

Centers for Medicare & Medicaid Services
Third National Medicare Fee-For-Service Education Call on HIPAA Version 5010
Moderator: Aryeh Langer
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Welcome

Operator: Good afternoon. My name is Sarah, and I'll be your conference operator today. At this time, I'd like to welcome everyone to the Third National Medicare Fee-For-Service Education Call on HIPAA Version 5010.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number 1, on your telephone keypad. If you would like to withdraw your question, please press the pound key. Mr. Langer, you may begin your conference.

Aryeh Langer: Thank you, Sarah. This is Aryeh Langer, from the Provider Communications Group here at CMS, and I'd also like to take the time to welcome you to the Third 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. Before we get started there are just a few quick items that I'd like to mention. For anyone that didn't get a chance yet to download the materials for this call, you can go now to the CMS 5010 Web page, which is the central source for all CMS 5010 information, 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 page and you'll see the presentation. If you don't have that web address, I'll give it to you now. It's <http://www.cms.hhs.gov/versions5010andD0> , again, versions 5010andD0.

Also, on that same page within the next two weeks you'll be able to download an audio version and transcript of today's call. As mentioned on the First National Call on 5010, I'd like to remind you of the release of the MLN Matter Special Edition Article, SE0904. This article is an introductory

overview of the Version 5010 and is the first in a series of MLN Matters Article that will be developed. To access this article, please visit the 5010 Educational Resources web page that I just mentioned.

Additionally, CMS is currently developing educational materials on 5010 and their availability will be announced via the CMS listserv messages. Finally, there will be a question and answer session following today's presentation that will enable participants to ask question of our CMS 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 if you could limit your question to just one per caller. Without further delay I'd like to introduce our speaker for today, Chris Stahlecker, our 5010 guru, is the Director of the Division of Medicare billing procedures and the Office of Information Services here at CMS. Chris.

Chris Stahlecker: Thanks, Aryeh. I just want to assure folks that I'm not the only subject matter expert. I do have others with me here in the room that will help bail me out if our questions are something that I can't handle. In any case, I want to reflect that our topic today is 5010. We call our project HIPAA Version 5010 Implementation, but it does also include the D.0 Version that Aryeh mentioned.

The 5010 transactions are products of the X12 Standards Organization and the D.0 is a product of the National Council for Prescription Drug or the DME Standard as a part of their standard materials. So, another introduction to today's discussion I'd like to point out that it is going to be a pretty technical discussion. So, if we seem to lose you along the way, please don't be concerned about that. It probably points out that you are going to be

dependent upon a vendor or some other technical component to support your 5010 and D.0 implementation.

We do have a couple of prerequisites that we would suggest to you: that you are familiar with the X12 EDI transactions and the structure of those transactions, that you have an awareness of the HIPAA Transaction and Code Set Requirements, the regulations requiring HIPAA Transactions and Code Sets, that you also have access to the X12 and Technical Report Type 3. That term TR3, or Technical Report Type 3 - that is the same meaning of an Implementation Guide. The 5010 Implementation Guides are called Technical Report 3, and they replace the Implementation Guides associated with Version 4010 implementation.

I'd like to point out that the earlier implementation of the HIPAA Transactions and Code Sets permitted you to go and download for free the Implementation Guide; however, that's no longer the case. You must now purchase the 5010 TR3 documents and you can obtain them at a URL called store.x12.org, but that is something that you are now required to purchase for yourself. So, expect today's audience to be somewhat technical in nature. We believe that you are representatives of provider organizations that perform the technical support for the HIPAA standard transaction sets and we wanted to reach you today to talk about the approach that Medicare Fee-for-Service is taking.

Slides 2 through 9

So, I'm going to move to slide number 2, and just as a little background recap talk a little bit about the regulations affecting electronic data interchange standards. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, mandated that the health care industry use standard transaction formats when these business documents were exchanged. So, that would be

for electronic claims and claim related transactions. And on January 15, of this year, a new regulation was announced saying that the industry needed to upgrade or update these versions of the standards from 4010 to 5010. We'll talk more about that in a moment. Another regulation that's important for you is to reflect on is the Administrative Simplification Compliance Act. And that requires the use of electronic claims for providers in order to receive Medicare reimbursement.

