FTS-HHS/CMS

HIPAA 5010 and NCPDP D.0 COB Testing Call

Moderator: Brian R. Pabst
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****DISCLAIMER:** The following is a transcript of a call between CMS and numerous State Medicaid Agencies and their fiscal agents. Whenever discussion points or answers given deviate from COBA documentation, such as the COBA Implementation Guide or future 5010 and NCPDP D.0 Companion Guides, please note that the language in these resources should be regarded as the most correct depiction of CMS COBA crossover operational policy.**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. After today's presentation there will be a question and answer session. At that time to ask your question you press star then 1 on your touchtone phone.

Today's conference is being recorded, if you have any objections you may disconnect at this time.

I will now like to introduce your host for today's call we have Mr. Brian Pabst sir you may begin.

Brian Pabst: Good afternoon, Lori, and thank you. Good afternoon everyone, for those of you who aren't familiar with my voice, I am Brian Pabst, the CMS Government Task Leader for the National COBA Crossover Program.

I welcome you to today's teleconference presentation regarding the HIPAA 5010 and NCPDP D.0 COB Testing.

CMS hopes its presentation will be useful to all state Medicaid agencies and their fiscal agents that currently participate in the COBA crossover process as they plan resources and processes that will ultimately lead towards their full implementation of HIPAA 5010 and NCPDP D.0.

Before I introduce members of the CMS and COBC COBA teams as well others who are present, I offer a word of caution to our teleconference participants: Please note that CMS will not be entertaining any questions that fall outside the scope of 5010 and NCPDP D.0 COB testing during this call. The purpose of this meeting is to discuss at a high level what willing testers may expect once CMS makes available 5010 and NCPDP D.0 COB claims to them for testing.

Now for some introductions of the CMS COBA team and various members of the COBA team and others who are present either by phone or in person…. The first person I'd like to introduce is Anne Wood, of the COBA team. She is a very invaluable member of that team, serving as the lead person responsible for financial issues and also, in some cases, she is your CMS COBA representative. Rick Mazur has joined as well; he is also very integral member of the COBA team, and some of you may already know him within the context of his being your CMS COBA representative.

Present with us today from the COBC are Bill Ford, our COBC EDI manager; John Leo, our COBC EDI supervisor; Don Fleischman, who is our technical consultant working on the COBC translator with Janice Pollard, who is joining us by phone. Charlie Collins is joining us by phone, and his is a systems engineer with VIPS/General Dynamic and is a very key player in terms of programming on the COBA team.

Also joining us by phone are Jim Brady and Donna Robinson Razor. Jim Brady is the COB project director. And Ms. Razor is our COBA marketing director. And present with us at CMS as well is Billy Haddox, an employee with ViPS/General Dynamic, who has a key role as part of our COBA process in terms of business analysis and programming.

Alan Shugart, with whom many of you are familiar, is also present with us at CMS today. He formerly was with CMS and served as an extended member of the COBA team. He left CMS and now has returned. Also with us in person today is Chris Stahlecker, who is a director within the CMS Office of Information Services (OIS) division responsible for HIPAA EDI compliance. And, along with Chris, we have Cathy Carter who is joining us today via phone. Cathy is a group director at CMS within OIS in the area responsible for HIPAA EDI compliance.

Now that we've had our introductions, I will now present information to you that topically follows the agenda your received point-by-point. So if you're following with us, the first item I am going to address is "Calendar year 2010 Testing Timeframes for 5010 and NCPDP D.0 Crossover Claims Testing."

Following some thoughtful and productive internal discussions, CMS has determined that it will be in a good position to offer external testing to all of its COBA partners during the period from June 1st to December 31, 2010.

CMS would actually prefer that all COBA trading partners that are willing to test during this time frame do so concurrently in the interests of stressing our test systems and uncovering any potential issues, which we hope and pray are not there.

Thus, there will be no attempt on either CMS or the COBC's part to assign COBA Trading Partners to differential testing windows during the June to December 2010 timeframe or after. Without question, all COBA trading partners will be eligible to receive the 5010 NCPDP D.0 crossover claims from the COBC during this timeframe.

As we had indicated during the winter COBVA broadcast to you, COBA Trading Partners that take advantage of 5010 and NCPDP D.0 testing the June through December 2010 timeframe will realize two benefits or advantages: 1) An ability to actualize any internal testing changes that payers have made as the result of their own internal testing by testing with a very large external trading partner, namely, CMS; and 2) you will realize greater readiness for the acceptance of 5010 and NCPDP D.0 claims as of January 2011—the timeframe when most providers, physician and suppliers will begin submitting HIPAA 5010 and NCPDP D.0 claims in production to Medicare.

