

Centers for Medicare & Medicaid Services
National Provider Call on the Current Status of Medicare FFS Implementation of HIPAA
Version 5010 and D.0
Moderator: Charlie Eleftheriou
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Operator: At this time, I would like to welcome everyone to the National Provider Call on the Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0.

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. You may begin.

Introduction

Charlie Eleftheriou: Thank you, Holley. As Holley mentioned, this is Charlie Eleftheriou from the Provider Communications Group here at CMS, and I will serve as your moderator for this call today. I would 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 current 5010 and D.0 metrics and share recommendations made by Medicare Fee-For-Service as well as possibly – I'm sorry, as well as possible outstanding fixes impacting the Part A and Part B Version 5010 transition.

Following the presentation, we will hold a question and answer session giving participants the opportunity to ask CMS subject matter experts questions related to 5010 implementation.

Before we get started, there are few quick items I would like to cover. One, the PDF slide presentation for today's call was included in your confirmation and reminder e-mails, which were e-mailed to all registrants this afternoon. If you registered and did not receive the e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Call Resource box.

Alternatively, you can find the presentation file on today's call details page. To access the call details page, go to www.cms.gov/Versions5010andD0, then

click the 5010 National Calls link found on the left side of the screen in the navigation panel. Once there, select today's call from the list to view today's call details page. There you will find general information about the call and a link to the PDF presentation file in the download section at the bottom of that page.

Also for today's call, we are using Adobe Connect Webinar which gives you the option to join our virtual meeting room and view and follow today's presentation as it's controlled by the presenters. A link to the webinar room was also included in this afternoon's e-mail and can be found on the call details page mentioned above.

Again, the location is cms.gov/Versions5010andD0, from there click on 5010 National Calls in the left navigation panel and select today's call from the list. Please note that you do not need to join the Adobe Connect Webinar in order to participate in today's call. You may participate in the audio only if you prefer and follow along with the downloadable presentation manually.

Lastly, a quick reminder that this call is recorded and transcribed, and an audio recording and written transcript will be posted to the call details page.

I would like to thank everyone who submitted questions in advance. When you registered for today's call, your questions were shared and helped prepare slides and remarks for today's presentation.

With all that said, let me introduce Chris Stahlecker, Division of Direct – I'm sorry, Director of the Division of Transactions, Applications and Standards, in the CMS Office of Information Systems. Chris, take it away.

Chris Stahlecker: Thank you, Charlie. I just wanted to add my welcome to today's call. We appreciate you taking some time out to spend time with us, and point out that today's call is the final call that Medicare Fee-For-Service will host on its 5010 Implementation between now and July 1st.

There is – it's not that you won't be seeing us or that you won't have an opportunity to speak with us. There will be an opportunity at the X12

Meeting coming up June 3rd through 7th where, as usual, CMS will host the caucus session on the Sunday evening. And then on June 20th, there will be series of regional webinars, that's three in one day, and the staff will serve to support those calls.

So, although I'm letting you know this is our last scheduled outreach for our 5010 implementation, we will still remain accessible to you.

So here in the room, not just Chris Stahlecker and Charlie, but we have Mike Cabral, Sumita Sen, Brian Reitz, Matt Klischer, Jason Jackson, and Angie Bartlett that I'm going to turn this over to in just a couple of seconds.

So today's call we want to reserve mostly for Q&A in case there are any final issues that we can support you in your implementation and transition. And with that, I would like to introduce Angie Bartlett.

Presentation

Angie Bartlett: OK, we are going to start with our purpose of today's call. It's going to be to focus on discussing the 5010 D.0 final preparations for the cutover and to review the productions for protocols and current status of the issues reported. As well as we are going to review some of our communication material and emphasize on our future plan conference calls with the industry.

On to the next slide, slide three: As I'm sure all of you're aware, OESS announced that an additional three months will be added on to what was already the OESS's enforcement discretionary period. So this guidance meant that it will not initiate actions for an additional three months through June 30th, 2012, against any corporate entity that is required to comply with the HIPAA Regulations.

Therefore, what you can expect for Medicare Fee-For-Service during this time: As the transition is nearly complete, MAC and CMS support will continue in the form of outreach and National Provider Calls as well as we are working with our resource mailbox to address all the questions that are coming in.

But just to emphasize, that Version 4010 will be turned off at the end of June to comply with the mandates. Now Jason's going to discuss some of our metrics for 5010. On to slide four.

Jason Jackson: At Fee-For-Service, we've been tracking the transition for both the Claims and Remittance volumes as well as the submitters, and on slide four at the bottom, month to date as of May 4th for the Part A institutional claim, we are – 93 percent of all Claims coming in are in Version 5010.

For the Part B, we are at 96.5 percent. For NCPDP, we are at 95.3 percent; and for our Eligibility 270/271, we are 96.3 percent; and across the board we are holding somewhere between 75 and 80 percent for the submitters for those transactions.

On slide five, this is our Remittance for Part A and B and the Claim Status Inquiry and Response. For remittance for Part A, we are at 36 percent, and we are hoping to see that that volume increases greatly after several fixes have been put in place at the beginning of May. For Part B, we are currently at 63.9 percent.

And then for the Claim status for Part A, we are at 93.8 percent, and for Part B, we are at 96.5 percent, and on the remittance overall, we are between 40 and 43 percent of all the receivers are now receiving Version 5010 835's. Back to Angie.

Angie Bartlett: On to slide six, final preparations for 5010 are cutover beginning on July 1st, 2012. On July 1st, Version 4010 will be turned off to comply with the mandated date. At that time, submitters who send in Version 4010 transactions to Medicare Fee-For-Service will have their transactions rejected.

Rejected responses will vary between Medicare Administrative Contractors, since Version 4010 does not have a standardized acknowledgment response. Version 4010 transactions submitted after June 30th will be rejected with either a proprietary message, a 997 Functional Acknowledgment, or TA1 Interchange Acknowledgment saying that the transaction version submitted is not supported.

Outbound transactions such as the remittance advice and claim status will be available in the only – in the 5010 format. Receivers of this transaction must be prepared to accept them in only the 5010 Version.

In addition, we are in the process of contacting the MACs to have them increase their EDI helpdesk support beginning mid-June, and it will run – actually the last week in June through mid-July.

We noticed that with the anticipated cutover in January there were a lot of additional calls through the call centers. So we are going to have the MACs staff up their EDI call centers just to help out. So that if you have a question or a concern, you are able to call and contact your MAC as well.

