Centers for Medicare & Medicaid Services
Tenth National Education Call on Medicare Fee-For-Service
Implementation of HIPAA Version 5010 and D.0 Transactions
Moderator: Aryeh Langer
September 29, 2010
12:00 p.m. ET

Contents

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

Provider Poll

Medicare is interested in polling today's participants to determine their readiness level for 5010. We appreciate your responses, as it will help us determine where the Medicare Fee-For-Service audience is in regards to 5010 readiness. Each question and response will be read only once. Please respond after each question and answer is complete.

Question 1, have you completed your system impact assessments and project plan for conversion to Version 5010? For system impact assessment completed, press one. For project plan completed, press two. For both system impact assessment and project plan completed, press three. For system impact assessment not completed, press four. For project plan not completed, press five. For neither system impact assessment nor project plan completed, press six. We'll pause for a moment to compile the answers.

Question 2, have you contacted your vendor or clearinghouse to learn when they will be ready with the 5010 version upgrade? For yes, press one. For no, press two. For non-applicable, press three. We will pause to compile the answers.

Question 2a, if yes, when will your vendor deploy their 5010 product to you? Select one. For January 2011, press one. For April 2011, press two. For July 2011, press three. For October 2011, press four. For December 2011, press five. For after January 2012, press six. For do not know, press seven. We'll pause for a moment to compile the answers.

Question 2b, if yes, when will your vendor be ready to engage in testing with you? Select one. For January 2011, press one. For April 2011, press two.

For July 2011, press three. For October 2011, press four. For December 2011, press five. For after January 2012, press six. For do not know, press seven. We'll pause for a moment to compile the answers.

Question 3, are you working with a vendor? For yes, press one. For no, press two. We'll pause for a moment to compile the answers.

Question 4, if you are not working with a vendor, what is your current readiness level? For have not started, press one. For started with minimal progress, 0 to 25 percent complete, press two. For started with steady progress, 26 to 50 percent complete, press three. For started with exceptional progress, 51 to 75 percent complete, press four. For almost ready, 76 to 99 percent complete, press five. For ready, 100 percent complete, press six. We'll pause for a moment to compile the answers.

Question 4a, when will you be ready to test? Select one. For January 2011, press one. For April 2011, press two. For July 2011, press three. For October 2011, press four. For December 2011, press five. For after January 2011, press six. For do not know, press seven. We'll pause for a moment to compile the answers.

Question 5, will you meet the January 1, 2012 deadline to implement Version 5010? For yes, press one. For no, press two. We'll pause for a moment to compile the answers.

Question 6, in your opinion, if you're not able to meet the January 1, 2012 deadline for conversion to Version 5010, what is your risk of nonpayment of claims by Medicare Fee-For-Service. Select one. For no risk, press one. For some risk, press two. For medium risk, press three. For high risk, press four. For do not know, press five. We'll pause for a moment to compile the answers.

Question 7, are you a Medicare Fee-For-Service provider? For yes, press one. For no, press two. We'll pause for a moment to compile the answers.

Thank you for participating in today's call. I will now turn the conference call over to Mr. Aryeh Langer.

Sir, you may begin.

Welcome

Aryeh Langer: Thank you, Shannon. Hello everybody. Once again, this is Aryeh Langer from the Provider Communications Group here at CMS and I'd like to welcome you to our Tenth HIPAA Version 5010 National Conference Call.

Today's call will cover the TA1, 999, and 277CA acknowledgment transactions. For anyone who may have not had a chance or had difficulty downloading today's presentation, please go to the 5010 website now to access the information. The web address is www.cms.gov/versions5010andd0. Again, www.cms.gov/versions5010andd0.

On the left-hand side of the page, you'll see a link for 5010 National Calls and you can access the presentation there. As with all of our 5010 National Calls, we'll have a question and answer session following the presentation. We'd like you to take advantage of your opportunity to ask questions from our Medicare subject matter experts. We'd also like to thank you for participating in today's polling.

With that said, I'd like to introduce our speaker for today's call. Jason Jackson is a Health Insurance Specialist with the Division of Medicare Billing Procedures here at CMS. Jason?

Slides 1-13

Jason Jackson: Good afternoon everybody. 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, as well as what CMS has been working on related to implementation.

I'll start off on slide 2. The purpose of today's call is to highlight the significant differences between the reporting for 4010A1 and 5010 or 5010A1. We will then provide an update on Medicare Fee-For-Service

activities related to the implementation of HIPAA Version 5010 of the TA1 Interchange Acknowledgment, the 999 Acknowledgement for Health Care Insurance, and 277CA Health Care Claim Acknowledgement. We will discuss the 999 errata, provide some guidance on what to do and to prepare, and finally, we'll wrap up with getting some feedbacks, questions and answers.

All right. The agenda for today: we'll go over the general overview, then we'll get into the changes, the 999 errata, followed by the timelines and deadlines, and what you need to prepare. And the timelines and deadlines are – that we've covered on previous calls. We'll try to go through those pretty lightly.

All right. Page 4, General Overview – what was adopted under HIPAA 5010? The Version 5010 is the X12 Standards Suite of Administrative Transactions. General Changes, the Implementation Guides also known as IGs are now referred to as Technical Review Type 3 documents, TR3s. The language in the opening section of the IG referred to as the Front Matter, was revised to be more consistent across transaction types – claims, eligibility, claim status, and the remittance. The content of the rules found in the IG that are labeled as situational were further clarified and updated to specify when an element is required or not allowed. The ambiguities in 4010A1 rules were corrected – "should" has been replaced with "must" in many cases. And finally, "if not required, do not send" is new for 5010.

Just to note, the acknowledgement transaction CMS will be implementing with Version 5010, are not currently part of the HIPAA suite and transactions. There is currently a recommendation – I lost that – there's currently processes begun to change – with the change request submitted by X12 to have these adopted under HIPAA.

