Centers for Medicare & Medicaid Services
Sixth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0 Transactions
Moderator: Aryeh Langer
May 26, 2010
2:00 p.m. ET

Welcome

Operator: Welcome to the Sixth National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions Conference Call. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for participating in today's call. I will now turn the conference call over to Aryeh Langer. Sir, you may begin.

Aryeh Langer: Thank you, Amanda. Once again, good afternoon to everybody. This is Aryeh Langer from the Provider Communications Group here at CMS. I'd like to welcome you to our Sixth HIPAA Version 5010 National Conference Call. As always, we appreciate your participation in today's call and we look forward to another informative session.

Today's call will focus on the 837 Professional claim transaction. There are a few quick items that I'd like to mention before we move forward. For anyone that did not get a chance yet to download the presentation for today's call, you can go to the CMS 5010 web page, located at http://www.cms.gov/versions5010andD0. You can click on that educational resources link on the left-hand side of the page, and then scroll down. Then you'll see today's presentation. Again, the web address is http://www.CMS.gov/versions5010andD0.

As I've mentioned on previous calls, this web page is a central source for all CMS 5010 information. So you can access all the educational resources CMS offers including fact sheets, MLN Matters national articles, and availability of transcripts and audio versions of previous national 5010 calls. As with all of our 5010 national calls, there'll be a question and answer session following today's presentation. Please take advantage of this unique opportunity to ask questions from our subject matter experts.

I would like to introduce our speaker for today. Brian Reitz is a Health Insurance Specialist in the Division of Medicare Billing Procedures in the Office of Information Services here at CMS. Brian?

Brian Reitz: Thanks very much, Aryeh. For those of you who don't know, both Aryeh and I are working a little bit challenged here virally – we both have some sort of head cold issues. So I'm going to hope that my voice doesn't fade in and out. If I happen to need to put the mute button on if I get into a coughing jag, I'll let you know beforehand. OK?

So anyway, as Aryeh said, I'm Brian Reitz with the Centers for Medicare & Medicaid Services. I'm a Health Insurance Specialist. I work specifically on the Medicare side of CMS. I deal in the Electronic Data Interchange arena as the subject matter expert on the 837 Professional.

Just to let you know, I have somewhere in the neighborhood of about 19 years of varied EDI experience. The primary area of my responsibility here at CMS, as I said, is working with the 837 Professional transaction. As such, I am the CMS Medicare representative to the X12 Standards Committee. For those of you that may or may not know, X12 is a standards body responsible for developing as well as maintaining the health care standards which are named under HIPAA.

Additionally, I'm the subject matter expert on the CMS-1500 paper claim form, which is considered by most as the paper equivalent to the 837 Professional electronic transaction. In that respect, I represent CMS Medicare at the National – excuse me – at the National Uniform Claim Committee. For those of you that don't know, the NUCC is responsible for maintaining the CMS-1500 form, developing as well as maintaining.

So I'd like to thank you all for taking your time out today to listen to my presentation. Hopefully you'll get some valuable information out of today on what CMS is doing with the 5010 implementation as well as some technical information about the transaction itself. Go ahead and move on to the next slide.

What's the purpose of today's call? We wanted to update you on 5010 a little bit, talking about the differences between the HIPAA I 4010, and now the 5010 version. We'll talk to you about what Medicare has been doing regarding Fee-For-Service activities related to the implementation of the 5010 837 Professional claim transaction. Also, I am going to talk about the errata. I won't get into too much detail there. But we're going to let you know that there were some issues with the transaction that were identified. That's usually done through this process of errata. I'll get to that, and in the presentation later discuss exactly what was identified and what our opinion is on the issues related to the 837 Errata.

One of the things that I hope you get out of here is to receive some guidance. We've heard a lot of feedback from providers asking, what am I supposed to do? I don't really know exactly how to work my way through this transition. So hopefully I'll be able to provide you some information that will give you some helpful advice on where you need to go from here. Then lastly, we're going to allow you all to have your opportunity to ask some questions, provide some feedback and concerns that you have.

I just wanted to make sure that everybody's clear that my presentation today will be coming from a Medicare Fee-For-Service perspective. I will not be addressing anything related to Medicare Advantage or Medicare Part D in this presentation. So, move to the next slide.

Slides 2 thru 8

So, the agenda for today is a general overview of the 4010 and 5010 transaction, mainly focusing on 5010 and what you need to know about that. I'm going to talk about the significant differences between 4010 and 5010. Obviously there are a lot of things different with 5010 than there were in the 4010, and I'm not going to be able to go through them all. There's just not enough time to discuss every difference. But I'm picking out what I think are the most significant differences to discuss today.

Next, I want to talk about the CMS implementation of 5010; exactly what it is that we've been doing on our end related to the 837 Professional, and moving

forward with 5010. As I said before, we're going to talk about the 837P Errata. I'm going to touch on the timelines and deadlines for the Fee-For-Service implementation, and talk to you – give you a little bit more detail on what it is that you need to do moving forward, give you some valuable information, website URLs, et cetera. Then, as I said, lastly we'll open up the lines for your questions and hopefully be able to provide you with answers.

We'll move on to the next slide. The general overview. What was adopted under HIPAA 5010? Well, it's pretty much the same set of transactions that were adopted under the HIPAA I, 4010. We have your claim transactions, your 837 Professional and Institutional, the remittance transaction or the 835, the 276/277 claim status and response, your 270/271 claims eligibility, and then your NCPDP D.0 which is your retail drug transaction.

Generally what is different now is that what was previously referred to as Implementation Guides are now being referred to as Technical Review Type 3 document or TR3. So you'll probably hear me flip flop between saying IG or TR3. When I do, know that they both mean the exact same thing.

What was mainly done in the TR3s in a general perspective is that the X12 work groups responsible for each of their transactions worked on their front matter. Basically it's like a prelude to the actual technical documentation. It lays out the expectations and provides some guidance. There were inconsistencies across the transactions in 4010 versions of the front matters, which have been addressed by the work groups. They've been revised so that they're consistent. So that one guide isn't saying to go left and another guide in the same front matter area is saying to go right. We made sure that, wherever possible, that the transactions are consistent and have the same language across them, so your expectations are clear.

The other thing that was done was the situational rules were reviewed by the work groups. They were reviewed to make sure that they were clear. In some instances, rules weren't written exactly with the level of clarity and specificity that they should have been. So, the work groups have gone into their individual transactions and done a fine job of trying to tighten down and

clarify and specify when a particular element is required, or whether it is not allowed to be submitted.

Part of that involved correcting the ambiguities related to special types of words. Now for those of you around in the 4010A1 implementation, you will remember the whole "should" versus "must" debate. "Should" is a very tricky word that was quite prevalent in the transactions. Sounds real impressive, but it doesn't really mean a whole lot. It doesn't have any sort of force behind it.

For example, I should exercise and lose weight. People in my room are chuckling now. I should, but I probably won't. Well, what happened is the work groups have gone through their transactions, and everywhere they found the word "should", they're replacing it with "must." So we're trying to be extremely clear as to when you must do something, not whether you should or you shouldn't. To that end, what has been added, and you'd find it throughout the IG and the TR3 is the statement or the phrase, "If not required do not send." That's how the work groups tightened down the language and made it clear that certain loopholes they were going to close down and make sure that people were absolutely crystal clear when they were to send something and when they were not to send something.