In addition, the Version 5010 outreach and education is increasing during the extended period. We are going to have some regional webinars that we scheduled on June 20th, three in one day. You are going to be looking towards some regional listserv messages to find out more information on those dates. As well as we are going to have frequent listserv messages beginning the first week in June, which will give further information and guidance to what is going on with the transition.

So on to slide seven: We are going to discuss some of our top operational concerns. This is a slide we are going to spend a decent amount of time on in today's presentation, just going through some of the items that we are finding and we are seeing going on through the transition.

The first is the failed delivery of the transactions. Medicare has learned that submitted claims may have failed edits during several hand-offs to providers in the delivery process to the Medicare Administrative Contractors. They may have never received – the providers may have submitted but haven't been received. Therefore, don't assume the Medicare lost your submitted claims.

If it is a provider using another entity to get their claims delivered to the MAC, tracking should begin with those entities. Although Medicare does recognize that we have, too, also experienced several issues as well which

were short-lived in the beginning as for problems that also caused failed delivery.

For example, we had a concern where four MACs all using the same translator were receiving a Part A claim, but the CEM was not producing the 277CA. This issue was resolved in March by the MACs working with the developer to identify the problem.

In addition, we also experienced an early start-up problem in January. A Legacy contractor was passing forward claims to a MAC who was running the claims through CEM, but the accepted claims were not entering the adjudication system for processing. This problem was also failed – caused failed transactions, and this was corrected in the early January timeframe.

So we are saying that a lot of these problems that are causing failed delivery of the transactions, often they were short-lived and pretty much all have been corrected at this point in time.

Therefore, if you continue to see concern with your failed delivery, we do encourage you to go back and talk with some of these other entities as well as feel free to contact your MAC.

At provider linkage, we have – the providers that use the clearinghouse billing service or vendor to electronically submit Medicare Fee-For-Service claims must request an update from their MAC for an EDI authorization to use Version 5010 in production.

If you believe you've not been properly transitioned to Version 5010, please contact your MAC in order to properly be setup. For security reasons, the provider must identify the clearinghouse or billing service in order for the MAC to perform the appropriate submitter linkage. The MAC is not permitted to accept this information from a clearinghouse without an audit trail showing when the provider has requested this from the clearinghouse or billing service to be updated.

Now, Jason's going to discuss the 277CA.

Jason Jackson: OK, for the 277CA, there was a period of time where providers were experiencing receiving a 277CA with claim control numbers, but they were unable to see their claims in the system. And on the same note, they were not receiving a 277CA, but their claims were entering the adjudication system for processing.

The MACs that were having this issue have been working and – with our maintainers – and this issue was resolved by around early March. So, as of recently we have not been experiencing any issues. All 277CAs have been generated and being sent back out. If you are not receiving any of your 277CAs or still experiencing problems where you are getting claims in, but not getting them back, or you are not getting your 277CAs and your claims are getting paid, you know, you need to contact your MAC ASAP so that they can, you know, get with us and we will be able to get this issue resolved. But as of right now, we have not been hearing any further information on this issue.

OK, and, of course, this also – this issue also impacted DDE. There were several instances where providers were going into the DDE system, and that's where they are seeing their claims.

So, if you are seeing your claims in DDE, but you haven't gotten anything back, then that's an indication that there's an issue.

Angie Bartlett: Brian Reitz?

Male: Hi, Brian is normally the person who speaks to COB issues, and he was unable to be on the call today. So he's provided a prepared statement that I will read now.

COBC relaxed many of its HIPAA 5010 redundancy as of May 14th. As a result, many more 5010 837 IMP claims will be crossing over and not rejecting at COBC.

CMS is unsure what the COB payer's reactions to these claims will be but has invited them to consider relaxing their redundancy edits for Medicare

crossover claim purposes only. Also, COBC will be relaxing its H41042 – discharge date should only be billed on 837 P claims when the claims is for inpatient services. That edit will be relaxed on May 29th.

This, too, will contribute to many more 5010 837 claims crossing over. CMS cannot predict how COB payer systems will react to receipt of claims where discharge date billing should not have occurred.

Therefore, CMS hopes that physician practitioner billing vendors will only bill admission and discharge date on incoming Medicare claims when appropriate, in the interest of not incurring rejections that maybe encountered once Medicare – excuse me – once Medicare crosses over claims with those conditions. Angie?

Angie Bartlett: Thank you, Brian. I'm going to turn it over to Matt Klischer who's on the 837 MSP concern.

Matt Klischer: Yes, this is Matt Klischer. The issue with MSP only affects the institutional claims. There is an issue where the payer information is not mapping correctly. The claims are hitting the shared system reason code, 31313, which is the error condition set up for this issue where the codes aren't mapping correctly, so it hits this issue.

The fix for this issue is identified by FS, it's like Frank Sam 6728. Again, it's FS6728. That's the fix identifier, and if you have issues with this problem, you will be able to contact your servicing MAC and identify, using this identifier. And they will be able to give you a status or an update on the fix. It's currently scheduled to start being tested around next week, 24th May, and it's scheduled for – it's scheduled to be in production that actual – to be fixed right around June 4th. Today that's the information on this particular item at this time. Thank you.

Angie Bartlett: Sumita Sen?

Sumita Sen: Hi. As Jason mentioned earlier, we are really working very hard to identify and resolve issues on the – for the remit that are in any way preventing

transition to 5010. At this time, there are some sporadic technical issues affecting some providers, some of the time.

Now, one of the issues that we have identified, and you may have experienced, has basically nothing to do with 5010 per se, but with a financial screen within our Part A system that is not allowing the MACs to turn a provider to 5010 production. This is only on the Part A side, and it's affecting only some providers.

And actually two fixes have been scheduled: one for early May – actually, May 18 – and the other one is in early June. In the meantime – having said that, in the meantime we encourage you to test and be ready. So that you know when the fix is in, everybody can be turned over to production.

Let me just kind of go over a few other issues that you may or may not have seen, and we have worked on them either – and we already have fixes in production or you know we have them scheduled for early June.

One has to deal with the data – some data issue in the SVC segment, and the fixes actually were put in production in early May – early March rather. Then there's another issue. This is, again, to deal with Part A remit – if there is any correction in the patient's name, the remit – the 835 on the Part A side was not reporting the corrected patient name.

This issue has been resolved and the fix went into production in early April. I would like to mention that with 5010 our expectation is that the quality of 835 would be actually better. It will be more aligned with the TR3, and there would be less variation between Part A and Part B remits, unless it is acquired because of the line of business.

