Centers for Medicare & Medicaid Services
Version 5010: Medicare FFS Error Handling Transactions Call
Moderator: Mary Loane
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Operator: Good afternoon and welcome to the CMS Version 5010 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 call over to Mary Loane. Ms. Loane, you may begin your conference.

Mary Loane: Thank you. Good afternoon, everyone. This is Mary Loane, from the Provider Communications Group at CMS, and I would like to welcome you to the second national HIPAA Version 5010 Provider Conference Call. CMS appreciates your participation in today's call and we look forward to a very informative session. Before we get started, there are a couple of important items I would like to mention.

First, for anyone who did not get a chance to download the materials for this call, you can go now to our 5010 Web page, which by the way is the central source for all CMS 5010 information, and click on Educational Resources on the left and then download the presentation that's under the download section toward the bottom of that page. And let me give you that web address right now, it's www.cms.hhs.gov/version5010andd0 . And also on that same page

within the next two weeks, you will be able to download an audio version and transcript of today's call.

Next, a third national provider call was announced last week and will take place on September 9. If you are participating in today's call, you do not need to call in for the next call because the topics covered in that call will be the same as today but just geared to a different audience. And finally, there will be a question and answer session following today's presentation that will enable participants to ask questions of our CMS subject matter experts.

As has been the case with other national provider calls, we have a very large number of participants on today's call so we ask that you limit your question to just one per caller. And without further delay, I'd like to introduce our speaker for today, Chris Stahlecker. Chris is the Director of the Division of Medicare Billing Procedures in the Office of Information Services here at CMS. Thanks.

Chris Stahlecker: Thanks, Mary. And welcome everyone, thank you for carving time out to participate in today's call. I'm not the only one sitting here in the CMS Central Office conference room. I do have several subject matter experts to support this conversation, discussion.

And we'll see how this goes, it's the first time that we've actually targeted the clearinghouse and vendor audience to have such a technical discussion. So we welcome thoughts and feedback during the Q&A session if you have any suggestions for improvements.

Let's see, I do want to just acknowledge this is a second in a series and the first session was held and targeted as more of an informational starting point with a provider audience. And at this time, we really want to draw upon the

clearinghouses and vendors. And this content for today is pretty technical, so we do have some prerequisites. We're expecting that the audience is essentially familiar with the X12 EDI transactions and structure.

This is not to say hang up if you don't have these as prerequisites, but it is to say that you probably will get more out of today's discussion if you do have these sort of prerequisites. If you don't please, you know, hang in here and follow the material and it will come together as we go forward.

So, essentially a familiarity with the X12 EDI transactions and their structures, an awareness of the HIPAA transaction and code set requirements from the regulation. You should have access to the X12 and technical report type 3 documents.

These documents will replace the X12 and Implementation Guides that were associated with Version 4010. And I would just make a note where you can obtain these documents. But before I do that, I want to acknowledge that you must pay - these documents must be purchased. And you can find them at http:// - forward slashes, at simply store.X12.org.

When you go there, there are two tabs, one tab will be for the HIPAA 5010 TR3s and the second tab will be for the acknowledgement TR3, that's the technical report type 3.

This kind of information that you should have as you go forward and try to program to the material that we're going to cover today. So I know I'm mentioning it at the get-go, but this is something that you can follow up and obtain after today's call.

So I'm going to move forward onto to slide number 2, and talk a little bit about the regulations that we are basing our work upon. The first one is the Health Insurance Portability and Accountability Act of 1996.

And that mandated that within the health care industry, where information is exchanged electronically, the standard formats must be used and that format pertains to electronic claims and the claims-related transactions.

Then on January 15, of this year another regulation was issued and it specifically updated the version of the standards that were implemented related to the regulation in 1996. They were implemented around 2003, 2005, time frame. But this is the first time that an instruction came out to actually upgrade the version. And there's more in our - the version upgrades in just a minute on a subsequent slide.

But related to these two pieces of legislation and regulation is another piece, which is the Administrative Simplification Compliance Act or ASCA. And that actually required the use of electronic claims for providers to receive Medicare reimbursement.

Of course there is some limited amount of waiver provisioning for the small provider or certain flu shot claim types. But overall, the expectation is to move toward electronic transactions.

On slide number 3, we have the Medicare Fee-for-Service 5010 and D.0 implementation timeline. As we are trying to convey here Medicare Fee-for-Service actually got an early start. We began in October of 2008 with our first release and then essentially the calendar year of 2009, from January to January 2010; we're devoting to the development aspects of this project. And we expect to be able to begin some degree of integration testing around

January 1, of 2010, but that's an internal CMS system to system test only, it doesn't involve anybody external.

We expect our development and integrated systems testing to be completed by the end of the calendar year 2010. And that will position the Medicare Fee-for-Service application systems as productionally ready on January 1, 2011, so that providers and clearinghouses and vendors, billing agents, they can begin their transition work.

So the whole calendar year of 2011 is devoted to the transition effort, where the Medicare Fee-for-Service application systems will process both the 4010A1 format and the new 5010 format. That would be a situation that will persist until January 1, of 2012, which is when the 4010A1 format ends and Medicare Fee-for-Service systems will no longer accept or exchange the 4010A1 format. And all of this work is in preparation for ICD-10, that cutover is expected October 1, of 2013. So to summarize this right now, Medicare's status is that we're on target, we're on schedule. We do not expect to need any extensions to these deadlines.

So on to slide number 4, what actually must be changed? Well the formats that we're currently using in production are the X12 and Version 4010A1 for the suite of transactions that Medicare Fee-for-Service processes. And we need to upgrade them from 4010 and 4010A1 to 5010.

As well the NCPDP formats that are currently exchanged in Version 5.1, they need to be upgraded to D.0. And the suite of transactions that we're referring to for Medicare Fee-for-Service are listed here on slide 4, it's the claims. And please realize it's both the institutional claim, which is the 837-I, the professional claim or the 837-P, and the coordination of benefit versions of both of those formats as well as the NCPDP format for the claim.

On the remittance side, it is simply the 835 and that's the explanation of payment but it's one transaction set for all lines of business. We're going to also be upgrading our claim status, inquiry and response; 276 is the inquiry, 277, the response, and the eligibility inquiry and response, 270, 271.

All of these transactions are expected to be upgraded in the timelines that we just spoke to so that we expect all these application systems to be productionally ready by January 1, of 2011.

So what needs to be changed again? Systems that submit claims, and that's where the clearinghouses and vendors come into play as well as receiving the remittances, exchanging claim status, inquiry responses or eligibility inquiry responses.

All must be analyzed and identify software and business processes changes. And you probably already have this information but Medicare has performed a comparison of the current and new formats for these transactions. And we've listed here on slide 4, the URL where you can obtain those, a side-by-side comparison. And again our last bullet on this slide reiterates that we are going to begin the transition on January 1, 2011. Medicare Fee-for-Service will be prepared to begin then.

On slide 5, we - the purpose of today's discussion, Medicare is introducing some additional EDI standards, so please note what we saying; we're not calling these HIPAA standards. They're non-HIPAA standards but they are EDI standards from the X12 perspective. They are the functional acknowledgement. In today's world we have as 997 in place and we're going to replace that with a 999 transaction.

