now the DME EDI transactions are being coordinated through the Common EDI contractor or CEDI and they would be a great contact point for you for when the 5010 versions will be available.

Karen Fox: Yes OK, thank you.

Chris Stahlecker: OK, good question.

Operator: Your next question comes from Leslie Wick and your line is now open.

Leslie Wick: Hey I wanted to ask a clarifying question about the P.O. Box no longer being allowed in the billing provider address. Again, I'm not a HIPAA 5010 expert either. My concern is can you clarify – when you say the billing provider loop to me that equates to what would be listed as the pay to address and like block 33 of the HCFA 1500. Is the billing provider loop the same thing as the pay to address?

Chris Stahlecker: Well, you're giving me a paper point of reference and...

Leslie Wick: Well, you know, does billing provider mean what would be in the, let’s say, a Medicare Part B provider's enrollment file as the special payment address otherwise known as the pay to address.

Chris Stahlecker: Right.

Leslie Wick: OK. My concern is that with huge organizations especially what's in that Medicare enrollment file as the pay to address is a P.O. Box because they're trying to centralize things and recently, if that address does not match there hasn't been an issue with Medicare Part B payment. But I've had a very large hospital organization and some other organizations having some issues with Railroad Medicare. That if Railroad Medicare is not finding a direct match in the PECOS file then they are not receiving their payments. So I'm not sure – the P.O. Box could be a big issue in terms of what's in an enrollment file although right now it doesn't seem to be an issue with Medicare Part B payment. But I'm not sure if this is a big issue that I need to say to people gosh you can no longer have a P.O. Box as your pay to address and now that would mean they'd have to go through a fairly extensive exercise changing their enrollment files, that's my concern.

Chris Stahlecker: No, I don't really want to imply that you need to make all that set of changes but on the – however your application system is preparing the 837, you just need to pay attention that the Post Office Box can't be used in the billing provider loop. I understand that when the 837 is received by a payer so I can speak for the Medicare payer, we're not using the address that you're putting on the claim to determine where we're sending the payment. We're using our internal files for that purpose, however, the transaction itself requires this element to be filled in so we're pointing out that you can no longer fill it in with the P.O. Box address because that's interpreted as an invalid format of an address.

Leslie Wick: All right that clarifies it. I really appreciate your clarification because if I'm hearing you clearly, in their enrollment file they might have a P.O. Box and that's still where you're going to send the payment, but in the billing provider loop they have to put a physical address, it can no longer be a P.O. Box.

Chris Stahlecker: Correct.

Leslie Wick: OK all right, thank you very much.

Operator: Your next question comes from Gloria Davis. Your line is now open.

Gloria Davis: Hi, this is Gloria Davis with NextGen Healthcare. I noticed all the way through your slides that you are specifically talking about Fee-For-Service in regard to the 999 and the 277CA. Is this only because it's the first phase, are we going to implementing both of those into the Part A as well?

Chris Stahlecker: Yes absolutely. Medicare Fee-For-Service Part A and Part B everything I said pertains to both.

Gloria Davis: OK. So the whole timeline and everything is for both sides.

Chris Stahlecker: Yes for Medicare Fee-For-Service, Medicare Part A, Part B, and DME.

Gloria Davis: OK.

Chris Stahlecker: And honestly the timeline of the cutoff of the format does also apply to all payers, that's not something that only applies to Medicare. We are only speaking to you about Medicare but it does apply to all the Medicaids and it also applies to managed care so from a provider perspective or a clearinghouse or billing organization you have all of those payers that you need to address. Of course the purpose of today's call is to speak to you about Medicare Fee-For-Service plans.

Gloria Davis: OK thank you. I was just clarifying that when you stated Fee-For-Service that you were talking about both Part A and Part B.

Chris Stahlecker: Absolutely yes, good question, thank you.

Gloria Davis: Thank you.

Operator: Your next question comes from Mary Crinkler. Your line is now open.

Chris Stahlecker: Are you on mute? If you're talking to us you might be – did you put your own phone on mute or did we lose you? I'm sorry we can't hear you. Could you come closer to the phone? I guess we'll need to take the next question please.

Operator: Your next question comes from John Tice. Your line is now open.

John Tice: Hi, this is John Tice from Starsoft Consulting. I had some further questions about that P.O. Box not being allowed on the billing provider loop. Is it allowed on the pay to provider loops?

Chris Stahlecker: Yes we understand it is.

