Centers for Medicare & Medicaid Services
Seventh National Provider Call on HIPAA Version 5010 and D.0 Transactions – 837
Institutional Claim Transaction
Moderator: Aryeh Langer
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12:00 p.m. ET

Welcome

Operator: Welcome to the Seventh National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transaction 837 Institutional Claim Transaction 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.

I will now turn the conference over to Aryeh Langer. You may begin the conference.

Aryeh Langer: Hi. Good afternoon, everybody. Again, this is Aryeh Langer from the Provider Communications Group here in CMS, and I'd like to welcome you to our seventh national HIPAA Version 5010 conference call.

This is the seventh national call we're hosting, and we'll plan on continuing to host these calls throughout the summer and into the fall. As always, we appreciate you taking time out of your busy schedule and joining us on today's call.

As you may have noticed, and I'd like to point out, that we have a new section page within our dedicated 5010 web page located on the CMS website. This web page will be the location for all 5010 national call information. The web page has presentations, transcripts, and audio versions of all calls, and is more user-friendly than the previous location.

The web address did not change. It's actually the same web address. It's at www.cms.gov/Versions5010andD0. Again, www.cms.gov/Versions5010andD0, and just click on the 5010 national calls link on the left-hand side of the screen. For anyone that did not get a chance yet to download the presentation for this call, you should go now to that site and you'll be able to locate it with today's date.

As with our previous 5010 national calls, there will be a Q&A session following the presentation. Please take advantage of your opportunity to ask questions from our Medicare subject matter experts. I'd like to now introduce our speaker for today. Matt Klischer is the Health Insurance Specialist in the Division of Medicare Billing Procedures in OIS here at CMS. Matt?

Matt Klischer: Yes. Hello. Thank you, Aryeh. I'm here at CMS. I've been here about 12 years in the EDI. I'm the subject matter expert on the 837 Institutional, and we use that here Medicare for Fee-For-Service. I'm also the subject matter expert for the UB-04. That's the equivalent paper format used for Institutional billing.

The form is maintained by the NUBC, that's the National Uniform Billing Committee. Again, I'd like to thank you for taking time out of your busy schedule to attend the call today. And, hopefully, it'll be informative and useful as far as it goes for your 5010 implementation. Please go to slide two.

The purpose of today's call is to highlight significant differences between the 4010A1 and the 5010. and to update you on the activities of Medicare Fee-For-Service related to the implementation of 5010, as well as discuss the 837 Institutional errata, as well as providing guidance on what we suggest you do, provide feedback from participants in the form of your questions and concerns at the end of the presentation.

I just want to level set that this call is focused on 5010 implementation related to the 837 Institutional transaction utilized by the Medicare Fee-For-Service and, you know, our providers. And the presentation does not address the Medicare Advantage program or the Medicare Part D insurance/plans program.

Some of the changes that have come about for the 5010, there's a lot of data elements where the sizes have changed, size of the elements have changed as far as the number of bytes for the elements. There's a – we're looking at – Medicare developed a Common Edits and Enhancements Module. We call that the CEM. And there also is a receipt control balancing process that we have developed.

Slides 3 through 16

You can go to slide three. Today's agenda, we'll take a look at the differences between 4010A1 and 5010 at a much higher level. We'll identify some of the more noteworthy differences in the transactions. We'll talk about a little bit about what CMS has been doing over the past three years and what's yet to come. We'll explain some of the errata, what's been identified in the errata for the 837 Institutional, and we'll review the implementation timeline for 5010, the 837 Institutional Transaction. We'll provide you with suggestions on how to proceed as well as some web links to some useful information that can help you with your implementation and then open the line for your questions.

We'll go to slide four. We wanted to give you some idea of what 5010 was implementing and some of the key items. 5010 uses a term called TR3. It's pretty much synonymous with the term IG that you're familiar with – Implementation Guide. It stands for the Technical Review type three. There's also language in the TR3 up near the front - we call it Front Matter - that is a lot more consistent across transaction.

The content also found where you have situational. It's a lot tighter as far as you know, they have "If not required, do not send" for a lot of the data elements. They have a lot of cases where they've tightened up the "should" language and replaced that with "must" so the implementer has a lot more idea of what's expected in the transaction.

You can go to slide five. I'm going to highlight some of the more significant differences between the 5010 and the 4010A1. The ability to put a P.O. Box in the address is now restricted. It's allowed in the pay to loop but not in the billing provider loop, not in the 2010AA. Also, the billing provider address in the service facility is now required to have nine position zip code. It used to be five, but that's increased.

The provider subrogation is added in the 2010AC loop, called the Pay To Plan. There's also modification in the SBR segment where it used to be just P, S, and T for primary, secondary and tertiary. Now, there are eight more specific payers that can be named.

There's a deletion of the responsible party and the credit card loops, because they weren't utilized. That's what was found with some outreach.

And the – there's been some modifications to many of the DTPs. There are some dates that no longer there; there's some also, some amounts that work group at X12 that works on developing the 837, they found a lot of the amounts could be calculated now. So, they were removed from the 5010.

There's also a website down at the bottom of this slide that shows a link to where you find side by side comparisons that CMS has done between the 5010 and the 4010A1. Not just for the 837-I but for the other transactions implemented by CMS.

It's not meant to be a one-stop-shop. There's not necessarily differences where you know, if the wording is different, OK? It shows what you would expect for a side by side, what in one that – is no longer in the other and vice versa. So, you can use this material in conjunction with your TR3 so that you can completely understand and accurately implement the 5010.

If you go to the next slide number six, please. Continuing with some of the differences that are found, the patient status code, it's just CL103 data element is now required. The ICD-10 qualifiers have been added to the HI, to the appropriate segment so that ICD-10 could be implemented. The Present on Admission, which currently in the 4010A1 resides in the K3 segment, that was your catch-all type segment where we had permission from the X12 work group to implement using that segment, is now moved to the appropriate HI segments following the diagnosis, you know the appropriate diagnosis codes where you can have that is where the POA would be.

The Home Health segments have been removed because they were not being used. The attending provider now must be a person. It used to be able to also not be – be a non-person. Now, they've restricted it where it must be person.

There's also description for the not otherwise classified procedure codes. And the Unit Rate, that used to be down at the line level, has been removed because the work group felt that it could be calculated.

Go to slide seven, please. I'm going to give you some information on the CEM, the Common Edits and Enhancement Module. We really wanted to standardize claim editing where we have one set of edits for each line of business and we wanted consistency among the editing. We wanted standardized error handling with the TA1. That's the top level where if you have TA1 – for example, an ISA followed by another ISA, that's a very high-level serious error. We're going to delete the whole thing. We're going to, you know, reject the whole thing, the whole file.

The 999 that replaces the 997 transaction, it communicates the actual X12 and IG for TR3 syntax violations. And it can result in all the claims being returned. Unless, it's the kind of error where we'll accept the remainder if a few are bad. And that's our 999, we call it an E for Except.