And we are going to be using the claims acknowledgement transaction, that's the 277CA for claims acknowledgement and that will be used to replace proprietary error reporting.

So don't confuse CA with claims attachments - that's not what this is - but it is a special use of 277. So you'll need two maps, one 277 to match up with your 276 claim status inquiry. You'll need the 277 claims status response. But this is a different use, so you'll need to obtain a different TR3, one that speaks only to the 277 claims acknowledgement.

I wanted to mention that we will be replacing certain proprietary reporting that you may currently be receiving. For example on the Medicare Part A side, I just wanted to give reference to a standard error report that you might be recognizing under the name of HV997ZRJ-A, that's a reject report that provides details on why something was rejected from the Medicare A system.

This would be the report that MedATRAN users receive - and we're going to be replacing that with the 277 claims acknowledgement. And on the Medicare Part B side, there's a series of reports, they all essentially begin with H99R and there's a number of them, these we would expect to be replaced - to use the 277 claims acknowledgement to replace.

I'm going to move onto slide number 6. We're going to give you a little bit of background about how the Medicare Fee-for-Service world is going to make all of this possible.

In the Medicare Administrative Contractor environment or MAC environment, CMS has required the MACs to use a COTS, commercial off the shelf translator product. And we are going to identify a method for the MAC to interface that output from the COTS translator to some standard system

software. So we're using a combination of both the COTS translator and components of the standard systems.

Now these standard system components you'll see abbreviated here is CEM - that stands for Common Edits and Enhancement Modules, and we're going to speak to that on a subsequent slide, so there's more to come on that in just a minute.

So we wanted to express our expectation that the translators are going to perform all the X12 syntax edits. They're going to receive the inbound X12 formats, translate them and in the course of translating them, perform the X12 syntax edits and CMS selected HIPAA Implementation Guide edits, that's again the TR3 edits. So we have made a pass through the edits in the Technical Report Threes, and selected which of specific outcomes we want to have the translators perform.

We expect the translators to output the following information or transaction sets. Essentially they're going to output the TA1 when the need is to reject an interchange and that would be based off of the ISA-IEA content. And we expect the translator will handle or recognize when a functional group, (that would be the GS to GE envelope) or the transaction set, (that would be the ST to SE envelope), is in error. We would expect the translator to recognize that situation and return that error condition using the 999 transaction.

The 999 transaction can be used to reject the functional group and this is a 999R for rejection. The 999 can also be used to indicate errors have been found but the functional group will continue to be processed. This is a 999E. The 999 can also be used to indicate no errors were found and this is called a 999A for accept. When non-fatal errors are found in the translator, the process is to continue to perform some detailed Implementation Guide edits

that CMS has selected but the result –as these edits are encountered is not to fail the entire functional group but to accept that for the next step in our process. That's not to say that we're going to accept all the transactions, the individual claims, if you will between the ST and SE, but they will be processed to identify additional errors.

We're calling that condition an “accept with error” situation and in subsequent documentation, you'll recognize that it’s indicated to you by a 999-E. And essentially that means that the data, the segments, are prepared as structurally sound but they may fail a business level edit. This condition is a structurally sound segment but non-compliant with business unit level of validation. And this data condition will be passed over to the common edit and enhancement module for further validation and potentially rejection at the individual claim level.

So we'll get into some more of that as examples in just a minute. We expect an additional output of the translator will be finally the file format that can be introduced as input to the Common Edit Module. So the flat files, if you will, are formatted by the translator for subsequent processing.

And moving on to slide number 7, Common Edits and Enhancements Error Module is essentially what we're going to talk about on this slide. This is where the Medicare specific edits will be performed and the CMS selected Implementation Guide edits are executed within the CEM module. So again this is software that's developed by the standard system maintainers and will be given to the MACs for them to incorporate in their local data center. The CMS flat files for the adjudication systems will be produced after the validation edits.

So some of the transactions may be completely clean with no errors and if that's a clean transaction, a claim number will be assigned and a 277 for a clean claim will be returned to you with the assigned claim number in it. And that will be the claim number that you can use to do subsequent claim status inquiries. So a 277 claims acknowledgement is to be returned to you for each accepted or rejected claim. The accepted claims include the claim number but the rejected claims will have a specific STC segment containing the particular error that was recognized by the Common Edit and Error Modules.

So we believe that this is an approach that will permit the MAC to do the maximum validation of information you send. And the MAC can keep the good transactions and return to you only the data that we believe is so syntactically incorrect or structurally incorrect that we do not feel we should be processing it further - that's the purpose of this approach.

On to slide number 8. CMS has developed a spreadsheet that details the edits we expect to perform in the translator and the edits that we expect the common edit enhancement modules to perform.

And the next slide, 9, is an excerpt from this spreadsheet. We do expect the entire spreadsheet to be posted on our website once we're a little more comfortable that we have all the I's dotted and T's crossed. We expect that to be within September, so keep an eye open for that.

So I think that I would like you to refer to slide number 9, and what I did was I took my slide and I put numbers going across the tops of each of the columns, so you'll see that there's ten columns. And I wanted to review column numbers 4 and 5. Number 4, is labeled TA1/999/277CA. When you are using this spreadsheet notation to examine CMS's expected returned

information to you, you'll notice that the first column has the element identifier in it.

And we have chosen the NM1 segment as an example for today's process. And this particular sample has been drawn from location of 2010 BB and you'll notice that over in column 7, the column heading is “Proposed 5010 Edits for Part B”. You'll also notice that the next column to the right says it's “Proposed 5010 Edits for CEDI”. So we have in our spreadsheet made a review of both the Medicare Part B and the CEDI edits.

This sample was drawn from the 837 professional edit spreadsheet, there will be a different spreadsheet for the institutional edits. But on this professional spreadsheet, we have listed the Medicare Part B and CEDI edits. Note that this example has the same language in both columns 7 and 8 indicating that these edits are exactly the same for Part B and CEDI.

Reviewing the information for the NM1 segment, move to the right of these columns over to column number 7. It says only one iteration of 2010 BB NM1 is allowed. And when that is not the situation, that being when an 837 is received and at this location, there are multiple NM1s, the syntax is determined to have been failed and this would be rejected. It would not be accepted for subsequent processing as in the accepted with errors situation.

When there are multiple NM1s at this location is an example of a functional group that is rejected. It will be rejected using the 999 transaction. You'll know that the requirement is to reject this condition by the R in column number 5. And you'll know the transaction that we're using to inform the receiver of this rejection by what's in column number 4. In this example, the 999 R is indicated by columns 4 and 5.

Column number 6 is labeled “Disposition and Error Code. When the NM1 occurs multiple times, Column 7 says that an IK304 has the value of 4. This is taken from the TR3. The value of 4 in this data element has a description of “Loop Occurs Over Maximum Times”. This is the process to follow to understand that data condition, edit performed and error returned.