There is a small waiver for submission of electronic claims and if you need to know what the specifics are, it reflects the number of employees, differs institutional versus professional and you can find more on our website about ASCA, but for the most part everyone is required to submit electronic claims and are submitting electronic claims. We have 99.8% of Medicare Part A claims that are coming in electronically and over 96% of our Medicare Part B claims are coming in electronically. So, now we are changing the formats or upgrading the versions of all those electronic formats.

I'm moving to slide number 3, and sharing with you here the Medicare Fee-for-Service implementation timeline. Medicare Fee-for-Service has been working on this project for some time now. We actually had our first portion of our work implemented into production on October 1, of 2008. We've made steady progress on the portions of what we are requiring to be developed. I would point out that October 1, 2008, was in advance of the Final Rule coming out.

The development, systems test, and transition phases that we see on this timeline are reflecting language from the Final Rule. That rule did say that most of the development should be completed in the calendar year of 2009, but the calendar year of 2010, should be devoted to integrated and systems testing and that around January 1, of 2011, we would like to begin the

transition work for providers to actually implement into production the use of their 5010 transactions.

And that is a timeline that Medicare Fee-for-Service has adopted. We expect to be able to begin our integration testing on January 1, of 2010. Now, that's not saying its all end-to-end, but very specific components of our implementation will begin their integration systems testing. And we will continue to build and improve upon our systems testing throughout 2010.

Our objective and our goal, that we're on time for, by the way, is to be able to support providers who want to begin their transition testing on January 1, of 2011. That would start a full calendar year of Medicare Fee-for-Service being able to process the 4010 formats alongside of the 5010 formats. And you'll note on this timeline that January 1, of 2012, no more 4010, 4010A1 formats will be processed. That is, again, according to the regulation that we must stop processing those old formats at that time.

On the same timeline we've indicated the ICD-10 cutover process of October 1, of 2013, and point out that the 5010 implementation is a precursor project for that effort. So, we do not want to be in the way of ICD-10 being able to start up, but they are two separate and distinct projects. The 5010 timeline we expect to be completed on January 1, 2012, but to begin our transition a year earlier, January 1, 2011. And Medicare does not expect to need any extensions to these deadlines. So, we will not be asking for any contingency plan.

And moving on to slide 4, and just the recap of what must be changed, the formats that are currently used must be upgraded from the X12 Version 4010 and 4010A1 to 5010, and from the NCPDP 5.1 Version to the D.0 Version. Now those are the versions. The specific transactions that are affected are the claims, and the X12 claim is known as the 837-I for the Medicare Part A

claim, the 837-P for the Medicare Part B claim and, of course, it also includes the C0B Versions, 837-I C0B, 837-P C0B and then the NCPDP format. It will also include the NCPDP coordination of benefit or C0B version. It will address the remittance transactions or the 835. It will also cause a change to the claim status inquiry response transaction, the 276/277 and the eligibility inquiry response transactions, 270/271.

So, the systems that are in place right now that submit claims, or receive remittances, that perform claim status inquiry, or eligibility inquiry, you must analyze your side of these transaction exchanges, identify the software and any business processes that you believe need to be changed and be in place according to the timeline that we just mentioned, no later than January 1, 2012.

Medicare has performed a comparison of the current and the new formats of these transactions and they can be found at the URL listed below on this slide and also on the last slide of today's presentation. And I wanted to reiterate that the transitions of these new formats for Medicare Fee-for-Service will begin on January 1, 2011.

Moving on to slide 5, it is very important to know and probably one of the most important points of today's presentation is to make sure you are aware that Medicare Fee-for-Service is implementing two additional EDI standards, not HIPAA standards, but they are national standards nonetheless. But they are not regulated standards. You're not required to implement these standards. You will be required to implement the standards to process Medicare Fee-for-Service error handling, however.

