Centers for Medicare & Medicaid Services
14th National Education Call on Medicare Fee-For-Service: Implementation of HIPAA Version 5010 and D.0 Transactions
Moderator: Charlie Eleftheriou
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Operator: Welcome to the 14th National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. And thank you for participating in today's call. I would now like to turn the call over to Mr. Eleftheriou. You may begin your conference.

Introduction

Charlie Eleftheriou: Thank you, Sarah. Hello, everyone. Good afternoon. This is Charlie Eleftheriou from the Provider Communications Group here at CMS. And I'd like to welcome you to the 14th National Provider Conference Call on HIPAA Version 5010. Today's presentation will focus on errata impact on HIPAA transactions and Fee-For-Service Companion Guides.

I'd like to mention that here in the Provider Communications Group, we're using a new webinar feature as part of today's call. This Internet-based webinar program is called Adobe Connect Pro and all registered participants should have received an e-mail with instructions how to log on. This webinar allows participants who have internet connections to share the presenter screen and follow the presentation in real time as it is given.

You will also have the opportunity to answer polling questions during the presentation. The polling results will help CMS determine Medicare Fee-For-Service provider needs and readiness for 5010 implementation. Please note that joining in on the webinar portion of this presentation is completely voluntary and will not have any negative impact on those participants who have dialed in today and are listening only to the audio portion of the presentation. You will not be at a disadvantage.

If you have not yet logged into Adobe Connect Pro and wish to, please use the URL for access at https://webinar – that's w-e-b (as in web) i-n-a-r.cms.hhs.gov/medicareffs as in Fee-For-Service 5010. Again, that's

https://webinar.cms.hhs.gov/medicareffs5010. Please sign in as a guest and when prompted, enter your first and last name.

For anyone who will not be following along with Adobe Connect Pro live webinar, please visit the 5010 website now and download today's presentation. The web address for this is www.cms.gov/versions5010andd0. Again, www.cms.gov/versions5010andd0. Click on the 5010 National Calls link on the left side of the screen and you can then scroll down and access today's presentation from the list.

Once downloaded, you can manually follow along while listening to the audio portion of the presentation. Following the presentation, there will be a short question and answer session, giving you the opportunity to ask questions of our Medicare Fee-For-Service subject matter experts. Please note this call is being recorded and transcribed. The Provider Communications Group thanks those of you who have chosen to participate in today's call via the Adobe Connect Pro webinar program, as it will help make future national provider calls more interactive and user-friendly and most importantly, more productive.

With all that said, I'd like to now introduce our speaker, Angie Bartlett. Angie is the new lead for outreach and education within the Division of Transactions, Applications, & Standards in the Office of Information Services here at CMS. Angie?

Angie Bartlett: I want to take this chance to welcome everyone to the HIPAA Version 5010 14th National Provider Call on the errata and the Medicare Fee-For-Service Companion Guide. My name is Angie Bartlett and I'm a Health Insurance Specialist with the Centers for Medicare & Medicaid Services, specifically on the Medicare Fee-For-Service side of the house as an electronic data interchange subject matter expert.

Slides 1-10

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

related to its implementation of 5010 and D.0. Next slide. The purpose of today's call will be focused on discussing the 5010 D.0 errata, as well as the Medicare Fee-For-Service Companion Guide. In addition, we will be providing guidance on what to do next to prepare for the transition, as well as provide additional resources to assist with the 5010 transition. Next slide.

Today's agenda is aimed at providing an overview of the 5010 errata, as well as comparing the errata against the base version of the transactions. In addition, we will provide directions related to the Medicare Fee-For-Service Companion Guide, as well as an overview of the content of the Companion Guide. To conclude the call, we will further provide guidance on what to do next to prepare and accept questions from the audience. Next slide.

Charlie Eleftheriou: I'm sorry. For all of you that are attending this call, we're having a little bit of an issue. Just give us one quick second and I think, actually, we're back. So we'll be moving to the next slide. Here we go.

Angie Bartlett: OK.

Charlie Eleftheriou: Sorry about that.

Angie Bartlett: Sorry about that. Well, who needs to know about Medicare Fee-For-Service implementation of 5010 and D.0? If you are a covered entity under the HIPAA, you are mandated to comply with the transition to version 5010 and D.0 for electronic administrative transactions. There are a number of electronic transactions supported by Medicare Fee-For-Service, all of which you have heard about this year if you've been tuning in to our previous national calls.

Quickly, they are the Institutional and Professional Claims, 837 I and P; the Eligibility Inquiry and Response known as 270-271; the Health Claim Status Inquiry and Response known as the 276 and 277; the Remittance Advice, known as 835 and acknowledgments, such as TA1, 999, and 277CA. Therefore, you need to know about the 5010 and D.0 if you transmit administrative health care data electronically using these or other transaction standards; if you have or work in a health care facility that relies on payment

through submission of electronic claims; if you serve a health care provider in the transmission of electronic claims or claims-related transactions; and if you use the International Classification of Disease, ICD-9, codes from administrative transactions

Let's see how many of you online are getting ready for 5010 and D.0. Please answer the question on your screen. Question number three: what is your current 5010 D.0 readiness level for Medicare Fee-For-Service? If you are unable to see the polling question on your screen, please momentarily remove yourself from full-screen access within Adobe. This should allow you to view the full-length question.

We'll wait about 15 or 20 more seconds. OK, I'm going to go ahead and close the poll. Now, on to the next slide. Let's first focus on compliance dates for 5010 and D.0. Mandatory compliance for 5010 and D.0 is to be achieved by January 1st of 2012 for all covered entities. Internal testing began on January of 2010 and we are pleased to say that external Trading Partner testing began this month, January of 2011.

Important errata dates to stay focused on are January 2011; the base version became available for testing. The errata version will become available for testing in April of this year. The timeline at the bottom of the slide is a quick snapshot of our expectations for the upcoming year regarding testing and production. And now, for one last polling question, question four: have you completed your system impact assessment and project plan for the conversion to 5010? Please check all that apply.

Remember, if you cannot see the polling question please remove yourself from full screen view. We'll do about ten more seconds. Now for the next slide – 5010 D.0 Errata and Medicare's Fee-For-Service approach. The purpose of this message is to clearly communicate the approach that Medicare Fee-For-Service has taken to ensure compliance with the Health Insurance Portability and Accountability (HIPAA's) new versions of the Accredited Standards Committee (the ASC X12) and the National Council for Prescription Drugs (NCPDP) Electronic Data Interchange (EDI) transactions.

The Standards Development Organizations have made corrections to the 5010 and D.0 versions of certain transactions. The Type 1 errata replaces the base version of the HIPAA compliance. Per the Federal Register published on October 13, 2010, HIPAA compliance will require the implementation of the errata versions and the base version for those transactions not affected by errata.

Compliance with errata must be achieved by the original regulation compliance date of January 2012. A link to the Federal Register can be found on this slide for further details. Listed on the bottom of the slide are transactions impacted by the errata. Medicare Fee-For-Service will implement the errata versions to meet the HIPAA compliance requirements.

All transactions listed above except for the 276 and 277, that is Inquiry Responses, are Type 1 errata changes, which are changes to the GS08 and STO3 guides. The errata for the 276 and 277 consist of Type 2 changes, which are typographical types of errors only. Next slide.

