Centers for Medicare & Medicaid Services
Twelfth National Provider Education Call
On Medicare FFS Implementation of HIPAA
Version 5010 and D.0 Transactions
Moderator: Charlie Eleftheriou
November 17, 2010
12:00 p.m. ET

Contents

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

All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for participating in today's call.

I will now turn the conference call over to Mr. Charlie Eleftheriou. Sir, you may begin.

Welcome

Charlie Eleftheriou: Thanks, Simon. Hello, everyone. Again, like Simon said, this is Charlie Eleftheriou from the Provider Communications Group here at CMS. And I'd like to thank you for joining us for the Twelfth HIPAA Versions 5010 National Conference Call.

Today's call will focus on Medicare Fee-For-Service implementation of HIPAA version 5010 and D.0 Coordination of Benefits. There's a presentation that accompanies this talk, which you could find and download on the HIPAA 5010 website located at www.cms.gov/versions5010andD0. Click the 5010 National Calls link on the left side of the screen, and there you can scroll down and access the link for today's call presentation from the list.

Please note, following this presentation, there will be a question and answer session, giving you the opportunity to ask questions of our subject matter experts. Also, this call is being recorded and transcribed as Simon mentioned, so please clearly state your name and organization before asking your questions.

Without any further delay, I'd like to introduce our speaker, Brian Pabst. Brian is a technical advisor and Coordination of Benefits Agreement, Government Task Leader here at CMS. Brian:

Purpose, Agenda, & COB/Crossover Process Overview

Brian Pabst: Good afternoon. Thank you so much. I'm very pleased to hear that there are so many folks joining us today, well over 800. So this should be a very interesting and hopefully productive call for all concerned.

I wanted to start up by going over the purpose of today's call. I am going to begin by providing an overview of the Medicare Fee-For-Service crossover, COB process. I'll then discuss the major areas of change from HIPAA 4010A1 to Version 5010, including Errata, within the Medicare Fee-For-Service COB context.

I'm going to also highlight some important Fee-For-Service COB-specific changes relating to NCPDP D.0. I will also review timelines for testing and deadlines for production and will provide guidance concerning how to prepare for these changes that are upcoming>Lastly, my goal today is to obtain feedback from participants regarding questions or concerns that they may have in relation to Medicare Fee-For-Service from a COB context.

And in that regard, just so you'll see this plays out according to certain advertised themes: The general overview will be discussed first. I'll then move into Medicare-specific COB changes, what you can expect, timelines, and deadlines, what you need to do to prepare, and finally we'll collectively move into questions and answers.

I realize that today's audience-is providers, vendors, and clearinghouses, so I've tried to customize my presentation accordingly. It is important that, you realize that this all relates to what we call the back end of claims crossing over and not the front-end.

To begin, what is the Coordination of Benefits? Generally, COB refers to processes or methods that are applied to ensure that various insurers and health benefit plans pay in the correct order. Within our environment, the Fee-For-Service Medicare environment, COB relates to Medicare Secondary Payer processes as well as to the Medicare Fee-For-Service crossover or Coordination of Benefits Agreement [COBA] crossover process.

Again, just to be sure that everyone's following and within the correct context, today's presentation will focus on the Medicare Fee-For-Service crossover or COBA component of that COB equation, and not Medicare Secondary Payer.

Now, what is crossover? Crossover is a Medicare Fee-For-Service term of art. No other insurer uses this term for its own COB process. Crossover refers to the processes where our Coordination of Benefits Contractor, on behalf of CMS, transfers Medicare Fee-For-Service claims electronically to other insurers or health plans, all of which we call covered entities in the HIPAA sense. There are two types of crossover. The first is automatic or eligibility file-based crossover, and the second is Medigap claim-based crossover.

How does the automatic crossover process work? In this regard I wanted to step you through this process, as a lot of you probably are curious about it. The first step is that the insurer or payer signs a national standard agreement with CMS' Coordination of Benefits Contractor (COBC). Within the agreement, the insurer or payer designates its claims selection criteria--that is to say what types of claims it wants to receive and what types it doesn't want to receive. And it also specifies file frequency specifications. For example, insurers or payers may want to receive claims daily or they may want to receive claims weekly. We offer either option.

The insurer or payer then sends a file which contains eligibility information for its covered members to the COBC. That's the next step. The COBC, in turn, sends the covered members via a secure maintenance transaction to our Common Working File or CWF. This is where the information is posted. The insurer or payer usually updates this information on either a bi-weekly or monthly basis.

Along with that, the COBC sends the insurer or payer's selection criteria to CWF, doing so on a weekly basis as a full file replacement. After the Medicare Administrative Contractors, or MACs, and Durable Medical Equipment MACs, or DME MACs, adjudicate their claims, they send them to CWF for normal approval processing.

CWF then searches for insurer/payer eligibility information and claims selection criteria in association with specific claims while performing its normal processing routines. I just wanted to let you all know that CWF really is the traffic cop for crossover and hopefully that'll become obvious as we continue this discussion. And what that means is that CWF either selects the claim for crossover or it doesn't.

The next bullet drives this point home. CWF either selects or excludes individual claims from being eligible for crossover. CWF also marks its claims history to indicate whether it selected or excluded each claim.

Now, normally, that works near perfectly. Sometimes, it doesn't. The CWF crossover decisions are made available to Medicare MACs and DMACs, as well as 800 Medicare staff. So if the provider were to call the Medicare contractor, theoretically, it should be able to find out why the claim crossed or didn't cross in a perfect world. Also, the 1-800 Medicare staff, which gets calls from beneficiaries, would be able to make the same determinations.

If CWF selects a claim to cross over, it returns what we call a trailer to the Medicare contractor through its shared systems; and this action causes the claim to be sent to the COBC after it has met the Medicare payment floor requirements as finalized.

The COBC initially subjects incoming claims to high-level business-level or claim structure edits. Those claims that pass these editing routines go on to HIPAA translation and thereafter HIPAA edit validation.

COBC sends resulting HIPAA-compliant claims to the appropriate payer or insurer on either a daily or weekly basis. The COBC sends a detailed reporting of claims that do not pass what we call the initial business editing or HIPAA ANSI compliance verification back to the Medicare Contractors.

Various insurers and payers also notify the COBC when they cannot accept crossover claims, along with reason. The COBC, in turn, includes this information on this detailed reporting that I just highlighted back to the Medicare Contractors.

Now, what happens at this point? If either the claim edits at the front end of the Medicare COB Contractor and doesn't make it through there, or it fails compliance at the COB Contractor, or it gets to the Trading Partner and the Trading Partner can't accept it, this all comes back to the Medicare Contractor again through what we call The COBC Detailed Error Report.

And then that, in turn, will cause the contractor system to generate a special provider notification letters to you all to let you know that these particular claims, specific to given claim ICNs/DCNs/CCNs and HICN number, did not actually cross over and it actually tells you the reason why.

Now, the other variant of crossover that we spoke about is Medigap claim-based crossover. A very small number of Medigap insurers do not participate in the larger automatic process these days.

For those who are interested—and I'm sure you are because you bill these claims to Medicare—a listing of the entities that participate in this process may be referenced at the website download link that I provided in these slides: http://www.cms.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf

Just to be clear, the mechanics of the COB process are the same for the automatic process as with this process, with a few exceptions: The Medigap claim-based process only applies to Part B or DMEPOS claims when the physician or supplier participates with Medicare; it does not apply to Part A. Also, it only occurs when the beneficiary assigns benefits to the physician or supplier, and it only occurs when the physician or supplier enters a particular 5-byte COBA ID, which COBC has assigned to the insurer, within a certain block on the 1500 form or within the NM109 element of the 2330B of incoming professional claims as appropriate.

