Centers for Medicare & Medicaid Services
National Provider Call on the Current Status of
Medicare Fee-for-Service Implementation of
HIPAA Version 5010 and D.0
Moderator: Charlie Eleftheriou
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Contents

Operator: At this time I would like to welcome everyone to the National Provider Call on the Current Status of Medicare Fee-for-Service Implementation of HIPAA Version 5010 and D.0 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.

This is Charlie Eleftheriou from the Provider Communications Group here at CMS, and I'll serve as your moderator for today's call. I'd like to welcome you to this Medicare Fee-for-Service National Provider Call on the current status of HIPAA 5010 implementation.

Today we have CMS subject matter experts here to address the current 5010 and D.0 metrics and share recommendations made by Medicare Fee-for-Service as well as possible outstanding fixes impacting the Part A and Part B versions of 5010 transition.

Before we get started, there are a few things I'd like to cover. First, the link to the slide presentation for today's call was included in your confirmation and reminder e-mails, as well as it was e-mailed to all registrants earlier this afternoon.

If you did not receive the link to the presentation, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls resource box. You may also locate the presentation on the National Provider Call section of the CMS Web site at www.cms.gov/npc, as in National Provider Calls. Again, cms.gov/npc.

Then, to the National Provider Calls and Events link, which is found on the left side of your screen in the navigation panel, and from there you can select today's call from the list. Today's call uses the Adobe Connect webinar technology which allows you to join a virtual meeting room and view and follow today's presentation as it's controlled by the presenter.

A link to the webinar room was included in the e-mail mentioned above and can also be found on the National Provider Call section of the CMS Web site. Again, that Web site link is www.cms.gov/npc. There you'll find instructions on how to join this Adobe Connect webinar and other details about the call.

Please note that you do not need to join the Adobe Connect room in order to participate in today's call. You may participate in the audio only, should you prefer. If you do choose to join us on Adobe Connect, you still need to listen to the audio over the phone.

Lastly, a reminder that today's call is being recorded and transcribed, and an audio recording and written transcript will be posted to the National Provider Call details page. I'd like to thank those of you who submitted questions in advance when you registered for today's call. Your questions were shared with the speakers to help prepare slides for today and remarks for today's presentation.

At this time, I'd like to begin by introducing Christine Stahlecker, Director of the Division of Transactions, Application and Standards – Applications and Standards – in the CMS Office of Information Services – excuse me.

Chris?

Christine Stahlecker: Thank you, Charlie. And welcome, everyone, to today's call. It's our 24th National Provider Call – unbelievable. And we do appreciate your persistence and continued support as we complete our transition to the new format.

There will be several outreach calls between now and July 1st in support of OESS direction; we'll get into that in just a moment. But today's call is the

second in such planning. The first was last week that WEDI had issued and sponsored a call, and OESS had played a heavy role in that agenda.

Today, here at Medicare Fee-for-Service, we do not have any direct questions or followup items that came to us as a result of that call. However, they may be in the pipeline on their way to us.

But we just want to share, looking at slide number two – the purpose of today's call is to share exactly where Medicare Fee-for-Service is with its transition progress. And to go over some of the top concerns that we've been addressing since we've been on this journey, and finally, to give most of today's time to hearing your feedback and issues that you're still facing with Medicare – with your implementation of exchanging HIPAA EDI transactions with Medicare.

Charlie had said some of today's agenda was in response to a feedback from our earlier call. And I did want to assure you that I'm not sitting here all by myself at the table. We have Mike Cabral who is our – you all must know Mike from the support that – you've come to know him as our industry point of contact for the X12 EDI standards as well as Sumita Sen on our 835 remittance transactions.

We have Jason Jackson who's stepped into the role of the claim status and done a lot of the reporting. And Brian Reitz is also in the speaker queue on the 837 professional claim as well as Matt Klischer in the speaker queue for the 837 institutional claim.

We also have Brian Pabst here on the coordination of benefits side on the COBC crossover claims. So, Brian will be able to be in fielding questions up until about 3 o'clock. I just want to let folks know that if you're hitting the Q&A line that Brian has a hard stop at 3 although our call continues until 3:30.

I also want to make mention that we do have nearly every single MAC represented in our speaker queue. So when it does come time to voice your questions and concerns we have nearly every MAC on call in the speaker

queue if you wanted to direct anything to them. And we may be asking for their support in fielding some of the questions that come on.

So, looking to slide number three, we do have reference to the new enforcement date that starts July 1st. So, OESS has issued guidance that it will not enforce any noncompliance with HIPAA standards until July 1st through any of the time remaining through June 30th.

So, what you can expect from Medicare Fee-for-Service is our session subject today. We were in the listening queue on WEDI's call last week. So we have – today's call set up especially for Medicare Fee-for-Service, we have another Medicare Fee-for-Service call scheduled for May 16th, and there will be a regional office sponsored event. So, three different areas across the country that both calls will be hosted, three separate calls hosted all on June 19th, hosted and sponsored through the Regional Office.

We understand that WEDI will have another national event to be scheduled sometime between that May and June timeframe, but that date is yet to be determined. And, again, that is with a lot of support from our OESS area. They really wanted to hear where the industry is as a whole and not just one payer, as today's call is focused on Medicare Fee-for-Service.

With that, I'm going to turn the presentation over to Jason Jackson, and he's going to walk us through some of the metrics on the Medicare Fee-for-Service slides, beginning on slide number four.

Presentation

Jason Jackson: OK. So, we put them on our Web site, probably about two months ago, the stats up to date, and I'm actually in the process of updating them. So, for Part A claims, Medicare Fee-for-Service is currently at 92 percent for 5010, and our submitters are – 73 percent are already transitioned to 5010. On Part B and DME claims, we're at 95.7 percent and – of the claims, and 71.1 percent of the submitters, in PPDP were at 97.7 percent and submitters only 9.1, but that number is in the process of being cleaned up right now. Eligibility is currently leading the pack, for the most part, at 95.9 percent, with 76 percent.

And then on slide five, our month to date for the remittance activities, we are at 32.1 percent for Part A and 59.7 percent for Part B. And the submitters for both are right around 44 percent. Our MACs currently are doing a lot of intense outreach to all the providers out there, narrowing down who needs to be –needs to be converted over and, you know, as we will do the next two months, there is going to be a lot more outreach coming from the A/B MACs and the Legacy guys.

On that note, I will turn it over to Angie Bartlett for the rest of the presentation.

Angie Bartlett: Thank you very much.

Now we're going to talk about some of our top operational concerns as we've seen the 5010 moving into production mode.

Medicare Fee-for-Service has learned that submitted claims may have failed during several of the handoffs in the delivery process to the Medicare administrative contractors, the MACs we've talked about earlier, and some of these claims may have never reached the provider or the submitted claims.

Therefore, don't assume that Medicare has lost your submitted claims. The provider is using another entity to get its claims to the MACs. So tracking should begin with those entities, such as your billing, your clearinghouse, or your vendor.

