Centers for Medicare & Medicaid Services
HIPAA Version 5010 National Provider Call: MEDICARE FFS' Discussion of Eligibility Request/Response
Moderator: Aryeh Langer
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Contents

Welcome

Operator: Welcome to the HIPAA Version 5010 National Provider Call, MEDICARE FFS's discussion of eligibility request response conference call. All lines will remain in a listen only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. MEDICARE FFS greatly appreciates that many of you greatly 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 key pad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, please enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9. Thank you for participating in today's call. I will now turn the conference over to Mr. Aryeh Langer. You may begin your call.

Aryeh Langer: Thank you very much. Good afternoon, and good morning to those of you on the west coast. I'm Aryeh Langer from the Provider Communications Group here at CMS, and I would like to welcome you to the Fifth HIPAA Version 5010 National Conference Call. We appreciate you taking out time today from your busy schedules to join us for this call, and we look forward to another informative session.

Announcements

Before we get started today there are a few quick items I would like to mention. For anyone who did not yet get a chance to download the materials for the call, you can go now to the CMS 5010 web page, located at www.cms.gov/versions5010andD0 and click on the educational resources link on the left hand side of the page. You can then scroll down to the download section towards the bottom of that same page, and you'll see the presentation is the first link in the download section. As a reminder, this web page is an essential source for all CMS 5010 information. Also on that same page you can download transcripts and audio versions of previous national

calls. The transcript and audio file of today's call will be available there in approximately two weeks. In addition, you can download two fact sheets and check lists that will help you in your preparation for 5010. Additional educational materials will be located there as they become available.

Finally there will be a question and answer session following today's presentation that will enable participants to ask questions of our subject matter experts. As has been the case with other national provider calls, we have a very large number of participants on today's call. So we ask that you limit your questions to just one per caller.

Without further delay I would like to introduce our speaker for the day. Ronnie Harshman is a health insurance specialist in the Division of Medicare Billing Procedures and Office of Information Services, or OIS, here at CMS. Ronnie …

Ronnie Harshman: Good afternoon, everyone, and thank you, Aryeh, for the introduction. Again, CMS welcomes all of you to the fifth national provider call from the Centers for Medicare & Medicaid Services on HIPAA Version 5010. This particular call will focus on the Medicare FFS implementation of the health care eligibility, benefit inquiry and response paired transaction, the 270/271. Again, my name is Ronnie Harshman, and I'm in the division headed by Chris Stahlecker that supports Electronic Data Interchange, or EDI, at CMS. We also represent CMS at various national and EDI standards organizations, including ASC X12 and CAQH CORE.

This is the reason I am giving this presentation here today. However, let me assure you there is a whole team of people at CMS who support the HIPAA eligibility transaction system, which is also known as HEP 270/271. Here in the room with me are members of our business side of the house, as well as our technical subject matter experts, or SMEs, on the 271, as well as all the other transactions supported at CMS. They are all here today and will be available to answer your questions during that session at the end of this presentation.

Slide 2

Moving on to slide 2, I would like to summarize what we will be discussing today, as well as touching on a few things outside the scope of our focus. First, we're here to provide the changes you can expect in Medicare FFS' 5010 implementation of the real time eligibility transaction set for our Fee-For-Service trading partners and provider community. Additionally, since our listening audience is so varied, we will make an effort to distinguish between the business and technical areas by explaining which codes address a particular function. We will make a distinction between Medicare FFS direct users or trading partners, and our indirect users who receive Medicare FFS information through a third party vendor, such as a clearinghouse or other software vendors. And what we will not be addressing today are the benefits covered by Medicare Advantage or Medicare Part D plans. Additionally, Medicare's other eligibility inquiry services are out of scope for today's focus. I will only note that there are discussions under way internally for CMS's future plans to retire them.

Secondly, I'd like to remind you to please take an opportunity to make note of any questions you might have along the way, with the slide number it may relate to, and that may help us in responding to them at the end of the presentation. Again, submit them to the queue as we progress through the presentation. We'll probably have about 45 minutes or so at the end of the presentation to hear from you.

We did receive a number of questions prior to the presentation and we've incorporated as many as possible along the way.

On slide 3 we show the agenda of what we'll cover today. We will be giving you a general overview of the 5010 changes across the transaction. The second topic will be a review of the Medicare-specific changes related to 270/271. Next we'll review the important timelines that you should be aware of for your own implementation. We will also cover what you need to do to prepare for 5010, and we will briefly touch on where we are with the 270/271 errata, or should I say proposed errata. And finally, we will open the lines for your questions and/or comments.

On slide 4 you see that HIPAA 5010 resulted in changes across the administrative EDI transactions in compliance with ASC X12 standards. Examples of these are the 837 claims, the 835 remits, and for our discussion today, the 270/271 eligibility transaction set. With 5010 you'll be hearing that the Implementation Guide, or the IG, is called exactly what it actually is – a Technical Reference Type 3 guide, or more popularly referred to as a TR3.

This is the comprehensive guide for each transaction that includes all the standard HIPAA 5010 rules, both business and technical, and not just the rules for a particular payer. Later in the presentation we'll show you a website where the IG, or TR3, can be found, along with a number of other websites of helpful information. Keep in mind that CMS is also bound by the Intellectual Property Copyright rules that all users of the IG must follow. Therefore, all information we relate to you, particularly in writing, cannot be cut and pasted word-for-word, but explained differently from what is shown in the published IG.

One of the goals of 5010 in the opening language of the IG, which is also referred to as the "Front Matter", is to correct the inconsistencies across all transactions so that the 837 claim transaction is not in conflict with what the 270/271 eligibility transaction, or the 276/277 claim status transaction or any of the other transactions supported by X12 or Medicare FFS. Also, there are certain situations where a particular element must be used or cannot be used. For 5010, that language has been updated to be more precise in meaning and to clarify the information that was previously viewed as ambiguous.

Over the next several slides, slides 5 through 11, we will review Medicare-specific changes for 5010. Just a couple of noteworthy items before we begin: a summary of Medicare-specific changes will be provided to all submitters who have a direct connection to the Medicare real time 270/271 system. This includes clearinghouses, third party vendors, and direct submitter providers. Medicare will be reaching out to these direct trading partners with additional documentation and further guidance. All indirect submitters, such as providers who communicate with MEDICARE FFS through a third party

vendor, will need to contact their software vendors for technical clarifications and additional information.