This slide contains a link to the 4010A1 and the 5010 side-by-side. This will show you a clear picture of the differences between 4010A1 and 5010. Please note that the side-by-sides do not contain the errata changes. From these links, you'll be able to access the edit spreadsheets. The edit spreadsheets are Medicare system instruction processing rules.

These edit spreadsheets were initially built on the base version of the transactions but they've been updated to meet the most current erratas. In addition, Medicare's Fee-For-Service Companion Guide will be published this February. In the mean time, errata changes to each transaction can be found in the respective edit spreadsheets located within the link provided. Next slide.

We have now discussed the errata and we'll move into the Companion Guide, since the Companion Guide is what will assist you to become compliant with errata. Let's start with the purpose of the Companion Guide. The Companion Guide is intended to provide information from the author of this guide to the

Trading Partners, to provide them the information they need to exchange EDI data with the author.

This includes information about registration, testing, support, specific information about control records setup. Why is Medicare Fee-For-Service publishing this guide? To clarify, supplement, and further define specific data content requirements to be used in conjunction with – and not in place of – the ASC X12 Technical Report Type 3, TR3s, for all transactions mandated by HIPAA or adopted by Medicare Fee-For-Service for electronic data interchange.

So who needs this Companion Guide? All Medicare Fee-For-Service Trading Partners will need the Companion Guide; therefore, I have included a quick definition of Trading Partner on this slide, which includes any Medicare consumer, provider, billing service, software vendor, or clearinghouses that transmit or receive electronic data from Medicare. Next slide, this is slide nine.

The Medicare Fee-For-Service Companion Guide will ensure alignment with industry efforts to standardize the Companion Guide across all MACs. The current version of the Companion Guide, which will be posted to the MACs website by mid-February, is a collaboration between several organizations, including WEDI, CAQH, and X12.

This means that you as a Trading Partner should see the same format of the Companion Guide across most other industry pairs, as Medicare Fee-For-Service is complying with industry standardization for its Companion Guide publication. Next slide, slide ten.

The general overview of the Companion Guide. Medicare's Fee-For-Service Companion Guide includes information needed to condense and maintain communication exchange with Medicare. In addition, the Companion Guide has been written to assist you in designing and implementing transaction standards to meet Medicare processing standards.

The Trading Partner and the MAC working together can use this document to provide several communication channels to ensure communication remains consistent and efficient. Some of the information included in this document that will assist you in working together with your MAC is: EDI enrollment and registration; testing and certification protocols; technical assistance via the help desk and website; and hours of operation.

Slides 11-22

On to the next slide, slide 11 – Companion Guide content. This slide provides a brief summary of the sections within the Companion Guide. Several of the sections include: getting started, testing and certification requirements, and contact information. We will go through further description of several of these sections in upcoming slides.

Slide 12 – the Companion Guide is comprised of two major components. The first component to note is the Trading Partner section. The Trading Partner information component is included in the Companion Guide to convey information needed to commence and maintain communication exchange. Then, the Transaction Instruction component, which is located in the appendices to the Companion Guide, is included to clarify the Technical Report Type 3, the TR3, instructions for submission of specific electronic transactions. Please be mindful that the Medicare Fee-For-Service Companion Guide does not replace the TR3s.

Next slide, slide 13. Now we are going to focus on the Trading Partner component of the Companion Guide. Medicare Fee-For-Service has provided a standardized format of the Companion Guide, which the Trading Partner section of the Companion Guide includes numbers one through eight on slide number 11. These sections include: getting started, testing and certification requirements, connectivity and communications, contact information, control segments and envelopes, acknowledgements and reports, additional Trading Partner information; and Trading Partner information change summary. Again, please refer to slide 11 for further details. In using this format, Medicare Fee-For-Service has created a consistent guide across all MACs. Although the information populated in a Companion Guide will be specific to

MAC, including communication and connectivity. Therefore, it is essential that our Trading Partners working with multiple MACs access each MAC's website for their specific Companion Guide. Next slide.

Now on to the Transaction Instruction component. Transaction Instruction component of the Companion Guide is primarily composed of instruction tables providing supplemental information specific to Medicare Fee-For-Service. The Transaction Instruction in the Medicare Fee-For-Service Companion Guide are located in the appendices. The Transaction Instruction component of the Medicare Fee-For-Service Companion Guide must be used in conjunction with the associated ASC X12 TR3s.

The instructions in the Companion Guide are not intended to be stand-alone requirements documents. Please note that Companion Guide conforms to all the requirements of any associated ASC X12 TR3. The instructions tables and Transaction Instructions contain rows for where supplemental instruction information is located.

The order of the table follows the order of the implementation transactions set that is presented in the corresponding TR3. Segment rows are lightly shaded to distinguish them from data elements and rows. You will note that the Medicare Fee-For-Service Companion Guide, we put all transaction data in to one large table. Within that large table, we place a slide and tag for the specific edit category. This was done instead of breaking up the table into individual categories to stay consistent with the content of the X12, WEDI, and CAQH templates. An example of the segments of the instruction table is indicated on the slide and provides you with a brief picture of the layout, including the category column. Next slide.

Now for a summary of the Companion Guide – the Companion Guide provides specifications for the following transactions: 837 Health Care Claim Institutional and Professional, 835 Health Claims and Payment Advice, 276 /277 Status Inquiry and Response.

It is important to note that there will not be a transaction instruction table for the 999 and 277CA, as those edits can be found under the edits for the 837

Professional and Institutional claim transactions. In addition, the 270 / 271 Health Care Eligibility Benefit Inquiry and Response has its own Companion Guide that can be found at the address located at the bottom of this slide. Also, NCPDP version D.0 has its own Companion Guide that can be found on the bottom of this slide, as well.

Next slide – MAC jurisdiction. Now you will note that the Companion Guide is necessary for knowing what is needed to be compliant and for information on testing with your MAC, including the errata. As you are aware, 5010 and D.0 testing has begun, so it's important that you coordinate with your MAC to schedule such testing. Therefore, the visual here on this slide is a map showing each MAC's jurisdiction. I want to note that the jurisdictions not yet awarded are two, six, seven and eight. These are all currently in progress.

Now we're going to move to slide 17 – resources. Since the previous slide identified the MAC you will be working with and coordinating with, this slide is a useful tool providing direct links to the location of each MAC's Companion Guide. All Medicare Fee-For-Service Companion Guides should be posted to these locations no later than mid-February.

Slide 18 – in summary, Medicare Administrative Contractors, the MACs, are the administrative arm of the Medicare Fee-For-Service. So, this means that any claims or transaction you submit to Medicare Fee-For-Service goes through them. Currently, our administrative contractors are being consolidated by jurisdiction. Most of those consolidations have already occurred, as you've seen on the previous two slides.

But some of you may be in a state where consolidation hasn't yet been completed. So, if you send your transactions to a Fiscal Intermediary for a Part A or a carrier for a Part B, you have yet to be transitioned to a Medicare Administrative Contractor jurisdiction. No matter, the links on this page will help you find the electronic data interchange help desk in your state. This is where you will want to go first for information on 5010 and D.0. So, if from slide 16, you noticed that your state's MAC is yet to be awarded, please use

the link on this page to find out who to contact for your Companion Guide information.

Slide 19 – what has Medicare Fee-For-Service developed in terms of communication resources to date? Medicare Fee-For-Service has established essential web pages on the CMS website where you can find a wealth of information and its growing every day.