A lot of you are probably understanding what these loops and segments represent are; I hope so going forward, particularly with respect to vendors. For incoming NCPDP claims that the supplier is trying to trigger for Medigap claim-based crossover, the retail pharmacy supplier or its agent would have to enter a 5-byte COBA ID within field 301-C1 of the T04 segment.

Review of HIPAA 5010 COB Changes

Now, in terms of our next section, what really is changing with COB under HIPAA 5010 and what can you really expect to see? This is, again, more geared towards the payers that are going to receive these claims, but for clearinghouses that would service providers and also services supplemental payers; this information will be very helpful.

First thing I want to draw your attention to is that the 2320 AMT COB Total Non-Covered Amount element is now added for 5010. What you'll notice as we go through is that you will not be seeing this on the COB transactions that we cross over, and I'll get into that momentarily.

One thing that a lot of payers are noticing is that numerous AMT segments were removed in the 5010. Only the 2300 AMT*F3, AMT*F5, and AMT*D will potentially appear on 837 COB claims.

One clear change with 5010 is that Present on Admission Indicators now have their own area within the claim. In the past, they were relegated to a K3 segment. They have their own home now in the 2300 HI segment, courtesy of the changes made for 5010.

Under HIPAA 5010, there is very limited use of Secondary REF segments. These will only appear within the 2010AA loop. The 4010A1 professional claim restricted taxonomy code reporting at the 2000A PRV level. Those restrictions no longer apply, which for Medicaid and a lot of other payers will be a very positive development because they utilize that in their NPI matching strategy.

Covered, non-covered, co-insurance, and lifetime reserve days will be reported as whole numbers, qualified by value codes 80 to 83 as appropriate within the 2300 HI segment. These elements were formerly reported in the 2300 QTY01 or QTY02.

All 837 COB claims must balance. With the full implementation of 5010, claims that do not balance will be ineligible for crossing over. Additional changes under 5010 COB entail that anesthesia timed units will always be expressed as minutes rather than units. A lot of folks probably know that we adjudicate as units internally at Medicare, but we are going to be putting out as minutes for COB in every instance.

Here's something that you folks will really want to pay attention to: The 2010AA NM109, which is the NPI information for COB claims, is going to be

derived from the claim for institutional claims 837-I, but will be derived from the internal provider files utilized during claims adjudication for professional claims, which would entail physician claims as well as DMEPOS supplier claims.

The importance of that is that if you had incorrect information on file with the Medicare Contractors, for example, your address information, you would want to change that. And I'm thinking a lot of you are doing that now as a result of current Medicare PECOS changes. So hopefully, there won't be much concern there once that finalizes. We regard our PECOS system as a trusted source, which is why we use that as the source for much of our COB provider address information.

The 2010AB N3 and N4 information will be derived from the Medicare Contractor's internal files and only created when the address differs from that in the 2010AA N3 and N4.

Right now, in 4010A1, we have the scenario where you actually have a 2010AB created when the information about the entity and the addresses differ. With 5010, the differences will be limited to address. So the only time we'll see a 2010AA N3 and N4 segment created for COB is when the address for the Pay-To provider is different from the Bill-To provider.

One thing that I know we all realize is that the rules for 5010 have made the 2010AA N3 segment a street address only field. You can't have a P.O. Box there anymore. So that's what really is driving all this decision making with regard to the creation of the 2010AB loop in a COB context.

For provider loop N403 elements, in most cases, the required nine-digit zip code will be available, as derived from the data within PECOS. But in those rare cases when it's not, which will be very seldom, we will need to develop a gap-fill for the plus 4 portion of the zip code, and that value will be 9998. We've notified all of our COB payers about that, so hopefully they've already made accommodations.

Fee-For-Service Medicare will only create 2010AA PER segment if the provider has supplied Medicare with complete contact information. We're not going to attempt the gap fill missing elements.

For COB, the 2000B SBR01 for the destination payer will always equal "U." The 2000B SBR09 will always equal "ZZ," unless the payer is Medicaid, where the qualifier will be "MC."

A little change to my third bullet: For COB, 2320 SBR01 will similarly be "U" and the SBR01 will equal an 18. That's true, but the SBR09 will not always be a "ZZ." The only time it will be an "MC" is if the entity that the claim is going to is Medicaid. So, that's a change that's in the works for one of our systems and already is in place for the others. I wanted to make that change modification to my prepared remarks because I thought there was a qualification regarding Medicaid and I wanted to alert you to that exception.

Remark codes MA04, MA18, and N89 will appear in the 2320 MIA segment and within the MOA segment as appropriate, which is how it works today.

For 837 Institutional claims, Fee-For-Service Medicare will not map out the 2320 AMT Remaining Patient Liability segment for COB. For the 837 Professional DMEPOS claims, Medicare Fee-For-Service will also not map out the segment for COB. For the 837 Professional physician-oriented claims, Medicare Fee-For-Service will map out the 2320 amount Remaining Patient Liability field.

None of the Fee-For-Service systems will map out the 2320 AMT COB Total Non-Covered for Medicare, and the reason for that is a note in the TR3 itself, which really stipulates that the purpose of this newly created segment is to skirt a particular payer in qualified situations. If it's a known fact that, for example, acupuncture isn’t covered by Medicare, which it isn't, there are some folks who would say, "Well, why even bother going through the motions of filing the claim to Medicare?" If that were tried, we just simply wouldn't carry that information onto the COB claim. It could be tried, but the 2320 AMT COB Total Non-Covered segment wouldn't actually be carried in the crossover claim is what we’re telling you.

The 2300 level PWK data will not be sent for 837 COB. Medicare Fee-For-Service will also not create the following: 2000A Currency, because in most cases we're not dealing with foreign claims where this would apply; 2010BB REF, Payer Secondary Identifier; 2010BB REF, Billing Provider Secondary Identifier; 2000 CL, Patient Hierarchical Level; 2000C PAT, Patient Information; and 2010CA, Patient Name. A lot of you probably recognize, for Medicare, the patient, the beneficiary, and the subscriber are all one and the same, which is why we don't create many of these loops for COB purposes.

Now, I turn to a review of some our gap-filling, which will be minimal, but I just wanted to give everyone a preview concerning what t that looks like. As I have indicated, gap-filling will chiefly become necessary in qualified cases when the incoming claim is 4010A1, hard copy, or DDE, but the payer is requesting a 5010 claim and vice-versa, which some folks would call up or down- versioning if you're going from 4010A1 to 5010 or from 5010 to 4010.

For incoming paper or DDE-entered claims where the dosage qualifier information needed to create 2410 CTP05-1 is not available, Medicare Fee-For-Service will always map an "F2".

For instances involving Part B claims where the date of admission is required but not available, Medicare will map the claim's earliest service date to fulfill the 2330 DTP03 requirement when the place of service reported in loop 2300 CLM05-1 is 24, 41, 51, or 61.

Here's one of the fun ones: For the creation of the N3 segment within loops 2310E and 2310F, in association with ambulance claims, Medicare Fee-For-Service will, as a gap-fill measure, map all "Xs." HIPAA 5010 has made us have a requirement that we have to have populate both the point of destination and the point of pick-up, whereas 4010A1 only required one of these. That's why gap-filling will become necessary in this instance, since you're taking a 4010A1 claim and converting it into a 5010 claim.

