Centers for Medicare & Medicaid Services
HIPAA Version 5010: Eighth National Provider Call –
276/277 Health Care Claim Status Request and Response
Moderator: Aryeh Langer
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Contents

Welcome

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

I will now turn the conference call over to Mr. Aryeh Langer.

Aryeh Langer: Thank you, Shannon. Good afternoon and good morning to those of you on the West coast. As you probably know by now, this is Aryeh Langer from the Provider Communications Group here at CMS. And for the eighth time, I'd like to welcome you to HIPAA Version 5010 National Conference Call.

Again, for anyone who did not have a chance to download today's presentation, please visit our dedicated 5010 Web site which is located at www.cms.gov/versions5010andD0. Again, www.cms.gov/versions5010andD0, and just click on the 5010 National Call link on the left-hand side of the screen. You can then see the link for today's call.

As with all of our previous 5010 National Calls, there will be a Q&A session following the presentation. Please take advantage of this unique opportunity to ask questions from our Medicare subject matter experts. With that said, I like to introduce our speaker for today, Gary Beatty is a HIPAA transaction subject matter expert and works closely with the Division of Medicare Billing Procedures here at CMS.

Gary?

Slides 1-10

Gary Beatty: Thank you, Aryeh. I'd like to also echo your welcome to everybody for this afternoon's call or those on West coast, the morning call. If you downloaded the presentation and the cover slide has Mike Cabral's name on it and,

unfortunately, he couldn't be here today so I'm going to do the presentation for him today. So I'd like to do is go to slide number two and just kind of talk about today's call.

We're going to highlight the significant differences between the version 4010A1, 276 and 277 transactions for Claim Status Inquiry/Response with the 5010, 276 and 277 transactions. We also have provided Medicare Fee-For-Service activities related to the implementation of these transactions, to discuss the errata that was – is being published by X12, to provide additional guidance on what to do, and then to solicit feedback from the participation – participants of this call during our question and answer session towards the end of the presentation.

On slide number three, we have the agenda. We're going to go through a general overview. We're going to talk about the significant differences, again, between 4010 and 5010. We're going to get into CMS's implementation of the 5010 transactions, touch on the errata for the 276 and 277, our timeline for implementation and the deadlines that we face, and then what you need to do to prepare for implementation of these transactions, and then the Q&A.

On slide number four, what was adopted under HIPAA for version 5010 are the X12 standards for Administrative Transactions. We do have a new term for these in version 4010. These were simply referred to as Implementation Guides. Now within version 5010, these are referred to as Technical Report Type 3s or TR3s.

So, if you hear people yelling out TR3s periodically, you know it's the same things that we have in the version 4010 as far as Implementation Guides. Some the general changes in the transactions, a lot of the Front – which what we refer to as the Front Matter of the transactions was revised to be consistent across the suite of the Implementation Guides.

We wanted to make sure that things all meshed together a lot better, clarified a lot more of the information inside these guides to make it clear and easier to implement the transactions. The content of the rules in the TR3s, we're going to talk a little bit about the situational data content and how those changes

were modified. A lot of the ambiguities are removed within the TR3s. A lot of the shoulds, coulds, mays, are now replaced with must in many of the cases relative to the situations, and how we handled, not required data content, and that is cannot be sent.

On slide number five, some – just wanted to kind of go over the family of the implementation guides or the TR3s for the 276 and 277 transactions. Just like the 837 for health care claims has several implementation guides for professional, institutional, and dental, we also have a suite of TR3s for the 276 and 277 transactions. The first of which is the one we're talking about today which is the 276/277 Health Care Claim Status Request and Response. And it is followed by the guide ID in parenthesis. So, the Guide ID for this specific TR3 is 005010, which is the version release andsub-release of this X12 standard, with a Guide ID of X212.

We also have a 277 Health Care Claim Acknowledgement, and actually will have one of the upcoming monthly presentations will cover this transaction. And we've actually touched on this one at several previous months' presentations as well, but it's another use of the 277.

There's a use of the 277 Health Care Claim Request for additional information which is part of the requirement under HIPAA, or will become part of the requirements under HIPAA for health care claim attachments andwe can use the 277 to request those. We also have two other ones, the pended claim status is used for a report for claims that are in adjudication and are being pended, and it's a way reporting that back to the health care providers. And then we have another guide that's – not as well-known out there that used for property and casualty insurance which is guide 227, which is used to support disability claim information.

So we're going to focus on the first one of those, guide 212 today. So on slide six, some of the overall changes in Section 1 of – in the business purpose and scope. A lot of information has been updated, again to make this guide consistent with the other Implementation Guides. It was one of the focuses of the version 5010 transactions.

One of the bigger changes out there is item number two, dealing with the situational loop segments and data elements where we modify the situational language to conform to one of two different formats. We have format number one where if the situation is – if the data is not required, you simply cannot send the data content. Where the second form is the data can be provided even if the situation is not true by the sender, but it cannot be required by the receiver. So when we look at the situations, we got rid of the shoulds, coulds, mays, became much more definitive on those situations and those situations will fall into one of these two categories.