OK. Move on to slide five. Now, as I said earlier, what I wanted to talk about here is just the significant differences, the things that I felt were noteworthy in the 837 Professional. What we do have available – and it is referenced in the bottom of page five – is a URL link that provides you with the Medicare side-by-side, the 4010 to 5010 comparison for the 837 Professional transaction. That is approximately 90+ pages in length. So, I've given you that so that you can go there in your free time and take a look. You would see every single difference between 4010 to 5010. But what I wanted to do here is just note what I think are the more major changes of which you might want to be aware.

Number one, the changes for 5010 to prohibit the use of a P.O. Box address in the billing provider loop, the 2010AA loop. I know that's gotten a lot of attention from providers that are concerned now that they're unable to send P.O. Box addresses. That is not the case. I want to clarify that P.O. Box

addresses are acceptable in the transaction. You're just not going to be able to submit them in that particular loop. The 2010AA loop is for a physical address. What you will be able to submit your P.O. Box address is in your pay-to loops in the transaction.

You have to forgive me. I talk very technical because of what I do. If these loops and segments don't mean much to you, then I suggest that you get with your vendors to make sure that they can provide you with the location in your practice management systems where you would be able to put the P.O. Box address information, as well as anything else that I mentioned today. Your vendor's a really good resource for the technical piece of this.

Number two, the modification for N403, which is the zip code element in the 837 Professional transaction; they've changed it now. In 4010 you were submitting five-digit zip codes, and now the requirement is for the nine, full nine, which is your five and your zip plus four.

Number three is the addition of a pay to plan loop, which is the 2010AC, which really doesn't have any bearing on Medicare. It's more a loop that was added for subrogation purposes; most people refer to subrogation as pay and chase. It's really for one plan to bill another plan and recoup money that they've paid out incorrectly because they should have been secondary instead of primary.

Number four is the modification of the subscriber loop. Currently in the 4010, you only have the ability to send primary, secondary, and tertiary other payers. For 5010, you can now send eight additional payers beyond the primary, secondary, and tertiary. I'm not exactly sure if there's a real-world reason for that, but the transaction now allows for it.

Number five is the deletion of the responsible party and credit/debit card loops. These were not used in 4010 transactions, so the work group just decided to get rid of any overhead if it wasn't of value to the transaction. So, those were deleted. We had modifications made to two segments within the transaction. First, the DTP segments, which are date segments. DTPs capture any particular date that you can imagine – date of service, date of injury, date

of x-ray. So, they made some changes in the 5010 to remove some dates that weren't being utilized. They've combined some dates that were listed separately and should probably have been under one segment.

The same is true for the AMTs, which are amounts – any sort of dollar amount, a paid amount, billed amount, et cetera. They deleted some AMTs. Primarily the biggest hit to the AMTs segments was in the coordination of benefit loops. The reason that was the case is X12 follows the premise that if you can calculate data, you should calculate it rather than actually receiving the data in a separate element. Why take up space in a transaction when the information can be calculated from what's already there?

Let's go and move on to slide number six. Number eight. The expansion in the 5010 transaction of the number of diagnosis codes from 8 to 12. Previously we were capturing eight, and now in 5010 they've added four additional diagnosis codes for providers to submit.

Number nine is the modification of the transaction, specifically the HI segment, where diagnosis codes are submitted; it will now allow for the ICD-10 diagnosis code. So, if 5010 wasn't enough work for you, now you've got ICD-10 coming right down the pike, and 5010 is the precursor that allows for the submission of the ICD-10 diagnosis code.

We had two additional HI segments added to the transaction. One was an Anesthesia Related Procedure HI; the other was a Condition Code HI segment. Basically, the anesthesia related procedure was added because in some cases anesthesia claims are paid off of a special anesthesia code and, in some cases, they're paid off of the actual procedure code.

So, when you need to know what procedure code was billed, you would be submitting that anesthesia related procedure in this HI segment. The condition code segment really was added for Medicaid usage. It is not really a Medicare issue. So, we don't really have to worry about that. Those of you who are Medicaid providers submitting claims there, you might want to look into that and see if the addition of that information provides you any extra horsepower for your claims.

Number 12 is the deletion of a Home Health loop, which is loop 2305. I don't want people to think that you can no longer submit home health claims in the 837 Professional transaction under 5010. That's not the case. It was just a situation, similar to what we described before with those credit card and debit card loops. The X12 Committee surveyed the industry, found that no one was actually utilizing this loop, and found that it was overhead that could be removed, and believed that the transaction in itself has the ability to still capture all the needed pieces for you to continue to bill home health claims using other pieces of the transaction, other segments, and other elements.

They deleted a Purchased Service loop at the claim level, and left it at the line level. So, what happened here is, in that particular section of the transaction, the 2310C loop was actually reassigned to another usage. So, I would warn you, probably one of the trickiest things that happened with 4010 to 5010 is the fact that where most folks were thinking if you deleted something the number was going to be removed, they actually restructured and renumbered certain segments within the transaction. So, you need to be really careful of that when you're talking about your loop structuring. Because it has changed, and things have been reused and reordered.

Number 14 is the addition of Ambulance Drop Off and Pick Up loops, both at the claim level as well as the detail line. This was a very important thing, it being here for the HIPAA I 4010 implementation. Ambulance payers were having a very difficult time with their adjudication of claims. Payers were constantly asking them, “Where did you pick them up? Where did you drop them off? We need that location.” It was very difficult to incorporate that into the first transaction, 4010A1. So, the work group added both drop off and pick up for the ambulance providers. I think that's going to be a huge enhancement for them in getting their claims adjudicated. They should be pretty pleased with that change to the transaction.

Number 15 is the addition of a freeform narrative note at the detail line. In the 4010A1 transaction, there was a claim level detail called the NTE or the note segment. But what happened is, X12 work groups felt that it would be more appropriate to actually capture your narrative description when submitting not

otherwise classified or NOC codes, right at the detail line where the procedure code exists. It makes the transaction flow a little bit cleaner. So, they opened that up for the 5010 version of the 837P.

Move on to the next slide. They made a change in relation to the PWK segment, or what's called the paperwork segment. I'm going to get into, a little bit later in the presentation, exactly what the PWK is, but they've actually added it for 5010 at the claim and the line level. It was previously just the claim level. So, that was moved to the line level, which I think will enhance transactions as well that require additional documentation to be adjudicated.

Number 17 is the deletion of the home oxygen therapy information. The work group really struggled with this. They went through and took a look at the transaction. The oxygen therapy pieces of data were scattered throughout in different places. When they took a look at the actual Certificate of Medical Necessity for DME, we found that all the pieces of information necessary were actually on the CMN. So, the work group decided to remove all of the bits and pieces related to oxygen therapy out of the transaction, and required all of the information to come in on the CMN, which would be submitted in the FRM – Frank, Robert, Mary – segments of the 837 Professional transaction.

Lastly, there were two quantity segments – QTY segments – added to 5010. One for a patient ambulance count, which is another thing related to ambulance services that were a bit of a problem in the past. You pretty much had to use narrative description to indicate how many patients you transported at the same time. Now it has its own segment added for 5010, which I think the ambulance vendors and providers would be proud to have, and really thrilled to know that it's there now.

Then there is the obstetric unit anesthesia count, which is really a Medicaid change; doesn't really affect Medicare at all. So, let's move on to the next slide. Now we're going to talk about what it is that we've been doing on the Fee-For-Service side with our implementation of 5010. There’s been a lot of work; a tremendous amount of work being done now. We are not only just

implementing a version change, but we're also implementing something that we're calling the Common Edits and Enhancements Module.

The Common Edits and Enhancements Module is being built in hopes that we're going to standardize our editing process and give the providers one set of common edits that their claims will be edited against, regardless of the MAC that you submit to, and regardless of where you reside in the U.S. We are putting one set of edits together per line of business. We actually have two sets of edit spreadsheets right now, slightly under 4,000 edits per line of business, one for Part B and one for Part A. So, we're hoping that that's going to provide you with consistent editing and consistent results for your transaction exchange of data with us.