To realize this later advantage, the interested COBA trading partners will, of course, need to move into production on those formats by January 2011. And, CMS and the COBC are jointly committed to assisting as many COBA trading partners as possible with meeting this goal.

The next item on the agenda that you'll find is a discussion of "COBA identifier and contractual changes needed prior to testing." All COBA trading partners will be able to utilize their current 5-byte COBA identifiers for purposes of 5010 and NCPDPD.0 COB testing with the COBC. Only in those cases where a COBA trading partner wants to vary its claim selection criteria while testing, would it be necessary for the trading partner to apply for a new unique 5010 or NCPDP D.0 test COBA ID.

In terms of contractual changes to indicate the desire to begin this type of testing, CMS and the COBC are in the process now developing a COBA 5010 NCPDPD.0 Testing Assessment Document, which, in effect, will represent an addendum to the COBA agreement. Our interested trading partners will need to complete this document prior to commencement of 5010 and NCPDP D.0 testing. We are targeting issuance of this document via COBVA broadcast in late July of this year.

Though it is not necessary for COBA trading partners to obtain new COBA identifiers for the testing of 5010 and NCPDPD.0 Claims, all COBA trading partners that will test 5010 and NCPDP D.0 claims with the COBC will need to complete an Electronic Transmittal Form, or ETF. Completion of the ETF will facilitate a new dataset name, thereby ensuring that the COBC will be able to properly direct test claims to each COBA trading partner, independent of production 4010-A1 and NCPDP 5.1 batch claims.

COBA Trading Partners will also be able to retain their current Secure F-TP (STFP) mailboxes while testing the 5010 and NCPDP claims with the COBC. The COBC will, however, need to establish a new transmission ID in connection with the usage of SFTP mailboxes to ensure that test claims will be properly routed.

The next topic that I cover, as referenced on your agenda, is “continuing receipt of production transmissions while testing is under way.” The CMS and COBC want to assure all COBA trading partners that they will continue to receive their production 4010 A1 and NCPDP 5.1 batch production claims from the COBC at the same frequency and via the same connectivity methods while they are simultaneously testing the other claim formats.

That said, prior to commencement of the testing process, COBA trading partners will need to make some systematic modifications to accommodate the reality of what we call “true parallel production”—that is, receipt of the same claim, down to ICN, procedure and diagnosis code, and service dates, in both the 4010 A1 production mode and the 5010 or NCPDP 5.1 production mode and NCPDP D.0 test mode. In other words, you’ll be getting a copy of the same claim—one in 4010-A1 (production) claim format, coupled with one in the 5010 (test) claim format; and one in NCPDP 5.1 (production) claim format, coupled with one in the NCPDP D.0 (test) claim format.
IMPORTANT: COBA trading partners should note that they should **not** make payment to providers, physicians, or suppliers in association with test claims received since these claims do not represent “true production.”

The next item on the agenda is “claim volumes.” In a related vein, COBA trading partners will notice that for COBA identifiers under which they receive 5010 or NCPDP D.0 test claims, they will receive the same volumes as they do in production. It is very important, again, that the trading partners realize that every 5010 claim that the COBC generates to them in test will be an exact duplicate of the 4010 A1 claim they receive in production. And, if they need to take necessary actions to allow for this reality during the testing period, they need to do so prior to commencement of testing.

The next item for the discussion is “Availability of HIPAA 5010 and NCPDPD.0 Companion Guides.” By late July 2009, CMS is planning to release HIPAA 5010 and NCPDP D.0 Companion Guides to all COBA trading partners. These documents will include, among other things, a listing of delimiters as well as non standard alphanumeric or numeric values—that is, values not specifically defined by the TR3 Implementation Guides or that are not within supporting source tables or listings—along with the corresponding 837 data fields (or elements) in association with the 837 institutional or

professional claims. Additionally, the Companion Guides will highlight new placement of information in specific situations where data had previously been either the notes (NTE) segment or the K3 segment. These two resources should prove extremely valuable to COBA Trading Partners not only in association with 5010 and NCPDPD.0 Testing but also when they move into production using those claim formats. Once completed, the COBA Companion Guides will be released via our COBVA broadcast system and will also be made available on CMS's COBA website.