To learn some of these specific changes related to Medicare, let's begin with slide 5. First of all, I'd like to mention that all benefit information that MEDICARE FFS returns today in the 4010A1 version, will continue to be returned in the new version, 5010. In addition, the Health Benefit Plan Coverage, or some of you may be more familiar with the term "Service Type Code 30" or STC 30, has a new requirement under 5010. Now an STC 30 request must return a "yes" or "no" coverage response for each of the ten benefit areas shown here. I'd like to make a special note and direct your attention to the items that are starred on slide 5. Medicare Part A and B, which is what we are covering with our eligibility 270/271, provides only limited coverage and only under certain conditions in the areas of dental care, pharmacy and vision. Please make sure you contact your MAC, DMAC, or clearinghouse if you have any questions regarding these benefits under Part A or B. If you have a question about the beneficiary Part D pharmacy coverage, their Medicare Advantage plan administrator should be able to respond.

Slide 6 continues with the way Medicare FFS will respond when a provider, or possibly a plan, would like a more tailored response to suit their specific business need. In this case, the provider would be expected to request the specific benefit area, or areas, that apply to their business. This is called an "Explicit Request" in the eligibility 270, and Medicare will craft the 271 response accordingly. An example of when to submit an Explicit Request under 5010 is for home health episodes and hospice periods. This information will be returned only if the relevant service type codes are specifically requested and will no longer be returned as part of the basic Health Plan Coverage Benefit, or some of you would know this as Service Type Code 30. Under 5010 CMS will only be supporting an Explicit Request for the benefit areas listed on this slide. These 16 benefit areas are also referred to as "Service Type Codes" and each of them have a related STC number that is included in the published Implementation Guide. This is an expansion over what is currently supported in 4010.

This only addresses requests for single benefit areas. If more than one is requested, the response will include the union of the data for the two requested areas. In other words, all of the benefit information for each requested benefit area will be returned, but all common data will be consolidated and only returned once. As in 4010, the request may contain up to 99 Service Type Codes, but Medicare will only support the 16 codes listed here. If a request contains only non-supported Service Type Codes, Medicare will return a minimal response consisting of general Medicare eligibility information. Please note that this listing also includes the starred items with limited coverage under Medicare Coverage Part A and B that was explained already in more detail on the preceding slide.

Slide 7 depicts a matrix showing the only beneficiary search options that Medicare will support under 5010. There are actually two types of search options that are allowed by X12. They are referred to as “required” and “optional.” Medicare will only be supporting the required or mandatory search options, but all three that are shown here on slide 7 and explained in detail in the published IG. Medicare will not be supporting any of the optional search options.

Medicare has always supported the required primary search options which matches against all four data elements listed in the matrix. The new ones Medicare will now support with 5010 are the two required alternate search options which allow for submission of only three of the four data elements listed in the matrix. The HICN and name must match exactly to what is present on the Medicare card. As noted on the matrix, whenever there is a name suffix, such as junior or senior abbreviations, et cetera, it must be included with the last name. The date of birth must also match exactly to what the SSA has on file. As most of our audience is aware, HICN, which stands for Health Insurance Claim Number is Medicare’s terminology for subscriber I.D. and is present on a subscriber’s Medicare card. As a separate note, for those of you who are familiar with cascading search functionality, Medicare does not plan to support this type of matching at this time. For 5010, all beneficiary data that is provided in the eligibility request must match what is on file.

Next we'll look at slide 8 which shows the five specific error codes that Medicare will return when there are discrepancies with any matching data. Those who receive the triple A error codes directly from Medicare FFS will see only the codes referenced here. Please note that those who receive Medicare data indirectly from a software vendor may not see these particular error codes shown on slide 8, and they will need to contact their vendor for the applicable information if it differs from the Medicare FFS 271 responses shown here.

I'd like to now briefly talk about each these five 271 response codes. 15 will be returned when both the date of birth and first name are missing on the 270. A 71 is returned when the date of birth provided does not match the beneficiary's date of birth that is on file. A returned 72 indicates a HICN error – a HICN error provided is an invalid length or cannot be matched to any actual active Medicare HICN. 73 is the code returned for two reasons surrounding the name of the beneficiary: if the last name is missing, or the first or last name on the request is not an exact match to the beneficiary's Medicare card. You will see 74 returned when the gender code is in error. Please note that the provided explanations for their associated error codes on slide 8 are all specific to the Medicare FFS implementation of the 271.

On slide 8 we discussed the specific triple A errors that will be returned in 5010 for beneficiary matching discrepancies. Slide 9 references overall error handling for 5010. Aside from the triple A errors specifically noted on the previous slide, all other triple A errors, as well as all TA1 and proprietary errors, will be returned much the same as they are today under 4010. Additionally, the 5010 version of X12, brought forth a new transaction, the 999, to communicate X12 and IG syntax errors. The 5010 version of the 270/271 requires that the 999 be used in place of the 997 that was allowed under 4010. The 999 transaction can also serve as an acknowledgement of receipt, but Medicare will not be using this acknowledgement feature for 270/271 with their 5010 implementation. Medicare will only be using the 999 to communicate errors in this particular transaction. Again, these errors may or may not be seen by the end user so this information is primarily relevant to

the software vendors and direct submitter providers. If you communicate with Medicare FFS through a third party vendor, it is strongly recommended that you discuss with them how these errors will be communicated to you and how these changes will impact you and your business.

Moving on, both slides 10 and 11 address the format and element changes for Medicare's 5010 implementation of 270/271. It is important to note that we will only be discussing the changes that are specific to Medicare in today's presentation. However, when you are submitting a 270 transaction to MEDICARE FFS, you will continue to be responsible for following all the standard IG rules that may apply to your location, in addition to what is discussed here to be in compliance with Medicare FFS..

Since this is the most technical part, these slides may be of particular interest to software vendors and other direct submitters. CMS will be publishing a companion guide later this year that contains complete details regarding the Medicare FFS 5010 270/271 transaction.

Slide 10 specifically identifies the Medicare 5010 270 request changes. As already mentioned in the beneficiary matching slide, subscriber first name and date of birth are no longer both required on every 270. However, one or the other must be present.

Finally, the qualifier used in conjunction with the date of service must now be submitted to CMS as a 291. This is because the value used in 4010, which was 307, is no longer available in 5010. There is one other thing I'd like to add now in response to a question that was submitted prior to the registration cut off, and is not included on this slide: Medicare FFS will accept either multiple EB loops with an individual STC in each, which is the current way; or we will also accept one EB loop utilizing the new "repeating element" feature to include multiple STCs. This will also apply to the 271 response, that will be described on the next slide.

