Centers for Medicare & Medicaid Services
Medicare Fee-For-Service Implementation of HIPAA Version 5010
and D.0 Transaction Standards
National Provider Call
Moderator: Charlie Eleftheriou
February 16, 2012
1:30 p.m. ET

Contents

Operator (Holley): At this time, I would like to welcome everyone to the Special National Provider Call on Medicare FFS's Implementation of HIPAA Version 5010 and D.0 Transaction Standard's Conference Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections you may disconnect at this time.

Thank you for your participation in today's call. I will now turn the call over to Charlie Eleftheriou. Thank you, sir. You may begin.

Introduction

Charlie Eleftheriou: Thank you, Holley. As Holley mentioned, this is Charlie Eleftheriou from the Provider Communications Group here at CMS in Baltimore. I would like to welcome you all to today's National Provider Call regarding Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transaction Standards.

This call will focus on addressing recommendations made by the industry as well as outstanding fixes impacting the Part A and Part B version 5010 transaction—transition, excuse me. We will be hosting a question and answer session toward the end of the call giving participants the opportunity to ask questions related to 5010 and D.0 Implementation.

Please remember the call is being recorded and transcribed. The transcript and audio will be available in the CMS Web site within approximately one week. That Web site is located at www.cms.gov/versions5010andD0. Again, cms.gov/versions5010andD0.

Finally, if you would like to ask a question and don't get the opportunity during the call, or if we ask you to send your question to the 5010 fee-for-service resource mailbox, please submit your question to 5010ffsinfo@cms.hhs.gov. Again, that e-mail address is 5010ffsinfo@cms.hhs.gov.

Please note, the mailbox will only accept questions for the next 24 hours. Questions and answers from this call will be posted on the Web site in the next few weeks. With that said, I would like to turn the call over to Chris Stahlecker. Chris is the Director of the Division of Transactions, Applications and Standards in the Office of Information Services, or OIS, here at CMS.

Announcements

Chris Stahlecker: Thank you, Charlie. Hi, everyone, and thank you for joining us on today's special national outreach on 5010. Let me just say that today's particular audience is intended to be the clearinghouses and the vendors, who are participating in the EDI exchange with the Medicare administrative contractors, but it's not a restricted call; it's open to anyone.

So we may have some providers on the line during the open question discussion time as well. Here in the room, I have several from the division and group that have participated in implementing and all the support work for 5010, and we also, on our speaker line, have a representative from each of our Medicare administrative contractors and I want to say thank you all, each and every one of them, for being here today, too.

The purpose of today's call is really just to share a general status of where Medicare fee-for-service is with its 5010 and D.0 implementation and we will talk about some of the common issues that have popped up. As with any large implementation, we can expect that there would be some issues and some have occurred, and we will talk about some action steps about how to address those issues, then we will have an opportunity for questions.

First of all, Medicare fee-for-service is happy to report as of February 3rd, our Medicare Part A volume of claims is in the neighborhood of 74 percent, and our Part B claims, they are over 83 percent. Our NCPDP number is over 91 percent, and our eligibility transaction is—the volume is over 90 percent in the 5010 format.

These metrics are posted on our Web site, and I can give you that location; it, too, begins www.cms.gov/ediperformancestatistics/10_5010statistics.asp. This is the regular location, where you might go to find any of the EDI metrics. So we've added this fee-for-service to that location. So Medicare is moving ahead optimistically. We are going to be in excellent shape on March 31st, with the end of the enforcement discretion period.

We have some work to do because we are not at 100 percent yet, but our MACs are ready to work with all of the trading partners. Today we especially wanted to work with clearinghouses and vendors on issues they're— they are seeing and having because you are really the closest link to the MAC in the delivery chain. But you also might be seeing some issues that we need to hear about.

But before we get into the open discussion, we wanted to present some of the common issues that we've already experienced. One is related to the provider and submitter linkage, with 5010, we added and edited on the Part A side that would perform a match between the submitter and the providers that are coming in on that same file.

If there is no match between the authorization that's been given to the submitter to send those claims on behalf of that provider, that provider's section of the transmission would be rejected. So the provider needs to be set up to work with the submitter, and if the provider is experiencing that rejection, he should be in touch with the MAC so that step can be accomplished.

In some cases, our MACs are accepting proof from the clearinghouse that there is an arrangement that proof that providers have selected that clearinghouse, and that would be in the form of the agreement that the provider has entered into with the clearinghouse, can be supplied to the MAC, and then the MAC can use that as authorization to complete that set up.

So, there has been a lot of confusion about this topic when calls have been placed to the helpdesk at the MAC. Sometimes the phrase "EDI enrollment"

has been used, sometimes “enrollment” has been used. Sometimes it’s been interpreted that the caller needed to reenter or redo their Medicare enrollment, and that is not necessary at all.

This is an update to an EDI enrollment process. So, no one is asking providers to reenroll in the Medicare program, but there is this linkage between the provider and the submitter ID’s EDI transaction that needs to be accommodated. The next—number two, I have about five items that I wanted to hit in general but after that first one, the provider submitter linkage, I wanted to talk about lost claims.

We are hearing that providers are concerned Medicare has lost their claims, we’re not hearing that. Now, when we do, we’ve investigated with the MACs and we’ve done some root cause on this. There are a couple of issues that we need to express. One example of a provider thinking they’ve lost their claims, the MAC has lost their Part A claims, is that the provider will get into the DDE portion of the FIS system and expect to see their claims there, and they are seeing some claims but not all of their claims, and we’ve come to learn that the login ID that has been issued to that provider resource does not have the full set of provider numbers linked to it, the PTANs.

So, in some cases, overtime, more PTANs have been identified that belong to that provider and the claim that came in, the A37 that was submitted, had a PTAN on it that— or an NPI on it—that was not linked to the individual FFS login ID. So again, a corrective action there would be for the provider to contact the MAC and have that login ID expanded to include the billing numbers that the provider needs to use.

We’ve—on the lost claim issue, we have heard that claim files that the provider has delivered to the MAC going through a billing service or clearinghouse may not seemingly have been received at that MAC when, in fact, when we drill down in some cases that’s true because the claim has errored out at the clearinghouse or billing service, but the provider’s expectation has already arrived at the MAC.

And in some cases the claim did arrive at the MAC but has failed the front end edit and been returned back, rejected out of the system in the format of a 277 Claims Acknowledgment rejection, but the provider hasn't been informed of that. So we would like to work very closely with clearinghouses to tighten up that communication chain, and if there is any explanation of necessity of the 277 Claims Acknowledgment transaction, we do have on our Web site some materials that can assist in that. We have it on our—again, www.cms.gov/mffs5010d0/20_technicaldocumentation.asp—so we have the edit spreadsheet located there and some technical documentation, and we have some educational materials on the 277, but we would be happy to take any requests for additional support during the Q&A session, and we could work with anyone directly if they need that support. I will repeat; the Web site begins with the common www.cms.gov/mffs5010d0/20_technicaldocumentation.asp.

The fourth point I wanted to bring up was that we've discovered that some improved matching would help a lot in letting the vendor, clearinghouse identify the 277 Claims Acknowledgment with the 837 that they had submitted.