So, what I will say is please go ahead, test, and if there is any issue of transitioning to 5010, we have already taken care of and it will be fixed in early June. In the meantime, please go ahead and test if you haven't done that. Thank you. Angie?

Angie Bartlett: Thank you very much, Sumita. Now we move on to slide eight. Many of you have probably already seen this. This is our A/B MAC and CEDI contacts list. We've updated a few things on the slide. We have listed here JF, which is Noridian Administrative Services. They changed their name. They were J3, they are now JF.

Then you will see also down here, for J12 we have changed from – the name, just it only changed – from Highmark to Novitas Solutions. So you can take a look here and see if you can find your MAC and your information.

Chris Stahlecker: And I would just like to interject at this point and let everyone on the call know that during the Q&A session that representatives from each of these organizations are present in the speaker queue, and you can pose any questions to them directly, as necessary.

Angie Bartlett: And on to slide nine. If you didn't see your jurisdiction listed on the previous slide, you may still be working with the Legacy Contractor and not have your MAC identified yet. So you may use the links here to go down and look at Part A or Part B, and this will direct you to who you can go to for further help, with your helpdesk questions or any of your transitioning over to 5010 questions.

So on to slide 10, Future Communication. We talked a little bit about this earlier in the presentation. We are working – our division is working with regional coordinators to host a series of regional webinars which are going to be on June 20th. We did this earlier this year on March 6th, and we had a very positive response.

So they are going to be probably one – going to do one for the Eastern half of the country, the mid, and the west. And they will be broken down by time zones. I think we are trying to do them around 1 o'clock for each of your times. And further information will be coming out. We'll probably do a listserv message coming from PCG as well, as it's going to be put out there by the region.

And your particular MAC will probably be present on these calls as well to address questions. And what we have decided to do moving forward, after our 5010 all the transition information goes over this summer, is we are going to also start off having quarterly meetings with the industry. So we can share information with you, which would – we feel is going on with the EDI exchanges and transactions as well as to hear from you as to any of the clearinghouses or vendors or even the provider community has concerns or questions they want to post to us or share with us.

Our first meeting, we are looking at scheduling in mid-September. We are looking at doing the second Tuesday of the month. So we are looking to having one in September, December, March, and then in June of 2012 and 2013.

So we really look forward to seeing what kind of information we can share with the industry on these calls as well as what kind of information you guys can share with us on your concerns. Because one of our number one lessons we've learned through this whole 5010 implementation is the importance of communication.

Obviously, you guys are well aware of that. The more information we get out there to you and you get back to us, it makes for a much smoother transition.

OK, on to slide 11. Medicare communication to date. We have established a central Web page on the CMS Web site where you can find a wealth of information and it still continues to grow daily.

We have our Version 5010 Web page. We then have all the listserv messages that we've had out there. We have our technical documents as well as all the information from the provider calls. We have our presentations – we have the recorded audio portion and now we are posting Q&A documents up there as well.

So we have quite a bit of information. I suggest you start with looking through some of our information if you find yourself having questions following this call.

Charlie Eleftheriou: OK, now...

Angie Bartlett: And now just we are going to start to move into the question and answer portion of our call. Charlie is going to run through some last minute things.

Polling

Charlie Eleftheriou: Sure, thanks to the presenters here at CMS. At this time we are going to pause just for few moments and complete keypad polling so CMS has an accurate count of the number of participants on the line today.

Please note, there may be moments of silence while we tabulate the results. Holley, we are ready to start polling.

Operator: 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.

And please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I will turn the call now over to Charlie.

Question and Answer Session

Charlie Eleftheriou: Great, we can now begin our question and answer session. I will just remind everyone that the call is being recorded and transcribed. So before asking a question, please state your name and the name of your organization and also in an effort to get as many questions as possible in, we ask that you limit your question to just one.

If you do have more than one question and would like to ask a followup question once you are done your initial question, you may press star one to get back into the queue, and we'll address additional questions as time permits. We are now ready to take our first question.

Operator: All right, 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 handset before asking your question to assure clarity.

Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Tony Merandes.

Barbie Steck: This is Barbie Steck with Elmcroft Senior Living. We have a question about crossover claims. Now that it's contracted with Cigna, our claims aren't crossing over automatically. Is there a plan to correct this?

Chris Stahlecker: Hi, Chris Stahlecker here, and unfortunately a representative from the COB area was unable to participate today. If this is an early startup from the payer side becoming a – what is called a crossover trading partner—is that the case with this question?

Barbie Steck: Yes.

Chris Stahlecker: OK, and you've gone live already? You completed the testing with the COBC?

Barbie Steck: We use an intermediary, and as far as I know they've done that with Cigna. I can double check.

Chris Stahlecker: So are you talking about the Medicare claim coming in originally is not getting to Medicare?

Barbie Steck: No, the co-insurance isn't crossing over to the secondary payer.

Chris Stahlecker: OK, there are a couple of issues where – that have been identified about that particular flow, and there is one reason where the crossover is not happening, and that's because some of the editing that's being done by the crossover contractor has rejected claims back to Medicare.

And we are in the process, as we've said earlier in the call, about getting our edits aligned, the edits being the ones in Medicare and the edits in the COBC, Coordination of Benefits Contractor. So that's step one.

And as of May 14, some of those edits should have been resolved. So you may see a change in the future.

The next step in the flow is that the crossover trading partner, Cigna in your example, may also have some edits that are not in alignment with either the COBC or Medicare, and some communication has taken place to those trading partners, and some alignment changes are scheduled for May 29th.

Beyond that, we've drawn – begun a working environment with OESS, Medicare Fee-For-Service, and the COBC contractor. So we expect to get some resolution where there are differences between the edits across those three sets of payer groups.

Of course, all of the community of trading partners may not have the same edits in place. So we cannot always be sure that the ultimate receiver of the crossover claim will consistently process – have the same exact results for what's valid and what's not valid through their EDI process. But we are working toward that end and hope to see that be a smoother process in the future.

If you continue to have difficulty with not – with your claims not arriving at the ultimate secondary payer, that would be a reason to contact your Coordination of Benefit Contractor. And if you do not know how to approach that, you can send a question in to the resource box. I hope that information helps you.

Barbie Steck: Yes, thank you very much.

Chris Stahlecker: OK.

Operator: And your next question comes from the line of (Rosanne Diaz).

(Rosanne Diaz): Good afternoon. My question is regarding the MSP claims, the 31313. Are they going to – when they finally update it, are they going to be able – those claims are going to just automatically go through, or we are going to have to rebill?