Additionally, what we're going to be doing with the Common Edits and Enhancements Module is standardizing our error handling. Right now I'm sure many of the providers out there that submit their claims get different flavors of reporting – response reports, acknowledgment reports from various payers. You probably have a difficult time keeping that straight. Well, from a Medicare perspective, we're going to make sure that it's consistent and standardized for your submissions.

There are three pieces that we're putting into play for the standardized error handling. Number one is the TA1, which is the Interchange Acknowledgment. This is your high level view of how compliant is your transaction. If your system is building transactions with serious technical flaws, the TA1 is where that failure's going to take place and where you're going to be provided information on what is wrong with your transaction. So, in essence, it's a complete file failure when you're getting the TA1 back.

Next we have the 999. For those of you who remember in 4010, the transaction was the 997. It has now, for 5010, been moved up to the 999 transaction. What the 999 does is communicate X12 as well as IG syntax violations. At this particular level, you can have complete batches of claims rejected. However, our approach for the 5010 implementation is, we want to reject the minimal amount of claims necessary as far as to communicate to you how well your file is built.

So what we're going to be doing is actually implementing two levels of the 999. There's one that's a 999R. 999R would be a complete rejection of the batch of claims. It's an error such that a value that's required in let's say the GS segment, and you're not submitting that specific value as noted in the implementation guide. Because of the location of the error, that would be a complete batch rejection of your claims. So, you would see a 999R coming back, and your claims would not have been accepted.

We also have the option, on the other end, to do what's called a 999 accept with errors. We refer to that as the 999E. What we're going to be doing with your file submissions is taking those situations and looking at every particular claim, and where it makes sense to flag the claim but still allow it to come in so that we're not rejecting the rest of your batch, because those claims are fine. So, in essence, we're not holding the whole batch hostage for one bad claim. That one claim would be flagged with the 999E. It would be sent back to you, indicating that this particular claim was accepted but has errors.

Then we would move it into the next level which you'll see is the third standardized error handling transaction, which is the 277CA; where we would be rejecting individual claims. What you will see on your 277 Claims Acknowledgment is a listing of every claim submitted, and whether each claim has been accepted or rejected. Obviously what we're hoping for is standardization in the error reporting that you're receiving. We'll hopefully replace all the different proprietary reports that you're currently receiving today.

Well, what I need to let you know is, it's very important, even though Medicare is doing what we're doing and we're providing the standardized error handling, we're talking about actually providing you with transactions. In order for you to be able to actually read a transaction, your vendor's going to have to get involved and take that information and produce readable reports for you. So, it's important that you get with your vendor now and find out from them what their plans are for how they're going to represent these error reports and acknowledgments to you, so that they'll be of some use to you.

Slides 9 thru 15

Then move on to slide number nine – continuing the discussion of Common Edits and Enhancements Module – another piece that we're adding to our implementation is what we're calling receipt control and balancing. We are building a system that contains internal checks and balances. So, as your claims come through the Medicare translators, to the Medicare Common Edits Module, through to the Medicare core adjudication system, and then on to Coordination of Benefits payers, each step along the way there's going to be a system of checks and balances so that we can make sure that there are no claims lost throughout this process.

If there's any situation where an out of balance occurs, if we have 100 claims leaving the Common Edits Module but only 99 showing as being received at the core processing system, that will immediately flag an out-of-balance situation. We have technical staff at the maintainer of the module, and our core system maintainers, that will immediately kick off a problem and start to review that, and make sure of what happened, to rectify that out-of-balance situation.

Another thing that we're doing with our implementation, which I think everyone should like tremendously, is we're going to be assigning claim control numbers early into the process, at the time they are coming into the edits module. By doing our claim control assignment early, we will be providing that number back to you in the error reports that I had referred to earlier in the 277CA reports. You will actually get the ICNs of accepted claims into Medicare. So, you will have them much earlier in the process, which will give you the ability to start doing your status inquiries earlier. You will not have to wait for batch cycles to run, as they do today, before claim numbers are assigned. Most of the time you don't even know what the claim number is anyhow until you get your 835 showing that it was either paid or denied. So, this is a huge enhancement, for what we think, moving forward with 5010, is going to be a tremendous benefit to all of you.

Move on to the next slide, 10. So, what are we doing from a business perspective? I sort of touched on the technical things that we're doing for

5010. But from a business perspective for 5010, what are we doing? Well, we're now going to modify our adjudication systems to accept and adjudicate up to 12 diagnosis codes. So, if you submit 12 codes, those codes will be accepted and will be used in the adjudication of your claims. We're also modifying the size of the diagnosis bucket in our core system to now accept a seven-byte diagnosis code which, as I mentioned before, is in preparation for the submission of ICD-10 diagnosis codes.

We're modifying our internal quantities in our core system. Currently, the largest quantity that you're able to send to us is 999.99. We're adding one additional byte to that, so now you'll be able to submit 9999.9 as quantity. This may affect some providers who previously had to submit multiple claims in order to account for the limitation and the unit size.

We're also going to be doing algorithm validation in our front end of NPIs that are submitted. There are – even though there's no intelligence in an NPI number – they are set up very much like credit card numbers. They have an algorithm check that can be performed to validate that the NPI is actually a valid NPI. It doesn't tell us that it actually belongs to the provider on the claim. It just lets us know that it meets the criteria for a valid NPI. We'll be doing that, checking at the front end as well.

As I mentioned before, the implementation of the PWK segment is near and dear to my heart. I've been working on that one for quite a while. PWK is a paperwork segment within the 837 transaction. It's the precursor of electronic attachments. What we're specifically going to be using that for in Medicare is for those providers who have claim situations where they often have to submit additional documentation after the fact to allow the claims to be paid. We're going to implement this link, which is the PWK, and by doing so you will be allowed to continue to submit your claim electronically. However, you will be also able to manually – either mailing or faxing – send in the additional documentation utilizing special cover sheets that we're going to be providing to you. That cover sheet will become a linkage when we image your additional documentation so that our claims examiners, when they look at

your claim, will be able to go out to our storage retrieval area, find your documentation and utilize it in the adjudication of your claim.

I'm not going to guarantee that's going to get your claim paid. I can't guarantee that. But it will give you the ability to send that documentation along with your claim, so you don't have to wait for us to send out automated development letters asking for this additional documentation. I think everyone's going to be pleased with that. It's going to speed up the process and speed up your reimbursement.

Lastly, Medicare Secondary Payer has always been an important aspect of Medicare. It becomes a cost savings, and we recognize that. But one thing that we did not do in our 4010 implementation was make sure that the amounts that were submitted from primary payers balanced on the submission of the inbound claim to Medicare. So, what we've done is added balancing edits into our Common Edits and Enhancements Module, to make sure that what is being submitted to us financially balances before we start adjudicating the claim.

Move on to the next slide. OK. The 837 Professional Errata. Now, when I attended the last call on the 270/271, we actually had someone ask a question, well, what is an errata? I think Ronnie would agree – she's in the room – that we all kind of looked at one another, and we sort of knew what it was, but we couldn't verbalize it. So, I went to the Webster's Dictionary to find out. The purest definition of errata is an error in a printed work discovered after printing, and shown with its correction on a separate sheet. That exactly describes what we're talking about here.