Now we'll move on to slide 11 which specifically identifies the 5010 changes on Medicare FFS's 271 response. Now that 5010 has a code that will allow the return of URL website addresses, CMS will be returning two of their

relevant website addresses within the information source data that is returned in every 271. Additionally, whenever Medicare Advantage or Medicare Part D plan enrollment is returned, CMS will return the corresponding website address for each of those plans. The maximum number of characters that may be returned for the beneficiary last and first names, have both been increased to 40 and 30, respectively for those. To comply with an X12 5010 rule, the qualifier used in conjunction with the Medicare Part A and B eligibility period will now be returned as a 291. There is a new X12 rule for 5010 that states "if a benefit can be codified, then a message segment should not be used." To comply with this rule, home health data and end stage renal disease data will be reformatted in the 270 response to exclude the use of any message text segment. New date qualifiers will be used as shown on the table on this slide.

Home health provider information will now be returned in the NM1 segment. Under 4010 this information was included in the PRV segment, but under 5010 the PRV segment is no longer allowed to be used for this purpose. To be more accurate under 5010, the Service Type Code used for therapy capitation data will now be AE, which is the code representative of physical medicine and no language will be returned in EB05.

Blood deductible benefit information code will be changed to "D" as in David for benefit description. This is to comply with the X12 5010 rule that states that all deductibles must be associated with a dollar amount.
The following is the 271 side of the question submitted that is not shown on the chart. MEDICARE FFS will utilize the new "repeating feature" for the EB03 element to return common benefit data or STCs. The carat symbol, which is the Shift 6 on the keyboard, will be the separating character.

We have now completed the portion of the presentation dedicated to our review of the Medicare specific changes.

Moving forward to slide 12, let's take a look at the schedule for transitioning to 5010. As you can see, internal MEDICARE FFS testing is underway and will continue throughout all of 2010. External testing is set to begin on or after January 1, 2011. According to the HIPAA 5010 final rule, CMS will have a production 5010 system available for use as of this date. More of the

details surrounding external testing will be provided on the next slide. The last day that MEDICARE FFS will accept a 4010A1 270 transaction will be December 31, 2011. After this date, any entities that have not yet switched over to 5010 will lose the ability to receive eligibility data from Medicare. To reiterate in another way, mandatory compliance with 5010 is January 1, 2012 for all covered entities.

The next several slides, from 13 to 16, will give you an idea of the steps you will need to take to prepare for your own 5010 implementation. Let's start with slide 13. As already mentioned, external testing will be conducted throughout most of 2011. Beginning on January 1, 2012, and in compliance with the published regulation, MEDICARE FFS will only accept 5010 transactions. Therefore, if you have not begun planning for your 5010 implementation, now is the time to start. MEDICARE FFS's direct trading partners should do as they do today, and contact the MCARE Help Desk to coordinate testing procedures and time frames. If you use a third party vendor, you will need to contact them for 5010 testing and timelines. Please do not wait until the end of 2011 to initiate testing since 4010 transactions will no longer be accepted after December 31st of 2011. Before any trading partners may submit production 5010 transactions, they will need to submit test transactions to ensure that their systems meet HIPAA X12 and Medicare FFS specific rules and regulations, and they must successfully submit and receive both valid and error responses.

Slide 14 contains several important reminders that you may not have yet considered. Medicare FFS has performed a comparison of its industry-wide changes between the current 4010A1 and new 5010 formats for all transactions they support. Please check the CMS website noted on the slide for this informative comparison. All software used to submit or receive eligibility data must be modified for 5010. Please contact your software vendor to determine when you can expect your software to be upgraded to 5010 so you can make your plans accordingly. In addition, don't forget many of your business processes which may also need to be changed. Because the implementation window for 5010 only encompasses one year of 2011, careful coordination is needed to ensure everyone's needs are accommodated within

that year. For example, you may need to continue to support the 4010 for exchange with some of your trading partners, while starting to support 5010 with the others.

Slide 15

Slide 15 contains a number of self-help CMS links and resources. Bullets number 2 and 6 are CMS specific websites for your use. The first bullet in number 2 contains CMS's main 5010 website. This is where you can find everything related to 5010 at CMS. The second bullet in number 2 references a link off that main page that contains a list of items that are available as educational resources. And the third bullet is another link off that main page, but can also be accessed directly. This is a very important technical link which also contains the side-by-sides comparing 4010 and 5010 for all the MEDICARE FFS-supported EDI transactions already mentioned in this presentation. Be on the lookout for news articles and updates to the FAQ page accessible through the main CMS 5010 website.

Number 5 and 7 include external websites related to the health care industry and the ASC X12 Standards. I'd also like to mention here that these URLs in number 5 are where you can also find information about the errata, and we'll talk more about that on slide 17.

Included on slide 16 are several questions that you may want to use to begin discussions with your software vendor regarding new 5010 software. Also remember, timing is everything. Please assess this response to be sure your vendor can promise you a transition date well before the cut-off date of January 1, 2012. Besides the technical changes, don't forget to consider how other areas of your business will be impacted by this transition. The examples included on this slide may just be a small representation of what will actually need to change with your transition to 5010.

Slide 17 explains the current status on the proposed 5010 errata. CMS is not expecting any change to the Medicare 5010 implementation or the mandated compliance dates as result of the errata. The 270/271 errata is currently available for public comment, as are the other MEDICARE FFS transactions. The review period for eligibility transaction set began April 16, 2010 and ends

on May 16. If you are interested in submitting a comment or question on this errata, or one of the others, there are two additional websites that may be of interest to you. I already mentioned one, I believe that was slide 15, the WPC-EDI website, and what you would need to do is just add a slash to that one, with "conferences" C-O-N-F-E-R-E-N-C-E-S, and then a dash, and the word "errata," spelled E-R-R-A-T-A http://www.wpc-edi.com/conferences/errata. And then for the X12 site, instead of the "www" following the "http colon," and then the slashes, you would put the word "store," S-T-O-R-E, and then it would be dot X12 dot org, just like on the other slide, and then a slash, errata; and again that spelling is E-R-R-A-T-A http://store.x12.org/errata. You will be asked to set up an account if you don't already have one, and there's no charge for the erratas on these sites.

That brings us to the Q&A session. You can take a look at some of the prompts shown on slide 18 to stir your thought processes and get some of your questions in, or we can just start with what's already in the queue. Do we have any questions ready?

Aryeh Langer: Chris, can we go ahead and …

Questions and Answers

Operator: We will open up the lines for a question and answer session. To ask a question, please press star, followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before you're asking your question, to ensure 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 Patrice Cupee. Your line is now open.

Patrice Cupee: Hi guys. Slide 5 and 6, I just want to make sure I understood what you were saying. If I submit benefit type 30, I will get the list on page 5 except for the ones you have asterisks next to?