John Tice: OK so it is allowed on the pay to provider loop, OK wonderful. Now the restriction on the P.O. Box on the billing provider loop does that apply to all carriers or just Medicare?

Chris Stahlecker: No it applies to all, it's part of the transaction standard requirement.

John Ty: OK, alrighty. Then a couple of other questions. The testing and/or transition is both going to start on January 1, 2011 right, we can't test earlier than that?

Chris Stahlecker: Medicare Fee-For-Service and please understand the timeline we're saying Medicare Fee-For-Service will be A and B and DME, will be all ready to begin transitioning January 1, other payers we can't speak to and if you want to test earlier than that please contact a MAC that you routinely exchange transactions with and if they are in a position to support early testing they may be able to accommodate you.

John Ty: Oh OK.

Chris Stahlecker: We haven't gotten that far in terms of giving direction to MACs if they are permitted to, but we understand the need for, you know, trusted business partners to exchange transactions early and can understand that need so we would support that and we would encourage you to contact a MAC that you routinely exchange transactions with.

John Ty: Then on the 277CA transaction, has there been any consideration for CMS to develop a reporting capability for that such as the Medicare Remit Easy Print for the 835 - something along those lines?

Chris Stahlecker: Well we think we did and the way that we are addressing that is through our PCAce and Pro32 package that will be, you know, that is used to submit the

claims so the 277CA is likely where it would need to be processed and that billing package will include that capability of accepting back the 277 Claims Acknowledgement transaction.

John Ty: Then one final thing, I haven't looked at the specs in detail, but for the 837 and the 835, are the changes significant between the 4010 and 5010?

Chris Stahlecker: We believe you should really...

Male: (inaudible).

Chris Stahlecker: OK yes.

John Ty: That's a yes OK.

Chris Stahlecker: That's a yes.

John Ty: All right, that's my questions thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from Barbara Williams. Your line is now open.

Barbara Williams: Yes, my concern with the P.O. Box is when I'm doing a new enrolment application. Do I still put the pay to address as the P.O. Box?

Chris Stahlecker: In your provider enrollment with Medicare, yes.

Barbara Williams: So this is only...

Chris Stahlecker: For preparing a claim or an 837.

Barbara Williams: OK I just wanted to make sure of that. All right thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from Jim Miller. Your line is now open.

Jim Miller: Good afternoon, this is Jim Miller with Indiana Rural Health Association and Indiana State Uniform Billing Committee. One question, you talked about standardizing the edits and the acknowledgement reports across all MACs, I think that's a great idea. Are you going to add that to your timeline because it seems illogical to begin testing with one MAC – for vendors who use multiple MACs- for them to be testing with different MACs if the reports are going to come back in different formats and ultimately they'll be back in one standardized format. So it seems logical to put that standardization of those reports as part of your timeline.

Chris Stahlecker: Well, it actually is part of our timeline and it will be available on January 1, 2011 and they will all...

Jim Miller: Well I'm talking about if you want to test prior to that date.

Chris Stahlecker: Oh again, if you would contact a MAC that you routinely exchange transactions with, the error reporting that one MAC produces for you will be coming out of the same software that all MACs are going to implement so it should be consistent.

Jim Miller: So you're saying that as of January 1, 2011 all the MACs should be using the same standardized reports?

Chris Stahlecker: Yes.

Jim Miller: OK good.

Chris Stahlecker: Remember it's for 5010 we're able to implement this. We're not addressing the 4010 format, the 4010...

Jim Miller: No I understand that. I just want to make sure that was clear, thank you.

Chris Stahlecker: Yes, you're welcome.

Operator: Your next question comes from Cheryl Simpson your line is now open.

Cheryl Simpson: I have a follow-up question regarding the – this is on the Fee-For-Service plan. Does this also affect skilled nursing PPS payment plans?

Chris Stahlecker: Yes it does.

Cheryl Simpson: Because it's affecting all Part A, all Part B, all submissions.

Chris Stahlecker: Correct. Everyone who is affected by HIPAA to begin with is affected by this.

Cheryl Simpson: OK thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from Dale Carter. Your line is now open.

Dale Carter: Yes, I have a question regarding the 277CA and when that goes with implementing – when will the human readable reports be stopped, that we receive now.

Chris Stahlecker: You won't ever get them from 5010 submitted transactions.

Dale Carter: I mean the ones that we're getting now; will they be just stopped once 5010 starts?