Situations within the 837 Professional transaction that may have inadvertently been missed, such as errors, omissions, clarifications – those types of things – are included in the proposed errata. I've listed a few here just to let you know what we're talking about. The first one relates to the N4 segment of the 837 Professional, which is the city, state and zip. It's where that information is submitted on your transaction. Well, in certain situations the N4 was a required segment. However, the prior segment which is the address – the N3 – was situational. So, we were putting providers in a position where you

didn't have to give us an address, but you had to give us a city, state and zip. So, that was something that should have been addressed and has been addressed as a proposed errata for the 5010 version.

Additionally, the property and casualty folks – Medicare is obviously not a property and casualty payer – those are State Farm, Allstate, et cetera – they came with a need to have some information added to the transaction which has now been proposed for the errata, which is the addition of a 2010CA loop. It captures patient identifiers, which are necessary for them to continue doing their business.

Another errata item is a change in the subscriber primary identifier information. Previously it was required, and has been changed or proposed to be changed to situational. The note is required when the subscriber is a person. I believe this was also something that was done for property and casualty, because there are some situations where in a property and casualty claim the subscriber may not necessarily be a person. So, the transaction was forcing some information to have to be submitted which was impossible; it couldn't be submitted. So, the proposed errata is going to fix that.

Then lastly, there's a change with the LIN segment, which is currently the drug identification segment, both to the situational rule for its usage as well as some code values that are to be submitted in the LIN02 segment. The reason this is done is because there's a demo project going on right now where providers are required to submit product number and device identifiers in claims. When they brought this issue to the work group, the work group felt that the best place for this to happen would be in the LIN segment. So, the Errata has gone forward to modify the usage of the LIN to be more than just for drug identification, but to also capture product numbers as well as device identifiers.

As I mentioned, there was a public comment period on the 837 Professional Errata, which unfortunately is closed now. So, there's not much that you can do as a provider if you had concerns. But what you can do if you're so inclined and want to take a trip to Addison, Texas on June the 8, we have our X12 trimester meeting there. There will be an informational forum for each of

the transactions, but specifically, the informational forum for the 837 Professional Errata will be held on June the 8 from 8:00 to 9:00 a.m. at that X12 trimester meeting in Addison, Texas which is a suburb of Dallas, I'm told. So, that's where you might want to come if you have some concerns about the errata that you want to raise. That would be the best place.

Now from Medicare's perspective, we don't see any implementation impactor concerns with what's been proposed with the errata, so we really don't felt that that's going to have any sort of impact on our implementation moving forward for 5010. Next slide.

Our timeline and deadlines. Right now we are in a testing mode. We're implementing our internal technical changes that I have mentioned regarding the Common Edits and Enhancements Module, receipts control and balancing, all of what I discussed earlier. We're in the testing phases right now. We expect on January 1, 2011 that we will be ready for you to come to our door to do your external testing of your products. If you're a provider submitting directly, or if you're a software vendor wanting to test your clients, a clearinghouse, anyone that wants to test, we will be ready come January 1 to open our doors up for you to do your testing.

It's important to note that you're going to have a year from January 1 to December 31, 2011 to do your testing. As of January 1, 2012-- that's the mandatory compliance date – you would have to be submitting 5010 version claims in order to be HIPAA compliant. At the bottom of the slide 12, I've given you a little representation of what is currently happening. All I can say is, don't wait until the last minute. Don't assume that there's going to be a delay. Because once that happens, you're going to be put into the line as you've been received. So, you might wait a while, and you might miss the deadline. So, taking advantage, do the work now, and start your testing as soon as you're able to.

Next slide. So, what I have on slide 13 is useful information for you. I'm not going to read all of these URLs. I hope that everyone has received the package and has the slides and is able to access all of these URLs. What I think I'm going to do, which I don't know if is suicide or not, but I'm going to

give you my e-mail address for anyone who does not have this package and will need to get this information, if you haven't gotten it. Feel free to e-mail me directly and I'll be happy to send you this information. That way it'll save you from getting into the queue at question time and saying, could you repeat that URL? Because my voice is just fading out.

So my direct e-mail is Brian – B-R-I-A-N – .Reitz – R-E-I-T-Z – @cms.hhs.gov. Once again, brian.reitz@cms.hhs.gov. If you need this information, feel free, and I will be glad to e-mail it to you. But just to describe what we have here, we've got links to our CMS web pages, both for our 5010 and D.0 – very useful information there. Educational resources such as MLN articles, fact sheets, readiness checklists, brochures, et cetera can be found. We also have our project web page where we store technical documents that would be of use to mostly our software vendors out there. We have news flashes and updates that are ongoing. So, look to this web page for that.

We have Frequently Asked Questions. I believe they're currently being updated. We have new questions popping up daily. We also provide you with the links for where you need to go to purchase your Implementation Guides. I say "purchase" because many of you remember being given them in the first HIPAA I transition. That process has been changed. You're now going to have to purchase these. The links are given there. You can go to X12 or to Washington Publishing Company to make your purchase of your TR3s.

We also have a URL there for some technical comments from basically X12 responses to issues, where people are concerned and have questions. They pose them to X12; X12 will respond back with technical guidance on how to move forward and those you can find there. Then lastly, for those who have the need and feel that they want to make changes to future versions of the standards, you can access the HIPAA-DSMO.org website and submit your comments there, and they will go through the process of being reviewed by X12. Whether or not the changes are made or not – I couldn't say. It would depend on what you would be asking.

Next slide, 14. What do you need to do now? Well, I think your first point of contact has to be your software vendor. You're a provider and you're submitting your own claims, you own your own software, you need to get with your vendors now, find out what it is that they're doing. Hopefully they've already started their work and they are pretty much ready to roll on this. If you're lucky, I hope that's what you find out.

You want to make sure what it is that you're receiving from your vendor. You probably purchased maintenance agreements, and hopefully your maintenance agreement also includes this upgrade for version. What else is included? Do you know what's included in your fee that you're paying? Are you going to be receiving regular updates?

As I mentioned earlier, we're going to be providing you with some new acknowledgment reports. Is your vendor going to be supporting the receipt and I guess the programming necessary to turn those reports into human readable format, user friendly format for you? Will they be doing that as part of their services to you? These are things that you need to discuss with your vendor?

If you're not using a vendor or your vendor's not going to be upgrading, you probably are working with a clearinghouse. So, instead of a vendor, you need to talk to your clearinghouse. Find out what their current plans are and where they stand. Find out where you stand in their schedule. How will they roll out their changes to you, where you are in their schedule, and when can you expect to receive your upgrade needed to move forward for 5010?

Also, I guess I would suggest, take a look internally at your internal business practices and see where 5010 might have created some need for change internally with your billing, your scheduling, registering, reconciliation, et cetera. It's important for you to just take a quick few minutes to survey what it is that's going on in your own offices, and make sure that there's nothing that you need to do in preparation for your 5010 implementation.

Next slide, on page 15. Test early and test often. That's the thing. If you take nothing else away, you need to test. As I said, we'll be ready for you, and we're expecting folks to come to the door. What you can expect as far as testing procedures from us, is that if you are a direct submitter to a Medicare Administrative Contractor, what we would be asking you is to contact your MAC and find out from them what the procedures are that you'll need to be following. They may have some paperwork that they need you to fill out. They may have some information that they can provide to you, letting you know what to expect during your testing process.

CMS requires our MACs to test a minimum of 25 claims. That may not be enough for you to feel good about your test results, depending on your specialty. I would suggest not holding to 25. Do what you think is a reasonable representation of what your business practice requires you to submit. Make sure that you've covered all the bases, and 25 claims may not be enough to do that. But that's what we're minimally going to be requiring from you. What are our expectations of your test files? Well, you will not be granted production access, submission of 5010 claims, until you have proven that you're 100 percent compliant for structure as well as syntax, and no less than 95 percent compliant for the Medicare business rules.