You will find resources such as fact sheets; readiness checklists; resource cards; FAQ's, which are still in progress but growing every day; technical resources, such as this 4010A1 to 5010 side-by-side; 5010 D.0 MLN articles; and all of our previous national calls- that includes the presentation, audio recording, and the transcript. We also post other communications, such as listserv messages and announcements for these calls. The link on this slide will take you to all of these resources and again, for those of you online, your links are active, so click away.

Important dates to remember– onto slide 20. This slide highlights many of the important 5010 D.0 events and dates to remember. In particular, months that you see "TBD", to-be-determined, specific dates will be advertised as they approach. If you received the announcement for this call via the CMS provider listerv, you will receive periodic updates on this calendar, showing specific dates as they are confirmed, as well as important reminders throughout the year. If you got the information for this call from another resource and would like to be on the CMS provider listerv, you can sign up on the link provided at the bottom of the previous slide, slide 19.

Next slide, slide 21. So what did we cover today and what do you need to walk away with? Well, I hope you take away the following: one- the need to understand what you need to do; two- the importance of contacting your vendor and knowing where they stand; three- the importance of working closely with your MAC throughout the testing process; four- the purpose of the errata and how it impacts the transition; five- the scope of the Medicare Fee-For-Service Companion Guide and how it can assist you; six- get involved - be proactive and take advantage of the support that is available to

you; seven- seek help earlier rather than later. The support will be there later, it just may not be on the same timeline you need - so be considerate of your and your MAC's time. And eight- finally, don't assume someone else will take care of things for you related to 5010 and the transition. Next slide.

So, again, I want to thank all of you for your time and now is your opportunity to ask questions.

Question and Answer Session

Charlie Eleftheriou: Thank you, Angie. As you can see, we've completed the presentation portion of this call and are moving now to question and answer session. Before we begin, I would like to once again remind you that this call is being recorded and transcribed, so please clearly state your name and organization before asking a question. In an effort to hear from as many participants as possible, we ask you that you limit your question to just one per person. At this time, Operator, 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 one on your touch tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Again, if you would like to ask a question, please press star, followed by the number one on your touch tone phone. And your first question comes from the line of Melanie Edwards. Your line is open.

Melanie Edwards: I'm Melanie Edwards from Emeon Business Services. In 837 Professional transaction to the DME MACs, the ordering/referring providers information is normally placed in the loop 2420 N4 segment. Our question is: is the physician's address, city, state, zip required in this loose end segment and is this information validated against any current CMS DME MAC or PECOS database?

Chris Stahlecker: Hey, it's Chris Stahlecker. I'm attempting to answer you but we don't really have the detailed information in front of us at this particular meeting. So, if we could get an e-mail address from you, we could send you back a response.

Melanie Edwards: Certainly. And that's Xxxxxxx – excuse me – xxxxxxxx@xxxxx.com.

Charlie Eleftheriou: Could you repeat that one more time for us?

Melanie Edwards: It's xxxxxxxx, x-x-x-x-x-x-x@xxxxx, x-x-x-x-x.com.

Charlie Eleftheriou: Thank you very much.

Melanie Edwards: Thank you.

Chris Stahlecker: We'll get back to you shortly.

Operator: There are currently six participants in queue to ask a question. And your next question comes from the line of Karen Demo. Your line is open.

Sharon Demo: Hello. This is Sharon Demo from the Lender's Center of Health. And my question is: if we are in Jurisdiction 15 and we are not officially assigned a MAC yet – so how do, you know, if we're not MAC, if we've not been assigned, then what Companion Guide do we use and do we have to wait for the MAC to proceed with testing?

Chris Stahlecker: Hi, it's Chris Stahlecker and let me just say that jurisdiction 15 was so recently awarded we didn't even get our slides updated yet to reference your points of contact. In fact, we had a strategy for the legacy contractors when a MAC was not yet awarded, so that that legacy contractor partnered with a MAC to do the testing on behalf of the legacy contractors so that no provider would be left, kind of, hanging in the breeze, hoping to test but unable to.

So, that rule of thumb is still in place for all of the legacy contractors. But quite frankly, when jurisdiction 15 was most recently awarded internally within CMS, we're still strategizing on our approach. So, I think my best response to your question is that we're going to have more information for you shortly, but we don't have it just yet. This jurisdiction 15 fell in the gray

area between the plan we had for the legacy contractors and our sense of urgency to bring the MACs up.

So, we will be getting word out through the recently-awarded MAC shortly, but we don't have that definition for you today, the definitive steps that you'll follow. We're making every attempt not to inconvenience providers. That's been our objective all along with supporting the legacy sites so that we're trying to minimize need for duplicate testing and duplicate transitions. So, we're trying to come up with the best approach for you possible.

Sharon Demo: All right. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Mary Felts. Your line is open.

Mary Felts: My question has already been answered. This is Mary Felts with Real Time Charts. Thank you.

Operator: Your next question comes from the line of Beverly McMurry. Your line is open.

Beverly McMurry: Yes, this is Beverly McMurry. I do EDI support for Medical Billing and Management Services. And my question relates to page 14. I understand that's just an example but it shows only primary and secondary claims and it was my understanding 5010 could handle tertiary. Will we be doing tertiary electronically with Medicare?

Chris Stahlecker: Oh, you threw in the with Medicare part in there. Yes, the answer is yes. Medicare as – we typically think of Medicare as a secondary payer because anything prior to Medicare receiving the claim can be contained in that 837, of course, but in terms of Medicare liability, we just know that we're not primary.

Beverly McMurry: So, you'll do tertiary, as well?

Chris Stahlecker: Yes. It's Chris Stahlecker trying to answer your question.

Beverly McMurry: All right.

Chris Stahlecker: The billing instructions for Medicare as a non-primary payer would apply to any role that Medicare Fee-For-Service has in subsequent to primary payment. So, yes, anything after primary, Medicare terms as Medicare secondary but the 837 billing instructions are all laid on and how to place the data. So, yes, those can come in electronically.

Beverly McMurry: All right.

Chris Stahlecker: Does that help?

Beverly McMurry: Yes. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Yvonne Werthor. Your line is open.

Yvonne Werthor: Yes, Yvonne Werthor with Spinner Physical Therapy. My question is for – relative to the clarity on the P.O. Box change on our reporting, box 31, 32.

Charlie Eleftheriou: Relative to the ability to send the P.O. Box or not send the P.O. Box – we're not allowing P.O. Boxes in that element.

Yvonne Werthor: Right. If you are allowing them or you're not allowing them – I need to have that clearly stated whether, you know, box 32, if that is allowable to have a P.O. Box there or not.

Charlie Eleftheriou: It is not.

Chris Stahlecker: Are you – it's Chris Stahlecker – can I ask you a question?

Yvonne Werthor: Sure.

Chris Stahlecker: Are you referring to the electronic 837 or are you speaking about the paper CMS-1500?

Yvonne Werthor: Electronic.

Chris Stahlecker: Oh, OK. Thank you. I'm sorry.

Charlie Eleftheriou: Yes, because that rule does not apply in the paper world.

Yvonne Werthor: OK, but electronic-wise, no?

Charlie Eleftheriou: Correct.

Yvonne Werthor: OK, great. That's what I needed. Thank you.

Charlie Eleftheriou: You're welcome.

Operator: Your next question comes from the line of Dr. Robert Nicholson. Your line is open.