In addition, providers that use clearinghouses' billing services or vendors to electronically submit Medicare Fee-for-Service claims must request an update from their MAC or EDI authorizations to version 5010 in production.

If you believe you've not been properly transitioned to 5010, please contact your MAC in order to be properly set up. For security reasons, the provider must identify their clearinghouse or billing entity that they're trying to use to perform this transition. MAC is not permitted to accept this information from the clearinghouse without an audit trail to show that the provider has requested to be moved into 5010 production.

In addition, Medicare has been made aware of issues surrounding the new health care claim acknowledgment, the 277CA. In effect, the providers may have difficulty receiving the information from the clearinghouse inter-billing service.

Medicare has issued guidance and education materials from submitters to address this issue. As a reminder, the Medicare Fee-for-Fee program offers free low-cost billing software available from the MAC or providers which act as a health care claim acknowledgment in a more easily readable format.

In addition, we were having earlier this year some concerns with NDC codes not matching up to the FDA files. We believe that most of this has already been corrected and the edit has been fixed. But if you continue to see some additional problems with your NDC codes, we'd like to tell you just contact your MAC and we'll look into that a little bit further, because at this time we believe that most of these concerns have been fixed.

As well as providers may have experienced claims receiving a 277CA for claims that can't be seen in the adjudication program. What is happening in this scenario is that providers are logging in to their DDE systems and are not seeing the claims to match up the 277CA.

Medicare has implemented fixes to correct this error. So if you are still experiencing a 277CA claim that you're not seeing in your adjudication systems, we encourage you to please contact your MAC and work in figuring out that process.

On to the next slide, on this slide seven, one of our other top operational concerns is that the P.O. Box in the Billing Provider Address Loop is causing providers difficulties. We haven't been hearing this issue rise much. We think that a lot of people have to figure it out and figure out what you need to do with the P.O. Box. But just to make everyone aware, this has been brought up.

Now, I'll turn it over to Sumita. She's going to speak on some of our 835 production fixes.

Sumita Sen: Hi, everyone. You can – as you can see from the statistics, you know, we just presented that we are a little behind claims with our remittance transactions, and we have been working diligently to make sure that any and every issue is identified and resolved ASAP.

Now, this list basically shows the top issues that have been identified and have been resolved with the May 7 production date. I'll just go very quickly into what the issues are.

The first one deals with new health care policies that mention 5010 that, for Medicare, will report the NCD/LCD code in their REF segment and then provide that URL at the claim level PER segment. And this will help you find detailed information about the NCD/LCD policies.

And, for example, the HCPCS, (inaudible), and ICD code combinations that will get paid and the rest of them would not get paid. This is – we believe this is really going to help you. So we have to make sure that this works perfectly.

The second one deals with the (inaudible) appropriate code to explain that (inaudible) audit contractor (inaudible) assessment. Right now, you know, we're having some issues with – reporting appropriate codes. So, you know, we also, for this one, we have (inaudible).

And the next two – number three and number four – these deal with the creation of incorrect CAS segments when there is no adjustment. So that is also – I mean, those two issues, one at the claim level, one at the line level, they have been corrected also with (inaudible).

The fifth one basically is a duplicate of the second one. So these are the most important 835s that, you know, we have identified, we worked with, and we have resolved and I will make a comment. If you have any concerns or anything, please make sure that you send your comments to the resource mailbox so that we know your concern, and we can take action on that.

With that, I will go back to Angie.

Angie Bartlett: Thank you very much, Sumita.

Our next slide, slide eight, we have up here our A and B MACs and our CEDI contacts. So if you want to look through and just make sure that you can figure out which MAC you're located in and which MAC you're referring to, as I said, we have this – first, is the Web site. You can go in and pull this down another time, and you can visit this URL and contact your MAC.

On to slide nine, here's the MAC help desk information. Medicare administrative contractors are the administrative arm of Medicare Fee-for-Service. So that means that any claim or other transaction you submit to Medicare Fee-for-Service goes to your MAC first. So use these links here to help you go through and find out more information about your particular MAC and to locate information on their Web sites.

On to slide number 10, we've been working pretty diligently this year as well as 2011 to update our Medicare Fee-for-Service communication. We have multiple FAQs out there, and we have our side-by-side update, MLN articles. We have – this is our 24th national call. We have all of our past national calls. We have the associated questions and answers with those as well.

And we have some technical documents up there. So, please, use the sites listed here to go on and find out what these technical documents are. And if you don't have the presentation in front of you right now, or you don't have it printed out, please go to our Web site.

Charlie, can you read off that Web site link one more time and pull down the information?

Charlie Eleftheriou: Absolutely. The Web site link is www.cms.gov/npc – again, as in National Provider Calls – www.cms.gov/npc.

Angie Bartlett: Now, on to our last slide, number 11, we're going to move in to our question and answer session now. And we hope that you use the opportunity to ask us questions. If you want to address your question directly to one Medicare administrative contractor, one of our MACs, just please point that out during your question and we will have them address it as well.

And you'll also see that our Medicare Fee-for-Service Outlook resource mailbox on there. It's 5010ffsinfo@cms.hhs.gov. This Web site or this mailbox will be open to take your questions.

Charlie Eleftheriou: Actually – I'm going to interrupt one quick second, Angie – before we run into Q&A, I wanted to do some keypad polling quickly. It's just a quick pause for a few moments so CMS can get an accurate count of the number of participants that are on the line with us today.

There may be a short moment of silence while we tabulate results.

Holley, we're ready to start polling whenever you are.

Polling

Operator: OK. 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 and attendants to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad to 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 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 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. Please continue to hold while we complete the polling. Thank you. This concludes the polling portion of the call.

I'll turn the call back over to you, Charlie.

Charlie Eleftheriou: Thanks a lot, Holley.

We can now begin our Q&A session. Let me just remind everyone that this call is being recorded and transcribed. Before asking your question, if you'd please state your name and the name of your organization, we'd appreciate it.

And in an effort to get as many of your questions as possible, we ask that you limit your question – sorry – we ask that you limit your question to just one. If you have more than one question or would like to ask a followup question, you may press star, two to get back in the queue and we'll address additional questions as time permits.

Now, Holley, we're ready to take our first question.

Question and Answer Session

Operator: To ask a question, please 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 pickup your handset before asking your question to assure clarity. Please know that 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. Please hold while we compile the roster.

And your first question does come from the line of (Sherry Shriner).

(Sherry Shriner): Hi. I just have a question about re-submitting claims. We were denied because of our address was wrong, but we had it correct in all the lines that needed to be filled out and we still got rejected. Could you answer that, please?

Christine Stahlecker: Could you let us know if that's an institutional claim or a professional claim?

(Sherry Shriner): It's an institutional claim for Medicare Part A.

Christine Stahlecker: Part A, and what MAC did you send that to?

(Sherry Shriner): Noridian.

Christine Stahlecker: Would Noridian be able to respond to that question, or would you like us to take some information from the person and contact them offline?

Matthew: This is Matthew with Noridian.

(Sherry Shriner): Hi, Matthew.