Similar to what we did in HIPAA I, when a vendor is approved, all of their clients will be approved. So, I've listed this as, approved for one, approved for all. That applies to software vendors as well as clearinghouses. Also, to providers that may utilize the same software package for different locations, you don't have to test every one of your locations. If you test one and it's approved and it's the same software, all of your locations will be able to submit production as well.

Question and Answer Session

OK. At this time, what I want to do, and, Aryeh, I'm going to say that I guess this is OK, we're going to open up the line to allow the folks to start entering the queue for their questions. But in the meantime, while the queue is filling up, I have received a couple questions submitted previous to the meeting via e-mail that I'd like to address. That way it'll give folks on the call an

opportunity to go ahead and get themselves in the Q&A queue. So, operator, go ahead and open that up, and start allowing folks to come in.

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

Brian Reitz: Okay, thank you. So, while the queue's filling up, I'm going to go ahead and go to the first question that we received. It was – is Medicare going to allow clearinghouses to send one claim per ST/SE? Actually this question was originally submitted as one ST/SE per claim. So, I assume that they meant one claim per ST/SE. Technically speaking, there's nothing that precludes that from happening. If you're submitting one claim in a file, you're going to have one claim in an ST/SE. However, I don't believe that's the intent that the questioner was trying to get at when they asked this question.

We recognize that folks have what they feel is a need to submit one claim per ST to SE for their own technical reasons. What we want to let you know is, we're not going to direct our contractors to prohibit such practice. We're going to allow our contractors the ability to decide for themselves. I know for a fact that there are some contractors that will not allow you to do that. It becomes a horsepower issue. It becomes a throughput issue to have to take one claim in that file in that manner per ST/SE. Contractors are free to make their determination based on their hardware and software configurations if they want to allow that or not.

Second question. Since there have been many changes in reference to billing oxygen items under the 837P format, what segments are required when billing oxygen claims beside the FRM segment? Do you require the CRC, the CR1, the MEA, and any others? I think I touched on this earlier, and I just wanted to reiterate, there will be no other segments required for oxygen therapy claims except for the FRM, which contains all of the questions and answers

that are in the CMN for oxygen therapy. So, we believe that this is what the question was trying to get at and I want to assure them that the FRM will contain it all. I've verified that with the maintainer that would be processing the claims for oxygen. That's their expectations, and that's what they've built in for 5010 as well.

The last question is will all MACs/FIs require EDI re-enrollment for submitter/trading partners? No, CMS is not going to be directing our MACs to reenroll just because of 5010. But what I want to clarify is that because there are some MACs that have been upgrading their hardware and software in preparation for 5010, which typically, replacing their translators, they may require the need for re-enrollment. If that's the case, if they deem that as necessary, then they're certainly within their rights to do that. But we are not going to across the board tell all of our MACs to re-enroll providers for 5010. So with that, we'll go ahead and take the first question in the queue, operator.

Operator: Your first question comes from the line of Gloria Davis. Your line is now open.

Gloria Davis: On page six you mention the NTE, the freeform narrative. I don't see that there was a difference between the 4010 and the 5010 on the claim level narrative.

Brian Reitz: Well, the difference between the 4010 and the 5010 is, in 4010 the line detail narrative which I'm referring to wasn't available to be used. It was a “not used” element in that transaction. So, for 5010, they've allowed the line level, at the SV1, the narrative line, to be open and is required when you're submitting a Not Otherwise Classified code. So, the NTE in the transaction for 5010 can be truly used at your discretion for anything that you want to submit. But when you're billing for Not Otherwise Classified, the IG requires you to submit the description of the service being performed at the SV1.

Gloria Davis: But I guess when you were stating not used, you were meaning for CMS, you did not use the 2400NTE?

Brian Reitz: Well, the 2400NTE was accepted under 4010A1 if someone submitted that, and there were certain cases where it was actually utilized in adjudication. So yeah, we have used that in the past, and will continue to use it moving forward if providers submit data in there.

Gloria Davis: OK. Then the other question I had real quickly, was page 15 – approved for one, approved for all. Are you stating for the approved for one, approved for all, based on submitter or submitter ID?

Brian Reitz: Well, no. It's typically done by the practice management product or your software product. If you are a provider practice and you've got a software product – let's say it's ABC Software, and you have it in 10 of your offices that are submitting claims – if you can get approved for a production status on that software for one of your offices, then all 10 of them are included in that and can start submitting production files, because it's the same exact software package.

Gloria Davis: Well, I'm the software vendor, and that's the reason why I was questioning that, because we have a number of providers who have separate submitters. Would I, as the software provider, be the one who would be testing, or would each of my providers who have a separate submitter have to test separately?

Brian Reitz: Will you be doing testing on behalf of your providers? Or are you expecting them to do it directly with Medicare?

Gloria Davis: They'll be doing it with Medicare with our guidance.

Brian Reitz: OK. Well, as long as your software is consistent across all of your users, technically what I'm stating is, once your software has been shown to be production worthy, then all of your providers could, in effect, go into production.

Gloria Davis: Then are you looking at it specifically by claim type, whether it's an institutional claim or a professional? Or would it just be all of the above?

Brian Reitz: We would want you to test each line of business.

Gloria Davis: OK.

Brian Reitz: It would be worth your while to also test specialty if your software is a broad-based type of practice management system that can handle let's say chiropractors as well as podiatrists. You would want to test both of those, just to be sure that the claims for both specialties are accepted and compliant.

Gloria Davis: OK.

Chris Stahlecker: This is Chris. I just would like to support the first part of your question, in that the MACs who have their trading partner management systems in place, and they're assigning the submitter IDs, may have a test for production indicator next to each submitter. So, that may require them to test independently. If your product is used on a national basis, each submitter may be required to test with their MAC in order to move from a test to the new version of 5010. If they're …

Gloria Davis: Yes, I kind of understood in regard to the MAC. As was said, I was just looking at it as the one for all, where I have a number of submitters submitting to the same MAC, whether I would end up having to test for each submitter.

Chris Stahlecker: Not you, but they may.

Gloria Davis: OK. Thank you.

Operator: Your next question comes from the line of Sonya Kirkman. Your line is open.

Sonya Kirkman: Yes. Hi, how are you today?

Brian Reitz: Still fine, thank you.

Sonya Kirkman: I need to know – we are a small business, Durable Medical Equipment. We deal with diabetic shoes and custom orthotics. Will this 5010 affect us in any way?

Brian Reitz: Yes, it does affect you. You're a covered entity. Your claims are covered claims. So, they would have to be submitted in the 5010 format to Medicare.

Sonya Kirkman: OK. So, I definitely need to get with my vendor and find out what type of transactions that they're doing as far as changing things over then?

Brian Reitz: Yeah. That's your first point of contact is with your vendor to discuss where they are in this process, and what you need to do to move forward to 5010.

Sonya Kirkman: OK. 'Cause we're presently billing on the 1500 claim form. Will the claim forms change in any way?

Brian Reitz: No. There's no change. Not right now. There's a possibility that the form may change. The National Uniform Claim Committee is entertaining that. But no – there's nothing final at this point in time.

Sonya Kirkman: Oh, OK. All right, thank you.

Brian Reitz: You're welcome.

Operator: Your next question comes from Bernadette Hayes. Your line is open.

Bernadette Hayes: Hi. My question is, I do billing for podiatry offices. I was wondering if you can tell me when you're going to have seminars geared towards specific specialties, such as podiatry?

