Centers for Medicare & Medicaid Services
16th National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions - Call to Action: Test!
Moderator: Charlie Eleftheriou
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Contents

Operator: Welcome to the 16th National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions - Call to Action: Test!

All lines will remain in the listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed.

If anyone has any objections, you may disconnect at this time. Thank you for participating in today's call.

I will now turn the conference call over to Mr. Charlie Eleftheriou from the CMS Provider Communications Group.

Sir, you may begin.

Introduction

Charlie Eleftheriou: Thank you, Sara. Hello, everyone. As Sara introduced, this is Charlie Eleftheriou from the Provider Communications Group here at CMS and I'd like to welcome you to the 16th National Provider Conference Call on HIPAA Version 5010 and thank you for your participation.

Today's presentation will be a call to action to test for 5010 readiness. Today we're offering the option to view this presentation via an Internet-based webinar program called Adobe Connect Pro, and all registered participants should have received an e-mail with instructions how to log on.

This webinar allows participants who have an Internet connection to share the presenter screen and follow the presentation in real time as it is given. You will also have the opportunity to answer polling questions – oh, I'm sorry. Scratch that.

Please note that joining in on this webinar portion of the presentation involved here will not – it will not have any negative impact on those participants who have dialed in today and are listening only to the audio portion of the presentation. You will not be at a disadvantage.

If you've not yet logged into Adobe Connect Pro and would like to access the webinar for today's call, please use the following URL: https://webinar.cms.hhs.gov/medicareffs5010.

Please sign in as a guest when prompted and enter your first and last name. For anyone who will not be following along with the Adobe Connect Pro Live webinar, please visit the version 5010 and D.0 website now.

The web address for that is www.cms.gov/versions5010andD0. Visit the 5010 National Calls link on the left side of your screen and then click on today's date at the top of the list to view this call's information page.

There you'll find a link to the presentation at the bottom in the Downloads section. Once downloaded, you can manually follow along while listening to the audio portion of the presentation.

If you've not – I'm sorry. The Provider Communications Group thanks those of you who have chosen to participate in today's call via Adobe Connect Pro, as it will make future national provider calls more interactive and user friendly, and most importantly more productive.

Following the presentation, there will be a question and answer session giving you the opportunity to ask questions of our Medicare Fee-For-Service subject matter experts.

One last item of note, we've established the new 5010 Fee-For-Service information e-mail box. This e-mail box accepts questions a day before, the day of, and the day after of 5010 National Call.

To submit questions related to – specifically to this call, please e-mail 5010fssinfo@cms.hhs.gov and answers will be posted to the 5010 website as soon as possible.

Again, this mailbox is only available to receive e-mails the day before, day of, and day after a 5010 national teleconference. The e-mail address again is 5010fssinfo@cms.hhs.gov.

With all that said, I would like to now introduce Angie Bartlett from the CMS Office of Information Services. Angie?

General Overview

Angie Bartlett: Going to move on to slide one. Good afternoon. My name is Angie Bartlett and I'm a Health Insurance Specialist for the Centers for Medicare & Medicaid Services, specifically on the Medicare Fee-For-Service side of the house as an electronic data interchange subject matter expert.

I'd like to thank you all for taking time out of your busy day to join us on this call. I appreciate the opportunity to provide you with useful and valuable information about HIPAA 5010 in general, as well as what CMS has been working on related to the implementation of CMS programs for 5010 D.0.

I am joined today by a panel of our Medicaid- our Medicare 5010 team, as well as our staff on Medicaid, 270/271 Medicare eligibility, and our coordination – our Coordination of Benefits Contractor.

We are now going to move over to slide two. The purpose of today's call will be to focus on discussing 5010 D.0 readiness for Medicare Fee-For-Service, COBCs, HETS, and Medicaid while emphasizing the necessity to test now.

In addition, we'll be providing guidance on what to do next to prepare for the transition. On to slide three.

On slide three you'll see our agenda. We're going to do a general overview of the Medicare Fee-For-Service perspective, HETS 270/271, coordination of benefits readiness review, and our Medicaid readiness review followed by our question and answer session.

For our panel today, it's myself, I am a Health Insurance Specialist. As I said, with the Division of Transactions, Applications, and Standards for the Office of Information Services. And Brad?

Brad Beatty: Good afternoon. This is Brad Beatty. I manage the MCARE Help Desk that supports the HETS 270/271 Medicare eligibility system.

Brian Pabst: Good afternoon. It's Brian Pabst, I'm the Technical Advisor and the COBA Government Task Leader in the Division of Medicare Benefits Coordination. What I primarily work on is the 837 institution and professional COB cooperative transactions.

Elizabeth Reed: And I am Elizabeth Reed. I am a Health IT Specialist with the Division of State Systems, Center for Medicaid, CHIP, and Survey and Certification.

Medicare FFS Perspective on 5010/D.0 Readiness

Angie Bartlett: OK. Now, we're going to move on to slide five. So, who needs to know about Medicare Fee-For-Service implementation of 5010 and D.0?

If you are a covered entity under the Health Insurance Affordability and Accountability Act, HIPAA, you are mandated to comply with the transition to 5010 D.0 for electronic administrative transactions.

There are a number of electronic transactions supported by Medicare Fee-For-Service, all of which you've heard about this year if you've been tuning in to our previous national calls.

Specifically they are the institutional and professional claims, the 837-I and P; the Eligibility Inquiry and Response, 270/ 271; Claims Status Inquiry and Response, the 276,/277; the Remittance Advice, the 835; and CMS implementation for standard acknowledgements, the TA1, 999, and the Health Care Claim Acknowledgement, the 277.

On slide six, let's first focus on the overall HIPAA compliance dates for 5010 D.0. We began several years ago to get this – to get to this stage, but in January, assistance was made available for external Trading Partner testing to begin with the Fee-For-Service translation software, which includes the standardized acknowledgements.

In April of 2011, the transition software implements- implementation was updated for the – for the transactions which had the allotted changes.

The timeline at the bottom of the slide is the quick snapshot of our expectations and where we are now in regards to testing and production.

On to slide seven. Currently MACs are conducting Trading Partner testing with the errata version of 5010, as the errata versions of the CEM have been deployed into production. For Part B, Trading Partners may be promoted to production upon successful testing with the MAC.

Please note, Part A Trading Partners should continue to test with their MACs, but will not be moved to production until early July following the successful implementation of the July quarterly release.

In addition, we are pleased to announce that external Trading Partners for B are now sending live 5010 claims and claim status inquiries to production.

In addition, the MACs began Certification Testing in December of 2010. MACs are currently working with translator vendors to resolve functionality issues and deviations. CMS is in the process of reviewing the MAC deviations to determine what issues require a resolution.

We are expecting Certification Testing to be completed no later than June 3rd. So, that's right around the corner.

Slide eight. This slide shows that the 5010 transition will be handled by only 10 MACs, plus CEDI for DME, and the remaining eight legacy contractors. These eight legacy contractors have already paired with the existing MACs for a seamless transition.

In most jurisdictions where MACs are not yet awarded, a provider should contact their local FI or carrier for information on the transition 5010. All others should contact their locally-awarded MAC.

On to slide nine. This slide shows the current maps of MAC jurisdictions. If you are unsure of your MAC, please make note of the jurisdiction number on the slide, and you'll see the name and the contact information on the following slide.

