Centers for Medicare & Medicaid Services
Ninth National Education Call on Medicare Fee-For-Service
Implementation of HIPAA Version 5010 and D.0 Transactions
Moderator: Aryeh Langer
August 25, 2010
12:00 p.m. ET

Contents

Operator: Welcome to the Ninth 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. This conference if being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

Thanks for participating in today's call. I will now turn the conference over to Mr. Aryeh Langer. You may now begin.

Welcome

Aryeh Langer: Thank you, Mason. I'd like to welcome you again to today's Ninth HIPAA Version 5010 national conference call. As Mason said this is Aryeh Langer, from the Provider Communications Group here at CMS. And today's call will cover the 835 Electronic Remittance Advice transaction.

I'd like to give out the web address to the 5010 website. If there's anyone who did not yet get a chance to download today's presentation. The web address is www.cms.gov/versions5010andD0. Again, www.cms.gov/versions5010andD0. Just click on the 5010 National Calls link on the left hand side of the page and then you can scroll down today's presentation is the last link on the web page.

Following the presentation, there'll be a question and answer session with our Medicare subject matter experts. I'd like to now introduce our speaker for today. Sumita Sen is a Health Insurance Specialist with the Division of Medicare Billing Procedures here at CMS.

Slides 1-10

Sumita Sen: Hi everyone. Welcome to the Ninth National Provider Call. My name is Sumita Sen and I work as a lead Health Insurance Specialist for the Centers for Medicare & Medicaid Services specifically on the Medicare Fee-For-Service side of the house. And my area specifically is remittance advice or remits.

I would like to thank you all for taking time out of your busy day to join this call. I appreciate this opportunity to provide you with hopefully useful and valuable information about HIPAA 5010 and D.0. and what CMS has been working on related to 5010 implementation effort.

Slide two. The purpose of today's call is number one, is to highlight the significant differences between the 4010A1 835 and the 5010 835; to provide an update on Medicare Fee-For-Services activities related to the implementation of the HIPAA transaction 835 Healthcare Claim Payment/Advice Version 5010; to discuss the 835 Errata as related to Medicare; to provide guidance on what to do, and to solicit feedback from you regarding questions and concerns with 5010 and/or Medicare Fee-For-Service's implementation of 5010.

This – I just want you to note that this presentation is focused on Medicare 5010 implementation activities related to transaction 835 as utilized by Medicare Fee-For-Service providers. This presentation does not address a Medicare Advantage or Medicare Part B insurers plans.

There are some additions, deletions and modifications throughout the TR3. Rules and notes have been changed, sizes of elements have changed. And we'll go by what changes are being implemented by Medicare because all the changes, they don't apply to Medicare. So, we are not implementing them.

Then discuss the latest information regarding the 835 Errata and how it impacts Medicare. Then you know, maybe some suggestions, advice for you to what to do and then there will be an opportunity to provide feedback and ask any questions that you may have.

Slide number three. Today's agenda – I'll give you a general overview, then you know, again, differences – significant differences between 4010A1 and 5010. Then CMS's implementation of 5010, like I mentioned before, that all the changes they don't apply to Medicare so we are not implementing all changes. Then the 835 Errata as it is related to Medicare, timelines, deadlines, what you need to do to prepare, and then a question and answer session.

I actually – before I go on to the next slide, I would like to go over some acronyms that come up again and again and would make sense if you know, what they mean.

FFS is Fee-For-Service like you know, I mentioned before that we are concentrating on Fee-For-Service only. We are not covering anything else. We also use a term of CR, that's Change Request. That's written instruction to Medicare Contractors and those instructions are available online so it's available to everyone. ERA, Electronic Remittance Advice, that's transaction 835 and it will be version 5010 of transaction 835.

SPR that's Standard Paper Remit and there is a note – I would like to note here that the paper format remittance advice for Medicare, it mimics ERA. We like to make the SPR as much as ERA. There are some differences but it's almost the same.

TR3 is the Technical Review 3 is basically the Implementation Guides from X12. And then we also have MACs – MACs are Medicare Administrative Contractors and they administer both Part A and Part B, and also Part D or DME.

And then we have HIGLAS. HIGLAS is the Healthcare Integrated General Ledger Accounting System and this is a dual-entry accounting system that is replacing and modernizing the existing Fee-For-Service Medicare Contractor accounting systems with a single standardized system.

And also, these two terms would come up later, one is NCD and LCD. NCD is National Coverage Determination and an NCD says for the extent to which Medicare will cover specific services, procedures or technologies on a national basis. And LCD is the Local Coverage Determination information and that is basically the same information on a local level. OK, that's slide number three.

OK. That's all on slide number three. Let's go to slide number four, general overview continues. What was adopted under HIPAA 5010, Version 5010 of

the X12 Standard Suite of Administrative Transactions. So, that's basically covers for Medicare 837-P, 837-I, 835-Remit, 276/277 Claim Status, 270/271 Claims Eligibility, and there are some other transactions which are not HIPAA transactions but Medicare is still implementing them.

General changes; Implementation Guides are now also referred to as Technical Review or Type 3 documents. Language in the opening section of the IG or TR3, referred to as the Front Matter, was revised to be more consistent across transaction types of claim, eligibility, remittance advice, and claim status. The content of the rules found in the IG or TR3 that are labeled as "Situational" were further clarified and updated to specify when an element is required or not allowed. Ambiguities in 4010A1 rules were corrected; "should" was replaced with "must" in many cases. And then also note, if not required, do not send. So, it's much less ambiguity.

Next slide please. Number five- which is a general overview for transaction 835. OK, changes between version 4010A1 and 5010 for transaction 835 fall into two categories: Refinement of Requirements and Enhanced Content to Promote Clarity. Now, Refinement of Requirements through providing stronger definition and strengthening the rules around usage. There are less than five percent structural changes in the revision from 4010A1 to 5010.

And of course you know, the impact to specific users was very like, you know, I already mentioned that some of them apply to Medicare and we are implementing. Some of them don't apply to Medicare; we are not implementing them. And some of the Front Matter sections have been added or substantially updated or enhanced to provide greater clarity and better directions.

A point to note is that there is only one TR3 for transaction 835 Health Care Claim Payment/Advice. It's not like claims, which has different versions for 276/ 277. It applies to – for Medicare, it applies to Part A, Part B and DME. Providers receiving ERA would receive the same transaction whether claims were sent using 837-I, or 837-P, or NCPDP D.0, or CMS-1500, or UB-04. The content would be different based on the line of business, but the format would be the same.

Now, the stronger definition, it applies to things that already exist in the 4010A1 Implementation Guide. These fields serve the same purpose but the language in notes and situations – situational rules have been enhanced to remove ambiguity and are required when statements clarify the intent.

Now, there are some, you know, business and financial benefits of this activity. I will just go to them very quickly. It reduces training cost, ongoing maintenance cost, increases speed to bring up new trading partners by decreasing testing time, increases desirability of electronic remittance advice over proprietary paper remittances, conveys complete and consistent information to providers and that means you know, reduction in telephone calls for respondents manual intervention, promotes automation, reduces cost associated with handling paper and we all you know, those costs are storage, destruction scanning.

And then of course you know, there is new enhanced Front Matters and there are, you know, some business and financial benefits and they're pretty much the same – you know, basically it increases automation – the chance of automation.