Chris Stahlecker: Right it's based off of how you're sending in the claim. The 4010 process remains the same so you'll continue to get the proprietary reports through the 4010 submitted claims but when you start submitting 5010, the 277 version of reporting will replace the proprietary reports so we'd like you to get your vendors lined up to take that 277CA and generate a human readable report for you or encourage you to use the 5010 version of PCAce, Pro 32.

Dale Carter: Thank you.

Operator: Your next question comes from Renee Lin. Your line is open.

Renee Lin: Hi this is Renee Lin from Tufts Health Plan, I have a couple of questions. One is actually regarding the slides I also did not receive them, if you can send them to me as well that would be great.

Chris Stahlecker: Can I get your e-mail address please?

Renee Lin: Sure it's renee_xxx@xxxxxx.

Chris Stahlecker: OK.

Renee Lin: The next question is regarding any claims that are submitted with ICD-10 before that ICD-10 go-live strike date what would be your approach for that, rejection?

Chris Stahlecker: That's a good question.

Male: That is the approach.

Chris Stahlecker: Yes rejection is the approach. Yes, we're going to have an edit in our front-end systems that will not permit the submission of an ICD-10 code value. That individual claim will be rejected until that edit is live, that is when the ICD-10 project says that they're ready to receive the ICD-10 code values.

Renee Lin: OK. So in other words we will never see a rejection through the 277CA or the 999?

Chris Stahlecker: The 277CA would be a code set rejection.

Renee Lin: OK it would be on the 277CA.

Chris Stahlecker: Correct. It's not a syntactical error. It wouldn't generate a 999 for that situation. It would only be the 277CA.

Renee Lin: OK and then my next question is regarding the 997, so with 5010 is there going to be no more 997 from your perspective?

Chris Stahlecker: That's correct. We'll only have the 999 and the 277CA.

Renee Lin: OK and then one more – sorry go ahead.

Chris Stahlecker: No I was just going to say and the TA1 .

Renee Lin: And then last question is around – I know someone brought up paper forms earlier, I don't know for the paper forms if they will match any of the 5010 rules, if you'll anticipate that. Such as like no P.O. Box in certain places if you'll mandate that I guess.

Chris Stahlecker: No we're not expecting to change the paper claim form data editing at this point. The paper claim forms do accommodate the longer lengths for the ICD code sets that are also being introduced with the 5010 upgrade so there is no real need to change the paper claim form for this implementation. We have asked the National Uniform Claim Committee to consider upgrading the CMS-1500, which we have co-branded as a CMS form, but there are many form numbers on that claim form because it's used for many insurers' paper claim billing. And the reason Medicare Fee-For-Service wanted it enhanced is to accommodate the 12 iterations of diagnosis codes, where there's currently only four. But that particular change will take longer than the same timeline that we're looking at the EDI implementation. So, we're not really dovetailing an upgrade to the paper claim forms in the 5010 project.

Renee Lin: OK, great, thank you very much.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from Mary Thompson. Your line is now open.

Mary Thompson: Yes, as a billing software vendor, would the CEM electronic edits be available for incorporating into our billing system?

Chris Stahlecker: Well the edits are all defined in the spreadsheets that we mentioned and so we believe that those requirements are available to you. In terms of sharing the software, no we're not for software vendors. We have offered to share that with the states. MACs, I'm sorry, the Medicare Administrative Contractors will be required to implement it and we have offered through the S TAG

group to share the software with the state Medicaids but that is the extent of where we have extended that offer at this point.

Mary Thompson: OK and the full spreadsheet of all the CEM checks is available on your website?

Chris Stahlecker: Yes it is.

Mary Thompson: OK thank you.

Operator: Your next question comes from Carol Jones. Your line is now open.

Carol Jones: Hello, thank you for the information that you provided.

Chris Stahlecker: You're welcome.

Carol Jones: My question was answered by previous callers so thank you.

Chris Stahlecker: You're welcome. May I just interject here that the spreadsheets that are posted on our website with all the edits, are works in progress. We expect that there will be quarterly releases of these spreadsheets, maybe for evermore as edits are refined and tweaked and needed to match the changes in the Medicare program. So, it is something that we would encourage you to come and look at frequently. There will be a versioning so you'll be able to tell if it's changed since the last time you've drawn it down but we would encourage you to look at that spreadsheet and there'll be a change log. There is one now we're trying to improve it. I believe that the change log addresses changes thus far. With the October release we're going to improve it so it only reflects the changes since this prior release. So, it's a work in progress and it's getting better all the time. So, maybe we can take the next question now.