Chris Stahlecker: Unfortunately, you're going to have to rebill. The crossover process is sort of a moment in time, when the claim is being adjudicated through Medicare, they are – those claims are funneled over to the Coordination of Benefits Contractor, and it's sort of a once-and-done process. If it's being rejected back to the Medicare contractor for a particular reason, they notify the provider that although the 835 the claim was crossed, it never really was, and the provider needs to take a corrective action. If you are getting a 31313 RTP, and you can get into the data entry system, I believe there is still an issue in the direct data entry feature in FISS that is not going to permit the correction of MSP information on the data entry screens.

So right now, MSP is not fully present on the DDE screen. And as we understand, that is not being addressed. So in those situations, you need to get the claim clean so it doesn't hit that DDE error, and address the claim directly to your coordination of benefit payer.

(Rosanne Diaz): OK, thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Judy Meyer.

Judy Meyer: Hi, I'm calling from Courage Center and we are licensed as a CORF. And my question is, I'm looking for clarification from Noridian on the type of bill. If we need to sequence them to be a 752 and then the subsequent month, a 753, or if we are just supposed to use 752 for all original claims and then the 7 and the 8 for the replacements in the voids?

Matthew: This is Matthew with Noridian. For that, if you could send that in to the mailbox so we can get that question answered. Unfortunately our – we don't have anyone from our billing side. We just have our EDI side on the call right now.

Judy Meyer: OK.

Matthew: If you can, send that in to that into resource mailbox, so we can get that question out to somebody that can answer that.

Judy Meyer: OK.

Charlie Eleftheriou: The resource mailbox should be on slide number 12. It's 5010FFSInfo@cms.hhs.gov. Again, 5010FFSInfo@cms.hhs.gov.

Judy Meyer: And then how will I know when the answer is posted?

Angie Bartlett: I will e-mail the answer directly back to you.

Judy Meyer: OK, great. Thank you.

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

Thomas Finkenstadt: Hi, my name is Thomas, and I work with EMOI. My only question is actually I sent two questions from the last two provider calls in to the 5010FFSInfo e-mail and have not received any acknowledgment or response, and I just wanted to find out when I would expect to get one and/or see it posted.

Angie Bartlett: We are working on responding to all those. We actually have gotten through majority of them. Some of them are still out with our MACs, and the MACs are still working on them, and some are working with our policy folks here. So we will be addressing them, and I will particularly pay attention to looking for yours.

Thomas Finkenstadt: OK, thank you. I was just hoping to get some acknowledgment before the July 1st date is all.

Angie Bartlett: OK, I will make sure to get back with you.

Operator: And your next question comes from the line of Gail Lamb.

Gail Lamb: I am calling from Cache Valley Specialty Hospital, and my call is in regards to a glitch that we are seeing in our 835 remit. We are seeing on just physical and occupational therapy claims that the provider adjustment is actually getting put in the non-covered/denied section within the remit rather in provider adjustment.

I've tried working with EDI previously on it and was directed back through my clearinghouse. Clearinghouse says that no, it's an EDI problem. I'm just not sure where to go at this point.

Sumita Sen: This is Sumita Sen. You were saying that it's provider-level adjustment but it's being put at the claim level?

Gail Lamb: On the remit itself, it's being assessed to co-insurance code of 59 and therefore kicking it into the non-covered/denied section within the remit when it really is a provider adjustment.

Sumita Sen: OK, I think you know if you can send your question to the mailbox, I will take a look at it.

Gail Lamb: OK.

Chris Stahlecker: That sounds like something that's going to take some research and some joint conversation between the MAC and perhaps with the clearinghouse involved

in order to get to a root cause. So we've coordinated calls like that in the past and would be happy to help you out with this, but we would need a little more detail, so...

Sumita Sen: Please have the information along with your question...

Angie Bartlett: Include your MAC that you are working with in that e-mail.

Gail Lamb: Include the MAC?

Female: Yes, please.

Chris Stahlecker: That was the vendor of your software or your clearinghouse that you are using.

Gail Lamb: OK, I will include those in the e-mail.

Female: I just wanted to ask you also – does it have to do with multiple therapy reductions? You know, how we have Medicare policy that reduces the practice expense for multiple services – does your issue relate to that as well?

Gail Lamb: It does not, if I'm understanding your question correctly – that if there are multiple services given within the same day, there is a reduction amount on a multiple services.

Female: Right.

Gail Lamb: Is that what you are asking? I'm sorry?

Female: It has nothing to do with that?

Gail Lamb: It does not.

Female: OK.

Chris Stahlecker: We will look forward for your e-mail. Thank you.

Gail Lamb: OK, thank you.

Operator: Your next question comes from the line of Pamela Smith.

Pamela Smith: Hello, this is Pamela Smith from MCV Associated Physicians. I have not gotten a satisfactory response on receiving an 835 5010 test file from our MAC, J11. I've had several tickets in, the last ticket number is 1210407200, which I put in on April 26th. I subsequently spoke with a Melanie, who assured me that things were going to get taken care of, and I will get some sort of response.

I don't have a response and we still don't have a test file.

Sue: This is Sue from Jurisdiction 11. If you would please contact me, and I won't give you my phone number on here. If you want to give me your e-mail, I will e-mail it to you and we will follow up on that for you.

Chris Stahlecker: Or if you don't want to put your e-mail out there, you can send it to us through the resource box.

Sue: That would be great. Thanks, Chris.

Chris Stahlecker: We will make sure that Sue gets it.

Sue: Thank you so much.

Pamela Smith: OK.

Charlie Eleftheriou: And again just to reiterate, the e-mail address is down on slide 12. It's 5010FFSInfo@cms.hhs.gov.

Chris Stahlecker: And Pamela, we are sorry that you didn't get a response yet. But we look forward to helping you out here.

Pamela Smith: Thank you.

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

Chris Stahlecker: Diane, are you there?

Diane Loughley: Yes, hi.

Chris Stahlecker: Hi, go ahead.

Diane Loughley: Hi, this is Diane Loughley I'm with Quadax. We are clearinghouse and actually I do have a specific question. One of the providers who uses us a clearinghouse had an interruption in their 835 flow that suspended the 835 for some reason almost for two weeks. The question was getting an explanation as to what the interruption was, and this is in the J15 MAC for CGS.

And we had a CGS EDI ticket number and were working with a representative there and had multiple requests to provide some sort of explanation to the provider. But we've not gotten a response after multiple requests. Do you need the ticket number?