We also made some modifications to the appendices at the back into the Implementation Guide, again, for consistency purposes as we did pull out sections of the TR3s dealing with acknowledgements and so forth, as they are now separate Implementation Guides rather than incorporated into each of the individual Implementation Guides. And then, we also modified the identifiers for the Implementation Guides to be based upon version 5010 and guide 212.

On slide seven, some more of the Front Matter changes. We have included a lot more – there's a lot more language inside to hear in section 1.4.3, dealing with the STC segment which is the Status Information. And it was basically there to report more consistent information on various status levels within the transaction. So, it describes how you use the status, whether it's the receiver, the status information, or the submitter of the request to the subscriber and the dependents. So, we're trying again to deal with a lot of consistency issues there.

There also – in item number two is additional language that was added dealing with real time versus batched transactions and transmissions. CMS is setting the stage for in the future to be able to do real time. We are not capable of doing that right now but we're setting the stage to be able to do real time claim status inquiries for the future. And a lot of new business terms were added to section 1.5 to, again, provide additional information to make it easier to implement the transaction.

Slide number eight, table two of the transaction. We start getting into more of the details of the transaction loop. 2008 is the information source, detail information. We've added additional language. There's more information in here that define exactly who is the information source.

We're also eliminating some of the qualifiers for the payer down to either the Payer ID which is called PI, or to the CMS Plan ID which we will be code XV of which that we will see the requirements for that coming up here in the future. Item number three. We've also setup that one. You do have a Payer ID that is established with the Trading Partner Agreement and the note on the NM109 was thus eliminated.

Slide number nine, ontinuing to the next level with 2000B. This is where we deal with who's the receiver of this request for information. Again, we – there is clarification language in here to better identify who is the receiver of this transaction. We've also changed the name from a required to situational - this is item number two - for the information receiver name. The suffix for the name was eliminated and then the qualifier was limited to just code 46 which is an ETIN or Electronic Transmitter Identifier Number now which is established by a Trading Partner Agreement.

Slide 10. We're going to get into the next level within the transaction that deals with the service provider. Again, additional of information was added to this section to over clarify who the service provider was. This loop was increased from a – an occurrence of one to two to allow for two providers names to be included in this loop. Again, we changed some elements from required to situational and we also eliminated the note on NM108. The SV, that Service Provider Number, was deleted to conform to what we need relative to the natural provider ID

Slides 11-20

Slide 11. We're going to get down into the subscriber and dependent sections of this transaction. Again, differences between 4010 and 5010. The HL segment notes changed to reflect the subscribers and dependents. Again, one of the changes that we've had across all of 5010 transactions is to clarify subscribers versus dependents. And that if you do have a dependent that's

uniquely identified, that that person is considered to be the subscriber so we have additional information to over clarify that within the HL.

We've also, in the DMG on item number two, removed the unknown gender and to also reflect the differences between subscribers and dependents. Item number three, the Claim Status Tracking Number, was changed, the name. from the Claim Submitter Trace Number. And then, item number four, the Payer Claim Control Number was changed to – from the payer claim identifier number and modified its usage. And I would like to point out that on item number four, as we look at what we've done relative to how we receive and process and edit claims, and we'll touch this a little bit later in the presentation, is that Medicare will be assigning the claim ID as the front end for accepted claims. And we will return that on the 277 Claim Acknowledgment to aid in the searching in the future when providers do want to do claim status inquiries, so that's what will go into this record segment. It will be the same data that will return at the front end when we do a receive claims that are accepted.

On slide number 12, we have some additional changes relative to the Institutional bill type. We removed some of the notes here and, basically, noted how REF02, the bill type identifier, is constructed so it's clear on how the information is to be put together.

We did remove the Medical Record Number which is item number six and added the Application or Location System Identifier for REF, and that's item number seven. And then the Usage Note for the group number was modified as well for the subscriber and the dependents.

Slide number 13, some of the new segments that we have in this section. We've added the Patient Control Number for pharmacy transactions. We have the Prescription Number added, as well as Claim Identification Number for clearinghouses and other transaction intermediaries or other organizations that handle claims between the providers and Medicare.

Number 10, we have an AMT, the Claim Submitted Charge usage and notes were changed to reflect the searching capabilities. Again, one of the major

changes we had in the 276 was modifying language to be able to better support the ability to search and find the claims.

Slide 14, again still at the same subscriber and dependent level, we have the – we're down into the details of the SVC segment, where we have the Service Line Information. We've added some additional qualifiers in the SVC for Jurisdiction Specific Procedure and Supply codes. There's also a Health Insurance Prospective Payment System or HIPPS Skilled Nursing Facility Rate code.

And we've also removed some codes, that being for the ICD-9-CM and the National Health Related Item Code. And we've also changed the Units of Service to required, so that's also another change. Item number 12, the Service Line Identification usage and those were updated, again, to aid in the searching for service lines within a claim.