So for the N3 segment, there may be situations where we need to have all Xs reflected for the street address, and, as indicated in the next bullet, we may need gap-filling for the city, state, and zip code, which is what that covers. For state, we will use Maryland, which is pretty innocuous. For the city, we will use Cityville, and we will plug a zip code that is certainly possible within the United States territories.

If the incoming UB-04 or DDE screen-entered claims do not contain minutes in association with Admission Date or Hour, Medicare Fee-For-Service will gap-fill the minutes portion of the required DTP03 with the value "00."

I turn now to some specific changes relating to the Errata, which we'll be implementing in April 2011.

For 837 Institutional claims, the 2430 SVD becomes situational. Right now, of course, this is required, which means that for every line item, you need to have a CPT-4 procedure code or HCPCS code and that's interesting. The pre-Errata version of HIPAA 5010 had made the 2430 SVD required, which has greatly affected the progress of HIPAA 5010 COB testing thus far.

For the 837 Institutional claims, the 2300 CL101, Admission Type Code, is now required. If gap-filling becomes necessary, our Medicare Fee-For-Service system will default to "9," Information not Available, for the 837 COB claims.

For both 837-I and 837-P claims, the N401, N402, and N403 elements within the 2330A are no longer required; thus, the gap-filling logic for these elements will be discontinued. For the 837-I, 837-P, the N4 is also no longer required; thus, gap-filling for that segment will also be discontinued.

Now, we'll get into the fun stuff, NCPDP D.0. And I hope all of these loops and segments and numbers will not tax you too greatly, but unfortunately, you have to talk about this, and I hope you'll bear with us as we go through this.

Within the Transmission Insurance Segment, Medicare Fee-For-Service will map the 5-byte Medigap claim-based ID within the 301-C1 Group ID. The

Medigap policy number will be mapped to the newly created 359-2A, Medigap ID element.

With respect to the latter, the NCPDP X12 folks actually must have heard one of our concerns in the past and made accommodations, which is great, and that's what we're going to use it for as part of our COB processes.

The following will not be created for COB within the Transmission Insurance Segment: 336-8C, 115-N5, 116-N6, 314-CE, 303-C3, and 306-C6. The Medicare HICN – and this is very important – will be mapped to the 332-CY Patient ID within the Transmission Patient Segment.

Element 325-CP within the Transmission Patient Segment may contain a base 5-byte zip code, followed by 9998. Just to let you know again that our plus 4 zip code gap-fill, should it be necessary, will also be 9998.

The supplier's NPI will be derived from the incoming claim and mapped to the 421-DL, Primary Care Provider ID, within the Transaction Prescriber Segment. Within the Transaction Prescriber Segment, elements 427-DR, Prescriber Last Name, and 364-2J, Prescriber First Name, will be mapped from the Medicare Fee-For-Service DMAC internal provider/supplier file..

Within the Transaction COB/Other Payer Segment, Medicare Fee-For-Service will qualify – this is important, a different change – deductible or co-insurance amounts remaining differently. Medicare is currently using 98 or 99 to qualify these amounts and that will be changing.

Also within the Transaction COB/Other Payer – Other Payment Segment, elements 392-MU, 392-MV, and 394-MW will not be mapped out for COB.

Medicare Fee-For-Service will not create the following within the Transaction Claim Segment if received, and there's a whole litany of them here, 461-EU, 462-EV, 463-EW, 464-EX, 354-NX, 357-NV, 995-E2, 996-G1, and 147-U7. Within the Transaction Pricing Segment, the following will not be created: 482-GE, 3483-HE, and 484-GE. Medicare Fee-for-Service will not create the Transaction Additional Doc segment or Additional Documentation Type ID as

these relate to the Certificate of Medical Necessity information, which is no longer supported. We have a different way of requesting that information now.

. Under current 5010 COB testing, we had seven testers initially start with us on September the 27th. The number has grown to 48 core entities now, I believe.

And all that really represents 110 lines of business, so the number of testers is growing. Current COB testers are receiving limited numbers of 837 Institutional claims due to the current 2430 SVD requirements that the COBC is enforcing as required. Clearinghouses whose insurer clients are interested in testing the pre-Errata version of HIPAA 5010 COB should ask their clients to contact their assigned COBC EDI representative. If there's ever a question as to who the EDI representative is, there's a general number at COB is going to offer to you. That number is 646-458-6740.

Timelines & Deadlines for 5010 COB Implementation

In terms of timelines and deadlines for 5010 COB implementation, please know that CMS encourages insurers and payers to test in the current pre-Errata 5010 COB claim formats with the COBC prior to April 2011. Insurers and payers and affiliated clearinghouses or vendors that are testing pre-Errata 5010 with the COBC must later test the Errata version of HIPAA 5010 after April 2011 before moving into production. All COB payers must have moved into production on the Errata 5010 claims version no later than December 31st 2011 to comply with the January 1st 2012cutover date.

Medicare Fee-for-Service is targeting July of 2011 as the timeline for ensuring that all COB insurers and payers have begun, or will have begun, testing the 5010 Errata 837-I and 837-P claim formats with the COBC.

How to prepare? Now again I recognize that a different audience is represented here today, but one thing that you'll want to do, of course, is to review the Technical Report 3 (TR-3) guides as well as HIPAA 5010 Errata

changes, which we're all doing. Providers and clearinghouses should also be on the watch for the CMS future- issued Companion Guides involving front end Medicare claims processing.

COB insurers and payers may reference the HIPAA 5010 Crossover Companion Guide by referring to our March 25th COBVA broadcast. Also, I want to let you that we're going to be putting this on the COBA web very soon. CMS will soon be issuing its revised COBA HIPAA 5010 COB Companion Guide once we've included the Errata changes and any other changes that may be needed. .

CMS is targeting late December 2010 as the timeframe for making the NCPDP D.0 Batch Claims COB Companion Guide available. Who knows, this may end up being a Christmas present! And that's all I have.

Question and Answer Session

Charlie Eleftheriou: Thank you, Brian; appreciate that. We've now completed the presentation portion of the call, and we'll move on to question and answers. Before we begin, though, I want to again remind you that the call is being recorded and transcribed so please clearly state your name and organization before asking your question.

And in an effort to hear from as many participants as possible in our limited time here, we ask that you limit your questions to one per person. At this time, I'd like to open the line for questions.

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number 1 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're asking your question, so anything you say or any background noise will be heard in the conference. One moment please for your first question.

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

Brenda Ding: Yes. Hi. This is Brenda Ding with Providence and I wanted to find out if you guys have a date for the Companion Guides? I know you said that for NCPDP D.0 that it would be December of 2010. But how about for the CMS future- issued Companion Guides? Is there a date yet on that?

Brian Pabst: And, Brenda, this is Brian. I'm assuming you're talking about the front-end part of the claims process as opposed to COB?

Brenda Ding: Yes.

Brian Pabst: OK, I'll direct that question to one of my other colleagues who is present today…

Chris Stahlecker: Hi. It's Chris Stahlecker here. Yes, we are expecting to have that available through our MACs by January 1st.

Brenda Ding: And those are through the MACs though?

Chris Stahlecker: Yes. You'll be contacting your MAC. It will also be on our CMS centralized website, but you'll need to have particular information from your MAC in order to connect.

There are actually two standard documents. One is for the Trading Partner management side of things, and you'll need that part from your MAC in order to know exactly what they're going to require for testing and what their EDI help desk numbers will be to take your call. So, you should be contacting your MAC.

Brenda Ding: Thank you.