We also have a 277 Claims Acknowledgement transaction which replaces the propriety reports. And the example of a 277CA would be a claim with an invalid procedure code. We're not going to reject the whole file because of one bad claim. That's the intent for CMS. We want to accept as many good claims that are sent to us.

If you can go to the next slide, number eight. We'll continue with – part of CEM is going to be the receipt and control balancing module. The system of internal checks and balances and it flags the out of balance situations where Medicare wants to keep track of the actual claims coming in. And we want to make sure that coincides with the number of claims that are coming out. So, we have a series of controls and checks and balances with this module.

We also have the designation of a claim number assignment. We'll have that included in the acknowledgments and it allows faster access as far as the status and inquiries go. Our main purpose for this is so we don't have any lost claims.

We can go to slide nine. Some – OK, excuse me a second. Some of the changes that – for the implementation Medicare Fee-For-Service, some of the business changes that we've done in – that we're doing with our 5010, we've actually taken some steps to align Medicare's processing with the actual number of some of the elements that are available in a TR3.

Specifically, we've gone from processing eight other diagnoses. Actually, they're actually called other diagnosis in the transaction. We've gone from processing 8 to 24. And the same thing with procedure codes, the other ones that are actually specifically designated as other, from 5 to 24.

We've also increased the size of the diagnosis code element to handle the increased size of an ICD-10. We have also worked in the paperwork segment, the -PWK- where we're going to allow submission of the additional documentation that would support a claim in preparation for the upcoming attachment transaction. So that's moving forward.

And now the inbound claims will also be required to balance payments and adjusted amounts as stipulated in the TR3 Front Matter.

And go to slide 10, continue with some of the changes that Medicare's Fee-For-Service has done. One of the things we discovered was – we're going to be taking out the actual NUBC codes from our chapter 25 in the IOM in order to protect the NUBC's intellectual property.

We also have an instruction that went out to providers to allow for a way to have those codes. You can either get them from the NUBC manual, and there's a website listed and go to NUBC.org and it'll step you through how to obtain a manual. Or you can get billing assistance from your servicing Medicare Contractor. The codes for – to get some of the NUBC codes, what we'll be doing is keeping the Medicare Contractors updated with new codes as

they you know, come available from the NUBC, but it'll just to go out to the Medicare Contractors.

And go to the next slide please, number 11. Let's talk a little bit about 837 Institutional Errata. According to the Webster's dictionary definition, it's just printed work that's discovered after printing and is shown with its corrections on a separate sheet, so it's actually a list of corrections that are discovered after something has been published and delivered. So we understand that, you know. that the X12 work group, they are volunteers and they do the best of what, you know, the best that they can, but sometimes there are things that will be discovered after something is published. And one of the things was the N4 that's going to go from required to situational.

There's an addition of the Property and Casualty in the 2010CA. There's a change to the 2010BA, the Subscriber Primary ID, changing that to situational. It's required when it's a person. There's change to the – what we call the Admission Type Code in CL101-- from situational to required.

And there's changes in the LIN segment that's in 2410, in that loop down the line where they can capture a product number or device identifier. Now there's not an ability for you to have comments on this because the comment period is closed. And we do not anticipate any major problems with the, you know – it impacting Medicare Fee-For-Service implementations because of the errata changes. And there's no impact on Medicare use of transaction because of these errata changes.

Go to slide 12. Slide 12 talks about some of the time lines and deadlines that are set up as a result of the final rules to 5010. And what CMS is doing on the Medicare Fee-For-Service side.

2010, so the year 2010, we're doing internal CMS testing. And then what it amounts to, the entire 2011 year is industry testing. Then on December 31, 2011 is the last day CMS would accept the 4010A1 transaction. And the very next, January 1st, 2012, is when, is compliance for 5010. So please don't wait until the last minute as far as submitting your transactions to us. Test early, test often, and let us know when you're ready.

And go to the next slide, number 13, please. Slide 13 as I mentioned earlier has some links to some websites that give you some information on what you need to do to prepare. These websites are all public websites – they're out at CMS – www.cms.gov. You can find information on 5010 and D.0. You can find information about our MLN articles, fact sheets. When you go to the website, there's a search box up in the upper right hand corner and you can enter – for example, MLN and it will take you to the place where you can find articles, you can also go the link – the direct link that's right there. There's also a link where we have our side by sides.

In that search box you can put EDI and it will bring it to lot of sites where we have a lot of useful information on our EDI implementation files, side by sides, different helpful pieces of information. There's a site where we have frequently asked questions; that's shown a link there. There's also a link to show where you can get Implementation Guides for the – actually the TR3s for 5010.

And one of the later slides, it'll have the actual store, but there is a store link. I haven't gone lately, but I'm pretty sure that the wpc.edi.com has the link to the store also. You can go either to X12.org and you can find a link for the store.

You'll find links for where you can purchase these TR3s. There's also a link listed there where you can review X12 responses to technical comments. There's a link also where you can request changes to standards through the DSMO process.

There's a – in a lot of links here where you can click on them and use the power of the Internet to find a lot of information for you that CMS provides to implement 5010.

You go to the next slide number 14. Let's talk a little bit about what you need to prepare, steps you can take now as far as contact your vendor. You're using a software vendor. Talk to them about what steps they've taken to implement 5010 and what kind of customer support they're going to have, whether their upgrades are going to include the 999 and 277CA. The – find out from them,

you know, what their testing schedule is and how you can – you know, what testing files you need to provide if any. Just overall ask them a lot of questions on how they plan to implement 5010 with CMS.

Also, you know same with a vendor if you're using a clearinghouse, the same concept where you contact them about 5010, ask them the same questions as far as when they'll be ready and what timeframe you could – you know you can be ready if you're using a clearinghouse.

Go to slide 15. That continues with information about what to do to prepare as far as testing early and testing often. Again, the whole year of 2011 is for industry testing. That's listed there. We go with the 25 claims minimum testing with CMS Medicare Fee-For-Service.

We have- prior to being granted access to submit the production 5010 transactions, you'll need to be a hundred percent compliant for the structure and the syntax, 95 percent compliant for Medicare business rules. And on the last call, there was a statement made about, you know, approved for one, approved for all. So there's a little bit of confusion about that and what we really meant to – you know, I can provide a little bit of clarification as far as what this – what this page on slide 15 says is a – the submitter is in a test status until installed with approved software. So, it kind of clarifies what we mean as far as being ready to go into production and how long you need to be in test. And so again don't wait until the last minute.

OK, on slide 16 is where – what I did was look at some of the questions that came in and I chose a couple of them. And I'd like to now open up the queue for the questions. And as you start filling the queue, I can go over these three if that's alright? Can they do that at the same time?