Operator: Your next question comes from Debbie Warren. Your line is now open.

Debbie Warren: Yes, I have a question about – I thought I understood that there may be some changes on the front-end part as far as the information that needed to be put into the system to generate the claim or that there may be a change in how you

have to do business based on this. Did I understand that correctly and if so what are those changes or where can I find those changes.

Chris Stahlecker: You are correct and we're encouraging you to look at the changes in the actual transactions, the 837 transactions. And as I mentioned we'd done a side by side comparison so you can see where the new format is causing changes in the data elements and that is what we believe drives changes in your business process. So, you maybe lucky and your business process may not be touched by the changes in the data content. If you are a certain type of biller you may have additional changes.

Debbie Warren: OK.

Operator: Your next question comes from Charles Johnson. Your line is now open.

Charles Johnson: Hi, yes this is Charles Johnson with First Coast Service Options, the Medicare contractor for J9. I just wanted to provide for you the web address for the presentation.

Chris Stahlecker: Oh, thank you so much. Are we supported by our MAC? Wonderful support, appreciate it.

Charles Johnson: Yes ma'am. The web address is www.cms.hhs.gov/versions5010andd0 that's the 5010 and D0 website. When you get to the website select educational resources on the left hand side; the list of the presentations with the fourth national call being the last one are listed in the middle of the page that you scroll down.

Chris Stahlecker: Good job J9, appreciate that, thank you.

Charles Johnson: You're very welcome, thanks.

Operator: Your next question comes from Amanda Rucker. Your line is now open.

Amanda Rucker: Yes, this is Amanda with Imaging for Women and I was just wanting to get the link for the slide show. Can you repeat that back.

Chris Stahlecker: You want to read it again.

Mike: Sure I'll read it. The website is http://www.cms.hhs.gov/versions5010andd0.

Amanda Rucker: OK thank you so much.

Mike: And then just pick the education links.

Amanda Rucker: OK thanks, bye.

Chris Stahlecker: Bye.

Operator: Your next question comes from Sarah Stevens. Your line is now open.

Sarah Stevens: Hi this is Blue Cross Blue Shield of Arizona and referencing your timeline on slide 10, if a provider submits a different version, what format will the COBRA files be sent to payers who aren't 5010 ready until after the January 1, 2011 date? Will you be converting back to the 4010 based on a trading partner flag?

Chris Stahlecker: We're strongly encouraging trading partners to be ready on January 1, 2011 since we believe that they are payers and all payers, we assume will support provider transitions. So, payers would likely be required to be ready on January 1, 2011. In the event that they are not, the 4010 format will be continued, but it will be skinny version of the 4010 format. If you're a trading partner that should mean something to you; it's a compliant 837, but s because it is sort of a backward forced fit it would need to be only the required data content, and it would not be able to be interpreted as fully as 5010 data.

Sarah Stevens: Our intent to be ready July 2011 so I just wanted to make sure that there was an approach for the 4010 version.

Chris Stahlecker: Yes there is and, you know, providers that are submitting Medicare claims that may cross over to you would come to you then in a skinny 4010 version.

Sarah Stevens: OK thank you.

Question and Answer Session Continued

Chris Stahlecker: OK.

Operator: Your next question comes from Alan Black. Your line is now open.

Alan Black: Hello, the previous party asked my question.

Chris Stahlecker: OK, thank you.

Operator: Your next question comes from Tommy Wilson. Your line is now open.

Tommy Wilson: Hi this is Tommy Wilson with NBI Achieve. I just wanted to double check and see where the 999 and 277CA specifications are. I've been on the WPC website, I do see versions of the 277 and the 999 but there are two different versions of the 999 on there and there are a whole bunch of 277s but I don't see a 277CA.

Mike: You're going to be looking for something called a health care claim acknowledgement guide and I believe it is X214 if you're familiar with the Washington Publishing Inventory Number.

Tommy Wilson: OK.

Mike: The 999 is going to say acknowledgement for the health care industry and I believe it is X231 in the Washington Publishing Inventory Numbers.

Tommy Wilson: All right, thank you so much I appreciate it.

Operator: Your next question comes from Barbara Pete. Your line is now open.

Barbara Pete: Hi they answered my question, thank you.

Operator: Your next question comes from Angela Mead. Your line is now open.

Angela Mead: We've had our question answered. Thank you.

Operator: Your next question comes from Art Erickson. Your line is now open.