So we have some recommendations that about how to—the content, the ISA, the STO 2, and the BHTO 3. We have some recommendations, and we will be issuing these recommendations in listserv messages. We will give you the—we will post them on our Web site—but in the list of message, we will give you the URL, and we expect that list of messages to come out early next week, like Tuesday next week.

And the purpose here of this improved content of the enveloping is so that the TA1 response can be linked back at the outer envelope, the ISA, and that the 999 response can be linked back to the individual STO 2, and that the 277 Claims Acknowledgment can be linked back to content in the BHTO 3.

So those of you that are not technical, excuse that information. For those that are, Q&A time and you want the details on that, we are happy to go over it with you.

And finally, the fifth point I wanted to raise, before we open up Q&A lines, is that we do have some transactions set limitations that we would like to recommend. And again this will be included, in the posting on our Web site and in the listserv message that will point you it—that's coming up next Tuesday. These transactions set limitations. There are four points to be made here. One is that the, the interchange envelope, the outer envelope, the ISA/IEA, should contain a single functional group or single GS/GE, and that GS/GE should contain less than 10,000 transactions sets, ST/SEs, within that GS.

So we're saying one-for-one the ISA and GS, but then within the GS no more than 10,000—actually less than 10,000 transactions. The next point we would like to raise, is that we would like to suggest that we limit the number of CLM segments within any transaction set to no more than 5,000 that's recommended in the implementation guides.

The third point we would like to recommend is that all the claims we're giving billing providers should be combined within a single ST/SE, and then that outer envelope, ISA/IEA, would contain multiple ST/SEs but each for a different billing provider, and then there would be no limit to the number of ISAs and IEAs that you could submit in any one day.

And then the fourth point, in addition, that we would strongly recommend that we do—that billers do not send a single claim within the ISA/IEA. I've seen a bit of that, and that is causing overhead in processing time by the MACs, and so we would strongly recommend that the billing process is no longer followed.

So with all of those recommendations and recognition that we have had some issues and concerns raised, we will open up our lines, but before we do that, I just would like to reemphasize that we're all stakeholders here. You can see by the numbers that you have helped us reach a substantial implementation already. So thank you for that, and we look forward to your continued support as we try to reach our hundred percent threshold by March 31st.

So, with that we will go ahead and open up the line for some questions.

Charlie Eleftheriou: OK, thank you. Chris. I would like to pause for a few seconds and complete keypad polling so CMS can have an accurate count of the number of participants on the line with us today. Just know that there may be moments of silence while we tabulate the results, and Holley, when you're ready we can go ahead and start keypad polling.

Holley: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Question and Answer Session

Charlie Eleftheriou: And while the polling is being completed. I would like to remind everyone, before we start today's Q&A, question and answer session, that this call is being recorded and transcribed. Before asking your question please state your name and the name of your organization clearly. In an effort to get as many of your questions as possible, we ask that you limit your questions to just one per caller, and also to ensure the National Provider Call Program continues to be as responsive to your needs as possible, we're providing an

opportunity for you to evaluate your experiences with today's call. The evaluations are anonymous and strictly voluntary. To complete the evaluation, go to http://npc, as in National Provider Call, that's npc.blhtech.com. Again, http://npc.blhtech.com and select the title for today's call from the menu. All registrants will also receive an evaluation reminder e-mail within two business days. Please disregard the e-mail, if you've already completed the evaluation.

We definitely appreciate your feedback. Holley, when we are done with tabulating results we will be ready to start Q&A.

Holley: Thank you for your participation, we will now move in to the Q&A session for this call. To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue please press the pound key. Please state your name and organization prior to asking a question and pick up your hand set before your question to assure clarity.

Please note your line will remain open during the time you're asking your questions, so anything you say or any background noise will be heard in the conference. Your first question comes from the line of Patti Brinkmeyer.

Patti Brinkmeyer: Hi, this is Patti Brinkmeyer with Health Fusion, and I would like to address the fact that we spent probably four and a half, five hours on the phone with MACs trying to find our 277 CA files. We get a good 999 transaction. Four, five days later we still haven't got our 277 CAs.

This is becoming a full-time job for us to track missing 277 CA reports.

Female: Hi, Patti, is this an ongoing problem or was this…?

Patti Brinkmeyer: Yes, it's been ongoing. It's with every, almost every single MAC that we worked with, we have had problems.

Female: OK, we just want to recognize that, we may have a problem but we may not. It may be a perception issue. We would suggest that, I don't know—your

process is calling for you to look for that 277 Claims Acknowledgment in the same timeframe that you have received it in the past under 4010.

But under 5010, we have added a significant amount of processing that happens before the claim is actually introduced in the claims system, so that the 277 CA may not be available the same day or within two days of when the claim was received and processed. So . . .

Patti Brinkmeyer: I think a week is long enough to wait.

Female: Well, I would agree with that.

Patti Brinkmeyer: OK.

Female: We are not suggesting that you need to wait for a week. But there are the couple case-by-case situations that we heard about, but we've not heard about anything systemic and repeated as you are trying to describe to us. So you are saying that this is an ongoing problem and every time you bill…

Patti Brinkmeyer: It's an ongoing problem with certain MACs. It seems like it's consistently one week, we will get all our 277 CAs back in a normal 24- to 48-hour period. The next week, we will get notice there are processing delays. We won't get 277 CAs for three days. That affects provider's accounts receivable because…

Female: It's all right, go ahead.

Patti Brinkmeyer: Because that's three days, they are not going, getting their claims processed.

Female: Right, let me also add on here that sometimes some of our MACs have had some startup issues with the performance and at this time all of those issues are resolved. Some MACs had backlog and at this time all of those issues are resolved. MACs are running current with their incoming claim volume. Now I must also head on that we have had MACs experience hardware outages, and when that happened they did have a recovery process that they had to go through, but at this time we understand all of those files have been

recovered or the provider was asked to resubmit them, and I think that has been very few in between.

So there has not been lost information, but you are saying your expectation is that, your claim is not getting paid timely by experience so far, and researching that is that even if it is taking a little bit longer to get the claim into the claims system by large measure none of the claims processing timeliness thresholds have been not met.

Patti Brinkmeyer: We're just told to follow that.

Female: Case-by-case basis, yes, they have not been met, and the appropriate interest penalty that has been paid and in some cases an advance payment has been made to certain providers who have had an experience with that long outage.

Patti Brinkmeyer: OK, we are a clearinghouse and we do for several MACs. We have just been told we have to resubmit a file from January 4th, this last week. Now they couldn't even update it. To the past two weeks is as far as they can go.

They had to file, we had a good 999 acceptance. They don't know what happened to the 277 CAs. We were consistently having that problem, consistently.

Female: OK, and your clearinghouse name again is?

Patti Brinkmeyer: Health Fusion.

Female: Health Fusion. OK, if any of those in our call queue—not our call queue, our speaker queue want to address that, you can at this time.

Patti Brinkmeyer: Even just this week, the reading came out. That said there was Medicare processing delayed on Monday, Tuesday, and Wednesday of this week. So what you are saying is, there is not a delay, then why are we are getting notifications that there are Medicare processing delays?

Female: OK, thank you. We will take that up with Noridian.

Holley: And your next question comes from the line of Rena Yeager.

Rena Yeager: Hi, this is Rena and I'm actually going to defer to Betty Gomez and she's going to ask the questions.