Angie Bartlett: Is anyone from J15?

Chris Stahlecker: In the queue, on the speaker queue.

Angie Bartlett: It seems we don't have anyone from J15 on the line right now. So what you can do is, can you please send your question in to the resource mailbox? Just all the information you gave us as well – you can go ahead and include your ticket number, and we will get a response back to you.

Diane Loughley: OK. I appreciate that, thank you.

Angie Bartlett: OK, thank you.

Chris Stahlecker: Thanks, Diane.

Operator: Your next question comes from the line of Alisa McAlpine.

Alisa McAlpine: Hi, I wanted to reference back to the lady with Cache Valley. I think she said where the – they are having an issue with the contractual – should be, they are being posted in the non-covered. We are also having that same issue.

Sumita Sen: And who is your MAC?

Alisa McAlpine: Trailblazer.

Sumita Sen: OK.

Chris Stahlecker: I believe we are going to have to also coordinate a discussion on that among various parties. So again, it will take a little doing to get the – that we would start with you sending us the detailed information.

Alisa McAlpine: OK. Our issue is only with claims that have been reprocessed.

Chris Stahlecker: That's good information to know, that could help us narrow the look.

Alisa McAlpine: And do you want us to send that information to the info line?

Chris Stahlecker: Yes, that would be helpful.

Alisa McAlpine: OK.

Chris Stahlecker: Because several people are going to be involved in troubleshooting it.

Alisa McAlpine: OK, I will get that to you. Thank you so much.

Chris Stahlecker: OK.

Operator: And your next question comes from the line of (Rhonda More).

(Rhonda More): Good morning. I'm calling from Dignity Health.

Chris Stahlecker: Hi, (Rhonda).

(Rhonda More): Good morning. I have a question, and it's both for J1 and JF MACs, that we are having an issue with cost report dates. Even though we are using the appropriate new value codes to identify the days, we are getting an edit saying that the days are not equal to what's being put in the (rep) codes.

It's coming up as an edit 15202. And we had not seen this prior to 5010 being implemented.

Sue: This is Sue from Jurisdiction 1. That, I believe, is a standard system denial. It's not something with EDI, so we probably should go with the mailbox for that, too, so that we can get that to the standard system folks.

(Rhonda More): I appreciate that help. Thank you.

Sue: Thank you.

Male: And this is JF. We have the same situation, and I believe we had that on the last call, and we had – we sent that over to another department outside of our EDI side to research that, so we'll also be getting that answer back. But I just want to include that this is also with JF. We can get you a response.

(Rhonda More): Thank you very much.

Operator: And your next question comes from the line of Gloria Davis.

Gloria Davis: Hi, Chris, this is Gloria. Just a question. We see the COB is – I'm sorry, we've been seeing with primary claims – and it hasn't been to one specific MAC, it's been kind of across the board. The first time we saw the issue was with First Coast in Florida, but I believe that they got the issue straightened out.

But when a provider sends a primary claim that has a tertiary payer as on there – so there would be three – there would be the primary payer and two other payers on there – the claims were rejecting. We understand that First Coast, or the client who first reported from First Coast, said the issue was resolved. And we thought that it was resolved across the board, but we are still seeing it with other MACs at this time. Have you heard of this issue?

Chris Stahlecker: We've heard of a similar issue, and that is – we were suspicious that the claim travelled out of a provider's billing system and to a clearinghouse, and then to a subsequent clearinghouse, and in troubleshooting that particular problem, we were suspicious that in that 837 forming, that the subscriber information that had one payer as their secondary payer on one claim and a different payer on a subsequent claim got combined.

So that there was more than one loop created underneath a subscriber for payer information, and that is what the error had been. The troubleshooting that we had done to the point of our discussion, that's where it was left – that the clearinghouses were working with the billing software vendor and the provider on troubleshooting that, and we did not hear that there was any additional trouble.

Gloria Davis: One that we had with First Coast, they were going direct to First Coast. You know, it was finally resolved and then there were finally good. The ones that we are seeing currently now, they are going through clearinghouses and they are getting the same error coming back. What was coming back was really a bad 999 coming back, because it was incrementing incorrectly in the 999 because it was finding that tertiary payer.

I can send more information in through the listserv exactly on this situation that I have, and maybe we can figure it out, because I really thought the issue was resolved, but I'm still hearing about it.

Brian Reitz: Hi, Gloria. It's Brian.

Gloria Davis: Hi.

Brian Reitz: Send it to me.

Gloria Davis: OK, I sure will.

Brian Reitz: OK.

Chris Stahlecker: Thanks, Gloria.

Angie Bartlett: I just want to remind everyone: If you guys have questions to please send them in, or please dial in to the queue.

Operator: Once again, if you would like to ask a question over the phone lines, press star one on your telephone keypad. Again, that's star one for questions.

Your next question comes from the line of Tim Barso.

(Mick Boskis): Hi, my name is (Mick Boskis). I'm with Datatel Solutions. We are a software vendor.

Charlie Eleftheriou: I'm sorry, could we ask you to speak up a little bit, please? We are having a hard time hearing you.

(Mick Boskis): Sure, my name is (Mick Boskis). I'm calling from Datatel Solutions; we are a software vendor. We are in the Trailblazer district, and my question is about MSP claims. Wanted to know what we should put in the payer I.D. field for MSP claims, when the primary claim went on paper?

Sue: This is Sue from Jurisdiction 4, Trailblazer. If – the payer I.D. is going to be the Trailblazer payer I.D. no matter when the claim comes or how the claim comes—paper or hard copy.

(Mick Boskis): Well when we submit the MSP claim, we have to put what the primary insurance paid. Well, when we include the amount the payer I.D. for the primary insurance is blank, because it actually went on paper.

Sue: You have to have that in there. I mean that's – it's a required field.

(Mick Boskis): Exactly, but if it went on paper what – is there a way, is there a workaround if it didn't go electronically?

Sue: No.

(Mick Boskis): OK, how are we going to submit those claims?

Sue: I would suggest that you contact our technology support center so that we can talk to you personally. That number?

(Mick Boskis): Sure.

Sumita Sen: This is Sumita. So let me ask you a question. Are you also receiving the 835 on paper, or are you receiving from your primary payer, or you're receiving an electronic 835?

(Mick Boskis): For those payers, we are not receiving 835s. For Medicare, we may be receiving 835s, but they are coming electronic.

Sumita Sen: So there is no payer I.D. on the paper or remit either.

Chris Stahlecker: OK, so you have Sue's e-mail address, or the contact center from our slide is appropriate, Sue?