Matthew: I think we need to look into a little bit more than that depending on what the actual rejection was. So, yes, if you can get some additional information, we can have somebody contact you with those rejections.

(Sherry Shriner): OK. That would be great. That would be great.

Angie Bartlett: If you submit your information with your name to our Medicare Fee-for-Service resource mailbox, and then I will direct that to Matthew.

(Sherry Shriner): OK. Thank you.

Angie Bartlett: Thank you.

Charlie Eleftheriou: And that e-mail address should be showing up on your screen currently. It's 5010ffsinfo@cms.hhs.gov.

(Sherry Shriner): OK. Thank you.

Christine Stahlecker: And some of the information that you might want to include in that e-mail in the resource box would be a submitter ID that you've used and the date that you sent in the corrected claim.

(Sherry Shriner): OK.

Christine Stahlecker: And also the error message that you received back.

(Sherry Shriner): OK. Thank you.

Charlie Eleftheriou: All right. I think we're ready for our next question.

Operator: OK. And your next question comes from the line of Secunda Jenkins.

Secunda Jenkins: Yes. This is Secunda. We send our clients to Cahaba, and all of our 141 bill tabs are just being returned to us on the correction screens, but even Cahaba themselves do not know what's wrong with them, and ours has worked from our facility, but we've got like 600 bills sitting out there since January that just haven't been processed and we can't get them processed.

Christine Stahlecker: OK. So, you're saying that these are institutional claims as well being returned to you – the DDE screen for FISS, is that correct?

Secunda Jenkins: Yes, ma'am.

Christine Stahlecker: OK. And that you've been in touch with Cahaba as your MAC, and they haven't been able to determine – do a root cause determination on what those issues are?

Secunda Jenkins: No, ma'am.

Christine Stahlecker: So, if you, too, put would put something into the resource mailbox, then, we may have enough details to jointly work with Cahaba and our shared system maintainer for the FISS system to determine the next course of action.

Secunda Jenkins: OK. So I just need to go to this e-mail address and put my problem in?

Christine Stahlecker: Yes, and...

Secunda Jenkins: Sorry. I wasn't paying attention. I was getting on the line while you were explaining that.

Christine Stahlecker: Right, right. So you have the resource mailbox, right? Do you need to have that repeated to you?

Secunda Jenkins: Please.

Christine Stahlecker: 5010ffsinfo@cms.hhs.gov.

Secunda Jenkins: OK.

Christine Stahlecker: We'd ask for your submitter I.D.

Secunda Jenkins: OK.

Christine Stahlecker: And although the previous caller (Sherry Shriner), I didn't get it out in time that we should ask you to submit your provider identifier, your NPI, if – not any protected health information, of course, which is – I was puzzling about when – if I didn't get it out. We don't want PHI.

Secunda Jenkins: OK.

Christine Stahlecker: But your NPI should not be necessarily considered PHI information. So again, this current caller and the prior caller, if you would please include your NPI and the date – at least, a date of – a sample of – I guess I can't ask the current caller to give us much more.

Secunda Jenkins: No. Thank you.

Christine Stahlecker: OK. That'll be fine.

Matt Klischer: Perhaps, excuse this – this is Matt Klischer.

Also, could you also include the reason code that you're getting back from the DDE system, please?

Secunda Jenkins: Yes, sir.

Matt Klischer: Thank you.

Christine Stahlecker: All right, thank you.

Operator: Your next question comes from the line of (Donna Sinderman).

(Donna Sinderman): Yes. I wanted to ask a question regarding the slide where it says providers may have experienced claims receiving the 277, where we – we use a clearinghouse to submit our claims. We do receive a 277 acknowledging receipt of claims. But when we go in the DDE system, our claims are not there. We have contacted our MAC, TrailBlazer, EDI Department, and when

we asked them about why we have – an ICN is even assigned to the claim, but you can't see it.

Because we're submitting 5010, they won't talk to us. They say they have to go – they have to deal with the clearinghouse. And it's not – it's sporadic. We have claims that get there and then claims that, you know, say that they got there, but they're not there.

So, how do we go about – because you say here we need to contact our MAC?

Christine Stahlecker: Paula, would you want to take that question?

Paula: Hi, Chris. This is Paula. I'm not actually over the EDI helpdesk area. I don't know if there's someone on – is Pam on today?

Pam: Paula, I'm on. This is Pam.

Paula: Thanks.

Pam: (Donna), you've contacted the EDI – our technology support center number?

(Donna Sinderman): Yes, ma'am.

Pam: OK. Can you give me your direct number? And after this call I'll give you a call and see if I can assist you in what transpired when you've actually spoken with us.

(Donna Sinderman): OK.

Christine Stahlecker: You could ask (Donna) to put that in the resource mailbox rather than out on the – on the audio part of our call here, (Donna), if you'd be inclined, and we could make sure that Pam gets that information.

(Donna Sinderman): OK. I'll do that.

Christine Stahlecker: Is that all right? OK. Thank you.

Female: Thank you.

Christine Stahlecker: OK. We should take the next caller.

Operator: And your next question comes from the line of Michelle Hamel.

Michelle Hamel: Yes. My question is regarding the Medicare Fee-for-Service transition statistics. I was just wondering if someone could explain to me how to read that chart really quickly.

I'm looking at the Part B DME, and from month to date, does that mean that 59.7 percent of claims are being submitted in 5010?

Jason Jackson: OK. We're on the slide four. And this is Jason Jackson. All right, now, in this slide, it's – yes, month to date, you know, where we stand overall for the Part B DME – 95.7 percent of all claims coming out of Part B have been in version 5010.

Michelle Hamel: OK. For some reason, I had a chart – my chart showed up with some different figures on it. I'm not sure what that was, but the numbers were a little bit different than the ones I was looking at.

But I may be experiencing technical difficulty.

Jason Jackson: Did you see the 59.7 percent ratio?

Michelle Hamel: I did. Yes.

Jason Jackson: OK. That's on slide five – that's on the 835 remittance advice – only 59.7 percent of the 835s have gone out in Version 5010.

Michelle Hamel: OK.

Jason Jackson: So, slide four, that was the inbound claim; slide five, 59.7 percent, that was on the outbound remittance advice.

Michelle Hamel: OK. And for submitters, we're referring to clearinghouses and vendors?

Jason Jackson: It's clearinghouses and providers, whoever is the actual entity submitting the claims to Medicare.

Michelle Hamel: OK. Perfect. Thank you so much.

Jason Jackson: You're welcome.

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

(Nick): Good. This is (Nick), first of all, with Gordian Medical.

I have a question. We billed some claims back in November with the 4010 format and they were delayed by the region in processing them, and they actually weren't processed or sent through until after April 1st.

Therefore, we just received notice of an N-2226 error in the crossover because they were not crossed over, but we already received the EOBs and we're talking 10,000-plus claims. So we're at a quandary here of why it happened and how we're supposed to go about this.

Female: How you are supposed to go about what – correcting the crossover claims?