All right. On page 5. It shows the Acknowledgement Family of Implementation Guides. First off is the TA1 Interchange Acknowledgement. This is actually contained within the Implementation Acknowledgement for Health Care Insurance, the 999. You'll see there is a - TR3 number is 005010X231. The 999 Implementation Guide is the Implementation

Acknowledgement for Health Care Insurance. That's also the X231. And finally, we have the 277 Health Care Claim Acknowledgment which is X214.

We will be asking providers to set the ISA-14 Interchange Acknowledgment to a 1 requesting a CA1, and this will be covered in the forthcoming – in our forthcoming Companion Guide CMS is currently working on.

All right. On page 6, Medicare Specific Changes for Reporting. Currently, each Medicare Administrative Contractor or MAC produces custom error reports that vary by jurisdiction. And by moving to the standardized edits and EDI error acknowledgements transactions, Medicare is going to be able to produce standardized reports across transactions. So that way, if you guys are in multiple states with multiple MACs, you'll all be receiving the same responses back from Medicare.

Clearinghouses and software vendors can use these transactions to produce reports tailored to their customers. On our Fee-For-Service 5010 web page, we have posted both the edit spreadsheets for the 837 Professional and 837 Institutional claims, as well as 5010 acknowledgement examples for the TA1, 999, and 277CA. I'll identify that link later on in the presentation. It's, for you guys, on page 22.

The new ASC standard acknowledgement or rejection transaction, the Interchange Acknowledgement TA1, with the differences will now be used. The Functional Acknowledgement 997 is going to be replaced with the 999. And currently, any proprietary error reporting are going to replaced with the 277CA Claims Acknowledgement transaction.

As mentioned, you'll only receive a TA1 when there is an error in the interchange loop but once you have transitioned over to the 5010 – and once you have transitioned over to 5010 for claims submissions – you will begin receiving both a 999 and 277CA for every Part A and Part B transaction submitted to Medicare.

All right. On page 8, the purpose of 999, TA1, and 277CA. When a TA1 is received, you will need to correct and resubmit your entire ISA-IEA

Interchange. When a 999 is received, you may recognize that syntax errors have occurred and begin to correct and resubmit. And you will need to recognize that all transactions-- or you may recognize that all transactions were accepted.

When you receive a 277CA, you may recognize that business rule errors occurred and begin to correct and resubmit on specific claims, and recognize that all transactions were accepted. And you may use the returned claim numbers for future claim status inquiries.

On page 9, how you will use the TA1 and 999 and 277CA. The TA1s and 999s reflect technical problems that must be addressed by the software preparing the EDI transmission. Thus the trouble tickets will likely need to be addressed by technical resources to identify corrections needed before resubmission.

The 277CA will reflect data problems that must be addressed by resources in the billing area. Billing staff will likely need reports to be produced using the 277CA transaction in order to identify claims corrections before resubmission.

Clearinghouses and vendors may consider offering a 277 reporting capability. For that, you're really going to want to contact whoever your vendor is and see what they have planned –planned in the way of 5010 reporting for you.

On page 10, this is an overview of what's going to be happening within the world of editing within CMS. Translators will perform all X12 syntax edits at the MAC locations, including some CMS-selected HIPAA IG edits and they will be outputting the following: a TA1 for rejected interchange, 999 for rejected functional group transaction sets which would be a 999 Reject or 999-R, the 999 for accepted functional groups which will be a 999-E, and 999-E is also structurally sound non-compliant business units will be passed to our new CEM functionality for rejection at the individual claim level. So on your 999 response, you would see some claims accepted, some claims rejected.

CMS flat files for accepted transactions will then be passed from our translator on to our new CEM software, where the CEM software will perform

Medicare-specific edits, CMS-selected IG edits and produce the following: a CMS flat file for the accepted transactions with claim numbers assigned, a 277CA for each accepted or rejected claim. And then the 277CA for an accepted claim will contain the claim number. So, you know, on your 277CA, you will have the accepted claims control numbers and you also have some rejects that would need to then be corrected and possibly resubmitted.

This approach allows for the return of individual claims as opposed to entire transaction sets when an error is not syntactically correct. And this is all in the goal of getting the claim number to the providers earlier in the process. Then if something goes wrong, it is easier to fix.

Some special situations on page 11. When a business error is encountered, a claim will continue to be edited so that all Front End Systems errors are identified and returned to the submitter.

When a non-fatal error is encountered with data at the provider level, claim editing will not be continued. All claims from that provider will be returned without edit results. So if the submitter is not authorized, for instance, we will not continue editing on that claim.

Moving on to page 12, CMS Edits Documentation. We, CMS, have developed a spreadsheet that details the edits we expect to be performed in the EDI translator at our MACs and the edits to be performed in the CMS Common Edits and Enhancements Module, the CEM.

On the following page, page 13, there is also – this is a sample of our edits spreadsheet. Columns 4 and 5 indicate the level of editing- whether it's a 999 or 2777CA and it also indicates the TA1, and also indicates whether it's an R or an E. Again, the 999-Rs are full rejects, the 999-Es are ones that would be accepted with errors and returned on a 277CA. Again, the full edits spreadsheet is available and I'll point out to the web link for that later on the presentation.

Slides 14-25

All right. On page 14, the next four slides are a touch more technical than previous ones. Page 14 is an example of the TA1. When an Interchange Envelope was processed at the receiver's translator, their Trading Partner's Interchange Sender Identifier was entered incorrectly with an extra "s" that was found.

And this example just shows what was submitted and then at the bottom, it shows the TA1 rejects that would be coming back. Again, we would hope that your vendor would provide you with a utility that would actually convert TA1 into a human readable form along with the 999 and the 277CA.

On page 15, this is an example of a 999 accepted with errors. This one here shows accepting an 837 Health Care Claim Functional Group with two non-fatal errors that are accepted for further processing.

These are at the CLM for an implementation pattern match in the first IK4 line. And on the second IK4, it's at the end four- with the zip code containing an invalid character. Again, we would hope that this would be – this is what comes back on the X12 – not really (inaudible) human readable format out of the vendors.

On page 16 is a 999 accept, and this just shows that there were two functional groups accepted within the transaction sets.