Our next item for discussion is "Future Availability of the Revised COBA Implementation Guide." The CMS and COBC teams are retooling their ever popular COBA Implementation Guide at the present time, and we are planning to finalize work on this by late July 2009. Updates will be specific to HIPAA 5010 and NCPDP D.0 as well as current COBA test and production processes. The revised Guide will be accessible on CMS's COBA website. Due to its size, CMS believes that the signing of this document via COBVA broadcast may not be viable, although we will check that out.

A very important notion for all of us to realize is that the current and future claim formats that we use within the crossover process are different, and I'm now going to highlight very high level discussions of those differences. As early as late last summer, CMS issued a COBVA broadcast that featured a 4010 A1 and 5010 side-by-side comparison document. That document highlighted, even at that early point, some of the key differences between the two claim formats. Indeed, it illustrated that certain elements were either changing from situational to required or were disappearing. It also illustrated that certain loops were being completely reordered and confirmed that several elements were being newly introduced within 5010 format. To assist our callers with identifying some of the more noticeable changes, I will draw upon some of the information conveyed in a recent OIS presentation delivered at

CMS. Then I will present some of the observations that the CMS and the COBC COBA team members have made concerning the differences between the formats.

The 5010 claim format allows for separate diagnosis code reporting by principle diagnosis, admitting diagnosis, external cause of injury and reason for visit. Indeed, as we are all discovering, the 5010 format serves as the foundational transaction for the robust reporting of morbidities and co-morbidities in the framework of the ICD-10 code set. The same cannot be said the 4010 A1 claims format.

The 5010 claim format adds a new element for present automation or POA indicators within the 837 institutional claim. Most of you aware, I'm sure, that in the current production 4010 A1 version the POA indicator is afforded a default placement within the K3 segment.

Unlike the 4010 A1 format, which supports reporting of anesthesia time in terms of either minutes or units, the 5010 professional claim format only allows for reporting of anesthesia services in terms of minutes. This will probably be a welcome change for a great many COBA trading partners, at least from a payer consistency viewpoint.

The 5010 claim creates new required pickup location elements in association with ambulance supplier claims. Now if incoming electronic claims do not have both pick up and drop off address locations, such claims will not be considered HIPAA compliant. Thus, such claims would never reach COBA trading partners for crossover purposes.

The CMS and COBC COBA teams have additionally observed that the 5010 claim version removes almost all "AMT" segments, with the exception of

those that reflect amounts paid by Medicare or by payer that is primary to Medicare. In other words, all approved or allowed amount AMT segments are disappearing within the 5010 format. Why? At the X-12 Committee, the thinking in this direction is that all payers, including Medicaid, will be able to approximate another payer's approved amount by taking the total amount billed and subtracting any reported CAS*CO*45 monetary amount to realize the amount Medicare or another payer would have allowed.

One important change from the 4010 A1 to the 5010 claim format is that Medicare will now insist that all 837 institutional professional claims balance, just as all financial information must currently balance in association with the 835 ERA.

Lastly, something that will definitely be of interest to Medicaid State Agencies and their fiscal agents is the following: Many of the restrictions concerning the reporting of taxonomy code within the PRV segments that once appeared in the 837 (version 4010-A1) professional Implementation Guide are now removed within the TR-3 Implementation Guide. Happily, the present 837 4010-A1 institutional IG never imposed any such restrictions, and the new TR3 Guide for 837 institutional claims imposes no new challenges in that regard.

I thank you all for giving me your undivided attention this afternoon as I, on behalf of CMS, outlined for you various topics that we, at CMS, hope will help you better appreciate how the 5010 and NCPDP D.0 COB claims testing process will unfold beginning in June 2010.

Operator, we are now ready to take questions from those on the phone.

Operator/

Coordinator: Thank you sir. If you would like to ask a question, please press star, then 1 on your touchtone phone.

If you need to withdraw that request, press star 2. And let's hold one moment for the first question.

Your first question is from Michael Heady. Your line is open, sir.

Michael Heady: Hi. Could you give me the date again for when the Companion Guides will be released?

Brian Pabst: Yes sir, we're planning to release the Companion Guide, along with our revised COBA Implementation Guide and the 5010 and NCPDP D.0 Testing Assessment document in late July of this year.

(Michael Heady): And while I'm asking I had another question regarding the date by which the ETF Form needed to be completed before testing would begin.

Brian Pabst: It could be anytime. We will not commence testing until June 2010. So, you could delay completion of the ETF until just before that timeframe if desired.

Michael Heady: Okay, great; thank you.

Brian Pabst: You're welcome.