Sue: Yes, it is.

(Mick Boskis): OK, so just send it there?

Sue: Just give us a call there and one of our technicians will speak with you in detail about it, and we will help you resolve it.

(Mick Boskis): OK, what is that number?

Sue: 866-749-4302.

(Mick Boskis): OK, thank you.

Sue: You're welcome.

Operator: And your next question comes from the line of Cynthia Sanchez.

Cynthia Sanchez: My name is Cynthia Sanchez, and I'm calling from Seton Highland Lakes, and our MAC is Trailblazer, and we are having an issue with the provider adjustment line, where it's a cancellation claim, which is 858, is being put in the non-covered, and I did contact the clearinghouse and our Trailblazer EDI.

I spoke to Cassandra and she said that there – it was a problem at this time. They didn't know when it would be fixed but it was at their UAT region being tested. And I was just wondering if it was because we received a negative reimbursement just because of our – on our reimbursement rate – and we are kind of like at a loss right now because we don't know how to make the accounts balance now.

Sumita Sen: So let me ask – this is Sumita Sen – let me ask you a question. So you are getting an 835 with denial of the whole claim?

Cynthia Sanchez: No, it's kind of like the similar issue that the other two representatives had called – or the other two providers spoke about, where they are putting the – whenever the correction claim, it's a cancellation claim, is being reprocessed, they are putting the provider adjustment line in the non-covered, and so it's not – it's like, we receive a negative reimbursement. So we are seeing two negative reimbursements for that same account number.

Chris Stahlecker: So, we were looking for some additional information in the resource mailbox. So that continued dialog could help us troubleshoot this issue. We are not going to resolve it right now.

Cynthia Sanchez: OK, so it's a 5010 inbox.

Chris Stahlecker: Yes, please.

Charlie Eleftheriou: Yes, it's on slide 12, 5010FFSInfo@cms.hhs.gov.

Cynthia Sanchez: All right, thank you very much.

Charlie Eleftheriou: You're welcome.

Chris Stahlecker: Thank you.

Cynthia Sanchez: Thank you.

Operator: Your next question comes from the line of Pat Trujillo.

Pat Trujillo: Hi, my name is Pat with Pathways Hospice, and CGS is our MAC, and we – back in March, we did the EDI application for use of our provider submitter I.D. for transmission under the 5010, and as of today, the claims are going through OK, under our I.D., but all of the remits are coming back under the CGS submitter I.D. Is that kind of a universal problem or...?

Nancy Turner: This is Nancy Turner calling from CGS, and if you would include that information in the e-mail address, I will be more than happy to respond to that.

Pat Trujillo: OK, and your name again please? I'm sorry.

Nancy Turner: Nancy Turner.

Pat Trujillo: Thank you, Nancy.

Nancy Turner: You are welcome.

Operator: Once again, if you would like to ask a question, press star one on your telephone keypad. Again, that's star one for a question.

And your next question comes from the line of Patricia Mink.

Tricia, your line is open.

That question has been withdrawn, and your next question is a follow up from the line of (Rhonda More).

(Rhonda More): I have a question regarding multiple PTANs that we have for our facilities. When we submit claims, generally 12x type claims, we consistently get ADRs. Is there a way to stop that with this new 5010 Version, since we are not supposed to be putting PTANs on the claims?

Chris Stahlecker: Can you say that question a little differently? Because I'm not sure that folks here are appreciating what the issue is.

(Rhonda More): OK, our facilities – our hospitals have both an acute care PTAN and an inpatient rehab PTAN, an IRF facility. When we submit a 12x type of bill, we receive an ADR back stating that there is more than one PTAN on file. And this is a consistent issue with four facilities that I bill for. It does not seem that, when we submit the claims, that it can be identified which is the correct, even though we use the appropriate (ref) codes, that it can identify that these should be actually under the acute care PTAN. Is there a way with the 5010

billing to resolve this issue, because 5010 billing, you no longer put the PTANs on the claims?

Matt Klischer: This is Matt Klischer here at CMS on the 837 institutional side, and on this – which MAC are you working with and which MAC service is your – is your provider?

(Rhonda More): J1 and JF.

Matt Klischer: OK, because this will be something – we will need to work together with, here at CMS, with the MAC, to find out what we can do to be able to resolve this for you. You can either – if you put it in the resource mailbox, you can put it to my attention. My name is Matt.

(Rhonda More): Matt?

Matt Klischer: M-A-T-T. That will be fine.

(Rhonda More): OK.

Matt Klischer: Thank you so much.

Chris Stahlecker: And (Rhonda) this is – and this is Chris Stahlecker too. I do want to just say that the level of editing that we put up front is really to make sure that the claim is clean enough to come in, and it does not resolve all the data inconsistencies in the claim. But some of those are handled in the adjudication system. I think that's what you are experiencing.

(Rhonda More): Well – and we had this issue prior to 5010 and we could never get it resolved, no matter – calling EDI, calling, you know, the provider service lines. It was never able to be resolved, and now that you no longer put PTANs on a claim, there has got to be a way, hopefully, to resolve some of this, of which PTAN do we use? You know?

Chris Stahlecker: So, in your e-mail, if you have a suggestion for the level of editing that you'd like to see happen upfront We've been sometimes cautioned not to make it be too restrictive.

(Rhonda More): Right.

Chris Stahlecker: We want to let the claim in. So if you have a suggestion, we'd be happy to hear it.

(Rhonda More): OK.

Chris Stahlecker: All right, thanks, (Rhonda).

(Rhonda More): Thank you.

Operator: Once again, if you would like to ask a question, press star one on your telephone keypad.

And your next question comes from the line of Jan Wheeler.

Jan Wheeler: Hi. I have a question regarding the MSP issue for that reject code 31313. If the claim is past filing deadline, how are those claims going to be handled?

Chris Stahlecker: That's something that you would have to take up with the MAC.

Jan Wheeler: It's not past the deadline yet, but it's going to be past the deadline by the time the fixes are in.

Chris Stahlecker: You know, there is – I know that there are situations where late filing is accommodated, if the problems are with the shared system software. So it is something for you to consider speaking with your MAC about. I hope that's helpful to you.

Jan Wheeler: I'm not sure, I'm going to have to wait and see, I guess.

Chris Stahlecker: OK, we do have a number of questions that we did receive as individuals registered for this call that – Matt has a couple 837 institutional-related questions. You want to see if there is anything more on the phone? Go ahead.

Charlie, I'm trying to overtake this.