And finally, on page 17, this is an example of a 277CA coming back. So this would have come into the translator, been processed through. You would have received a 999, either probably an accept with errors or a full accept, and then you would be receiving 277CA back. This is an example where the billing provider was not associated with the submitter. So, therefore once we realize that, it would stop editing and get kicked out of the system.

All right. On page 18, this kind of covers what Medicare has been working on with their 5010 and some of the things we've done. We've been working standardized editing, one set of edits installed for each Part A and B MAC location, consistent editing, consistent results for each transaction exchange.

Standardized Error Handling. Which we're going over right now. The TA1, which is the high-level report for the ISA-IEA and TA1 to cover complete failures. The 999, which again replaces the 997 transaction, communicates X12 and IG syntax violations, and this one can result in the claims being returned. The 277CA Claims Acknowledgement- used to communicate the status of individual claims, whether they're accepted or rejected, and this of course replaces the proprietary reports that you're currently receiving from your FI, carriers, or MACs.

All right. On page 19, it's just a continuation. We're also, within our new CEM modules, we're putting in place receipt, control, and balancing functionality. This really adds internal checks that weren't so much standardized across the MACs for 4010A1. So, that hopefully, no claims will be lost and it will find whenever we have an out of balance situation between our MACs and our adjudication systems. And this will, of course, be seamless to all the providers out there, but hopefully with the reports and everything it will work.

On page 20, there was a – there is a 999 errata currently in place awaiting a final rule, I guess, to be issued on this. And within the 999 errata, there were several changes to the CTX segments, the 2071 AK2, and situational rules for the TA1 segment. The TA1 is no longer required when the interchange is rejected. Of course, the TA1 is contained within the 999 Implementation Guide.

Public comment period is already closed for the 999 errata. Medicare Fee-For-Service does not anticipate that there is any impact on the 5010 implementation or the mandated compliance dates and there is no anticipated impact on our Fee-For-Service system for this.

All right. Slide 20 – or 21. This is the timeline. We've had this in all of our previous National Provider Calls. It shows where we stand with 5010. And currently in calendar year 2010, we're in our system test phase, testing all the changes that we've made over the past year and a half for 5010. And we do plan that we will be going live January 1, 2011 to be in testing with external

Trading Partners. So, probably within the next three months or so, providers out there should be contacting their vendors, or if they're direct submitters contacting their MACs, to start setting up testing opportunities.

All right. On page 22. This slide again has been in several previous presentations. It just shows all of the pertinent links that you'll find useful.

Under bullet number two, the products included. We have the current 5010 D.0 web page where you went to register for this call. Also, the next bullet is for educational resources. And finally, the third bullet under number two, that's our Medicare Fee-For-Service designated 5010 page and that's the page where you can find the spreadsheets, side-by-sides, the acknowledgment examples. So, please go out there, poke around, and pull down whatever you want to.

And then number four is an FAQ that we've put together for 5010. Number five shows the X12 store where you can purchase the Implementation Guides and also resources under number six. And number seven is for the HIPAA DSMO process which is what- it's where the acknowledgment guides are currently in. It's in that process.

Slide 23, what you need to do to prepare. First off, you need to contact your software vendors and find out if your license include the regulation updates. Will the upgrade include the 999 and 277CA, and will the upgrade include a readable error report produced from the 999 and 277CA instead of looking at the X12 format?

You need to inquire about your vendor/clearinghouse plan for upgrading your system and you want to evaluate the impact of your practice and begin planning for training and transition. Consider the impact this may have on patient registration, billing, appointment scheduling, and claims reconciliation.

Your first point of contact should definitely be your practice management vendor. We would certainly hope that your vendor is aware of what's going

on with 5010. Hopefully, you've already worked on your 5010 upgrade and have a plan for rolling out your updates.

And slide 24, test early and test often. We'll be testing you here for HIPAA 5010, January 1, 2011 through December 31, 2011. Direct submitters should contact the MAC Help Desk to coordinate testing procedures. CMS indirect submitters will need to contact their respective vendors for their testing process.

Prior to being granted access to submit production 5010 transactions, direct submitters will be required to be 100 percent compliant for structure and syntax, and 95 percent compliant on Medicare business rules. Submitters will be in the test status until installed with the approved software.

All right. And that concludes the presentation. I guess we'll now open up for Q&A.

Question and Answer Session

Operator: At this time, I would like to remind participants that if you have a question, you may press star and the number one on your telephone keypad. We'll pause for a moment to compile the Q&A roster.

Your first question comes from the line is Melissa Stiffler. Your line is now open.

Melissa Stiffler: Yes. I had a question on page 4, "if not required, do not send". What does that refer to? Does that refer to claims?

Jason Jackson: That's a formulated methodology that X12 has put into their Implementation Guide due to the author's handbook. The way that X12 has felt it clarifies when data shall be sent and within the situational requirements when it does not – it's not required in the condition.

Melissa Stiffler: So, it's not referring to claims. It's referring to data transaction?

Jason Jackson: Correct. It's a…

Melissa Stiffler: OK.

Jason Jackson: …formula in the Implementation Guide. It will tell you what the data – the situational data elements will all have that kind of a note on them, if not required, do not send.

Melissa Stiffler: OK. Thank you very much.

Operator: Again, I would like to remind participants that if you would like to ask a question, you may press star and the number one on your telephone keypad.

Your next question comes from the line of Tara Nicola. Your line is now open.

Tara Nicola: Hi. I'm calling from a provider's office. We're in Pennsylvania and New Jersey, and we're just getting started with the 5010 – we're just learning about what we have to do.

I contacted our clearinghouse today, and they said they are not even accepting transactions from us to begin testing until January 1st of 2011. Shouldn't they be allowing us to test our transactions before then?

Jason Jackson: No, because the plans in the rule really states that they don't have to –they don't have to accept. The testing period was set as the calendar year 2011, so they really don't have to. I'm sure, somewhere out there, some clearinghouses are.

Tara Nicola: OK.

Jason Jackson: But they're not required to accept them prior to January 1st of 2011.