Betty Gomez: OK, so we have been experiencing, continue to experience the issue with Trailblazer and we can't get the issue escalated. This was back since the call before, prior call, and we now have thousands of providers that we haven't been able to get their claims due to the submitter not being linked.

We try to get through to Trailblazer to work with us, and we are still experiencing that situation. Is there anybody at Trailblazer that I can discuss this with, so we can get—we are tying up millions of dollars for providers at this moment, and this is very discouraging, needless to say. So that is one situation. The other situation is, I don't know if the MACs have addresses, we continue to experience rejections for batches that they are redirecting the whole entire batch for few claims that are rejected and not accepting with errors. So I would like that to also, to find out where they are standing with that, if they are going to change it so that we can batch normally and not have to batch by single claims, because I know you don't want that. But if we can't get the claims through, we have to do something.

The other issue that we are experiencing is, there was a—Trailblazer acknowledged that there was a problem and this affects our hospitals. Specifically our ambulatory ones that they know they have any issue with an attending provider, and they are saying, send the claims, let the claims be denied, and then you have to go into the DDE system and remove the attending NPI.

Hospitals can't do that for the hundreds of claims that they are sending, and this is their livelihood. So they were tying up probably and just two providers. We have about $500,000 million claims, so have a $1 million worth of claims, so can you address – help us address that.

Female: I guess, you could probably go in reverse sequence. The ambulatory claims, yes, that is a workaround at this time that is affects of being scheduled. I'm struggling to see if I can locate the implementation data on that.

Betty Gomez: This April 1st.

Female: April 1st, OK.

Betty Gomez: That's a long time doctors are not going to be able to do that. Is there any way that we can speed that up a little bit?

Female: We've looked into expediting the deliveries for some of these specs, and we will keep you apprised of any changes in the delivery date.

Betty Gomez: Thank you.

Female: So, the single claim rejecting by batch—that sounds a lot like the provider, and we have not by any stretch attempted to reject entire batches or entire transmissions of claims when at all possible. However, if the providers themselves are not authorized to send in the claim, we do not do the detailed claim-by-claim validation.

So that, we will skip to the next provider.

Betty Gomez: No, that's not the situation, Chris. The situation—the provider is authorized, the submitter is authorized. We submit a batch, let's say, with 5,000 claims, and there are maybe 100 that get reported with errors, perhaps. We get the file back and it says "accepted with errors," but we are having to resubmit the 4,500 other ones just to experience that there are still rejections that were not reported the first time.

You are not accepting the ones that were good or that you said they were good. You are rejecting the whole entire batch back, and it's just a vicious cycle. So we resort to billing just one claim for ST/SE, because then we know

if that's the one that has the error, then we—they will report the rejection, and then all the others get accepted.

Female: But it doesn't sound like a problem that we are hearing, so it may be just a misinterpretation, and if we could—are you experiencing this with one MAC?

Betty Gomez: We are. We've had to make readjustments on our batching because it was several. So, if we—I mean, I would be happy to get back offline and discuss the particulars. It's not everybody, it's a few. But I know you don't want us to be backing ST/SE.

Female: A single claim, that's in a lot of overhead and really slows down the processing.

Betty Gomez: Definitely.

Female: That didn't happen. But we would like to understand the real issue that you have at hand. So, yes we would like the details on that. If you could send that in to that resource mailbox, we will pick that one out for sure, and we will be able to look into that.

Betty Gomez: OK, now would we be able to get a call back once we submit that in the resource?

Female: Yes, put your name and telephone number in there, and we will get you a call back.

Betty Gomez: OK, great. What about the enrollment with Trailblazer situation?

Female: So, would you want to take that? OK, Betty what's the name of your clearinghouse.

Betty Gomez: It's ZirMed.

Female: ZirMed, OK. I'm writing, excuse me for just one second.

Betty Gomez: No problem.

Female: OK, I would like to use your question as an opportunity to go over several things. First of all, I am personally doing some linkages for the larger clearinghouses, and I've learned a few things that I'd like to pass on to all of you. First of all, the 496 edit that indicates that linkage is not established doesn't just happen because of linkage and the clearinghouses need to understand that.

There are other reasons for this edit to fire. One of those reasons is because the 496 is looking to see that the NPI you have on the claim isn't associated with—is in association with—that submitter ID through its PTAN. If it's an invalid NPI on the claim, it's not going to be recognized, so it can't be linked.

I've been working with one very large clearinghouse, and she knows who she is, and she's been wonderful, and she and I've been working through some of these. So, I have a couple more things I'd like to share with you.

We've seen customers using the rendering physician NPI, and when the NPI translates to linkage, the rendering is not linked to the submitter, therefore the 496 there comes out. Your linkages are just fine, the billing is incorrect. And my final tip with this is that when we receive the submission attempt for Part B provider, who's a member of the group, OK, and it's associated with bad linkage, really what is happening is the NPI for Part B is billed under the group NPI not the individual NPI, and the individual NPI is not even linked to the submitter ID.

So many times I'm getting complaints about the 496, and I'm finding out that billing is inappropriate and that they are billing for the individual provider who is a member of a group, and that will throw you a 496 every time. So, Betty, what I'd like to have you do is, contact our technology support center, that number is 866-749-4302, ask to be transferred to level two.

And level two, after you tell them that you are ZirMed and that you're having linkage problems, will get those to me and I will communicate with you offline and try to help you resolve those.

Betty Gomez: So, it was my understanding that we've even escalated it to level two and we haven't been able to get anybody to get back with us. So, we've already called the 866 number, we've already asked for level two and we are not getting anywhere.

Female: All right, first of all...

Betty Gomez: One thing, I do want to mention, is these providers. We were successfully transmitting their claims in 4010, and it only started happening when we switched to 5010. I don't know if that makes any difference or not.

Female: Yes, Charlie, would you like me to address that globally?

Charlie Eleftheriou: Yes, go ahead, that would be great.

Female: Ok, all right. First of all, everyone needs to understand that 4010 and 5010 are very different. Because you are linked in 4010 does not necessarily mean you will be linked in 5010. The reason behind this, as Chris said on our last call, is because the clearinghouses declined to go ahead and test with all of their providers.

In 4010, there were instances where different MACs, who at that time had control of their front-end edits, had the linkage edit off, and that was for a variety of CMS reasons, that in conjunction with CMS, that those edits were not there. Therefore, if you did not get caught in 4010 and you did not have your linkage established, 5010 has been set up to catch you.

So I have seen in my work thus far with the larger clearinghouses, that I'm having one clearinghouse group who have had, I count so far, five different names in the last 10 years who have changed their submitter IDs but continue

to try to bill under their old submitter ID and think that they are linked to one when they are linked to another.

I found 18 incidents of that out of 26 given to me the other day, so that's a big thing that's happening as well. What I'm saying is—the bottom line is, if you are caught with a linkage error, and it's really a linkage error, and there is really none of the other mistakes that I elucidated previously on there, then what you need to do is contact our second level support for whichever MAC (J1, J4, or J11) and they will get that offline to me, and I will work with you, but what I need to have confidence in is that all of the clearinghouses are listening to what I said about what the 496 could be, and if they are actually evaluating the errors on behalf of their providers when they come in, because as I said before, I have data and I know that not all of the 496—that it's out for linkage. But 4010, again, and 5010 are very different. I think I've explained the reason why, and if anyone has linkage errors for J1, J4, or J11, if you will please contact the second level, just request when you contact our technology support center to be sent to them.