Let's do another one. The next row down, NM101, is the Entity Identifier Code. The NM101 has a valid value at this location of “PR”. And if you look at the edit columns 7 and 8, you’ll see that the NM101 must be present. And if that's not the case, you'll see in column 6 that an IK403, will have the value of 1, to indicate to you that what you sent to the MAC did not have the NM101 populated. The MAC translator recognizesthat a required data element is missing. The resulting transaction that you will receive is the 999 R, as a reject. That tells you that additional detailed validation edits are not performed. This is the process that you'll see repeated for every row where column 4 is a 999 and column 5contains R.

Let’s look at the example of a 999 with an E. There is an example that is found three up from the bottom. And you'll see the edit situation in column 7 and 8 is that at location 2010 BB the NM103 must be 1 to 60 characters. In this case, that edit has been failed and the translator has recognized that the data element is too long as indicated by the content in column 6. The data element IK403 is equal to 5 indicating “Data Element Too Long”. As indicated in column 5, the translator will identify this as a 999E. And you will receive that 999E in the transaction set returned to you.

But because it is an E, the claim will be sent to the Common Edit and Enhancement Module for additional validation so that we can see what else might be wrong with that transaction so that we can send that information to you. And that's the same situation for the next row down, same data element.

It must be populated with accepted alphanumeric characters. And if that has failed, you'll see an IK403 data element will be populated with a 6, which means that there's an invalid character in the data element.

So I think you get the gist for how we want to express the use of the 999 back to you. A 999R means we're not keeping this transmission that you sent to us or this functional group rather. But the 999Es means that we have accepted it and we are going to process it in our next step, which is the Common Edit and Enhancement Module and that is still occurring in the local data center under the control of the MAC.

The last row on there, you'll see it says it's 277. That would indicate that the translator did not find any errors at all with what it had translated. And it did pass the data forward in that flat file we mentioned to the common edit and enhancement module. However, what we have here is an example of another error that we found in the transaction. We didn't give you the data example here but in column 6 is the content of the STC segment. The claim status category code contains “A7” that means “Acknowledgement/Rejected for Invalid Information”; the claim status code is “511” that means “Invalid Character”; and the Entity Identifier “PR” with claim status code of “504” that indicates it is the “Entity’s Last Name” that contains the invalid character. And we'll see the details of this example on slide 13.

When the Common Edit and Enhancement Module has finished processing all the data, i.e. all the claims contained within the ST to SE, the individual claim where this situation occurred would be returned to you in a 277CA transaction. The 277CA would include information on the good claims such as their claim numbers and this one claim in error. The STC segment will be returned to you with specific error information.

So that's essentially an overview of how to use the edit spreadsheet. Now I wanted to go to slide 10, and back up a little bit and just walk through an example of the TA1 and how it would be used. On slide number 10, we have the interchange acknowledgement example. And this is when the entire interchange that you had sent to one of the MACs is being returned to you.

In this example, there is an error in the ISA envelope processed by the receiver's translator with the sender ID. The sender created an ISA with an error in the “Sender Identifier” data element and subsequently, once it was received by the MAC, the MAC was unable to find it when they did their valid submitter ID check.

Under the caption “Submitted Envelopes” the ISA data content is listed. If you would refer to the first row that starts out with ISA and you move to the right, eventually you'll the Ss followed by the unintelligible space, and you'll see that lowercase S. That is the example of the incoming ISA data containing the error situation. The resulting acknowledgement transaction would be a TA1; we would not accept this submission. It would be returned using the TA1.

And what you see at the bottom of this slide, the ISA-IEA envelope would contain the TA1 and we see the interchange number, the date, the reason why this is being returned to you.

Moving over to slide 11, we have an example of 999 transaction. This is a situation where the incoming 837 had a functional group, one functional group, but what was in it had two non-fatal errors that were accepted for further processing. Each of those non-fatal errors is identified in the IK4 segments. So we've broken up the 999 example on slides number 11 and 12. And you'll see on the left side where we've given the specific segment layout.

On the right side, we've tried to label the specific data element content that you'll find in that segment.

So of course, the first segment is the ST; it is a transaction set header, followed by “999” indicating it is the Implementation Acknowledgement transaction. The next data element is a Transaction Set Control Number followed by the TR3 Guide Identification or 0050x231.
The next two segments, AK1 and AK2 serve to identify the Functional Group Response Header Segments of “HC” and “837” respectively. The interesting content begins with the IK3 segment. This example it shows that the “CLM” is the segment that contains an error and that “120” is the position of the segment within the transaction set that has an error and the value “8” is a qualifier to indicate that there was an error in a data element.

So the IK3 and the IK4 work in conjunction with each other. You'll need to move onto the IK4 to understand the very detailed error information. The IK4 has a “2” in the first IK4 01 position. And that is the data element position within the segment that had the error. So the CLM 02 had the error. And the data element that had the error is data element 782, and that “782”, is drawn from the X12 data dictionary. If you look up data element 782 in the X12 Data Dictionary or the TR3you will find that it is the data element that conveys monetary amount.

The next data element you see is I12, and that's drawn from the TR3 for the 999to convey that the segment has data element errors. The next field contains the data with the error; it's a copy of the data that was found to be in error. So the monetary amount that was received was ninety-two dollars, a decimal point and 511 penny positions. We can understand this as an invalid configuration for a monetary amount. A monetary amount assumes just two

decimal places and this input data element has three, so this is what it's being returned as an error.

Now we said there were two non-fatal errors, so that describes the non-fatal error number one. And on slide 12, you'll see the second non-fatal error. It is another IK3 and IK4 paired. The IK3 indicates the N4 segment is the segment with the error. And the position within the transaction set is 127 and the “8” indicates that a segment contains data element errors. The IK4 is explaining that ”3” is the data element position within the segment that had the error, so it would be N403 that had the error.

The data element referenced from the data element dictionary is “116”. They type of error is indicated by a “6” is again drawn from this TR3 for the 999 that states there is an “Invalid Character in the Data Element” and then we have a copy of the bad data element. So essentially that's how the 999 transaction set will be returned to you so that your troubleshooting can begin and you can determine what needs to be fixed and resubmitted if it was a 999R or in the case of a 999E, you probably want to wait to see what else comes back to you in the format of the 277CA. And we'll talk about that on slide number 13.

In this particular example, we have a submitter “Best Billing Services”. The receiver is a clearinghouse, “First Clearinghouse”. The billing provider is “Smith Clinic”. Additional information includes the submission date, number of claims, total charges. This particular file in our scenario is going to be rejected due to an invalid character. The data example shows that the extended character set is used that includes lowercase and a a prior agreement to use the extended character set is not in place.

The use of upper and lowercase is in the the billing provider name, NM1 with the qualifier of 85 for the billing provider. The data stream found on the bottom of slide 13 is what was submitted and subsequently found in error.

On slide 14 is the sample of the 277 claims acknowledgement transaction that's returned by Best Billing Service (Information Source) to First Clearinghouse (Information Receiver) to express the error that was found. You're familiar with the ST segment and the BHT as part of the X12 syntax as well as a hierarchical loop, the HL. So I'm going to drop down using the segment names listed here and draw your attention to HL2, which is the Information Receiver followed by HL3, the Provider of Service., You will see an STC is inserted at each location following the TRN segment.