Tara Nicola: OK. And in the case – in our case, our vendor does not support our software anymore. It's a few years old. The last time we had it upgraded was when the 4010A came out. Is it going to be possible for us to send transactions to a clearinghouse and the clearinghouse make the 5010 changes or must we purchase some upgrade to the software?

Jason Jackson: You're really going to want to contact your clearinghouse to see if they are going to provide that functionality. And if they're not, then you're probably going to need to update your software.

Tara Nicola: OK. Thanks for your help.

Jason Jackson: Yes.

Operator: Your next question comes from the line of Enrita Caucula. Your line is now open.

Enrita Caucula: Hi. We are a software vendor. I'm calling from Medi-Facts. And I had a question with regards to the point mentioned on page 23. It talks about a readable report for the 999 and 277CA transactions. And I was wondering if you recommend a particular format or we follow the format that we think is readable?

Jason Jackson: No. We don't. We've put some of the – put the 999 and 277CA examples out on our website but as far as the readable format, that's really kind of up to your own development.

Enrita Caucula: OK, OK. Thank you.

Operator: Again, I would like to remind participants that if you have a question, you may press star and the number one on your telephone keypad.

Your next question comes from the line of Carmen Gasca. Your line is now open.

Jason Jackson: Carmen?

Carmen Gasca: Hello?

Jason Jackson: Hello.

Carmen Gasca: Hi. I had a question in regards to the 5010. Is that only for implementation for providers as far as doctors, or is that for everyone that bills to Medicare? We're a DME pharmacy.

Jason Jackson: The DME pharmacies, you guys will be submitting the D.0 on the NCPDP format and we will actually be covering that in next month's National Provider Call.

Carmen Gasca: OK.

Jason Jackson: And that's on the 27th of October.

Carmen Gasca: Thank you.

Operator: Your next question comes from the line of Kristin Block. Your line is now open.

Kristin Block: Hi. What are the exact differences, you know, now when you're transmitting? You know, what exactly are the changes that are occurring?

Jason Jackson: On the Professional claim and Institutional claims?

Kristin Block: Just the traditional claim for E&M services because we don't really – we don't bill anything other than E&M codes.

Chris Stahlecker: Could you say what an E&M code is and then give us a little – is that a professional claim?

Kristin Block: It's just for office visits. We don't do any procedures, injections. We don't do anything in the office.

Chris Stahlecker: Hi. It's Chris Stahlecker to help out with that answer. We had conducted a prior audio cast on the Professional billing and that audio cast is available on the website that you were referred to earlier and you might want to have a look at that. That did go into detail about the data element changes between the 4010A1 version that you're currently billing and…

Kristin Block: And the 50…

Kris Alacar: …the 5010 version.

Kristin Block: And that, you can get on the cms.gov/versions5010?

Chris Stahlecker: Yes. You can find that audio cast there.

Jason Jackson: Right.

Kristin Block: OK.

Jason Jackson: Right. And the real side-by-side on the Medicare Fee-For-Service that's in that page.

Kristin Block: OK. Thanks.

Operator: Your next question comes from the line of Agnes Spielberg. Your line is now open.

Agnes Spielberg: Hi. We're calling from DarMed. We're a clearinghouse and we're wanting to know during the transition period of 1/1/2011 through 2012, how CMS is going to handle dual submissions, 4010 and 5010? Since we're a clearinghouse, we're submitting for many different providers and we're wanting to know once we're approved for 5010, do we have to send everything 5010 or can we send some 4010s and some 5010s?

Chris Stahlecker: Hey. It's Chris Stahlecker. Let me try to jump in here. We're going to have an upcoming audio cast where the MACs will be able to share with you the MAC provider outreach and education calls.

And depending upon the MAC, they may support your simultaneous 4010A1 submission of claims for some of your customers and the productional use of the 5010 errata version for other of your customers.

And depending upon that MAC, the rollout schedule of when you could begin your testing and transition to production should be made clear to you during the provider outreach.

So, just know that we're going to have an upcoming audio cast in December. I believe it's on December 8, and we'll cover the MAC provider outreach plans at that time.

Agnes Spielberg: OK. And one other question, on page 13 of the slide, on your spreadsheet, where you have all of your edits and at what level the edits we're going to hit?

The two headings onto the right, Proposed 5010 Edits Part B and for CEDI proposed, are those edits still proposed or are these now is done?

Jason Jackson: This is a screenshot from many months ago so these are actually the edits that are going forward. I'm not really sure if what we have here are the true edits. This is an example of them but…

Agnes Spielberg: OK. But your…

Jason Jackson: Whatever is on our website is what we're going forward with.

Agnes Spielberg: OK. And that's – OK. So if it still says proposed on the website and it's still – and then you all will as soon as you got them done, will update that?

Jason Jackson: Yes. Well, I mean the proposed – it's probably something that we just haven't taken off from our edits spreadsheets. I mean, everything posted on the website is what we are currently implementing within our adjudication systems and at the MAC.

Agnes Spielberg: OK. Because the last time I looked at it last week, it still says proposed so.

Jason Jackson: All right. So we'll make that change to our spreadsheets.

Agnes Spielberg: OK. Great. Thank you.

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

Paula Engardy: Hi. This is Paula Engardy from Altcare. We wanted to ask, what translator for the syntax editing is going to be used?

Jason Jackson: Go ahead.

Paula Engardy: Go ahead.

Jason Jackson: The translators are the ones that are – they are going to be – they are COT translators that our A/B MACs are using. It varies for A/B MAC jurisdiction. Is there any reason that you need to know exactly what's the translator?

Paula Engardy: Well, the reason, for the syntax editing, what we're finding is that many different organizations have their syntax editors editing in different ways. So for example, if I'm receiving from multiple trading partners, I might be rejecting claims that they would expect me to accept because they're using different products, Freddy versus Clarity. So is there's going to be one editing tool that gets everyone in sync that we're all using the same rules?

Jason Jackson: Well, we're currently – we're actually kicking off next week a certification process within CMS with all of our MACs. We have probably about 16,000 different test cases that they're each running and that they each have to show the expected results on the edits spreadsheet, which is on page 13. So, our goal is that all of our MACs will be editing the exact same way, so that no matter where you sent your claim, you will get the exact same response.