Ronnie Harshman: No. You'll be getting all of them. We just wanted to caution you about the ones with the asterisks. Because of the fact that dental, pharmacy, and vision care have limited coverage under Medicare Part A and Part B . So, all of those things that you see there will be returned.

Patrice Cupee: Thank you.

Operator: Our next question comes from Mary Erin. Your line is now open.

Marie Erin: Hi. This is Marie Erin from Kaleida Health in Buffalo. I have a question about the transition year 2011. If we submit a 270 4010A1, will we receive the same 271 4010A1, or is there any …

Ronnie Harshman: Yes. Nothing will change during 2011 if you submit the 4010, but you do have to take steps to begin submitting the 5010.

Marie Erin: So we could be doing both, and if we do the 5010 we should expect a 5010 response.

Ronnie Harshman: Correct. However, once you change to 5010, you will no longer be able to submit 4010 transactions.

Marie Erin: Thank you.

Operator: Your next question comes from Dedee Fishman. Your line is now open.

Dedee Fishman: I just want to clarify during the transition year you're going to accept both the 4010s and the 5010s?

Ronnie Harshman: That is correct.

Dedee Fishman: OK. Thank you.

Dedee Fishman: In other words, a given vendor can send you both at the same time? From some clients?

Ronnie Harshman: Yes.

Dedee Fishman: OK. Thank you.

Operator: Again, if you'd like to ask a question, please press star, followed by the number one on your telephone key pad. (Silence)

Again, to ask a question please press star, followed by the number one on your telephone key pad.

Your next question comes from Patrice Cupee. Your line is now open.

Patrice Cupee: (laughter) Am I the only one on? (Laughter)

Female: No.

Patrice Cupee: I'm the only one who loves eligibility. I don't think this happens very often, but I think we've come close and it's about slide 11 where you do not support the maximum number of digits for last name and first name. Why is that? Did you do a study that said you've never had a last name longer than 60 or a first name longer than 35?

Ronnie Harshman: I'm going to let one of our technical people take this. Amanda?

Amanda: We will allow for the full maximum X12 length to be submitted on the 270. However on the 271 this is the maximum length that the Social Security database keeps on file. So, no name will exceed the 40 and 30 characters that we've mentioned.

Patrice Cupee: Interesting. Thank you.

Operator: Our next question comes from James Butherford. Your line is now open.

James Butherford: Hi. I have a question about the additional searches. Will Medicare do those on their own, or will we have to submit three different 270s?

Ronnie Harshman: You'll have to submit separate ones for those different searches.

James Butherford: OK. Thank you.

Operator: Your next question comes from Robert Thickens. Your line is now open.

Robert Thickens: Thank you. I thought I heard you to say that you would include the "junior" or "senior" suffix within the last name. I'm presuming that's in the NM103. Did I hear that correctly?

Amanda: Yes. It can also be submitted using the suffix field and in 105, I believe.

Robert Thickens: OK because... It says, I mean the notes in the Implementation Guide say that the information sources cannot require the subscriber's suffix to be sent as part of a name.

Amanda: Right. You can submit it in the suffix field, and we will add on the back end match using that.

Robert Thickens: OK.

Amanda: It must be a part of the transaction, though, if it is a part of that beneficiary's Medicare card.

Robert Thickens: OK. Thank you.

Amanda: It's NM107. I'm sorry, I misspoke earlier.

Robert Thickens: OK.

Operator: Your next question comes from Jason Frost. Your line is now open.

Jason Frost: Yes. This is Jason Frost with Endion Business Services and I was calling about the mental health value in the request. Will that be available to all providers or will that information be returned, will it be provider-specific, for only mental health providers?

Ida Sanchez: Jason, this is Ida Sanchez. That data will be considered to be returned to a specific provider who require, or allowed to receive that kind of data. We are making some studies right now and in the near future that data will be returned just to those specific physicians.

Jason Frost: Thank you.

Operator: Your next question comes from Roxanne Pough. Your line is now open.

Roxanne Pough: Yes. I heard you referencing throughout the conference about slides. I didn't get any information on how to access slides. Can you please tell me where I can download those?

Aryeh Langer: Yeah. Those are available on our 5010 home page at www.CMS.gov/version5010andD0 and if you go onto that web page you can click on the educational links on the left side of the page and scroll down to the bottom there. You'll see it in the download section.

Roxanne Pole: Thank you.

Operator: Your next question comes from Sharon Decano. Your line is now open.

Sharon Decano: Hi. I just – this might just really sound like a foolish question, but 5010 is just for eligibility checks? Going across to Medicare from our system to your system?

Ronnie Harshman: Oh no. It affects all EDI transactions.

Sharon Decano: OK. So what you're talking about here, though, in this presentation was just about the eligibility?

Ronnie Harshman: Correct. We have a whole series of other presentations that are coming over the next several months – through September?

Sharon Decano: OK. I didn't think so, but I just wanted to make sure. Ok! Now will the eligibility portion of it only be this timeline, or that timeline is for everything with 5010?

Ronnie Harshman: That timeline is for everything.

Sharon Decano: OK. Thank you very much.

Ronnie Harshman: You're welcome.

Operator: Your next question comes from Ned Palmer. Your line is now open

Ned Palmer: Thank you. You already answered my question.

Ronnie Harshman: All right. Thank you.

Operator: Your next question comes from Leonard Muller. Your line is now open.

Leonard Muller: I have a very quick question and it's more related to content. And it's, I want to know on the 271 response in the 2110C loop, when the date segments come back and there's say a qualifier 435 with their admission date and maybe an end date, are those dates the date that CMS learns of an admission? Or is that the actual date that the patient was say, had an episode of either hospice or home health or hospital?

Amanda : That is actually the date the episode began. I believe we use 435 for home health and hospice.

Leonard Muller: OK. And then, 193 for home health maybe.

Amanda Yes, that is actually the day that that episode of care began.

Operator: Your next question comes from Heather Mallard. Your line is now open.

Heather Mallard: Yes. This is actually a pretty basic question. Does CMS actually have a protocol for providers that feel like maybe the contractor, or like the MAC, is not upholding just basic patient privacy rules?

Chris Stahlecker: Hi. It's Chris Stahlecker. That kind of behavior would be of interest to CMS. It is a different area here at CMS that would be interested in that. Your Regional Office contact would be a good one to relay that information back to our Central Office.

Heather Mallard: Well, as far as, when you reference the regional, are you talking about our MAC?

Chris Stahlecker: No. We have CMS Regional Office Administrators and – you can go ahead and send me an e-mail if you would like to, for contact information.