(Nick): Well, no, they didn't – the crossover – we sent – submitted the claims within the timeline. This is in November of 2011 and – to Medicare, and Medicare paid their part after April.

And since they crossed them over after April, even though we submitted them back in November, they did not cross over properly because they were the 4010 format, but those claims were submitted in November.

Christine Stahlecker: Well, there [are] a couple of questions rolled up in here. You're, number one, asking about why there was a delay in processing claims you submitted in November, why did it take until April to pay those claims?

(Nick): We know why there was a delay.

Christine Stahlecker: OK. I mean, I would have imagined you would have been following up with the individual MAC that was trying to complete that processing and you're fully informed.

(Nick): Yes. We were on payment suspension from the (ZTECH) – was why it was delayed.

Christine Stahlecker: OK. So now that you have the Medicare claim paid, your question is really about...

Brian: Probably what happened – sorry, this is Brian – is that by the time that came through in April, the trading partner that we were going to direct the claim to was in 5010 production.

(Nick): Correct. And the question is – so, because of payment suspension, we're now required to manually bill tens of thousands of claims to multiple secondaries?

Christine Stahlecker: OK. The policy folks for, if there is any opportunity for having an electronic crossover occur, there needs to be a triggering event, and usually a submitted claim completes its Medicare adjudication process and then initiates the crossover process, so sort of a domino effect.

And without – with the interruption in the Medicare claims process, it seems to have interrupted the automatic triggering event for the crossover. We'll have to research that and if you give us your name – we don't have an answer sitting here at the table or in our queue.

Brian: I fear though that because of the way this all works, and I hate to be the bearer of bad news, it is – as Chris is saying– it's a point in time thing, because when that claim came through, they were released maybe in April, you were in suspense for a while. At that time, the claim came through our system and the question being asked of the receiver is, "Well, what for format are you now accepting?"

And the receiver was not accepting 4010 anymore. So, I know you know why it happened, but I'm sorry it happened. But I don't think – I really don't think there is anything we can do to reverse that.

(Nick): So, if the enforcement is extended until June, you guys still aren't crossing for the secondaries, from 5010 to 4010 or 4010 to 5010 like you…?

Brian: What it is, we have the ability to convert. Like, if someone is still a 4010 receiver which could happen until July. If a claim came in 4010 – I'm sorry, 5010, we can convert it back to 4010 or vice versa, if it came in 4010 to 5010. We could do that.

We have a rule that we only allow – we only require trading partners to accept two weeks of claims once they move into production from the earlier format.

So if someone is now 5010, they are only required to accept 14 days' worth of 4010 production run-out.

(Nick): OK. We can submit, like I said, our contact info from where to go from there. And we've submitted the question to the e-mail addresses as well. It's basically where we go from here.

Brian: OK. All right.

Charlie Eleftheriou: All right. I think we can move to the next question.

Operator: All right. And your next question comes from the line of Thomas Finkenstadt.

Thomas Finkenstadt: Hi. My name is Tom. And I work for EMOI and it's just an integration type of Web site. But we have a question regarding LCD and other edits that were entered into the MACs during the 5010 transition.

We are getting rejections for approved HCPCS codes on the Medicare. But they are not actually Medicare Part B so they weren't entered into the edit system. And they were rejecting on a 277 CA instead of on an 835 for us to submit to secondary insurances for payment.

And when they finally noticed the problem after a couple of weeks of calls, they told me that I would have to call every time a code was coming back bad, that they were not going to review their edit process to make sure they got all the codes entered right. And I thought that was not correct.

I wanted them to be preventative, not reactive. There are a lot codes in the HCPCS book that won't pass Part B but do DME and vice versa that we need to submit and get rejected.

Christine Stahlecker: That is an interesting question that you ask. And without delving into specific code – codes that you're trying to build, we do know that there are some codes in the HCPCS book itself that are labeled not for Medicare use.

And in some cases, those claims being billed using those codes are being rejected through the MAC's front end system and, therefore, unable to be crossed over for secondary payers.

Thomas Finkenstadt: Right. These are codes that are actually marked blue in the book as Medicare-acceptable.

Christine Stahlecker: Right.

Thomas Finkenstadt: And they even had to take it to not only second level but third level to resolve the issue because it was an "operations" issue inside their department in EDI. And then, I said, "well, sir, are they going to go through the whole HCPC book and make sure all of these blue codes are entered?"

No. You'll have to call every time you get a reject in the wrong area.

And I just thought that should be addressed at a national level because I am assuming it's not just the two MACs I deal with. Since it's been more than one MAC.

Christine Stahlecker: And, clearly, that was not the intent. So…

Thomas Finkenstadt: I understand that. I was just bringing it up. It's not really a question so much as – this is going on and it should be addressed to all the MACs from the national level.

Christine Stahlecker: So if you want to send CMS the detailed identification of the MAC where you have experienced this issue, we can follow up with them.

Thomas Finkenstadt: I can do that. Thank you.

Christine Stahlecker: Thank you. Next caller.

Operator: Your next question comes from the line of Jill Butler.

Jill Butler: Good afternoon. My name is Jill Butler. I'm calling from Hill Associates. We are part of jurisdiction 14 NHIC, and this is regarding a professional claim.

When we're billing Medicare as primary for a clinician who is noneligible licensure, we need to get a denial in order to bill the secondary insurance. However, Medicare won't accept the claim. It doesn't even – it rejects on the 277 as a code 562 entity National Provider ID.

Any idea how we can get a claim through just to get a denial for noncovered clinicians?

Christine Stahlecker: Again, that is – the edits that have been billed are to comply with the Standards Implementation Guide, and it does require the use of an NPI. You're caught between a rock and a hard place at this time.

Jill Butler: I know. The clinician has an NPI. There is just not an LICSW, RN – you know, the four billable requirements by Medicare. But the providers are losing because they can't get paid. They can get paid by the secondary insurance but not without a denial from Medicare.

Brian Reitz: This is Brian Reitz speaking.

Jill Butler: Hi, Brian.

Brian Reitz: Hello. One of the things [ ] in the 837 transaction is a new AMT segment that was added specifically for the purpose of bypassing a primary payer if the total noncovered AMT amount . . . .

And I…

Jill Butler: Yes. I am familiar with that.

Brian Reitz: I'm sorry.

Jill Butler: But that's only – in Massachusetts that's only good for Medicaid. It doesn't work for secondary insurances.

Brian Reitz: Well…

Jill Butler: You're not crossing over two insurances like UBH or United Healthcare.

Brian Reitz: I am just simply pointing out that it's available. There is no payer-specific limitation that has been added to the implementation guide regarding Medicare.

So, it's over…

Jill Butler: Even if it's billed they don't accept it. I am familiar with the AMT segment.

Brian Reitz: Right. And that's really the only option that you have. I mean, Medicare is only going to accept claims from Medicare-eligible provider types.

Jill Butler: Right. OK. Yes. They did use to.

OK. So, the message to the providers is don't allow these clinicians to see Medicare clients, I guess. Right?