Brian Reitz: Well, that's typically done at the actual MAC level. Their provider education departments determine that. I would suggest that you contact your MAC, depending on where you are. If you're a billing service, you might be dealing with a few of them. But contact them and ask them what their plans are for specific educational seminars related to your area of specialty.

Bernadette Hayes: OK. Thank you very much.

Brian Reitz: Sure.

Operator: Your next question comes from the line of Leslie Witkin. Your line is open.

Leslie Witkin: Hi, this is Leslie Witkin at Physician's First in Florida. On slide 10, I was very interested in that PWK segment. I wondered if you could give a little more information. I guess what I'm looking for is how that segment would

work in terms of someone filing a claim, and they're on prepayment review. Are they going to get an immediate notice of some sort in the claim editing system? Did you say they would then be able to download immediately a form to complete? So, if you could give me some detail on that, it sounds like a terrific enhancement.

Brian Reitz: Sure. It doesn't quite work that way. I'll try to give you a quick overview of what it is. The provider submits their claims electronically the way they always have. But within the transaction itself is a segment, the PWK segment, it indicates that they're sending additional documentation. Within the PWK segment, there are qualifiers that identify what exactly that additional documentation is; it can be something like a consult report, operative note, those types of things. There's about 60 of them in there.

You would identify in that PWK segment that you're sending us – let's use a consult report as the example – you're sending us a consult report. You're sending it to us by mail or by fax. There's a couple of different values that are allowed. But for now, in our first implementation of this, we're going to be accepting by mail and by fax only. You'll indicate that you're sending that to us by mail or by fax.

Then you're going to assign an identification number to that information. Whatever it is that you want to assign it. Let's just say you want to assign 123 as the control number for that document. You will then, through the normal process of education that our MACs do (e.g., newsletters, news bulletins, websites), be provided with these cover sheets, these draft cover sheets for you to print and utilize. They're specific to the line of business – so there'll be one for Part B, one for Part A, one for DME.

You'll use the proper sheet, fill it out. You would attach that to the additional documentation. If you're faxing it, you would fax it over. You'll be given a telephone number by your Medicare Administrative Contractor. That information will go into an imaging system at the contractor site. It will now be able to be linked to the claim that you've already sent electronically. The adjudication staff will have both the claim as well as the additional information handy, and utilize it to adjudicate your claim as it stands with

what they have in their hand. That, in a nutshell, without getting into too much detail, is how this is going to work.

Leslie Witkin: Oh, that's very helpful. It does sound like a terrific enhancement.

Brian Reitz: What you'll see is, we will be rolling this out in January of next year, and you'll see educational materials coming out from your contractors letting you know how to go about utilizing this if you so choose.

Leslie Witkin: OK, thank you.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Becky Litke. Your line is open.

Becky Litke: Hello. My name is Becky Litke. I'm from Catholic Regional Medical Center. My question is in regards to – our facility does not have a MAC yet, and so how is that going to play out if our award is still under protest when we're supposed to be testing? How is that going to work?

Chris Stahlecker: Hi, this is Chris. I can take that question. The situation is that CMS has required all of the current remaining legacy contractors, the non MACs, to partner with a MAC in order to support the tests of providers who need to test and come up on their 5010 format. So, you'll continue to work through your legacy contractor, your current contractor. They have already established a partnership with a MAC who's going to take in the new 5010 formats and then send those claims back to that legacy's claims processing system, for either Part A or Part B. So, you should be ready to begin your transition and conversion on January 1, 2011 like everybody else, knowing that behind the scenes Medicare's contractors are working together to satisfy your needs.

Becky Litke: All right. Thank you.

Operator: Your next question comes from Alison Phillips. Your line is open.

Alison Phillips: I work for a Federally Qualified Health Center, and we do institutional billing for Part A for encounter rate. I would assume these rules will be the same for institutional as they are professional?

Brian Reitz: As far as 5010 in general, yes. I mean, the regulation applies to both.

Alison Phillips: OK.

Brian Reitz: But your implementation transaction is different than what I'm talking about here.

Alison Phillips: OK. Well, here's my question. We've been told by our practice management vendor that since we are an FQHC with multiple sites who are all currently enrolled and billing using their site name and their site NPI rather than our organizational name and our organizational NPI, that we will have to reenroll all 14 sites.

Brian Reitz: Actually, I'm sorry, to specifically address your question, there will be another presentation similar to this one, and it will be specific to the Intermediary, the 837 Institutional transaction. That call is scheduled for June the 30th of this year.

Alison Phillips: OK. So you don't know about the re-enrolling thing?

Pat Peyton: This is Pat Peyton from provider enrollment. I'm not familiar with exactly what went out, but I know that there were questions asked about it with respect to whether each location had to get its own NPI – is that what you're asking about?

Alison Phillips: No. Each of our locations does have its own NPI. That's how we've been billing. But our practice management vendor, is telling us that this new 5010 is going to require us to bill under our organizational NPI, and that we can no longer bill under the clinic site location NPI, and that we would have to reenroll all of our sites using our organizational NPI. That would be a big deal for us.

Pat Peyton: If those sites send their own claims electronically now, they need their own NPI's and there's no reason they can't keep sending their claims.

Alison Phillips: So the way we're doing it with each site using its own NPI, that will not change?

Pat Peyton: Well, the NPI final rule acknowledges that sometimes different locations submit electronic claims to health plans, and when they do, they have to have their own NPI. So, I see no reason why you would have to change that.

Alison Phillips: OK, good. I was hoping that our vendor was wrong. All right. Well, thank you very much.

Chris Stahlecker: This is Chris again. I don't want you to go away all happy. I want you to carry forward a little bit of a worry. Your vendor's advice to you may be because they know additional information about how you've been established with your MAC in terms of their submitter identifier, the relationship between the submitter ID that you've been assigned and the NPI for which it is authorized. So, there may be an operational concern by your vendor on your behalf, because if your billing NPI is not the one that's represented as linked to your submitter ID, it may be a concern. So, I would just advise you to have some additional conversations with your vendor and just try to understand exactly why they believe you needed to make this change.

Alison Phillips: OK.

Chris Stahlecker: As you've heard from Medicare, there's no reason that you can't bill under your NPI, and that's true. But on the other hand, if your MAC has established a different NPI related to your submitter ID, then you might have some difficulty.

Alison Phillips: OK. Thank you very much.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Cathy Martin. Your line is open.

Cathy Martin: Ah, yes. Will the HCFA 1500 form change?

Brian Reitz: Right now the NUCC is discussing whether it's going to make changes to the form, but nothing has been finalized.

Cathy Martin: OK. That's all I have. Thank you.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Annie MacDonald. Your line is open.

Annie MacDonald: Hi, Brian. I just really wanted to thank you and congratulate you on this great presentation. Because you know, everybody's been told to call their vendors of which I am one. We've had no formal training from anybody. So, this is really the best technical presentation I've heard since I started attending all these conferences.

I just wanted to point out – I don't really have a question, because you covered everything – but I wanted to point out to providers that we as vendors can't start testing until January 2011. We can start hopefully putting people live in January 2011. But there's a little bit of a dichotomy there, in that we need time advantage to test. So, I hope the providers aren't expecting to be put live that very day, because we're not going to be able to get any 277CAs, 999s, or 835s back until we complete a billing cycle with the new 5010 in place for test. So, I don't think that was made quite clear. But other than that, I just want to thank you very much, Brian, for your presentation.

Brian Reitz: Thank you. We agreed on a check for $25, right? Thank you.

Annie MacDonald: OK.

Question and Answer Session Continued

Operator: Your next question comes from the line of Beth Lester. Your line is open.

Beth Lester: Hi, Brian, how are you?