Coordinator: Your next question is from Nina. Your line is open.

Nina: Hello, you mentioned that the Medicare allowed amount will be going away with 5010 and how it can now be calculated. Will there be recommendations

or clear guidance on how we can determine the allowed amount—the Medicaid allowed amount.

Brian Pabst: We are planning to address that in our Companion Guide.

Nina: Okay, that's what I assumed. So they'll actually be the formula or a calculation to help us because I know that's a big concern here.

Brian Pabst: Yes. The main thing is that we have to remember that, in terms of calculation of Medicare's allowed amount, the CAS*CO*45 segment really becomes your best friend in that respect.

Nina: Mm-hm.

Brian Pabst: That is to say that if you take the amount billed and subtract the CAS*CO*45 segment, you will arrive at Medicare's allowed amount. If you then subtract further CAS segments, as expressed by CAS*CO and CAS*PR, from what you have derived as the Medicare allowed amount, you will be left with the amount Medicare paid.

Nina: Okay; right.

Brian Pabst: And that for the most part is a very good method for determining Medicare's allowed amount. However, there will be certain instances involving IPPS (inpatient prospective payment system) claims where you will actually need to add the amount, expressed by CAS*CO*94 to the billed amount and then subtract the CAS*CO*45 to derive the Medicare allowed amount.

(Nina): Okay, great, thank you.

Brian Pabst: You're welcome.

Coordinator: As a reminder, to ask your questions, please press star, then 1 on your touchtone phone.

The next question is from Ethie Blake. Your line is open.

Ethie Blake: Hi, this is Ethie Blake. Brian, earlier in your presentation, you referenced a compare document that was distributed to the COBA Trading Partners. Was that via COBVA?

Brian Pabst: Yes, and it was sometime during late summer in 2008 that we issued that, as far as I can remember. COBC will confirm for you off-line.

Ethie Blake: Okay, thank you.

Brian Pabst: You're welcome, Ethie.

Coordinator: Your next question is from Steven Bishop. Your line is open.

Steven Bishop: Hi, are there going to be any changes with how we send enrollment data to you as part of this project?

Brian Pabst: Do you mean with respect to eligibility for crossover purposes?

Steven Bishop: That's correct.

Brian Pabst: No, sir; none contemplated.

Steven Bishop: Okay.

Coordinator: As a reminder, to ask your questions, please press star 1. Your next question is from Stacy Barber. Your line is open.

Stacy Barber: Yes, my question concerns the testing window is from June 1, 2010 to December 31, 2010. If a trading partner is not ready to test during that time frame, is there going to be an additional testing window that is available for trading partners. Or, is that the only window available for testing?

Brian Pabst: Stacey, we're making that testing window available hoping that a lot of folks will have gotten so far with their internal testing that they will feel that it will then be appropriate to test with CMS. The June to December 2010 testing timeframe is not the only window, but it is the earliest available window for 5010 and NCPDP D.0 testing.

Stacy Barber: Okay, thank you.

Brian Pabst: You're most welcome.

Coordinator: Your next question is from Gwendolyn Crenshaw. Your line is open.

Gwendolyn Crenshaw: Yes, I have a two-part question: Part 1: We will be having more meetings as the time gets closer to 2010, right?

Brian Pabst: Do you mean via Open Door Forum or via the bi-monthly Medicaid meetings?

Gwendolyn Crenshaw: Internal meetings involving Medicaids.

Brian Pabst: CMS will most likely have several internal meetings with Medicaid before commencement of testing in 2010. These could occur as part of our normal bi-monthly calls. However, rather than the meetings occurring bi-monthly, these meetings would most likely occur much more frequently prior to June 2010.

Gwendolyn Crenshaw: And, now for the side portion of my question: In terms of the NCPDP D.0 claims, will the States then be picking up parts of the drug claims that Medicare does not cover?

Brian Pabst: Now I believe may be heading in the direction where a lot of people go when it comes to NCPDP, and that is to assume that NCPDP refers to Part D COB activities. When CMS refers to NCPDP within the crossover context, it is referring to NCPDP balances tied to Part B claims for oral cancer medications or immunosuppressive drugs.

Gwendolyn Crenshaw: Okay.

Brian Pabst: Such claims would come to you in the NCPDP batch claim format rather than via real-time transmission directly from pharmacies or suppliers.

Gwendolyn Crenshaw: Okay that clears it up. Thank you.

Brian Pabst: Have a good day.

Coordinator: Your next question is from Jodi Holmes. Your line is open.