As well as the DTP, we also originally only had the old files for range of dates. We've also – we now have the ability in Version 5010 to use the D8 qualifier, which is a Y2K happy date, CC/YY/MM/DD, so century-century, year-year, month-month, and day-day, so giving a little bit more flexibility to the searching capability there.

On slide 15, we have, again, additional information dealing with – specifically to the subscriber. The subscriber, we removed the QCs now that we have better identified who's a subscriber versus who is a dependent of the subscriber. We've removed the QC qualifier and we've also replaced the ZZ Mutually Defined ID qualifier with the identifier we're eventually going to use for the HIPAA-mandated individual identifier which is code II for the Unique Health ID. For specifically for the dependent item number two, we removed elements for dependent identification.

We get to slide 16, we start switching and we move away from the 276 transaction and request to a 277. And a lot of the information that we get into this section will be somewhat repetitive to the information we have in the 276 because they are inquiry responses with a lot of repetitive information in the

response to the inquiry. So, you're going to see a lot of information that's similar to what we just talked about.

So we have a lot of clarification information on item number one defining who the information source is. Again, we've limited the qualifiers for the Payer Name to just PI or XV, so, Payer Identification or the CMS Plan ID. And again, and in 108 and item number three, the identifier is established in the Trading Partner Agreement.

Number four, the Payer Contact Information, this segment was changed in the 277 from – the situational rule was updated and the communication qualifiers were also updated, again, to be consistent with the other TR3s.

Page 17 or slide 17, the 277 Information Receiver, now of the status and we had added additional language in item number one to the HL to over clarify who the receiver of these – the status information is. Item number two on the slide, the Information Receiver Name was changed from required to situational; the subtext was eliminated.

And, again, in NM108, it is now limited to just the ETIN, again, Electronic Transmitter Identifier, again, if that's established between the submitter and receiver in the Trading Partner Agreement. The trace number was added, the TRN to – for audit purposes and tracking of the transactions. And the STC information for the receiver was added as well to over clarify how to use the status information.

On slide 18, we have, again, table two for the Service Provider and we added the TRN for the Provider of Service Trace Identifier, again, for audit and tracking purposes of these transaction to link – the 277 back to the 276. We've also added the STC for the Provider Status Information and this is used to provide information relative to – from a provider perspective, especially in cases where if the provider isn't authorized or they didn't find the claim or they didn't find the provider in the system, we can report that with the STC at this level.

The subscriber and dependent, we've removed the demographic information, again, because we now have better identified subscribers and dependents. We don't have the QC, the patient qualifier and we also have the Claim Status Tracking Number in the TRN.

The next line actually has a typo, it should be 277 Table 2 Subscriber/Dependent Detail. Again, that we have the Claim Status Tracking Number and the loop has changed again from the Claim Status Trace Number. The STC, the actual status for the claim, was changed from usage of 1 to >1, which means that this segment now can be used as many times as the submitter wants to use relative to the submitter information. And then well again, we have the Payer Control Number and, again, that's the same number that Medicare has assigned to the claim.

Slide 19, it's a little bit more detailed. The subscriber and dependent for the Institutional bill type, again, have additional information to clarify how REF02 is constructed. We – again, we've removed the Medical Record Number, and again, we have added the same segments for Patient Control Number, the Pharmacy Prescription Number, the identifier for the clearing house or other transmission intermediary. And one other one that we didn't have it in the 276 is the Voucher Identifier, a new REF.

Item number seven, we have changed the Date Qualifier from 232, which was Claim Statement Period Start to 472 simply, which is just for the Service, which is also consistent with the claim Implementation Guides. So, again, for consistency purposes. And we also added that same D8 qualifier for eight digit dates versus having a range of dates.

Slide 20, again, again we're getting into the detailed section. We have the SVC, the Service Line Information. We added the code ER and HP for Jurisdiction Specific Procedure Codes for the supply codes and the HIPPS Skilled Nursing Rate Code, and then we also, again, removed the ICD-9 and the National Health Related Item Code. And Units of Service, again, were changed to required. At these levels of the transaction, we also changed the ST from 1 to >1 so you can have as many status STC segments at this level.

The Line Item usage and notes were changed in the REF segment and again the DA qualifier was added so you can handle single date versus a range of dates. So those are the changes from a fairly high level. It might be a little bit detailed, but it's good to know that there you know what the changes are and where the major changes were.

Slides 21-28

On slide 21, we start getting into some of the discussion relative to Medicare's implementation of 5010. And the first thing I'd like to talk about in the slide is our Common Edits Enhancement Module. We've talked about this on some of the prior calls and want to include it here, as well, because we're also using the CEM or Common Edits Enhancement Module for Claim Status Inquiry/Responses. And as we do receive the 276 transactions, they will also go through the CEM and be edited to make sure that they are also valid. And we're doing this so that we can have consistency as we do look at those edits.