Medicare started with a detailed side-by-side comparison between 835 version 4010 and 5010 and we actually started back in 2007. And this side-by-side flat file is available for 835 and I'm not going to go over the web address. If you go and do a web search, under CMS HIPAA 5010, you can find that.

And there are some things you know, which have changed. Let me just go over them very quickly. Field length size to maximum in the TR3. There is new PER segment, new technical contact. Medicare is going to use that. New PER - Payer website. Medicare is going to use that and that's I think in slide 11, again. Modified Payer ID will use FI, and of course you know, we have also included XV for national . Medicare is ready to send that on day 35.

Then rest - other claim related ID it's you know, it's added Qualifier 28 and Qualifier 60 in addition to EA, and that's you know, we are using for 4010A1. Then there is a new DTM segment, coverage expiration date, Medicare will

provide that. And then there is another DTM, claim received date, we'll use it. As we see, 067s will provide the Not Otherwise Classified procedures code description if we receive it on the claim. And then there is a REF segment for health quality identification and Medicare is definitely going to use that. And that is again discussed in slide 13. OK.

Next slide please. Slide number six. OK, this is an example of Refinement of Requirements and I'm not going to go through that. I think, you know, what the intent is – this basically defines clearly when this is required and also how to use this segment so that there is less chance of different interpretation and ambiguity.

Next slide, slide seven, Refinement of Requirements, there is no – this is another example, reversal and corrections refined. This is basically give - and this is actually in Front Matter section 1.10.2.8 and this is you know, gives – provides alternate solution- claims splitting in case of partial payments which was not available or which was not mentioned in 4010A1 Front Matter.

Then you know, the CLP07 Payer Claim Control Number, there is explicit directions that should help reconciliation. And especially go and see bullets number three and number four on the notes. For Medicare because of regulation, the money may not be recouped immediately in the same 835. In that case, what we would do is you know, we use forward balancing and we are going to provide detailed information when money is actually recouped. And there is CR for that, CR 6070 which is for 4010 as well as 5010.

Slide number eight, Refinement of Requirements. This is you know, another example, removal of "should" and it's replaced by "must". Again you know, there is less ambiguity and less chance of different interpretations. Addition of the new "required when" language, tighter business rules to eliminate options.

In addition, Medicare is standardizing the code usage in the 835 to help increase automation and reduce manual intervention. Basically, our goal is to make automation a reality for as many providers as possible. And

standardizing the RA codes usage across the board should help increase automation and, of course, you know, reduce cost on both sides.

Slide number nine. This is an example of new Front Matter sections, Advanced Payment and Reconciliation. And I'm not you know, reading that. It's there; it was not there in 4010A1. It's been added so that there is clearer direction, or at least the intent of the IG or the TR3 developers was clearer and less ambiguity and less chance of different interpretations.

Slide number 10; this is an example of enhanced Front Matter section, Coordination of Benefits Instructions. It was there in 4010A1, but it was you know, – there were a number of questions. There were a number of different interpretations so what X12 has done is they have tried to tighten the language and made it as straightforward as possible so that you know, there is less ambiguity.

Slides 11-21

OK, slide number 11. This is newly enhanced segment, 1000A Loop PER Segment Additional Uses. There is a Payer Technical Contact Information. This basically in addition to- there was one contact information and that has become the business address information. This is an additional segment. Medicare is going to use that. Medicare is going to use both the business and the technical contact information.

Then the next segment is PER - Payer Website and this one is definitely Medicare is going to use when the – and if they are going to use the MAC specific website containing NCD/LCD information related to information reported in the new Medical Policy segment and that is in slide number 13.

Slide 12, new enhanced segment continued, 1000B Loop RDM Segments. This was not in 4010A1. Medicare is not going to use this segment because this – of the situational rule currently does not apply to Medicare. Two thousand -2100 loop NM1 Segment Additional Uses- used to convey the Subscriber Name and ID when another health plan is identified. Medicare will use this if the situational rule applies.

Slide number 13, new enhanced segment. This is 2110 loop, REF Segment Additional Use. This is something you know, Medicare is definitely going to use. This identifies any applicable medical policy that affected the adjudication of the claim. Medicare will use this segment to identify any denial related to LCD/NCD policy and the website would available and that was slide 11. So, if there is any LCD/NCD denial, that information provider would be able to go and get directly from the website that would be covered. And the website would be at the – are the MAC level.

Related information about the LCD/NCD will be provided using the new PER or Payer Website. This one provides updated information on Medicare policy helping denial management, claims corrections, appeals and exchange of telephone calls or reduction in exchange of telephone calls and/or correspondence.

Next slide 14, Medicare FFS implementation of 5010, Common Edits and Enhancement Module or CEM. I am not going to go through that because I'm sure that you have heard when 837-P, 837- I and 276/277 presentations were on. But let's look at what is going to be the impact of CEM. Number one is there'll be more and more clean claims will reach the adjudication system. Faster rejection will mean faster resubmission of corrected claims. And then there will be – we expect that there will be some positive impact on cash flow because providers would be able to correct and re-submit much faster because it'll be rejected at the front end.

Slide number 15, Medicare's implementation of 5010 continued. On the 835 side, there'll be enhanced free software available for Part A. PC-Print software will be available and software has been enhanced for PC-Print. You can actually go and see 6601, CR number 6601. It has actually an Excel spreadsheet and it's kind of does a crosswalk between 4010A1 and 5010. PC-Print, you know, what is not in 4010A1 and what is going to be in 5010.

And for Part B, the MREP software will be enhanced also by including more information and for that, you can go and you can check CR 6473. And MREP also now would include a number of additional fields which you know, you don't see now – see them now.

And the most important thing where in we are very excited about is we're trying to standardize the standard. Medicare will standardize the use of PLB reason codes at the provider level and Claim Adjustment Reason Codes and Remittance Advice Remark Codes at the claim line level. And potential benefits include increased automation and cost reduction, of course. And those CRs will be out shortly. They are not out yet but you know, we are working on them.

Next slide please. This is the 835 errata and actually I have a copy of the errata. Medicare- for Medicare there is definitely now going to be the TR3 name change. It'll change from 005010X221- 221A, other than that, it's really not going to affect the Medicare. And the implementation impact, CMS does not anticipate that there will be any impact on the Medicare 5010 implementation or the mandated compliancy dates.

Medicare transaction usage impact- like I said that the number will change in the TR3s but otherwise I don't see now any change in whatever you know, we have planned so far.

Slide number 17, time line and deadlines. Now, this is also you know, I don't want to go into detail because this has been discussed in our previous presentations. It's basically you know, December 31st, 2011 is the last day CMS will accept 4010A1 transactions. And January 1st, 2012, this is mandatory compliance for all covered entities and for all transactions. And Medicare will be ready for testing on January 1st, 2011. So, you have one full year from January 1st, 2011 to December 31st, 2011 for testing and getting ready.

Slide number 18, what you need to do to prepare. CMS has developed educational materials on the Medicare Fee-For-Service 5010 project to provide technical assistance and direction for our trading partners and providers. And then you know, there's a list of products, number two, products include under the list of websites. So you can go in, you should check. I'm not even trying to read them.