Jody Holmes: Yes hi, this question is regarding the dates for testing and implementation. You stated that June 1 2010 to December 31, 2010 will be the first available testing window. And then I'm not clear about what you stated regarding

January 2011. Is that the start of the dual usage period where providers or clearing-houses could send us 5010 as well as 4010 in production or did that timeframe refer to something different?

Brian Pabst: Yes, you're correct, Jody. But the main thing we wanted to emphasize is that if, during the 2010 testing period, COBA trading partners become comfortable enough to move into production, we wouldn't expect them to still be receiving 4010-A1 in production. They would just receive the 5010 claim version at that point.

So we're not going to be sending you a 4010-A1 and a 5010 "production" claim at the same time. The providers are going to be able to send either claim format to Medicare beginning in January 2011. And, prior to that timeframe, we're offering a COB testing window in case folks would like to get an early jump at dealing with the new format. If COBA trading partners are ready to accept 5010 claims by January 2011, this allows for complete throughout in a great many instances, considering that a great many providers will, by then, be submitting claims to Medicare in the 5010 format.

Jodi Holmes: Okay; thank you.

Brian Pabst: You're welcome.

Coordinator: Your next question is from Rene Thomas. Your line is open.

Jan Thornton: This is Jan Thornton, and I work with Rene Thomas at Kentucky Medicaid. What is Medicare's cutoff date for accepting 4010 A1 and NCPDP 5.1?

Brian Pabst: Jan, first, to address your question from a broader COB perspective, if folks have not approached us by perhaps May or June of 2011 to start testing, we're

going to approach them because if trading partners have not begun testing by that timeframe, this makes CMS very nervous. Under most circumstances trading partners tackle testing within 90-120 days and then are sufficiently happy with the results. But there are some who will need a full six month testing window before they will be ready for 5010 production claims. Thus, taking that into consideration as a benchmark, if trading partners have not begun testing before May to June 2011, CMS will be contacting those entities.

But the bottom line is that we have to cut off the crossover claims in this 4010- A1 and the NCPDP 5.1 formats as of December 31, 2011. The HIPAA 5010 regulation clearly states that as of January 1, 2012, all payers have to be accepting claim transactions in that format. Thus, you would no longer be able to receive claims via the crossover process after that date.
Does this speak to your question adequately?

Jan Thornton: Yes, that's fine; thank you.

Brian Pabst: Okay. Thank you.

Coordinator: Your next question is from Stacy Barber. Your line is open.

Stacy Barber: After January 2011, if Medicare receives your claim in the 5010 format from a provider and the trading partner is not ready to receive 5010 what's going to happen with that claim? Will Medicare be able to cross it over or not?

Brian Pabst: We would but, that is not our preferred state and this represents one of the reasons why we're encouraging folks to test during 2010. We are hoping we can avoid that eventuality. However, we have in place a systematic process that we can activate that will allow for transmission of an incoming 5010 claim as an outbound 4010-A1 "skinny" claim.

Stacy Barber: Okay. Thank you.

Coordinator: As a reminder, to ask your questions, please press star then 1 on your touchtone phone.

Your next question is from Evelyn Roberson. Your line is open.

Evelyn Roberson: Yes, I understand about 5010 claims format, but the in terms of the NCPDP DO format for crossing over pharmacy claims, we presently receive them as Part B claims on the CMS-1500 claim form. Must we move towards acceptance of the NCPDP D.0 format?

We must move towards the NCPDP DO?

Brian Pabst: Hi Evelyn, to answer your question, when it comes to crossover, we're offering the NCPDP D.0 batch format whereas today we transmit the NCPDP 5.1 batch format. But as you may know, a supplier may bill a claim for Part B drugs to us in either the NCPDP or the professional claim format.

(Evelyn Roberson): Mm-hm.

Brian Pabst: And, as it true today, we would simply cross the claim over in the manner that it was received. So if we received the claim in 837 professional format, that's how you would receive it. If, by contrast, we received the claim in the NCPDP D.0 format, that's how it would come to you via crossover. But there is no compulsion one way or the other. You may exclude either NCPDP or 837 professional claims via the national COBA crossover process. But as far as the CMS-1500 claim format goes, that would be something that would probably be internal for you, because as you know we don't cross claims over in that format.

Evelyn Roberson: Yes, but, we presently receive them as what we call “physician other services.”

Brian Pabst: Yes, and it is still possible that you could receive Part B drugs via the 837 professional format (version 5010) if that is how the pharmacy or supplier billed the claim to Medicare.