And so, it's basically one set of at it for both part A and part B. Looking at, you know, applying a consistent set of edits. And those -the edits that we will apply to these transactions as they do come in will be posted to the CMS website similar to the same fashion that we've been publishing the edits for the claim transactions for the 837 Institutional and Professional. So that providers will know specifically what types of edits we are applying to the inbound 276 transactions of claim status request and what the types of error messages that will be coming back and the codes that we'll be sending back when there are problems with the inquiry transactions.

So, the error handling, where we do have errors, we're going to be using the same that we have discussed previously with the 837s. If there are problems with the interchange envelope, if you will, the big envelope that we have, those will be reported with the TA1, which is the Interchange Acknowledgement, so this is a high level report, and generally when we do get one of these back, it will be a complete file failure so you'll have to re-transmit that interchange.

The 999 will replace the 997. The 999 is the Implementation Acknowledgement whereas the 997 is the Functional Acknowledgement and

it's where we'll be able to report X12 syntax and guide syntax violations back to provider relative to the inbound 276 transactions, and can result in all or single transactions being returned.

The 277CA, as I mentioned earlier, when we do receive claims, we will be sending back the 277CA, the Claim Acknowledgement. Again, we'll have an upcoming presentation in one of our monthly conference calls that will go through this transaction, how it is used. And again, please consult your vendors for specific questions regarding error reports and how they will format these acknowledgments as they are sent back to the providers.

The other thing that will be part of this – the Common Edits and Enhancements Module will also be Receipt, Control, and Balancing. It's a very important feature that we want to make sure that all of the various checks and balance are in place, the flags for balancing are in place, so nothing gets lost and we can track it and report on transactions, both coming as well as going out the door.

On slide 23, we have a couple of bullet points relative to the errata for the 276 and 277. The major changes for these transactions really are to the Front Matter. They're dealing with Appendix B and the Front Matter. The public comment period did close. The comments that came in produced what I called pay-to errata which basically are dealing with typographical types of errors.

And so, there really are no changes other than really replacing the values from the enveloping segments within the transaction to identify this that is – it is based upon the errata. So, CMS doesn't really anticipate that there will be any impact in moving to the errata for these two transactions. And so, really not a big impact here for the errata on the 276 and 277.

Slide 24 is our timeline for compliance dates with version 5010. The year – this year, 2010, CMS was going to internal testing towards the end of this year. We're going to be going through a certification process with the MACs to make sure that they do have and can demonstrate the capability of processing these transactions.

January 1st, 2011 we will begin external testing with providers and our production systems will be available for that testing. December 31st of 2011 is the last day CMS will accept any transaction based upon version 4010. So, starting on January 1st, 2012, if that is the mandatory compliance date with version 5010 for all of the transactions.

So what do you need to do to prepare? Slide 25. CMS has developed education materials such as these monthly presentations. There's also additional information on our website. So it's listed on item – bullet number two here, as Aryeh mentioned earlier, our version 5010 and D0 website. We also have our educational resources and we also have the dedicated page as well. We will have ongoing updates and News Flashes. We do have a frequently asked questions and the link is here.

If you need to obtain the implementation guides for the TR3s, please visit store.x12.org. One of the other websites that's very important especially for this particular transaction is the Washington Publishing website because some of the very important codes sets that we use within this transaction are the Health Care Claim Status Category Code, as well as Health Care Claim Status Code. Those are published on this website. When you do go to Washington Publishing's website, there is a link or a button for code sets and that's where you can find these codes, and those are available for free.

We also have the responses. The link here for the responses to the technical comments that came in during the regulatory comment period. And we also, if you do find in the future that you need to make changes or suggestions to these Implementation Guides or the TR3s, we included the link to the DSMO or the Designated Standards Maintenance Organizations website where there is a change request form that you can fill out to request changes to those Implementation Guides.

Additional steps you need to get ready. A lot of providers out there are dependent upon their software vendors to get ready. So you got to make sure that your license to that product or your products will include regulatory updates.

You may have to look at what their capabilities are relative to receiving the acknowledgments whether it's the 999 Implementation Acknowledgement or the 277 Claim Acknowledgment.

Will the upgrades be readable, include readable error reports for those two acknowledgments? You know, when will your vendor be upgrading it so you can kind of plan your timeline? Again, looking at 2011 and setting that timeframe into your testing timeframe as you look to implement the transactions. And then evaluate the impact to training and transitions as you go through 2011 so that you can be ready by January 1, 2012, for full compliance with version 5010.

In big bold prints on slide 27, test early and test often. You know the earlier you can test these transactions, whether it's your own internal testing or testing with the MACs, the earlier you test them, the better of you are so that you can address any issues that do arise during your testing timeframe.

Again, our testing timeframe is January 1, 2011 through December 31st of 2011. Submitters, direct submitters are recommended to contact their MAC helpdesk to coordinate the testing procedures on what they have set up. Locally, CMS indirect submitters will need to contact their respective vendors for their testing process.

General numbers that you have to look for from an inbound perspective is to have the ability to submit 25 276 Health Care Claims Status Requests at a minimum. And those transactions, prior to being granted production status, need to be 100 percent compliant from a syntax and structure perspective, and 95 percent compliant with Medicare business rules. And again, those business rules will be documented in that edits spreadsheet that will be found on the CMS website as well as in our supplemental documents. So you will be considered in a test status until you are approved for production.