Robert Nicholson: This is Dr. Robert Nicholson. I'm a pediatrician in California. I have two questions. I know I'm only allowed to ask one but they're very easy. What does MAC stand for, M-A-C?

Female: Medicare Administrative Contractor.

Robert Nicholson: OK. I don't take Medicare at all, so does the 5010 compatibility change apply to me, as well, because I do, of course, Medical, as well as all the various insurance companies. So, I still need to go from 4010 to 5010?

Chris Stahlecker: That's absolutely correct.

Charlie Eleftheriou: Correct.

Robert Nicholson: Because I'm a HIPAA covered entity.

Chris Stahlecker: Yes. Your electronic billing will need to be upgraded to stop using the current format, that 4010A1 that you're using, and switch over to the new format that's required by all payers.

Robert Nicholson: OK.

Chris Stahlecker: The 5010, yes. And by that same timeline. All payers are operating on that same timeline.

Robert Nicholson: OK. Thank you.

Chris Stahleker: You know, just as a point of reference – you know, the material that we had linking the Medicare Administrative Contractors, that's for Medicare billing only. You would need to use your software vendor or your clearinghouse that you're currently using or independently contact all of the payers that you send those electronic claims to, to understand what their Companion Guides would be about.

Robert Nicholson: OK. Thank you.

Chris Stahlecker: OK.

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

Christian Lawrence: Hi. This is Christian Lawrence calling from the Lifepoint Hospital. My question is in regards to the NPI enumeration. And I'm still a little lost on that. So, if I have a scenario where I have one central billing office, but I have multiple NPIs at my single facility, how would that get submitted on, let's say, an 837 Professional? Is it determined by where the service was provided at and that's where I would gather the NPI?

Chris Stahlecker: I think – it's Chris Stahlecker – I'm not sure we have the answer in the room with us today. So, I think that you should contact your Medicare Administrative Contractor. Are you asking a Medicare billing – I mean, your question applies across the board to any payer because the way you've established your enumeration process would apply across the board. But from a Medicare perspective, your MAC would be in the best position to help you understand that.

Christian Lawrence: OK. Thank you.

Chris Stahlecker: OK.

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

Jennifer Newear: Yes, this is Jennifer Newear from the University of Minnesota Physicians. We are just wondering, on the resources link – and I'm not at a computer right now – but on the resources link, there was a link for the crosswalks for the 835 transactions, the 4010A1 to the 5010 crosswalk. And there was a PDF format but there was also a link for the zipped format that included Excel. What I got that crosswalk, it was 4010 to 4010.

Jason Jackson: This is – this is Jason Jackson. Which one were you looking at? The 837 or the 835?

Jennifer Newear: The 835.

Jason Jackson: OK. We're actually currently in the process of updating our crosswalks. We do know that when they were initially put out, those documents were created initially for internal use, but we had a lot of requests for them to be shared so we posted them. But we are currently revising those so probably within the next, I'd say three to four weeks, look for the revised side-by-sides. And when they are revised, they will be from 4010 to 5010A1, the errata version.

So, we know there are issues and mistakes in there right now and we are working to correct those.

Jennifer Newear: Is it possible to be individually e-mailed that in the mean time?

Jason Jackson: I don't even know. I think it's still in progress. It hasn't been corrected yet, so no, unfortunately not.

Jennifer Newear: OK. Thank you.

Jason Jackson: Yes.

Operator: Your next question comes from the line of Lauren Redfern. Your line is open.

Lauren Redfern: Lauren Redfern with Phillips Remote Cardiac Services. I had a question based on another webinar that I was on last week, where it was stated that if an original claim was sent in the 4010 format before January 1st, 2012, you could do your re-submittal in the 4010 format after January 1st, 2012. Is that correct?

Chris Stahlecker: It's Chris Stahlecker. At this time, no. It is a date of submission requirement, not a date of service requirement. And the compliance requirement in the regulation says that after January 1, 2012, that 4010 formats are no longer processed.

Lauren Redfern: OK.

Chris Stahlecker: So, in the Medicare Fee-For-Service environment, the intent and plan is to have 4010A1 no longer processed after January 1, 2012.

Lauren Redfern: All right. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Debra Wagner. Your line is open.

Debra Wagner: Thank you. Obviously, the Companion Guides are very important. First we were expecting them in January and now we're hearing that we won't have them until February. Has any consideration been given to the fact that providers are now down to somewhere between nine or ten months to prepare for 5010?

Chris Stahlecker: It's Chris Stahlecker. Could you say the last part of that question again, please? Is there any intent to do what?

Debra Wagner: Any consideration being given …

Chris Stahlecker: To what – extend the timeline? No. Unfortunately, we're not in a situation to be able to do that. The Companion Guide, you know, took some doing to be prepared minimally and we have a change review procedure in house and their readiness is soon. And we're expecting that they may be available through

our change control process as early as the end of this week or early next week. So, they should be available to you very shortly. I hope that can help you.

Operator: Your next question comes from the line of Shauna McKinney. Your line is open.

Shauna McKinney: Hi. This is Shauna McKinney with Data Strategies. We're a software vendor. And my question is in regard to testing. In testing, can we as the software vendor test on the behalf of our providers or will they still have to test individually? And also, considering that there are multiple states for each jurisdiction, can we test per jurisdiction or do we have to test every state within the jurisdiction?

Chris Stahlecker: Well, those are good questions. Hey, it's Chris Stahlecker trying to answer. Let me see. The answer is, it depends, to the first part of your question. I'm sorry, the second part – no, you'll have to establish your relationship with each MAC individually. But let's go back to the first part of your question. Can you use a software vendor to test on behalf of a provider?

And yes, you can. It depends upon the vendor's methodology of their product. If they are a central site vendor, so that they only process within their own data center, for example, then they will automatically test on your behalf. If they produce a product, if that vendor produces a product that's deployed and installed at your location, once that product is initially tested, the product is fine, but if the arrangement is then for each provider to be assigned an individual submitter ID, that individual submitter ID must be tested with the MAC.

So, the answer is a little bit complicated and that's why it's best for you to deal with your MAC and they can advise you how they have established the relationship with each of those users of that software product.

Shauna McKinney: Now, I guess my second question, though, was, is that, you know, each MAC can administer more than one state. So, do I have to state, for example, California and Nevada? Do I have to test both of those states or can I just test the MAC for those two states?

Chris Stahlecker: If it's one MAC processing both states on behalf of that software product, you can contact that MAC and most of them will be able to test with you just fine.

Shauna McKinney: OK. Great, thanks.

Chris Stahlecker: But you should contact that MAC and make sure that you're squared away with how they have you established as a Trading Partner.

Shauna McKinney: Great. Thank you.

Chris Stahlecker: Yes. You're welcome.

Operator: Your next question comes from the line of Amy Nichols. Your line is open.

Amy Nichols: Hello?

Chris Stahlecker: Hi.

Amy Nichols: Hi. I am just curious that – we've been sitting here listening to all the questions and the whole time, you've only been able to answer two questions. I'm just curious as to why, when we ask questions, they don't ever get answered. And we feel like you're so unprepared but yet, you know, Debra brought up something that you guys haven't completed but you expect us all to be, you know, on your time line.

Chris Stahlecker: Well, Amy, that's good input and good observation, I guess. What we're trying to do is share with you where Medicare Fee-For-Service is with meeting the regulatory compliance that we're all subject to. So, the time line pertains to all of us. And if you have a specific question, I'll gladly try to answer it.