Art Erickson: Yes, thank you very much. Art Erickson from IMA Systems in Edison, New Jersey. I just wanted to clarify that we're a software vendor and if we accept or we submit a successful file that meets all the syntax rules and the business rules, will we get both a acceptance 999 and an acceptance 277CA back in return?

Chris Stahlecker: Yes you will.

Art Erickson: OK, thank you.

Operator: Your next question comes from Nora Hernandes. Your line is now open.

Nora Hernandes: Yes I wanted to clarify with the P.O. Box that it was no longer going to be allowed but I'm wanting to know for sure if we're going to be able to continue to submit our claims. We obviously are a larger group. If we talk to the vendor about editing our P.O. Box are we also going to have to update our NPI or our NPPES on the PECO system?

Chris Stahlecker: We don't believe so at this time but...

Male: That's a better question for the MAC to answer.

Chris Stahlecker: As Mike said --it's a better question for the MACs to answer.

Nora Hernandes: OK so I need to contact our MAC.

Male: Yes, your enrollment area would give you better instruction on that than this group can.

Nora Hernandes: OK, thank you, that was all I needed to know.

Operator: Again, if your question has been answered please press the pound key to remove yourself from the queue. Your next question comes from Kathy Haggard. Your line is now open.

Kathy Haggard: Yes, thank you very much for the call and for taking my question. My question is I understand that some of our hospitals will not be converting to a MAC until later in the year 2011, possibly even as late as October 2011 and

my fear is that will not allow us time to test prior to January of 2012. Do you have any current updated information on the change to the MACs?

Chris Stahlecker: Well we have updated information on how we're going to support your needs to convert to 5010 on the same timeline that we've talked about. We are calling that aspect of our project an alternate option for a MAC and we have required the FI or carrier that you're currently exchanging your Medicare claims with to select one of the MACs that will be ready. And so you will be encouraged to submit your 5010 test transactions January 1, 2011 to your FI or carrier that you're currently sending your 4010 transactions to and they will route them to a MAC that is able to execute the Common Edit Modules that we just talked about.

They have an arrangement that's underway to exchange transactions between the FI or carrier and a partnered MAC to do the EDI processing, and then processed transactions will be returned to the FI or Carrier systems to then be forwarded to the provider. I hope that made sense. You should be receiving some communication shortly. We have a meeting tomorrow and that's our internal kickoff for these paired arrangements. So, we haven't laid out the outreach in communications strategy but you should be hearing more in the not too distant future.

Kathy Haggard: As far as my submitting claims from a clearing house standpoint, I would continue to send to my FI and they would forward to a MAC?

Chris Stahlecker: That's correct.

Kathy Haggard: I would only be testing really with that FI.

Chris Stahlecker: Correct.

Kathy Haggard: Will those communications be on the same 5010 website or should I look somewhere else for those?

Chris Stahlecker: No you can look on our website; we'll get some information there. It's just not available just yet but in the not too distant future we'll have something there for you.

Kathy Haggard: Thank you very much. I don't have to get nervous.

Chris Stahlecker: No, no need to get nervous. But please don't think because the MAC isn't set up in your geographic area that you're going to have a different timeline. You really won't. You're encouraged to get started on the same timeline as the other providers.

Kathy Haggard: OK thank you, thank you very much.

Chris Stahlecker: OK.

Operator: Your next question comes from Christina Borden. Your line is now open.

Christina Borden: I'm sorry my question has been answered.

Chris Stahlecker: We like those. Those are good.

Operator: Your next question comes from Betsy Core. Your line is now open.

Betsy Core: Yes, I'm from Wake Forest University Health Sciences.

Chris Stahlecker: Hi Betsy.

Betsy Core: Hello. I just want to make sure that everyone understands that while the billing provider address is required and it cannot be a P.O. Box, you always have the option of also sending associated with that billing provider address a pay to address that is different from that physical address and it can be a P.O. Box. I know some people did say that. I just want to make sure everybody understands that you can't send both addresses for your group, but you must send a physical for billing, the P.O. Box goes with the pay to address.

Chris Stahlecker: Appreciate that comment and again, here's an example of Medicare being supported by a provider. Thank you, Betsy.

Betsy Core: You're welcome, thank you.

Operator: Your next question comes from Monty Jenkins. Your line is now open.

Monty Jenkins: Hi. Monty Jenkins with Quality Enhanced Management Systems, a vendor supplier for software. A couple of things for those who are looking for the e-mail address. If they've gotten a reminder notice yesterday that link was on that e-mail for the slide presentation.