It is use of the STC segment that will convey the detailed errors back to you. At the HL2 location, you'll see in STC A7 and there is a colon following that A7 followed by a 23. That is the use of a composite data element. And actually that composite may contain three data elements within it as we will see at the HL3 location. At HL2 the A7 means the claim is “Rejected for Invalid Information”; the 23 means it is “Returned to Entity”. and we would suggest the use of “40”, at this location to indicate that the entity that it's being rejected to is the receiver. If you move down to the next HL3, which is the Billing Provider of Service, you'll see the STC at that location has A7:511:85. The “A7” means “Rejected for Invalid Information”; “511” means there is an invalid character in the data; “85” means the Billing Provider” is the Entity with the error; “U” means the hierarchical loop and all content within it is rejected; “1000” refers to the Total Submitted Charges for Unit Work. The second “A7” again states that the Acknowledgement/Rejected for Invalid Information and the “504” indicates the error is the Entity’s Last Name. By using the second iteration of the composite data element in this STC, the explanation of the error is made

clear.On slides fifteen through eighteen you have each segment on the left side with the detailed explanation of each data element, its' content and purposed listed on the right side.

On slide number 19 is a review the purpose of the TA1 999 and 277CA and the potential uses of each. The expectation is to return a TA1 when there is an error in the ISA or IEA envelopes. While a positive TA1 can be requested, it is not the typical use. When an error is described by a TA1 it means the entire content within the envelops is not retained and must be re-submitted once the envelope error is corrected

There are multiple purposes or uses of a 999 transaction. When you receive a 999 that may tell you one of two things. A 999R explains that the functional group is being rejected and the 999 details can tell you where to begin to troubleshoot to make your corrections and resubmit that functional group.

You may receive a 999E that would indicate to you that some errors were discovered and you can use that 999 to locate precisely where in your submitted transmission an error was discovered. A 999E also meansthat the MAC is continuing to process the functional group and that additional errors may be identified for you in the 277CA transaction.

And finally, when you receive the 277 claims acknowledgment i.e. the 277CA, errors identified by the STC segment convey that billing data has failed the validation process. The action needed is to correct and resubmit the specific claims in error.

When the 277CA that all the individual claims have been accepted, you will have a claim number for each one of the accepted claims. And you can use that claim number for future claim status inquiries. There t may be a combination of some accepted claims and some rejected claims. You may want to capture the claim numbers from the accepted claims for subsequent claim status inquiries and correct/resubmit claims in error.
On slide number 20 are the special situations. When a business error is encountered on claim data, the claim will continue to be edited so that all errors are identified and returned to the submitter for correction. However, when a fatal error is encountered with critical envelope segments, detaile claim editing is not continued and all the claims within that envelope are returned without detailed edit results. The enveloping error is described but not the details within that envelope.

For example at a billing provider level in the example that we spoke about there was problem with the provider name. And if that information cannot be processed or they're not authorized, the detailed validation for subsequent content is bypassed. This is a little bit of a special situation.

Slide 21 addresses potential use of the TA1, 999 and 277CA. All of the - the TA1 and the 999 error situations reflect technical problems that you must address. These errors will typically require your software engineers to correct. These transactions would likely go to a technical area where a trouble ticket would likely be addressed by technical resources who would identify the corrections needed before the functional group or the transaction set could be resubmitted.

However, at the 277CA presents the business reasons for rejecting a claim. Problems with billing data is thought to be corrected by the billing

department. They will need reports and as I said early on that Medicare Fee-for-Service is not expecting to produce reports.

This is an area we expect the clearinghouses, vendors, providers who are developing their own software, to address. Software is needed to take in this 277 claims acknowledgment transaction and produce human readable error reports. Clearinghouses and vendors are encouraged to develop software solutions to process the 277CA transaction and offer a reporting capability.

On slide 22, in today's world, currently each Medicare Administrative Contractor as well as our Fiscal Intermediaries and carriers are producing custom error reports and these can vary by jurisdiction. The intent of moving to the use of the standard editing and the standard EDI error acknowledgment transactions is that Medicare enables the production of standardized reports across all of our jurisdictions, across all of the MACs. An additional positive outcome of this process is to reduce the amount of effort for clearinghouses and software vendors to perform the necessary support work for their clients.

On slide 23 is a segue to slide 24, which is information on where to go to purchase the Implementation Guides and access to the technical questions. You see that we have for X12, the http//www.x12.org. And early on I complimented that with the http://store.x12.org, and you'll find the two tabs on that page for the 5010 Technical Report 3s and the acknowledgment transactions. And then the NCPDP formats as well.

There is a site for transactions and codes sets to receive X12 technical comments and then the DSMO site is listed for you as well as additional CMS information about the Version 5010 and D0 and comparison documents. The CMS 5010 URL is finally listed at the bottom of slide 24.

There are just a couple of points to reiterate: the spreadsheets will be posted on the 5010 site and we're estimating that will be done in the next two or three weeks.

Please be reminded that it is a working document and if you program to it too early we made need to modify it so please pay careful attention to the version numbers that will be indicated. Currently, CMS is evaluating how we're going to disseminate information when an update is applied.

We recommend registering to the CMS Clearinghouse listserv. A suggestion it that you obtain TR3 documentation, come back to the website in a couple of weeks, check to see if our spreadsheets are posted and you begin your design and analysis and just be advised that we're looking for a way to disseminate notice to you when we've needed to update those spreadsheets.

And at this time I guess we can open for questions and answers. Sarah.

Operator: We will now open the lines for a question and answer session. To ask a question, please press star and the number 1 on your touchtone phone. And to remove yourself from the queue please press the pound key. We also ask that you limit your questions to one per caller. Today's conference is being recorded and transcribed, so please say your name and organization prior to asking a question.

Your first question comes from the line of Shannon Bruman. Your line is now open.

Shannon Bruman: Hello. I'm calling to find out how does this new version affect people like myself that do direct billing that we don't use an actual clearinghouse or other service?

Chris Stahlecker: If you submit Medicare claims, if you are a billing service that does work on behalf of others...

Shannon Bruman: No, I just - I work for the hospital that I bill for.

Chris Stahlecker: Okay. If they're currently billing electronically, if you're a hospital, I expect you are...

Shannon Bruman: Yes.

Chris Stahlecker: ...they will need to undergo a software upgrade to - they're currently producing the 4010 or 4010A1 format and sending that to their designated fiscal intermediary or MAC that processes the Medicare Part A claims. They'll need to upgrade from their current 4010 formats to a 5010 format according to the timeline that we talked about here today.

Shannon Bruman: Okay. Okay. Thank you.

Chris Stahlecker: Okay.

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

Susan Berrigan: Yes, I have a question on page 9. Anything that would be on the 277 would have initially been on the - initially would have gotten an A on the original submission, is that correct?

Chris Stahlecker: On slide 9, anything - could you repeat that please? Anything that what?

Susan Berrigan: What I'm saying is on the 999 you have Rs and Es...

Chris Stahlecker: Yes.

Susan Berrigan: ...and then on the 277s there is no accepted or rejected. I'm assuming that the 277 is a follow up to the Es on the 999.