Female: Every one of the questions that they've asked has been a specific question.

Amy Nichols: Well, every one of the questions have been specific – question number one, question number two, question number three, question number six, seven, eight and nine.

Chris Stahlecker: But we've answered, according to our …

Amy Nichols: You answered number four and five.

Chris Stahlecker: We've answered three through ten.

Amy Nichols: Well, indirectly but I just think that you guys need to be a little bit better prepared. Thank you.

Chris Stahlecker: You're very welcome.

Question and Answer Session continued

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

Maury Sadikas: Hi. This is Maury Sadikas at The American Medical Association and I have two questions and one of them may be ignorant, so I apologize if this is something that has been covered elsewhere. During the 4010, the Implementation Guides were subsidized by CMS and I was wondering if there are any plans under 5010 for CMS to subsidize the Implementation Guides. That's question number one.

And question number two you may or may not have the right people in the room, but if you could get back to us, it would be great. It has to do with the MACs, the Medicare Administrative Contractors. My understanding is that there is a consolidation plan under way to further consolidate the current MACs from 15 down to even fewer. And I don't have a lot of details on this, but I was wondering how CMS is going to handle the consolidation with respect to the implementation guidelines for 5010 and ICD-10 so as to minimize any disruptions to physicians and other HIPAA covered entities.

Chris Stahlecker: Well, let's see.

Mike Cabral: This is Mike Cabral. I'll try this first one. There are a couple of issues on the first part. You're right. The first time, all the OESS set up a contract with Washington Publishing to subsidize the free download of the 4010 Implementation Guide. That contract expired and was not renewed.

Therefore, the revenue that is generated by people purchasing the ASC X12 Implementation Guides is just exactly like what the National Conference of Prescription Drugs, the NCPD does, with their standards. So, that was a decision that was made not to renew that contract.

Maury Sadikas: OK. So, that's definitely off the table for 5010?

Mike Cabral: Yes.

Maury Sadikas: OK.

Mike Cabral: You get a member's discount if you're a ASC X12 member, which I'm pretty sure the AMA is but you …

Maury Sadikas: Right. I mean, I wasn't asking for us. I was asking more for, you know, a small provider. But that's fine. I just wanted to understand where you stood on that.

Mike Cabral: Right. That was a contractual thing.

Maury Sadikas: OK.

Mike Cabral: Your second question is, as well, procurement sensitive, as far as the plans to go with the MAC consolidation. And your best source for that is the Federal Business Opportunity, the Fed Biz Opps, website.

Maury Sadikas: Yes, I know. I actually have a little bit of information but I think it would be helpful if CMS were to – and I know this kind of crosses over and it veins into the operational aspect of the Medicare side of, like, Kathy – not Kathy Carter – I'm forgetting her name.

Mike Cabral: Tara Jackson …

Maury Sadikas: Tara Jackson, thank you. But if you guys could message out – because I mean, there's a lot of people on the phone who probably have no idea that CMS has planned to consolidate the MACs. And, you know, I know that you have, in the past, been very sensitive to big deadlines. But if there's going to

be some kind of overlap with the 5010 and the I-10 deadlines and the consolidation, that is going to be disastrous. So, if there's any way you could put out some information to the public that would be really helpful.

Mike Cabral: And that's what I'm trying to say. They do put that stuff out in Fed Biz Opps and notify …

Maury Sadikas: Well, OK, here's the thing: Fed Biz Opps is not something that – first of all, the AMA does not monitor that very carefully because it's a procurement website, as opposed to the Federal Register. So, I guess what I'm trying to say is, like, through your – listserv, in plain English listservs, I'm asking you to put out information that is, you know, understandable to the general public; not just the AMA but to physicians, clearinghouses, payers. We need to understand, like, when this is happening.

Mike Cabral: And you're correct. What I was trying to get to – all of these things were predicated by the MMA legislation from 2003. So, CMS has been trying to comply with that consolidation to get to our 15 MACs. Now, we're at those – those were a single-year contract with four option years and those are coming up for renewal. That's, I think, what you're alluding to with the new jurisdictional reductions.

So, what we can do is, we will take back to Karen and to the Office of Acquisition Grant Management, your suggestion for listserv traffic.

Maury Sadikas: Yes, that would be helpful because again, I mean, if I'm in the dark on this, I have to imagine that most of the people on the phone have no idea this is coming.

Mike Cabral: Well, I mean, the other thing CMS does take very seriously is every time these configurations are changed, we do take into account the provider impact, the beneficiary impact.

Maury Sadikas: Right. And I'm recognizing that you've done that. I'm just saying that there's a dearth of information on what is coming forward on the next, kind of, like, wave. So, that would be great. We appreciate that.

Mike Cabral: Right.

Maury Sadikas: Thank you.

Operator: Your next question comes from the line of Diane Hermalian. Your line is open.

Diane Hermalian: Hi. This is Diane Hermalian, University of Connecticut Health Center. And I have a question in regards to the Companion Guide. Right now, I'm working with a 5010X222 and on slide 14, it mentions 5010X223A2. Does that mean the Companion Guide that I'm working with is no longer valid?

Mike Cabral: This is Mike Cabral again. I think what you're pointing out is – we talked in the slides about Type 1 and Type 2 errata. The designation for the second Type 1 errata for the – I think that's the Institutional claim that you're using. That had been published by an ASC X12 in 2010. It went through the public comment period, et cetera. So, you are one release behind and if you purchased the guide from Washington Publishing, you should have gotten a notification that there was an errata available for you to download.

That's going to be a good resource for you to go contact Washington Publishing if you haven't gotten that notification. For all of the errata, because if you purchased, you know, the claim and the remit and, you know, maybe the eligibility, all of those had errata documents that you need to have in your possession and are entitled to because you purchased those, the guides.

Diane Hermalian: OK. I will check with our secretary here. Thank you.

Mike Cabral: Yes. She should have gotten a notification through e-mail or something that it was available for download.

Male: And there's no cost for subsequent downloads.

Mike Cabral: Yes, there is no cost for subsequent downloads, either.

Diane Hermalian: Very good. Thank you.

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

Terry Keen: Yes, this is Terry Keen at United Regional Health Care System. I have a question regarding testing. If there is an errata version to the transactions, do we go ahead and test on the base testing or do we wait until the errata version is available for testing in April?

Chris Stahlecker: Hi, it's Chris Stahlecker. Actually, that's your choice. What you will have available to you by contacting your MAC today is the base version listed on slide six. That's the version that will be available through April. And then starting in April, you will have the errata version available to you.

The point to consider when you're making your decision about starting to test or not, is you need to know that you cannot be promoted to production until the April errata version has been tested. So, you can get some experience by testing now, but you will not be able to be promoted to production when there's an errata coming out until April. We're requiring everyone to wait until the errata version is available before you can be placed into production. So, I hope that helps you make your decision.

Terry Keen: It does. Thank you.

Chris Stahlecker: OK.

Mike Cabral: I would just like to add – I'm going to add to that one last statement that Chris made. You'll also get to expose yourself to some of the acknowledgement transactions that the health care industry is going to- the 999 and the Health Care Claim Acknowledgement 277CA. So, if you haven't seen those transactions yet, testing with the base may behoove you now through April so you can get some familiarity with it and see how your translators and vendors adopted that solution. So, there is benefit to going early because you will have to retest when the errata becomes available in our system.