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

Joe Wolfling: Hello Brian. I have a quick question. This is Joe Wolfling with KSI Healthcare. What we have seen so far with the COB Contractor in the

4010A1 is that if it is crossing over to Medicaid, a lot of the Medicaid providers are registered as individual providers in terms of Billing-To entity.

But yet for Medicare, they're enrolled as a group or organization. And I know in 5010 the rule is you're only supposed to bill one NPI. But have you had any of the Medicaids do any 5010 testing with you guys so far on the COB Contractor?

Brian Pabst: Good question, sir. Yes, we actually have three right now that are in testing. But to your point, there is a difference between Medicare and Medicaid that we find to be present no matter how we try to resolve the differences. In essence, Medicaids do enumerate their entities differently than we do.

The one thing, Joe, that we find is that Medicaids tend to rely a lot on taxonomy codes, which I had mentioned. And with the 5010 changes, that's going to be made a lot easier for them. Right now there were some problems with professional in terms of what can be reported up on that higher part of the claim (2000A PRV) based on the way the current 837 4010A1 Guide reads. But to get back to your question, there are three that are currently testing with us.

Joe Wolfling: OK. And so far are you aware of any issues where the initial claim was billed under the group and the subsequent crossover to the Medicaids where they were requesting the individual NPI and looking for that NPI within the 2010AA loop.

Brian Pabst: That has not come up, but we will be monitoring for that kind of response from the Medicaids.

Joe Wolfling: OK. I guess I'll just wait to see what happens.

Brian Pabst: OK. We hope whatever happens, it's going to make the providers a little more pleased.

Joe Wolfling: Thank you.

Brian Pabst: Thank you.

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

Sharon Decaniel: Hi. My name is Sharon Decaniel. I'm calling from Optima Consultants of Long Island.

I have a question regarding testing. If we begin testing before the April 2011 deadline and do it in the pre-Errata version, do we have to then test again once all the changes had been finalized and then we go to the Errata version?

Brian Pabst: Even though I believe your question is relating more to your front-end experience, the folks across the table are shaking their head in agreement that you will need to test again/

Chris Stahlecker: Yes, that's correct. You will need to retest after we have installed our April changes to handle the Errata. You will need to retest before you can go to production using the Errata version.

Sharon Decaniel: OK. So to me, as the end user, I wouldn't want to test prior to adoption of Errata. I would just wait until after that because I'm sure the changes that you're going to make are going to also cause changes down to our vendors. So, that's got to involve our software and we're going to need to then configure our software to be able to successfully transmit this data to you in a different version.

So, it sounds like right now there are two versions out there or one pre-Errata version and you're going to make some changes to it and then the final version won't come until after April. Am I understanding that correctly?

Chris Stahlecker: Yes, you are understanding it correctly. The standards themselves were modified somewhat. We're talking about the original standards; we're using the term baseline to refer to them.

And that's the version that we'll have installed and ready for your to check with in the January to March 2011 timeframe. And there may be some benefit to testing and, yet again, there may not be, depending on the scope and

breadth of what you need to test. We're expecting that many will want to test just to get an early experience with their own installation of their changes along with the individual Medicare Administrative Contractor set of changes. It's ultimately your choice if you want to defer testing then wait until the Errata version is installed after April.

That does cut down on your transition time, so vendors that have to deploy software will have a larger scope of change in fewer months, but that's just how it has become necessary if they must accommodate the Errata changes. So, that's the situation we have.

Sharon Decaniel: So, you'll be able to though accept the claims in both versions 4010A1 and 5010 in test whether it is Errata or post Errata, right?

Chris Stahlecker: We're saying that we're going to accept 4010A1 in production all through 2011.

Sharon Decaniel: OK.

Chris Stahlecker: And then we will accept the 5010 base version during January to March 2011, and then only 5010 post Errata (you've used that term), but with the Errata changes included after April 2011.

Sharon Decaniel: OK. And then once we successfully test in the 5010 version, we can just go in production with that?

Chris Stahlecker: I want to be clear. After you successfully test after April 2011 with the Errata 5010 version, then you can go to production.

Sharon Decaniel: Thank you very much.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Gloria Davies. Your line is open.

Gloria Davis: Hi. This is Gloria Davis with Neptune. I actually got my question answered with Joe's question previously on the Medicare – Medicaid crossovers with the billing NPI being different for the two entities.

Male: Thank you.

Operator: Your next question comes from the line of Gregory Bates. Your line is open.

Gregory Bates: Yes. My name is Gregory Bates. I'm with Nationwide Laboratories Services.

And I was following along with the printed paper that you're reading from and at two different locations, you read something different than what was printed on the paper. On page 11, bullet point number four, remark codes MA07, you said MA04. And on page 13, bullet point three, the last little bit in loop 2300 CLM05, you said 24 and it's printed as 21. Which is the correct?

Brian Pabst: Greg, with regard to page 11, it is MA07. You're correct there. And I'm sorry I didn't catch your other page.

Gregory Bates: Page 13, Remark Code number bullet point number three starting with four instances involving Part B. The very last bit you said 24, 41, 51 or 61, where it is actually printed as 21, 41, 51 or 61.

Brian Pabst: 21 is definitely correct.

Gregory Bates: OK. Thank you.

Brian Pabst: Thanks for bringing that to my attention; I did not mean to misstate those values.

Gregory Bates: OK.

Operator: Your next question comes from the line of Sammy Buben. Your line is open.

Sammy Buben: Hello. My name is Sammy Buben. I'm with the Pacific Family Health Center in South Bend Washington. We're a very small clinic and we do all our submissions hand entry to PC Ace. One of the problems I have is on page 10, bullet number two.

I know the X12 Committee is changing over strictly to requiring a street addresses within the 2010AA N3 and N4. We live in a very small area, where 100 years ago, the US Postal Service elected not to make deliveries to physical addresses in our town and so that's not really an option for us. We must use the Post Office Box to receive mail, unless you want to send it UPS or FedEx.

And we've run into a problem with new postmasters who've told us that if we continue to not get this changed, our mail may be stopped in Olympia, which is our state capital, before it gets here. So, I need to double check with this because in PECOS there are two areas that you can use and the one includes the billing addresses opposed to the street address. Again, I understand that the P. O. Box address is no longer going to be used; it'll be just the street address. How do we approach this?

Brian Reitz: Yes, hi. This is Brian Reitz. I think I'm probably just going to need to get your contact information and speak to you directly about this issue off-line. Basically, we don't write the Implementation Guides. The Implementation Guides come from X12, which is a bigger industry that oversees healthcare, and its requirements are what we have to follow and so we must reflect a physical address, whatever it may be.

Internally, we use our own internal systems to adjudicate. So, whatever you enrolled with Medicare under, in terms of billing address, is what we're going to be using. So, the only thing I could say is let's talk offline and see if we can come up with something for you.

Sammy Buben: OK. Do you want me to give you a call?

Brian Reitz: If you could provide me with your name and telephone number, that would be great.

Sammy Buben: My name is Sammy and the last name is Buben [B-U-B-E-N] and I'm with the Pacific Family Health Center in South Bend Washington. And the best

number to reach me is probably my cell phone, and that's area code XXX-XXX-XXXX. Do you need an email as well?

Brian Reitz: No. Let me just verify, Sammy. You said XXX-XXX-XXXX?

Sammy Buben: That is correct.

Brian Reitz: OK. I'll be getting in contact with you after this call.

Sammy Buben: All right. Thank you.

Operator: Your next question comes from the line of Kimberly Mumphrey. Your line is open.

Kimberly Mumphrey: Hi. Yes, my name is Kim Mumphrey and I'm with Emdeon and I just wanted to mention that I wasn't sent the website for web chat so I can follow what you discussed.