Brian Reitz: Hello.

Beth Lester: Hello. You were talking about the link there at the bottom of page five about the 4010 to 5010.

Brian Reitz: Yes.

Beth Lester: I actually tried to click on that link, and it just takes me right back to your PDF for the session.

Brian Reitz: Well, maybe you need to cut and paste it into a browser.

Beth Lester: That's what I actually did.

Mike Rolf: Well, you know what?
This is Mike Rolf, and I did the same thing earlier. They haven't posted – after the sessions, Aryeh, they post a Word, a document that gives you two links – one for the voice and one for the PDF. Right now they only have the presentation out there on the website. They haven't converted, like they did for Ronnie's. Probably a timing thing, when they get back the audio. So it may be just a point in time right now, the way the link is going.

Brian Reitz: Did you get that? It sounds like there's some technical things that need to be taken care of.

Beth Lester: OK, great. That was all I needed. Thank you.

Brian Reitz: Welcome.

Operator: Your next question comes from the line of Sammie Buben. Your line is open.

Sammie Buben: Hello. I represent a very small clinic – Pacific Family Health Center in South Bend, Washington. This is a solo provider, and we've just gone through a lot of stuff with a changeover with revalidation and everything. But I wanted to ask you, we use PCAce software and submit electronically in-house. We have two separate PCAces. I wanted to verify that one is for institutional and Part A which is rural health. One is for our Professional, which is our Part B. The

Part A is through Cahaba and the Part B is through Noridian. I'm assuming, when you said, "once approved, all approved" that I still have two separate approvals that I have to go through. Is that correct?

Brian Reitz: Yes, yes. Rest assured that, since the software is ours, we have our maintainer already in the process of upgrading that software for 5010. But you would still want, just to be on the safe side, to do your own testing. It would probably be a very short test. I would do both lines of business.

Sammie Buben: OK. My next question is, the Post Office Box thing – we actually live in a very small area. There is no physical delivery at all to any locations here unless we do Fedex or UPS. So, the post office is absolutely essential for billing. I just now looked on the PCAce – and I guess you are familiar with that software. How am I going to fix this? You said that there was a separate loop. But the general info asked for address, and I usually put our physical and our post office box in there. If the post office box won't be accepted, where will I put that?

Brian Reitz: Well, actually I have to admit I haven't used PCAce in quite a long time, so I'm not really familiar. I'll look around the room if anybody else is. Because most likely what we'll have to do is we'll have to get with the vendor of the product and find out what screens you'll need to populate that would equate to the pay-to, to be able to put your P.O. Box information in there.

Sammie Buben: OK. So should I just contact both Cahaba and Noridian and find out – because the PCAces are so similar but they're not identical?

Brian Reitz: Yes, I mean, you can start there. Absolutely. I've provided my e-mail address. If you find that you're not getting anything there, feel free to e-mail me. But start with Cahaba. Talk to their EDI help desk. I'm sure they would be able to tell you a lot faster where you would go to populate that information within PCAce and Pro32.

Sammie Buben: OK. Is all of this, what we've been talking about, fall under the preparation stuff? I need to have all of this done before January 1 of 2011?

Brian Reitz: Yeah, it would be wise for you to know exactly where you need to populate the data elements within your software to be able to submit a compliant transaction. So, sure. You should take the opportunity to be working on that now.

Sammie Buben: OK. It won't affect current submissions?

Brian Reitz: Well, you have the ability to flag your files in the software as test. What you would probably want to do right now is do all your investigative work – finding out where you need to populate the data internally. Create some test files; maybe ask Cahaba if you can send them a few to take a look at, make sure everything is in the right place. But you would want to coordinate that through them. So, it's unofficial testing. Then come the official test of January 1, where you're looking for formal approval, you can submit the same files again and get your formal approval to go into production.

Sammie Buben: OK. Now I'm a little bit confused. Within the PCAce, each PCAce program there is a separate spot where I can do, test files that will only go through and come back on different registers where I can figure out what's happening to them that won't be related to my claims that I'm actually submitting for payment?

Brian Reitz: Correct. When you flag them as test, the indications within the actual transaction will be that you're sending a test file. You could actually send it with production files and it would be treated as a test file when it's properly flagged. If you don't know how to do that, you would want to talk to Cahaba about that as well.

Sammie Buben: OK, will do. All right, thank you very much.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Jamie Ou. Your line is open.

Jennie Ou: Hello, this is Jennie. I want to know, what is the property and casualty. Because I'm the leading company. I write the software for the (inaudible) company now.

Brian Reitz: Well, as I said, property and casualty would be your insurers like State Farm, Allstate, when you get into loss through either fire or flood or if you've been in an automobile accident. This claim transaction is utilized for property and casualty as well as health care. So, that's what I mean when I say by property and casualty.

Jennie Ou: Thank you. I have another question, do you have the special example for the surgery EDI text file? The example for the surgery?

Brian Reitz: I'm not following what you mean by an example of surgery.

Jennie Ou: Because in the x-rays (inaudible) document you have the example for the anesthesia related, an example. Whether you have the surgery example …

Brian Reitz: The surgery is actually billed in the transaction itself at the service line. The reason why they added that anesthesia-related procedure is when the procedure being billed is an anesthesia procedure and the payer wants to know exactly what was the anesthesia for – was it surgery of the brain, surgery of the spine, et cetera, you would use the procedure code that applies to the surgery for which the anesthesia was utilized. You would put that into the transaction.

So, it goes within the same transaction. It just goes in a different place, depending on whether you're billing anesthesia codes, or you're billing surgery codes for anesthesia reimbursement. I hope that made sense. There's pretty much two ways to bill an anesthesia claim. You can bill the surgery code and put a modifier that says, this was surgery of the brain but what I'm billing for is the anesthesia for this; or you can bill anesthesia of unlisted time, and then you would have to submit in that new HI the surgery code for surgery of the brain. That would indicate to the payer for what the anesthesia was billed. I'm not a policy person so hope I said that correctly, but that’s my understanding of how it's supposed to be done.

Jennie Ou: OK, thank you.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Robin Wilson. Your line is open.

Robin Wilson: Hi, yes. I'm calling to ask about actually specifics of the PWK segment. Now I know it's claim level and line level. Now are there going to be requirements that you have to do both? Or can you do it just for the claim level if you're sending all docs for all the procedure codes billed on the claim?

Brian Reitz: No, you're free to submit where you see it to be appropriate. You can submit your PWK information at the claim level as well as if you feel like it's appropriate to do it at a detail line, you can do it there. You won't be required to do it one way or the other.

Robin Wilson: Okay, and so for example, appeals. If I'm appealing a certain procedure code, would I then do it on that detail line? Would I do it on that line level? Or would I still just go ahead and do it on the claim level?

Brian Reitz: Well, I guess what concerns me in your question is, you're talking about appeals, and that's really a separate type of process. We're talking about the submission of an inbound claim. I don't believe that appeals come in, on the Part B side, I don't believe they come in as an original claim.

Robin Wilson: OK, so, so …

Brian Reitz: Appeals is something that has to happen outside of the normal processing procedures.

Robin Wilson: OK. Because Medicare doesn't do that currently?

Brian Reitz: We don't do that on the Part B side. I think Part A has something similar for you to be able to replace previous claims with corrected claims, but I'm not a Part A person.

Robin Wilson: OK. So then, for now then, basically paper will still continue on that side?

Brian Reitz: Well, you have to recognize that Medicare has a mandatory electronic filing, so you can't bill paper if you don't meet the requirements.

Robin Wilson: Right, not based on original, but sort of (inaudible).