Heather Mallard: I would really appreciate it. We're just really concerned and not sure what to do.

Chris Stahlecker: We can actually contact you after the call if you would like to give us your e-mail address.

Heather Mallard: Yes, Ma'am. It is Xxxxxxx, X-X-X-X-X-X-X-X-X-X-X at xxxxx.com

Chris Stahlecker: OK.

Heather Mallard: And my phone number is X-X-X-X-X-X-X-X-X-X, and it's a direct line.

Chris Stahlecker: Thanks. It's a good question. Appreciate it.

Heather Mallard: Thank you.

Operator: Your next question comes from Keba Suballier. Your line is now open.

Keba Suballier: Looking at slide 7 and the issue about the last name and suffix, it sounds like if the patient does have a suffix and the suffix is not submitted, then the eligibility will not find the match. And if the patient does have a suffix it must be submitted. So, there's actually a fifth column in slide 7 for the suffix?

Amanda No, it actually gets tacked right onto the last name. It directly follows the last name in that column.

Keba Suballier: I thought I heard that it can be sent as NM107.

Amanda: It can be sent in NM107 as well.

Keba Suballier: OK. Thank you.

Amanda So, you would send it in both.

Amanda ?: Your question was related to the fact that if the beneficiary has a suffix on the card, it must be submitted in your request.

Keba Suballier: And it can be submitted as either …

Amanda Yes, as either. You can either follow the last name or you can use the NM107.

Keba Suballier: OK. And if it's submitted in both it would not work. And if it's not submitted, it would not work either.

Amanda That's correct.

Keba Suballier: OK. Thank you.

Operator: Your next question comes from Dan Kelsey. Your line is now open.

Dan Kelsey: Yes, I've just got a question for you on slide 7 and 8 regarding the beneficiary matching. On slide 8, on point 5 you mention the invalid or missing subscriber gender code – the gender isn't asked for in the beneficiary matching. Is that asked for elsewhere? What is the purpose then of that code if it's not asked for?

Amanda The gender code is not required on a 270, but if it is provided it must match.

Dan Kelsey: OK. And it can be part of the matching criteria then?

Amanda Yes. And then it will be matching.

Dan Kelsey: OK. Thank you.

Operator: Your next question comes from Peggy Mullen. Your line is now open.

Peggy Mullen: Toward the end you were giving us some additional references for the errata to add to the codes to the e-mail addresses on 15 and I didn't catch what they were.

Ronnie Harshman: OK. It was the WPC-EDI site. So, the entire thing is http: two slashes, www.wpc-edi.com/conferences C-O-N-F-E-R-E-N-C-E-S/errata, E-R-R-A-T-A http://www.wpc-edi.com/conferences. And then the X12 website is http:

the double slashes, the word “store” S-T-O-R-E dot X12 dot org slash errata, E-R-R-A-T-A http://store.x12.org/errata. Did you get that?

Peggy Mullen: Thank you.

Ronnie Harshman: OK. Great.

Operator: Your next question comes from Laura Kaufman. Your line is now open.

Laura Kaufman: I had a couple of questions regarding the level one compliance. Is there a penalty if a covered entity is not able to demonstrate it can create and receive compliant transactions by the end of this year?

Chris Stahlecker: This is Chris Stahlecker. That type of enforcement has not been discussed at length yet by those at CMS that are responsible and would be. undertaking that action. So, at this time we don’t expect that to be the case.

Laura Kaufman: OK.

Chris Stahlecker: But in terms of industry expectation, all trading partners are expecting covered entities, which now includes business associates, to all be ready to exchange transactions starting January 1, 2011.

Laura Kaufman: OK. The other question I had was related to behavioral health. Would you return that in the 271, and I think the answer was that there was a survey or some sort of information gathering going on, but some people would be able to get it, but not everyone. How will you determine that? How is that going to be determined? Is it based on the provider, how they’re credentialed with you?

Ada Sanchez : There’s probably two questions in here. If we’re talking about the top ten types of service, it’s called “mental health,” to be returned as a part of the 30? Or are you talking about data related to psych data?

Laura Kaufman: Probably both in a sense. So, first of all, I also did not have the slide show when this started. I had to scramble to find it, so it would be helpful, I think, for future presentations to send that out in your confirmation e-mail. So, I

didn't get to slide 5 when you were talking about it, so I see "mental health" on there, but someone asked the question, "Mental health values, can they be returned to the providers who need the information?" And someone responded that you were doing a study right now on that.

Questions and Answers Continued

Ada Sanchez: Yes, right now – Let me just answer the first question. The types of services related to mental health, if your question is just related to what will be returned, will return a covered or not covered response for every request that requires those types of services. However, the data related to psych, is being studied to ensure that whoever requests this data should be receiving it in the first place. So, right now we're in the process of looking at the data for different situations. Who will be the physicians or the facilities that really need to have that data available to them. That study will probably be done in the next year or so, but I'm not sure. We're trying to gather that data together to ensure that when we're ready to return this data, it will be to the right person.

Laura Kaufman: OK. Because we have a lot of that. It's basically an office setting, but we're verifying they're eligible for that service, so we definitely want to know if they were covered or not covered.

Ada Sanchez: If you're a specialty provider, the physicians you actually work with, are psych physicians. They have that specialty, so you probably will be able to receive that data.

Laura Kaufman: OK. And then I'm sorry I have another question, and I may have missed this when I was looking earlier, but I don't know what the "errata" means.

Ronnie Harshman: The "errata" is something that's actually put together by all the work groups in X12; it's an addenda to the current implementation guide for 5010. So, what everyone did was go through some of the inconsistencies that were in the implementation guide and some of the more minor changes where we can clarify things and make things that are ambiguous clearer to the public and everyone using them. You have an opportunity to comment on the proposed changes, or ask questions about them, and see if there are other

things that you agree with or that you don't want in there, or other things that you might want to input. So, there's a comment period, and that comment period is one month. And that's what we'll be coming up on for this particular transaction on May 16. Actually, the errata comments for the other transactions are due sooner.

Laura Kaufman: OK.

Ronnie Harshman: So, if you want to look at those erratas and comment on them, those websites are included in the presentation there, for your information.

Laura Kaufman: OK. Great. I have just one more and then I'll be done. You were speaking of direct connect clients. We currently have G.E. as our vendor but we are working towards G.E. having a direct connect with Medicare, but we would still consider G.E. as the person that would be following up on these specs and making sure everything is in place and then we would just continue testing with them. Would that be an accurate statement?

Ronnie Harshman: Yes.

Laura Kaufman: OK. Thank you.

Aryeh Langer: Can I just ask about your point to today's presentation? Did you receive a CMS listserv announcing the availability of this call? Or how did you hear about it?