So, we're going to get to our questions and answer session, just like to, first of all, say thank you. And also I like to say that we do have upcoming 5010

National Calls. The call in August is currently scheduled for August 25th; this will be on the 835 Remittance Advice, so that's August 25th.

September 29th will be the acknowledgments, followed up in October for the NCPDP Standards. And then in early December, we're going to do a presentation relative to the MACs and their implementation. So with that, I'd like to open it up for questions and answers.

Question & Answer Session

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

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

Your first question comes from the line of Brenda Howell. Your line is now open.

Lara Underwood: Hi. My name is Lara Underwood and I work at Pediatrics Medical Group. I have a question. Will we be doing a way with all claim status reports? Will the 276/277 be the process going forward to get claim status responses? Will all other reporting mechanisms be no longer applicable or will we receive both versions?

Gary Beatty: Well, the – if you're referring to the reports that come back when we receive claims, they will be replaced with the 277CA starting January 1, 2012. All proprietary reports that we currently send today will be replaced with that one transaction.

Lara Underwood: OK, thank you.

Gary Beatty: You're welcome.

Operator: Your next question or comment comes from the line of Gary Gibler. Your line is now open.

Gary Gibler: This is Gary Gibler from MAC's I.T. Consulting Group. Two-part question, two different questions. On page 27, the certification, I understand the mechanics, but is that an official document that's sent out and who is it sent to especially when the providers use vendors a lot?

Gary Beatty: Which document are you referring to?

Gary Gibler: When you – when they pass the certification, after they test it, they pass it.

Gary Beatty: Will they get some type of document?

Gary Gibler: Does that just come back to the tester or does that come back to the provider so that they know what's going on type thing?

Gary Beatty: Say for example, if you have a vendor and they have you know a host of providers that they're testing for …

Gary Gibler: Right.

Gary Beatty: The vendor itself can get certified. You don't have to certify each individual submitting provider for that given product.

Gary Gibler: But how does the provider know that vendor is officially certified? That's where I'm – rather than getting the word from the provider or – excuse me, from the vendor.

Chris Stahlecker: Contact the Medicare Administrative Contractors, the MAC, and ask them because each MAC will be maintaining a list of the vendors that have passed or completed their testing on 5010.

Gary Gibler: OK, that makes sense. My second question is I know you're CMS, so you're speaking for the Medicare, but the presentations are great because it should – in theory, it should be covering all communications. But if you have a carrier or Medicaid, should we be watching those presentations or will this all be the

same or is this just your interpretation of the rule? I'm receiving it as these are the transaction sets, these are the official directions.

Gary Beatty: Certainly.

Gary Gibler: Or they're just the CMS point of view?

Gary Beatty: Certain sections of the presentation, the difference – the sections that deal with the differences between version 4010 and 5010 are generic in nature and are actually are also documented within the TR3s as well. But when it gets to how other carriers will go through implementation, testing and certification, it will be up to those individual organizations to determine their process of doing that.

Chris Stahlecker: And this is Chris Stahlecker. I'd just sort of like explore that question with you a little bit. When you use the term carrier, did you mean other Medicare Part B?

Gary Gibler: No, no. I'm moving it to insurance carriers.

Chris Stahlecker: OK. You meant payer?

Gary Gibler: Yes.

Chris Stahlecker: OK. All right. Well, let me just use this as an opportunity to say where Medicare has not fully completed as deployment of MACs, you know Medicare Administrative Contractors, where some provider might still be dealing with the Medicare Part B Carrier, we have made arrangements for those carriers to be supported for 5010 by partnering with MACs. So, from a Medicare perspective, you'd be able to test any 5010 workload.

So, just I want to cover the base from a Medicare perspective, but I realize your question is more directed to other payers and Gary, I think, answered that with transaction perspective. Everything he covered is pertinent from a transaction and then the specifics than about how Medicare implementing that, it would only (inaudible). OK.

Gary Gibler: Thank you. That helps clarify it.

Aryeh Langer: You're welcome.

Operator: Your next question or comment comes from the line of Meredith Haddock. Your line is now open.

Meredith Haddock: Hi, this Meredith Haddock from QuadraMed Corporation. I just wanted to clarify what value you are wanting in Loop 2100B, NM109 on the 276? And if that should be the receiver like tax ID or should it be their submitter ID that's assigned by the payer?

Aryeh Langer: 2100B, the information receiver?

Meredith Haddock: Since it's changed to the 46 qualifier …

Aryeh Langer: Right.

Meredith Haddock: …I was wanting to clarify what should be in the NM109. If it – it had said that was based on the Trading Partner Agreement.

Aryeh Langer: Right. When you establish a relationship with your trading partner, you will mutually agree to whatever value you chose to within your Trading Partner Agreement for this value which is also consistent with the other transactions. So, when you're doing claims, for example, you have to establish an ETIN there as well. So, you can use the same ETIN once you enter a Trading Partner Agreement between you or whoever you're dealing with, the same value you use, for example, a claim you can use for these transaction as well, or you can agree to something else.