Aryeh Langer: Krista, can you go ahead and do that?

Question and Answer Session

Operator: We will now open the line for a question and answer session. To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and the 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.

Matt Klischer: Yes, so Krista, what I'll do is go through three of these main questions and then I'll, you know, go return it to the queue for the questions. Would that be all right?

Operator: Please continue.

Matt Klischer: OK. Thank you.

Question one, is Medicare going to allow clearinghouses to send one claim per ST/SE?

And technically speaking, if you want to have one claim in your file, that would be one claim in an ST to SE and we don't believe that's exactly what people really want to do. That's a lot of overhead. We're actually looking for a lot of claims in a file. The TR3 actually allows you to do this but and it's the – you know it would probably be a pretty big throughput issue if you did that. So, even though it's allowed, we don't really recommend that.

Second question, will all MACs/FIs require EDI re-enrollment for Submitters/Trading Partners?

We will not be directing contractors to re-enroll because of 5010. However, some MACs maybe upgrading their hardware and software products in preparation for 5010 and then, as they do that, re-enrollment may be necessary.

And the final main question is the UB-04 changing for 5010?

And no, it's not. It does have an indicator that currently Medicare ignores. It's Form Locator 66. You need to put a nine or a zero, depending on the version of ICD. And we find that since we're just viewing, you know adjudicating on ICD-9, there's no reason to check for zero. So we don't check the bucket at all.

So, that's the three that I have and I'll be happy to address questions on the line. Thank you.

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

Gloria Davis: Hi. I have a question in regard to 5010 and Part A secondary claims. It's my understanding in the SVD loop is you said you're no longer – the 5010 no longer allows a revenue code in the 5010 and the FCD and only wants a CPT.

Aryeh Langer: Can you give us one second while we discuss that here?

Gloria Davis: OK.

Aryeh Langer: Can we have your contact information so we can get back to you on that question?

Gloria Davis: Absolutely, xxxxxx@xxxxxxx. X-X-X-X-X-X-X.com.

Aryeh Langer: OK. Somebody will get back to you after the call. Thank you.

Gloria Davis: OK, great. Thank you.

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

Renee Lin: Hi, my name is Renee Lin. I work at Tufts Health Plan. My question is around with this transaction some of the name elements have been lengthened to be longer. And I'm just wondering if Fee-For-Service will be supporting that and taking that in and passing that back out or if you're still going to follow the current name length.

Matt Klischer: We're going to follow the – we're going to allow the additional size elements in, OK, on the – as far as HIPPA compliance. But we're only – we're going to continue to process the actual sizes that we currently process today as far as the names go. A lot of that is tied to the Social Security system as far as names go. So, we're a little bit tied in that regard. But yes, we will accept the larger sizes.

Renee Lin: OK. And just to take this to clarify and to take it a little further where I'm going is on the 835, we have to send back with the errata. With the errata, we have to send back on the 835, the name that came in on 837. So I don't know if that means that you will match it, the name length that comes in or not? That's really my question…

Matt Klischer: I'm going to have to get back to her. I'm going to have to get back to you on that one, I'm going to have to check with our 835 expert.

Renee Lin: Sure, not problem at all.

Aryeh Langer: Renee, can I have your e-mail address, please.

Renee Lin: Sure, it's Xxxxx. X-X-X-X-X _ Xxx. X-X-X @xxxxx. X-X-X-X-X xxxxxx.com.

Aryeh Langer: Okay, we'll have someone get back to you after the call, thank you.

Renee Lin: Thank you so much.

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

Jim Wicker: Hi, this is Jim from Kaiser Permanente. I have a couple of questions for you. I appreciate you taking the time today to take these calls. First question is with the 277CA, is CMS going to provide a reader for that like you do the – for the 835 or is that going to be totally left up to the provider and their vendor?

Matt Klischer: That's going to be up to the provider and their vendor.

Jim Wicker: Okay, all righty good to know on that. The second question relates to the – accepting those additional diagnosis and procedure codes, in the past I think it was five and eight, now you're going to the 24. Will Medicare views all of those now in the calculation of the DRG.

Matt Klischer: Well, right now we're looking at bringing them in as far as adjudication, but there's, the place in CMS that's going to actually develop the processes for say adjudication as part of the DRG, they're still working on that CR.

Jim Wicker: Okay. So, can you update us in the future on that? Because I know that I know one of the issues we have today is on the provider side, generally, we count all the diagnosis and procedure codes and then sometimes Medicare will come up with the different DRG than we did based on only reading part of those.

Matt Klischer: Okay.

Jim Wicker: And then just a last question that's related to the testing that I've – I may have missed it if you said this, but are all the MACs going to have the same requirements as far as testing? I think you mentioned that, I think it was 25 claims and when we tested for 4010, we had to have a certain mix and types of claims. Is that going to be standard across the MACs for those of us that practice in multiple states?

Matt Klischer: I do know that we're going to have standard numbers for testing different claims types but that's – that may be different depending on the provider.

Jim Wicker: Right, but if for example, just a general acute hospital, If I have the same software and multiple states billing with multiple MACs, I could use the same general testing practices at each one of my hospitals in the different states.

Matt Klischer: That would be correct.

Jim Wicker: Okay, great. Thank you very much.

Matt Klischer: You're welcome.

Operator: Your next question comes from the line Deb – Debbie McNamara.

Your line is open.

Debbie McNamara: Oh yes, I'm calling from a provider office and just – my first thing - a statement, is there a way for you to post the questions and answers on the website, for you know for some of us. I know you have the email addresses where you're going to contact people individually but if you could post that information on the website it would be helpful. And then when and where will we be able see what a new CMS-1500 might look like or where are we going to? How soon before we might be able to see that and where is the best place to go to get the requirements for that form, with the data requirements?

Matt Klischer: Okay, your first question, yes, we plan to post questions and answers on the website. The second question about the 1500, we have a 1500 person here to answer that one.

Brian Reitz: Well, first of all, the content of this call has nothing to do with the 1500. This is an institutional forum and there is no new 1500 form so hopefully that addresses your question.

Debbie McNamara: The old form isn't changing…

Brian Reitz: Correct.

Matt Klischer: Not for 5010.

Debbie McNamara: Okay but, are you still hearing me? Oh, no.

Aryeh Langer: You're still there, Debbie.

Debbie McNamara: Okay, I understand this is for the 837 Institutional, but the information,, the HIPPA version 5010 that is affecting the 837 Institutional, so, from what I understand already is the UB is not going to change because of all this?

Matt Klischer: That's correct. Correct.

Debbie McNamara: But the CMS-1500 is going to change, correct?

Brian Reitz: That has not been decided. The NUCC, the National Uniform Claim Committee is responsible for the 1500 form and they are looking into that right now but there has not been a firm decision whether or not there will be changes to the 1500 form specifically because of 5010.