Laura Kaufman: I received it actually via e-mail from another teammate who works on the claim portion of this, who sent it to me, and then I registered for the class. And then I received a confirmation that I was registered, but there wasn't anything in there. There were no links …

Aryeh Langer: OK. So, at the time of the initial announcement, the presentation wasn't available. We sent out a reminder listserv about a week ago, and the link to the presentation was on that reminder listserv. However, just for future reference, we have calls scheduled, as someone stated before, through October, monthly, and those dates will be coming out shortly. But if you go to that CMS 5010 web page that I announced before, if you're ever in doubt or

didn't receive a link, go to that website and you can download the presentation for the call there.

Laura Kaufman: Yeah. When you were talking about that website I was madly trying to write it down and get to that place to try to be on the same place. But I am looking back at my reminder, and there is no link on my reminder. It says if you require hearing impaired or if you want to unregister, the audio for this event is here, if you need assistance for audio or registration, call here; but there's no link.

Aryeh Langer: Yeah. I think you're looking at the confirmation e-mail, as opposed to the reminder of when you …

Laura Kaufman: Well, the subject is "Reminder for HIPAA Version 5010 National Provider Call, CMS Discussion of Eligibility Request Response."

Aryeh Langer: OK. If you don't mind sending that to me, I just want to confirm – Can you give me your e-mail address?

Laura Kaufman: Yes. It's xxxxxxxx at xxxxxxxxxxx dot org.

Aryeh Langer: Say that again. xxxxxxxx at …

Laura Kaufman: xxxxxxxxxxx dot org.

Aryeh Langer: OK. I'll contact you.

Laura Kaufman: OK.

Aryeh Langer: Thank you.

Laura Kaufman: Thank you.

Operator: Your next question comes from the line of Susan Welch. Your line is now open.

Susan Welch: Hello, this is Susan Welch. I have a question for you regarding the implementation of 5010. Would this affect our ability to access the eligibility inquiry function on the DDE system?

Ronnie Harshman: I'm sorry. Could you repeat the question again?

Susan Welch: Yes, will the 5010 implementation replace any of the function, the eligibility inquiry function, on the DDE system – Direct Data Entry system?

Ronnie Harshman: There may be some data content changes because the screen displays will need to be compliant with the data content in the new 5010 upgrade. So, there may be some data content changes.

Susan Welch: OK, but basically we'll still be able to access eligibility inquiry through that system. Is that correct?

Ronnie Harshman: That's correct.

Susan Welch: OK. Thank you.

Operator: Your next question comes from Sophia Lopez. Your line is now open.

Linda Yingle: Hi. This is Linda Yingle. I have two questions that are related really. The 270 and the 271, does that refer to the eligibility only? Eligibility request response only? And does it need to be indicated on the 5010 anywhere?

Ronnie Harshman: Well, the 270 is the eligibility inquiry, and we're moving to version 5010, away from 4010A1.

Linda Yingle: Right. I understand that, but how are these two related?

Ronnie Harshman: The 270 is the eligibility inquiry, and the 271 is the eligibility response.

Linda Yingle:. Response, right. But do we have to indicate that we've used that anywhere on the 5010?

Ronnie Harshman: I don't know what you mean by "indicate on the 5010." Are you talking about an EDI registration, or EDI enrollment?

Linda Yingle: No, no. No, I'm just wondering because this conference call seemed to talk about both, the 5010 and the 270/271.

Ronnie Harshman: Yes, exactly. The purpose of the call is to go over the changes to the 270 eligibility inquiry, the 271 eligibility response, as we upgrade to version 5010.

Linda Yingle: As we upgrade. OK. So we don't have to indicate that anywhere on the 5010, that we used the 270/271. OK. Thank you. You've answered my question.

Ronnie Harshman: OK.

Operator: Your next question comes from Beth Turner. Your line is now open.

Beth Turner: I just wanted to get the link for the slides that you presented.

Aryeh Langer: Sure, it's www.cms.gov/versions5010andd0. Do you want me to repeat that?

Beth Turner: Please.

Aryeh Langer: http://www.cms.gov/versions5010andd0.

Beth Turner: Thank you.

Aryeh Langer: You're welcome.

Operator: Your next question comes from Elizabeth McBride. Your line is now open.

Elizabeth McBride: Hi. My question is, how do I sign up as a vendor to do testing?

Amanda Do you access CMS directly?

Elizabeth McBride: Yes.

Amanda OK. All the information is available at this website. It's www.cms.gov/hetshelp. H-E-T-S-H-E-L-P

Elizabeth McBride: I'm sorry. What was that dot portion again?

Amanda The last part?

Elizabeth McBride: Yeah.

Amanda HETS for HIPAA Eligibility Transaction System help. And that is for direct users only. All other users should go through their third party vendors.

Elizabeth McBride: OK. All right. Thank you very much.

Amanda You're welcome.

Operator: Your next question comes from Conrad Calve. You line is now open.

Conrad Calve: Hi. Slightly off topic, a couple of years ago when HIPAA announced the national provider I.D., they also talked about a national plan I.D. Whatever became of the national plan I.D.?

Chris Stahlecker: It simply hasn't been addressed just yet.

Conrad Calve: So, not in the foreseeable future?

Chris Stahlecker: Yeah, we don't have additional information to share at this time.

Conrad Calve: OK. Thank you.

Operator: Your next question comes from Angela Robinson. Your line is now open.

Angela Robinson: Hi, good afternoon. Calling from Embion. The previous caller had answered part of my question, but I did have a question about when CMS expects testing to commence. Is that going to be something shortly, like a quarter three or four?

Chris Stahlecker: I'm sorry. We kind of missed that part of your question. When CMS what?

Angela Robinson: When does CMS expect testing to commence?

Chris Stahlecker: January 1, 2011 they'll be ready for that, and we're expecting everyone to come in staggered all through the year.

Angela Robinson: When we've tested and have been approved, are we going to be expected to immediately transition to 5010, or do we have all the way up until December 31, 2011?

Ronnie Harshman: You will have all the way to the – December 31, 2011 to finish 4010A1 testing. You can continue submitting the 4010A1 and 5010. However, January 1, 2012 we will only accept 5010.

Angela Robinson: OK. Thank you.

Chris Stahlecker: Just as an aside to that. There is some set-up involved, so please don't wait until 6:00pm on December 31 to be saying, "OK, I'm ready to switch over now." That would be unable to be accomplished, for MEDICARE FFS to convert everybody all at one time.

Operator: Your next question comes from Julian Sentron. Your line is now open.