Paula Engardy: And are you're – what you're utilizing, is that going to be available for other vendors or clearinghouses to purchase so they can be in sync with you?

Jason Jackson: As far as the translators?

Paula Engardy: Yes.

Chris Stahlecker: Well, they're task products – again, it's Chris Stahlecker trying to appreciate the nature of the question here. We're resigned and honed the edits that Medicare Fee-For-Service will be performing and we've shared that in terms of these spreadsheets. It's not clear what value that would be for other billers.

I mean you're not going to be producing those error results. You're going to be producing the clean claims in order to be processed by our translator. So help me appreciate your question, what are you looking for?

Paula Engardy: OK. We're a payer that you're submitting claims to. So, if I have a different editor in place, from what you're sending to me, I may reject claims to you. Which I understand CMS will not accept rejected claims because you edit it with your rules.

So we're trying to keep our editors, you know, as close to yours as possible so we don't run into those types of issues. So, I didn't know if there's going to be something that a vendor in the industry is going to be very, very close to your editing rules that we should be looking at them.

Chris Stahlecker: Is that – I'm taking away from your question that you're really focused on coordination of benefits or crossover claims.

Paula Engardy: Exactly.

Chris Stahlecker: OK. And there will be an upcoming audio cast held on November 17th…

Paula Engardy: OK.

Chris Stahlecker: … on Coordination of Benefits…

Paula Engardy: OK.

Chris Stahlecker: …processing.

Paula Engardy: All right. Perfect. Thank you.

Operator: Your next question comes from the line of Carmen Starkweather. Your line is now open.

Carmen Starkweather: Hi. We're with Michigan Medicaid and this might be a question that you're going to answer on your upcoming call that you just mentioned, in November. But do you know when Medicare is going to start sending 5010 crossovers to Medicaid?

Chris Stahlecker: Crossover processing has actually – testing, I should say, crossover testing has actually started this week. There are six Trading Partners that have started to

receive the 5010 claim format. So, I believe in earlier calls or presentations, we had shared where you could go to sign up to begin testing and it's your regular COB website.

Carmen Starkweather: OK. Thank you.

Operator: Your next question comes from the line of Deb Gibson. Your line is now open.

Aryeh Langer: Hello?

Operator: Ms. Gibson, if your line is on mute, will you please unmute your line?

Deb Gibson: Yes. Can you hear me?

Aryeh Langer: Go ahead.

Deb Gibson: OK. I just want to confirm, on page 10, there is a couple of reference to generating flat files. Those flat files are just for the MAC's internal use, right?

Jason Jackson: Right.

Deb Gibson: It's nothing you'd be sending?

Jason Jackson: Correct. Yes.

Deb Gibson: OK. Thanks.

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

Paula Tooey: Hi. I have experienced some technical difficulties and in viewing the presentation so my apologies if I have missed this.

On a previous call, it was requested that we receive, or you would make available, actual sample files of the all these different reports so that we can – so that we can run a sample file versus just saying, "Here is the format that

we're expecting into our test environment". So, that we can ensure that what we're parsing and mapping is correct because experience has taught me that what you put on paper doesn't match what goes into production.

Jason Jackson: Yes. And actually, we're you able to download the presentation?

Paula Tooey: No. It froze up on me. I'm still trying to download.

Jason Jackson: OK.

Paula Tooey: I've been trying since 2 o'clock.

Jason Jackson: All right. Now, let me give you the website for our designated 5010 work and we have posted acknowledgment examples out there. So the website is www.cms.gov/mfff – for Medicare Fee-For-Service – 5010d0 and just go down to the Download section and I believe it's the last download on the page. It's a zip file that contains examples on the TA1, 999, 277CA, and a readme file that gives an overview of everything.

Paula Tooey: OK. And so these are files that we can actually use to test whatever it is that we're going to be creating, so that we can pull this into a database or what not?

Gary Beatty: Yes. This is Gary Beatty. You may have made some slight modifications to the files so that they run through your system to correct your Trading Partner IDs and so forth, so it makes it looks like something that you would expect to receive, but the base content is all there.

Paula Tooey: OK. Great.

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

Ben Johnson: Hello and good afternoon. I had a question on slide number 10. It says that claim numbers will be assigned with the new 277CA. Does that mean corrected claims will start to be accepted by Medicare? Is that coming down the road now?

Question and Answer continued

Michael Cabral: No. What they're saying there, is in the Implementation Guide for the Health Care Claim Acknowledgment, it is an option at the payer's discretion, if their system can provide as a response in the acknowledgement transaction, the particular claim control number, ICN or DCN (they're often called different terms in the industry) in the responding transaction. So when a good claim comes in, we take it and put it into our system.

We give you back that claim control number of inventory control number or document control number so that in the future, you could actually go in and do references either through a claim status inquiry and response transaction or an IVR. You won't have to call and get a customer service rep to say, "Did you get my claims?" By getting that number back then that would be positive confirmation that that claims has entered our system (inaudible) on legal responsibility. I'm sorry. It's Michael Cabral again.

Ben Johnson: OK. So at the present time, we wouldn't be able to use for corrected claims, you know, sending the claim back to you and saying- referencing that control number and…

Michael Cabral: No. No, we're not.

Ben Johnson: OK. Thank you very much.

Michael Cabral: OK.

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

Barbara Scott: On the 1500 form, we currently have in box 33 a Post Office box for the billing address, and in box 32 for the place of service, our physical address. Even though we get electronic downloads of checks and EOBs, will that have to be changed to a physical address, in box 33?

Brian Reitz: No. The HIPAA rules do not apply – I'm sorry. This is Brian Reitz. No, the rules don't apply to paper claims, so the P.O. Box prohibition in the 5010 837 Professional is not applicable to the paper form.

Barbara Scott: So, I'm OK just leaving it the way it is.

Brian Reitz: And it's working now? Yes, you're OK.

Barbara Scott: OK. All right. Thank you.

Operator: Your next question comes from the line of Nerage Patel. Your line is now open.