Debbie McNamara: So, should we look to the – NUCC and the NUBC for that information?

Brian Reitz: Yes, you would look to both committees for anything related to the paper forms as far as updates are concern. I actually sit on the NUCC representing Medicare so, what I'm telling you is accurate for the 1500 form.

Debbie McNamara: Okay.

Matt Klischer: That's Brian Reitz.

Chris Stahlecker: It's Chris Stahlecker speaking. I just wanted to ask Matt – and suggest that we clarify the use of the paper form and the fact that the diagnosis codes are already include on the paper form an instruction to precede with a zero or a nine to indicate if it's being drawn from the ICD-9 or 10 code set. Could you say a few words about that, Matt?

Matt Klischer: Well, right now Chris, well, right now, the, in other words the field, or the bucket that would house the zero or the nine, Form Locator 66 on the UB-04, currently Medicare ignores data in that bucket or field coming in on UB-04s because we only process the ICD-9 right now. Now, when the time comes for ICD-10 implementation, there will be instruction put out by CMS on how to start to use that piece of data, the zero or the nine. But right now, since we only process ICD-9, we ignore data coming in on that field, on the paper format.

Chris Stahlecker: But perhaps the person asking the question would realize then that, it's not necessary to make a change for diagnosis codes at this time for 5010.

Debbie McNamara: Obviously, because ICD-10 isn't in implementation…

Matt Klischer: So, when the time comes for 50, for ICD-10, when the time comes, they'll need to make changes so that they could read the data coming in on Form Locator 66 on the UB-04. What Brian is saying on the 1500, there is no designation to tell whether the diagnosis codes are ICD-9 or ICD-10 on the 1500 right now. There is a bucket – there is a form locator, a field on the UB-04 that can tell, but not on the 1500 right now.

Aryeh Langer: Can we take our next question please?

Operator: Your next question comes from the line of Brad Stuart. Your line is open.

Brad Stuart: Good afternoon. How are you doing today? I'm Brad Stuart calling on behalf of Biztech Computer. Now, we're a software vendor and we have many different clients across – spread across with different MACs, but we - they all use the same software that we're using. Do we have to be - each, does each submitter number have to pass their - the edits or can we just do it for one submitter number? And since we're all using the same software that would be fine?

Aryeh Langer: Give us a second to discuss that here.

Michael Cabral: Hey, Chris Stahlecker, this is Michael Cabral, you're probably going to want to follow up on that but it's been in the past. We felt, to answer your question, Brad, that if you're a vendor and you have clients that are installed across multiple sites, not everyone needs to go through all of the testing. If you've tested and the MAC has approved you and you bring your first Trading Partner on, it's probably a good idea to at least do a communications test and make sure your software has been installed right.

But we're not forcing every provider that has an approved vendor that has completed their testing appropriately to re-test every client.

Brad Stuart: All right. So then test per provider?

Michael Cabral: Say that again? Communication test, that's just proof to make sure that your comm hasn't been that the installation previously, as set in the second guide, is sending to the wrong place.

Brad Stuart: OK.

Michael Cabral: Chris, do you have anything to add to that?

Christ Stahlecker: Yes. And just to say it another way is, yes, if your software solution is deployed and installed at a separate location, each location would need to be assured that they had installed it correctly and appropriately, and would need to do some minimal amount of testing. But yes, your product would undergo an intensive level of testing, perhaps just one time.

Brad Stewart: OK.

Chris Stahlecker: I think we're on the same page.

Brad Stuart: All right, thank you.

Operator: The next question comes from the link of Pinku Somia.

Your line is open.

Pinku Somia: Hello. This is Pinku, I'm calling from Connecticut Social Group, and my question - this is a providers group, and my question is along the lines of slide number four, where you're talking about information that is not - if it's not required, do not send. Now, I'm talking about site taxonomy information that right now is not required by Medicare, but some secondary insurances like, for instance, Medicaid, requires those to pay their claim.

Now, will this new 5010 claim start rejecting those claims? If we start providing that information to you?

Matt Klischer: No, we will not. We will check to make sure that's a valid taxonomy code and then pass it on for coordination of benefits.

Pinku Somia: To whoever the secondary is?

Matt Klischer: Correct.

Pinku Somia: OK. I have two more questions. There was something about patient status codes. I'm not aware of this, I don't know if our current claims are being passed on with this information. Can you explain more on that? I can't remember what slide was it on.

Matt Klischer: I'm sorry. Could you say, like, what slide you're referring to with that?

Pinku Somia: Slide number six, patient status code. What status is Medicare looking for, for patients?

Matt Klischer: The patient status code is in the CL1 segment and it used to be situational and now it's required because it's for inpatient/ outpatient. It's just that you could say that, let me pull this up. The - it's now going to be required.

Pinku Somia: OK. One last question would be about the loop numbers. Are they remaining the same with the new 5010 format? Because there are some unlisted codes that we provide description for those codes in loop 2300 and 2400 at this time. So, would we need to work with the vendor to actually go back and look up what - what are the new loops, if there are any new loops going forward?

Brian Reitz: Hi! This is Brian Reitz. Can I verify - first of all, are you a provider?

Pinku Somia: Yes.

Brian Reitz: So, you bill 1500s normally or Part B.

Pinku Somia: Yes.

Brian Reitz: OK, I can address that. There's no changes related to 2300 or 2400 loop at claim or line level for what you're talking about. The changes to loops in the Professional transaction were related to secondary provider types, your rendering, referring, supervising, ordering, that kind of thing.

Pinku Somia: OK. So, whatever we have, the current information passing on in existing loops can continue with this new system too?

Brian Reitz: Yes, but you would definitely be wanting to talk, have conversations with your software vendor right now regarding 5010 to make sure that they're on board with what needs to happen and if there's something that's going to affect your business practice that you are aware and how you're going to handle that. So, definitely get with your software vendor.

Pinku Somia: OK. All right. Thank you, Brian.

Brian Reitz: Sure.

Question and Answer Session Continues

Operator: Your next question comes from the line of Gail Kindwond. Your line is open.

Deb Ribson: Yes, this is Deb Ribson, Strong Memorial Hospital. And I have a question regarding the slide 10, about the NUBC codes being removed from your internet manual. I just wanted to make sure that when Medicare does adopt a change that NUBC has issued, you're still going to come out with instructional notices and everything that tell you - tell the providers what the values are that are changing, right?

Matt Klischer: Actually, it's a little bit different than what you're saying, the - let's see if I can explain it. There - the - there are some actual NUBC codes that don't apply to Medicare at all. And when a - an entity comes to the NUBC, for example, and they - for example, if they want a newborn code but we don't process codes for newborns in Medicare for the most part, so there are some codes that we're going to inform our contractors that per HIPAA, we are going to accept them and cross them over.