Number three is updates, announcement and News Flashes- that's ongoing. Frequently asked questions so you can go - there is the website is there you can go. And you can check the frequently asked questions. So, if you have a question, maybe you can go and check because somebody may have already you know, asked that question.

And, of course, you know, in order to purchase the TR3, you can go this x12.org or you can go to the WPC website to buy from Washington Publishing Company. To view X12 responses to technical comments, there is a portal, you can go there. And then to request changes to standards, you have to go to this HIPAA DMSO org website.

Number 19, what you need to do to prepare, steps you could take now. Start early, start as soon as possible. Contact your software vendor. Inquire when your vendor clearinghouse is planning to upgrade your system. Evaluate the impact to your practice and begin planning for training and transition. Consider the impact this may have on patient registration, billing, appointments, scheduling, claims reconciliation. So, it's not just how to send the claims and how to receive 835. There are other things, you know, within your organization that's may be impacted.

What you need to do to prepare continued – slide number 20. Test early and test often. Testing procedures like I mentioned before January 1st, 2011 to December 31st, 2011, but I have to make a request here, please don't wait until December. Please go and try to test as early as possible. And when I say test, test not only claims but test for all other transactions to include 835.

Receivers need to contact their respective MAC help desk – help desk to coordinate testing procedures. Now for 835, on the Part A side, once you know, you request test files for 835, they'll be sent continuously until you know, you say, "OK, now I'm done. I have been tested and you know, I'm ready to go into production" or whatever.

For Part B, it is – it needs to be requested every time. So, they will send you one – but one time but if you need more test files then you really have to go in and you have to request through your MAC.

After January 1st, 2011, receivers can request transition to 5010 after successfully completing that testing process. So if you are – if you have successfully completed the testing process you know, you can go into production, Medicare will be ready. MAC will support testing 5010 while sending 4010 in production throughout 2011. So, starting on January 1st, 2011 to December 31st, 2011, MACs are ready to do that simultaneously send testing of 5010 for testing and then sending 4010 in production.

And on or after January 1st, 2012, Medicare will transition to 5010. And I just would like to add something here. It really doesn't matter when we received or when you sent the claim. It will be after, if it's processed after January 1st, 2012, it will be 5010 version. OK. So, now, we know we are at the question and answer session. So I'm turning it over to Aryeh.

Question and Answer Session

Aryeh Langer: OK, Mason, can we open the lines for the Qs &A session?

Operator: All right. We will now open the lines for question and answer session. To ask a question, press star followed by the number one on your touchtone phone. To move 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 a question to assure clarity. Please note that your line will remain open during the time you are asking a question, so, anything you say or any background noise would be heard in the conference. Your first question comes from the line of Gloria Davis. Your line is now open.

Gloria Davis: Hi. This is Gloria Davis, NextGen Healthcare. In regard to the errata data, do we know when that final rule will be adapted to adopt the errata and what – when Medicare is going to include that as part of the process?

Chris Stahlecker: Hi. It's Chris Stahlecker, Gloria.

Gloria Davis: Hey.

Chris Stahlecker: That's a good question. Everybody is dying to know that answer, right? Well, we really don't have the answer just yet. We know that X12 has taken the

steps to promote and approve and get the errata versions available for industry adoption. What we don't have is the process defined for how – OESS will respond to that.

So for Medicare Fee-For-Service, you know, we'll be dependent upon that release of information from OESS and then we'll strategize on how we're going to address it.

I think in other – in other forums, I've taken the approach of answering that question to say that Medicare, because of the lead time that we need to give to our shared systems to put forward a change request, requires about eight months lead time. So, depending upon when the instruction is published and for the general industry to comply, Medicare Fee-For-Service would need significant amount of lead time to get any changes into our shared systems.

So we had said earlier in some of the other national forums and things, and maybe not in our audiocast, we would be targeting no sooner than April of 2011 for the errata release to be implemented in the Medicare program.

So, like I say, we still need to address how we're going to strategize for incorporating an errata and that will all be forthcoming as soon as we see the publications from OESS. I hope that helped some.

Gloria Davis: Yes. And so we see it as that probably January we'll be doing the current final rule versions and then having – and then when it is adopted by Medicare, then doing the errata versions at that point.

Chris Stahlecker: That's our – best estimate at this time, but please don't hold me to that.

Gloria Davis: Yes, I will.

Chris Stahlecker: We really need to do the direction that comes out, any requirements that may be published in respect to the errata. It may be that you know, our baseline version of the transactions is what we start with. That's what our programs are all geared toward right now. So that's – that's been our expectation, to start in January with that.

Gloria Davis: OK. Great. Thanks, Chris.

Chris Stahlecker: OK.

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

Marie Aaron: Thank you. This is Marie from Collida Health in Buffalo. I have a question in slide 15. You mentioned standardization of the PLB reason codes. I'm wondering where I might get a list of these and their definitions.

Sumita Sen: Are you asking what Medicare is using or just a list of PLB codes that are available?

Marie Erin: I'd like to know what you're going to use in the 5010 version, the codes and the definitions, because part of those fields are you know, defined by you (inaudible).

Sumita Sen: Actually – actually, you know, if you go and look at the platform that is available, it has a list of all the PLB reason codes that Medicare is going to use. It does not have a definition. But, like I said, there will be like CR come out. And I have the CR number, CR 60 – 7068. It's not – or you know, actually, don't hold me on to that because I may be incorrect. But it'll come out in a couple of months and that will have the definitions that you know, we are using. We are using basically the definitions that are given in TR3. But it'll tell what – under what situations you know, that particular PLB reason code would be used.

Marie Aaron: Well, there's a subfield, though, that's designed you know, by you that's not in the TR3. And I always have trouble even in 4010 knowing what those codes are and what they mean. So, I was wondering if you were going to publish a list. And I'm not sure what you meant by flat file because I'm just talking about the 835. That's all that I see.

Sumita Sen: Actually, 835 – does anybody want explain what a flat file is?

Chris Stahlecker: Let's see. This is Chris again. The shared systems actually output a file that does not look like the EDI standard. And we have placed that definition of the flat file on our website for your review. It's a little easier to read, perhaps. And Sumita is saying that that's available for you to use in your analysis and comparison to the X12 835 EDI file.

Sumita Sen: Actually, what you know, you can do right now is you can go and get that list from the flat file and you can go to the TR3, because it explains what a particular PLB reason code means. And we basically follow that. But, of course, you know, we have to kind of put in that bucket whatever edits we are doing. And for that, you have to wait until that CR comes out because the CR would have much more explanation. Does that – does that help you?

Marie Aaron: Yes. I guess, I will be looking forward to that. Could you repeat the CR number, please?

Sumita Sen: Actually, I think it's 7068.

Marie Aaron: OK. Thank you.

Sumita Sen: And it's not out yet, but it should be out because this is scheduled for April implementation. So, it should be out shortly, but it's not out yet.

Marie Aaron: OK. Thank you.

Chris Stahlecker: You're welcome.

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

Renee Lynn: Hi. This is Renee Lynn from Tufts Health. I actually have three questions. And the first one was related to the first question on this call, related to the errata.

So, the erratas were published on X12 about two or three weeks ago. So, those are final, right, and we should all be marching to those erratas. Is that correct?

Mike Cabral: They were published by X12. I'm sorry, this is Mike Cabral. X12 has gone through their publication process. Now the government just has to go through whatever processes they will do to –make them enforceable by law. And that's (inaudible).