Evelyn Roberson: Okay; thank you.

Brian Pabst: You’re welcome.

Coordinator: Your next question is from Betty Woodson. Your line is open.

Robert Bell: Yes, actually this is Robert Bell. The question I had--and it’s a clarification question. Someone was asking if Medicare receives a claim from the provider in the 5010 format, and the actual Medicaid was not ready to accept that 5010 format, how would you cross it over? Would you transfer the claim in the 4010-A1 and map backwards, or would you send the claim in the 5010 format as the provider sent it to Medicare?

Brian Pabst: The Medicaid would receive a 4010 A1 production claim, but the claim would be in what we call a “blended or a skinny” version, which means that our Medicare shared systems would produce the outbound COB claims file as if the incoming claim had been submitted to Medicare via hard copy (paper UB-04 or paper CMS-1500).

Robert Bell: So it would be a full 4010-A1 production as far as the format, but some of the full data content may not be mapped over. Is that correct?

Brian Pabst: The data will be there, it's just that certain fields not currently available on incoming paper claims but that are required for HIPAA compliance with contain gap-filled values or notations such as "submitted but not forwarded."

Robert Bell: Oh, okay; thank you.

Brian Pabst: You're welcome.

Coordinator: Your next question is from Mary Kay McDaniel. Your line is open.

Mary Kay McDaniel: Good morning, Brian, and great job by the way. Let me just clarify that, as of January 1, 2012, no matter what format you get the claim in prior to then, we will receive the outbound crossover claim in the 5010 format, unless we're incapable of receiving the 5010 and you'll create the skinny 4010 A1.

Brian Pabst: Mary Kay, you've drawn a very good demarcation line in the sand in terms of what happens as of January 1, 2012. As of that date, there is no skinny process for converting from incoming 5010 to outbound 4010-A1. If an entity is not able to accept claim in production in the 5010 format claim by that date, CMS will discontinue the crossover process with that entity until it is able to accept production claims in that format.

Mary Kay McDaniel: Okay. And to just kind of further that, if between January 2011 and December 2011, the provider submits the claim to Medicare in the 4010-A1 format but we are ready to accept the claims in the 5010 format, is it correct that Medicare would be able to convert the claims to 5010 for COB purposes?

Brian Pabst: Yes, though, you would receive a 5010 "skinny" claim, since the original claim was submitted to Medicare in the 4010-A1 format.

Mary Kay McDaniel: Okay, I think that answers my question. Thank you so much.

Brian Pabst: You're welcome.

Coordinator: Sir, the next question is from John Bock. Your line is open sir.

John Bock: Hey Brian, I want to clarify the NCPDP D.0 discussion a little better, just to make sure that I'm following it correctly. In today's world, in terms of those anti-cancer drugs and whatever come in on the professional claim, am I hearing that, under the new rules, Medicare will accept the claim no matter how the provider submits it but then we will have to accept the claim as the NCPDP D.0 format?

Brian Pabst: John, I know that, in terms of NCPDP batch COB claims, not a lot of folks accept such claims, for whatever reason. In your COBA agreement, you have the opportunity to exclude NCPDP claims if desired.

John Bock: I understand that. If we do not change to take such claims, we will be losing crossover claims that we normally would be receiving.

Alan Shugart (CMS): I think John is trying to determine if Medicare will send the claim out exactly as it comes in with respect to Part B drug claims. Is that correct?

John Bock: Yes. Aren't the vast majority of drug claims submitted in the 837 professional format?

Brian Pabst: The majority do come in to Medicare in the 837 professional format. The key with respect to pharmacy claims, though, is that however the claim is submitted is how it must go out for COB purposes. There cannot be an instance of NCPDP D.0 coming in and 837 professional going out.

John Bock: Okay; thanks.

Coordinator: The next question is from Verita Buck. Your line is open.

Verita Buck: On the 4010 A1 format, we're finding that we're not always getting the NDC on our 837 professional crossover claims. To whom should we address this?

Brian Pabst: You will want to contact either your CMS or COBC COBA rep. and provide examples so that this matter can be researched for you.

Verita Buck: Thank you.

Brian Pabst: You're welcome.

Coordinator: And, as a reminder, to ask your question, press star then 1. Sir, there are no further questions at this time.

Brian Pabst: Well, thank you very much; I assume that concludes the call. Is that correct?

Coordinator: This does conclude today's conference. Thank you for joining and you may disconnect.

Brian Pabst: Thank you.

END