Codes that do implement are – or are going to be implemented for Medicare adjudication of claim, we will, you know, actually have CRs for the providers to instruct them how Medicare is going to adjudicate on these codes that we actually process. But we don't plan on having a full announcement, you know, to the general public, on codes that we're not going to adjudicate on.

Deb Ribson: So, the codes that you will be using for adjudication will still be in your internet manual?

Matt Klischer: No, they will actually be distributed or at least announced through CRs.

Deb Ribson: OK.

Matt Klischer: Provider Education.

Deb Ribson: All right. And then one other question, you mentioned that CEM module, is that something that will be turned on for the testing?

Matt Klischer: Yes.

Deb Ribson: All right. Thank you.

Matt Klischer: You're welcome.

Operator: Your next question comes from the line of Heleno Kelano. Your line is open.

Heleno Kelano: Hi. This is Heleno Kelano from (inaudible). I have a quick question about the errata. And I've seen your timeline and it seems like you were done with development in January 1st, 2010. And my question to you is if errata are going to be implemented by January 1st of 2011?

Matt Klischer: They will not. We're thinking the earliest would be April. We're not sure of that until they're fully published.

Helena Kelano: OK. And it's my understanding that they are planning to be published in the next two weeks, is that right?

Matt Klischer: That could be – that would be optimistic, but that could happen.

Helena Kelano: All right. OK. We have a second question.

Steve Welch: Hi. This is Steve Welch from Blue Cross Blue Shield. I'm going to slide six.

Matt Klischer: So, you are actually like in the same conference room as this other person?

Steve Welch: We are.

Matt Klischer: OK.

Aryeh Lanager: Do you mind just lifting your phone off speaker? It's a little bit hard to hear you.

Steve Welch: I can't, we're on a speaker phone.

Aryeh Langer: OK, go ahead.

Steve Welch: The – on slide six, item 10 POA, the change to – aside from the change from the K3 to the HI segment, there's been a change that, in terms of situational, there's a code value that no longer exists. The code value is – of the original file has been removed, which is a 1, which is the IC indicates that the diagnosis is exempt from POA. My question is do I then assume that when I interrogate that segment and that data element, if it's not present, I treat it as exempt or do I treat it as they needed to put something in there and it's an error if it's not reported?

Matt Klischer: You treat it as exempt, and that's per the NUBC manual.

Steve Welch: All right.

Heleno Kelano: And our last question, it's related to the 999 files, are they actually mandatory or they're optional?

Michael Cabral: Medicare has chosen to eliminate its proprietary reports and standardize across our MAC implementation. We are currently requiring our MACs to produce the 999 and the 277 health care Claim Acknowledgement, also known as the 277CA in hopes that the provider community won't have to deal with some larger number of proprietary reports when dealing with Medicare program. We feel that by standardizing the acknowledgement process this way, it will benefit the provider community and both the Medicare program.

Heleno Kelano: All right. Thank you so much.

Michael Cabral: I'm sorry, it's Michael Cabral.

Aryeh Langer: Next question please.

Operator: Your next question comes from the line of Betty Gomez. Your line is open.

Betty Gomez: Hi. Yes, this is Betty Gomez with Vermed. Would you mind adding me to the e-mail you're going to send dealing on the SVD?

Aryeh Langer: We're going to post that on to the website...

Betty Gomez: Oh, good.

Aryeh Langer: Once that's over so you can go to the website and you'll see it there. It'll probably be up in about a week or so.

Betty Gomez: OK, great. Thank you.

Aryeh Langer: Sure.

Operator: Your next question comes from the line of Adam Seymour. Your line is open.

Aryeh Langer: Adam, are you there? Can we take our next question please?

Operator: Your next question comes from the line of Erin Fernandez. Your line is open.

Erin Fernandez: Hi, Erin Fernandez calling from the Cirius Group. I just wanted some clarification regarding the adjudication of the diagnosis and procedure code starting January 1, 2011. I do realize that it's opened up for testing for providers, but I wanted to know if CMS will actually adjudicate on this since I know right now they're only looking at the first nine.

Matt Klischer: Actually, Medicare's – the Fee-For-Service, we're looking at the actual CR has not been put out for policy on – I mean, they're going to use them for processing, we just don't have the information on how the, you know, the DRG is going to be built and how that's going to all work out yet. We're still working on that.

Erin Fernandez: I guess my – what I'm talking about more is for outpatient claims in regards to LCDs and NCDs. So, if there was medically necessary code in the 22nd position, is that going to be adjudicated on or is the claim going to fail medical necessity because we're still looking at the first nine?

Matt Klischer: All right. I'm going to have to get back to you on that one. Could I have your information?

Erin Fernandez: Sure. My email address is xxxxx @ xxxxxxxxxxx, one word, dot com.

Matt Klisher: Thank you.

Erin Fernandez: Thank you.

Operator: Your next question comes from the line of Tammy Beaven.

Your line is open.

Tammy Beaven: Hi. I actually have an issue before I ask my question. I – on page five of the slide, I've been trying to look at that and it keeps coming up saying, "Page not found. There's no web page that matches your entry." I'm – I was kind of wanting to look at those side by side comparisons. So, if you could address that some time before we terminate that would be great.

My actual question is, we're a very small solo practice and we use the PCAce for direct submission. We do go through an intermediary, and I guess I'm confused with the syntax – they're not really a software vendor or a clearinghouse, but is PCAce going to be something that will update and allow us to go through this entire testing procedure?

Cahaba is our intermediary, but they're not our clearinghouse and they're not a software vendor. So, I'm assuming that we have to take this upon ourselves. And as a direct submitter, I just wanted to check and see if you know if we update PCAce, are we going to be ready to roll or we're going to have to take even further action necessary?

Matt Klischer: The PCAce will be updated. That's your first question. I mean, your second actually, your second question. But the first one, make sure you don't have the asterisk when you cut and paste the website and make sure you don't have a space after the PDF at the end.

Tammy Beaven: OK. Well, I'll try it again.

Aryeh Langer: If for some reason that's not working, you can go to the website where the presentations are found that I mentioned earlier and you can actually access that from that website by using the section pages on the left-hand side of the page. If you go to Medicare Fee-For-Service, you'll be able to actually get to there from that website I mentioned.

Tammy Beaven: Oh, OK. OK.

Aryeh Langer: And if there is a problem with that link, we'll update that and that will be posted on the web.

Tammy Beaven: OK. So, just to clarify about the PCAce, everything we need to go to do as far as any changes will be there available for us and we'll feed things in just as we always have? And I'll make the changes to test for the 2000, I mean not 2000, 5010, like the zero in front of diagnosis codes and that sort of stuff. Is that correct?

Matt Klischer: That part is correct, yes.

Tammy Beaven: OK. Thank you very much.

Operator: Your next question comes from the line of Virgie Lluvido.

Your line is open.