Nerage Patel: Hi. Nerage Patel. This is – we're a chiropractic office and unfortunately, I'm about nine calls behind since I missed nine of the first few calls.

My question is do we have access to the past calls and the slide presentation that you have?

Aryeh Langer: Yes. All of those presentations, the audio as well transcripts are available on the website I mentioned before. I'll say it again. It's www.cms.gov/versions5010andd0. Do you need me to repeat that?

Nerage Patel: No. I got that.

Aryeh Langer: OK. And then on then left-hand side of the screen, there is a link that says 5010 National Calls, and all the calls are listed there. And you can scroll through that page to go through the different presentations and…

Nerage Patel: Do you have – each calls are different as far as subject matter?

Aryeh Langer: Correct.

Nerage Patel: OK. So I should basically – and join in later on.

Aryeh Langer: All right. They're actually listed by date so you can just start with the first national call and – let's say to move forward.

Nerage Patel: OK. Just listening to your presentation today, not knowing the terminology and everything, I was kind of lost. So, I just want to make sure that do I need to go through each one of those before I listen to the future ones that are live?

Aryeh Langer: No. I would also recommend we have on that web page that I just mentioned, there is – again, on the left-hand side of the page, there's a link that says Educational Resources. And there are two fact sheets and two checklists as well as the special edition MLN Matters Article and that has a lot of the background of 5010. So that might be a good place for you to start.

Nerage Patel: OK. Thank you.

Operator: Your next question comes from the line of Rebecca Standfire. Your line is now open.

Rebecca Standfire: Hi. We're going to be 837 documentation. We're having a hard time interpreting what the situational semantics are. It says when we need to send this situational data elements but then if finishes with "if it's not required by this Implementation Guide, do not send". What does that mean?

Michael Cabral: This is Mike Cabral. And I was – I'm not sure if you heard the answer to the previous question. When X12 authored all of the Implementation Guide, they did it in keeping the note consistent across the different TR3s that are now out there. That was actually a requirement from the author of the handbook as direction to create the TR3s.

Now, to your true question, I think, what I'm hearing is you need to understand when do I send a particular data element and when do I not? And I'm sure that's nothing we can get into right now unless you're doing a simple provider claim, that you may be better suited to go back and look at the – are we in the third one, Brian – the third national call? Do you remember that?

Brian Reitz: Sure.

Michael Cabral: The 837 Professional if that's what you're filing or the 837 Institutional, may give you some background on how to file your particular claim form, that type in the 5010.

Rebecca Standfire: OK.

Chris Stahlecker: And that would be in the…

Rebecca Standfire: OK. So, it sounds like I can't just look at the description above there to decide whether we need to send that data element.

Brian Reitz: This is Brian Reitz. And that's exactly what you should be looking at. The intent is to make it clear when you are to send something and when you are not to send something.

In the past, the language was very soft. They would use words like should and a word like should doesn't really tell you and give you a firm direction to go in. So what they've said was, they'll give you a rule and then they will say, if not required, do not send. Which means if the situation doesn't apply, don't send that particular element.

Rebecca Standfire: Okey-doke. Thank you.

Operator: Your next question comes from the line of Lydia Tickwind. Your line is now open.

Lydia Tickwind: Hi. I'm calling from a provider's office. We send Professional claims. And a lot of this is a little bit over my head but I was just hoping you could bear with me and help me sort this out.

I understand that the 5010 is sort of like a new platform that we're going – a new version, but I'm a little confused as far as the 277 and the 999. Is that basically new edits set up so that the communication between the clearinghouse and us as a provider is more – like the 999, is that where – like there is errors in the loops?

Aryeh Langer: Yes.

Lydia Tickwind: And then the 277 is basically we see the status that a claim actually did get to the MAC?

Aryeh Langer: That's correct.

Lydia Tickwind: OK. And then I don't understand why wouldn't – could you say will the upgrade include the acknowledgment of transactions of the 277, 999? Wouldn't that kind of be like a package deal? How can a vendor pick and choose what they're going to offer us as a client?

Chris Stahlecker: I'll take that one. It's Chris Stahlecker, if you don't mine, and then I'll toss it back to you, Jason.

A vendor –we are encouraging you to contact your vendor and ask questions like, does your license agreement with your vendor include regulatory updates only? Because we tried to point out that the 277 Claims Acknowledgment is not yet a HIPAA regulatory…

Lydia Tickwind: Oh, I see.

Chris Stahlecker: So it's proposed to become one and Medicare Fee-For-Service, as well as many other payers, are taking this as an opportunity to implement that transaction.

Lydia Tickwind: I see. So the only regulation is the upgrade, but the transactions are not.

Chris Stahlecker: No. There are many transactions that are part of the HIPAA- current HIPAA-required transaction set - an 837 Professional claim and 837 Institutional claims. And the required format today is Version 4010A1.

Lydia Tickwind: Right.

Chris Stahlecker: And so the real crux of this is to make it clear that the next HIPAA version required to be used is Version 5010. It will be a 5010A1 or this 5010 errata version.

Lydia Tickwind: Right.

Chris Stahlecker: But still, the 277 Claims Acknowledgment is not required.

Lydia Tickwind: OK. OK.

Chris Stahlecker: But it's only- Medicare Fee-For-Service will not be producing today's proprietary version of error report. Today, you get back like an H999 something or other out of the Medicare shared systems. That will be going away and being replaced by 277 Claims Acknowledgment.

Lydia Tickwind: OK. And then this is kind of -probably a weird question to you but for a provider's office, is it really – I mean a lot of this is more behind the scenes at the clearinghouse.

Chris Stahlecker: Absolutely.

Lydia Tickwind: But as a – from a provider's standpoint, is really the only difference we are going to see, because we send our claims electronically, is the ICD-10?

Chris Stahlecker: Well, you're not going to see a change with ICD-10 at this time. ICD-10 has a different timeline.

Lydia Tickwind: OK.

Chris Stahlecker: That won't go live until October 1, 2013.

Lydia Tickwind: OK.

Chris Stahlecker: What you're going to see are subtle changes regarding different data elements and some improvements in some of the transactions. If you happen to be an electronic remittance receiver, are you?