Charlie Eleftheriou: You're trying to access the actual presentation, -the slide show?

Kimberly Mumphrey: Yes.

Charlie Eleftheriou: It will be www.cms.gov/versions5010, the word “and” [a-n-d], and then “D” as in dog, along with zero [0]. No spaces in between any of that.

Kimberly Mumphrey: OK. Thank you very much.

Charlie Eleftheriou: You're welcome.

Operator: Your next question comes from the line of Dawn Ducheck. Your line is open.

Dawn Ducheck: Hi. This is Dawn Ducheck with Gateway EDI. My question is after the deadline of January 1, 2012 when 5010 is required, how will the secondary crossovers work if say a Medicaid is not ready for 5010? Will the crossover claims be sent in an alternative format that the Medicaid needs to adjudicate the claim?

Brian Pabst: This is Brian Pabst from CMS. We are keeping that deadline very much in mind. There is a "potential," and I'll put that in quotes, systems work- around if we need it, but we're really trying to avoid using it to the greatest extent possible.

In other words, there is a possibility of giving Medicaids the 4010A1 production claim after the date, but clearly the date is there for a reason and we're telling Medicaids and all others that we are serious about the 2012 date. We're trying to get to the point where the systems workaround will not be needed. But, in a worst case scenario, we didn't want to drop everything to paper, so we do have a workaround process that could be used but we're trying not to invoke it.

Dawn Ducheck: All right. If you do not have a workaround, will communication be sent back to the submitter in this case, the clearinghouse, indicating the claim has not been crossover?

Brian Pabst: Well, –the signal would be that Medicare Remittance Advice may not reflect that it crossed. We'll send have communications out to the proper channels through CMS about that because we don't want you all to be in the dark as to what we're doing. We'll make sure that happens in December of 2011.

Dawn Ducheck: All right. And then I have one more question if I could ask it.

Brian Pabst: Sure.

Dawn Ducheck: Regarding the statement that the 837 COB claims must balance, am I correct that there will be a rejection message provided back to the provider if the claim does not balance? Or will the claim will just drop out of the system?

Brian Pabst: My understanding is that it will go back to the provider or submitter, being rejected on the front end with a message I believe.

Brian Reitz: She is referring to a situation of imbalance?

Brian Pabst: Yes.

Brian Reitz: Yes. This is Brian Reitz. We have inbound edits requiring balancing on the original submission. So they would be rejected back to the submitter.

Dawn Ducheck: All right. Thank you.

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

Kathy Sites: Hi. This is Kathy Sites from RealMed. And on prior calls we've been told to contact the MACs to set up testing and to get information on whether they will truly be accepting dual 4010A1 and 5010 at the same time. And we still have a lot of MACs that are telling us to go to their website and not getting into conversation.

Is there any timeframe that we're going to have in order to talk to MACs? Or is there any other way we can get this information?

Chris Stahlecker: Well, it's Chris Stahlecker, and I would suggest that you come back on December 8th for our audiocast on MACs and testing. We can attempt to cover that territory during that dialogue.

However, each MAC will be required to support 4010A1 production all through 2011. So, it's not a question of if a MAC will or not. MACs are required to support production 4010A1 all through 2011.

Perhaps I'm not appreciating all that is contained in your question. But CMS has also directed the MACs to only bring up new Trading Partners using 5010 after the April 2011 release installed with the Errata transaction. Does that help you?

Kathy Sites: Right. But we're interested in the ability to send both 4010A1 and 5010 claims from the same submitter ID for the duration of 2011.

Chris Stahlecker: For the duration? Well OK, we're still working through some of those issues with the MACs to understand if they are able to support a single submitter ID production for 4010A1 and test for 5010 or if they're going to require you to have separate submitter IDs. So there are some details that are still being worked out.

But they will be supporting 4010 production all through 2011 and they will be supporting testing of 5010 in 2011.

Kathy Sites: OK. Thank you.

Chris Stahlecker: All right.

Operator: Your next question comes from the line of Darlene Blair. Your line is open.

Darlene Blair: Hi. I'm Darlene Blair and I'm calling from Family Line Chiropractic Center. I just needed some clarification. I don't know if I understood this correctly but t on the crossovers, is it correct that a non-covered service for Medicare will not cross over to the secondary?

Brian Pabst: To clarify that again. If this involves the 2320 COB Total Non-Covered Amount part, and the function of that, as I understand it, is that the provider knows going in that the entire services are non-covered, this would be true.

Darlene Blair: Right.

Brian Pabst: Various interests wanted the X12 Committee to memorialize this within one area of the claim without having all to CAS segments indicating non-coverage. . But this intention runs contrary to crossover in every way in terms of what crossover is supposed to be in terms of being HIPAA compliant COB transactions.

So, if you are referring to claims not being crossed over if they only contain the 2320 COB Total Non-Covered Amount, you're correct.

Darlene Blair: OK. Well, I have a question then. Say we're from a chiropractic office and the only thing that Medicare will cover is the adjustment. Our secondaries may cover the exam, x-rays, therapies, things like that, but they have to have denial from Medicare first before they'll pay for it. So, then what do we do?

Brian Pabst: I don't necessarily think that the same thing unless you're talking about where you're billing just for the non-covered x-ray and that's all you're billing. If

you billed the subluxation and there's other parts that are denied on the claim, that's fine. We have COB payers that do pay even if we don't and we would cross those claims over.

Darlene Blair: OK.

Brian Pabst: Let's just take an example of acupuncture. None of those are kinds of services performed by an acupuncturist are covered.

Darlene Blair: Right.

Brian Pabst: That's what the new field is for; it accommodates situations where you, as a provider, know for a fact that Medicare never pays for hearing aids or other statutorily non-covered services .

Darlene Blair: Right.

Question and Answer Session continued

Brian Pabst: But in your situation it's qualified, since certain parts of your work t are covered and may be billed along with the non-covered parts. Such claims would definitely still be crossed over.

Darlene Blair: Right.

Brian Pabst: But I guess what this comes down to it is how you would bill it. If you're going to try to bill all non-covered services it in that fashion with a 2320 with the COB Total Non-Covered Amount, then that wouldn't be cross.

Darlene Blair: OK.

Brian Pabst: I understand. OK. Thank you.

Operator: Your next question comes from the line of Dawn Wallcheck. Your line is open.

Dawn Wallcheck: Hi. This is Dawn Wallcheck and I'm with the University of Chicago Physicians Group. I've also got a question regarding balancing at the COB

level at claim level because the types of records that we could submit have changed. We used to send the allowed patient responsibility and paid and balance among the three items.

And now the only item remaining, based upon the documentation, would be Paid Amount. How do we balance now?

Brian Reitz: This is Brian Reitz and the balancing edits that have been put in place for inbound claims mirror what is in the TR3, which is the Implementation Guides for the 837 version 5010. And I don't have one of them handy right now so I can't quote verbatim exactly what it is. But if you're not able to get that information, you can contact me and I'll be glad to share that with you.

But what we've done is simply mirrored what the transaction is requiring for the industry. Things like Submitted Charges at the line items have to balance to the total claim. If you have prior payments being submitted – in other words, if you're submitting a Medicare secondary claim to us—it's s about ensuring that your prior payments and adjustments from other payers before Medicare match up to submitted and total charges, those kinds of things. It's very basic balancing, and it's outlined in the TR3 Implementation Guides.

Dawn Wallcheck: Can you give me your email?

Brian Reitz: Why don't you give me your name and you're number.