On slide 10, here's the contact information I was speaking of on the previous slide. If you do not see your jurisdiction, please note that towards the end of the presentation, we have a slide which provides general contact information related to the help desk of Part A and B which will be very useful to you.

At this point, I'm going to turn the presentation over to Brad Beatty to discuss the HETS 270/271 Medicare eligibility transaction.

HETS 270/271 Medicare Eligibility Readiness Overview

Brad Beatty: Thank you, Angie. Again, my name is Brad Beatty. I manage the MCARE Help Desk that supports the HETS 270/271 Medicare eligibility system.

HETS is an acronym for HIPAA Eligibility Transaction System. HETS is the nationwide Medicare eligibility application that is located in the CMS Baltimore Data Center.

Let's move to slide 11, please, HETS 270/271 Medicare Eligibility: Preparing for 5010A1.

The entire HETS application was recently transitioned to a new environment that has improved system performance for 4010A1 transactions. This new environment is also ready to support the X12 5010A1 standard.

HETS submitters began sending 5010A1 test transactions to HETS last month. Currently, more than seven percent of HETS submitters have begun 5010A1 testing.

There are a handful of HETS submitters that have already begun migrating their HETS 270/271 production traffic to 5010A1 as well. HETS and the MCARE team will participate in CMS National Testing Days in June and August of this year, but we want to emphasize that there's no reason to wait. You can contact MCARE immediately to begin discussing your testing schedules.

Moving to slide 12, HETS 270/271 Medicare eligibility system changes for the 5010A1 version. CMS made a number of changes to specific transaction elements in the 5010A1 version for general compliance with that standard.

5010A1 requires that payers support new beneficiary search options and HETS 5010A1 supports those options. HETS also returned new AAA error codes for beneficiary matching errors.

HETS now offers enhanced Service Type Code supports. HETS now returns specific beneficiary data for nine new Service Type Codes.

Documents detailing all of these changes both to the 270 request and the 271 response are available online at the HETSHelp website. So, please visit http://cms.gov/hetshelp and click the 5010 information-270/271 link for more information.

Next slide, slide 13, HETS 270/271 Medicare eligibility testing, let's discuss how the testing process will work.

Direct Trading Partners, that is those organizations that have a HETS 270/271 submitter ID and send their transactions directly to CMS, these organizations need to test 5010A1 with MCARE.

Submitters should contact MCARE to initiate the testing process. Submitters will need to provide at least 24 hours advanced notice to ensure that your testing profile is updated and ready to test in HETS.

The testing process is relatively simple. CMS requires all HETS submitters to obtain a successful 271 response with benefit information. We'll also work with you to ensure you receive a sample 271 with a AAA error to ensure that you're handling those errors successfully.

CMS permits a maximum of 50 test transactions to be sent to the 5010A1 system. Indirect Trading Partners, those of you that do not have your own HETS 270, 271 submitter ID, but instead submit your transactions through a vendor clearinghouse or aggregator, these Trading Partners must contact their

vendor, clearinghouse or aggregator for additional information about how your partner will be testing Medicare eligibility.

Next slide, slide 14, HETS 270/271 Medicare eligibility, tips for successful testing. We have a couple of specific recommendations for HETS 270/271 submitters based on testing that has already occurred.

We will update and post a copy of this slide on the HETSHelp 5010 270/271 information page that we mentioned earlier.

So, the first suggestion that we have is pertinent to the gender code, that is the 2100 DMGO3 element, and the middle initial, the 2100 CMN105 element.

Under the 5010 A1 standard, these data elements cannot be present if you are using the primary beneficiary search option. That's the same search option that HETS users have been using for the last five years.

If you use that primary search option and you send either or both the gender code and/or the middle initial, the result will be a 999 response to your request.

These data elements are not required for any of the beneficiary search options that are supported. Again, gender code, middle initial, are not required for any of the search options. So, CMS' recommendation is simply do not send this data in your 270 request.

Number two, the actual version that needs to be sent in elements GS08 and ST03 of the 270 request must indicate that the request is a 5010 A1 version request.

The value that must be entered in this element is, quote, "005010X279A1." That A1 is the key. Some of our initial testers for 5010A1 have not been including that A1 at the end of that element. Again, that's in the GS08 and the ST03 elements of your 270 requests.

Number three, CMS has made changes to its rules for returning preventive, blood deductible, smoking cessation, and therapy capped data in the HETS 271 response.

Effective with the 5010A1 version, HETS will only return these data elements if a Service Type Code 30 is sent in the 270 request. Otherwise, this data will not be returned in the 271 response.

This was a requested change from HETS submitters and we hope that it meets your needs accordingly. So, we have preventive, blood deductible, smoking cessation, and therapy capped data would only be returned if you send in a Service Type Code of 30 in your 270 request.

And finally, number four, CMS would like to note at this time, per the 5010A1 errata standards, HETS can only successfully return a 2000C TRN03 element in a 271 response if that value begins with a one, a three, or a nine.

The TRN03 value in the 270 request is a user-defined field. The 271 response is simply echoing back what you were sending in your 270.

So, CMS would request at this point that submitters, if you are choosing to use a 2000C TRN03 element in your 270 request, that you begin that number with a one, a three or a nine. Failure to do so at this time per the current standard would result in a 999 error.

OK. Let's move on to the next slide. Slide 15, please. HETS 270/271 Medicare eligibility and resource. The MCARE Help Desk is available via your phone at 866-324-7315. Our e-mail address is mcare@cms.hhs.gov. 5010A1 testing is supported Monday through Friday from 9:00 a.m. until 5:00 p.m. Eastern Time.

Please do remember that submitters need to allow at least 24 hours advanced notice to the MCARE team prior to beginning your testing efforts. We've mentioned it a couple of times that the HETSHelp website listed here – again, that's http://www.cms.gov/hetshelp and then clicking the navigation bar on the

left-hand side to the 5010 information-270/271 link, that is your very best resource for getting started with testing HETS 270/271 Medicare eligibility.

That concludes the HETS portion of the presentation. So, I'll turn this back to Angie Bartlett.

Angie Bartlett: Thank you very much, Brad. We're now going to turn the presentation over to Brian Pabst who is going to discuss coordination of benefits.

COB Readiness Overview

Brian Pabst: Thank you, Angie. Good afternoon, everyone. I wanted to begin my discussion by giving a context for this whole discussion, that is the COB or crossover process. I think most of you are familiar with it, but just to be on the safe side, I'll go over it briefly.

Crossover refers to the process whereby the Coordination of Benefits Contractor, on behalf of CMS, transfers Medicare Fee-For-Service claims electronically to other insurers or health plans.

Currently Fee-For-Service Medicare, through the COBC, crosses over 750 million claims in version 4010A1 to 830 Trading Partners, which really represents 404 payers on an annual basis.

Additionally, Medicare Fee-For-Service transfers a small volume of NCPDP 5.1 COB claims to 54 receivers. So as you can see, NCPDP is a much smaller universe compared to the larger 837 universe.

My next slide is slide 17. Since September 27th of last year, we've been testing with various Trading Partners the 837 pre-errata claim version, and that's gone very successfully.

We estimate that since September, and also getting to this more in depth, we've crossed over well over 80 million claims in test, which is very good. Our testing is characterized by a parallel production concept, which means that you're getting the 4010A1 claim, and you're also getting a 5010 test claim.