Meredith Haddock: We're a vendor, so I was trying to correlate it to like you know something on the 837 if it's going to be like the, you know the submitter ID versus the way – since it's been worded slightly differently by using that qualifier.

Aryeh Langer: The 837 uses the same exact qualifier.

Meredith Haddock: And the – is that in the 1,000 loop?

Aryeh Langer: I think it's in loop two – I'd have to go back and look for sure.

Meredith Haddock: I'll look. I'll double check...

Aryeh Langer: Yes.

Meredith Haddock: But as long as it's the same.

Aryeh Langer: But if you look up – if you look up you know an ETIN, you'll find the same qualifier …

Meredith Haddock: OK.

Aryeh Langer: …In the 837.

Meredith Haddock: Thank you.

Aryeh Langer: You're welcome.

Operator: Your next question or comment comes from the line of Kathy Sites. Your line is now open.

Kathy Sites: Hello, I'm Kathy Sites with RealMed and I was just questioning, when you say to view the edit spreadsheet in order to get information on the specifics, will there be a Companion Guide for this?

Gary Beatty: Thank you. That's a really good question. We are actually working on developing a Companion Guide, and that will be out later this year. I'm not sure of the exact date. Again, we'll post that to the CMS website.

That will be, you know, partially developed by the local MAC as far as their capability, but we'll also have generic content relative to each of these transactions. The other piece that I refer to, similar to the 837, we have an edit spreadsheet that defines each of the elements and how we're going to uniquely edit the elements within a given transaction. We'll have one of those for the 276 and 277 spreadsheets. So, that if you do have an error, you can see what the error codes will be coming back when a given error is produced.

Kathy Sites: OK. And this is not yet available, correct?

Gary Beatty: Correct.

Kathy Sites: OK. And just for a – sorry, go ahead.

Gary Beatty: The edit spreadsheet will be available within the next week or two. The Companion Guide won't be available until later.

Kathy Sites: And so, I'm assuming there'll be an edit number followed by a description?

Gary Beatty: Yes.

Kathy Sites: And all the MACs will use the same edit number on all the rejections and so?

Gary Beatty: Right. The edit number will be – its format is very much the same as the edit numbers we have in the 837 spreadsheet.

Kathy Sites: OK. OK and then I just had a clarification, when you talk about – we're talking about the 276/277 transaction and you talk about a 277CA response. That's 277CA is just going to be the response for the 837, correct? I mean …

Gary Beatty: For the 837, correct.

Kathy Sites: OK.

Gary Beatty: So when we do receive the 837 claims coming in, we're going to produce a Health Care Claim Acknowledgement which is 275, 277 as guide number 214.

Kathy Sites: Right. OK.

Gary Beatty: Yes.

Kathy Sites: I just didn't want any confusion with the – because we're talking about – I'm just expecting a 277 response, not the CA for a 277 request – 276 request.

Gary Beatty: Right. When you send a …

Kathy Sites: OK.

Gary Beatty: … 276, we'll send back a 277.

Kathy Sites: OK, thank you.

Gary Beatty: If we can find it and there are no problems with it.

Kathy Sites: OK, thank you.

Gary Beatty: Yes.

Operator: Your next question or comment comes from the line of Myrna Climaco. Your line is now open.

Myrna Climaco: Hi, this is Myrna Climaco from Nurture In Home & Hospice Services. Question is we use a clearinghouse for our vendor. So, when the 277 comes in, is the clearinghouse free to format it in the way they need to so that it's user friendly or you have that part in the Implementation Guide where you are restricting them to format it the way you want it?

Gary Beatty: If the clearinghouse is your clearinghouse and they're acting on behalf of your organization. When they get the 277, you can work with them to format the human readable report anyway you would choose. The beauty of this is that the reports that you do get back will be the same regardless what payer sent back the 277.

Myrna Climaco: OK. Follow-up question to that. Will there be guidelines in your Implementation Guide though for clearinghouses or vendors? As to how they would format it?

Gary Beatty: No. That is totally up to you and your vendor or clearinghouse in your case.

Myrna Climaco: OK. All right, thanks.

Aryeh Langer: You're welcome.

Operator: Your next question or comment comes from the line of Greg O'Neil. Your line is now open.

Ben: Hi. This is Ben with Intermountain Healthcare, and I had two quick questions. One was, is there going to be a cascading search with the 276 like there is with the 270? If that makes any sense?

Gary Beatty: Can you better define cascading search?

Ben: Well, like with the 270, you'll search on patient name, date of birth, date of service, things like that. With the 276, you just search on the claim control number or – how does that work exactly?

Gary Beatty: Well, we're hoping because, if, when we receive a claim, if we're accepting it into the adjudication system. We will be sending back a 277CA, again, that's one of the other ones, and that will have Medicare's claim ID, the internal control number for that claim. Certainly, the best way for you to use that is when you do a 276, to use that internal control number in the 276 transaction so that we can go directly to the specific claim that you are asking for the status on.