I have both the managers of those areas sitting with me right now. I've all three of them sitting with me right now, and they know that global linkage error edits from a clearinghouse need to come to me.

Female: OK, very good.

Female: Thanks so, Betty, just that was that single claim rejecting my batch. Why don't you go ahead and throw that e-mail into the resource e-mail box and we will get a response to you on that one?

Betty Gomez: Thank you again, will do and I appreciate what you mean. We only just want to get it fixed. I mean, we are not pointing fingers at anybody, we just want to know what it is that we need to do and we will be more than happy to comply. We are just are not getting the responses, that's all.

Female: I think you should have them now. But thank you, and we will look for that e-mail on the resource box.

Female: Next question.

Holley: Your next question comes from the line of Anne-Marie Lesny.

Anne-Marie Lesny: Hi.

Female: Hi, Anne-Marie.

Anne-Marie Lesny: Hi, I represent Memorial Sloan-Kettering Cancer Center. We are direct submitter of our claims. And I cannot go the same frustration we've heard from the prior two callers. Our experience has been similar with our direct submission of claims.

But the question that I have outstanding is we are also starting to see some RTPs with the Code 31279. And when we followed up on that, we were advised that this was a problem on Medicare side, CMS side, that was being worked on, but there was no ETA on a fix and I didn't see information about it in the site, and I'm just wondering if there is an ETA for a fix that has to do with claims submitted with both an ICD–9 and ICD–10 diagnosis.

We are still submitting 4010. We are not including both values, and we were told that, if there is nothing we could do, just wait for the problem to be resolved.

Female: I guess we are puzzled by your description that mentions ICD–10. If you are billing 4010 or 5010, ICD–10 should not enter the picture yet. Is it?

Anne-Marie Lesny: That's correct. So we're surprised to get back claims "RTP-ing" with a reason code 31279. The description in the RTP reads: "Any claims submitted with both an ICD–9 and ICD–10 diagnosis code on the same claim will reject. Please verify billing." When we contacted them and said, "What is this about?" and were informed that it was a known problem and that multiple providers have reported to them and it was being investigated.

Female: OK, well we are not. Thank you for that information and we will pass it on, the office area those responsible that Part A system to make sure that they have this known problem on their books for correction, but it does not necessarily seem to be related to 5010. At least it's new to us, we haven't heard about this one. At least I'm not recognizing it as a known issue. So . . .

Anne-Marie Lesny: Right, I just also wanted to express. Even though we continue to send 4010—even though we successfully tested 5010, because it's the issues that we've been seeing, we are still having the same problems that were voiced by the speaker from Health Fusion and the other speaker as well.

So, in particular what's been most vexing to us, and I'm still glad that you explained this issue that our claims were getting the 997, the 277 and everything is fine. We are calling NGOs, we are being told yes, we have these files, and they can't tell us why we are not able to view them, and we call it FIS, as you said, that the DDE system.

So this was the first time, we were given any potential explanation as to why that could be after being on the phone almost daily, for two weeks.

Female: Well—Anne-Marie, right? I do want to say that this root cause has really just been identified this week, and we've had many digging to try to identify. So it's not just one MAC, it's not just—so we do want to recognize this. Some of these issues, it takes a bit of digging to find out what the symptom is leading us to, so.

But I'm glad that you found it to be helpful and will pass the RTP 31279 issue over to the Medicare Part A team.

Anne-Marie Lesny: Is there anyone in particular I could follow up with there, who might be able to give me a status?

Female: If you want to put an entry in the resource box, so we could pass that to them as well and they could respond to you directly.

Anne-Marie Lesny: Great, thank you.

Female: OK, thank you.

Operator: Your next question comes from the line of (Vergi Levito).

Female: Hi.

Female: Hi.

Female: Hi, can you hear me OK?

Female: Sure can.

Portia: My name is Portia. And I just have a simple question regarding the status on MSP issues, and I know that on the last call it stated that the fix would not take place until April 1st. Is there any possibility that there will be some movement prior to that date?

Female: I believe that MSP issue has been delivered. The fix is in the hands of the MACs for user acceptance testing and I believe—hang on a second—March 5th.

Male: Looks like 223 to UAT 325 because the MSP PR2.

Female: We have information that we have, we have the correct MSP issue. We believe that it is scheduled for implementation on March 5th, and that it's currently in a test status with the MACs for—so the fix has been expedited and delivered to the MACs and they're testing.

Portia: March 6?

Female: 5.

Portia: March 5, OK. Thank you very much, that's good news. OK, we'll stay tuned. Thank you.

Female: All right. Thanks.

Operator: Your next question comes from the line of Brian Baum.

Brian Baum: Excuse me, hi my name is Brian Baum and I'm not a clearinghouse, I'm a direct biller. Just wanted to ask for some clarification, I'm taking notes for several of our teammates. Could you repeat the Part B metrics real quick and also, if we could just repeat the e-mail address, the URL, for the complete abstract?

Female: Just one second, the Part B metrics. The Medicare Part B claims, we have 83.5 percent of the claim volume is in 5010.

Brian Baum: Yes, so, right.

Female: And the locations, is that what you asked?

Brian Baum: The URL where the abstract will be held?

Female: www.cms.gov/ediperformancestatistics/10_5010statistics.asp

Brian Baum: I am sorry. I was asking for—the gentleman that opened the forum listed an e-mail or, I'm sorry, URL, for the complete abstract of this call.

Female: I'm sorry.

Brian Baum: No, that's OK. If you could please repeat that.

Male: Yes, in order to get to the overview page for the entire HIPAA 5010 and D.0. The conversion is cms.gov/version5010andd0 and that will get you the overview page, and from there you will be able to access all the information that you might need on the program.

Brian Baum: So then this call would be, the abstract of this call would be on that Web site?

Male: Right, it hasn't posted yet. But it will post within the next few days.

Brian Baum: Great, thank you very much.

Male: You're welcome.

Holley: Your next question comes from the line of Thomas Finkenstadt.

Thomas Finkenstadt: Hi, my name is Tom and I work at a billing service, and I had some follow-up questions from Health Fusion and the other people after them regarding not only the missing 277 CAs but also enrollment and EDI departments not communicating internally inside of MACs since they are hand-in-hand with 5010 switch over and the revalidation that happened pretty much at the same time.

We had few providers that were unable to submit because enrollment changed their methodology of submitting, and we didn't have time to submit paperwork to attach that to the submitter code on file. That's one issue. The 277 CAs, I've been told by a couple MACs, that the pay-for starts when I receive my 999 acceptance and I can't find any documentation that states that.

We had 277 CA that was delayed by almost two weeks and they could not explain why no ETA, just keep checking for it, and that has been resolved, but the lack of accountability between the MAC and FIS with the company that actually does the processing. It's pretty distraught. We get to tell the doctors we don't know because the MAC can't find out from the middle man company that what's going on between them and the FIS.