These new ASCX12 transaction standards are the acknowledgement and rejection transactions. It's the functional acknowledgement. The 999 transaction will

replace the today Version 997 Functional Acknowledgement. So, Medicare Fee-for-Service is implementing with 5010 the use of the 999 Functional Acknowledgement Transaction.

We are also implementing the 277 Claims Acknowledgement Transaction. That will be used to replace all the proprietary error reporting that's in place today. You're probably familiar with certain error reports that are returned to you from our shared systems. On the Medicare Part A side, we have a series of reports that might start out HB997ZRJ-A. That will be replaced by our standard or 277 Claims Acknowledgement Transaction.

And on the Medicare Part B side, you may be familiar with H99RA Series of error - proprietary error reports. Those will be replaced by the 277 Claims Acknowledgement Report - I'm sorry, Claims Acknowledgement Transaction. It's not a report. That's the key part here. We are going to be returning an EDI transaction and not a human readable report. That's the key point of information.

On slide number 6, the Medicare Administrative Contractors will be using a COTS Translator and also Standard Systems software supplied to them to perform all of their front end processes to achieve processing the 5010 transactions and returning the standard error transactions that I just mentioned.

The translators will perform all the X12 syntax edits and CMS has reviewed the Implementation Guides of the TR3s for the TA1 and 999 transactions and selected which ones will be performed by the translator.

The TA1 will be sent to you when the translator has discovered difficulties with the interchange envelopes, the ISA and the IEA. That's kind of what we're doing today. It shouldn't be a big change for you. The 999 will be used

now for rejected functional groups. That would be the GS to GE envelope and the transaction sets, the ST to SE envelopes. When we find difficulties - when the translator discovers difficulties with these functional groups, the transactions sets, you can expect to receive back a 999-R or rejection transaction.

There's a certain situation in addition to the 999-A for an accepted transaction which you will also receive. There's a special situation where the translator may discover a certain set of errors, but they want, we don't want, to reject the transaction. We want to continue to process that to discover business rules difficulties and the translator will send on a 999-E.

That means it's a transaction that has been discovered by the translator to have a certain set of error situations in it. It means that it's structurally sound, but it's non-compliant from a business unit perspective. It will be passed to this new set of software, the Common Edit and Enhancement software or Common Edit and Error Handling Modules, where we will determine the specific reasons for rejections and return back to you a 277 Claims Acknowledgement Transaction.

So these are a special situation where the translators discovered a problem, but we're going to continue to validate the transaction. We'll pass it to the CEM module. In either case the translator will produce flat files for the accepted transaction and the subsequent processing. That would be either case being a 999-E for errors or -A, for accepted.

Moving on to slide 7, this Common Edit and Error Handling or Enhancement Modules that we're referring to - this is actually being developed by our shared system maintainers and will be delivered to our MACs for inclusion in our front end system. The CEM software will perform the Medicare specific

edits CMS has selected from the Implementation Guides and produce the following that we have bullets on this slide 7; the CMS flat files for the accepted transactions. And note that we will be assigning claim numbers. This is a new feature in our front end system.

The CEM modules will also develop a file - the 277 Claims Acknowledgement File for each accepted or rejected claim. The 277CA for the accepted claim will include the claim number and if it's rejected we'll include the details about the error. So, this approach allows us to return individual claims as opposed to needing to return the entire transaction set when an error is not of a syntactical structure concern.

On slide number 8, we'll continue some discussion about the edits. CMS has developed a spreadsheet that details all of the edits that we expect to be performed either in the EDI translator and separately the edits to be performed in the Common Edits and Enhancement Module.

And on slide - our next slide number 9, we have an excerpt from the spreadsheet. I want to note that the entire spreadsheet will be posted on our website. We expect to have that posted prior to the X12 meeting. We hope that will be posted within the next week, but it may be two. But it should be posted shortly.

I'm going to have a joint conversation about slide 8, and slide 9, at this point. So, if you want to open up your presentation materials to look at both - on slide number 9, you'll note that it is a sample of the 837 Professional Edit Spreadsheet and so I've just taken - we've just taken - one page or one section of that entire spreadsheet for discussion purposes now.