Chris Stahlecker: Yes, exactly.

Susan Berrigan: Okay. Thank you.

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

Martha Johnson: Hi. This is Martha Johnson. I'm with Practice Insight. We are a clearinghouse submitter. And I just wanted to clarify on the 277 CA that that will be a response that we can expect from every single jurisdiction contractor or is this an option for each one to adopt this when we go to 5010 or will this be like every single person, TrailBlazer, Palmetto, Cahaba, everyone's going to go to the 277 CA for their Medicare responses?

Chris Stahlecker: Every one of the MACs that you mentioned will be going to the 277 CA for Medicare future service.

Martha Johnson: Woo hoo

Chris Stahlecker: May we quote you on that?

Martha Johnson: You have no idea how happy that will make our processing department.

Chris Stahlecker: Excellent.

Martha Johnson: And that's unsolicited, right? You're not waiting for a 276 request; the 277 CA will come no matter what.

Chris Stahlecker: That's correct.

Martha Johnson: Okay.

Chris Stahlecker: For the claim transmission.

Martha Johnson: For the claim, right. Okay. Fantastic. Thank you.

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

John Tice: Hi. John Tice, from Starsoft Consulting, vendor. Currently we get the 997s and I understand they're going to be replaced with the 999s but that's only for if there's a problem. It's really nice to get a positive acknowledgment on a batch level. Any plans to have a 999 on a batch level for a positive acknowledgement?

Chris Stahlecker: Yes, that’s our intention, you'll get a 999 for every one and it will tell you whether or not it was rejected or if it was accepted.

John Tice: Okay, because I had understood it was either rejected or accepted with errors. But will we get a 999 if it's accepted without errors?

Chris Stahlecker: Yes.

John Tice: Okay. Great. Thank you.

Operator: Your next question comes from the line of Betsy Clore. Your line is now open.

Betsy Clore: With Wake Forest University Health Sciences. Just a clarification on the TA1, if a submitter includes the flag of one to request the TA1 all the time, will you be returning a positive TA1 in response to that or will you only be returning the TA1 if there's an error in the interchange?

Chris Stahlecker: You know, we didn't expect anybody to want to get a TA1 if it - and hi, Betsy.

Betsy Clore: Hi.

Chris Stahlecker: If it was a positive situation. And is that something that is desired? We can take that under advisement. And we just simply didn't consider doing that at this time.

Betsy Clore: Well, we don't really care. I was just trying to clarify whether or not you were only going to do it with error thing, I just know there's been a discussion about that need, whether or not it's really needed and I just wondered which way you all were going.

Chris Stahlecker: At this time we're thinking we're not going to give a positive acknowledgement with a TA1, only when we are returning the transaction sets.

Betsy Clore: Because you'll be sending the 999 right directly after you would send the TA1, correct?

Chris Stahlecker: Exactly, yes.

Betsy Clore: Okay. Thank you.

Chris Stahlecker: Okay.

Operator: Your next question is from the line of Peter Geisagum. Your line is now open.

Chris Stahlecker: Hey, Peter. If you're talking, you're on mute. I guess we may have lost Peter, Sarah. Can we go to the next caller, Sarah?

Peter Geisagum: Oh, geez.

Chris Stahlecker: Is that Peter?

Peter Geisagum: Yes, hello?

Chris Stahlecker: Yes, go ahead with your question.

Peter Geisagum: In the IK4, you showed how elements are specified. How would composite elements be indicated?

Chris Stahlecker: We're going to let Gary Beatty address that question for us.

Gary Beatty: Pete, the IK4 segment, the very first data element itself is a composite data element. They're actually three components to that data element. The first one is the position of the data element. The second one is the component element position and when we do get to the point where do have repeating data elements you could use the third component to report a repetition number.

So using IK401, that first data link, you could point to simple data elements, components within composites or repetitions when you do have repeating data elements.

Peter Geisagum: Perfect. Thank you.

Chris Stahlecker: Is there another question in the queue, Sarah?

Operator: Your next question comes from the line of Alex Dufault. Your line is now open.

Alex Dufault: Yes, hi. I was wondering if we send a claim level Ref E9 clearinghouse identifier number will you return that on any of the acknowledgments.

Chris Stahlecker: Yes, we will.

Alex Dufault: Thank you. Will that be on the 999 or the CA or both?

Chris Stahlecker: Just the 277 CA.

Alex Dufault: Just the 277 CA.

Chris Stahlecker: Yes.

Alex Dufault: Perfect.

Operator: Your next question comes from the line of Mike Dennison. Your line is now open.

Mike Dennison: Hi. Couple of comments and a couple of questions. The comments are basically, I'm very glad to see that Medicare taking a leadership position and, you know, doing the transaction acknowledgements and in a standard manner the TA1, the 999 and the 277. And then also, obviously, very glad to see the professional edit spreadsheet. I think that's an excellent example of, you know, kind of exposing the rules so that, you know, people need to follow. And a couple of questions. Basically, will you be also doing the 277 requests for additional information and the pending status?

Chris Stahlecker: Not at this time. We would be doing a 277 request for additional information once the final rule comes out on claims attachments.

Mike Dennison: Okay.

Peter Geisagum: Pending the ...

Mike Dennison: And then the 276, 277 real time, will this be truly real time instead of fast batch?

Chris Stahlecker: We're trying to make some significant inroads with the 276 and 277, so we do expect it will be fast batch at this time.

Mike Dennison: It's not going to be real time?

Chris Stahlecker: We need to walk before we run. We're able to do real time with a 270, 271 and we would like to think that we could get to real time with a 276, 77 but we wanted to make real improvements with the content in the returned 277s first. And then we'll see how much interest we have in using the 276, 277 because quite frankly, we believe it doesn't have the market penetration we would like it to have because the data content is a little too poor for it to be

meaningful. So we wanted to address the data content first and then see where we are with its use and then consider real time.

Mike Dennison: All right. Well, thank you. Very good presentation.

Chris Stahlecker: Thanks.

Operator: Your next question comes from the line of Julie Sanderbeck. Your line is now open.

Julie Sanderbeck: Hi. I'm not very familiar with the 277s. When you keep saying 277 CA, are you talking about just a regular 277 used in a specific way? So if I were to buy the 277 standard, it's just the 277 and you apply it a certain way, is that what

Woman: ----------.

Julie Sanderbeck: Hello?

Chris Stahlecker: Yes. I guess someone doesn't have their phone on mute. So we're picking up some subsequent conversation. So, when you go out to the X12 store...

Julie Sanderbeck: Yes, I'm looking at it.

Chris Stahlecker: Yes, there'll be a couple of 277s involved. You'll likely need the 276, 277 pair for claim status inquiry. But the one we've talked about today for claims acknowledgements it's the one that's 5010 X214.

Julie Sanderbeck: Okay. I see that one. Because it doesn't mention the other that you referred to. It just has the X214. I just wanted to make sure we get the right one.

Chris Stahlecker: Right. Under that tab on the store tab, you look at the 5010 HIPAA transactions.