So, we feel as though that model seems to work very well. Prior to April 4th, we prompt – as I indicated, we did call for the claims in the pre-errata version; however, not all Trading Partners received many test 5010 institutional outpatient claims, and this was due to the notes that were in the TR3 for April – the pre-April 4th- having to do with the 2430 SVD composite requirement. Happily, that changes with the errata version.

Slide 18. Despite this obstacle, we have crossed over in excess of 70 million claims from October 1st to March 31st . I did the count again yesterday and we're at about 88 million at this point. So we've been very successful , haven't we?

Of the current universe of 830 production Trading Partners, 344 were testing as of May 10th. The number is now 352.

Currently, there are no major 837 version 5010 errata claim problems affecting COB testing. The largest known issue we did have was affecting the professional claim 2320 SBR03, which was being populated with the same information that was in the 2330A MN09.

That was fixed on Friday and as a result, we're at 92 percent compliance on professional claims.

Next slide. NCPDP D.0 COB testing is currently available for interested Trading Partners, but to be perfectly honest, it's going to be a challenge to get folks to have that testing because we only really have a universe of about a thousand claims.

So, at any given point in time, we'd have to be able to ensure that those claims which are actual live data would be able to be crossed over. We are trying to see what we can do about that and for folks who are interested, they may come forward now and express their interest in NCPDP claims.

A lot of you are already testing, as we've indicated, with the 5010 errata. We do think that by August 1st we'll be able to reach our goal of 80 percent of all Trading Partners testing based on the current trending.

If folks have any interest in this testing and haven't already called the COBC, I wanted to offer a phone number for that and that is 646-458-6740.

Thank you. I will turn the call – the conversation to Angie.

Angie Bartlett: Thank you very much, Brian. I'm now going to turn the call over to Elizabeth Reed who's going to speak for Medicaid.

Medicaid Readiness Overview

Elizabeth Reed: Hi, everybody. This is Elizabeth Reed from the Division of State Systems. It is my pleasure to be with you this afternoon to provide an update on the state Medicaid agencies' progress for the 5010 transaction implementation.

CMS is currently monitoring the states' progress during conference calls and quarterly online assessments. We are currently on slide 20.

This slide represents the 5010 progress based on conference calls that were held with the states. Four state Medicaid agencies indicated that they are struggling to meet the 5010 compliance dates.

They did provide – one of them provided a contingency plan that provided three options. One is capturing the 5010 transactions from the web portal and holding it on the EDI translator.

They also have an option where they're going to have their providers drop their transactions to paper or they're going to have their providers hold their electronic transactions. So, that's just one state's contingency plan.

One other state has no funding to implement 5010, and then the other two states are having issues implementing their new MMIS systems and do not plan to remediate their old system.

Despite the high degree of confidence in meeting the 5010 compliance date for the remainder states, we also identified some risks that have to be managed.

There are five state Medicaid agencies that are depending on an MMIS replacement. Two states have – are possibly implementing a step-up/step-down solution to meet 5010 compliance. And then there are 10 states who are still finalizing their testing schedules.

The states indicated that the two key issues facing 5010 implementation are funding and competing priorities.

Now, moving to slide 21. The following are the state's answers to their progress on updating their edits under the 5010 changes. For example, the X12 syntax edits Implementation Guide and et cetera.

So, four states who indicated no edit updates under way; there are nine states who indicated developed edits requirements and change requests. Nine states indicated designed edits changes; six states indicated developed edits changes; 11 states indicated performed edits tests, three states indicated edits transitioned and implemented; and then nine states did not respond to the assessment.

Moving to slide 22. The two tables represent the states' responses to the 5010 internal and external testing questions and the ICD-10 readiness assessment. This is from the April 2011 snapshot. Again, we are doing quarterly assessments on the state.

There were nine states that did not complete the impacting implementation section of the assessment. Maryland is the only state that indicated that they have completed end-to-end testing for 5010.

We do have some states that will be participating in the National Testing Day. If you want to make one correction, and that is Minnesota is not participating. So, if we can scratch them off the list?

The states will notify the payers or, I should say, Trading Partners, clearinghouses, with instructions that will include the testing site and which transactions they will assess and process.

At a minimum, they will accept 837 claims files and produce the 999 and TA1 responses to files to validate compliancy of the files received.

OK. At this time, I'd like to move it back to Angie.

Next Steps and Resources

Angie Bartlett: Thank you very much, Elizabeth. OK. On to slide 24. Therefore, with all this information provided, where should you start?

We hope that you are now familiar with the basic requirements by participating in events such as this. Next, you should contact your software vendor, clearinghouse, or billing service to see where they stand and begin testing now.

Contact your MAC to find out their testing protocol. We will hold more outreach and education events throughout the transition year for you to participate in. So, I encourage you to stay engaged in this transition.

On slide 25, the Medicare Administrative Contractors are the administrative arm of the Medicare Fee-For-Service. So, that means that claims or transactions that you submit to Medicare Fee-For-Service go through them.

Certainly, our administrative contractors are being consolidated by jurisdiction. Most of those consolidations have already occurred. But some of you may be in states where this consolidation has not been completed. So, if you send your transactions to a fiscal intermediary, Part A, or a carrier for Part B, you have yet to be transitioned to a MAC jurisdiction.

No matter. The link on this page will help you find your Electronic Data Interchange Help Desk in your state. This is where you'll want to go first for information on 5010 and D.0.

So, if on slide nine you notice that your state's MAC was under reconfiguration, please use this link on the page to find out who to contact for your Companion Guides and testing information.

On slide 26, a paramount step in preparing your Trading Partner for this upgrading is testing the transactions in the new 5010 D.0 format. The concept of Trading Partner testing is designed to validate the Trading Partner's ability to meet technical compliance and performance processing standards, while measuring data integrity to meet standard transaction standards.

The testing transactions using version 5010 and D.0 standards will ensure the Trading Partners are able to send and receive compliant transactions effectively. This testing will allow the Trading Partner to identify any potential issues and address them in advance of January 1, 2012, compliance date. Therefore, two independent testing days will be facilitated by the contractors to submit 5010 D.0 Trading Partner testing.

These testing dates will provide real time help desk support by the MACs. The testing days are June 15th, and August 24th, and we highly advise you to go onto your MAC's website and register for these testing days. We don't want to preclude you from testing now for these testing days, but we – so you're ready to start to test now, but if you're not, please do register and engage in the testing days. It will be a very useful tool.

On to 27. What has Medicare Fee-For-Service developed in terms of communicating resources to date? Medicare Fee-For-Service has established a central web page on the CMS website where you can find a wealth of information and it's growing every day. You'll find resources such as fact sheets, readiness checklists, resource cards, FAQ lists- which have been posted to the CMS main page and are searchable…with a searchable database and growing every day as well - technical resources such as 4010A1 and 5010 side-by-sides, and 5010 MLN articles. And then we also have recordings of our previous national calls.

OK, on to slide 28. This slide highlights many of the important 5010 D.0 events and dates to remember to mark on your calendar. To obtain the transcript or listen to the audio portion of the previous national calls, please visit the CMS website. A link is provided at the bottom of this slide, which is slide 28. In addition, you may also visit the site to register for future national

calls. Please note: registration for the upcoming calls will not be posted until three weeks prior to the call.