Certainly, the 276 also has other data content that if that number is not found that will be used to actually do the search for that specific claim. But the best of the world is to use that internal control number that we sent back to you in the 277CA.

Ben: OK. And then, do you know what the turn around time is from when you get the 276 to when the response would come back?

Gary Beatty: Chris, can you have this?

Chris Stahlecker: This is Chris Stahlecker. We have not worked out the definition of that with Medicare Administrative Contractors just yet, so that should be something that would be specified in your Companion Guide.

Ben: OK. Thank you.

Operator: Your next question or comment comes from the line of Frank Denario. Your line is now open.

Frank Denario: Good afternoon. My name is Frank, and I'm with Edgeman Healthcare. We're a vendor in South Florida. And I just like a clarification please, back to the 277CA. I get that we're not going to get the proprietary reports anymore and we're going to get this thing called the 277CA that's earmarked as, I guess, X214, but I don't see an X214 anywhere in the guides right now, in the X12, or the Washington Press sites.

I was wondering, is that format going to follow pretty closely to the normal 277 or is it going to be very different, and how do we request that from the MAC after the claims get sent – after the claims get sent up?

Gary Beatty: OK, thank you for your question. Right now, the 277 Claims Acknowledgment is not a HIPAA-mandated transaction. This is the transaction that Medicare will use to report back the status of a claim that is received.

From a perspective, where you get the guide, it is on in the Washington Publishing website. However, it is not on the HIPAA page if you will. There's a generic link to where other guides are located. If you have any questions, you can contact WPC directly, but it is listed there under the non-HIPAA Health Care Implementation Guide.

Frank Denario: I see. OK. And it's going to be requested similar to how we request the current? I guess, you know, we send a request for the current proprietary report and they send us back with a human readable file and I guess this will be similar to that. We'll just say give us this report and they'll give us this dump of whatever it is they've queued up in between the last time we sent a request. Does that sound about like how it might work?

Gary Beatty: From a 276/277 perspective, you'll send in the 276, and then the, again, the MAC will send you back a 277. How that gets formatted is really up to you and your vendor on how they will format and the same is going to be true for the 277CA.

Frank Denario: Well, I guess, what I'm asking is from more generic point of view on the 277CA. We don't have to physically do a 276 request for that, right?

Gary Beatty: Right.

Frank Denario: I mean because you're going to queue up all of the claims that have been sent from the provider at that point and give us back that CA report, right?

Gary Beatty: Correct. So, what's going to happen is when we receive the claim, the claim will run through, our front end EDI translators. They will then go through the Common Edit, the CEM, and then eventually it will produce as it goes through that process, the 277CA that will be sent back to you.

Frank Denario: OK. And when it gets to the mechanics of that, is that something we should go to the MAC for at some point?

Gary Beatty: Yes.

Frank Denario: OK.

Gary Beatty: Yes.

Frank Denario: And is there a timeline that you're enforcing with the MAC as to when they you know they should be ready to work with the vendors on how this process is working? Like are they supposed to be ready by 1/1 of next year or is it pretty much up to the MACs themselves?

Gary Beatty: Again, Medicare will be ready to start testing this January 1st, 2011 and the mandated implementation date will be January 1st, 2012.

Frank Denario: OK, so the MAC has to adhere to that as well then?

Gary Beatty: Correct.

Frank Denario: OK. Super. All right, thanks, gentlemen. I appreciate it.

Gary Beatty: You're welcome.

Operator: Your next question or comment comes from the line of Dennis Sullivan. Your line is now open.

Dennis Sullivan: Yes, thank you. This is Dennis Sullivan from Partners Health Care and my question has to do with the real time claim status inquiry. You mentioned that it's not capable at the moment and you're setting it for the future. When do you expect this to be available?

Gary Beatty: We don't have a timeframe established yet for when do we have the real time capability, but it's certainly on our radar scope.

Dennis Sullivan: But no expected time period?

Gary Beatty: As soon as we get a better idea, we'll be sending out you know again, more announcements relative to the real time capabilities.

Dennis Sullivan: Do you know when that will – OK, thank you.

Gary Beatty: Yes.

Operator: Your next question or comment comes from the line of Carol Hall. Your line is now open.

Matt Warner: Good morning. This is Matt Warner. I'm calling from Zyphen. A quick question on slide 21. You note that the TA1 Interchange Acknowledgment and then you note that it's a complete file failure. However, current CMS interpretation allows for multiple interchanges inside of a single file. Is CMS going to be issuing something to clarify how that should be used?

Gary Beatty: Actually we are, and I thank you for your question. A transmission file will have the ability to have multiple interchanges within a transmission file. The TA1 will be related to the interchange, the ISA, the IEA. So if you do have a transmission file with multiple interchanges with TA1, you could have some that are accepted and some that are rejected. So you're correct there. There can be, you know a multiple interchanges within a single transmission file.