Chris Stahlecker: Ok appreciate that, thank you.

Monty Jenkins: OK. The Medicare Remit Easy Software, will that be transitioning for the 5010 as well?

Chris Stahlecker: Yes, there'll be a new version for MREP, the Medicare Remit Easy Print, software that will be upgraded for the 5010 version and yes you'll be encouraged in future communications to obtain a fresh copy.

Monty Jenkins: All right, and during the transition in the 4010, for a period of time the fees were paid for through some type of programs for WPC for the technical guides, the implementation guides, is there going to be any funding of that type for 5010 or not?

Chris Stahlecker: No there isn't. Actually it was paid for by our Office of E-Health Standards and Services. That's an arrangement that was made in the early years.

Monty Jenkins: Just want to make sure we shouldn't wait for a little bit before we go purchasing if they were going to be funded.

Chris Stahlecker: Don't wait too long because it's not coming.

Monty Jenkins: All right and the only other question I have right now, is regarding the transition timeline that affected 4010 and the seemingly constant delays that were put in place for that. Are we expecting any of that to occur with the 5010 or not?

Chris Stahlecker: We're not expecting it and Medicare is doing everything that it can be to not be requiring it. So no, for 4010, we kind of needed it but we don't at this time.

Monty Jenkins: Oh, we needed it but from a vendor perspective it caused a lot of havoc when we were changing business practices over with our clients only to find that there then was a delay in the implementation of the 4010 from when the initial scheduling was being put out. That transition from 3051 to 4010 will have been as significant as what 4010 is to 5010.

Chris Stahlecker: No, we're on target...

Monty Jenkins: From our business practice perspective and software implementation, with you know, with a go to date that says OK, your switch is on start using this.

Chris Stahlecker: So, no and an answer to your question, no. We're going to be on target and in a position to take the full workload in 5010 format on January 1, 2011.

Monty Jenkins: That's great. That answers my questions, thank you.

Chris Stahlecker: OK thank you.

Operator: Your next question comes from Annie McDonald. Your line is now open.

Annie McDonald: Hi, I'm Annie and I'm also a software vendor and some of my questions have been answered but I do have a suggestion. Because we're all testing the 999 and the 277CAs, would it be possible for CMS to put just one sample of each up on the website because hopefully they're all going to be standard across the MACs. I work with a lot of different MACs, and if we could just get one test trial from you guys we could start developing it when we feel like it.

Chris Stahlecker: Yes we can take that into consideration and I'm seeing a lot of heads going up and down here in agreement with that suggestion so, we , I don't want to promise anything on the call but that’s an excellent suggestion.

Annie McDonald: Super and I have one other thing. Standardization of file names that are coming back, is it possible to standardize them? I've been working with this business for over 20 years and I appreciate that every time we get an update we're more standardized. But one of the things across the MACs is that there's no standardization in file names either submitting, which includes submitter IDs, but is it possible maybe to standardize these and then we could automate

things much more and then all that would be different between the MACs would be things like the (inaudible) ID and the submitter ID.

Chris Stahlecker: That's another excellent suggestion. We can take that into discussion into our work groups but again I'm not in a position to promise anything on this call but as I said it's a good suggestion, thank you.

Annie McDonald: OK and I just had one more comment because I've got the specs of the 277 here in front of me. The person who asked about the CA, the CA is just one implementation of the 277 because the 277 is also the same spec that, i.e. the 214 designation, is also the claim status response and it's also a response for request for additional information. So the CA is just one implementation of the 277 but when you get the spec it includes all these other implementations as well.

Mike: Let me clarify what I think you're trying to say. There are four separate implementations of the 277 transaction. There's a pair that has a different Washington Publishing Inventory Number which is I believe X212. There is an X228, which is, I think, was pended claims list but the title might have changed recently. I don't want to give the impression that when you get X214 you get all four, you have to purchase those individually.

Annie McDonald: OK. Well I wasn't clear about that but I'm just looking on page 13, there's a diagram of the 277 coming back from the pair and they all seem to be same, they're all 277 with a different implementation.

Mike: That's correct in the front matter of each guide they try to standardize it and use the same slash, symbol, or business model but the point is if you want each of those guys they are separate purchases, they are separate Washington Publishing Inventory Numbers as assigned by the ASC X12 registry.

Annie McDonald: OK thank you.

Chris Stahlecker: Thank you.