Julian Sentron: Hi. My question is in regard to slide 7. The beneficiary matching logic. Can a provider under 5010 initially submit a 270, using alternate 2, and retrieve back in the 271 a date of birth? Am I understanding that correctly?

Chris Stahlecker: Yeah. That's how it works.

Julian Sentron: So, then a provider just needs the I.D. last name, first name, and a date of birth can be supplied back by the result.

Chris Stahlecker: Correct.

Julian Sentron: Thank you.

Chris Stahlecker: Uh huh.

Operator: Your next question comes from Kim Walker. Your line is now open.

Kim Walker: Hi. This is Kim Walker calling from Harvey Durham Hills. I have a question regarding the testing phase. I do transmit claims through CEDI. So, this testing that we're speaking of, is it in regards to the 270/271? Or is that all changes that need to be tested prior to December 31, 2011? My question is, I

do use a software vendor and I'm not sure which part of the testing they are to complete, and which part I am to complete. And I'm sorry if my question's confusing.

Chris Stahlecker: Essentially, – hi, it's Chris again, – you would use your vendor to make this transition. So, you should be working with your vendor to find out when you, as their customer, your use of your vendor will be accommodated in their plan to switch over all of their customers to the 5010 version. So, an outreach at this time would be prudent on your part to make sure your vendor is on board and has a plan, and that you as their customer would be well taken care of.

If you are sending transactions directly, as we've talked about in this presentation, you would be able to contact the HETS help desk. But if you are using a vendor, please contact your vendor to make sure that they are working with our help desks and they have a plan for you to transition your workload.

Kim Walker: You have answered my question. Thank you.

Operator: Your next question comes from Paula Schoon. Your line is now open.

Paula Schoon: Hi, can you hear me?

Chris Stahlecker: Yeah.

Paula Schoon: I have a couple of questions, or one question and a remark. OK, as far as a software vendor, I use the PCAce Pro32, if that's the proper order of the name of the software, which was recommended. So, are they completing all of the required updates, I mean, is there anything that I have to do?

Chris Stahlecker: The PCAce product, the product is used for submitting electronic claims, receiving back the new – in the 5010 version, will receive back the new error handling, the new error transactions. It does not; it is not really used for the eligibility inquiry unless you've obtained a product directly from that vendor for that service. If you've obtained a free copy of that package from your MAC, your Medicare Administrative Contractor, it is really supplied for the purposes of submitting claims and getting back responses to those claims, so you must have an alternate method for performing your eligibility inquiries

today. So, it is that vendor that supports you for eligibility inquiries that you should be contacting.

Paula Schoon: OK. I'm kind of new to this and we're very, very small limited DME provider. So, when you say "eligibility inquiries," I don't have any software at this point for that.

Chris Stahlecker: OK. If you're not doing electronic eligibility inquiries, are you only using the telephone?

Paula Schoon: Correct.

Chris Stahlecker: Then the version upgrade will be performed, but the integrated voice recognition units, or the telephone features, will be enhanced to supply back to you the additional data elements that the new transaction version brings about, but your process of using the telephone is not really changing.

Paula Schoon: OK. OK, and then secondly, going back to the whole being able to log on and see the slides, I have four different notifications in front of me. I have the 4/14 when I originally signed up for the call, and then I have one dated 4/21 which does not have the website, one dated 4/27 that does have the website, and one dated 4/28 that does have the website. …

Chris Stahlecker: We apologize …

Paula Schoon: Well, I'm just saying you know, because they came through four different e-mail notifications, so if people did not open up every single e-mail notification, there was only two of them that contained the website, out of four.

Chris Stahlecker: Thank you.

Paula Schoon: OK. Thank you.

Chris Stahlecker: You know, we had a website – not to offer excuses, but we had a website upgrade in the past six or so weeks that we kind of are still living through.

Paula Schoon: OK (laughter).

Chris Stahlecker: Appreciate the feedback.

Questions and Answers Continued

Operator: Your next question comes from Debbie Fishman. Your line is now open.

Debbie Fishman: I'm asking, – there's a new segment, the HI which has diagnosis codes in it. Are you going to require that on the 270? Do you want that on the 270?

Ronnie Harshman: No, that will not be required. If you do include that on your 270, we will validate it for syntax, but we will not do anything with that. It will be dropped off ...

Debbie Fishman: And then I think the military one is also new?

Ronnie Harshman: Yes, same with that. It's not something we expect or that we will use, but you may include it if it's part of your software.

Debbie Fishman: Oh, thank you.

Operator: Your next question comes from Karen Beege. Your line is now open.

Karen Beege: We were wondering if you're going to have any pilots.

Chris Stahlecker: That is something that we haven't really entertained on our timeline. There may be more information made available a little bit closer to the start of the testing period for you.

Karen Beege: Do you know if it would be something that you would choose them, or would we be able to volunteer? Or you don't know yet?

Chris Stahlecker: We haven't really decided yet.

Karen Beege: OK. Thanks.

Operator: Your next question comes from Annie McDonald. Your line is now open.

Annie McDonald: Hi, I'm Annie McDonald from M Systems and I have a question about name matching when there are non-alphanumeric characters in the name. Can they be replaced by a space or, because obviously in the 5010 there are certain characters that are not allowed. I just wondered how exact the name matching was.

Ronnie Harshman: Our system will strip all spaces and special characters, anything that's not alphanumeric. So feel free to submit it as you have it stored, and you should be submitting the name as it is present on their Medicare card, and then you should be fine. But if there are any spaces or special characters you may submit them, and then we'll strip them out in order to make an accurate match.

Annie McDonald: So when you strip them out, do you actually compress that or do you replace with a space?

Ronnie Harshman: We compress it.

Annie McDonald: OK. I do that already. 'Cause I've seen carets and things like that which are not allowed and colons, and all sorts of things. My second question, real quick, is if as a vendor we do testing, and we pass the tests, does that mean that all of our clients have to test or will a vendor get a clearance to go ahead and install because all the software will be the same?

Ronnie Harshman: The vendor will get the clearance to go ahead, and then you will have that direction with your own customers as to how you let them go forward in going through your system.

Annie McDonald: OK. Thank you.

Operator: Your next question comes from Anthony Carbone. Your line is now open.

Anthony Carbone: Hi. Chris, it's Tony Carbone, National Government Services.

Chris Stahlecker: Amazing. Hi.

Anthony Carbone: I know. Nice to hear your voice. Actually I was going to chime in on the woman that was asking about PCAce but you actually answered it perfectly.

Chris Stahlecker: Oh, thank you. It's good to hear from you.