Julie Sanderbeck: Right. That's where I'm looking at, yes, the TR3s? Yes, that's the one that says the X214. Okay. So that's the one I would have to get then.

Chris Stahlecker: Thank you. The actual title of the guide is *Healthcare Claim Acknowledgement – (277)...*

Julie Sanderbeck: Claim Acknowledgement, yes.

Chris Stahlecker: ...Claim Acknowledgement. But it should also say ASC, X12 - well, standards - never mind. You've got the right one.

Julie Sanderbeck: Yes. I just wanted to make sure because when you guys keep saying 276 CA because we actually get 277s back from some clients. But I've never heard of it referred to that way.

Chris Stahlecker: Yes, there are a number of uses of the 277 transaction, so we wanted to be specific with you today.

Julie Sanderbeck: Right.

Chris Stahlecker: It's X214.

Julie Sanderbeck: Okay. Thank you.

Chris Stahlecker: You're welcome.

Julie Sanderbeck: Bye.

Operator: Your next question comes from the line of Maria Madrigal. Your line is now open.

Maria Madrigal: Hi. Yes, I just wanted to know how it's going to affect home health providers with these new changes. Is that also going to happen for them?

Chris Stahlecker: Yes it will. Home health providers likely will be billing electronically. Most certainly, I know that there is a waiver situation for the small, those that have fewer than ten employees. But most home health agencies are larger and are required to use electronic transactions. But you will need to upgrade to the 5010 format, everything we said today applies to you too.

Maria Madrigal: Is there a specific timeline for that or a date when that's going to be effective?

Chris Stahlecker: Yes, and we covered that on our timeline slide early in the presentation. Let me just see. On slide number 3, if you look at that slide, you'll see that you should begin soon and be able to start sending 5010 transactions to make sure you've applied your changes correctly beginning January 1, 2011, to some of your supporting contractors.

Maria Madrigal: Thank you.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Paula Serivan. Your line is now open.

Deborah Hannon: Hi. This is Deborah Hannon actually, asking that question. I have a question related to page number 21. And what I'd like to ask is it says clearinghouses and vendors may consider offering a 277 CA reporting capability. I was under the impression that all the reporting was going to be combined within the 277. Would there be a reason why the vendor, the actual clearinghouse, would have any other report to offer? They would have to report the 277, is that correct?

Chris Stahlecker: What we mean by that is to take the 277 CA and produce a human readable version.

Deborah Hannon: I had thought that's what - after I had started thinking about it more I thought that's what you meant and then - and now it makes more sense. But I didn't see that in the writing, as if that's what they would consider to make it readable. So it was confusing to me.

Chris Stahlecker: Sorry about that, but that's...

Deborah Hannon: No, that's okay. But they will have to obviously supply some sort.

Chris Stahlecker: Unless you've got a technician looking at all of these files you're going to have to have a machine readable one, yes, somebody's going to have to do that.

Deborah Hannon: And they're going to have to offer some type of 277 readable to them. Thank you very much.

Chris Stahlecker: Yes.

Operator: Your next question comes from the line of Karen Shut. Your line is now open.

Lou Ann Heatherington: Hi. This is Lou Ann Heatherington. There's some discrepancy with the 999 and whether intersegment errors can be reported as well as intersegment. Are you going to be doing just the intrasegment as the scope is laid out for that guide or are you looking at doing some intersegment as well?

Chris Stahlecker: Gee, that's a tough question. I'm not sure that we've considered that yet and I'm not sure I can honestly fully appreciate your question. So since you are - you know, you do work with us under our Medicare contract, you could send us that question, give us a little more detail behind it and we might be able to use that as a feeder question in upcoming presentations, educational forums that CMS will offer.

And this is a nice segue for us to say that we do expect to offer continued educational sessions. As CMS refines its use on these transactions we'll offer additional opportunities even if it's just a quick review and then spend most of our time with Q&A, we'll continue to offer these sessions. We haven't quite figured out the frequency yet, but there'll be more to come on that and we could use this as a feeder question Karen - or Lou Ann rather, if you would send us the details on it.

Lou Ann Heatherington: Sure. I'd be glad to.

Chris Stahlecker: Thank you.

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

Maria Erin: Hi. I'm from Covida House in Buffalo, New York. I have a question on page 14 of the 277 claims acknowledgement example. I didn't see anywhere where you're providing the claim number back to us from the CLM L1 field. Are you planning on doing that so we can reference it?

Chris Stahlecker: Yes we are. Let's just see. It's in the - in our example, it's an HL3 and in the TRN segment it's - the content is Smith 789.

Maria Erin: Oh. Okay. Great. I didn't recognize it there. Okay. So an HL3 herein. Thank you very much.

Chris Stahlecker: Okay.

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

Annie McDonald: Hi. My name is Annie McDonald. I'm from Insistence Software vendor. I had a question about the TRC documentation final version. Is it absolutely the final version now, so if we purchase it now it will not be updated like the 4010 was to the 4010A1?

Chris Stahlecker: I think that when you go to that site or have some discussion with X12, you should make sure that if there are changes that your purchase price would include the corrected changes. They've been very good about that, but I think that that's worth asking them.

No one expects to have a new version like an A1. I think that everyone is really - everyone involved in promoting the use of the 5010 transactions is trying to avoid the A1 situation.

But as errata is recognized within, you know, typos and things like that there is some publication of errata. And if you negotiate with X12 when you purchase your TR3 if future errata is addressed, likely they will give you the

subsequent documentation at no charge. But I don't want to speak on their behalf. That's something that you're going to need to coordinate with them.

Annie McDonald: Okay. And I have another quick question about the translators for the 277 CA and the TA1 and the 999. Now if CMS is not going to come up with a free program to translate these as they did with the Pro Ace and the 835 - I spent a lot of time developing an 835 to EOB translator and then CMS came up with a free copy of the program. So I really didn't recoup my cost. And I was just wondering that because we're all going to be reinventing the same wheel that you guys aren't going to come up and produce something.

Chris Stahlecker: Well, we have negotiated with Pro32, they are under contract to CMS - sub contract through our Medicare Part A contractor, our shared system maintainer, Pinnacle. And they will be upgrading Pro32 to accommodate these transactions. So the answer to that part of your question is, yes.

And as far as MREP is concerned, we will be upgrading that to handle the 5010 formats as well. So the answer to that part of your question is also, yes.

Annie McDonald: Okay. Well thank you very much. And again, like some of the others, I do appreciate the increased standardization as we go forward. It just makes HIPAA much more user friendly for everyone. Thank you.

Chris Stahlecker: Right. Oh, thank you. PC Print which is the 835 remittance receiver on the Part A side is also going to be upgraded.

Annie McDonald: Okay. Thank you.

Chris Stahlecker: Yes.

Operator: Your next question comes from the line of Kirstie Little. Your line is now open.

Kirstie Little: Yes, we just had a quick question as far as I guess where to get started as a billing company. For - I think it's on slide 4, there's a link that ends in the 5010D0.asp to that comparison sheet.

Chris Stahlecker: Yes.

Kirstie Little: Is that pretty much the best place for us to get started as far as looking at where we're at now and software upgrade, where we need to go?