Operator: Your next question comes from Debra Gram. Your line is now open.

Debra Gram: Hi, this is Deb Gram from UMass Memorial and I think you just answered my question because we bought the complete set of nine guides, oh back in '09, August, I think, of '09 but we didn't get any acknowledgement documents, so that means I have to go back and try to get more money for these acknowledgement files?

Mike: That would be correct, what you probably got if you made the HIPAA suite purchase, is eligibility, the referral, the claims, the remits, etc. The acknowledgements are not named in the HIPAA regulation from January of '09 timeframe. They are currently working their way through the DSML process and, you know, that's as far as I'll say on that, but they are a separate purchase. You would have only gotten the X212 guide if you purchased the HIPAA Suite probably.

Debra Gram: Yes I've got nine reports, six of which I need and three I could care less about. But the 277CA I just looked is another $525 as is each one of them. It was a hassle getting the OK to get the complete set. They're going to kill me when they find out they got to shell another 1500 bucks.

Mike: I think your argument is, how much time did you spend working with each payer on their proprietary reports- if there’s a loss then you can make the argument there.

Debra Gram: Yes, OK thank you.

Chris Stahlecker: Thank you. Good luck with that.

Debra Gram: Yes thanks.

Operator: Your next question comes from Frederick Neher. Your line is now open.

Frederick Neher: Yes, with Enable MD Practice Management software and I had a couple of questions. First the spreadsheets of the edits that we were looking at on the slide, is that going to include the other edits that you all published, the National Clean Claim Edits or are those going to remain separate?

Chris Stahlecker: I believe those edits are documentation from our shared systems and so these edits that we're referring to today are for 5010 only and for the electronic transactions only.

Frederick Neher: OK. And then the other is basically just a couple of observations I guess. If you're still not finding the address and typing in the address for the presentation isn't working, go to Google and search for 5010 national provider call, which is what this is, and it's actually the second hit on Google so you can just search in the 5010 national provider call. Then the other thing is when you're looking for the transactions on the WPC EDI website, they have them on their front page. One of them, the batch of nine is the HIPAA 2.0 that they're advertising and then the remaining the 999 and the 277CA transactions they have as a separate entry for the 5010 acknowledgement transactions and that's it.

Chris Stahlecker: Thank you so much and I love it when people share information, appreciate that, thank you.

Frederick Neher: You're welcome.

Operator: Your next question comes from Jodie Rudolph. Your line is now open.

Jodie Rudolph: Yes I'm also somebody who just wants to give my e-mail address so I can get the slides and I looked at my e-mail where I registered and I did not see any link on there where I could have clicked to get the slides.

Chris Stahlecker: OK we'll take your e-mail address please.

Jodie Rudolph: It's xxx@xxxx.

Chris Stahlecker: OK got it.

Jodie Rudolph: Thanks so much, bye-bye.

Operator: Your next question comes from Nancy Reid. Your line is now open.

Nancy Reid: Hey Chris, hi Mike, this is Nancy. First of all, I have one suggestion is that when you send out the acknowledgement registration e-mail, that you include those links because we kind of had to scramble at the last minute to get the presentation because there wasn't anything included in the confirmation e-mail. So I think that would help everyone based on the comments that you've received.

Chris Stahlecker: Appreciate that, thank you.

Nancy Reid: And my second question is regarding testing with each of the carriers and intermediaries have you standardized or have you discussed standardizing the actual testing process with each of the carriers in intermediary so that if we, you know, especially with the consolidation of your front-end that it shows in your presentation. If we test with one carrier intermediary could that testing approval be applied to all other carriers or intermediaries that we test with?

Chris Stahlecker: Excellent suggestion for us to work to standardize the process and procedures that the MACs will have in place. They currently have a requirement to look at their internal training needs and their helpdesk training needs and to plan for their transition support that they'll be offering for their training partners. So we can bring up this question along with the standardized data file names in future discussions that we have with them but, you know, just to point out that they are separate organizations so, you know, we can think of this as an ongoing process that will continue to improve on the amount of standardizing that we can get to but that's an excellent suggestion. Thanks, Nancy.

Nancy Reid: OK, thank you.

Operator: Your next question comes from Janice Rooter. Your line is now open.

Janice Rooter: Hi, my questions have been answered.

Chris Stahlecker: Thank you.

Operator: Your next question comes from Martha Johnson. Your line is now open.