Renne Lynn: Oh, I see. So they're not final in terms of HIPAA – the HIPAA programs.

Sumita Sen: Right, right.

Chris Stahlecker: Exactly.

Renee Lynn: I see. And sorry, but what's the date around that? Do we know?

Mike Cabral: We don't. That's what Chris was alluding to earlier. We're waiting for OESS to inform the industry of the availability and they work closely with X12. So, I would – I wouldn't even be able to venture a date on it right now.

Renee Lynn: OK. All right.

Mike Cabral: But you should see that in the Federal Register.

Female: Right. I would keep my eye open on the Federal Register, as Chris was saying then.

Renee Lynn: OK. And then my next question is related to, on page 16, the 835 errata 2100 loop NM1 Patient Name segment. So as far as the errata there, the clarification is that it should match – the patient name on the 835 should match the one coming in on the 837 2010CA or BA depending on what's submitted. Is that a change for the CMS Fee-For-Service?

Sumita Sen: I am very glad you brought this up because we are currently doing it on the Part B side because we are sending both as it is coming on the 837, as well as you know, if there's any correction we send it. We get our information from Social Security and we send that. But it's not happening on the Part A side and that is being corrected.

So, yes, and I think that CR is going to be implemented in April. So, from April, for both 4010A1and then moving forward for 5010, for both Part A and Part B, yes, you will see that. If there is any change, there'll be two names – one that we have received on the claims and one that you know, is in our record.

Renee Lynn: OK. That makes sense. And then my last question is related to slide 20, the Part A and Part B testing for those test files. What numbers are going to be – are they numbers from our specific systems or do you have your individual test numbers?

Mike Cabral: Can you repeat the question?

Renee Lynn: Yes. For – on page 20, for Part A test files sent continuously, for Part B you need to request for test files. I was wondering for those 835 test files that you'll be sending out, where are you getting those claims from? Or are those providers – are those numbers test numbers? Where do you get them from?

Mike Cabral: No. That happens in the A/B MAC's system. This is Mike Cabral speaking again. The standard systems that will function where your production claims, whether it be for 4010 paper, et cetera, can be test simulated in the 5010 835 output. So, they would probably be your account that should be seeing that test 835.

Renee Lynn: OK, perfect. That answers that question.

Chris Stahlecker: OK.

Sumita Sen: OK.

Renee Lynn: Thank you.

Operator: Your next question comes from the line of Sharon Steve. Your line is open.

Sharon Steve: Hello. I have a couple of questions on – probably it's been talked about a couple of times already – but on this PLB update where they have a CR open, is it going to include the same reference PLB number for both the pay – either

the forward balance and the recovery so that we can automate? Is that what you're referring to?

Sumita Sen: OK. Let me just first try to explain why even this CR is going out. What we are trying to do here is exactly you know, what you mentioned that both Part A, Part B, and eventually the DME side would use the same PLB reason code for the same adjustments. And I think you know, you are referring to a CR – CR 6870 where you know, the recoupment part is explained and there are some PLB reason codes mentioned in there. Yes, those PLB reason codes would stay the same and they'll be included again in this new CR. Does that answer your question? Hello?

Mike Cabral: Sharon, are you – are you still there?

Operator: I bet she has disconnected.

Chris Stahlecker: OK.

Operator: So your next question comes from the line of Bud Westright. Your line is open.

Bud Westright: Yes, thank you. Bud Westright, Reliable Health Systems.

My question has to do with the test files that we will be receiving on the 835. Is that contingent upon us sending out 837 5010 claims or you can ask for basically the 835 5010 without actually sending the 837?

Mike Cabral: That's correct. This is Mike again. And that's correct. They will take – if you're currently getting a 4010 remit, you'll still continue to get that, they'll use that base file of the 4010 835 remit to populate the 835 simulated test files.

Bud Westright: Thank you very much.

Mike Cabral: OK.

Operator: Your next question comes from the line of Mathias Resnick.

Your line is open. Mathias Resnick, your line is open.

Mathias Resnick: Hello?

Aryeh Langer: Go ahead.

Mathias Resnick: Hello?

Aryeh Langer: Hello, we hear you.

Mathias Resnick: Oh, OK. I have two questions. I'm Mathias Resnick from US Systems. The first one is if CMS will publish a companion guide or a crosswalk for 5010?

Sumita Sen: You want to add something about the companion guide?

Chris Stahlecker: Oh, I thought you said a crosswalk. OK.

Male: (Inaudible).

Male: Companion guide.

Chris Stahlecker: Companion guide. Yes.

Chris Stahlecker: I'm sorry. We're all talking here. Could you repeat your question please? This is Chris Stahlecker asking.

Mathias Resnick: Yes. If CMS will publish at any time a companion guide or a crosswalk for 5010?

Chris Stahlecker Well, let me take part of the question and Sumita can answer the crosswalk question. But the companion guide question is a good one. We are looking at trying to standardize our companion guide. And, yes, we will have a companion guide, but it will be something that you will obtain from your Medicare Administrative Contractor, your MAC. And we're working with all our MACs as one big team right now to try to have a common look and feel of what the companion guide will include.

We're actually trying to use an industry standard template that's available, produced by the X12 WEDI CAQH joint effort to produce a common industry standard template. That's the one that we're looking at most closely.

Let me just ask Anisha Pandya, who's present here and coordinating our Medicare work if she wants to add anything to that.

Anisha Pandya: No, I think what Chris was saying is that the template that's out there and being reviewed by the X12 WEDI workgroup is the one that we are going to adopt and for our needs. CAQH has come out with an earlier template which is being updated. And if you go to the X12 website, you can actually find what the template looks like, but that's what we're using for Medicare Fee-For-Service.

We anticipate having the companion guides out you know...

Chris Stahlecker: Before the end of the year.

Anisha Pandya: ... before the end of the year or the next year.

Sumita Sen: OK. And ...

Mathias Resnick: Sorry. When do you send it? Beginning next year?

Chris Stahlecker: No. Early – well, later this year. We'll have it later – have them available later this year.

Sumita Sen: Hopefully, before January 2011. And, basically, what – and I think you know, you have – know that the team here, we are trying to standardize. So here, also, I think, for 4010A1, the companion guides are different for different transactions. So we are going to have the same format for all transactions. And, yes, for 835, there would be a companion guide.

The other question was a crosswalk between 4010A1 and 5010. We have already done that.

We actually started out with a comparison, side-by-side comparison. And that side-by-side comparison is available publicly and that website is included in the presentation, page 18.

Mathias Resnick: Eighteen?

Sumita Sen: Slide 18, right.

Mathias Resnick: OK. I have another small question. The uh… Yes, hello?

Aryeh Langer: Go ahead.

Male: Yes. The other question is you mentioned that from the January 1st 2011, the 5010 will be available for testing simultaneously with the 4010. The question is, if there will be, sorry, because I'm talking from a – from a software vendor for Home Health agencies. So, my question is, if an agency will start sending production 5010, they will need to do anything at all or they can just send production 835 with a 4010 or 5010 you know, at any time? I don't know. I would be …

Sumita Sen: Let me understand your question. Are you asking if somebody is sending 5010 claims whether that would automatically mean they are going to receive 5010 835? The answer is no.