What is the next step here?

Charlie Eleftheriou: Holley, do we have any questions in queue?

Operator: Charlie, we have no more questions at this time.

Charlie Eleftheriou: OK, well, just like Chris just mentioned, we will move to look at some that came in via the registration page. We appreciate all of you who sent in questions from the registration page. That's wonderful. We appreciate it. Thank you.

Matt Klischer: OK, this is Matt. One of the questions that was received was, what is the current version of the PCAs/Pro billing software? The Pro 32 – Pro 32 billing software. And the current release is 2.35. Those of you that are using 2.34, – that's still 5010 compliant though. That was one question that came in. So, the most current version is 2.35.

Also, there was a question that came in and it was a little bit vague, but it asked about configuration of NDC, or the National Drug Code information, and I don't know what claim format it is, you know, what line of business. But on both lines of business for the institutional and professional on the 837, the NDC is found in loop 2410. That's the LIN, the LIN segment.

So the TR3 is going to have notes and situational usage language says that you will be able figure out how to use or how to submit NDCs in that part of the guide. There is a person that asked a question about a change request that had to do with emergency transport or, like, nonscheduled transportation claims.

And it was CR7557, and I was able to get with the analyst, and the question they had was, if you have procedure codes that are in effect for nonscheduled transport as well as scheduled transport, if you put both of those on the same claim, the claim is considered then to be not meeting the criteria of a nonscheduled transport.

So, what that means is you'd have to have the attending provider 2310A segment on the claim. OK, you can only not provide that, or not have to have the attending if it meets the criteria of a nonscheduled transport claim, and

that's specific in that CR. And that person was just asking how – you know, what happens if you got two types? So two types makes it, in essence...

Chris Stahlecker: Logical?

Matt Klischer: Scheduled, right. Or not – doesn't meet the criteria. So at this time, do we have any more calls that came in the queue?

Operator: Not at this time, sir.

Charlie Eleftheriou: All right, give us one quick second to see if there are any other questions here we can address.

Brian Reitz: Hi, this is Brian Reitz, and looking through the questions that were submitted ahead of the call, there are a few that I should be able to take a stab at here. There was a question asked about billing oral anti-cancer drugs, and specifically you would need to contact your servicing MAC or DME/MAC to find out exactly what the policy is.

What I know about billing of the oral anti-cancer drugs is that they are billed on NDC codes. There is a process by which you have to submit a special code in the HCPCS if you are billing an 837, and then I assume that is the case here. The question didn't indicate whether it was NCPDP or an 837. If you are billing an 837, since you're required to submit an NDC code for this procedure, you are also required – in order to comply with the 837, you have to submit a procedure code, a HCPCS procedure code.

So the procedure codes have been established as to what you will submit in there, in essence a dummy HCPCS code, and then you would submit the appropriate NDC code for the drug that you are billing and that would go to the supplier for coverage. But whoever – if the person is still on this call right now who submitted this question, I would definitely suggest that you contact your DME/MAC, your servicing MAC for durable medical equipment, and just make sure on how to bill those claims to them.

There was another question submitted ahead of time regarding how to see the test results – of how to see results of a submitted test. I assume they are

talking about a 5010 transition testing. The submitter of the question was a skilled nursing facility and the answer depends. Typically, testing for the most part is done between your software vendor and the Medicare contractor. Software vendors are the ones that really want to see the results of the test, and they know how to read those.

If you are a provider, such as a skilled nursing facility, and you are doing your own testing, you should be receiving the results of that test. Now, the results of the test are nothing more than the acknowledgments coming back to you, indicating that your claims have passed.

And I would – I guess if any of the MACs that are on the call, if you have anything to add to this I don't believe that there is anything else that goes back to a submitter indicating what the results of the test were other than successful 277s and successful 999s. So that is what you would be looking at, that is your test result.

And one other question that was submitted here: What is the actual cutoff date for everyone to be 5010 compliant? Well, we actually passed that; it was January. We've been extending enforcement and allowing folks some opportunity to catch up.

But the date now that you really, really need to be in place is July 1. So that's the few questions that I was able to address for those submitted ahead of time.

Charlie Eleftheriou: All right, did we get any other calls come in while we were covering some of the questions that came in before the call?

Operator: Yes, sir, we did, but just as a reminder: If you would like to ask a question, press star one. And we do have a couple of questions in queue.

The first is from the line of Catherine Keslin.

Catherine Keslin: Yes, I'm Catherine, and I'm from Community Healthcare System, and this is not necessarily related to 5010. But we did get back a rejection a couple of days ago on a 277 for a Part B–only claim which was quite long, and it's

telling us that the service line number is greater than the maximum allowable for payer.

When I look at the 4010/5010 crosswalk, it looks like up to 999 service lines would be acceptable. Is that correct?

Male: No that's, that part is not correct. It's what it says in the QR3. But Medicare has a limit of 450 service lines.

Catherine Keslin: 450.

Male: Yes.

Catherine Keslin: OK, thank you.

Male: You're welcome.

Operator: And your next question comes from the line of Gloria Davis.

Gloria Davis: Hi, this is just a quick question. In regard to the edits, the edits for both the 999 and the 277CA is – are there any notifications, when you make the changes to the edit sheets? I understand of reading at the April release, July release, and all of that. But is there any notification of when you have a new – or you've made changes to those edits so that we know to go and look for the new ones? Because I just downloaded those spreadsheets.

Brian Reitz: Hi, Gloria. It's Brian Reitz, and the edit releases go through the normal change request process and from my understanding, each CR that is issued has a MedLearn Matters article that normally follows that. That is my understanding of how they are communicated to the general public, that we now have this new set of edits out there.

We do publish the list. We post it to our Web site. And looking to Jason, if he can, if he knows the site link – if he doesn't, that's fine, I can get it to you.

Gloria Davis: No, I have the link. It was just that I haven't been able to find the MedLearns or the notification of when those edits have changed. And so that's what I

was looking for is that I have been trying to find something to notify me, when those edits do change.

Brian Reitz: Well, just – they will change every quarter.

Gloria Davis: Right.

Brian Reitz: I mean, we will always have changes to be made. We've yet to have a release where there was nothing to be done in the spreadsheets, so regardless of how many or how few, we will have changes quarterly. So expect to see them.

Gloria Davis: If even just – so an example is, that for the quarter, is that what I expect to see those changes like the first week after the quarter.

Brian Reitz: I'm sorry, I was being posted a note to comment on. What was it Jason – the four months prior?

Female: Go ahead.