Brian Reitz: Right. On appeals, being manual – yes, I think that is a fair statement.

Robin Wilson: OK, OK. Thank you.

Brian Reitz: Sure.

Operator: Your next question comes from the line of Jeff Grey. Your line is open.

Jeff Grey: Yes, Brian. Thanks for answering the oxygen question.

Brian Reitz: I'm sure you appreciate that, Jeff.

Jeff Grey: Yes. Along with the FRM segments, will there be any additional FRM segments included in the 5010 versus the 4010A1?

Brian Reitz: I'm not sure I followed your question. The FRM …

Jeff Grey: Do you think there's going to be any changes to the FRM segments in the 5010 standard versus the 4010 standard?

Brian Reitz: I don't believe there are any changes to the 5010 version of FRM. It captures the same questions and answers that it did the first go round.

Jeff Grey: OK, like for oxygen claims – there wouldn't be any additional FRM segment required for 5010 versus 4010?

Brian Reitz: No, I believe that what you have on the specific CMN will cover the claim.

Jeff Grey: OK, thanks. Chris, I have one more question. For the 277 and the 999, will you be providing any samples that we can be running through our software for testing internally?

Chris Stahlecker: Hey, it's Chris. We've been asked that question a couple of times now, to put up a flat file on our website, a sample of a flat file. I believe our spreadsheets do contain enough coded examples. So, we'll take that into consideration. Let me just leave it at that with you – that we'll take it into consideration in the

posting of our flat file if we include any example of a populated version of a flat file.

Jeff Grey: All right, I guess it would be really nice to have an actual 277 that has all the ISA and the GS and everything already populated so we wouldn't have to manually do that; so I could just run it right through my system and see if I'm going to be able to create my reports correctly.

Chris Stahlecker: So you're saying you'd like to see an X12 version of a 277CA so that you could run it through your translator? Is that what you're saying?

Jeff Grey: That is correct.

Chris Stahlecker: OK. We'll take that into consideration.

Jeff Grey: OK, thank you.

Chris Stahlecker: OK.

Jeff Grey: That's all my questions.

Operator: Your next question comes from the line of Sean Stone. Your line is open.

Sean Stone: Yeah, thanks for taking my call. Just a quick question. The timeline is January 1. Optimistically, if we were approved and ready to go, March of 2011, are the MACs required then to take that, the 5010, at that point? Or do we have to wait until January 1st of 2012 before we can start submitting?

Brian Reitz: No, you wouldn't be required to start if you felt that you were ready and sufficiently tested. But you could.

Sean Stone: So they're going to run parallel then?

Brian Reitz: I believe that's the case. Yes.

Sean Stone: OK. Thank you.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Susan Montauk. Your line is open.

Susan Montauk: Hi. Actually, this is Anne Marie calling. I have Susan here with me. I just have a question – two questions, actually. Page eight, for the standardized error handling – saying that the 999 – so we're not going to get 997s anymore? It's going to say 999 when I go to download it?

Brian Reitz: Correct.

Susan Montauk: OK. Then also, now you were saying they might not be readable. I currently go through Blue Zone and I get everything directly from you guys. Is it going to be the same format, or am I not going to be able to read it?

Brian Reitz: Well…

Chris Stahlecker: Blue Zone doesn't sound like Medicare. But that would be a good question for your vendor. Ask them what they're going to present to you.

"Post call clarification - The following clarification was received from National Government Services (NGS) – Jurisdiction 13 Medicare Administrative Contractor (MAC):
Blue Zone is the IVANS connection (NSV) to the J-13 EDI front end. If the caller is using the free PCAce software, and is a J-13 provider then, NGS would be her vendor."

Susan Montauk: OK. Also page five – modification to note N403 to require nine-digit zip code. So, you're going to be rejecting claims at the submission level that don't have the actual four digits at the end?

Brian Reitz: Well, according to the Implementation Guide, it is a requirement. So, the nine is a required…

Susan Montauk: So, it's going to reject when I submit the claims? Or it's going to reject on the remittances a couple weeks later?

Brian Reitz: No, it's going to be rejected at the Common Edits Module.

Chris Stahlecker: So when you submit it.

Brian Reitz: Right. When you're submitting the claim to us, the Common Edits Module would flag that claim as an accepted with errors, because we're not going to hold the rest of your claims on account for that one error. That one particular claim would fail for the zip code size, and that would be returned back to you on your 277CA.

Susan Montauk: OK. Are we still going to get the RPT reports?

Chris Stahlecker: No.

Brian Reitz: Chris is saying no.

Susan Montauk: So, what are we going to get instead of that? You know how we usually get the three reports, like the TA, the 997, the 277 and then the next day, you know, we'll get the RPT reports? What are we going to get to show that all our claims were accepted?

Brian Reitz: Are you an intermediary?

Susan Montauk: I'm sorry?

Brian Reitz: Is this a Part A question you're talking about, RPT?

Susan Montauk: RPT being like …

Brian Reitz: Part of the FISS system, a Part A claim?

Susan Montauk: No, for Part B. Like the big file coming back, and that's where all the errors usually come back on right now.

Chris Stahlecker: CMS' intention is to replace the error handling with an error transaction.

Susan Montauk: Right. So, we're not going to get any more reports the next day? It's all going to be these reports that we get back right away?

Brian Reitz: Correct.

Chris Stahlecker: I'm not trying to suggest to you that you're going to get an instantaneous response when you send in an 837, that you're going to hang on the line to get back your 277CAs. As Brian has explained, it's a step-by-step process– first the 837 is received, and then it is processed by a translator. The high-level errors, or the TA1 level or the 999 levels would likely be returned or made available to you before the 277 Claims Acknowledgement would be available to you.

Then, depending upon any claims that are accepted, are processed by the MCS system or VMS system the next day or that evening. So, the reports that those systems may generate — and have to say I'm not familiar with the name that you used – we can investigate and find out if that is a report that is being retained. But we did intentionally replace all of the error reports with the 277, the TA1, the 999, and 277CA transactions.

Susan Montauk: OK, so that's going to be like my main report showing that my claims were either accepted or rejected? Then the 999E is going to be another report that I might get if claims kick out right away?

Chris Stahlecker: These transactions need to be processed. So, you're referring to them as though they were reports, and they're not. They're transactions. So, you will likely have a vendor that will take that transaction, process it, and produce for you something that's human readable. You need to talk to your vendor about that.

Susan Montauk: OK. All right. Thank you very much.

"Post call clarification - The following clarification was received from National Government Services (NGS) – Jurisdiction 13 Medicare Administrative Contractor (MAC):
The RPT report is the MCS pre-pass report which is only for 4010A1. Providers will not receive this report with 5010."

Brian Reitz: Thank you.

Susan Montauk: Have a good day.

Conclusion

Aryeh Langer: Unfortunately, we've run out of time for further questions. But fortunately for those who are still in the queue, Brian gave out his e-mail address. I'm sure he'd love to hear from you if you have any outstanding questions. I just wanted to reiterate that we will be having our next 5010 National call on June 30. That will be held at the same time 2:00 Eastern. A listserv message will be coming out with information on how to register for that call.

There's one other call that we're sending out a listserv message on that you'll see shortly. It's a joint 5010 and ICD-10 national call, which is going to be held on June 15. We'll have representatives, both from ICD-10 and some of the folks you've heard here, 5010 subject matter experts. There'll be a discussion of how 5010 is a precursor to ICD-10 giving folks information that's applicable to both of these outreach campaigns. So I'd like to thank Brian for his wonderful presentation today, all our CMS staff, and for everybody taking time out of their busy schedules to join us today. Thank you very much.

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

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