Virgie Lluvido: Hi. This is Virgie from Caritas Business Services. Our question is found on slide five, number one. It says modification of note in 2010AA billing provider to prohibit use of P.O. Box address. Does this apply to UB-04?

Matt Klischer: I don't have that in front of me, so I'll need to get back to you. But I'm just about positive it does. I'll need to get back to you on that though.

Virgie Lluvido: OK.

Aryeh Langer: Can I have your email address?

Virgie Lluvido: It's X-X-X-X-X-X-XX-X-X, as in xxxxxx, X, X as in Xxxxx, X, @X, as in Xxxxx, X-X-X, as in Xxxxx, X.org.

Aryeh Langer: I hope someone followed that.

Male: Yeah, I don't have it.

Aryeh Langer: Can you repeat the ending of that after your first name? I'm sorry.

Virgie Lluvido: OK. It's X-X-X-X, as in Xxxxxx, X-X, as in Xxxxx, X, @-X-X-X-X-X.org.

Aryeh Langer: OK, great. We'll get back to you. Thank you.

Virgie Lluvido: Thanks.

Operator: Your next question comes from the line of Regina Parim.

Your line is open.

Regina Parim: Yes. Hi. My question is regarding a hospice claim. In the 4010 transaction, there was no way to send a Notice of Election because that claim type has no service line detail. So, those had to be submitted using PCAce or using a DDE online. Does the 5010 take it into account to now accept a claim with no service line?

Matt Klischer: So, I guess, you're asking if the 5010 can – you'll be able to submit your NOE, and the answer is no.

Regina Parim: So, still can't send a Notice of Election using the 5010 transaction.

Matt Klischer: Correct.

Regina Parim: OK. Was that considered in this – it's not possible to send a claim with no service lines or...?

Matt Klischer: Well, NOE is not considered to be a claim under HIPAA.

Regina Parim: OK. All right. Thanks for the response.

Matt Klischer: You're welcome.

Operator: Your next question comes from the line of Dawn Detech.

Your line is open.

Dawn Detech: Hi. This is Dawn with Gateway EDI. My question is on slide seven where it says, "One set of edits per line of business," what does "line of business" mean? Does that mean line of transaction?

Matt Klischer: No, it means Institutional or Professional.

Dawn Detech: Oh, all right.

Matt Klischer: Part A or Part B.

Dawn Detech: OK. Thank you.

Matt Klischer: You're welcome.

Operator: Your next question comes from the line of Dale Bush.

Your line is open.

Dale Bush: Yes. We wanted to clarify on page six, item number 12, the attending provider. We do have a situation in our emergency department setting when the patient leaves without treatments, but we bill a triage fee that we use the group's name of the physician group that's staffing. Does that mean we're not going to be able to do that anymore?

Matt Klischer: That would be correct.

Dale Bush: OK. So, that this change, we always have to have an individual physician name? Is there a reason for that?

Matt Klischer: I'm just pulling this up real quick in my – on the attending. Yeah, it's actually – I mean, the NM103 are actually the – you know it has the – the last name is for a person. That's the way the qualifier reads. In the past, it used to be a one per person or two for a non-person and they took the non-person away because they because the work group believed that actually on an Institutional claim, the attending has to be a physical person doing the – actually doing the service.

Dale Bush: OK. We'd like to clarify then something on page five.

Female: Actually, back to that, because as Jane mentioned, the ER is staffed by a group, that could be one of a couple of doctors. And, historically, we've been able to bill a triage, so in our provider dictionary, we have that group set up and they have a group NPI number.

Matt Klischer: Actually, for this particular call, I mean, I understand that there's maybe a business need and there's a procedure to address you know business need to the work group at X12. And that's what I would suggest.

Dale Bush: OK. And then our second question would be just to clarify on slide five, the prohibiting use of the P.O. Box. We are to understand that we are to use the physical address of each of the facilities?

Matt Klischer: Actually, when you have a billing provider, they are looking for a street address, not a P.O. Box or a lockbox or something of that nature.

Dale Bush: Correct. So we're using the physical address.

Matt Klischer: Correct.

Dale Bush: That was a clarification. Thank you.

Operator: Your next question comes from the line of Vishay Oldberg. Your line is open.

Vishay Oldberg: Hi, Vishay Goldbrick from Siemens. I'm wondering when you're going to be issuing a Companion Guides.

Michael Cabral: This is Michael Cabral. That's currently in our internal work plan to be a fourth quarter type calendar year 2010 activity. That would probably also require incorporation of errata, which will probably be the second version some time in the next calendar year.

Vishay Oldberg: Isn't that like kind of late, I mean, for it to be ready for everything by January 1st, issuing the Companion Guide fourth quarter could you know create a problem.

Michael Cabral: Our Companion Guide will follow the standard Implementation Guide that you already have, the Implementation Guide in your hand. The thing that the Companion Guide will cover is operating hours of our MACs, telecommunication protocols, et cetera.

Vishay Oldberg: Will it cover things like was mentioned before like the use of the expanded fields and how you were going to match the expanded fields from the 835 to 837 or 837 to 835?

Michael Cabral: I don't see that being a Companion Guide issue.

Vishay Oldberg: OK.

Operator: Your next question comes from the line of Victoria Nagatibia. Your line is open.

Victoria Nagatibia: Oh, yes. Hi. My question is all from page seven when you indicated the standardized error handling for the TA1. Will there be like a list of those types of rejections that we could be watching out for? Compilation of those errors?

Matt Klischer: Yes. They will be published on the website.

Victoria Nagatibia: Are they published now or when – next year?

Matt Klischer: Actually, when we publish CRs that have our edits, documents, for example, 69, 79 in example. When you call up one of those spreadsheets as part of that CR in the final, like the PDF, you go to – actually, there's, in that – it won't be in Excel format anymore. But it'll be in – you know when the Excel is converted to PDF, it goes through there and it will list the different scenarios for the TA1, the 999E, 999R and the 277CA will be listed, the different scenarios. You just take a look at that CR, for example, you'll find what you need.

Victoria Nagatibia: OK. Thank you.

Matt Klischer: Welcome.

Question and Answer Session Concluded

Operator: Your next question comes from the line of Ronnie Beaderman. Your line is open.

Ronnie Beaderman: Hi. And thank you for presenting today. My name is Ronnie Beaderman, I'm with Bronx-Lebanon Hospital in New York. And I was wondering if you could elaborate on the testing. Will it be syntax testing or will you be doing end-to-end with the return of actually, like adjudicated claim information?

Matt Klischer: It's actually going to be end-to-end.

Ronnie Beaderman: OK. And…

Male: No, no….

Matt Klischer: Oh… just a moment.

Michael Cabral: This is Michael Cabral again. The MACs will be able to do front-end testing with you in our A and our B system. There is a way for them to take your production claims and create a parallel – what's called a parallel production

835 and you would be able to use that to take a 5010 835 and attempt to run it through your translation software.