Even though a 5010 claim is in production, in order to go into 835, 5010 you need to go to the testing process. And then you know, once you have successfully tested, then, you know, you have to let the MAC know, the relevant MAC know that you are ready and then you know, you can go into production with 835.

Mathias Resnick: OK, but I'm you know, – I'm talking about a home health agency's so they will be sending – OK, they are sending 4010 now and they will be sending 5010 in test mode, right? But what happens if they send 5010 in production mode. Or, how they will be able to let the MAC know that they will want to start sending 5010 production or if they need to send a certain amount of transactions before they can send the production transaction for such activity?

Sumita Sen: You have to let the MAC know that you are ready to receive 835 in production and then the MAC would go and put in your record. And then you know, you will be able to receive 5010 835 in production.

Mathias Resnick: Sorry, the thing is, I mean, I'm talking about sending, not receiving, because I work for a software vendor for home health agencies. So home health agencies will be sending the 835 to the HHI. You know, what I'm saying?

Chris Stahlecker: So, this is Chris speaking. The 837 is the claim format and you can review our prior audio cast material on our website for the audio cast we've already delivered on the 837 Professional claim or even the Institutional claim if you need to submit an Institutional claim. So you're …

Mathias Resnick: Yes, Institutional claim.

Chris Stahlecker: So, today's call is only related to you receiving back an explanation of the adjudicated claims results.

Mathias Resnick: OK. Thank you very much.

Chris Stahlecker: OK.

Operator: Again, if you would like a question please press star followed by the number one on your telephone keypad.

Your next question comes from the line of Frank DeMario. Your line is open.

Question and Answer Session continued

Frank DeMario: Good afternoon. This is Frank from Benjamin Health Care, a vendor in South Florida. My question is very similar to the last gentleman. When we start to actually roll out our 5010 837 files next year once we are approved with the MAC, I guess the question is almost the same. If we are approved as a vendor and the customer or provider sends a 5010 837, will the ERA file, the 835, come back automatically in the 5010?

Sumita Sen: No. Go ahead. Go ahead.

Mike Cabral: Let me try and take this one. No, that's actually controlled at the MACs. You can be sending in 5010 claims and still receiving 835 in the previous 4010A1 version.

Frank DeMario: Right.

Mike Cabral: Do the opposite too. You can be sending 4010A1 claims and receiving 835 in the 5010 version. You must coordinate which versions of the transactions you're willing to accept, to send and receive with your local MAC as part of their Trading Partner profile update.

Frank DeMario: OK.

Mike Cabral: So, you could work with your local MAC.

Frank DeMario: I can appreciate that because I know there's probably all kinds of flavors you know, sending back and forth, but I guess let me just simplify it a little bit. You know, we have 500 customers we have to update over the period of next year.

We're obviously going to go through the testing process with the MAC to make sure our 837s are clean and you know, we understand what to do with the 835. So let's say, for the sake of argument, in April, we have MAC approval as a vendor to send 5010s 837 and we're ready to get to the 5010s back.

Now, all of our customers, from what I understand from previous calls, will then automatically be approved for 5010 because once the vendors approved the customers, by then, are default approved. So then we start to send the 5010s and start rolling out the software, would we then expect to get – in other words, we can't roll out our software to all 500 customers over night.

So, as we roll it out and we get the 5010s sending on the 837, will those providers then get back the 5010 or do we run the risk of sending or having all of our providers who are still sending the 4010 start getting back 5010s once we have our MAC "flip the switch"?

Mike Cabral: Now, that's what I'm saying, is the MACs have an individual process that they have to go through like if I'm a clearinghouse and I have five clients, I can turn on the individual five clients one at a time, but I still have to coordinate that through the MACs because they have internal files that they need to update to get that activity to occur.

Frank DeMario: OK. So we may have to do this on a provider-by-provider basis? Sender-by-sender?

Mike Cabral: Well, the provider-by-provider is probably correct unless they're parts of groups. You know, if you've got a group practice that's got five providers and the – the MAC would have possibly one screen to update for the five providers of that group.

Frank DeMario: OK.

Mike Cabral: Does that clarify? I mean, it is individual transaction-by-transaction because you're sending claims. It doesn't mean you're going to get to remit automatically in that same version.

Frank DeMario: Right. I mean, it does clarify it, but it kind of takes away the benefit, I guess, if you will, of once the vendor is approved then by default all of their customers or providers are approved. Now that's great on the sending side, but if we have to then go sender by sender by sender to have them flip back the remit, then, that gets back into a you know, paperwork drudgery. You know, what I mean?

Mike Cabral: Well, you have – I mean you can coordinate that with your MAC. If you've got a list of I'm installing 50 of my 700 sites this week, that's what you'll need to coordinate with your MAC.

Frank DeMario: OK. All right, that's fair enough. I just wanted to kind of get a qualification on that. Thank you very much.

Operator: Your next question comes from line of Tammy Oakley. Your line is open.

Tammy Oakley: Hi. This is Tammy Oakley with Reid Hospital and I have a question about the COB on page 10.

When the remittance comes back for a secondary claim, currently, we do not see the adjustments that were made by the primary payer. And so, then, the contractual, if you are processing a claim that had a contractual on the primary claim, then the contractual on the secondary claim is overstated because it doesn't take in to effect the primary's contractual.

So then if we try to post that electronically, the only thing that we can post automatically is the payment for- by the secondary payer. The contractual is overstated so we can't post it. Is that problem going to be addressed in this new format?

Chris Stahlecker: Hi. This is Chris. That's a coordination of benefit discussion point that we would really need to coordinate internally with our COBC area to give you do a better response. And actually, you want to take a stab at it, Sumita?

Sumita Sen: No, actually, I would like to have you contact me directly maybe or – I don't know…

Aryeh Langer: Tammy, can we take your number and we'll give you a callback?

Tammy Oakley: OK, that would be fine. Area code XXX-XXX-XXXX.
Aryeh Langer: OK, great.

Tammy Oakley: This is a problem across the board. Whenever I bring it up with other providers, they say, "Oh, yes, we all have a problem with it, but we can never get an answer." So, everybody is having to post every secondary payment manually as far as the adjustment is concerned.

Sumita Sen: And do you have already contacted your contractor?

Tammy Oakley: I've contacted everybody that will listen.

Mike Cabral: Tammy, just a quick question for you. How was that claim filed to Medicare? Was it with the adjudicated information from the previous payer or was it kind of that shotgun approach where he sent it to multiple places at the same time?

Tammy Oakley: Well, this problem – the problem exists on Medicare claims that crossed over to the other payers. The other payers then automatically processed it, that they either don't have the information or they don't think they need to report it.

And so, it does – their contractual, and what I hear from the other payers is that, well, we need to report to you what our contractual is based upon the original dollar amount, not the amounts that the primary paid. And so I can understand that, but that does not help us with posting because they cannot or they don't have a place to report the primary's contractual, the primary's co-insurance, or deductibles.

So there's a whole – there's an entire hole there that cannot be automatically computed.

Sumita Sen: But, Tammy, wouldn't you have that information already posted when you received it from the primary payer?

Tammy Oakley: We have the – yes, but how – when you are automatically posting into a system, you are only looking at that 835 file. Your logic, posting logic, does not go in and look at the account and see what's already posted and then bounce stuff back. I don't know of any payment vendor that has programmed it that way to be able to bounce back and forth in and out of the mainframe.