Dawn Wallcheck: Dawn Wallcheck, and my number is XXX-XXX-XXXX.

Brian Reitz: One more time, Dawn, on the phone number, XXX …

Dawn Wallcheck: XXX-XXXX.

Brian Reitz: Great.

Dawn Wallcheck: Thank you.

Operator: Your next question comes from the line of Mercy Medical. Your line is open.

Katie Reed: This is Katie Reed with Mercy Medical Associates. We just need a little more detail in regards to bullet number three on page 10. Are we incorrect in understanding that we can no longer in box 33 of the CMS 1500 have a P.O. Box as our physical address (our billing address) for remittances to be sent to us? Is that correct or are we misunderstanding?

Brian Pabst: This is Brian. I'll start this off. Bullet number three address, I believe, the 2010AB loop?

Katie Reed: Yes, sir.

Brian Pabst: Yes. That's the Pay- To address and …

Katie Reed: Right. Can that no longer be a P.O. Box?

Brian Pabst: That can be a P.O. Box. In fact, that's the only part that really can be a P.O. Box now. The 2010AA N3 segment historically could reflect a P.O. Box, but now under 5010 it can't be.

And the main thing is that, as we all know, the 2010AB function has changed now with 5010 compared to what it was before. It's just that now the 2010AB is only created if the provider has a different Pay-to address. It's one of those strange things where if you have a physical address and you want your payment to go to the same physical address, then Medicare wouldn't create a 2010AB in that case for COB purposes. But, if you have a lockbox or some other P.O. Box arrangement for payment purposes, that's when we create the 2010AB N3 and N4 segments.

Katie Reed: OK. Thank you.

Brian Pabst: You're welcome.

Operator: Your next question comes from the line of Leslie Stevens. Your line is open.

Leslie Stevens: Thank you. This is Leslie Stevens. I'm with Providence Health and Services, Home Services division. I'm calling in regards to the home health and hospice claims that we send out. As a general rule, Medicare covers 100 percent of

the allowed. And we still have crossover over claims that go across. Will the 5010 change affect how the zero patient balance due claims are sent over to the other insurances, to the COBs?

Brian Pabst: I wish I could say that it would. But one thing that we did recently through a change that was made--I want to say in October 2008—was that now with regard to the TOBs 32x and 33x, we only cross those over if there is co-insurance on them. These days that doesn't happen as much, because in the past the DME component was on those claims and now I understand it's not due to DME competitive bidding requirements that also affect home health agencies in many instances.

So, by design, most of those aren't going to cross over. Hospice claims are another story. But in terms of home health claims, as I think I've mentioned to other folks who have asked this before, we do give the Trading Partners an option to exclude those and we even say in our information that it would be in their best interests to not accept these because you're likely not going to have any liability. But we haven't made it an actual auto exclusion up to this point.

Leslie Stevens: We're still getting calls and explanations of benefits from the other insurances asking for the Medicare EOBs just so that they can clear them off of their books.

Brian Pabst: Yes. Right. But the reality is that they don't really owe anything.

Leslie Stevens: And I tell them that. And they say no, but it’s still showing up in our system. We still need to have a documentation to clear them off the book. So, yes, if it's possible to move forward to having it as an exclusion that would be great.

Brian Pabst: We will consider that. I can't promise, but we will consider that.

Leslie Stevens: OK, thank you.

Brian Pabst: OK.

Operator: Your next question comes from the line of Brett Miller.

Your line is open.

Brett Miller: Hi. Brett Miller with Health Care software. My question actually came up in the presentation. It's the N4 segment, in particular N403, where X12 is going to require that full nine-digit ZIP code be present for US addresses. If we don't have the full nine, are we allowed to send zero fill for the remaining part of the zip code? Or should we be gap filling with the 9998 that was in the presentation?

Brian Pabst: Well, I'm flattered that you would use our gap fill, but that's just our particular standard that we would use. But for COB, just so everyone knows, we do take that information from our internal PECOS files. So unless your organization has an invalid address – or I should I say an incomplete address on the file with Medicare— hopefully that shouldn't be an issue, because COB comes from the internal and not the claim.

Brett Miller: OK, because I'm thinking more of the 837I or 837 P, because I'm a vendor.

Brian Pabst: Yes.

Brett Miller: So I'm just sending out originally.

Brian Pabst: Right.

Brett Miller: And for the N4, I noticed in the Implementation Guide, it says, loop 2010AA requires a nine digit. Now, I didn't it see requiring the nine digit in some of the other loops, say 2010AC. Is that something just missing from the Implementation Guide? Or is it only going to be specifically the 2010AA loop.

Brian Pabst: When you say Implementation Guide, do you mean the TR-3?

Brett Miller: The5010 Institutional or Professional Guides.

Brian Pabst: Oh, for the TR3, right? My understanding, and I will have to defer to the other folks here, but isn't this applicable only to all provider loops?

Matt Klischer: This is Matt Klischer. I hope you can hear me.

Brett Miller: Yes.

Matt Klischer: You're correct that the TR3 does intentionally distinguish when you need nine-digit ZIP Codes as opposed to five. And you only need the nine-digit ZIP Codes in the segments where it applies.

Brett Miller: OK, excellent.

Brian Pabst: And to get to Matt's point, I apologize for not knowing this off the top of my head, but I'm pretty sure our HIPAA 5010 COB Companion Guide actually specifies the answers where it'll be there.

Brett Miller: Right.

Brian Pabst: And you're right; it is limited and only applicable to provider loops.

Brett Miller: Yes. That's what I thought. And I just want to know if it was possibly missing or that it's meant to be that way. May I ask one more question real quickly?

Brian Pabst: Sure.

Brett Miller: All right, now, with the 5010 deadline being January 1st, 2012, is that a calendar date switch over or did that by any chance have to do with service dates? So, if we are January 2011, but we're rebilling an old claim with old dates of service, would we send those as 5010?

Brian Pabst: It's literally a calendar date, Brett.

Brett Miller: OK.

Brian Pabst: A one calendar date in time requirement.

Brett Miller: All right. Well, thank you for answering my questions.

Brian Pabst: You're welcome.

Operator: Just as another reminder that if you would like to ask a question, please press star followed by the number one on your touchtone phone.

Your next question comes from the line Chris Larson. Your line is open.

Chris Larson: Hi, so does the NCPDP 3.0 apply just to the insurance companies and not the providers?

Brian Pabst: OK, did you mean the NCPDP 5.0 or 3.0?

Chris Larson: The 3.0.

Male: I'm not familiar with that version. Is that our older version?

Chris Larson: Yes.

Mike Cabral: The 3.0 version is on the Medicaid side, not for Medicare. So, on Medicare we're adopting the D.0 version.

Chris Stahlecker: That's true. It's Chris Stahlecker. The 3.0 version, I believe, is only in place, for subrogation billed to Medicaid.

Chris Stahlecker: So that's not what we're talking about here today.

Male: Thank you.

Chris Larson: And then I have one more real quick question also. We're looking for the December call information on your website and can't seem to find it.

Chris Stahlecker: That should be there shortly.

Chris Larson: Oh, it's not there yet.

Chris Stahlecker: Check back in about another week or so; it should be there shortly.

Chris Larson: All right, thank you.

Operator: Your next question comes from the line of Matilda McCoy. Your line is open.

Matilda McCoy: Thank you for taking my call. This is Matilda McCoy from Connecticut Medical. I would just like you to tell me again the online information for accessing the webcast. I know it's on your publication where to go online to get this information that you're discussing today. But I'm having a problem once I get in to the site to get the actual information for this seminar. Can anybody help me out with that?