Operator: Your next question comes from the line of Rhonda Gudell. Your line is open.

Rhonda Gudell: Hi, this is Rhonda Gudell from Lakefront Billing Services. I have a question about our jurisdiction being awarded. Is there a time line that's going to be held against them since we won't be having this information available?

Chris Stahlecker: Can you …

Rhonda Gudell): Because we're currently in jurisdiction number six.

Chris Stahlecker: Oh, you're in jurisdiction six.

Rhonda Gudell: Correct.

Chris Stahlecker: So, you would contact your legacy Fiscal Intermediary carrier, OK?

Rhonda Gudell: Yes.

Chris Stahlecker: And they have partnered up with a MAC who is ready to test the 5010 transactions.

Rhonda Gudell: OK.

Chris Stahlecker: You'll be able to test your transactions now, just like everybody else, using the base version. And again, as we just said, in April, test the errata. And once jurisdiction six is awarded, then the MAC that is named in that award will become your key point of contact.

Rhonda Gudell: OK. Is there a time line that you guys have put on the MACs to become awarded?

Chris Stahlecker: Yes. That time line is quite old and all the awards were actually made, but some have been protested and so they're in a state of resolution right now.

Rhonda Gudell: OK.

Chris Stahlecker: So, assuming all of the concerns are resolved, there'll be announcements made about the final MAC awards.

Rhonda Gudell: All right, very good. Thank you.

Female: OK.

Operator: Again, if you would like to ask a question, please press star, followed by the number one on your touchtone phone. And your next question comes from the line of Tina Hyatt. Your line is open.

Alicia Bougie: Hi. Actually, this is Alicia Bougie calling from Clinical Laboratory Partners in Connecticut. We have a question going back to the P.O. Box not being allowed. How do we handle that because we have bank lock boxes that are, of course, based upon a P.O. Box?

Chris Stahlecker: It's Chris Stahlecker. Our billing expert for the 837 Professional claim is unavailable to us today. But the transaction itself does not permit the use of a P.O. Box in a certain location, but does permit it in another location. So, your ability to include a Post Office Box in the overall transaction is not eliminated. It's just that you need to pay attention to where it must be placed.

So, we can take your e-mail address and get a more definitive response to you today – or, not today, but when our resource is back in the office.

Alicia Bougie: OK.

Chris Stahlecker: And your e-mail address, please?

Alicia Bougie: Excuse me. xxxxxxx, x-x-x-x-x-x@xxxxx.com.

Chris Stahlecker: Could you let me repeat it? x-x-x-x-x-x-x-x@ – and I'm not sure …

Alicia Bougie: No, I'm sorry. It's xxxxxxx, x as in xxx, x-x-x as in xxxx –x-x-@xxxxx, as in xxxxxxxxxxxx.com.

Chris Stahlecker: OK. Is that cxx.xx.com or just xxx …

Alicia Bougie: Xx …

Charlie Eleftheriou: Can you give us – is it x as in Xxx?

Alicia Bougie: Yes. xxxxx.com.

Charlie Eleftheriou: OK. Got it.

Alicia Bougie: Thank you.

Chris Stahlecker: Thank you very much.

Alicia Bougie: OK. Thank you. 22

Operator: Your next question comes from the line of Jill Gillman. Your line is open.

Jill Gillman: Yes, is there a Post Office Box number we can use for the payer address in the file?

Chris Stahlecker: The P.O. Box requirement only applies to the billing provider, I believe.

Jill Gillman: We can use a P.O. Box in the file for a payer?

Chris Stahlecker: Yes.

Jill Gillman: Perfect. That's all I needed to know.

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

Sharon Tolbrook: Yes, this is Sharon Tolbrook with August Systems. My question is in regards to the Companion Guides. Do you know if there will be a separate Companion Guide for the Home Health PPS payment system or will it be one in the same as the FFS system?

Female: There will not be a separate Companion Guide for home health. It will be included with the other transactions.

Sharon Tolbrook: OK. Thank you.

Female: No problem.

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

Sharon Nichols: Yes, this is Sharon Nichols from Real Med. Last week in one of the webinars, it was mentioned that providers being new to Medicare after April must be 5010 and not use 4010. Does that apply to a provider whose submitting directly or does it also apply to a provider whose going through a clearinghouse?

Chris Stahlecker: It's Chris Stahlecker. It's meant to apply to providers new to the Medicare program that are just beginning to submit claims. So, it would be regardless of – if they need to use a particular clearinghouse, that clearinghouse clearly would need to be compliant with 5010 before their new customer, this new provider – I guess you're presenting us with a theoretical situation.

But the intent is to not set up new Trading Partners at the MAC using 4010A1 format once the 5010 format is implemented and available.

Sharon Nichols: OK. Thank you.

Operator: Your next question comes from the line of Rhonda Williams. Your line is open.

Jamilla: Yes, this is Jamilla from Newberry Hospital. I just wanted to know: what does errata stand for?

Chris Stahlecker: OK. Let's see. In this context – it's Chris Stahlecker – the Implementation Guide are those Technical Report 3s that we talked about earlier in today's discussion, they had a version – and you can see that base line version and it's listed on our slide six. Those were available probably 24, 28 months ago. And since they were initially made available and industry started to implement and started to work with them closely, some corrections were recognized that needed to be made.

And there are two types of corrections. One was just typographical errors and that was referred to – there's a Type A and a Type B, if you will. Typographical errors did not necessitate having a new version of the technical standard issued; however, the other type of error that was discovered was right

within the Implementation Guide itself, not just typographical errors but the structure of the detailed technical requirement.

For example, if an element had a particular list of valid values, perhaps the value was omitted and needed to be added and it required a re-publication of that TR3. So when the TR3 needed to be re-published and reproduced, the version of that TR3 was modified and that's where the A1s and A2s come into play.

That errata version is actually contained in a data element of the transaction as it comes from the provider and sent to the payer. So, the payer is processing in its computer systems, it will know whether or not the errata version is used by looking to see if it's got the A1 or 2 as appropriate.

So, an errata is just a general term to mean a mistake was made in the original documentation and there's two types of errata: one that required a technical change to the transaction and one that did not. But nevertheless, on slide six, all errata versions that are listed are the ones that Medicare Fee-For-Service will process in production to become compliant with 5010. Does that help?

Female: Thank you.

Jamilla: Yes, thank you.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from the line of Lauren Hughes. Your line is open.

Lauren Hughes: Yes, this is Lauren Hughes. I'm calling from Superior Optical in Illinois and we are a DME supplier. We do not have any – we don't collect the – we basically are just billing a patient. So, we're doing, like, the smallest amount with you folks as we can. It's just, basically, where someone comes in and gets a pair of glasses after their cataract surgery, we're just filling out the forms.

We're not collecting or under assignment or anything. So, my question is – and we're talking about all of this – what's the best place for me to go to, for

instance, like, where you've got the paperwork from the study where we did the PC-Ace Pro. Are they the best people to go to first to have an updated version?

Chris Stahlecker: It's Chris. Is that what you're currently using, PC-Ace?

Lauren Hughes: Yes.

Chris Stahlecker: Well, PC-Ace – and you mentioned vision care or you mentioned eye glasses, right?

Lauren Hughes: Right. The only thing we're doing is the eye glasses. We're submitting after cataract surgery where the patient has some allowance for the frame and/or lenses.