And my third question is about the claim acceptance codes regarding from Washington Publishing Company. We get some codes where there's just a single moniker like each HCPCS, whatever the acronym is, and it doesn't actually detail what's missing. Well, that's a lot of things on the HCPCS code. I mean, it could be anything.

So I'm just wondering if there's documentation for the pay-for being changed that included 999, or maybe I misread CFR 545 on the Federal Regulations, and whether or not there's been a request for the MACs to coordinate between the enrollment and EDI so that doctors' claims aren't held up.

Female: Appreciated the question. I just want to make sure that there isn't a perception. There really isn't any difference between the MAC, and let me just ask you some questions. Are you saying that there has been a perceived delay between the MAC receiving your claim giving you back a 999, and I will come back to the issues for the 277, and the entry of that claim into the FIS system—is that what you've said?

Thomas Finkenstadt: That's correct. They were mentioning that there is a middleware company, CMEA, EMEA. I would have to go get my notes.

Female: OK.

Thomas Finkenstadt: And that's basically outside of their control. It's basically a CMS-controlled company. When we contacted Chicago Regional, they told us there is nothing they can do. The claims people, Bertha and—I forgot the guy's name.

Female: Let me just say it, it's not a company. It's a piece of software, and so yes, the pieces of software that come together to do the exchange your inbound file will go through bulletin board, go through a translator that then goes through this new software, CEMA, and that is where the generation of the 277 Claims Acknowledgment starts.

And then finally your accepted claims are sent forward for entry into the FIS system. So what we have seen is that the—it has taken some time between the receipt of the claim and when you may have received back the 999, and then getting through the CEMA, the new software, and then delivery of the claim to the main, to the main FIS processing system.

And that's what I tried to describe earlier by saying that, although it has taken some extra time to get through that CEMA software, the claim itself is dated by the date of receipt of the 999. So your claim hasn't aged in the delivery to the FIS system. The system itself will be determining the length of time they've had the claim by the date that it was received and acknowledged in your 999. That's what you should be seeing.

Thomas Finkenstadt: So the MAC, what they told me, that they—we couldn't provide any SE documentation, any kind of a change documentation, because when I read, it says, when it's accepted by the FIS IVR system, that's when the pay-for starts.

Now they told me that it's possible that if I receive my 277 CA more than 13 days after the 999 date that the doctor would get his EFT literally the day we got the 277 delivered to the mailbox. But where is that document? Is that just part of the CFR 545 and I misread it and I have to go back and reread? Or is there a change that was done with the 5010 knowing that delayed this in order to speed up the payments for the physicians?

Female: No, this is some, one of the cases where there is no change to the CFR. This is a situation where this is a new process, and it's being executed as quickly as it can be executed. There is, there has not been a planned delay; in fact, the performance improvements of the CEMA module has improved and continues to be refined to get to today's 4010 throughput capability.

But in the meantime, although it may happen that EFT and an acknowledgment transaction happened at the same time is not by intent. It is just—it could happen that way that that …

Thomas Finkenstadt: And I agree with you. I didn't mean to indicate that it would be held on purpose or anything like that. It was more if we don't see a 277 CA for 19 days. We are now six days past the pay-for from a 999, which is OK—we know there's an unplanned outage delays, not outages per se.

I can't point to—I have to say to the doctor, you'll need to call EDI to have them tell you this. I can't point to a documentation anywhere in the listserv

that says, we know we are delayed, pay-for has been adjusted for the 999 receipt date, and we are using the 999 as the receipt date, not the 277 CA.

And I just—it's not a huge deal. I just like to have the documentation official instead of saying, "well that's what they are telling us, doctor."

Female: I understand, so you are really asking for, for one, there is this outage or case-by-case problem situation that you would like to receive a listserv or know that a site, a Web site at that MAC can indicate that to you?

Thomas Finkenstadt: Correct.

Female: OK.

Thomas Finkenstadt: And that's just to—basically, we go for total accountability instead of, well, we shrug our shoulders and try again.

Female: No, no, I appreciate that.

Thomas Finkenstadt: Every clearinghouse is like that. We want to know.

Female: We want to emphasize that the claim is dated appropriately as the date it was received, and aged appropriately, and paid appropriately. It may have taken longer than we wanted to get it through, but it is all aged appropriately, the date of receipt, the day that you got the 999 back.

Thomas Finkenstadt: Right now I appreciate that. I was trying to get more clarification to make sure we're not just going on hearsay.

Female: I appreciate that. Great suggestion, and if you want to drop us a note about which MAC you are talking about, we can emphasize that directly with that MAC, and will give a reminder to each MAC that all of our MACs that are on the call, this is something that the billing community is very dependent upon, to know when there are outages to keep their list of messages issued appropriately. Thank you.

Thomas Finkenstadt: As far as the WPC claim acceptance—and you can tell me I can only get one question—the claim acceptance rate points not being as specific as they used to be right back in the day 4010. We called provider contact, and they actually told us we don't know why they rejected you. Off to look in the book and see what's required for that procedure code, HCPC code—same thing to me.

And I kind of was like OK, sure, I guess I will call Washington Publishing Company and ask them what they meant when they were in ASCP meetings. Where do we get more detail on the WPC claim acceptance codes? The 496s, 480s?

Female: I think that you're—you've got two parts for that question. One is, we have tried to improve our error description, and there is a new document that can also be found on the Web page that I've mentioned earlier, www.cms.gov/mffs5010d0/20_technicaldocumentation.asp. We have a list of the error codes there and the description of that error code.

The actual billing situation that might pertain to your use of HCPCS code, we can take that under advisement and if you have some additional description about what that situation is, we can try to improve our editing or error messaging on why that failed. But let me just say that the descriptions have been improved and made more public on our Web site.

Thomas Finkenstadt: I appreciate that. I try to browse the CMS Web site every other week just to find the documentation and save it on our Web site here for our people. So that will help because they are asking me, and I'm like, I don't have any documentation—sorry, that's the error we got, go call provider contact.

Female: Well, have a look at it, Tom, and then send us an e-mail note in that resource box, since that's not going to help you.

Thomas Finkenstadt: Absolutely, I appreciate you taking the time to answer my questions.

Female: OK, thank you.

Holley: Your next question comes from the line of Robert Burleigh.

Robert Burleigh: Hi, Chris. This is Bob Burleigh on behalf of HPMA. Just more of a general administrative question. A lot of our member companies have been reporting extreme changes, negative changes in the—their ability to get through on the telephone with the various MACs to try to solve problems and case manage some of the issues they're experiencing.

But I just wondered—is that something either your people or someone else within CMS is actually monitoring? And whether there was any advanced planning to change staffing or change the way the call centers receive calls to anticipate the increased demand? It's been a real problem, and one of the earlier callers mentioned, it's now become a full-time job for one person, and we heard that echoed many times across various MACs.

Female: Well, Bob we appreciate the comment, and yes, we have recognized the call centers were just inundated with way too many calls. Yes, the calls, individual MACs had staffed up their call centers for what they had expected to be the normal increase number of calls following any large implementation.

But quite frankly, the calls far outweighed any anticipated incoming calls. When we try to do a little research, we did find that some, I'm not going to name a clearinghouse, but one national clearinghouse was pointing all of their customers to call the MACs, when in fact it was the clearinghouse that should've been fielding the questions regarding the 277 Claims Acknowledgment transaction.