Lydia Tickwind: Not yet.

Chris Stahlecker: Not yet. Well, you might like to know that when a claim is denied for medical review purposes, the transaction will now include the URL of the local medical policy where you can look up to see why the...

Lydia Tickwind: Oh, OK.

Chris Stahlecker: So there are some improvements in the 5010 version of transactions that might make some of these more useful to you.

Lydia Tickwind: OK. Great. Thank you so much.

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

Jason Jackson: Go ahead.

Operator: Mr. Davis, if your line is on mute…

Jeffrey Davis: I'm sorry.

Jason Jackson: Go ahead.

Jeffrey Davis: All right. I have a question in slide nine.

Jason Jackson: OK.

Jeffrey Davis: I'm not pretty sure about the third point, the clearinghouse and vendors may consider offering the 277CA.

Jason Jackson: That goes back to the last question that we're just talking about and that the 277CA is not part of the HIPAA reg…

Chris Stahlecker: Regulation.

Jason Jackson: …regulation. So therefore, they're not required to include a human readable format. I mean, obviously, I would assume they'll have the 277 back to you but hopefully, your vendor would take that X12 format and turn it into a human readable screen so that you would know exactly what happened with your claims.

Jeffrey Davis: All right. Thanks.

Operator: Your next question comes from the line of Gracey Oaks. Your line is now open.

Gracey Oaks: Hi. I'm calling from a dermatology office and I am just curious. You had said earlier that you could get the audio and transcript for the education call

for the Professional billing. And I found the one for the Institutional, but not the Professional. I'm wondering if I'm looking in the wrong place. Can you tell me again where we can find those?

Aryeh Langer: They should be on the same page that you're looking at. Are you on the 5010 National Calls page?

Gracey Oaks: Yes.

Aryeh Langer: And which – I'm sorry, I don't have it in front of me. What – is that the May 26th call?

Gracey Oaks: Well, I went through several of them, but I didn't see it. Let me see. I've went from the first to the 8th.

Aryeh Langer: Do you want to – I can send you an e-mail? Do you want to just give me your e-mail address and I can get in touch with you after the call?

Gracey Oaks: OK. It's xxxxxxxxx@xxxx – X-X-X-X – xxx.com.

Aryeh Langer: Xxxxxxxxx@xxxxxxx.com.

Gracey Oaks: Right.

Aryeh Langer: OK.

Gracey Oaks: All right. Thank you.

Aryeh Langer: Sure.

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

Robin Biggs: Hello. We are a small independent outpatient physical therapy clinic. We do not have a vendor. We bill directly to our MAC through their free PC-Ace Pro32. Will this be able to continue or are we required to have a vendor?

Jason Jackson: No. You can continue submitting claims thru the PC-Ace Pro32 tool.

Chris Stahlecker: There will be a new version. Hi, it's Chris again. There'll be a new version that will accommodate the 5010 format and actually that is available right now to your Medicare Administrative Contractor but there will be a need to have a new version given to the MAC that will include the errata transaction.

So, yes, it will be upgraded. And just to say it, for any – that will be for Medicare Part A or B billing and the Medicare Remittance Easy Print software for Part B. Remittance handling will be upgraded as well as the Easy Print Medicare Part A remittance package will be upgrade.

Question and Answer Session continued

Robin Biggs: OK. And so when all those upgrades are available, we'll just be notified by our MAC?

Chris Stahlecker: Yes, you'll get a notification from your MAC. And just to make sure that we're getting in full information, the Pro 32 product will also be upgraded to receive the 277 Claims Acknowledgment and produce a readable report for you.

Robin Biggs: Great! OK. Thank you very much.

Operator: Your next question comes from the line of Margaret Stewart. Your line is now open.

Margaret Stewart: I just wondered, where should we be at this time as far as testing in the office is concerned?

Chris Stahlecker: It's Chris again. In terms of the regulatory timeline, calendar year 2010 was meant for all of us to be doing our own internal testing. So, every covered identity, every provider, every payer, every clearinghouse, it was meant for you each to be doing your internal testing in preparation for January 1, 2011 where we're all required to support testing with our external Trading Partners.

Margaret Stewart: Well, our vendor says that they are still testing. So, they have until January of 2012, correct, to be testing through all next year as well?

Chris Stahlecker: Well, they have until January 1st of 2012 to completely transition all of the vendor's customers so that they're all all ready productionally submitting the 5010 version. So as of January 1, 2012, the current version 4010A1 will no longer be able to be exchanged. So, everybody needs to be on the new version and all the dust settled so that we're all ready to turn off the 4010 format.

Margaret Stewart: OK. And one other question. Are there going to be any changes in the 1500 form for the ICD-10 or is that Form going to be pretty much the same because I do submit quite a few paper claims to different companies. So, I was just curious?

Brian Reitz: Right now, the form is not ready to change. The National Uniform Claim Committee is currently working through that. I'm sorry, I forgot to say my name again. It's Brian Reitz.

The National Uniform Claim Committee is working through that and they will make some determinations on how to make modifications to the form. Where they're leaning right now is nothing drastic to change, just taking the existing fields that are currently on the form and tweaking them a little bit. One of the things that you said, for diagnosis codes, to get that to be able to handle the 12 that are now allowed in the 5010 837.

Margaret Stewart: Thank you very much.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Sheppard Collins. Your line is now open.

Sheppard Collins: Yes. Hi. We're an RNHCI, so our claim volume is low and we have a very limited scope of codes that we use in our claims. If we confirm that our MAC and our software vendor, which in this case is PC-Ace, are 5010 compliant and we're pretty much – are we pretty much set or do you know if there are any other 5010 RNHCI specific changes that we'll need to implement?

Brian Reitz: To the MAC question, what you mentioned about the free billing software, that will be updated for your 5010 claim submission, you'd be fine there.

Sheppard Collins: OK. Since we don't use a clearinghouse and we do use the PC-Ace as I mentioned, we – should we contact our MAC to make sure that they have the latest version, the 5010 compliant version?