The MACs, the Medicare Administrative Contractors, and Common Electronic Data Interchange will host outreach and education sessions. The two remaining sessions are July 20th, and October 5th, with guidance for Medicare Fee-For-Service during the 5010 D.0 transition year. The objectives of these sessions is to drive participation and enthusiasm to engage providers and other business partners in the steps necessary to implement version 5010 D.0 successfully.

Each of these outreach and education sessions will be two hours in duration and will be held from 1:00 to 3:00, local contractor time. Each MAC will host a registration site for these outreach events. I encourage you again to go to your MAC's website and look for such events.

OK. On to slide 29. This is going to be your opportunity to ask questions for the event. But first I want to – just to point out that we have a CMS HIPAA compliance enforcement process. If a provider needs assistance with HIPAA transaction or code sets, they should file a complaint with CMS on the online – with the URL listed above.

This is a link to ASET, CMS Administrative Simplification Enforcement Tool. You should follow the direction and complete the online complaint submission form. This will trigger the HIPAA TCS enforcement process. This is if you're having trouble with contacting with individuals related to the HIPAA 5010 transactions, not just to look up a code set or other questions, but to actually file an enforcement issue.

In addition, you'll notice that our 5010 Medicare Fee-For-Service Outlook Resource Mailbox is the address that's provided at the bottom of this slide. This will allow you to ask questions the remainder of today and tomorrow.

So, now I'd like to turn the presentation back over to Charlie. Thank you.

Question and Answer Session

Charlie Eleftheriou: All right, thanks, Angie. Before we begin this Q&A portion of the call, I'd just like to remind you one last time that the call is being recorded and transcribed, so please clearly state your name and your organization before asking your question. Lastly, in an effort to hear from as many participants as possible, we ask that you limit your questions to one per person.

All right, at this time, I'd like to go ahead and open the lines for questions.

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

Please state your name and organization prior to asking a question, and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Burnham Amid. Your line is open.

Burnham Anid: Yes, I just wanted to – hello? Hello, can you hear me? Can you hear me?

Charlie Eleftheriou: Yes.

Burnham Amid: Yes, my question is that I was trying to get a couple of details, the one – about that – the 27 – 270 and 271, who was going to do that, what are the changes slide, but I don't see on that slide, so where was that detail hidden?

Brad Beatty: Good afternoon. Yes, we didn't go into every single change on the slide here. I would refer you to the HETSHelp website, and I can give you the URL again if you need that. There is a link on that page, and there's several documents available that specify exact changes that were made to the 270 request file that you would send, as well as changes that were made to the 271 response file that you would receive. Do you need that URL again?

Burnham Amid: Yes, sir.

Brad Beatty: OK. It's http://cms.gov/hetshelp. And that's H like Henry, E like Edward, T like Tom, S like Sam, hetshelp. There's a navigation bar on the left side, and you would click the link that says 5010 Information-270/271. And there's several documents there, as well as additional information.

Angie Bartlett: In addition, you'll be able to find a detailed- basically everything that Brad said in the transcript of this call, which will be posted shortly. Thank you.

Burnham Anid: Thank you.

Operator: Your next question comes from the line of Cindy Ford. Your line is open.

Cindy Ford: Hi, this is Cindy Ford, I'm calling from Keane Care, we're a software vendor. On page seven, you mentioned that the MACs continue working with translator vendors in resolving functionality issues and deviations from expected test results. And so, I think that we have encountered some of those issues in submitting test files, and those issues prevent us from successfully passing with the files as they should be. Now, it's easy enough for us to manipulate the files or to exclude certain claims so that those files will pass, but the software we've delivered to our clients will produce them the correct way, and we can't instruct them on how to exclude claims or manipulate files to get them to pass. So, how should this be handled on June 5th's National Testing Day when our providers' clients start submitting test files that then won't be able to pass?

Mike Cabral: Hi, this is Mike Cabral from the Office of Information Services. I would make that recc– first thing, I would contact the MAC and make sure that as of the testing date, they haven't gotten that deviation corrected. The MACs are receiving ...

Cindy Ford: No, we have received ...

Mike Cabral: The MACs ...

Cindy Ford: We have received responses that they won't be – some of the issues won't be corrected until July.

Mike Cabral: OK. Can I get your direct information?

Angie Bartlett: Hi, did you submit your information to the resource mailbox?

Mike Cabral: Right.

Cindy Ford: I did.

Angie Bartlett: OK.

Cindy Ford: I sent an e-mail.

Angie Bartlett: OK, perfect.

Mike Cabral: Ok, Cindy. We'll take a look at that and see what we can do between now and the testing day and get back to you.

Cindy Ford: OK, appreciate that, thank you.

Mike Cabral: Sure.

Operator: Your next question comes from the line of Terry Hershberger. Your line is open.

Terry Hershberger: Yes, skilled nursing facility in Ohio, the jurisdiction 15. We've been with National Government Services as our – as fiscal intermediary, and we're changing to CIGNA Government Services, and I'm not exactly sure who we should be working with on testing 5010 transactions. Can you advise?

Mike Cabral: There's – this is Mike Cabral again, and there is a transition plan in place for the J15 jurisdiction, where I believe NGS is staying on through some period of time. I don't have the exact date. Probably September-type timeframe, so you'll be able to work with them through, you know, the August-September, then it'll transition to the MAC that was awarded the J15 timeframe, so there's a subcontractor currently in place.

Terry Hershberger: So, for right now, I should be contacting National Government Services and working – trying to work with them to get these test files submitted to them? And then when the transition comes, hopefully that effort with them won't go for naught in working with another MAC now?

Mike Cabral: Correct, and those two entities are currently working together on their transition schedules and activities.

Terry Hershberger: All right. OK, thank you.

Operator: Your next question comes from the line of Tim Brasso. Your line is open.

Tim Brasso: Hi, this is Tim Brasso, a vendor, and we were talking with a client this morning, and they were mentioning some Companion Guides. And just a brief question to ask, I thought 5010 was going to do away with Companion Guides?

Elizabeth Reed: No, we currently have Companion Guides. We have the – on each MAC's website is the Trading Partner portion of the Companion Guide. So, it's a standardized Companion Guide across all the MACs, but they are posted to the MAC's website.

Mike Cabral: This is Mike Cabral. You know, let me just clarify, what we're putting in our Companion Guides are things that you'll need to delineate with information from MAC to MAC, with things like contractor IDs. Our Companion Guides don't change the Implementation Guides in any way, they just supplement the information that the TR3s are providing. That help?

Tim Brasso: This Companion Guide was from TMHP.

Mike Cabral: I'm not familiar with the acronym. Can you explain it for us?

Tim Brasso: It's the Texas Medicaid.

Mike Cabral: OK.

Tim Brasso: We were doing some research for a client on a 5010 issue, and when we went to their EDI page, it said oh, download our Companion Guides. So this is for discussion on another call, I just – we wanted to call in and ask. Our understanding was one of the things 5010 was going to give us, was there weren't going to be any Companion Guides. So, now already – yes.

Elizabeth Reed: Well, again, I would have to look at their website to see, you know, exactly what is included in their Companion Guide. Is it something specific? They're allowed to publish, you know, anything specific to that Trading Partner/ clearinghouse, but, you know, it's not the complete Implementation Guide, Companion Guide that they're allowed to publish, It would be specific to – you know, maybe the receiver ID, you know, whatever's specific to them, or specific qualifiers that they utilize to adjudicate, you know, information. They can publish those pieces. Or, you know, or – yeah.