Chris Stahlecker: I would suggest that, yes. And, you know, of course obtaining the TR3 documents for all the transactions that you're involved with.

Kirstie Little: Okay. So those are both available at the store link or URL that you gave?

Chris Stahlecker: Yes.

Kirstie Little: Is there also on the slide 24, any kind of software upgrade documentation specific to just a software upgrade?

Chris Stahlecker: No. What would you mean, like something like the question that was just asked about Pro32 which is also known as PC Ace and PC Print and MREP, is that what you're suggesting?

Kirstie Little: Yes.

Chris Stahlecker: We could certainly add that, but thank you for that suggestion.

Kirstie Little: Thank you.

Gary Beatty: One of the questions earlier was where is the patient account number? The example doesn't go down to the level of the patient account number. So it's not in that example, but when you do have it - when you get down to the level or the patient level within the 277 it does go in the TRN segment with a qualifier 2, same as the patient account number.

Chris Stahlecker: We can likely get into more detail in future presentations as well.

Operator: Your next question comes from the line of Leanne Lewis. Your line is now open. Ms. Lewis, your line is now open.

Chris Stahlecker: If you're talking, you're on mute. Okay, Sarah.

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

Gail Scott: Hi. This is Gail Scott, Tampa General.

Chris Stahlecker: Hi, Gail.

Gail Scott: Hi. I had a question on slide 8. I'm a little confused. It says if the 999 is output from the translator indicate either the rejected or accepted with errors. And the next bullet under that says the 277 indicates no errors found with a translator. So, does that mean that you would be - I mean that's different than the 277 CA. And so is it saying that there's not a third type of 999 coming back as in the rejected or accepted indicated by the R or E, but you would be sending back a 277 to indicate there were no errors.

Chris Stahlecker: So we tried to have slide number 8, and 9, kind of work together and what we failed to have on here was an example of no errors...

Gail Scott: Okay.

Chris Stahlecker: ...or the claim 999 being returned and we'll add that.

Gail Scott: Okay. So there would be a 999 totally accepted with no errors.

Chris Stahlecker: Correct.

Gail Scott: Would that be an A?

Chris Stahlecker: I think that's the plain 999.

Gary Beatty: Yes.

Chris Stahlecker: It's just a plain 999 with no suffix.

Gary Beatty: Well, yes, I mean it does have an A on it.

Chris Stahlecker: It does?

Gary Beatty: Yes.

Chris Stahlecker: Thank you. Thank you, Gail, good catch.

Gail Scott Thanks. Bye.

Chris Stahlecker: Bye.

Operator: Your next question comes from the line of Sue Knight. Your line is now open. Ms. Knight, your line is open.

Joe Knight: This is Joe Knight, is that acceptable?

Chris Stahlecker: Hello to you, Joe, go ahead.

Joe Knight: I have a question related to slide 7, 11, and 12. On slide 7, you imply that a set 277 CA will be accepted or rejected - or will be sent for each accepted or rejected claim implying that there's a one for one relationship between 277 CA and a claim.

On 11 and 12, you start out with an ST and end with SE. Does this imply that you are going to open and close an ST SE for each claim or will there be multiple claims in a single ST SE?

Chris Stahlecker: We're expecting there will be multiple claims within the ST and SE.

Joe Knight: Okay.

Gary Beatty: Even be very clarifying, the 277's health care claim acknowledgment does the transaction level. It operates at the ST to SE, so a bundle of claims would be acknowledge via the 277 health care claim acknowledgement.

Joe Knight: But there will be multiple acknowledgements for multiple claims within a single ST SE?

Gary Beatty: No, there would be one 277 transaction that acknowledges many claims.

Joe Knight: Okay.

Gary Beatty: And to your point of sending a single claim ST to SE, that's highly un-recommended. It is a resource problem for our contractors as well.

Chris Stahlecker: I mean, once we get...

Joe Knight: You do not have a 277 CA for each claim.

Gary Beatty: Repeat that one more time.

Joe Knight: You do not have a 277 CA for each claim.

Gary Beatty: When a health care claim 837 transaction comes in with three claims you can acknowledge that with a single health care claim 277 with three STC segments that say the status of the claim whether it was accepted or rejected. But it would be one 277 transaction that would - performing that activity.

Joe Knight: Thank you.

Operator: Your next question comes from the line of Stacy Sanchez. Your line is now open.

Stacy Sanchez: Hi. I was just wondering when that September 9, teleconference was going to be available to register. And if it is available now, where do I go to register?

Chris Stahlecker: We think probably within a week or so that you can come back and look on the site. We're trying to figure out how to communicate that the registration is open. So once that is - the distribution list is identified that should be forthcoming and...

Stacy Sanchez: It'll be on the website as well.

Chris Stahlecker: ...it'll be on the website as well.

Stacy Sanchez: Okay. Thank you.

Operator: Your next question comes from the line of Marlene Peak. Your line is now open.

Marlene Peak: Hi. Great presentation. CMS offered before the 4010 to 5010 PDF and Excel files. Are you going to do that for the 997 to the 999 and for the 277s or not?

Chris Stahlecker: No, we did not expect to do that. The - we're not trying to say that there's only one mapping from a 999 that might be your discretion to whatever format you want to map it to. And so - and the same with the 277 CA, we were expecting you would take it and make it a version of a readable report for your client. So, no, we did not expect to do that mapping.

Marlene Peak: Okay, because the other ones were very helpful. Thank you.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Donna Lamoko. Your line is now open.

Chris Stahlecker: Donna, if you're talking to us, you're on mute.

Operator: Your next question comes from the line of David Miller. Your line is now open.

Olek Simpkin: Hi. This is Olek Simpkin from Nebo Systems. I'm talking on behalf of David. I have a question regarding the 277 CA. Right now you're stating that CLMO1 will be returned. However, that's not enough to uniquely identify a claim. Are you going to provide anything else like the I Sud, FT - the functional control number or maybe the Ref B9?

Gary Beatty: Yes. David, on the clearinghouse, that's a qualifier, the D9, and it does get returned with a clearinghouse claim control number assignment. We're looking to have that passed through the inbound 837 translation to the outbound 277 formulation that goes back to you as a clearinghouse provider.

Olek Simpkin: Where would the Ref B9 be returned then?

Gary Beatty: It in a Ref segment within the 277. It's one of the Refs at - Loop 2200 – Claim Status Tracking Number (page 86 of the TR3 005010X214)

Chris Stahlecker: We'll have to cover that in a future discussion where the clearinghouse location of the clearinghouse ... So I guess we'll take away from your question that you would like us to be sure that we include the claim number assigned by the clearinghouse.

Olek Simpkin: Yes, because the COMO1 is very much not a unique identifier especially for clearinghouses because our providers tend to reuse claim numbers for the patients.

Chris Stahlecker: Yes, when we get some examples on our website and...

Michael Cabral: Page 86.

Chris Stahlecker: Okay. We're being referred to here - thank you, Mike. On page 86 of the 277 TR3 it is...

Olek Simpkin: 86 or 76, I'm sorry.

Chris Stahlecker: Eight six. And it's in loop 2200D, claim status tracking number and it's got a qualifier of D9 for claim number.