They were unable to deliver that back to their providers. There had been a miscommunication on their end. They haven't been able prepared to do that. So on top of the routine of calls, the MACs were fielding the calls that should have gone elsewhere. We think right now that the call volume has gone way down and that our MACs have advised us that they have staffed up their call centers.

They have added more hours, added more people, and we believe that the timeliness of the call is dramatically improving. If that's not being experienced, please let us know in that resource box and tell us which MAC you might still be having a difficult time with, and the period of. We know that they were severely backlogged with handling calls through January, but we think that recently they've gotten a much better handle on the situation.

So if you could let us know when the backlog is occurring, if it is still a problem.

Robert Burleigh: All right. The data we found somewhat interesting is that when things like this that happened in the past, it seemed to be the usual suspects, some say, that the same MACs that were problems previously in other situations like this were problems this time as well. But I guess to be fair to everybody, what is that? Does CMS have a reference point or a benchmark that what's a reasonable amount of time to wait to be answered, assuming if you get through at all, because there were actually cases the lines were so jammed, you couldn't even get a call in to wait in line?

But assuming you get through, what's a reasonable wait time, and what crosses the line into not reasonable?

Female: That's a good question, and yes, we do have a component here at CMS that is responsible for the call centers and managing the performance of each MAC's individual call center and IVR unit against those benchmark standards. Unfortunately, we don't have them on the call today, but if you need to have some of that information, if you send us your question in the resource box, we'll get you in touch with that area.

Robert Burleigh: OK, thanks very much.

Female: OK, Bob.

Holley: Your next question comes from the line of Bryant Saxon.

Female: Hi, Bryant. Do we have Bryant?

Bryant Saxon: Hi, I'm with SouthernCare, we are hospice providers, and we bill through Palmetto and Cigna as the intermediaries, and also use clearinghouses. And the question is for a particular field on the 5010—it's the point of origin, for hospice care. We got a few different responses on the—whether this is required, or what might be required for hospice for this particular field from different billing software companies who have also worked with the intermediaries as well as clearinghouses. And we had kind of—overall, the response has been that this could be left blank for hospice, for that we could use the option nine for information unknown. And I just kind of wanted to clarify that is the quick way to—for the correct value for 5010 format for this particular field?

Female: Unfortunately we don't have—appreciated the question, but I don't have my institutional billing subject matter expert with me today. I don't know if any of the MACs mentioned would be able to field that question or not. I mean, just pause to see, if they speak up.

That had to do with whether or not the point of origin, you're placing it where, Bryant?

Bryant Saxon: Just ask them if it's required for hospice potentially, is kind of the question? And if blank or putting "information unknown" is an acceptable default value is for—or this is for hospice? Because it seems it's not necessarily in the regulations targeted for hospice.

So we are just kind of overwhelmed. We have heard it's not, but we had one of our billing software companies—we use a couple of different ones—say that they should be filled out on every, every claim, and so we are kind of, have a little bit of mixed message. Most people are saying is not required with one thing, that it is required, and I just wanted to kind of confirm close to the source, this information could be marked unknown.

Female: OK, well, if you be so kind to send us a question in the resource box. We will get an answer for you. And I apologize that we don't have our SME with us today.

Bryant Saxon: That's OK, how do I—the resource box? Where—how do I ask that question?

Female: Send an e-mail.

Charlie Eleftheriou: The resource mailbox e-mail address is 5010ssinfo@cms.hhs.gov.

Female: I mean, you probably won't be tempted to send us PHI, but we ask you not to.

Bryant Saxon: All right, it's just—that's obviously… OK, all right, well, thanks for your time.

Female: Thanks, Bryant.

Holley: Your next question comes from the line of Janett Checo.

Janett Checo: Yes, hi. My name is Janett Checo. I'm with a clearinghouse as well with MedAssets. And I have a question in particular as it relates to particularly COB data, and particularly also your crossover process. We are experiencing high levels of rejections from our clients that are saying that the crossover features are not working well either.

And I think it has to do primarily with some of the deviations that are out there related to patient reason for visit and admission date, and also some of the requirements that they may have had that are not 5010 compliant. So a question I have in particular is what is being done to test with the crossovers?

And we have clients that are claiming that they are not yet 5010 on the crossovers. Is that the standard at this time? Can you address that?

Female: Let me just make sure of the area that you are speaking about. Are you saying that you are representing questions from a payer that is a crossover recipient?

Janett Checo: A crossover recipient. Yes.

Female: OK.

Janett Checo: And their statement to me was that they were not yet 5010 with crossovers.

Female: Well, the way our crossover process works through this entire transition has been for the COB receiver, so the health claim you are talking about, they need to say when they want to receive test 5010, and then when they want to cut over to 5010. The COB delivery can be either 4010 or 5010, and so your health plans receiver needs to say when they want to receive it.

So it's their choice, up until March 31st.

Janett Checo: We experienced some very large rejections with providers with payers or claims were being rejected, as a result of being 5010 with the MACs, and I believe they are not being 5010. And some of these things that changed shouldn't have been issues—things like the admission date being allowed to be different than your statement from, the calculation date for accommodation—those are causing significant rejections across the board, industry-wide for the commercial world, not for the CMS world.

But one of the biggest problems I'm seeing is even the Medicare Advantage product lines are not implementing that rule set, hence information-only claims were the IME claims that would be submitted will be out of balance, and I'm really concerned that there is a lack of enforcement on some of these elements.

Female: We, our coordination to benefit area, unfortunately is not on the call to answer your questions directly. They're doing, maintain a top 25 list that, I believe, of frequently experienced problems, and we can take this issue back to them and make sure they have it on their, on their list as these things need to be addressed.

I will say that there are requests for changes to the shared systems that are preparing the claims for crossover after Medicare has made its primary payment. And so some of, it has to trace your particular situation to find out if it's something that's in the pipeline being worked.

Janett Checo: I'm glad to send the e-mail detailing out to these examples. Will I get to you—I mean, we have specific issues that are related, and I could trace it back without giving you PHI.

Female: Well, that would be excellent if you would send us that. We would like to make sure that if there is an issue that it's not falling through the cracks.

Janett Checo: OK, and as a follow-up: the young lady that mentioned the 31279, as a clearinghouse—we too have seen this happen across the board, across the multiple MACs, with that RTP indicating that we've submitted both ICD–10 and ICD–9 on the same claim. Just for sake, I did check all the outbound files and no, we are not submitting in that fashion, of course.

So I do believe there is a DDE issue. I mean, I can help just support her statement as well that there is an ongoing problem. But there is no posted associated with this being identified at the DDE issue today.

Female: We haven't heard that until this call. So thank you, Janett we will look for that e-mail from you.

Janett Checo: OK, thank you.

Holley: Your next comes from the line of Sharon Nichols.

Female: Sharon?

Operator: And that question has been withdrawn. Your next question comes from the line of Andrew Belz.

Andrew Belz: Hi, can you hear me?

Female: Yes, is that Andrew?

Andrew Belz: This is Andrew Belz. I'm with Software Group out of Nashville. We develop software for our clinics, and of course 5010 has been a nightmare, not too much for us, but I see that there is not enough compassion by CMS for the software vendors and clearinghouses. We have to tackle with MACs and their interpretation of the 5010 spend it clearly is a nightmare. We finally decided and successfully install six different programs to file 5010 claims with six different MACs.