Tim Brasso: That might be the way it is. We just found it today, we're going through them. Did you want me to send you the link to that e-mail address y'all provided earlier, the info? I can send you a link if you want.

Elizabeth Reed: Yes, that would be great, if you can, again, submit it to the resource link, that would be helpful.

Tim Brasso: OK. And also, on the testing on June 15th, we got an e-mail invitation to join, and when we went out to the site to sign up, because it said you have to pre-register, it asked us for an NPI and a PTAN. So, being a vendor, should we provide them with the NPI and PTAN for the provider we're going to test for? Because obviously, we don't have an NPI or a PTAN, and those things are required.

Angie Bartlett: Hi, this is Angie Bartlett. What MAC are you working with for that?

Tim Brasso: TrailBlazer. We're in the J4.

Angie Bartlett: OK.

Mike Cabral: If you include that in the resource mailbox request, we'll try to contact you.

Tim Brasso: OK. Yes, because we selected "vendor" to sign up, and then later, when we were putting in our information, it requested information that we did not have. So, OK, so you want that also e-mailed to that info e-mail inbox?

Angie Bartlett: Yes, please.

Tim Brasso: OK. I appreciate it. Thanks for letting me ask two questions.

Angie Bartlett: Thank you.

Operator: And your next question comes from the line of Cynthia Fry. Your line is open.

Cynthia Fry: Hi, I work at Catholic Health East, a multi-state health system, and my question was about the Medicaid status report you gave. You mentioned one state has no funding, two do not plan to remediate their old system, and one proposed a contingency plan, as well as nine states not responding. Can you tell us who those states are?

Elizabeth Reed: Not off the top of my head, but ...

Cynthia Fry: Is there any way we can access the information?

Elizabeth Reed: Not at this time, actually. We do intend on publishing more information later down the line. Our next quarterly assessment is going to be conducted in July. Most of the tests – states that are testing plan to test in the June-July time frame, and so the statistics are going to change drastically. So, I would say later in July/August, it's – possibility that we will publish that information so that payers – our, sorry, Trading Partners, clearinghouses, and providers can be prepared.

Cynthia Fry: OK, thank you.

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

Angie Bartlett: Susan?

Operator: Susan Olan. Your line is open.

Susan Olan: Hello? Can you hear me? I'm sorry. I guess my question was almost like the girl – the woman from Catholic Health. North Carolina Medicaid, we're a large multiple-facility in North Carolina, and I can't get any information. I mean, I can't hardly get a person, and then I'm only told, "Keep checking our website. Keep checking our website," like Catholic Health.

Elizabeth Reed: Do you submit claims – this is Elizabeth Reed. Do you submit claims directly to North Carolina Medicaid, or do you use a clearinghouse?

Susan Olan: Directly.

Elizabeth Reed: OK, and so as a direct, you know, Trading Partner with them, I would imagine that you would be able to contact their EDI department to find out, you know, where they're at with their testing process.

Susan Olan: Right. And I guess part of it is the little bit of frustration at the lack of information that we can get from Medicaid. And I guess I was hoping this call would have more detailed information or when, you know, or how to get a hold of somebody, or a person, or – you know, they just keep – they tell me to check their website, that when they have something to report, they will publish it on the website.

Elizabeth Reed: Right. And all this ...

Susan Olan: Is that – I mean, is that valid?

Elizabeth Reed: It is valid. But the challenge with states and monitoring their progress is that, you know, there's 50-plus states and territories, and they're all on a different schedule. And to have everybody shift to the left at the same time is very difficult. Again, with all the budgetary issues out there and the competing priorities, I hear from the states' perspective, you know, the challenges that they are facing. At the same time, you know, I can appreciate your concern, and I would think that the communication with their provider community, you know, I mean, would be there.

And so what I would recommend that you do is submit your concern to the resource mailbox. That will be forwarded on to me. I will contact the – my point of contact at the state that, you know, North Carolina, that you're concerned about, and see if I can assist in getting you some information.

Susan Olan: I mean, I appreciate that, it's just that, you know, we're told to test and to contact, and, you know, we're kind of hitting a little bit of a roadblock here. But I will submit that through the website, and I appreciate your follow-up.

Elizabeth Reed: Thank you.

Mike Cabral: We're going to ask you all to – would you put Medicaid in the title so we can forward – sift through those and forward those off to Elizabeth quickly enough? If they're Medicare-related, that's fine, but if they have – if they're dealing with a state issue, please include the term Medicaid in the title so that we can forward them almost automatically to Elizabeth. Thank you.

Elizabeth Reed: Thank you, Mike.

Operator: Your next question comes from the line of Wanda Lilly. Your line is open.

Wanda Lilly: Hi, I'm with CHS Professional Practice, and my question is, with the 5010 loop, when we submit claims for DME for Medicare patients, will we be required to provide the patient's home address as their place of service when it is a place of service number 12, the patient's residence?

Brian Reitz: This is Brian Reitz. I don't think we have anyone in the policy staffing here in the room to answer that question. I believe that the answer is yes, but I'm going to have to ask you, like the other folks, to put that into the resource box, and we'll just verify that.

Wanda Lilly: And you will confirm back with me?

Brian Reitz: Yes.

Wanda Lilly: Thank you.

Operator: Your next question comes from the line of Janet Rob. Your line is open.

Janet Rob: Thank you. This question has to do with the FFS communication piece that's changed. I get an e-mail from availability that AT&T is transitioning to Verizon. Can someone explain a little bit more, as a direct submitter, if we need to do anything as far as changing our communications? We use SSI software as we are a direct communicator.

Mike Cabral I'm sorry, could – if you wouldn't mind, could you please repeat the first half of your question? We kind of lost you there.

Janet Rob: OK, sure. I received an e-mail from – that AT&T network is changing to Verizon in June. And my question is if because of the communication piece that's changing for the Medicare FFS system, do we, as a direct submitter, need to follow up and with who, that – to make sure that our communication link is being changed so we don't lose any down time?

Mike Cabral: Well, your Medicare connections that would, I'm sorry, this is Mike Cabral, contact your local MAC. They should have some provider outreach relative to the communication change and its impact on you. So, that would be your first place to start. But we are aware the switch from one vendor to another is occurring. There should've been communications sent out to you. So maybe you just need to get a hold of the provider communications to…

Janet Rob: The MAC itself?

Mike Cabral: Yes.

Janet Rob: OK. Thank you very much.

Operator: Your next question comes from the line of Anne Kravitz. Your line is open.

Male: Yes, hi. I just have a general question. Does these – do these changes affect anything else other than the actual formatting of the bills?

Brian Reitz: This is Brian Reitz, and if you're referring to HIPAA in general, there are other types of transactions besides just claims that are included. Is that your question?

Male: My question is, is anything, aside for the formatting of the X12 – the X12 bills, is there any other changes that are going to affect providers?

Brian Reitz: There are the claims changes, there are eligibility inquiry changes, claim status changes, 835 remittance changes. Those are all kind of in this suite of transactions which are covered under HIPAA. So, yes, it's more than just claims and what's on your bill.

Male: Thank you.