Olek Simpkin: Okay.

Chris Stahlecker: The segment name is Ref hyphen claim identifier number for clearinghouse and other transmission intermediaries.

Olek Simpkin: Okay. Excellent. Thank you.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from the line of Monique Harold. Your line is now open.

Monique Harold: Hi. My question has to do with the timing of getting the responses back. Can we expect both the 999 and the 277 CA to come back quickly or is it kind of a next day or next week or any sort of timing constraints?

Chris Stahlecker: Our expectation is that you will receive a TA1 and 999 fairly quickly after sending in an 837. The 277 CA would likely be a separate event. We would like to think that that's going to come back to you fairly quickly not too long after the 999 but it depends essentially on time of day that you sent it and if there are - if it's end of day processing, middle of the night processing, that kind of thing.

So we'll have, you know, additional discussion about how to articulate expectations for the timing of the return and we'll address that in future presentations.

Monique Harold: Thank you.

Chris Stahlecker: But the takeaway for today is it should be fairly quick.

Operator: Your next question comes from the line of Andrew Bell. Your line is now open.

Andrew Bell: Hi. My name is Andrew Bell, and I'm with a software group, we're a small software vendor. And I just had a general question. The nightmare that we have is that from one intermediary to the other even so they're supposed to comply with let's say 4010 or 4010A1, they're still allowed to deviate from these formats.

So like some of our clients have two programs to file with Palmetto, one is to do the Railroad Medicare, the other one is the Medicare. Because is there any assurance that intermediaries from now on will be kind of strongly encouraged to stick closer to the 5010 format or...?

Chris Stahlecker: Well, you're asking a couple of questions. One is if there are difficulties with getting payers to accept the current format. If they're not then you really should be making a complaint to the CMS OESS, the Office of e-Health Standards and Services. And you can access them via our website. That's part of your question. For the Medicare Fee-For-Service Contractors, they will all have very similar solutions executing the same edits, returning the same error handling reports as we've all described today. So from a Medicare Fee-for-

Service perspective, we are trying very hard to make that be a standard process. Did I answer your question?

Andrew Bell: Pretty much. I suppose we cannot really look ahead in the future. I was just thinking of one example where one Medicare Intermediary required a certain entry in the file and the other one, that intermediary lost the contract and another intermediary took over. They required a different line. And, you know, it's the same format.

In other words, any time the intermediaries change, we have to more or less kind of reduce most of the programs simply to comply with the, you know, what the new intermediary wants.

Chris Stahlecker: We empathize with that situation and that is essentially why we're trying to standardize this whole EDI exchange process as much as possible so that future business changes whatever they might be in terms of, you know, contractors that you send Medicare claims to, your experience should essentially be the same. You'd have a different contractor ID number perhaps; different TCP IP address perhaps but your experience with receiving errors and error handling that should essentially be the same. So that's one of the objectives of this approach we're taking for the 5010 implementation.

So we hope that we achieve that. We also know that other industry action groups are looking at hard at implementing these transactions, so Medicare isn't alone - Medicare Fee-for-Services isn't alone - in trying to pursue this. And we also expect to get some synergy, if you will. When we post our detailed editing spreadsheets in the error handling selections that we've made we will be going to X12 and asking for additional code values to express some of the detailed edits. Where they may be insufficient right today, we expect to get some additional code values to fully describe the errors. So we believe that

we're taking the best steps that we can think of taking to get to that consistent process that you're looking for.

Andrew Bell: Well, I appreciate your time. Thank you very much.

Chris Stahlecker: Welcome.

Operator: Your next question comes from the line of Randa Kefelix. Your line is now open.

Randa Kefelix: Hi. This is Randa, I'm calling from California and we're one of the vendors who had to transition from NHIC to Palmetto, which by the way has gone much smoother than we thought it would. But our question has to do I guess more with the - and I think one of your people answered it. I just wanted to reiterate.

On the CLM portion of the files, when it comes in we're sending right now, we're sending a unique sequence number in the data file. And we wondered, when that information comes back, is that sequence number also going to be included on the - I guess it's the 999 - or, I'm sorry, the 277 CA, if there's an error?

Chris Stahlecker: The sequence number?

Gary Beatty: Are you referring to what you put into CLM01 for the patient account number?

Randa Kefelix: No, not necessarily, but we have what we call is a unique transaction number for each set of claims within a batch, so if I have five claims and I'm sending a batch with five claims, each one of those has one transaction line.

So for example, the first transaction line I have a unique sequence number of 20. The other one is 21, 22, 23. When we get the file back, will you those also included in it or is that something that - I mean in the CLM portion of it, or is the CLM always going to be just the account number?

Chris Stahlecker: If you give us your phone number, we can place a follow up phone call with you and try to understand and appreciate your question. Because we need to flip through some of the documents here and we might be able to address more calls if we take this one offline.

Randa Kefelix: Okay. I mean I can always go look online later. But I also had a question about your spreadsheets on Page 9. On the spreadsheet, is this just going to be on your website are you just going to have samples of the edits that can occur based on the error numbers that you have, or are the error numbers going to be included, much like what they have for the MACs right now. They have for example error ML1 and that indicates that there's a problem in the 2010 AA list for whatever. Is that going to be part of this spreadsheet information as well? Are you making it current for all of the loops and segments that may have caused an error or...?

Chris Stahlecker: Yes, we've actually used the outline of the data element spreadsheet and we've applied the edits that we are planning to apply to each of those elements. And so it should be a very robust spreadsheet.

Randa Kefelix: Okay. Great. Well, thank you very much.

Operator: Your next question comes from the line of Peter Geisagum. Your line is now open.

Peter Geisagum: Hi again. I have a question regarding the TR3s for the acknowledgment. On the X12 - the store dot x12.org website, they list the 997 and an 824. I thought the 997 was going away and I don't know what an 824 is.

Chris Stahlecker: For Medicare Fee-for-Service we are replacing the 997 with the use of the 999. And so although X12 continues to offer it and many other transactions, we're going to be using the 999. You could look for the 5010 X231 TR3 guide.

Peter Geisagum: Yes.

Chris Stahlecker: That should be the one you need for the Medicare Fee-for-Service 999.

Peter Geisagum: So for non-Medicare use they can continue to use the 997?

Chris Stahlecker: Non-Medicare can do whatever they - you know, that's separate, we can't speak to that. Just the 824 is not one that Medicare Fee-for-Service is going to implement.

Peter Geisagum: Okay. Thanks.

Chris Stahlecker: Okay.

Operator: This concludes today's Q&A session.

Mary Loane: Okay. This is Mary Loane. I did want to say the September 9, call was announced and I do know that it is posted on our 5010 Web page, the registration information. So if you go to the www.cms.hhs.gov/versions5010andd0 and go to the Educational Resources in the download section, you will find the registration information. And the

same presentation will be made at that call, but you can register again and submit questions ahead of time if you so desire. And at this time I'd just like to thank everybody for participating on today's call and remind you to be on the lookout for new educational products and announcement of any future calls that we'll be distributing via listserv messages and postings on that 5010 Web page. Thank you very much.

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

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