Ronnie Beaderman: OK. So, we actually have to pass syntax testing with CMS and then do – to run parallel, we have to go to our individual MACs to get the 5010 remits. Is that what you're saying?

Michael Cabral: No. No. No. No. Your MAC will be doing all of your testing with you. In other words, if you want to test the 837 Institutional claim with – you'll work with that – and you're in New York, so you're probably J13. So, you work with National Government Services which is the A/B MAC for New York Connecticut. You'll send them an 835 – 837 test files. They'll run it through the translator and the CEM module and they'll send you back either TA1s, 999s, or 277s as appropriate for that test transaction that you sent them.

They also have the capability inside their production system to generate a 5010 835 based upon claims that are in the systems for your organization. They'll create a flat file that will go through the CEM and actually get translated to the X12 version 835. And they'll be able to transmit that to you.

Ronnie Beaderman: OK. So, we won't get the 5010 835 off of any test claims, is what you're saying?

Michael Cabral: No. Unless you work in – that, that – we'll, we'll – that they might be able to do there – some of the MACs may do some things in their UAT environment. But that's generally not what happens in the production environment.

Ronnie Beaderman: OK. Can I ask one more question about crossover claims? Will you be going ahead and updating the list of who you will automatically cross over claims to, because I imagine that will change as they are ready or not ready for the new 5010?

Michael Cabral: We have Brian Pabst from the Office of Financial Management who happens to be over the COB area and they'll try to address that for you.

Brian Pabst: We certainly will, sir. We are going – we have that listing out there now on our website for coordination of benefit agreement and a list of all people. Of

course, not everyone's in 4010A1, but we will, in fact, make that known when they're in 5010 production. Yes, sir.

Ronnie Beaderman: And if we go ahead and start moving over to 5010, then, I imagine the people that you're crossing over the claims that are not ready for the 5010, will no longer cross over?

Brian Pabst: We have…

Ronnie Beaderman: Because New York Medicaid is always a lagger over here in New York.

Brian Pabst: Yes. That's true. Our hope is that by the time providers start sending in 5010 claims, that folks here would have already had some testing experiences to allow for them to accept 5010s in production. We'll see.

We're going to cross the claim over. And if they're not, we have the provision of doing with what we call a reverse process where they'll still get 4010A1.

Ronnie Beaderman: OK. So, even if they're not ready to take the 5010, for example, New York Medicaid which I doubt will be ready, you will be able to crossover a 4010 version of our 5010 claims to them?

Brian Pabst: Yes.

Ronnie Beaderman: Great. Thank you.

Brian Pabst: Believe me, we're keeping that January 2012 date in there very close to their visor of their windshield.

Ronnie Beaderman: It didn't help for 4010.

Brian Pabst: Hopefully, it will. Thank you, sir.

Ronnie Beaderman: Thank you.

Brain Pabst: OK.

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

Gloria Davis: Hi. It's Gloria Davis again. Back to your previous question in the CL1 information, it says that the information is required, but then there is note in the CL101 that says that it's only for inpatient claims only. But my question is if the loop is required, what about the situations when were talking about outpatient, or, in our situation that we work with Federally Qualified Health Centers and the rural health centers said do bill institutional to CMS and it's not really an admit?

Matt Klischer: I'm sorry, when you're talking about CL1, I'm not sure. Are you actually looking at a 5010?

Gloria Davis: Yes.

Matt Klischer: OK, because a required element is not going to have, for inpatient, a situational rule.

Gloria Davis: But the loop is required. So, now, you're telling me that I'm required to send that, on a Federally Qualified Health Center outpatient claim?

Matt Klischer: OK. You're on – let me see – you're on slide…OK. When you're – you are talking about slide six, correct?

Gloria Davis: I'm talking about slide six.

Matt Klischer: OK. Because that talks about CL103 and that is required.

Gloria Davis: OK. But the whole loop of the CL1?

Matt Klischer: That's correct. It's required.

Gloria Davis: OK. That's never been required on a Federally Qualified Health Center or rural health center which is really an outpatient claim, in 4010.

Matt Klischer: I'm going to have to get back because I have to pull up the 4010, didn't bring that with me.

Gloria Davis: OK.

Matt Klischer: But I will…

Gloria Davis: You got my information. I'm the one who asked about the SVD. So, if you could follow up on that as well.

Matt Klischer: OK.

Aryeh Langer: Thank you.

Gloria Davis: Thank you.

Operator: Your next question comes from the line of Tanya Crummett. Your line is open.

Tanya Crummett: Hi, we are listening in from Woodrow Wilson Rehab. And my question is on slide five, number three - the addition of the 2010AC loop Pay-to Plan section. Is there a field located on the UB that goes with that addition?

Matt Klischer: I'll need to get back to you on that since that's not something that Medicare would – Fee-For-Service would be interested in. So, I'll check on it for you.

Tanya Crummett: Yes, we've never used that, so I was just wondering where it matched up to on the claim. We didn't know what field it might be in reference to.

Matt Klischer: I'll find out.

Aryeh Langer: May I have your email address?

Tanya Crummett: It's Xxxxx, X-X-X-X-X.xxxxxxxx, X as in xxx, X-X-X-X-X-X-X@wwwxx.xxxxxxxx.gov.

Aryeh Langer: Thank you.

Tanya Crummett: Thank you.

Sumita Sen: Hi, this is Sumita Sen. I just wanted to respond to a question that was asked about the 835 name length. The answer actually – the question is actually, it's a two-part question. Part one is whether in 835 5010, the name field has been expanded? Yes, it has been expanded to be compliant. And the second question was whether the name that has been submitted would go back on the 835? The answer to that is, yes. We are doing that. Currently, we are doing that on the Part B side, but we are not doing it on the Part A side. But in – for 5010, we'll do it for both Part A and Part B.

Aryeh Langer: Thank you. Can we take the next question, please?

Operator: Your next question comes from the line of Ellen Sephalos. Your line is open.

Ellen Sephalos: Yes. We wondered about on page five about the Post Office Box. I know we don't use a Post Office Box, but we do have two different– we have the place of service and we have an address where to send the payment to. How does that affect, the fact that we can't send to a pay-to and a requirement that says, that we must have the place of service?

Matt Klischer: For the pay-to can – that can have a P.O. Box, the pay-to. It's not the billing can not.

Ellen Sephalos: So, there's still a row for the pay-to?

Matt Klischer: There is still a bucket for the – or field for the pay-to, correct. That didn't change.

Ellen Sephalos: Can you tell us what that loop? It's at the same loop?

Matt Klischer: No, that's going to be – I want to say 2010AB, but I'll get there in a moment.

Male: Should be bullet number three.

Male: No, the pay-to addresses. It's still AB.

Male: OK.

Matt Klischer: It's AB, 2010AB.

Ellen Sephalos: Thank you.