Angie Bartlett: This is Angie Bartlett. And for further information, you can go to our website. We have many resources on there- resource cards, we have FAQ lists, and we'll also have information there that may help you.

Male: OK, thank you.

Operator: Your next question comes from the line of Lorraine Hunter. Your line is open.

Lorraine Hunter: Hi, this is Lorraine from North Shore LIJ in New York, and I just had a quick question as well. Besides the HETS website, is there any additional communication or documentation that's going to be coming out regarding like the search criteria for the 270/271 transaction?

Brad Beatty: Hi, Lorraine, this is Brad Beatty with the Medicare Eligibility Help Desk. On the website, there's links to a lot of information. Honestly, it's probably everything you need. There are links there to the HETS 270/271 Companion Guide for 5010A1. It does talk briefly about the different search options. So, you know, I think the information that you need really is there.

If it's not and you have any questions at all, feel free to contact the MCARE help desk that supports that, and we will take care of you in any way possible. So, we've been proactively contacting submitters to start talking about testing

and what the requirements are, so they – we are – we are eager to talk to you and find out what we can do to help.

Question and Answer Session Continued

Lorraine Hunter: OK, thank you.

Brad Beatty: Sure.

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

Deeky Little: Yes, this is Deeky Little with DST Health Solutions. I am trying to print the pages of the webinar, and I am unable to print it all. Can you tell me how I can do that, please? The presentation?

Angie Bartlett: Yes, this is Angie Bartlett. Go to the website that was provided within our – I think the first two slides, actually, Charlie did announce it at the beginning, and you can pull it right from the website.

Deeky Little: OK, because I'm on a – I'm –

Angie Bartlett: Are you in Adobe?

Deeky Little: Yes, I'm in the Adobe.

Angie Bartlett: Yes, go off and – it's a separate download, if you go to the website where you pulled the Adobe link from, right next to it, you'll see the link to download the full version of the document.

Deeky Little: OK, thank you so much for your help. I do appreciate it.

Angie Bartlett: No problem.

Operator: Your next question comes from the line of Elizabeth Arnest. Your line is open.

Elizabeth Arnest: Hi, good afternoon. This is Elizabeth A. Arnest from Sheridan Health Corp. Talking about page 14, which is the HETS 270/271 Medicare Eligibility, you had mentioned some loop and segments where there was going to be

significant changes, and that we might be getting some errors response back when we do our testing, and this is in regards to the gender code and the middle initial of the patient, I was wondering if you could repeat what the segment was.

Brad Beatty: Hi, Elizabeth, sure. This is Brad Beatty, I manage the help desk that supports HETS. Specifically, we are recommending that you not send the gender code and the middle initial in your 270 request as a general statement, but the gender code is sent in the 2100C DMG03 element. That's the DMG03, is the gender code.

Elizabeth Arnest: OK.

Brad Beatty: And the middle initial is sent in the 2100C NM, that's N like Nancy, M as in Michael, 105 element.

Elizabeth Arnest: OK.

Brad Beatty: If you do send either of those while you're doing the primary search option, you would receive a 999 response. Again, there's no search option where you're required to send gender and/or middle initial, so as a general statement, we just say don't send it and you won't run into any problems.

Elizabeth Arnest: OK. And then the other one was the 2000C TRN03. I just needed a description of what that was for. I know that there's going to be code values, and that we are to use the one, three, or nine.

Brad Beatty: Sure. Correct. A TRN03 element in the twenty- the 2000C loop is basically a tracking number. It's a user-generated number. It's something that the submitter sends in, and then we echo it back on the 271 response, and it helps you just match up the request and the response.

Elizabeth Arnest: OK.

Brad Beatty: So, it's optional, it's not required to be used, but if you do send it, we would ask that you only start that number with a one, a three, or a nine.

Elizabeth Arnest: OK. And I have this one final question. You stated on slide number 20 that Medicaid, there were going to be some states that are not participating or they're just not ready yet. When we do the national testing, which will be June 5th, 2011, we get this rejection back. But if they determine that they are not going to participate with 5010, how is that going to reflect us at the back end when it comes to rejection?

Elizabeth Reed: On June 15th? I'm confused about...

Elizabeth Arnest: This is the – I'm talking about the National Testing Day.

Elizabeth Reed: Yes, that's on June 15th.

Elizabeth Arnest: Right.

Elizabeth Reed: And the participating states are on this slide, minus the state of Minnesota.

Elizabeth Arnest: Right.

Elizabeth Reed: These are the states that have committed to accepting 5010 837-track transactions at a minimum. So, these particular states that are on this grid were supposed to have notified their Trading Partners/ clearinghouses, and they should've provided instructions as to what transactions they will be accepting as well as which transactions you should be receiving back.

Elizabeth Arnest: OK. Because I'm a little concerned, because as you know, Medicaid does not allow paper claims, they're totally electronic claims. So, in the event, at the end, that they do not meet the requirements of 5010, how – are they going to be able to switch to paper claims and accept those paper claims?

Elizabeth Reed: This is Elizabeth Reed again. That is not a true statement, that they don't accept paper claims. There are still a lot of states who are accepting paper claims today.

Elizabeth Arnest: OK.

Elizabeth Reed: Which state are you concerned about in particular, can I ask?

Elizabeth Arnest: Well, I'm in – I'm in multiple states.

Elizabeth Reed: OK, so there may be particular states that have omitted a paper process.

Elizabeth Arnest: Right.

Elizabeth Reed: But I don't know who those states are off the top of my head.

Elizabeth Arnest: OK. All righty. Well, thank you very much.

Elizabeth Reed: You're welcome.

Operator: Your next question comes from the line of Christian Lawrence. Your line is open.

Christian Lawrence: Hello, my name is Christian Lawrence, I'm calling from LifePoint Billing Services. I have two questions. One is a follow-up for the eligibility gender code and middle initial issue. There is a lot of times where we don't have control what we send in the eligibility request. If our clients put the gender code in the EHR record, then it's going to get picked up on the 270 request. So, the concern is, is this a bug that's out there, or – that's getting fixed, or why is there a 999 coming back?

Brad Beatty: This is Brad Beatty from the MCARE Help Desk. It is not a bug. That is per the standard. Again, the suggestion to work around that is, this is, honestly, for the purpose of an eligibility request, extraneous data. So, if you have the ability to remove it, that would be our recommendation.

The data, if it is present in the alternate search option, that is acceptable, so perhaps you wish to manipulate the data so that you're only using the alternate search option. In that case, it would not generate a 999. But even in that situation, if the data is not accurate, if, for some reason, the gender code is wrong, it would result in an error. So, again, I understand what you're saying, but CMS is complying with the standard, and that is how the standard is written.

Christian Lawrence: OK, thank you. And kind of a follow-up question is, around NDCs and the submission of that. I just need to verify, because I believe I've read where the NDC standard, is that going to be across all health plans, or is that still situational, where each health plan determines whether they want to see NDC information with the claims?

Brad Beatty: I don't have the answer.

Mike Cabral: This is Mike. Could you submit that question to the resource box, and we'll get it to the policy people here from Medicare, I don't know if we'll be able to answer that here.

Elizabeth Reed: Yes, if you could just – I think that's a question for both of us, and generally, I know the NDCs are provided for the corresponding J code that's submitted, but again, I think that's part of the drug rebate program. So, I'm – I'm going to assume, you know, that the states still want the NDC information if it's, you know, with the J codes, but I'll do some more research on that.