They're only reading the 835 and able to post what's reported in the 835.

Sumita Sen: So basically, are you saying that, for example, if Medicare is secondary payer and you would then like to receive something from Medicare which would include not only Medicare information but the primary payer information also for you to do …

Tammy Oakley: Exactly. The primary payer's information is reported in the 837 to the secondary payer. And as long as those COB segments are reported to the

secondary payer, the secondary payer needs to report that primary information back in their secondary file, and right now there's no place to do that.

Sumita Sen: OK. I mean, I don't think that there was any point discussing this any further. We'll take it offline. OK, thank you.

Tammy Oakley: Thank you.

Operator: And your next question comes from the line of Sharon Owen. Your line is open.

Sharon Owen: Yes, we have a couple of questions. We got on the call just a little late, so I apologize if they're redundant. Is the process for sending the 837s and getting the 835s that going to be still by modem or is that going to eventually become Internet-based where we can send that electronically.

And then my second question is, when you are talking about that you need to contact your MACs for testing. I'm assuming you're talking about clearinghouse because I'm not a technical person here. If we're just working with a vendor who we're querying up our files and then sending currently through modem, is that the person that we'll have to contact? Will we have to contact Medicare directly for testing of those files?

Sumita Sen: I will actually request Chris to answer the first question about the Internet.

Chris Stahlecker: You asked a good question about use of the Internet, and actually our MACs are able to accommodate that request in various fashions. There are entities that perform a service in health care delivery and they're called network service vendors.

And the MAC may be able to put you in touch with one that is able to connect you to them. We do require – CMS does require- the MACs to connect with providers over what we call the Medicare Data Center Network, MDCN. And there are various centers out there that support providers, clearinghouses in getting that connectivity up and operating. You're not required to only use the dial-up modem.

Each MAC can support several methods of connectivity, that being one, but it is within their purview to deal with each of the providers trying to connect to them and offer the best solution. If you are only submitting a very, very small number of transactions, plain transactions to the MAC, it may be in the MAC's best interest to keep you on the modem.

I'm not quite sure how the MAC makes that determination about a cost-reasonable solution for those Trading Partners. But we do enable the MAC to make use of network service vendors who in turn support the requirement to connect to the MAC over the approved network services that CMS requires.

But still there's an opportunity to permit the provider to use the Internet. The Internet is used by the provider to connect to a network services vendor. The network services vendors connect as the conduit to the MAC.

So that is in place already. That's one method. There are some MACs that are – have received permission from CMS to support some Internet connections if they have the appropriate security levels in place.

So, it all comes back to you needing to work closely with your MAC to understand what your profile is for how many transactions you've sent and received to the MAC and they will work with you to get you the best fit for that connectivity. Did that help answer your question?

Sharon Owen: Well, again, does MAC stand for, what, Medicaid Clearing House? That's what we're trying to understand.

Female: No.

Sumita Sen: Medicare Administrative Contractor.

Female: Yes. We're talking about …

Sharon Owen: OK. Your administrative contractor, OK. We're getting confused by the acronyms. OK. And then, how would we know who our MAC is?

Female: I mean …

Chris Stahlecker: That would be available on our CMS website. It would be a geographic area that you are in. You would have a specified Medicare Administrative Contractor that would provide these services in your area. Now, if you …

Sharon Owen: OK. It is sometimes difficult to navigate through all of these things on the website. Is there a specific – is that something you could send to me, the specific link to the specific geographic area?

Sumita Sen: I think …

Aryeh Langer: Yes. It covers by states.

Chris Stahlecker: Why don't tell us your email and we can send you something. Go ahead.

Sharon Owen: OK. You want my email right now?

Chris Stahlecker: Unless – yes. Unless …

Sharon Owen: Yes, I can give it to you.

Chris Stahlecker: OK.

Sharon Owen: It's Xxxxxx X-x-x-x-x-x dot Xxxx X-x-x-x at xxxxx x-x-x-x-x xxxxxx x-x-x-x-x-x NC as in North Carolina dot gov.

Mike Cabral: OK.

Chris Stahlecker: Thank you.

Mike Cabral: All right. This is Mike Cabral. What we know about your particular state if you're doing business in the state of North Carolina is, there is not a MAC established there yet.

Chris Stahlecker: Well, that's OK. We have …

Mike Cabral: But you still have your current contracter, your FI …

Chris Stahlecker: Your current contractor, your legacy contractor will act on your behalf and get you the information that you need. And we would be in the position to support you, testing 5010 transactions, the same timeline that we discussed, because we've already arranged for a partnership relationship between the legacy contractors and those MACs that will be able to act on their behalf across the legacy contractor.

So, did we help answer your question? Was there something more?

Operator: It would appear that she has disconnected.

Mike Cabral: OK. Thank you.

Operator: You're welcome. So your next line comes from the line of Brenda Duncan. Your line is open.

Brenda Duncan: Hi. This is Brenda Duncan from the Rady Children's Hospital San Diego. I apologize in advance for the somewhat generic question, but the words of wisdom and advice that we're getting is prepare on the front end for any changes in registration and scheduling. That needs to be done, I hear that repeatedly.

But I'm looking for a specific example of data elements and things that we will be changing or adding to our capture you know, our data capture processes in those areas. Do you have examples of those?

Chris Stahlecker: It's Chris. I just want to ask you a clarifying question back. When you say data capture, are you saying in order to submit a claim or from the data changes on the 835 when the 835 comes back to you? Changes on the 835 remittance transaction?

Brenda Duncan: I'm looking for any – I'm trying to find the slide that it's on, as far as starting early, and looking for any changes that need to happen in registration and scheduling. I'm trying to identify what are those changes that would need to happen on the registration scheduling process to support the 5010 transition?

Chris Stahlecker: OK. So, you're in, say, a provider institutional setting for patient – you're talking about patient registration and appointment scheduling?

Brenda Duncan: Correct. Yes.

Chris Stahlecker: So, you're likely more interested in the 270 eligibility transaction. That's the eligibility inquiry, the 270, and the response is the 271. And we'd already conducted an audiocast some time ago and that should be available on our website for you to – I'm sorry?

Female: It was on April 28th.

Chris Stahlecker: April 28th – thank you, Alicia. That information should be in our CMS website with the materials that you've obtained for today's call and it should be …

Brenda Duncan: OK. Actually, I've already downloaded them so I'll review them. Thank you.

Chris Stahlecker: Thanks.

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

Betsy Core: Yes. This is a follow-up of the CR 6870. I pulled that up and it looks like if that is already in effect. Am I understanding correctly that you've already changed the recoupment process to report the ICN when you do recoup the money in the PLB?

Sumita Sen: Yes. As I mentioned that this is happening in 4010A1, but it will continue in 5010 . And that CR actually now has been implemented on the Part B side, but …

Betsy Core: It has not been or it has been?

Sumita Sen: It has already been implemented on the Part B side. Part A would come in October.

Betsy Core: OK. Perfect and thank you so much.

Sumita Sen: You're welcome.

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

Karen Peters: Hi. My name is Karen Peters. I'm with First Health of the Carolinas. And this is a general question for the 835.