Christine Stahlecker: Yes. That is not exactly the message. That's not the take-away message. I think the bottom line here is that the standards have some difficulties. Whereas, one payer, such as Medicare, would be required to put in processing capabilities, not to pay the claim, not to take care of its Medicare patients, but only to service the delivery channel to get that claim over to the secondary payer.

And that there is a standard – there is data content put into the transaction to enable a direct electronic bill to go from the provider to that secondary payer clearly labeling that Medicare has no liability. It's only the secondary payer.

So, as far as standards go, we would like to champion the use of that transaction. And if you would like to have Medicare enter into a dialogue

with that other payer, you can clearly request that of us and you can send us that kind of a request in the resource box.

Jill Butler: OK. OK. The only one they are crossing over right now is Medicaid.

So, all our other insurances are not being electronically crossed over.

All right. I'll do that. Thank you.

Christine Stahlecker: OK.

Operator: And your next question comes from the line of Crystal Hawks.

Crystal Hawks: I have a question with regards to the Medicare part A claims.

Christine Stahlecker: OK, Crystal, go ahead.

Crystal Hawks: Our facility is still having issues with the Medicare Part A claim once it's processed crossing over to our Medicaid program on inpatient claims and missing taxonomy information.

And I know CMS had sent some information about that being an issue. I just wondered if anything else had become of that, if that has been resolved, because we are still having that problem.

Brian Pabst: This is Brian from CMS, Brian Pabst. April 2nd, there was a fix put in through FISS to fix the taxonomy problem that has been in place. Though, you might be seeing the effect now because, of course, claims had 14 days from submission to be crossed over if electronic as we follow payment for requirements.

But that fix as far as I know has in fact worked.

Female: OK.

Crystal Hawks: We'll keep watch on it then. Thank you.

Brian Pabst: I hope for good things for you.

Crystal Hawks: Right. Thanks.

Brian Pabst: Yes.

Operator: And your next question comes from the line of Joe Baranowski.

Joe Baranowski: Hi. This is Joe Baranowski with the Emergency Groups Office.

Hello?

Christine Stahlecker: Hello? I'm sorry. Your first name again please. Joe?

Joe Baranowski: Hi. This is Joe Baranowski with the Emergency Groups Office.

Female: Hi.

Joe Baranowski: We currently submit 837P Medicare Part B claims to Noridian for Alaska, Arizona, and Washington. And we're getting 4010 835s for six providers that we do the billing for.

Noridian claims that our specific providers have to log on to their ability total onboarding Web site to add the 5010 835 so that we can receive them. But we should be able to handle that.

So, how can I get those remits added without having to bother our providers?

Christine Stahlecker: Well, the security provisions that surround electronic exchange require that agreement exists between the provider and the Medicare Administrative Contractor.

So, the provider can make a request for Noridian to treat you as a processor of their 835s as if it were the provider. But that request needs to come from the provider directly to Noridian.

It's our security provision. You wouldn't want someone else speaking on your behalf.

Joe Baranowski: Is that done through paperwork or does that have to be completely through the Web site?

(Sean): This is (Sean) with Noridian here.

It is all done through our total onboarding Web site. And there are two ways of actually adding that 835 for the 5010. One would be for the provider to go into their profile and make that update. The other way is if the provider selects you as the managing vendor. There is an option in their profile where they can select you as the managing vendor.

And what that does is it gives you, as the vendor, control over their profile to make those changes there.

So, either-or would work; but, ultimately, it has to be made through the total onboarding Web site.

Joe Baranowski: I can pretty much tell you that it is ultimately going to be us logging on as them and then telling the Web site that it's us who [are] going to add the 835 5010s. I wish it would be easier than that.

(Sean): Well, ultimately, like Chris stated, it is the provider who has to agree to enter into that 835 5010 transaction there. So, it is a provider's responsibility to create their profile and enroll their transaction.

In the case of using paperwork instead of the total onboarding Web site, if you, as the vendor, have signed their updated paperwork and sent it to us, it would reject that paperwork because we need it to be signed and issued by the provider.

So, the same kind of rule applies with the Web site there. We need the provider to either go into their profile and add that 5010 835 transaction, or allow you, as the vendor, to manage their account by giving you that right through their profile.

Joe Baranowski: All right. Thank you. That's what we're working on.

Christine Stahlecker: OK. Thanks, Joe.

Operator: And your next question comes from the line of Cheryl MacDougall.

(Rob Sikorski): Hi. This is (Rob Sikorski), actually, from DaVita. And we have also been experiencing problems with crossover claims. Specifically, we did have some with the taxonomy codes and the value codes which were known issues and appear to be fixed.

But we also had lost files. We had about 8,000 claims for MediCal that didn't make it, and we're continuing today to see duplicates being sent across. I was in two provider advisory group meetings this past week, and it was reported in both of those by other providers that they were experiencing the same problems. Are you aware of anything going on?

Brian: (Rob), this is Brian. Of course, we know each other. To my knowledge, I – we had a Medicaid call – two of them recently. And from a Medicaid perspective, we asked every one of them if they were receive – receiving duplicate claims, and none of them were except for Oregon. And they weren't actually on the call. I was taking that from the examples you've had. But I've never heard of missing claims in California.

(Rob Sikorski): And this is a January file. So – can we – since then, we've seen the next – the February file has crossed over. But this is being reported in the CDS provider advisory group meeting which would have been Ohio and Indiana, I believe, or I'm sorry, Kentucky.

So they said that they were getting reports – the MAC did. They were going to escalate up and see if there was something more global going on, but I just wanted to make you aware.

Brian: Our trading partners themselves haven't said anything, which is kind of unusual that they wouldn't have, but thank you for keeping me informed. We'll – if you need us to look at some examples of claims that didn't crossover or got lost, we'll see if we can track error on our side, whether we actually sent them out.

(Rob Sikorski): OK. Great. Thank you.

Brian: Sure.

Operator: And your next question comes from the line of Nancy Lavergne.

Nancy Lavergne: Yes. I'm not sure if this problem is our clearinghouse or if it is a Medicare issue. When we've been receiving our 835 Medicare AOBs? When we have a WO or FB for money that they're going take that in the past that always had the patient's Medicare numbers, so we knew who the patient was – we can look it up by there.

Now, it's no numbers there, it's just, I mean, there's no Medicare number, no – it's just like the, I think it's really the actual claim number or whatever. Is that going to change or is that an issue with our clearinghouse or is that an issue with Medicare? We're with Cahaba.

Sumita Sen: Actually, I think – who is your MAC?

Nancy Lavergne: Cahaba.

Sumita Sen: Cahaba. I think we have just changed that from the Medicare case number to the patient control number because the patient's control number basically comes from you, from the provider – that's one of the requests made to us, and that was the case. And you are saying you are not seeing anything. Whether it's…

Nancy Lavergne: Well, we're seeing a number. We're seeing the control number, but we can't pull up a claim by the control number. So, I mean, if we have a Medicare number, we can pull it up from the, you know, we can pull up patients by their ID number from our system or their name or their insurance number, but we can't pull them up from a control number on a claim.