Christian Lawrence: Well, yeah, I mean, I understand that Medicaid still wants it. I'm just wanting to make sure that if Medicare doesn't want it still, or BlueCross BlueShield doesn't want it, I'm just making sure it's still situational and health care plan-specific. I'll go ahead and submit ...

Mike Cabral: Hey, this is Mike. I just want to clarify. Today's talk is about the Medicare Fee-For-Service, and we only have a limited – the oral cancer drugs will come to my mind right off the bat, but if you're talking about the other types of Medicare coverage, Medicare C and D, you – again, we have to talk about those policy folks if that's truly where your question is going.

Christian Lawrence: OK, thank you.

Mike Cabral: And if you can clarify that in your statement – your question, that'll be good.

Mike Cabral: OK. Yes, I'll e-mail it in. Thanks.

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

Paula Webster: Yes, this is Paula Webster from Blessing Hospital in Illinois, and my question is regarding COB. We are with National Government Services, and we have been getting literally hundreds of claims back on our COBC detailed error report stating error code H10614, Missing Mandatory Pay-To Provider Name Entity Identifier Code. And we're trying to figure out if maybe the problem was National Government Services, a problem with our claims being generated from some of the testing you were talking about earlier, Brian, or where I might go with this.

Brian Reitz: If you could send – if you could send your contact information to the resource box, I'll be glad to call you back and we'll try to get through it together. If you could put COB on your – on your inquiry, and that H10614 code, that would be great.

Paula Webster: OK, thank you.

Brian Retiz: Thank you.

Operator: Your next question comes from the line of Terry Ming German. Your line is open.

Terry Ming German: So, in Jurisdiction 1 – sorry, this is Multi-Care. Jurisdiction 1 – Jurisdiction 2, I'm sorry, for Medicare, I did not see that listed on your screen. I only saw Jurisdiction 1, and then it jumped to Jurisdiction 2. So, from Washington State, we go through Noridian for Parts A and B. Who do we contact for questions?

Angie Bartlett: Contact the help desk, the A and B MACs on – that was provided on slide 25, they will help you walk through that. And you can contact Noridian. Their information will be provided – if you look on –the help desk would be under J3.

Jason Jackson: Hi, this is Jason Jackson from OIS you'll actually want to go to the slide 25 and use those – the link there for Noridian. They do have a separate help desk for their legacy work and their MAC jurisdiction work. So, if you go to slide

25, find for the state of Washington, and that'll supply you with their toll-free number.

Terry Ming German: Thank you.

Operator: Your next question comes from the line of Meredith Serad. Your line is open.

Meredith Serad: Hi, this is Meredith Serad from CentraState Medical Center in Freehold, New Jersey. We are in J12, so we're submitting that HighMark. And we are not big enough to be able to go directly with an FTP connection, so we have to go through an intermediary that's approved. So, we're currently using ABILITY, who used to be VisionShare. And they are not ready to do any type of testing or process any 5010 claims in test or production, so I wasn't sure if anybody was following up with the approved intermediaries for the different MACs.

Brad Beatty: Hi, this is Brad Beatty. I actually some had contact with VisionShare, now ABILITY, earlier today, and I know that at least for the 270/271 part, they are now ready to begin 5010 testing. So, if you haven't touched base with them in the last couple of days, you may want to check back and see if ABILITY can now support that.

Meredith Serad: OK, yes, we were actually looking for the 837-I and 835 remits, because HighMark won't support the 835 in a test environment, but they will give us a parallel 4010A1 and 5010 over our production files. But we're just unable to get them back, because they go into our directory that we get our production files from and ABILITY picks those up, whereas we have to do our direct 837 testing through a dial-up connection with a test submitter ID, and the only thing we can get back for that is a 999 and a 277CA. But even those, honestly, we've been, since they were ready, trying to test, and every time we submit a test file, we find another issue with – one was that they released their errata version, and it was still requiring situational fields. And then the 277CA had, you know, wrong values in the ISA segment. And then once we got past that – and they said that they would change that- then we got to where the EDI is formatted incorrectly, so it's got, you know, a DTP segment with no elements in it. It's just been – we haven't been able to get a clean test without

having to manually go in and manipulate their files coming back to us, so we haven't really been able to do any testing with anybody, to be honest.

Our Medicaid posted last week that they'd be ready to test – or, actually, go to production May 16th, for New Jersey Medicaid. So, we told we wanted to start submitting production files, and then we come to find it's actually going to be sometime late in June that they're going to be ready to start testing. So, we're having a really difficult time finding anybody to be able to test with other than, you know, getting certified through the Clarity site.

Mike Cabral: This is Mike Cabral, and there has been – and we have actually been using, this year, as part of our Medicare testing year some externals, and all the things you're finding, we're trying to correct. You said you were an institutional biller. We have been working hand-in-glove with our Part A maintainer to get our "Common Edits Enhancements Module" up to speed. The months of April and May were – were quite a few releases that we had. When was the last time you were actually able to test a claim?

Meredith Serad: I tested a claim a couple weeks ago. I believe it was May 6th, was the last test file that I submitted that I got the 277CA back with. It was an ISA05 segment – or, element, that's supposed to be the ZZ, just the basic header, and they were returned on a 28 saying that that was valid. So then I showed them their limitation guide, which states we'd use a ZZ, and then they said they found CMS documents that says they need to use a ZZ, so they'd get back to me, but didn't have an ETA on when that would be fixed. But the last time we opened an issue and they said it was a problem, it took about a month to get that corrected, and that was with the errata version still requiring what were now situational fields. So, just not a real quick turnaround, you know, kind of frustrating.

Mike Cabral: They are – they are also working with their translator vendors as well. But on the 2728, CMS has actually reviewed all the MACs' Companion Guides, and I'm not sure where we're standing, but we're close to republishing some of the TI information. And I believe the 2728, the ZZ, would clarify the 2728 on the claims, and the ZZ on the 276/277. So, the other point being that I'm not – I have – I'll check internally on our release dates, but our CEM

software supplier put out a release, and I don't have the date in front of me, but we'll check on that. It's out.

Meredith Serad: OK.

Mike Cabral: Someone will tell me- it may be going out as soon as today. So, they'll be installing the latest release probably in the next four to five days in preparation for the National Testing Day.

Angie Bartlett: And this is Angie Bartlett.

Meredith Serad: OK.

Angie Bartlett: I expect the revised Companion Guides to be posted in the next week or two from the MACs.

Meredith Serad: OK. I'll keep an eye out on the site, then.

Mike Cabral: Thanks, Meredith.

Meredith Serad: Thank you.

Operator: And again, if you would to ask a question, please press star, then the number one on your telephone keypad. And your next question comes from the line of Antonio Ong. Your line is open.

Antonio Ong: Hi, this is Antonio Ong from Community Home Health Care Foundation of Northwestern (inaudible). My question is, we have a vendor software. We're told they would be the one to do the testing of 5010 with our MAC, which is Palmetto GBA. Is it – they said that once we get the approval from our MAC, the carrier would get approval. Is it true? And once they've got the approval, does it mean we don't have to test that 5010 with our jurisdiction-level MAC?

Angie Bartlett: This is Angie Bartlett. Yes, that is true. If your vendor is doing the testing, then you are – your testing is covered through him.