Chris Stahlecker: Covered by Medicare Fee-For-Service?

Lauren Hughes: Right.

Chris Stahlecker: So, you would contact your MAC and you should know that the PC-Ace software is also known as Pro32 and it all has been upgraded for 5010. So, your MAC will have a 5010 version of it available for you and if you contact your MAC, they'll give you information about when it can be given over to you so then you can …

Lauren Hughes: So, if I'm currently using it now, they've automatically done it for me?

Chris Stahlecker: Oh, all right.

Lauren Hughes: Hopefully – that's what I'm asking. If I'm currently using it now, then they automatically have done this?

Chris Stahlecker: No. I believe that – I'm sorry; you're telling me that you are already using the upgraded version or you're asking?

Lauren Hughes: No, I'm asking. I'm asking if I need another version right now.

Chris Stahlecker: OK. Then no, you should contact your …

Lauren Hughes: OK.

Question and Answer Session continued

Chris Stahlecker: Yes, you should contact your MAC and find out how they're going to deploy that to you- if they'll tell you to come to their website and download the new copy or if they're going to mail you something. You need to contact your MAC and find out what their particular process of issuing the upgraded software will be.

Lauren Hughes: OK. Great. Thank you.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from the line of Betty Fitchman. Your line is open.

Betty Fishman: Hi, this is Betty Fishman. I'm with Siemans Medical. I have a question regarding testing of real time 270 transactions. They don't go to the MAC. They're going directly to a CMS data center. And I'm wondering if you're beginning to do that testing and how I would get set for a time to test?

Chris Stahlecker: Hi, this is Chris. We call that the HETS application. Is that the one you're talking about? The HIPAA Eligibility Transaction System?

Betty Fishman: Yes, correct.

Chris Stahlecker: Well, it's currently having some infrastructure enhancements made to the base 4010 version and following conclusion of that, they will be ready to test their 5010 version. The current schedule that they have shared with us for 5010 testing is that they will be ready in April of 2011 to test with you on 5010.

Betty Fishman: And is there someone I should be contacting to schedule that or you would expect them to contact the Trading Partners?

Chris Stahlecker: Their regular help desk is your point of contact for the HETS application.

Betty Fishman: OK. Thank you.

Chris Stahlecker: OK.

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

Terry Robbins: Yes, this is Terry Robbins from Group Health Cooperative in Seattle and actually, we have two questions, just kind of for clarification. The first one is, on slide 14, 2000B of the subscriber loop, and this question was asked – I just need to make sure what we heard. Your slide only shows P for primary and S for secondary and the question was about a tertiary. The IG indicates you use a T for tertiary but if I understand correctly, you're saying you will only accept S for secondary?

Mike Cabral: I think what Chris was trying to point – I'm sorry, this is Mike Cabral. What she was trying to point out is, in our slides are mere examples of extracts from our Companion Guides. Medicare Fee-For-Service will handle the 5010 guides where we've programmed our systems to handle all the values coming in that are appropriate for billing with Medicare.

That being said, if you've got, you know, an accident claim with someone who has commercial primary and they're putting Medicare as tertiary, we already process claims for that. So that's what we've been doing for the last two years with our system.

Terry Robbins: OK. Thank you. We just needed to make sure we didn't need to do special coding. The second question – and I believe this was answered. It's just, we may have not heard it – is, we're in region two so we do not have a MAC assigned. And once we go through to begin our testing in April, and then at that point – and we certify our files. At the point that we are then assigned a MAC, will we have to go through a new certification period with that newly assigned MAC or will it just transfer over?

Chris Stahlecker: At the time that you are a productional submitter of the 5010 transactions and after that, the MAC is awarded, there is a different process Medicare Fee-For-Service follows to transition work load across changed contractors. And that transition does not typically include a need to test with the new contractor.

Terry Robbins: Thank you very much.

Female: I want to go back and clarify for the previous question related to Health Care Eligibility and Benefit Inquiry response as related to HETS. If you look on back to slide 15, you'll notice that the help desk for CMS.gov is on there. That can probably provide you with a lot more guidance on this. OK. Thank you.

Operator: Your next question comes from the line of Kerry Denton. Your line is open.

Keri Denton: Yes, this is Keri Denton calling from Accredo Health Group. I have a question about – we currently bill for J codes and we haven't been able to do them electronically in the past because the units field isn't large enough for some of our claims. Doing it this way with the new 5010, will that still be a problem or do you know?

Gary Beatty: This is Gary Beatty. How many digits do you need?

Keri Denton: We need more than four at times. It's not all the time but we do have claims that are over 9,999 units or over $100,000.

Gary Beatty: Yes, because I think right now, the size limit is six, a total of six digits.

Keri Denton: So, we can do it with six digits?

Gary Beatty: Yes, and the question is: is this for Part A or Part B?

Keri Denton: B.

Gary Beatty: It's smaller for Part B.

Keri Denton: Yes, we have to split them now if they're over four digits.

Chris Stahlecker: Do you want to give us your e-mail address?

Keri Denton: Sure. It's xxxx, x-x-x-x.x-x-x-x-x@xcxxxxxx, x-x-x-x-x-x-x.com.

Chris Stahlecker: OK. We'll get back to you on that, Keri.

Keri Denton: Thank you.

Operator: Your next question comes from the line of Tina Goodric. Your line is open.

Tina Goodric: Good afternoon. This is Tina Goodric from Montafury Medical Center. My question is specific to the service facility. When we're required to report an actual physical location when these services are performed in the patient's home, are you expecting any type of identifiers in the NM109? This is 837P related.

Chris Stahlecker: NPI, right?

Tina Goodric: I'm sorry. I didn't hear the beginning of your response.

Male: (Inaudible).

Tina Goodric: I cannot hear.

Charlie Eleftheriou: I'm sorry. We're just consulting amongst ourselves.

Tina Goodric: Oh, OK. I'm sorry. I thought maybe there was something wrong with my line.

Charlie Eleftheriou: No, no, no.

Chris Stahlecker: Just a minute, please.

Chris Stahlecker: Hi, it's Chris. We just want to make sure we're understanding your question. We probably don't have the answer for you. But I think you're asking us if a home care provider must be issued an NPI, because the NM109 is where an NPI would be placed or a provider identifier would be placed.

Tina Goodric: Well, Chris, the change is specific to service facility location, which used to be 2310D, now it's 2310C. And when the services are performed in a patient's home, we're required to report the address now. So, I'm just wondering, even though it shows that NM108 and 109 are situational for that loop, are you expecting some sort of identifier? Also, in this 2310C, we're

reporting the patient's name if the services are performed in the home. First, last name – are you expecting any type of ID?

Chris Stahlecker: Yes, again, we don't have our professional biller here with his Implementation Guide so we can't really see to answer your question.

Tina Goodric: Oh, OK. OK.

Chris Stahlecker: And I do apologize. But we could take your e-mail address.

Tina Goodric: OK. It's x-x-x-x-x-x as in xxxxx x-x-x @ xxxxxxxxx.org.

Charlie Eleftheriou: I'm sorry. What was the rest of the e-mail address? At …

Tina Goodric: xxxxxxxxx.org.

Charlie Eleftheriou: Got you.

Chris Stahlecker: x as in xxx, x as in …

Tina Goodric: xxxx.