So, it's kind of difficult, I mean, we have a hard – the hardest time trying to match who they're taking money back from or it's because…

Sumita Sen: All right. This is something, you know, exactly opposite of what, you know, we were requested to do. In fact, that's the reason why we've changed from the Medicare pay number to the patient's control number, because the patient's control number is sent to – on the claim by the provider.

So if providers sent in – would generate the patient control number, that's the reason why we changed it. So…

Nancy Lavergne: OK. Well, then I need – I just need to check with my practice management system to see if we can pull up a patient by the control number of a claim then.

Sumita Sen: Absolutely, yes. Thank you.

Nancy Lavergne: OK. Thank you.

Operator: And your next question comes from the line of Bridgette Sanlon.

Bridgette Sanlon: Hi. We sent some professional claims to Part B. We're an oncology practice and I was wondering if you are going to now be requiring NDCs on all drugs or just unclassified, and if there will be instruction on how to fill out the dosage.

Brian Reitz: I'm sorry. This is Brian Reitz. I missed the beginning part of your question. Could you repeat it again, please?

Bridgette Sanlon: Sure. We're an oncology practice and we give chemo in the office. And I wanted to know if the – are the NDC codes going to be required on all of the drugs we give or just the unclassified, and if there will be any instruction on how to fill out the dosage area.

Because right now, we calculate how many units to bill based on the J code, description in the HCPCS book so we know what quantity to bill there. And I just want to know if there are – is there going to be instructions on how you want to the dosage filled out if it's required for all drugs, not just unclassified?

Brian Reitz: It sounds like you got a couple of questions rolled into this and I guess – first the level set: there's no one in the room today with us who is in a policy capacity who can talk about changes for oncology billing, so …

Bridgette Sanlon: Hello? Sorry, (Kim), cut out.

Operator: Ladies and gentlemen, please standby. The conference will resume momentarily.

Ladies and gentlemen, please standby. The conference will resume momentarily.

Once again, ladies and gentlemen, please standby. The conference will resume momentarily. Until that time, your lines will briefly be placed on music hold.

Once again, ladies and gentlemen, please standby. The conference will resume momentarily. And until that time, your lines will be placed on brief music hold.

Once again, ladies and gentlemen, please standby. The conference will resume momentarily.

Ladies and gentlemen, please standby. The conference will resume momentarily.

Ladies and gentlemen, please continue to hold. The conference will resume momentarily.

Ladies and gentlemen, please continue to hold. The conference is scheduled to resume momentarily. We appreciate your patience.

Operator: Ladies and gentlemen, we will now resume the conference. Mr. Eleftheriou, you may resume.

Angie Bartlett: We want to apologize. The fuses got cut off from the call. So we are in the process of rejoining back in, but we want to take the Q&A session, so we can take our next caller, please.

Operator: OK. And your next question does come from the line of Daphne Culver.

Angie Bartlett: Hey, Daphne?

Daphne Culver: Hi. We bill WPS Part B, and our claims are not crossing over due to our having a discharge date. When I talked to our vendor, they asked me to find out if I could put a loop in the segment that was appearing in so that we could have it corrected. Is there anyone who can help me with that?

Female: Repeat it please?

Charlie Eleftheriou: Daphne, can you please repeat the question for us?

Daphne Culver: We bill WPSB, our claims are not crossing over from Medicare to secondary due to the fact they have a discharge date in the field, and our vendor has asked me to find out what loop in the segment that is, so that I can have it corrected.

Brian Reitz: OK. This is Brian Reitz. And if you'd give me a second I will try to find that out for you.

Daphne Culver: Thank you.

Operator: All right and your next question comes from…

Brian Reitz: No, we will wait – we're getting the answer for that person, can we get them back?

Operator: Yes, sir.

Brian Reitz: Yes, hang on. I'm trying to – I'm trying to get in there and get to a place where I can give her an answer.

Operator: Daphne's line is open.

Brian Reitz: OK, the admission and – well, likely admission and discharge you want to look at. You need to know the loop and the segment – is that what your vendor's asking, Daphne?

Daphne Culver: Yes, please, yes.

Brian Reitz: There will be – the DTP in the 2300 loop – and I'll give you, the qualifier for admission is 435 for the admission code and 096 for the discharge. And so, you'd want to have your vendor looking at those two DTP segments to make sure that if they are there, that they truly need to be present.

The trading partners, they utilize compliance checking software to validate to them what a valid HIPAA cross-over claim is. And when they see a discharge date or admission date, say, on an office visit claim, that's what's causing difficulty. And I recognize you may have a vendor that's defaulting that information into every claim, but the trading partners don't see it that way. So you would really only want to submit valid information when it's needed.

Daphne Culver: And that answers that question. Thank you.

Brian Reitz: You are very welcome.

Operator: And your next question does come from the line of Dawn Larson.

Dawn Larson: Hi, we're actually at eProvider Solutions, an electronic clearinghouse. I have kind of a question. We have a lot of clients that have previously been receiving rejections for all of their MSP claims. We finally did get a response that they did need to be passing the coordination of benefit information on their claims versus passing just the value codes, institutional and secondary.

Now we're questioning, can you clarify what is really required on the MSP claims? As our clients are calling Noridian and are being told by Noridian staff that they should not be passing all the coordination of benefits, that the value code only is still acceptable.

Christine Stahlecker: Is that a Part A, are you talking about Part A crossover claims?

Dawn Larson: This would be when the other insurance is primary and Medicare is secondary on Part A claims.

Christine Stahlecker: And so, I would have to – Matt, are you able to take that question?

Matt Klischer: Well, I would need system – I would need a lot more information as far as – what value codes are you trying to use?

Dawn Larson: Previously, providers have been told that they were able to use value codes 12 through 44 to indicate primary payment information, and no coordination of benefit information was sent. Now since 5010 we are being told that the coordination of benefit information is required according to 5010 MP guidelines. However, when the provider is contacting Noridian to question this they are being told that they do not have to have the coordination of benefit, they can still continue to use value codes only.

And we're needing clarification of what is actually the correct way for them to be submitting those claims?

Male: OK, this is one of the situations where I will need for you to enter your contact information in the contact e-mail so I can contact you directly. I'll also touch base with Noridian.

Matt Klischer: Yes, this is Matt, I think just send that e-mail, and we will have to dig into that. Now, of course, I don't have an answer for that right now.

Dawn Larson: OK.

Angie Bartlett: Do you have the address for the fee-for-service mailbox?

Dawn Larson: Yes, we still have that address.

Female: OK, thank you.

Operator: And your next question comes from the line of (Sharon Nickles).

Christine Stahlecker: Give us an easy one, Sharon.

(Sharon Nickles): I'm actually asking on behalf of my manager, who is not able to be on this call, and so if you need to ask me a bunch of questions about it, I may not be able to answer.