Brian Reitz: Yes, we post them on our Web site four months prior to the implementation.

Gloria Davis: OK.

Brian Reitz: We have a five-month lead time, so for example, right now I'm crafting the spreadsheets for January 2013.

Gloria Davis: OK. All right, that is – then I will just – and I will go look again through the MedLearn modules again to see if I can find – I just haven't been able to find the notification of the new edits.

Brian Reitz: OK.

Gloria Davis: Thank you.

Brian Reitz: Sure.

Operator: And your next question comes from the line of Troy Burrus.

(Connie Melcher): Hi, this is (Connie Melcher) from Washington University. I've been sitting on the call, too. I have a question for you guys, and I don't want to say this is necessarily 5010 related, but it did start happening after 5010. When we bill a noncovered code, and I'm going to use robotics for an example, we are a university, so S2900 – we are getting an electronic rejection that we can't send that claim into WPS because we have a noncovered service on there.

Prior to 5010, when we were on 4010, we could bill that and get denied, so I could bill it out to a secondary payer. When I spoke with WPS, they were pointing me to their Web site, telling me to print off a sheet and turn it in. But I ran into problems because we have to do charge corrections, we have to remove that code to get it off the invoice to bill Medicare, we have to do another charge correction to add it back.

So is this something that's normal? Because when I go out to the CMS fee schedule, I see that code listed with a zero. WPS tells me they don't even have that code in their system.

So how are we supposed to do this? And here is a nice kicker: If I happened to bill you guys secondary, I have to have that on EOB. So I don't understand the backwards concept on why I can't bill for a denial for a secondary payer, billing you guys primary.

Brian Reitz: Hi, this is Brian Reitz. The situation – the reason why it changed from 4010 to 5010 is in the 5010 implementation, we built a common edits and enhancements module. We built the front end, and that front end contains tables for the code sets, and the code sets for CPT as well as HCPCS are loaded in there. Medicare did not load CPT codes and HCPCS codes which it has no coverage for. And what had happened was the X12 workgroups, in anticipation of the need for providers to submit claims for denial purposes, included a segment, an AMT segment, in the section of the transaction, the Coordination of Benefits section, which allows the provider to bypass having to submit claims for denial.

So that's the reason why you're seeing it now and you weren't seeing it before. We didn't have a front end before. We took the procedure codes regardless of what they were, brought them into the system. If there was a zero in there, we denied them as probably an invalid code, maybe we denied them as a noncovered. I can't speak to how they were denied, but they would have been denied that way. But we are not doing that now. We believe that that's not a very good use of the Medicare Trust Fund to simply clear claims and deny them using Medicare resources, when we have no coverage for the service to begin with.

(Connie Melcher): OK, but do you realize that creates an issue on the provider side? Because we have – we send our claims through a scrubbing system. So there are things on there that should be bundled. I'm having to unbundle them, I'm having to do charge corrections. You're really putting a lot more work on the payer side.

Plus, if there was – this was something that I was billing out to a primary insurance, that they said, "Oh, go out to the Web site and print this little piece of paper and bill Medicare." I have other payers I'm required to bill electronically, too. So, if I was – since I'm required to bill you electronically, how would I bill Medicare electronically in that same scenario? So I don't believe that's a level playing field across the board for everyone.

The only other comment I'm going to make on top of that: The edit that you guys have in place for – I know you're comparing all the claims to the post office ZIP code file – that edit is a little bit invalid because we get one back saying, the primary EOB is missing on secondaries, and it's really a ZIP code issue. But I still don't agree with you on the not allowing to bill for denial.

Chris Stahlecker: That's fine. If you would like to share your thinking with us, you know, go ahead and send us an e-mail in the resource box. We can take that into consideration, but at this point in time, we don't have that process in place to receive the AMT for Medicare secondary payer. And we are expecting this to be a longer term socializing the solution with the crossover trading partner community.

So we are optimistic that will become a workflow going forward. But we are happy to have you share your thinking with us in the resource box.

(Connie Melcher): All right, thank you.

Chris Stahlecker: Thank you.

Operator: At this time, there are no further questions. Charlie, I will turn it back over to you.

Charlie Eleftheriou: OK, great. We thank everyone for all their – just kidding, I think we have one more here in the room.

Jason Jackson: Hi, we did. This is Jason Jackson. We do have one more question that we can answer, that we found. The question submitted was, we get denials for detailed descriptions of service – or the denials that the detailed description of service is missing/invalid. Where can we get a list of codes needing detailed descriptions, and what specific information are they looking for? Simply a cut-and-paste of the CPT description, or specifics such as lot number on meds, units given, et cetera? This is actually the NOC code list that we have produced, and I will give you the e-mail address. It's actually little bit long. It's www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/FFSEditing, and down at the bottom we have a list of our NOC codes, and this is being updated on a quarterly basis, and for those NOC codes – technically you can put anything in there. The goal of the field for the description is to put as much information as possible in the ...

Male: SB1017 or SB2017.

Jason Jackson: Which makes it?

Male: Eighty.

Male: Eighty bytes.

Jason Jackson: Eighty-byte fields. So therefore, you know, that can hopefully alleviate any need for an ADR or further development of the claims.

Additional Information

Charlie Eleftheriou: All right, I think that does it for us. Again, I will thank everyone for all their questions. If you have or think of an additional question to ask, please feel free to e-mail it to the resource box, which again is on slide 12. It's 5010FFSInfo@cms.hhs.gov.

Please note that while we may not to be able to address every question, we will review them all to help us develop Frequently Asked Questions, educational products, and future messaging.

Looking at the last slide presentation quickly, slide number 13: I will also point out that all registrants for today's call will receive a reminder e-mail from CMS from the National Provider Calls Resource box after this call regarding the opportunity to submit an evaluation of the call. You may disregard the e-mail if you already completed the evaluation.

Please note that evaluations will be available for completion for five days from the date of today's call, and we do appreciate the feedback.

And finally, I would like to remind everyone that details about this call and other CMS National Provider Calls can be found on the National Provider Calls section of the CMS Web site at cms.gov/npc as in "National Provider Calls." Again: cms.gov/npc.

There you will find more information about the National Provider Call Program as well as a listing of upcoming calls and an archive of materials from past calls and events. Thanks again to everyone who participated in today's call, both on the phone and here in the conference room at CMS.

I wish everyone a great day. Thanks for participating. And the calls in the queue. Thank you. Goodbye.

Operator: Thank you for participating in today's call. You may now disconnect. Speakers, please hold the line.

END