I have been calling many people trying to get some information on balancing the TS3 segments back to the individual clip records within the 835. I didn't know if there was such a document.

I feel like I'm speaking Greek when I ask the question to Palmetto or to anybody that way. For example, TS37 is supposed to be non-covered charges. For our auditors, when we upload our 835 and we get totals – we have a programming person calculating the totals off the individual clip records. How do I – is there a document that balances back the 835 to what comprises that figure?

Sumita Sen: Unfortunately, there is no such document and …

Karen Peters: Why? Sorry. I mean – yes. I mean, our auditors come in and they say we'll book, X number of dollars as non-covered and X number of dollars on contractuals, and we do it based on the 835 that we're electronically uploading. They want us to balance back and prove it. How are we to do that if we …?

Question and Answer Session continued

Sumita Sen: They should, you know, match and you are saying they don't match. Is that your question?

Karen Peters: Not all – well, I can get the majority. I have covered days, non-covered days, discharge – all those segments – and for the most part, I can. But when I've gotten this breakdown of an electronic RA that we've got calculations in a spreadsheet, there'll be a segment or two that will not tie back to that segment. And I can …

Sumita Sen: Actually, then, you know, you'll have to kind of …

Karen Peters: We'll go like crazy to balance it back and I cannot. I have to go back.

Sumita Sen: I know that in, you know, Medicare uses this particular segment quite extensively and we do try to you know, balance. If you have found something, then please bring this up. You know, we can take this offline. But I know that like a couple of years ago there was some issue and we worked you know, throughout the issue but we do. And this is – you are – you're like the hospital, right, on the Part A side.

Karen Peters: Yes. A hospital.

Sumita Sen: Sure. So, you know, if you have a particular field which does not match, you need to bring this up.

Karen Peters: To whom? Because I've tried.

Sumita Sen: Maybe you know, you can send it to Aryeh or do you have your…?

Chris Stahlecker: No. Her appropriate point of contact would be the MAC.

Sumita Sen: Yes will you do the MAC.

Karen Peters: And I'm in North Carolina. I'm also in North Carolina.

Karen Peters: I brought it up to Palmetto and they sent me to the reimbursement. Reimbursement couldn't help me. They sent me to somebody else. I mean, I have been through the gamut. And I was just hoping, you know, you guys could direct me more specifically to somebody.

Sumita Sen: OK. And which particular field you are talking about?

Karen Peters: For example, one of them is the non-covered, TS37.

Chris Stahlecker: This is the – I just want to make sure that we're talking about a Medicare remittance that you're saying that it is out of balance with itself.

Sumita Sen: OK. No, and now...

Karen Peters: Well, I don't know necessarily – I'm not saying that it's out of balance with itself.

Karen Peters: I would like to take that total that's reported in that segment for that NPI.

Sumita Sen: As do we…

Karen Peters: And balance it to the individual clip records – individual accounts.

Sumita Sen: This is going to be a 4010A1 problem only, because TS307 is not within 5010.

Karen Peters: And that was my second question. When – since hospital use this data extensively, these TS3 segments, and many of them – I think six or seven if I read it correctly – are going away…

Sumita Sen: Right.

Karen Peters: …how will they balance their individual – what's the replacement for the TS3, you know, segments?

Sumita Sen: Basically, you know, they are going away because the X12 groups found that that's not really necessary.

Karen Peters: Oh, really.

Sumita Sen: What you know, you are – because what you do is you know, you go and you would just calculate what the total is. And this is electronic and you should be able to do that. So, you really don't need another field to reconcile. You just go and do the calculation by yourself or your system would do the calculation. That's why you know, all these things are going with – 306, 207, 208, 209, 310 – I mean, all these fields are going away in 5010.

Karen Peters: So, if I'm not – so, we're provider-based and we have two facilities. We use these segments to get totals for one department versus another. Without the TS3 segments to tie back to, how do we know that we've calculated correctly? Where's the total coverage charges or the total contractual adjustment TS311 going to be in the 5010. We're just going to take off the clip records?

Sumita Sen: This is you know, – I think you know, your case is a little bit unique but that was the rationale why you know, all those fields were in taken out in 5010. But if for 4010 you know, you have an issue, you can get in touch with me and I think you know, my e-mail address is there. No?

Karen Peters: No. I don't see it in the slides.

Sumita Sen: OK.

Aryeh Langer: You want to give us your contact information, Karen.

Karen Peters: Sure. It's x– my first initial for Karen and my whole last name – xxxxxx@xxxxxxxxxxx.xxx – First Health, all spelled out. Yes. Any help I could get with this would be greatly appreciated. Truly.

Sumita Sen: OK.

Karen Peters: And the program will...

Sumita Sen: And like I said, this is only for 4010A1 because this is not going to be in 5010.

Karen Peters: I understand and…

Sumita Sen: Yes.

Karen Peters: I understand. But, at least, if I could understand the 4010, when we transition to the 5010, I'll know that my clip segments – that the figures that I'm taking off the clip are accurate. So long as I've got one that is out of balance with the TS3, either I'm not calculating correctly or there's a mistake on the TS3.

Sumita Sen: OK.

Karen Peters: So, I'd like to know that I'm balanced perfectly before I go to 5010.

Aryeh Langer: OK. Well, we'll contact you and hopefully we could help resolve your issue.

Karen Peters: That would be great. Thank you very much.

Operator: Your next question comes from the line of Daila Albert. Your line is open.

Daila Albert: Yes. I probably have a real easy question, I'm hoping. I still submit claims using the PCAce Pro 32 and receive my remit using the Easy Print form during dial-in. Is that all going to stay the same? Is there going to be anything that I need to change on my end or am I still on – going to be good?

Chris Stahlecker: This is Chris Stahlecker. Would you mind repeating that question please? You're going to be using PCAce.

Daila Albert: Yes. I use the software that Medicare supplies the PCAce Pro 32 to submit claims.

Chris Stahlecker: Right. Yes.

Daila Albert: Is anything going to change with that that I need to do to still be, you know, be able to use this system or is that all going to stay the same?

Chris Stahlecker: No. It will all be changed. It will all be upgraded to accommodate the new 5010 format. And you'll need to contact your MAC to obtain the replacement set of software between, you know, – I don't really have the date when your MAC will have it. We are scheduled to have an audiocast for – that will address the MAC's outreach with messages, you know, for all of their Trading Partners and that will be later this year.

But you should know that the PCAce or Pro 32 product has been upgraded to accommodate the 5010 transactions. You will need to make use of that in order to transition over to the new format.

Sumita Sen: And that is true for MREP also because MREP has been updated to include, you know, the new fields and everything in 5010. Those things, you know, are going to change. In addition, there are some additional fields.

Daila Albert: So, the Easy Print is also going to change this type of thing.

Sumita Sen: Right. Right.

Daila Albert: OK. So, when you say MAC, you are talking about the…

Sumita Sen: The Medicare Administrative Contractors.

Daila Albert: OK. Through whoever we're contracted with.

Sumita Sen: Right.

Daila Albert: If you – and probably I'll get an email you're thinking or something to let me know that you know, it's time to upgrade or…?

Chris Stahlecker: If you have a question or concern, you can contact your MAC to find out what their schedule will be.

Sumita Sen: Right. They have a help desk.

Daila Albert: OK. All right. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Sandra Mills. Your line is now open.