What she said was – I'm calling from RealMed, we're a clearinghouse – and she said we continue to have issues with 277-CA response files not being received. Sometimes it's due to the files failing in the CEM module, and the 277-CA does not get generated, but there are also times when we have accepted 277-CA files but when the clients call the IVR days later after submission, the claim through the IVR, they're being told the claims are found which requires resubmission.

I know it's causing a problem as far as our clients and their level of understanding with us because they think, you know, you're telling us this, you're telling us that, and not really giving a good answer or a good explanation or a way to explain what's going on.

Are there fixes coming for the 277-CA? Are there…?

Christine Stahlecker: OK, well, I think we have enough of the description here with the problem. We have experienced – now this is not a situation that's pervasive across all MACs. It is very situational. But we did have this situation reported to us or made known to CMS here at Central Office. But during certain end-of-day processing if a file was in the middle of being processed through the validation, through the common edit module which does output both 277 claims acknowledgment and the claim going forward to the shared system.

If end-of-day happened, and it's not each and every time but in some situations, the claim went forward but the 277 did not come out, or the 277 came out and the claim did not go forward. Now, that problem is situational, and I understand that part of that has been programmed and has been released for user acceptance testing at MACs. I do not know for certain if it's been installed production, and I believe the other side of that problem is still being researched.

Now it is not, as I've said, a pervasive problem. Actually we've only had one of the MACs report that problem, and again this is not something that is occurring on a daily basis. So the research on one side is ongoing and a solution and – I don't even know if it requires software – but a solution has been put in place for the other side of the equation.

And I hope that helps you, Sharon, but you've got all the information that I have on that topic.

(Sharon Nickles): OK, thank you, I appreciate it.

Operator: And your next question comes from the line of Leslie Stephens.

Christine Stahlecker: Hello, Leslie.

Leslie Stephens: Hi, I'm calling with Providence Home Health in Portland, Oregon. And my RHHI is National Government Services. I have a question regarding the issue that we're finding not only with – or we just – it's an issue that we're finding more with our Med Advantage payers than we are with Medicare, but it is a coding issue because it's regarding the PPS billing methodology.

We're experiencing with these pairs that use the Medicare PPS billing format that they are not accepting a zero in the unit field of the HIPS charge line. This is revenue code 0023. Also, when we are setting up our claims to – our MST claims through PCA's pro-32, that software does not accept a zero in the unit field. However we are finding that some payers are accepting a zero in the unit field, and our claims that we're sending through to Medicare allow a zero in the unit field.

Is this a new standard that is new to 5010, that we have to have a one in that field now? I haven't been able to find an answer on that in any of the documentation.

Christine Stahlecker: Matt, would you be able to take that on?

Matt Klischer: Yes, can you hold just a moment? I'm doing a find on a spreadsheet.

Leslie Stephens: Sure.

Matt Klischer: OK, for Medicare claims, one of our – it is a business edit. The value must be greater than zero even though the TR-3 is silent. Logically you need to have at least a one in the field bill unit, you can't bill a zero.

Leslie Stephens: OK, and so, where is this documented?

Matt Klischer: Well, we have our edit spreadsheets, and they are actually on the 5010 Web site that's part of the – Jason can confirm on the call – it's part of the presentation today. Also there are Medicare CRs. I can give you, for example CR-7596 – that was our April edit spreadsheet CR.

There is an edit. There is an Excel spreadsheet that's part of that CR, and that if you could write this down and (Sam Victor), SV-205. That's the data element that you're talking about with the units.

Leslie Stephens: OK.

Matt Klischer: If you're doing that spreadsheet, do a find on SV-205, there's about seven or eight edits for it. One of the edits will say that it must be greater than zero.

Leslie Stephens: OK, cool. And I can pass it on to my software company and say, OK, this is the required field. We need this on all of our PPS file claims. So this is very helpful. Thank you very much.

Female: The link to that spreadsheet is on the bottom of slide 10.

Leslie Stephens: Slide 10? Thank you.

Operator: And your next question comes from the line of Jacqueline Kirejczyk.

Jacqueline Kirejczyk: Hi. This is Jacque from Beaumont Health System. I have a question about billing and billing NPIs. And I was wondering – under 5010, will providers be required to bill the same NPI number to all payers regardless of whether it's individual or a subpart NPI?

Christine Stahlecker: The 5010 didn't change the use of your NPI at all. It does require NPI, but it doesn't change the entity. It doesn't dictate to you which one you must use on a claim. So you would continue to use the NPI that you have been billing with.

Jacqueline Kirejczyk: OK, thank you.

Christine Stahlecker: OK.

Operator: And your next question comes from the line of Albert Offer.

Albert Offer: Hi. This is Albert Offer, with XLHealth. My question is, where would I go to keep up with the latest and greatest changes to the requirements as well as any timeline changes?

Christine Stahlecker: I think probably by subscribing to the provider listservs and communications to the Provider Communication Group would be your best bet. And Charlie, I don't know if you have those listservs links handy, or if it's in the presentation at all?

Charlie Eleftheriou: Sure. Well, it's not in the presentation. But if you're interested, feel free to send an e-mail to our fee-for-service provider relations e-mail inbox, and the e-mail address for that is – give me one quick second. Actually, why don't we take the next call? I'll announce that e-mail address in one second, unless we're not done answering this question.

Brian Reitz: Hold on one second. This is Brian Reitz. Albert, could you just expand about what do you mean by keeping up with the requirements? Which requirements are you talking about?

Albert Offer: The 5010 requirements and I guess some of the ICD-10 timeline changes.

Brian Reitz: OK. And by 5010, do you mean Medicare only, or are you interested in the industry 5010, because depending on your answer, you may have to go to different places to keep up with current information, and it may not reside with Medicare. So I'm just trying to clarify what you're looking for. Are you looking for information related to the implementation guides? You wouldn't

get that from Medicare; you'd have to go to a different place for that. If you're looking for our updated edit spreadsheets, we would have those, and we have those posted to a Web site.

So the information is kind of scattered all over the place. There may not be one pat answer for you.

Albert Offer: Both would be great.

Charlie Eleftheriou: All right. Well, then let me give you the e-mail address that you can send an e-mail to and just request to be added as a recipient of our Medicare Fee-for-Service provider e-news. And the e-news comes from, and this is the same e-mail address you're going to e-mail, it comes from ffsproviderrelations@cms.hhs.gov. That's FFS as in fee-for-service, provider relations, no spaces, at cms.hhs.gov. And well, ask for the mailing list, and you'll receive all sorts of great information on everything you can imagine related to fee-for-service Medicare.

Albert Offer: That's great.

Charlie Eleftheriou: You're welcome.

Albert Offer: Thank you.

Operator: And your next question comes from the line of Mary Schreiber-Dooley.

Mary Schreiber-Dooley: Hi. We're also having troubles with our crossover to Medicare and Medicaid, and we were told again by CGS that it was a national problem, but they didn't give us any details to what the problem was, so we're not sure if it was part of what you already talked about with the taxonomy code or if they're – it sounds like you're not aware of any other problems?

So what we're getting is where Medicare says there's a crossover and Medicaid doesn't have any record of them.