Charlie Eleftheriou: Yes. You're going to go to the CMS main website, cms.gov.

Matilda McCoy: Yes.

Charlie Eleftheriou: And then the easiest way is just to type the URL; type this address in cms.gov/ and type out the word versions …

Matilda McCoy: With an S?

Charlie Eleftheriou: … 5010

Matilda McCoy: Yes.

Charlie Eleftheriou: … and the word and[A-N-D], D as in dog, and zero [0]. And hit enter and it will take right there. And then on the left hand side, in order to get to the specific presentation, on the left hand side of the screen and there's a little listing of links within the version 5010 and D.0 website. There is actually a link to 5010 National Calls. You click on that. And that will take you to all the information on every call we've had and including today's.

Matilda McCoy: Great, thank you very much.

Charlie Eleftheriou: You're welcome; good luck.

Operator: Your next question comes from the line of Gaile Cerakowa.

Your line is open.

Gaile Cerakowa: Hi, this is Gaile Cerakowa Texas. I wanted to ask about your timelines and deadlines? You say that we can test the Errata versions of 5010 after April 2011? Is that April 1st, 2011?

Brian Pabst: It would be April 3rd. And the reason we were saying that is because that's when our systems change will be in effect.

Gaile Cerakowa: April 3rd.

Brian Pabst: Yes.

Gaile Cerakowa: OK, thank you.

Brian Pabst: It's always the Monday after the beginning of the month, so whatever that works out to be.

Gaile Cerakowa: That's when we can start testing the Errata version of the system.

Brian Pabst: Oh, Jason Jackson is telling me it's the fourth. My mistake; it's April 4th rather than 3rd...

Gaile Cerakowa: OK; thank you.

Operator: Your next question comes from the line of Rowena Ashe.

Your line is open.

Rowena Ashe: Yes. I'm Rowena Ashe with the Duggan Chiropractic in Brevard, North Carolina. We are a small practice. And our problem has been that we have changed locations and the physical location we're at now does not have a mail drop. So we are using the Post Office Box. But we're working with the Post Office and it just, in turn, forwards the mail to his Post Office Box. Is there a problem with that?

Brian Reitz: That's pretty much the same issue we discussed earlier. This is Brian Reitz again. If you want to give me your name and telephone number, I'll give you a call directly.

Rowena Ashe: OK. My name is again Rowena[R-O-W-E-N-A] Ashe [A-S-H-E]; telephone number= area code XXX-XXX-XXXX.

Brian Reitz: OK.

Rowena Ashe: Thank you.

Operator: And your next question comes from the line of Mercy Medical.

Your line is open.

Katie Reed: This is Mercy Medical, again. This is Katie Reed. On page seven, bullet number two, it says the COBC sends a detailed reporting of claims that do not pass the business level auditing or HIPAA compliance back to the originating Medicare Contractors. How are we able to get that report?

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Brian Pabst: This is Brian Pabst. You actually wouldn't get that report, but what will happen is that the result of that report will come out to you in the form of a provider notification letter. To be clear, the business level edits for the most part can be resolved through a systems change at the Medicare Contractor in most cases within less than two weeks.

There are some exceptions, as happens with major systems problems, but I know there are exceptions where we take like 6 or 8 weeks to address issues. After trying that long to address the issue, and if we are not successful, that's when we l let those provider notification letters to go. So, really in reality in those cases where you get those letters, you're getting the content from the letter that we send back to our Medicare contractors.

It's just we have our own reporting mechanism that's internal, but it is specific to claim number, HICN number, beneficiary, and actually the problem itself. If you're not a participating provider, you wouldn't get those letters though.

Because just like we don't issue the 835, to the non-par doctors, you wouldn't get the supplemental notice either.

Jenny Muse: We are participating. Our question is we have no knowledge of receiving that kind of documentation at this point in time. And we're wondering where it would be coming from?

Brian Pabst: Oh, OK. I tell you what, let t me take down your name and number. I'll get back to you on that, because we can look in to that for you.

Jenny Muse: My name is Jenny Muse.

Brian Pabst: I'm sorry, J?

Jenny Muse: Jenny.

Brian Pabst: Jenny, yes.

Jenny Muse: Muse [M-U-S-E].

Brian Pabst: OK, Jenny.

Jenny Muse: And the email is xxxxxx@xxxxxx-xxxxxxxx.xxx.

Brian Pabst: xxxxxxxxxxxxxxx.xxx. OK, very good.

Jenny Muse: Oh, -xxxxxxxx.xxx, I'm sorry.

Brian Pabst: Oh, xxxxxxxxxxxxxx.

Male: Dash.

Jenny Muse: xxxxxx-.

Brian Pabst: Oh, xxxxxx-xxxxxxxx, OK. Got you. Now, which Medicare Contractor do you bill for your services?

Jenny Muse: Palmetto.

Jenny Muse: Palmetto GBA.

Brian Pabst: Is that your main contractor?

Jenny Muse: Yes.

Brian Pabst: OK, great. That helps me to know where to go after here, OK. Thanks a lot, Jenny.

Jenny Muse: Thank you.

Brian Pabst: I'll get back to you on that very soon.

Jenny Muse: All right.

Operator: Once again in order to ask a question, please press star followed by the number one on your touchtone phone.

Your next question comes from the line of Gregory Bates. Your line is open.

Gregory Bates: Yes. I've got another question concerning something you said versus something that is written in the report, page 11, bullet point number three. You mentioned that the SBR09 will always equal ZZ. But what you said was not only will it equal ZZ, but it could equal MC.

Brian Pabst: And, Gregory, you're correct there. That's something that I just myself discovered after these slides were already sent forward. What happened was we have testers that are testing 5010 right now and that question arose. They're saying, gosh, you guys sent us the MC and a 2000B SBR09. Why wouldn't you also give us that same thing in the 2320 SBR09?

And, as I had indicated, one of our systems, our FISS system, which is our Part A claims system, is now making changes to do that. And the other systems have already done it, so that's why it wasn't there. I wanted to double check that fact before the meeting. I didn't get a chance to get that fact into the slide before today's presentation.

Gregory Bates: OK. So, it is correct that the value will be either equal ZZ or MC?

Brian Pabst: Correct. Yes, sir.

Gregory Bates: OK, thank you.

Operator: Your next question comes from the line of Shelley Peace. Your line is open.

Shelley Peace: Yes, I'm Shelley Peace with InterMedics, and we are a billing service. And we're in over 40 states. And I'm a little concerned about—and maybe I misunderstood—if we originally began testing in January, can we start testing the 5010 A1 version? Or, do we have to test the 5010 and then wait until April and come back then to test the 5010 A1 claims with Medicare?

Chris Stahlecker: Hi, it's Chris. And, yes, you're correct. The baseline version of HIPAA 5010 would not have an A1 at the end of it for most of the transactions. For the 837 Institutional Claims, that already does have an A1.

Shelley Peace: OK, I'm just talking Professional claims.

Chris Stahlecker: OK, Professional. . So if you tested the baseline versions in the January through March 2011 timeframe you would need to test with us again after we install those Errata changes. Then you may go into production.

Shelley Peace: So, basically, my testing through January, February, March 2011 is inconsequential, because I have to retest starting in April?

Chris Stahlecker: Well, the reason that we think early testing has value for you during the first quarter of the calendar year is you may be able to receive some of the new error handling transactions, i.e., the TA1, the 999, the 277 Claims Acknowledgments. And you may have testing to do with your vendor software to make sure that it is operating correctly.