Antonio Ong: OK, thank you.

Angie Bartlett: Welcome.

Operator: Your next question comes from the line of Janet Breier. Your line is open.

Janet Breier: Hi, thank you very much, but I did receive an answer, one of the prior questions.

Angie Bartlett: OK, thank you.

Operator: Your next question comes from the line of Kathleen Sherman. Your line is open.

Kathleen Sherman: Hi, my name is Kathleen, and I'm calling for East Side Medical Radiology, and I wanted to know, if New York State Medicaid is not ready for the 5010 transactions, and I have a patient who has Medicare and Medicaid, so Medicare is going to forward the claim to Medicaid, what will happen with my claims? Will they all then be automatically denied?

Elizabeth Reed: Well – this is Elizabeth – I am actually going to see New York Medicaid next week. So, if you could, post the question to the – to the resource mailbox, and then when I return from my trip, I will have an answer for you.

Kathleen Sherman: OK, and – thank you. And also, I wanted to know if – I'm a small medical business, so if I don't have 270 people to verify eligibility at once, am I still going to be able to use Medicare's connect website and the telephone IVR to obtain information?

Mike Cabral: You do need – this is Mike Cabral. I just want to clarify the question, please. Are you asking, do you need the 270 transactions to verify eligibility, or can you use the current IVR structure? Is that your question?

Kathleen Sherman: Yes, I want to know if I'll still be able to use the current IVR.

Mike Cabral: We'll verify that and put it as part of the follow-up, but I believe that's true. I don't think there's any way that we can – we're stopping you from using the IVR.

Question and Answer Session continued

Kathleen Sherman: OK. Thank you.

Brad Beatty: Just to – this is Brad Beatty. Just to clarify that, the HETS 270/271 system is not an IVR. There are some Medicare contractors that have built IVRs that utilize HETS 270/271. So, I suppose the answer is, is whoever you used to call to use that IVR system, they should be able to answer for you if they have any planned changes for that IVR system. But HETS 270/271 itself is not an IVR, and there are, as I know – as far as I'm aware, there are no planned changes to, you know, remove access to it.

Operator: Your next question comes from the line of Nellie Bilkie. Your line is open.

Nellie Bilkie: Hi, our question is, how does this affect the Tribal IHS in Anchorage, Alaska?

Mike Cabral: We're understanding that they billed one of the current MACs, and if you're billing electronically, you will be required to be compliant with the 5010 standard. Nellie, does that answer your question?

Nellie Bilkie: Yes. And another one is, we use Noridian as our electronic submission, so we'd have to contact them to see if they're doing anything with that 5010?

Mike Cabral: Correct. Well, they – we know they are doing stuff with 5010. They're doing it for the MAC and for the legacy systems out in the Northwest. They took all the old region systems. Again, contact, and I think Jason pointed out slide 25 has the appropriate 800-number for the legacy contact information, otherwise, you can use the regular MAC dialing numbers for help. Does that help?

Nellie Bilkie: OK. Yes. Then I have one more question, it's, we also have one FQHC hospital, our clinic. Does that go with the National Government Services, or can that go with Noridian?

Mike Braus: I'd have to check on that one. Can you…. I'm not 100 percent sure, so can you submit that question, please, and we'll follow up on the Federally Qualified Health – FQHC, thank you.

Nellie Bilkie: Thank you.

Operator: Your next question comes from the line of Paul Grossman. Your line is open.

Mike Cabral: Paul, if you're speaking, you're on mute.

Paul Grossman: Hello, thank you very much. I'm honestly a software developer, and my question may be a little technical in nature, but I wanted to put out there. I'm actually working on – currently just doing some coding for the 837 transaction set, and in the loop 2010AA, the code for providing a commercial insurer's ID, which was – used to be code 1G, is now deleted. And I'm wondering, is that just going to suddenly be replaced, because that – now all commercial insurers are going to have to have an NPI? Because I believe in the 5010, you now have to have a segment to report the NPI number, versus the commercial provider number instead.

Mike Cabral: Paul, just to clarify, here, you're talking about the plan ID, correct?

Paul Grossman: Well, I believe so. I believe I am – because actually, what we're passing is now the employer ID information about – I guess when we're submitting a commercial claim, a claim that's being paid by commercial insurance. They accept the HIPAA format, and I'm just – I know that on the 5010, there, you know, somewhere in the 2010AA loop, in the REF – in the REF – the REF element there, there is the – in the 4010, there was a code 1G that identifies the number as a commercial provider, or a commercial insurance. And for the 5010, that 1G has been deleted.

Mike Cabral: Right. And that was because of the – X12 took the – took the NM1 segment and compressed it for the national plan ID, but truly, if you're trying to file it with the commercials, you really need to contact your commercial community. But you may also want to look at the – there might be a REF segment where there were some other ways to file Tax IDs in that loop. So, I would suggest ...

Paul Grossman: Right.

Mike Cabral: ... contacting your commercial plan that you're going to be doing business with. We're really just focusing on the Medicare Fee-For-Service and the Medicaid business for these calls.

Paul Grossman: OK, thank you. I didn't mean to take up time with something extraneous.

Charlie Eleftheriou: And this upcoming question, if there is one left, will be our final question.

Operator: And your last question comes from the line of Wendy Packis. Your line is open.

Wendy Packis: Yes, I was meaning to find out, our trading partner is TrailBlazer. And I need to see, do they require that we test as an individual provider, or can they test as a vendor level, where they do the testing for us?

Angie Bartlett: Can you repeat the question one more time, please?

Wendy Packis: Our software carrier is TriTech, and they are telling me that we need to verify that our carrier or Trading Partner can receive individual provider testing, or is it OK that they do testing through a vendor level?

Mike Cabral: Would the – this is Mike, and – again, and the answer to your question, they can actually do both, because the MACs get approved vendor lists out there by testing with the vendors. But to get on that approved vendor list, you have to have clients that are Medicare providers enrolled. So, it's kind of both are correct answers to your question the way you're phrasing it.

I would also ...

Wendy Packis: So, us being an ambulance provider ...

Mike Cabral: Say again?

Wendy Packis: ... we do not have to test individually, we can test as part of a vendor level with our TriTech?

Mike Cabral: You're an individual ambulance provider, is that correct?

Wendy Packis: Correct.

Mike Cabral: And you are asking if you can test as a vendor?

Wendy Packis: Correct.

Mike Cabral: That seems wrong, but I would – I would – I would, again, check with the J4 TrailBlazer Help Desk.

Wendy Packis: OK.

Mike Cabral: Because they're taking care – they're the ones that manage the vendor list, and they'll tell you what you have to – if you're qualifying as a vendor. But to me, it sounds like you're really a provider.

Wendy Packis: All right, thank you.

Charlie Eleftheriou: All right, thank you. At this time, I'd like to thank everyone who joined us today, including our subject matter expert here at CMS. I'd like to remind everyone that answers to questions e-mailed to the 5010 resource e-mail box will be posted to the 5010 website as soon as possible.

Frequently asked questions from our March 30th call on provider testing and readiness are now available in the Downloads section of that call information page, on the same page you found the call information page for today's call.

Our next and final 5010 National Call is scheduled for August 31st. This will be a MAC panel for your questions and answers. So, be on the lookout for a message announcing call details on that soon. Have a great day, and we thank you again for participating.

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

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