Christine Stahlecker: I have to apologize, but as I said earlier in the call, our coordination of benefit crossover specialist had to leave at three o'clock, so Brian Pabst is not

here to take that question right now. And if you want to re-submit it to the resource mailbox, we'll get that to him after the call. I'm sure they are aware of other issues, not just that one. They've been working, just as Medicare fee-for-service has been working, on issues since last fall – the crossover – has been working their hot spots as well.

Charlie Eleftheriou: And I'll just remind everyone that we're running a little short on time. If you do have any questions, you don't want to wait on the queue, you want to send it right into the inbox. You should see the e-mail address on your screen, it's 5010ffsinfo@cms.hhs.gov.

So, you want to go to the next question?

Operator: And your next question comes from the line of Wendy McClennan.

Christine Stahlecker: Was that Lee?

Wendy McClennan: It was Wendy McClennan, I'm sorry.

Christine Stahlecker: Hi.

Wendy McClennan: We are also having problems with the 277 responses coming back, and when we call Palmetto GBA, the claims are not on file. And we just want to know if – do you know if that centers on Palmetto GBA, and if so, what's going to happen with those claims? Do we need to re-submit those claims or are you able to identify which claims, you know, did not – were not received? Are you going to be able to process those, you know, individually? Because we have probably 4,000-plus claims that should be on file but are not on file that we have 277 responses for.

Christine Stahlecker: Would someone from Palmetto like to take that question?

Carol: Hi. This is Carol, with Palmetto. Wendy, I'm going to have to ask you to send that question to the 5010 fee-for-service info mailbox. Depending upon the situation, we need to research and look at what you had submitted to us. There could be, you know, various reasons. And without doing some research, we wouldn't want to give you an answer.

Wendy McClennan: We've, you know, dealt with our clearinghouse on most of the batches, and they've been contacting Palmetto GBA, but we're just getting the response that you're researching, you're researching, and our claims are just aging, and I mean these are accruing. We have February claim files where, you know, like for three days in a row no claims were accepted, and then the next day, those are accepted and paid in, you know, in our normal timeframe.

So we wanted to see if we could get anywhere, get any more information, because we're not getting that response back from our clearinghouse.

Carol: OK. If you can give the – submit your inquiry to their – through that 5010 fee-for-service info mailbox. That way, we can – you know, if we're working with your clearinghouse, we can go back and look at the information we've already researched for the clearinghouse, and we'll get in contact with you to give you a better explanation then.

Wendy McClennan: OK, thanks.

Carol: OK, you're welcome.

Operator: Your next question comes from the line of Diane Loughley.

Christine Stahlecker: Hi, Diane.

Diane Loughley: Hi. Thanks for taking my call. I'm with Quadax, we're a clearinghouse. Probably the broadest issue we're dealing with in the particular clients I'm representing in the J-15 CGS for Part A is that when their MSPs get past front-end rejections, they get into the system and then FISS, they bump up against this reason code 3131 on the – and fortunately, CGS does have like a claims-processing issues log that's been very handy. It was just updated April 23rd; it's listed as a top item.

On that, the most recent thing is saying that it's still being researched. At one point, they were told that this field, the RI field, could be changed from an N to a Y. I've had providers report, they try this in FISS, and then they get a new reason code 31265. So it seems as though it's a catch-22.

The question I've been challenged to answer is, did they just leave these in the RTP status in FISS? If there is a fix, do these automatically process then, or do they need to resubmit after a fix is made?

Christine Stahlecker: If they leave them in the RTP process, they will at least need to bring it up and hit enter. There will be some small manual action.

But, Matt, is there anything you want to add to that?

Matt Klischer: You know, Chris, I need to look up those specific reason codes, and that's going to take a little bit. I don't have that readily in front of me to research those. And you're saying that you're also working on the J-15, that particular MAC?

Diane Loughley: It's the – right, J-15 Part A, and it's CGS. They've got it listed, and we're getting a little conflict because they've got a separate section for home health. On that, for the – I'm sorry, health and hospice, the health and hospice processing noted that there's a fix or a resolution tentatively scheduled for June 4th. For the Part A, it does have this listed as an issue, but it just says the implemented fix did not address all issues, is still being researched.

I've just got a lot of very anxious providers who would like to see these claims finally processed.

Matt Klischer: OK, did that particular fix that you're reading from, some of the language, did that have like an FS, like a (Frank Sam) identifier, did it have an identifier for the fix?

Diane Loughley: Not listed on this issues log. The issues log – I'm looking at it at the www.cgsmedicare.com/parta/claims/issues_log.html.

Matt Klischer: OK, I'll do some more research with J-15. If you could also please send that into the resource mailbox, please?

Diane Loughley: Sure.

Matt Klischer: Thank you.

Diane Loughley: Thank you.

Christine Stahlecker: I don't think we have anyone from CGS in our speaker queue today.

Nancy Turner: Yes, Nancy Turner. I'm here. And I would ask that you put her information into the mailbox because I'd like to get it researched for her.

Diane Loughley: Thank you, Nancy.

Nancy Turner: You're welcome. Thanks, Diane.

Charlie Eleftheriou: And I think at this time we have enough time for one more call.

Operator: OK.

Charlie Eleftheriou: And then we'll call it for the day.

Operator: All right. And your final question does come from the line of (Catherine Thompson).

(Catherine Thompson): Thank you. I'm with Clinical Pathology Laboratories, and I just wanted you to know that there is also a problem with – through Trailblazer – in receiving our claims and acknowledgments. We have found two batches so far. One batch fortunately was very small, the other close to 7,000 claims. And we were told two weeks ago that that large batch would be processed, they did locate it.

We haven't received the responses yet, so I'll be calling next week if they don't show. But I just want to warn providers that you may need to start looking in your aging buckets because this honestly is the way that we came across them. So Trailblazer does have the same problem as other MACs.

That's all.

Christine Stahlecker: OK. Well, thank you for your comment, (Catherine).

(Catherine Thompson): You're welcome.

Additional Information

Charlie Eleftheriou: All right, thank you so much for all the questions. Unfortunately, this is all the time we have for the day. If we didn't get to your question, again, please e-mail us at 5010ffsinfo@cms.hhs.gov. The e-mail address, one more time, 5010ffsinfo@cms.hhs.gov. That e-mail address can also be found on slide 11 of today's presentation.

Please note, while we won't be able to address every question, we will review them all to help us develop Frequently Asked Questions and educational products and future messaging on these programs.

I'll also point out, looking at the final slide of the presentation, that all registrants for today's call will receive a reminder e-mail from the CMS National Provider's Call – I'm sorry, Provider Call's mailbox – after this call, regarding the opportunity to submit an evaluation of today's call. You may disregard the e-mails if you've already completed the evaluation.

Please also note that evaluations would be available for completion for five business days from the date of today's call. We appreciate all your feedback and thanks again to everyone including CMS subject matter experts and callers who participated in today's call, and I hope everyone has a great evening.

Operator: Thank you for participating in today's call, you may now disconnect.

END