The transaction exchange changes for the Errata versions were really not all that significant.

Shelley Peace: No, they're not at all. And that takes away three months for us, unless we've extended the deadline on how long it takes you to go move to the 5010.

Chris Stahlecker: Yes. That's a regulation; it's not within our authority to change any dates. So, we're working very hard to work within those dates. And, right now, the best testing we can offer to you is the baseline in January and then the Errata versions after April 2011 before you go into production.

Shelley Peace: OK, well, I understand that. I'm just saying for some of us that's turning into big hardship. Because you figure over 40 states, then you have your Medicares, your Medicaids, your Blue Cross Blue Shields, your CHAMPUS, all your extras. You know, we are going to be hard pressed to get everybody tested in a year, because even if it's like a Medicare, like a Noridian that's in six states, that contractor will still require us to test. Even though our software is internal and it's the same program, we have to test every six states separately.

So, a year's timeframe is going to be really hard to get everything done. And now, from my understanding, we've lost three months, almost.

Chris Stahlecker: Are you a vendor?

Shelley Peace: We're a billing service. And we have all our own internal software. And we bill everything from our system.

Chris Stahlecker: We have some testing provisions where if a particular software vendor or a billing service vendor has been tested with a MAC, that each customer of that vendor does not need to retest. But I'm not fully certain this applies in this case …

Shelley Peace: Even if it's a….

Chris Stahlecker: I'm not trying to downplay it.

Shelley Peace: No, no, no; I understand.

Chris Stahlecker: You have a very big job on your hands to get your product deployed and tested and have all your customers transitioned.

Shelley Peace: Well, it's really scary, because when I was doing the math concerning time for testing; it wasn't looking good even before I lost three months. So, if I have like Nevada and Arizona under the same MAC, I don't have to test each of them separately. Is that what I'm understanding?

Chris Stahlecker: No, you do. You know you probably have been issued a different submitter ID by one MAC from another.

Shelley Peace: Yes.

Chris Stahlecker: So, you do need to test with the MAC.

Shelley Peace: Yes, so I'm still going to have to test with everybody?

Chris Stahlecker: You'll need to test with that MAC.

Shelley Peace: Yes.

Chris Stahlecker: The customers may not need to test, but you will need to test with your MAC.

Shelley Peace: Oh, yes, that's way we've always been able to do it.

Chris Stahlecker: Yes.

Shelley Peace: And, you know, even though we're Edifecs (and declare) and are EDI certified, you know, is there any break on testing again? Because we spend all this money and time and then we have to just sit here and do the same program, the same system. We just sit there and do this repetitive testing that's enormously expensive and I know other people's line of business is different. But ours, to change, it's so incredibly minimal for our line of business and it's going to cost a fortune.

Chris Stahlecker: CMS and Medicare Fee-For-Service are making strides in realizing some efficiency improvements to our front end systems and to our testing. But, at this point in time, I'm afraid that that's the situation that we have to work with.

Shelley Peace: OK.

Chris Stahlecker: Thanks.

Operator: Your next question comes from the line of Wanda Lily.

Your line is open.

Wanda Lily: Hi, this is Wanda Lily of Coordinated Health, Bethlehem, Pennsylvania. And my question goes back to one of the other attendees with the provider notification letters. We too are not getting them. Could someone contact me also?

Brian Pabst: Sure. And, Wanda, do you participate with Medicare as a provider?

Wanda Lily: Yes, we do.

Brian Pabst: OK, great. What's your phone number, Wanda, or your email – however you want to handle it.

Wanda Lily: You can call me at XXX-XXX-XXXX, extension XXXX.

Brian Pabst: OK. One thing for your benefit and for the other person who had the concerns about this too is that that when the provider notification letters get mailed out, Medicare mails them to your provider correspondence address which the Medicare Contractor has on the file. So, it may be that is not the only piece of mail you would receive in that Medicare envelope. So, that may or may not help, but sometimes in the past when I mentioned that to folks, they indicated: like, "Oh, is that envelope I get from Medicare contractor X?".

And that generally helps them to find the letters. But I'll more than glad to track this through and see what could be going awry with your letters.

Wanda Lily: OK, maybe we don't have an issue, but I was listening to the girls the other day talking about why I think some things get crossed over and why some things don't.

Brian Pabst: Yeah.

Wanda Lily: So I would like to see if we do or don't have an issue.

Brian Pabst: Right; I understand.

Wanda Lily: Thank you.

Brian Pabst: You're welcome. Now, with Medicaid—and I don't know if Medicaid is your area of concern--but a lot of those payers don't always dispute claims back. They just drop them on the front end if they don't have a particular NPI or provider taxonomy characteristic included on them. So we could chat about that when we talk.

Wanda Lily: OK, thank you. And your name?

Brian Pabst: Brian Pabst.

Wanda Lily: Thank you, Brian.

Brian Pabst: Sure.

Operator: Your next question comes from the line of Charlene Berenger. Your line is open.

Charlene Berenger: Hi, Charlene Berenger from Columbus Diagnostic Center in Columbus, Georgia. We are the billing center. We have six different sites within Georgia alone. My concern relates to the P.O. Box and the physical address issue. Maybe I misheard you earlier, but did you say there was a Companion Guide where we could verify which fields need to be populated, whether it's the physical address or the P.O. Box?

Brian Reitz: This is Brian Reitz, and if you're billing electronically using the 837, you are required to submit a physical address as the billing provider. You can submit on your claim a P.O. Box address in the Pay-To loop within the transaction. That's a requirement; that's a fact.

Charlene Berenger: OK. So the physical address is the billing address. And then you said the Post Office Box represents the Payee Address?

Brian Reitz: The Pay- to Address, correct.

Charlene Berenger: Pay- to; OK. All right, great. Thanks, Brian.

Brian Reitz: Sure.

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

Rebecca Flugence: Yes. We're a hospital; I'm with Lafayette General Medical Center. And I was calling about the correspondence coming back to providers. This is not for hospitals, right?

Brian Pabst: Yes. It would be.

Rebecca Flugence: It would be too, oh, because I haven't been receiving any of those either, so I'm kind of concerned.

Brian Pabst: OK, Rebecca, let me get your phone number.

Rebecca Flugence: Oh, XXX …

Brian Pabst: XXX …

Rebecca Flugence: XXXXX …

Brian Pabst: Something got missed there. XXXX …

Rebecca Flugence: XXX-XXX-XXXXX …

Brian Pabst: Yes.

Rebecca Flugence: XXX …

Brian Pabst: OK.

Rebecca Flugence: XXXX.

Brian Pabst: Is it XXXX?

Rebecca Flugence: Yes.

Brian Pabst: OK, very good. Thank you.

Rebecca Flugence: All right, thank you.

Brian Pabst: I'll cal you back soon. I want to make sure that that works for you.

Rebecca Flugence: Thank you.

Operator: And there are no further questions in the queue at this time. I return the call back over to our presenters.

Conclusion

Male: All right, thank you. I just want to thank everybody for joining us. Audio files and transcripts of this call are going to be posted in approximately-within two weeks on the HIPAA versions 5010 and D.0 website. Again, under the 5010 National Call link from – on the left hand side of the screen.

Also, note that the new version 5010 reference card is available under Educational Resources. That's the name of the link, again, on the left hand side. It's called Educational Resources, click on that and you'll see a download of that new reference card.

Just, please, keep an eye out for messages announcing the next call with details on how to register. And I'd like to thank all our participants very much and have a great rest of the day.

Good bye.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

END

This document has been edited for spelling and grammatical errors.