Chris Stahlecker: xxxxx for the rest of that and xxx at the end @ xxxxxxxxx.org? OK.

Tina Goodric: Yes. Thanks, Chris.

Chris Stahlecker: Thank you.

Mike Cabral: The only thing you may want to check, too, is usually when they do the NPI requirements; they tie it to a REF segment. So, there may be a note at the segment level you need to …

Tina Goodric: Well, I'm looking at your crosswalk, your professional claim crosswalk from 4010A1 to 5010.

Mike Cabral: Right.

Tina Goodric: And the REF doesn't give me much information specific to this requirement when the physical location is 12 or a patient's home, PTH. So, that's what

I'm looking for. Even though it's situational and I wouldn't report anything in the NM 108 or 109, I'd like to know if you're expecting something like the member's certificate number.

Mike Cabral: We'll get back to you when …

Tina Goodric: OK. Thanks, much.

Chris Stahlecker: OK. Thank you.

Operator: Your next question comes from the line of Diane Angelbert. Your line is open.

Diane Angelbert: Yes, can you hear me?

Chris Stahlecker: Yes. Hi, Diane.

Diane Angelbert: OK, thanks. My question has to do a little bit with what Sharon Nichols from Real Med had asked you about before. I would like to just tell you my understanding of it. She had asked if – she had learned from another webinar that new Medicare providers would need to, after April, would need to submit as 5010 and she asked you if that was direct versus clearinghouse. And you believed that it would be across the board. Is that what you answered her?

Chris Stahlecker: Yes. There a lot of factors that come into play here. Yes, that is our guidance from CMS to our MACs.

Diane Angelbert: OK. Well, I understand because I do a lot of direct enrollments myself. But we do have plans who use clearinghouses like Real Med but I also have billing services who use our software. And I understand that, for me to do a direct enrollment for a new client that would be doing Medicare, I get it, that the MAC does not want to enroll them for anything but 5010. So, I'd have to bite that bullet.

But for my billing services who submit under a single submitter ID just like Real Med and Gateway EDI and Emeon – just like all of those submit under their own single submitter ID. All they have to do is add a provider to their

submitter ID. I can't see why they would have to do the same thing that I have to do. And I want to know this for my billing services because they all submit under a single submitter ID and when they get new business, they bring in new providers but they're all going to be submitting a single file with existing providers that may or may not be ready to go yet to 5010 but may be a new Medicare provider. You know what I mean?

Chris Stahlecker: Yes, I get your picture. It's really a moment in time kind of a question. And so any of those, you know, larger clearinghouses, software vendors that have current customers would be in the process of transition over to 5010 and likely would be ready to go fairly soon and the remaining calendar year - month.

So, what you're asking is about a moment in time for a provider who's brand new to the Medicare program and brand new …

Diane Angelbert: Right. And just being added to an existing submitter ID, which may or may not be ready to switch to 5010 yet. Maybe testing would occur – I don't know – June, July or August.

Chris Stahlecker: Right. They would be established in whatever clearinghouse list of customers that that provider was going to try to use. And if that clearinghouse was not yet swung over to 5010, they could still become the biller, yes. But if they're trying to become a brand new biller independently with a MAC, then we would want that provider to come up and bill on 5010 and not be established as a 4010 biller.

Diane Angelbert: But that would only be because they would be getting – as a direct connection, they would be getting their own submitter ID but without having their own submitter ID. You know, I mean, the MAC doesn't have to establish, really, very much for an existing submitter ID. Just add a provider to it.

Female: Hold on one second. We're going to talk internally.

Diane Angelbert: OK.

Chris Stahlecker: You're right. It's only the direct billers. That's essentially what we're talking about.

Diane Angelbert: Yes, that makes a lot more sense to me. OK. Thank you.

Chris Stahlecker: Sure.

Diane Angelbert: OK. Bye.

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

Darlene Parker: Hi. This is Darlene Parker from Peck Health and my question is regards to – when you do the transcription from these calls, do you provide an FAQ so that when you e-mail those responses to those people, that the others of us on this call would also have knowledge of those responses?

Chris Stahlecker: The short answer to your question is no, we don't do question-for-question on our FAQ list. We look at the topics that are covered. You know, some of them are just asking for websites and, you know, general information. So, we don't really transcribe and try to post in the FAQ list all of the questions that are asked. But the Q & A section of this discussion is available on the transcript, yes. But we don't try to take the questions that came up during this session and question-for-question add them to our FAQ list.

Darlene Parker: OK. Thank you.

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

Kathy Sikes: I'm sorry. Diana came back and asked what we were going to ask about the direct submitter and the must-go-5010 issue.

Female: OK.

Kathy Sikes: Thank you.

Charlie Eleftheriou: Operator, could you clue us in as to how many callers we have left in queue to ask a question?

Operator: There are currently three participants.

Charlie Eleftheriou: Thank you.

Operator: OK. And your next question comes from the line of Mary Felts. Your line is open.

Mary Felts: I've heard – this is Mary Felts with Real Time Charts. I've heard a lot of technical questions. I have one that's totally off the wall. Is there going to be or is it possible that we would get any continuing education credit for this call or for this webinar?

Chris Stahlecker: Oh, that's a good question. Unfortunately, that takes a little setup and pre-approval, which we do not have arranged for these calls. So, no, we don't offer that. It was a good question. We have considered it. It's just a little costly on our side.

Mary Felts: OK. Thank you.

Chris Stahlecker: You're welcome.

Charlie Eleftheriou: Operator, I think we're going to – or do we still have two more calls on the line?

Operator: Yes. Now, there are four participants who would like to ask a question.

Hazeline Roulac: This is Hazeline Roulac. In regards to the continuing ed question, if you are a member of the AAPC or AHIMA, if you maintain your registration information, you can record that on your tracking document, and you would need to contact AAPC or AHIMA, and they may provide you with some continuing ed credit for participating in this training. They may provide you with continuing ed credit but you – and that's only for AAPC and AHIMA. So, you would need to check with those.

Chris Stahlecker: Next question? We have about two more minutes.

Charlie Eleftheriou: We'll make this the last question.

Operator: Your last question comes from the line of Susan Chickel. Your line is open.

Susan Chickel: Good afternoon. I, first, have a comment and then a request. Let me just say that all of the persons involved with all 14 of these national calls have been most informative and most helpful along the line and some of the flack that you're taking is because these are not billing-related calls. These are informative on 5010. So, let me just defend you a little bit. And then let me ask if I could please have my e-mail added to the response for the information in block 32 on the 837-P regarding services provided to a patient's home.

Chris Stahlecker: OK, sure.

Susan Chickel: My e-mail is x-x-x-x-x-x-x-x-x-x@x-x as in xxxxx –x as in xxx-x as in xxxx-x as in xxx-x-x.com.

Female: Thank you very much.

Susan Chickel: Thanks.

Chris Stahlecker: And thank you for the kind words. We appreciate them.

Susan Chickel: You're welcome, Chris. Thank you.

Charlie Eleftheriou: OK. Well, thank you. I'd like to thank everyone who called in today and our Medicare subject matter experts for joining us. Please remember to send – I'm sorry. Our next call is scheduled for March 30th on the topic of provider testing and readiness. So, be on the lookout for a listserv message announcing more call details coming soon. Have a great day, everyone, and we appreciate you calling in and taking time out of your schedules. That'll wrap it up for us. Thanks.

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

END