Medicare, Railroad Medicare, Medicaid—you name it. It's just—I could not believe that the interpretation of the 5010 standard can be so different amongst the MACs. Normally, they should have been able to give our clients one program to file 5010 claims, but there are so many exceptions by each vendor.

Our last problem is that, claims their patient has secondary insurance of Medicaid, they want to, they insist on getting a group number and a plan number. Well, even the person who answered the phone at the MAC, you never heard of the group number or claim. I mean a plan name of Medicaid.

But anyways, the batch all the claims that we checked for the reason that there is no clue of our plan. So we fudged it. We put in arbitrary number one, two, three, four, five and we fudged a name, and soon enough, they get through. That really is strange. If it's terrible that we have to resort improvisation of.

Female: Andrew, I'm sorry that you are having such a difficult time. From a Medicare fee-for-service perspective, is there something we can help you with today?

Andrew Belz: Well, I've been waiting for four weeks now to get an answer from that MAC about the group name and on the plan name and the group number, we still haven't heard. So I probably will just have to improvise with it. But it is a pity, the MACs can implement 5010.

Female: You know Andrew I would caution to you as a software vendor changing any of the data that the provider is trying to bill by backfire, and that's not a wise

thing to do. If you want, if there are questions that you have specifically, you could send us an e-mail in that resource box and you did mention several of our lines of business. You mentioned Medicaid, you mentioned Railroad board, mentioned Medicare fee-for-service.

Those are different lines of business, and they may truly have different editing requirements. So if you do have questions about how to address—yes, the standard should be the standard, but within it there may be different data content requirements by line of business. So if you have questions, you could certainly send them to that e-mail address that—we you need—just to send it again to read it again.

Andrew Belz: I've got it. Thank you, thank you for your time.

Female: OK, Andrew. Thank you.

Holley: Your next question comes from the line of Marlene Wright.

Crystal: Hi, this is Crystal. Marlene has to step out for another meeting. We represent Medical Insurance Filing Services. Going back to the MSP issue, I know something was mentioned that a fix is in place for March 5th, but I didn't really catch what the fix is for. We're currently having a problem with our secondary claims going to Medicare.

The primaries are placing the payment or placing the claims to deductible. When we send the claims to Medicare secondary we are getting rejections stating that the primary payment information is required. There is obviously no payment because these claims are going to the deductible.

There is only adjustment, is that part of the issue that is being fixed, and the second part of that question: We are also having an issue with secondaries from Medicare. Medicare is crossing over known the claimant the secondaries. Secondaries are either not getting those crossovers, or they are getting the crossovers, but the payments are being sent to the physical addresses instead of the PO boxes, which are specified on the claim.

Secondaries are just telling us, they are sending the payments to addresses that Medicare is providing to them, and our MAC is telling us that, well, we are sending to the secondaries to information that you are sending to us. So it's like everybody is trying to put the blame on somebody else, and we are getting no answers from anybody.

Female: Well, from the chart that I'm looking at, I probably— I'm not able to answer your question in detail because I'm not sure we are going to be able to dialogue our way to making sure we're on the same page. I have an MSP payer A is not mapping to the CLMs. Let's see, that's going in on March 5th.

I have a COB C change going in with an MSP payer number two. There were issues with a CAS, a CAS segment that's going in on March 5th. We have some other fixes that are all going in March 5th. But for us to truly know if we've addressed your particular problem if it's included in the fixes, it would be best if you would send us the details in an e-mail. And then we could get back to you on whether or not we think that we've captured your problem with these fixes.

Crystal: OK, and what's the general turnaround time for these e-mail responses, because I know when I call our MAC, they will tell us, OK, we will send this to another department, they will get back with you within 7 or 10 business days, and we won't hear for a month.

Female: If you give us the details—and your name again is (Crystal) on behalf of Marlene from Medical Filing Services—we can get back to you in a week.

Crystal: OK, thank you.

Female: OK.

Holley: Your next question comes from the line of Jaime Hebert.

Jaime Hebert: Hi, my name is Jaime. I work for Acadiana Computer Systems. To quickly address the last girl that was on the call, we had a lot of issues with payments

being mailed to physical address instead of PO Boxes. And what it took for us is calling all of the different payers—and this had nothing to do with CMS or Medicare—but calling payers and changing the enrollment form addresses, PO Boxes. So it was an enrollment issues for us in our instances more so then what we were submitting on the claims that might not even been looking at PO Boxes submitted on claims.

They were looking at enrollment forms as to where to send the payments back.

Chris Stahlecker: Jaime, pause you for a second, and now you're saying that from as being the COB receiver, right. The secondary payment.

Jaime Hebert: Well, we are a vendor and a clearinghouse, and a lot of our providers are calling in saying we are getting our payments sent to the hospital, and we need them sent to our lockbox.

Chris Stahlecker: OK.

Jaime Hebert: We were sending out the correct information, but what was enrolled, the particular payer was a physical address and not the PO Box, and the payers were looking at the enrollment forms and not what was being submitted on the claims. So we got it fixed by calling and fixing enrollment.

Chris Stahlecker: That's great. Thank you, Jaime. Thank you for your patience. Now what was your question?

Jaime Hebert: Well, my question is, we work with three different MACs, and we honestly have had no problems at all with WPS and really hardly any at all with Trailblazer. We are working with Palmetto GBA. We're in that weird jurisdiction seven for Louisiana, who is transitioning still and don't have a true MAC. And Palmetto GBA is processing our claims for our fiscal intermediary, our consultant, Blue Cross. We've had many problems like I think your caller's name was Tom, had. But we would get a good 999, a good

277 CA, we thought: send it back out to our providers, and then our providers call us and say, well, the claim is not even on file.

When we called, the claims weren't on file. But we got back a 277 CA. Our fiscal intermediary got involved with us and helping out to contact Palmetto GBA for us, and they didn't put our claims into the Medicare system, which scares the hell out of because we were getting back 277 CA's valid some rejections, a lot accepted.

But they weren't getting into the Medicare system. We went back to 4010 because—and we're scared now to move and 5010 because we heard this happened three different occurrences with Palmetto GBA in particular. We just wanted, I guess to let you know that that's the reason that we are not going 5010 until last possible second because we don't want our claims to go missing, and that really is loss claims for getting back valid good reports, and they weren't getting into the Medicare system.

And this is validated by the fiscal intermediary. We talked to them and they said that's absolutely right, what you are saying.

Chris Stahlecker: Yes, Jaime. Thank you for bringing that up, it is unfortunate that that happened. Honestly, with the information that we have—and I'll ask Sue if she wants to say anything in just a minute—the information that we have, and it's normal operational procedures when the claim file is introduced into the FIS system.

If there is a problem with it, certain claims will be stripped off, and it is the MAC's responsibility to get those claims input fixed—fixed and into the system. And there are operational procedures that start with the data center that's executing the file, and they are the ones who recognized the jobs go down and recognize that claims need to be pulled off, and their job is to notify the MAC.