Aryeh Langer: Sandra, are you there?

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

Jeanette Rob: Hi. This is Jeanette Rob and I have two questions. One you mentioned about the LCD and then the NCD and then the 835, you're actually going to have your – a link to the website? Is that correct?

Sumita Sen: Yes. Actually, in the REP segment the LCD and NCD codes will be there and then you would be able to go to that website and check what that code means. Because usually you know, there is – this is the relational denial that if you have this particular code and this particular diagnosis code and those two don't go together.

And right now, in order to know that – and then you have to call or you have to find out. But this one, you would be able to do it by yourself. You can see the code and you can just go and check the MAC website, which would have that information.

Jeanette Rob: OK. So, it's not like a direct link.

Sumita Sen: Well, you know, ...

Jeanette Rob: A direct link to the LCD or NCD?

Sumita Sen: No. But you know, you can have – somehow you know, your system go directly to because the website is going to be there.

Jeanette Rob: OK.

Sumita Sen: In your 835, so, you know, you can have your system go directly to that website.

Jeanette Rob: OK. And my other question is if y'all are working with vendors and you're talking about we can send an 837, but we'll still have to talk with our MAC providers for 835. I just want clarity, can we receive both the 4010 and 5010 835 files at one time until we get it to where we want it? Or is that just going to be where they just continually send test files? Is that just – will that be both or one file that will be changed from 4010 to a 5010?

Mike Cabral: This is Mike Cabral. Let me clarify what I was talking about earlier in the call. When you request of your MAC to begin 835 parallel testing, you will continue to get your 835 in the 410 for your production claims, for the claims that you would post to your accounts receivable. You will do that from your 4010 production 835.

Jeanette Rob: OK.

Mike Cabral: You will also receive another file that is the task indicator on the ISA of the 5010 version of the 835. You'll have two files to pick up you via the mechanism that they've delivered from MAC to you or your clearinghouse.

Jeanette Rob: OK. So, if we are with the third party vendor who actually picks it up and sends it to us ...

Mike Cabral: You just need to notify him of the new procedure and let ...

Jeanette Rob: And then they will also just forward it to us. OK, great. That's helpful. Thank you.

Chris Stahlecker: Oh, it's Chris. I just would like to add on a little bit to that last question.

Jeanette Rob: OK.

Chris Stahlecker: On slide 20, you'll – an earlier question came in about, you know, the difference between Part A and Part B. When you do contact your MAC to ask to begin to receive test 5010 transactions, the Part A side sets you up one time and then continuously sends you the 5010 test file that matches your 4010A1 production file.

But on the Part B side, you'll only get – once you call in and ask for a test file, you'll get only one. And then when you're ready to get another one, you'll call back and ask for another one. You'll have to call each time you want to get a test file. Just the function of how the two systems work.

Jeanette Rob: So, would that – if that we have third part vendor sending in that, would they handle that or would we...?

Chris Stahlecker: Well, your vendor does not really have a relationship with our MAC.

Jeanette Rob: OK.

Chris Stahlecker: The MAC establishes a relationship with your vendor at your request. So, it's really treating your vendor as if it were treating you.

Jeanette Rob: OK. And I have one another question that I forgot. Do you know, if MACs are going to require re-registration?

Chris Stahlecker: That's something that we're going to address in our future audiocast when we understand the MACs' approach in part. So, that'll be a MAC decision.

Jeanette Rob: OK. Thank you.

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

Aryeh Langer: John, are you there?

Operator: Your next question comes from the line of Joel Wolfling. Your line is now open.

Joel Wolfling: Hi, good afternoon. I just wanted to find out, one of the things I've recently noticed, coming back on a 4010 from a specific carrier was a Medicare crossover plain where Medicare had actually changed the modifier from the submitted 837 claim and not in the correction segment.

It had actually change the modifier and paid something on it so that when it got to the imported into the client system after the secondary was paying on it, we were unable to post it because of the charge mismatch, because of the modifier mismatch.

Is – I've always thought that if the modifier on the claim was not correct, it was just cause for denial. Are you aware of any of the MACs or any of the Fiscal Intermediaries…?

Chris Stahlecker: Did you contact your MAC to understand their response?

Joel Wolfling: Well, actually, the reason we – and we just found this literally yesterday. It was a Blue Cross payment after it had been crossed over from Medicare. And I do believe the client is in the North Carolina Part B with the (inaudible) services.

But it appears that the modifier was changed because then with 51 modifier, it should have been 59. And it came back on the 835 file at 59 but it's not in the correction segment.

Sumita Sen: We would encourage you if there's question that you have regarding an adjudication that has taken place on a prior claim to contact your MAC and have them explain that to you.

Joel Wolfling: Right. And my second question is during the transition to 5010, I know Medicare was realigning the jurisdiction and obviously assigning MAC. Do you see any problems with if a MAC is transitioned during the 5010 transition or can you tell me if they won't be doing that during the 5010?

Chris Stahlecker: We have worked very diligently in standardizing the editing and the look and feel of all the exchanges that you would experience with the MAC to have that type of business process sort of transparent and seamless. There will be some changes, of course, because there'd be different contractor identification numbers, potentially different Trading Partners or submit a receiver numbers assigned to you.

But overall, it should not be a major issue..

Joel Wolfling: We went through, I guess, transitions from (inaudible) to a different contractor.

And because we were enrolling clients at that time, I guess there were some definite issues, at least the (inaudible). I'm sure. you're right about the electronic transaction side hopefully these things will definitely –the administrative side can – we'll have as good of a time..

All right. Well, that's the only questions I have. So, thank you very much.

Sumita Sen: OK. Thank you.

Aryeh Langer: OK. Mason, we have time for one more question.

Operator: Your final question comes from the line of Paula Tulley. Your line is open.

Paula Tulley: Sorry, my phone is a little funky.

Good afternoon, this is (Paula Tulley) from Hanger Orthopedic Group.

We are DME and currently for DME we go through CEDI which is the central gateway that was established to act as the front line for the DMACs. Is the coordination for us going to be with CEDI or with the DME MACs or with both when we speak in testing?

Chris Stahlecker: Mike, you want to take this?

Mike Cabral: Hi, This is Mike Cabral again.

The majority of the work – we've gotten actually the same question from the contractors as well on our certification program that we'll be rolling out. And CEDI will be handling the majority of the work with you directly. They do need some support on certain things from the MACs. And we're looking at that internally.

They may have HCPCS updates to take care, or they may have NPI groupings that they take care of at the DMACs' site. So it's a coordinated overall effort but the majority you'll see it done through CEDI.

Paula Tilley: OK, great. Thank you.

Aryeh Langer: Well, thank you very much, everybody. I know you guys took out time from your schedules today, and CMS truly appreciates that. I'd also like to thank our Medicare experts here at CMS for diligently working on some of these tough questions.

Our next call is scheduled for September 29th. And for those of you who can't wait for the listserv message to find out about the call information, I can tell you that the next call will be on the acknowledgement transactions, the 227 CA ...

Mike Cabral: Seventy.

Chris Stahlecker: Seventy-seven.

Aryeh Langer: Excuse me, the 277CA, the 999, and the TA1. Again, that will be on September 29th, and just be on the lookout for the usual listserv message announcing the call details and registration information.

Thank you so much and have a great day.

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

END