Anthony Carbone: Yes, we're internally testing, as well. So for PCAce users they shouldn't have any concerns as far as 5010.

Chris Stahlecker: Excellent to hear.

Anthony Carbone: All right. You take care, guys.

Chris Stahlecker: Thanks for your support. Take care. Bye-bye.

Anthony Carbone: Right. Bye.

Operator: Your next question comes from Stacey Morrison. Your line is not open.

Stacey Morrison: Hi. This is Stacey Morrison from UPMC. This is actually another question on the suffix, but most of my question has been answered. How will you return the suffix in the 271 message? Is it based on how you have it in your system or how we send it to you? Whether we send it in the suffix field or in the last name field?

Amanda It will always be returned as part of the last name field, which is in NM103.

Stacey Morrison: OK. Can I ask why, why you're choosing that field instead of the suffix field?

Amanda That's how the Social Security Administration stores that data. They contain it as part of the last name, which is where Medicare receives that information. Therefore, that's currently the only way we're able to communicate that.

Stacey Morrison: OK, so if we send it in a suffix field, we'll get it back in the last name field.

Amanda Yes.

Stacey Morrison: OK. All right. Thank you.

Operator: Your next question comes from Patrice Cupee. Your line is now open.

Patrice Cupee: Hi again. On slide 7, the matching, did you indicate that if all four pieces of data are sent, the provider has to continue to use alternates to figure out what's wrong? Or don't you report back? There is a match, you did find them and the first name might be spelled wrong.

Ronnie Harshman: Yes. We will not be supporting the cascading searching at this time. You will need to resubmit with only the three pieces of data.

Patrice Cupee: And in our goal to reduce costs for healthcare, because this can increase the provider's cost dramatically, why has that decision been made? You're just requiring somebody to resend something instead of doing it on your end.

Ronnie Harshman: Well, we're governed by a lot of rules surrounding privacy, and they are the choices that we've made to protect those privacy, the privacy of the individuals that are being inquired of.

Patrice Cupee: What makes it less private to them to require me to try different combos?

Ronnie Harshman: I'm sorry, I …

Patrice Cupee: Or more secure, I guess, is what you're trying to say. So, if I tried the primary option and you don't find them, I then can try I.D., last name, and date of birth; and then if you don't find them I can try I.D., last name and first name. So, I'm just having to rematch things that we're asking you to do once, because if a provider relies on a vendor, they're going to charge them a fee, plus you have the programming logic, plus if you have people manually doing this, it's a huge increase in cost and time.

Chris Stahlecker: We kind of looked at this as a small, maybe not even a step, maybe a half-step, or we say we must crawl before we can walk before we can run. And this might be a crawling wiggle by even getting down to the alternate search options rather than the four matching criteria. So, I think over time we will probably see some continued improvement, but this is where we are right now. And it's not – we can express your concern and your request for

continued improvement to those internal components at CMS that are not present here today, to see if they can assist in future improvements.

Patrice Cupee: Is it a privacy concern? Or is it a programming cost? Just so we know where else to elevate this?

Chris Stahlecker: It may be "all of the above" and having that cascading inquiry could also effect response time. And this is an application that we really want to maintain with optimal response time. It's all of the above, Patrice.

Patrice Cupee: Thank you.

Chris Stahlecker: It's not a silver bullet today, but we'll get there.

Operator: Your next question comes from Jane Pleckia. Your line is now open.

Jane Pleckia: Yes, I just want to reiterate that I, we also did not receive the website. I know enough people have said that at this point and I'm sure you're sick of hearing that, but I just want to make sure that you understood that and that it made it a little difficult at first to follow the slides. My question is I think that our practice is doing, – everybody seems to be going to slide 7. We, I believe, already do a very good job of submitting that data the way that you're asking for it. Is this just something that maybe some practices are lagging on?

Chris Stahlecker: Well, that's an observation that we have been left with, and it's an exact match as you can, you're getting the sense of that. It does need to be, the data that's populated in these data elements needs to be an exact match to what we have in our file. So …

Jane Pleckia: But it also seems that at this point we are getting, our claims are rejecting because of that, if you don't have those exact matches. So, why is this something new?

Ronnie Harshman: The new items are the additional the search options, it's just allowing people to do a search if by chance they don't know the exact spelling of the first name or the correct date of birth.

Jane Pleckia: So, allow them to search before they actually submit the claim?

Ronnie Harshman: Yes.

Jane Pleckia: OK, so that's really what the difference is.

Ronnie Harshman: Yes.

Jane Pleckia: Thank you.

Aryeh Langer: Chris, we have time for one more question.

Operator: Your last question comes from Dee DeSchwanday:

Dee DeSchwanday: Yes, I have just a very general question on your page – the slide number 15. Can you hear me?

Chris Stahlecker: Yes.

Dee Deschwanday: OK. On slide 15 you have various websites you can go and download the 5010 format. I was wondering, and I was actually searching on one of yours here trying to see, we already have a 4010A1 pretty good format with us. Do we have to purchase the 5010 in order to do the next versions, which are pretty expensive – the sites that you've given us, the WPC, the Store, and all those things?

Chris Stahlecker: Yes …

Dee DeSchwanday: Is there somewhere we can get …

Chris Stahlecker: These are not free with this version upgrade. In the past they have been made available for industry to access without cost, but that's no longer the case. Everyone is purchasing their own copy.

Dee DeSchwanday: So we have to purchase our own copy. Because what I'm seeing is 4010 was of course, a big change. And 5010 is just enhancement or whatever you want to call it. And then we do have to have the actual format with us in order to work on this particular version.

Chris Stahlecker: For you to understand what the new requirements are, it's highly recommended that you purchase the guide.

Dee DeSchwanday: OK. All right. OK, I was just wondering because I'm on your site here and trying to see here and I'm looking at a comparison of 4010A1 and 5010 side by side, and you know the other site which I was not aware of, and they give pretty good idea about what did change. But I guess it will be a good idea to get the 5010 format. Thank you.

Aryeh Langer: Well, I'd just like to thank everybody for participating in today's call. I want to reiterate the importance of going to the website before any other calls. The listserv messages went out the same way this time on the fifth national call as they went out on the four previous calls, and we didn't have this much feedback about missing presentations. I apologize for anybody who wasn't able to see it during Ronnie's presentation. But as I said, you can go on the website and you will be able to see the presentation now. Additionally, within approximately two weeks' time you'll be able to see the transcript and hear the audio version, or you can tell your friends about it if they missed the call.

So thank you CMS staff here for taking time today and answering all these questions. And we look forward to hearing from you in the future. Have a great day.

Operator: This concludes your conference call. You may now disconnect.

END