And there will be clarification out in that in our IOM documents that would be coming out in the near future.

Matt Warner: All right. I could probably good details in the IOM documents but for the moment, I'd like to ask, would we be expecting that multiple TA1s or a single TA1 with multiple responses?

Gary Beatty: You will get a TA1 for any interchange that is rejected.

Matt Warner: OK, the multiple TA1s for multiple failures in a single file.

Gary Beatty: Correct.

Matt Warner: Thank you.

Operator: Your next question or comment comes from the line of Bruce Halawa. Your line is now open.

Female: Bruce …

Male: OK. (Inaudible).

Male: Bruce, you're on.

Jim Lyson: Yes, we're here. This is Jim Lyson, SurMed. I'm with Bruce's line. Our question is can we send both 5010 and 4010 transactions at the same time during the calendar year of 2011?

Female: If we're approved as a …

Jim Lyson: If we're approved- it... Once we're approved for 5010, can we send both transaction types?

Gary Beatty: So, you've gone – you're sending 4010, you're testing 5010, once you get approved for 5010, can you send either 4010 and 5010 in production?

Jim Lyson: That's correct.

Chris Stahlecker: This is Chris Stahlecker speaking. I'm not sure that any of our MACs are going to be permitting that, if it's a theoretical question. There isn't any technical reason, but I believe that our MACs are not going to be supporting that.

So any one trading partner will be established for production in one of the formats. Now, if you're a large clearinghouse, we might need to step back from this answer and give you you know a more specific answer. So, I'd have to beg off on that until we really formulate our Companion Guide options with our MAC.

Gary Beatty: But – thank you for the question. That does lead to you know we'll have to have a discussion on that here because that's a very good question.

Jim Lyson: OK. Thank you.

Chris Stahlecker: Joseph, can I just, probably your line is close now. But the question we would have is that almost necessary from your – a business support perspective that you would need that. We would like some insights on that.

Female: Yes.

Jim Lyson: Yes, we would. We think it would be important for us to be able to send both for various providers because we deal with multiple MACs.

Gary Beatty: No. Are you a clearinghouse or other types of …

Jim Lyson: Yes, a clearinghouse.

Gary Beatty: OK.

Chris Stahlecker: Multiple MACs, you say. So, and I guess …

Jim Lyson: Well, or any single MAC. I mean, yes, we would want to be able to send for different providers.

Female: Different versions.

Jim Lyson: Different versions.

Chris Stahlecker: Different providers. Same MAC, different providers so, I guess, what our question is, you don't – do you foresee the need to send for any specific provider both 4010 and 5010 to one MAC?

Jim Lyson: No.

Male: In production.

Female: No, no.

Jim Lyson: No. No, not for any single provider.

Female: But for – have multiple providers, and for one provider 4010 and another provider 5010.

Chris Stahlecker: That's a good question and we'll have to take that under advisement and formulate a response to you at a future time.

Gary Beatty: Well, thank you, I appreciate that.

Chris Stahlecker: It's a good question though.

Jim Lyson: OK.

Operator: Again, I would like to remind participants that if you have a question or a comment, you may press star and the number one on your telephone keypad. Your next question comes from the line of Kathy Sites. Your line is now open.

Kathy Sites: Hi. I'm also with the clearinghouse perspective and we're kind of under the assumption too, it'd be great to be able to send dual files you know a 4010 file and a 5010 file to the same MAC.

Gary Beatty: Again, as both test- or production? For the same provider?

Kathy Sites: Not from the same provider. Just to be able to send both types of formats in production.

Gary Beatty: OK.

Kathy Sites: And then, I also had a question about when you talk about the MACs that select or an FI that selects a MAC that is 5010 compliant. Can you kind of just give a brief overview of how that works?

Gary Beatty: Well, I mean, it really won't be too much different from what you're handling today. Today, if you're submitting transaction to your Carrier or Fiscal Intermediary, what will happen mechanically is that they will then work with one of the - the MAC that they have selected, actually, to provide the front end translation and processing. And so, to you, it would really be somewhat transparent.

Kathy Sites: OK, so all of these are going to happen behind the scenes. We'll get a regular, you know, our regular response file that we're expecting from the current FI that we're working with and they'll be no changes.

Gary Beatty: No.

Chris Stahlecker: No, no, no.

Gary Beatty: They'll be sending back 277CAs - all these transactions. It's just that the actual translation will be facilitated for them by one of the MACs.

Chris Stahlecker: This is Chris Stahlecker. I want to emphasize this point that the current report format that you're getting back are no longer going to be supported for 5010. So all the – on the 5010 leg, all they're going to send back is the 277 Claims Acknowledgments.

Kathy Sites: OK, thank you.

Operator: There are no further questions at this time.

Aryeh Langer: OK, great. Well, that's unusual but, I'd like to take this opportunity to thank Gary for stepping in here. And remind you guys as Gary has said that the next call is August 25th, so we'll be sending out a listserv message announcing the call details on how to register.

That's from it from CMS today. Have a great day and thanks for joining us again. Bye-bye.

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

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