Operator: Your next question comes from the line of Lisa Man. Your line is open.

Lisa Manuel-Turner: Hi, my name is Lisa Manuel-Turner and you had mentioned that the erratas are expected for approval in April. And I'm just wondering if the MACs will allow testing or go live with the errata version before they're officially approved, or will we need to wait or potentially retest?

Michael Cabral: Let me – this is Michael Cabral. Let me clarify because what you just stated is not what we stated - what we said in the meetings here. The erratas – we need to schedule with our core systems to make those changes but they're all currently programming for the 5010 non-errata. When the erratas are adopted and pushed out, we'll need several months to get the system coded from a change request perspective. So, that's why we're saying we'll probably be ready around the April release if they're approved, which we anticipate that they will be. Did that clarify your question Lisa?

Lisa Manuel-Turner: So, we're probably not going to be able to test the errata version then until April, is that what I'm hearing?

Michael Cabral: I would not anticipate the errata being available in January. That's correct.

Lisa Manuel-Turner: OK, thank you.

Chris Stahlecker: It may be important to note that the scope of change that the errata brings to the Medicare Fee-For-Service program is not hugely significant. So, it's not really going to affect our overall timeline. This is Chris Stahlecker, thanks.

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

Annie McDonald: Hi, this is Annie, I'm in Systems and I'm a vendor. I keep – I'm like a broken record, I keep asking for this in each of these calls. But I was wondering, because we're getting closer to the time now, if there's any chance of getting

999 and 277CA test files? Because I've written my 999 stuff now. I don't what I'm going to get back from you. And you know, of course, all my tests are going to claims. So I'm always going to get accepted. So, I need to see what errors look like, you know rather than a few months down the line after I have implemented people. That's a joke, by the way. But, I'm just wondering if you guys have any plans for putting 999 and 277CA test files out for us?

Jason Jackson: This is Jason Jackson with CMS. We will actually be uploading those. We're currently in the process of finalizing those files with some minor tweaks and hopefully they'll be up probably by the end of next week posted to the website.

Annie McDonald: Wait, under the 5010 and D0, under that page, is it?

Jason Jackson: I'm not sure exactly – yes. Yes, yes, 5010 and D.0, that's where it'll be.

Annie McDonald: OK.

Michael Cabral: And those will – this is Michael Cabral – those will be generic type 999s, it's not going to be specific to any particular entity.

Annie McDonald: No, no, but the implementation nationwide across CMS will be the same, won't it?

Michael Cabral: That's our hope.

Annie McDonald: Yes, OK, great. Thank you.

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

Sammie Devens: Hi, once again, we are solo practice, very small, we use direct submission to PCAce. And I hate to rehash this P.O. Box thing, but we are in such a small area. There is no physical delivery to any of the sites in our town. The only way we can receive U.S. Postal Service mailing is if it has our P.O. Box. And our Postmaster is very stringent about that. He will sometimes even stamp "no such place" and return it unless it has our P.O. Box on it.

I'm looking at our PCAce right now and we have both the physical address and the P.O. Box in our provider information. Will that be stricken because that P.O. Box is in there? Or since the physical address is in there, will it go ahead and pass?

Matt Klischer: What I'm going to have to do is take your information and then provide the website where you can contact X12 to submit either a you know, data maintenance or what they call a DSMO request for a change because X12 needs to hear from you. And many, you know, rurals like you because what they've done on – actually – on 837-I is they've – for 5010 – they required no P.O. Boxes, no lock boxes. It's got to actually be a physical you know – and for Institutional billing that, that's what they're looking to do.

Sammie Devens: OK, well, are you guys willing to send stuff UPS or FedEx as opposed to postal service?

Matt Klischer: In fact, if that look – if you actually look – if you look on slide 13, there's a website to request changes to the standards, www.hipaa-dsmo.org and I mean that's …

Sammie Devens: OK.

Brian Reitz: Hang on one second. This is Brian Reitz. This – the limitations that are being addressed in the presentation are related to inbound claim submissions. Those are the requirements on what a claim needs to contain when you send it to us. You've already enrolled and been enumerated by Medicare. We already know where to send your payments to.

Sammie Devens: OK.

Brian Reitz: So, none of this has any impact. You just need to have a physical address in that billing loop and a pay to address in the pay to loop. That will satisfy the requirements of the transaction. We will continue to send your payments where you've requested them to be sent based on when you came to us and enrolled.

Sammie Devens: OK. So, if I eliminate the P.O. Box out of the PCAce information, will it be good to go?

Brian Reitz: Right. You're not required to send a pay-to. You just need to send a physical address in the billing loop. And you will continue to be paid based on how you've enrolled with us. If you enrolled with us and you said, "My payment needs to go to P.O. Box 123," that's where your payments are going to go. That's where your mailman is going to deliver it to. None of this is…

Sammie Devens: OK

Brian Reitz: …going to impact – this is just a requirement on your claim submission inbound to us via PCAce.

Sammie Devens: So, it's a – when you say enrolled, are you talking about PECOS?

Brian Reitz: Correct, and when you came to our door and we want to be a Medicare provider with you and we sent you that lovely 855 form, everything that you put into that form, we stored and it directs payment appropriately.

Sammie Devens: OK. So, this is just the electronic portion when we're sending it must not have the Post Office Box on it.

Brian Reitz: Well, that's actually correct.

Sammie Devens: All right. Well, thank you very much.

Brian Reitz: You're welcome.

Operator: Your next question comes from line of Laura Johnson. Your line is open.

Laura Johnson: Hi. We are a software vendor and we need some clarification as to the level one testing date. Do we – do we have to be ready on January 1st, 2011 or is it – we should be ready on 1/1/2011?

Michael Cabral Well, what the regs actually state is there were three different types of test of preparedness to be addressed. Level one was your internal testing. Level two was your – was the external testing. And what we're saying, when we put our

time line out there is we've done our build out of our system from the 2010 time frame, which is the level one date you had. The external testing can begin as early as January 1st of 2011, but must be concluded by December 31st of 2011 to be fully productionalized by January of 2013.

Chris Stahlecker: 2012.

Male: There are too many years around here. We built it in 10. We test it in 11. We're productionalizing it in 12.

Male: If you're with a vendor, you probably have your own schedule you may need to build out.

Laura Johnson: Okay. All right, thank you.

Conclusion

Aryeh Langer: Thank you. We've actually ran out of time for any further questions, but we got some really good feedback here and I think we can put together some FAQs and post them on the website and send out a listserv message. And those will include the questions that we're going to be getting back to some of the folks about who asked some of these that we need to take back a little more here.

So, once again I want to thank everybody here at CMS for participating in the call today, everybody on the line. And our next call is actually scheduled for July 28 and you'll be receiving a listserv message with information on how to register for that call. So, for now, have a great day and a happy Fourth of July.

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

END