But unfortunately, the problem here is, stemmed from not having Palmetto on the list to receive the notification. So, in that situation Palmetto was

uninformed that the claim file had been stripped, the EDs, our enterprise data center thought they follow the appropriate action to notify the appropriate people. But the chain of receiving that notification was not correct and I do…

Jaime Hebert: You know, when this was fixed—because we will move back to 5010—but we are just so nervous at this point, because we heard twice after we move back to 4010 that it occurred again.

Chris Stahlecker: We, we're aware of it. I believe there have been some problems the first week in January, and then out again the first week of February. So we believe…

Jamie Heber: So, they were still not, sure then.

Chris Stahlecker: Pardon me?

Jamie Heber: You are still not sure everything is been fixed?

Chris Stahlecker: It's been corrected the first week of February.

Jamie Heber: OK, and we are positive because this happened to us, the first week in December and last week in December, and we just do not want to move back to the system that's not going fail it, that's going to fail us. They are not even going to be our MAC soon, and that's what I think first in our place the most—because we are going to move somebody else from April or May, whenever they decide our this jurisdiction stuff. And in this MAC that we have to use, we are getting forced to use, that is not even going to be our MAC is losing our claims.

I mean, I bill for 6,000 claims for our providers every day, and it's not nice to call five different hospitals and say, guess what, they didn't get your claim three weeks ago. We just found out.

Chris Stahlecker: I can appreciate the frustration, and that is very unfortunate, and the claims to my knowledge has all been recovered and processed.

Jaime Hebert: They have, but we went back to 4010 because we didn't want it happening again to us.

Chris Stahlecker: I can understand the reticence, but we can only advise that the fix has been put in and.

Jamie Heber: And you said the first of week for February?

Chris Stahlecker: That's right.

Jaime Hebert: OK, I appreciate it. Thank you so much, Chris.

Chris Stahlecker: OK, Jamie.

Holley: Your next question comes from the line of Laura Pineda.

Female: Laura?

Laura Pineda: Hi.

Female: Hi, go ahead. Is that Laura?

Holley: That question has been withdrawn. Your next question comes from the line Debra Farley.

Debra Farley: Yes, we represent—I represent a Medical Billing Annuity and Electronic clearinghouse, and the previous caller was worried about you went back to 4010. We experienced the problem especially, the first two or three weeks in January. Our claims that were transmitted on January 4th, actually did disappear. We called Medicare. We got our 277's back, et cetera. We resubmitted all the claims and have received payment. They have not been denied as duplicates. There were other short-term problems, but just to allay her fears, we have never went back to 4010, 5010. We are experiencing no problems right now.

Our only comment is, if the MACs would send the listserv when there is a problem—and I appreciate you stating there were startup issues when you know 5010 came aboard. But we are experiencing one problem with our current MAC that we, concerning a few CPT codes. They know—there's a known problem but all the claims are being denied by all of our providers. Again, this was just a comment, and thank you.

Female: OK, thank you, Debra.

Holley: Your next question comes from the line Tim Brosseau.

Female: Tim, are you out there?

Tim Brosseau: I'm with DataTel Solutions, we are software vendor. My question is just on MSP claims.

Female: OK.

Tim Brosseau: And 2430, SVV01.

Female: Can you speak up a little bit? Tim, we are having a hard time hearing you.

Tim Brosseau: OK, how about now?

Female: That's a little better.

Tim Brosseau: OK, my question is on the MSP claim in loop 2430 and segment SVV01. The MAC asked for a payer ID of the primary—basically, a primary payer ID on the primary payment—and my question is, what should we put there, when the primary payment, when the primary payer went on paper?

Female: Well, you know, you stumped us. What's the Car Talk? You stumped the chumps. Could you send us an e-mail on that one and either MACs on the call. Are you able to speaker to hear or anything that you can advise? [A

pause.] Would anyone who wants to speak up? Well, you stumped us there, Tim.

Tim Brosseau: I will send an e-mail on that one.

Female: OK, thank you.

Tim Brosseau: My other question is, where we can get a listserv for the March 5th release?

Female: That's a great suggestion. We will get a listserv message for the content of what the March 5th release will contain. That's a good suggestion. We can inform, work to form that message and then share that with the MACs for distribution.

Tim Brosseau: Good. I appreciate it.

Female: And what was your last name, if you are still on the queue.

Holley: His last name was Brosseau.

Female: Thank you.

Holley: And your next question comes from the line of Michelle Voss.

Leslie: My name is Leslie with Muleshoe Area Medical Center, and when we started 5010, we received rejections on our Medicare claims, all of them. A very non-specific generic that we had invalid data. There was no segment anything like that listed. We had got in touch with our clearinghouse.

Our clearinghouse said that it was, we needed that information for Medicare. We contacted Medicare, they said it was our clearinghouse's responsibility to find out what was wrong with these claims. We've gone back to 4010 in the process of this because of this rejection. But we tried to find out what is wrong with the claims on our own.

But somebody said something about the linkage, of how do we find out if we are linked or if this is our clearinghouse? If that's their responsibility to link with you. We tested and our testing went fine. And we just submitted some claims 5010 yesterday, and they came back with the same rejection.

Female: So, what format—how are you are receiving the rejection information? What does it look like? Are you getting a 277 Claims Acknowledgement transaction?

Leslie: I would suppose it would be the same. It is not called that on our, with our clearinghouse that it's a delayed payer report. It's what we get from Medicare.

Female: Both your term there "delayer payer report" implies to me that the clearinghouse is taking the 277 Claims Acknowledgment transaction generated by Medicare and reformatting that for you into this delayed payer report, and it's in that reformatting process that we think probably some of this detailed information is being lost.

So, it would be a responsibility of your clearinghouse to take 277 Claims Acknowledgment from the MAC and format that into something that is readable by you, so, that you can understand how to correct your claim. If you want to send us the details about which MAC you are using, and we might—and which clearinghouse you are using, we might be able to leverage your situation between the two and see what help we can get for you.

Leslie: OK, that would be great. Where would we send that?

Female: To that e-mail address we've been talking about. Do you need to hear it again?

Leslie: Yes.

Charlie Eleftheriou: That's going be, excuse me. The e-mail address is going to be 5010ffsinfo@cms.hss.gov. And unfortunately, I think we've reached the end of our allotted time. So, that will have been the last question.

Chris Stahleker: Thank you all for participating in today's call. We hope that you found the information helpful, and if ,well, we do look forward to working closely with you through this transition time.

Charlie Eleftheriou: We do have one update to announce. And I'm going hand you all over to you Angie Bartlett from OIS.

Angie Bartlett: Hi, this is Angie Bartlett. I just want to let you know that on the Web site that we were talking of earlier on the cms.gov/version5010andd.0, that we now have this recently published, the listserv announcing—we have a Web posting, and we are going to keep that updated with information we feel is important to you, and we will help you throughout this transition. That document has been posted at the top of the page now.

We will be sending a listserv about this today and as well as next week and as soon as it is updated. That will help throughout, and look for that as well.

Charlie Eleftheriou: OK, and that page one more time. It's cms.gov/version5010andd.0. That's going to bring us to the end of our call. I would like to thank everyone who participated today, and if you'd like to complete the evaluations in today's call, the Web address again is npc.blhtech.com. And thank you very much. Have a great rest of the day and a great weekend everyone.

Operator: Thank you for participating on today's conference call. You may now disconnect.

END