Jason Jackson: Yes. The A/B MACs will all have the system, the compliant version, so you'll just need to contact your MAC and set up testing with them…

Sheppard Collins: All right.

Jason Jackson: …so that you can move from 4010A1 to 5010.

Sheppard Collins: OK.

Chris Stahlecker: And note that we're going to have an audio cast on the MAC provider outreach, so likely they will be contacting you with what you need to do to obtain the new 5010 compliant version.

Sheppard Collins: All right. Also, VisionShare and IVANS are two companies that provide access to Medicare's Direct Data Entry system. Are there any 5010 compliant guidelines that they'll need to adhere to or as simple portal providers is 5010 compliant, something they don't really – doesn't really affect them? Are you familiar with the VisionShare and IVANS?

Chris Stahlecker: Absolutely, absolutely.

Sheppard Collins: OK.

Chris Stahlecker: We're mostly familiar with them. It's Chris Stahlecker. Mostly familiar with them as connectivity…

Sheppard Collins: Right.

Chris Stahlecker: And with that respect, again, it will be part of the MAC outreach whether or not a MAC is requiring different submitter IDs. So, then there is – each MAC

may have a different approach and that's within their purview to establish, you know, those patterns.

So the network services, vendors, the ones that enable connectivity will also be part of the MAC outreach, and any changes that that MAC is requiring will be specified by them to their Trading Partners.

Sheppard Collins: All right. And pardon if I repeat this. I'm just not sure here. Do you know if there's any 5010 RNHCI-specific changes that we'll need to implement? Or am I getting too specific?

Brian Reitz: This is my question. There's no specific changes for that line of – for your specific line of business. What I would encourage you to do is, as what's mentioned to other callers is to go to that – go to our website where we have the Institutional, you know, the 837 Institutional files, the audio and the transcripts and view those slides also and that would answer your question because there isn't anything specific for that RNHCI.

Sheppard Collins: All right. Thank you very much.

Brian Reitz: You're welcome.

Operator: Your next question comes from the line of Jerry Reeds. Your line is now open.

Jerry Reeds: Yes. My question was answered. Thank you.

Operator: Your next question comes from the line of Enrita Caucula. Your line is now open.

Enrita Caucula: Hi. Sorry. We found what we were looking for, so thank you.

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

Donna Dusit: Hi. Good afternoon. The 999 examples that you have do not have any of the CTX segments. I wondered if you could talk a little bit about how the CTX

segments will be used and if there are some examples other than in the TR3 notes?

Michael Cabral: Actually, with the errata, some of the CTX segments were changed to not used. It's an issue with the way the Health Care Insurance Subcommittee – this is Mike Cabral again. Thank you, Misha. I lost my train of thought now.

Oh yeah, thank you. The CTX segments, we found there was a problem with the way health care identifies a looping structure like 2100 AB or 2110, you know, BA. That doesn't actually fit into some of the composites within the CTX segments. You will find when you review the errata, some of the CTX segments were changed to not used…

Donna Dusit: Right, but, only a couple of them, like…

Michael Cabral: Yes.

Donna Dusit: So, OK, OK. Thank you.

Operator: Your next question comes from the line of Anthony Carvone. Your line is now open.

Anthony Carvone: Hello.

Chris Stahlecker: Hi.

Male: Hi.

Anthony Carvone: Hi, Chris.

Chris Stahlecker: Hi.

Anthony Carvone: Hi, everybody. Actually, it's not a question. I just wanted to mention, I work for NGS and I deal with the PC-Ace program and the EDI department. And I just want to make sure that those that have called, especially the one that said she didn't have a vendor.

If you're using PC-Ace and using the free program, we are actually a vendor. So, you know, you should just establish that if you're using the free PC-Ace program, we are your contact for any questions on 5010. You can contact us directly at our EDI Help Desk number. That's 1-877-273-4334. Again, it's 1-877-273-4334. Sorry about that, I almost forgot the number.

And the other thing is as far as the 5010, the PC-Ace, we're actually working on it with each upgrade that you get silently behind the PC-Ace, 5010 is being implemented. So, I just wanted to bring that out, Chris, and to everyone on the call.

Chris Stahlecker: Well, thanks for your comments, Tony. And I just wanted to remind everybody on the call that Tony is only speaking from one of the MACs from…

Anthony Carvone: Yes.

Chris Stahlecker: … one Medicare Administrative Contractor's perspective. So although he gave out a number, please, the rest of the audience needs to realize that each MAC has their own EDI Help Desk number. Tony only related NGS'.

So, although that's true, the MAC will be your point of contact to receive a copy of the Pro 32 software and to that extent, they are your conduit to obtain that packet. You do need to stay working with your own individual assigned Medicare Administrative Contractor, your own MAC.

Anthony Carvone: Yes, I appreciate that, Chris, because basically, in the MAC universe, I only think of my own world.

Chris Stahlecker: I appreciate that Tony. Thank you for your comment.

Anthony Carvone: Take care, guys.

Aryeh Langer: And Shannon, we have a time for one more question.

Operator: Your last question comes from the line of Barbara Scott. Your line is now open.

Barbara Scott: How do you do internal testing if everything that's involved in the changes is behind the scenes at the clearinghouse?

Chris Stahlecker: Hi. It's Chris. I'll take that one. Really, the clearinghouse is meant to do their internal testing. Providers that are doing their own EDI and their own software development to bill directly, that would have been their opportunity to do internal testing.

For those sites that are dependent upon supplied software, of course, the developer of that supplied software is doing their internal testing right now. That vendor will need to deploy their product and have an install test or a site test at each of the provider location. And that's what you'll undergo when you begin testing with your Medicare Administrative Contractor.

Barbara Scott: Thank you.

Chris Stahlecker: Thanks, everybody.

Aryeh Langer: Well, I'd like to thank everybody for joining us on the line for today's call as well as our Medicare subject matter experts here at CMS.

As mentioned previously, our next call is scheduled for October 27th and will focus on the NCPDP Version D.0 transaction, so you might want to mark your calendars now and be out on – be on the lookout for a listserv message announcing the call details. Have a great day.

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

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