Martha Johnson: Hi this is Martha Johnson I'm with Practice Insight and we are a clearinghouse so we do interact with most of the MACs across the country. My question has to do with a transaction that I don't think we've really talked about and that's the 835 electronic remit. I'm just curious with any particular MAC, if we make the transition and start sending our production files in 5010 format I would expect a 999 as a response or 277CA as a response. If the claim is sent in 5010 format, should we then therefore also expect the 835 to be returned in the 5010 format or is that going to be done a completely different schedule.

Chris Stahlecker: There will be a different setup and we may have some providers that would need to use a different vendor perhaps that would have a different readiness date for the 835. So really the submission of the claim in the 5010 format is separate from the receipt of the 835. Likely you would do the claim first but it is a separate exercise to come up on the 5010 and 835 than it is to submit the 5010 and 837.

Martha Johnson: OK, so then we would be sending claims in 5010 format, but we would be receiving ERA files possibly in 4010 format, is that – am I understanding that correctly?

Chris Stahlecker: I believe the answer is yes.

Martha Johnson: OK. I think I can't...

Chris Stahlecker: I'm sorry I don't...

Martha Johnson: I can't speak for all clearing houses but I know that, you know, we're planning on needing to possibly translate files backwards to 4010 for our individual providers who may or may not be ready to read a 5010 file back in their own office, but as a clearing house we were just trying to anticipate what we would be getting back once we send the claims in 5010. And so it sounds like – it doesn't necessarily mean the 835 is going to be in 5010.

Martha Johnson: No it's a separate setup with the MAC. They manage each of the transactions independently.

Martha Johnson: OK.

Chris Stahlecker: You can be testing on one transaction in one format and be in production on different versions for different transactions so it's not that you turn over into the suite of transactions on all of them all at once for 5010.

Martha Johnson: OK. All right. I appreciate it, thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from Gloria Jones. Your line is now open.

Cynthia Burney: Yes. My name is Cynthia Burney and I'm calling from Medical Management Professionals. I have a question in reference to the Post Office Boxes. I think you've answered the majority of them but what I'm trying to find out – we are a billing service and if the vendor in service is – the facility is in one state, the billing provider address is a different state now that we can't use a Post Office Box and the pay to address, the lock box, is a third state. Do you know whether or not that will present any problems by us having three different states or three different addresses?

Chris Stahlecker: I don't. The only change really is that the format in the billing provider address can't be a Post Office Box. As I tried to say earlier it's really not affecting how payment is returned.

Cynthia Burney: OK I was just curious just based on the fact that we may be providing you information with addresses with three different states opposed to just a lock Box address and the actual physical address.

Chris Stahlecker: I don't believe that we have relationship edits across those various provider type loops to compare them against each other for reasonability. It's just the address in and of itself.

Cynthia Burney: OK thank you.

Chris Stahlecker: OK. Chris, can you tell us how many more questions are in the queue right now?

Operator: We have 23 questions left in queue.

Chris Stahlecker: OK and we only have a few short minutes. I think that we could direct folks to our web page and there is an opportunity to submit an e-mail on our web page and so if we don't get your question in the line. We'll take one more. You could send your questions to us on that page. Perhaps although they're showing 23 in the queue maybe the questions have been answered but let's take one more and then we'll conclude.

Conclusion

Operator: So our last question comes from Starla Sutton. Your line is now open.

Starla Sutton: Just wanted to give my e-mail. I've tried the link that was given earlier and don't seem to be able to get to the handouts.

Chris Stahlecker: OK. Your e-mail, please.

Starla Sutton: xxx@xxxx.

Mike: The first part again, ssutton.

Starla Sutton: Sp.

Mike: P as in Peter.

Starla Sutton: Yes.

Mike: Thank you.

Starla Sutton: Thank you.

Mike: tton, correct?

Starla Sutton: Yes.

Mike: OK.

Chris Stahlecker: All right well, thank you all very much, great questions, great participation in the call. I love it when people are mutually supportive. This is going to take all of us to get this thing done so really thank you and... If you go to – the URL on slide 13 you should be able to submit your questions we weren't able to get to today, it's http://www.cms.hhs.gov/electronicbillingeditrans/18_5010D0.asp. It is I think the only URL on slide 13, its bullet number four.

Mike: If you could put something in like the beginning of the message saying this relates to this provider call that would be really appreciated.

Chris Stahlecker: And then we'll try to respond to your questions via e-mail. Again, thank you so much for your participation and we look forward to working with you.

Operator: This concludes today's conference call you may now disconnect.

END