You'll notice that across the column headings we have an element identifier in column 1. We have a brief description in column 2, about what that data element is. If there are specific values, column number 3, identifies the potential 5010 values for that element. In column number 4, you'll see titled TA1/999/277CA, and if you look vertically underneath it, you'll see that we have examples of a 999, or the very last row has a 277. So, when you're using this spreadsheet you will look here to see if it's - you would expect to have an error returned to you in a 999 format or a 277 format, potentially both. And I'll get into that in a moment.

The next column, column 5, is titled Accept/Reject and the reject is indicated with an R. And we do not have an example on this excerpt of an accept transaction. The two - well, we'll get into some discussion about how to interpret that last row.

The next column, 6, is titled Disposition/Error Code. And this is the details of how the transaction set will be formed for you to understand the actual disposition of the transaction that was validated once received by Medicare.

And slide - and column number 7, Proposed 5010 Edits Part B. You'll notice that this is an edit description. The 2010 AA.NM1 must be present. And that is the same as - language that you'll see in the next column 8, for CEDI. We have allowed for the potential of different edits to be performed from a Part B perspective versus the CEDI perspective.

CEDI, being the common EDI front end validation process for DME claims. This particular excerpt has all of the edits the same. I said it was a professional edits spreadsheet and we have the same edits performed between Part B and CEDI.

I'm going to drop down a row and just walk through one with you as an example. The 999 - just to remind you and I am referring back to slide number 8, now - the 999 - the use of the 999 transaction is output from the translator. And it will indicate either that the transaction being processed is rejected or accepted with errors. The E indicates it's accepted with errors. There is a potential for an A, but we have not taken a point of making that be visible on the excerpt.

The 277 does indicate that there are no errors. So, it doesn't say 999A, it indicates 277. So, that just means that if there was a subsequent error identified you would know that by the presence of the 277 information. So, if the Common Edit Module identifies an error the 277CA will be sent back with the error codes indicated. If there is no error, the 277CA will be sent back as an accepted transaction and the claim number will be assigned and given back to you.

I do want to mention that the spreadsheet is currently being reviewed and we do expect it to be published on our website. But I would also caution that when you do see it we believe it's very sound. We believe it to be 80, 85% finalized. In some cases we have certain situations where some of these error code values that we're going to talk about in just a minute on slide 9, have not been assigned yet by the X - by the code set committee that typically meets at the Sunday session at X12.

So, we do have a code set maintenance activity that we're going through to have new codes assigned when they are not currently available. So, we do intend through the course of upcoming weeks to enhance those spreadsheet, but we do believe it's about 80, 85% finalized.

I want to come back to our spreadsheet here. And on the first row, NM1, indicates a description of a billing provider name and if you look at the column 7, and 8, the edit that's performed at the 2010AA.NM1 must be present. In an error situation for this edit to fail means that that segment is missing.

So, on column number 6, the disposition or error code you'll see that we have an IK304 segment, IK3 segment element number 4, is populated with a 3. And from the TR3 guide you'll note that it means required segment is missing. The disposition on this - if this situation occurs - is that a 999 rejection transaction would be returned to you.

I'll do another one right underneath; it's the same NM1 element and a different edit. If you look at column 7, and 8, it says only one iteration of the 2010AA.NM1 is allowed and if that edit is failing it would mean that there was more than one iteration present. And that would be identified with an IK304, as well, but this time the value in that data element would be a 4. And if you look in the TR3, that 4 means that the loop occurs over a maximum number of times. So, these are considered syntactical errors and would result in a 999-rejection transaction.

If we go down the page here just a little bit, we'll see in the second to the last row, again the NM103 data element and we'll see that the error rejection is a 999E. And if you look over to column 7, and 8, you'll see that the edit that has failed is, again, a 2010AA.NM103.

It says that it must be one to 60 characters. So, for that to have failed and be present, of course, must be longer than zero length. We assume that it would have been too long. And you can see in the error disposition that we are using,

again, the IK4, and again, the 03, will be populated this time with a 5, to indicate that the data element is too long.

Now we can process this situation. So, we are not going to reject the entire transaction for this type of a failure. And we would indicate to you – we would send you a 999 with the error indicated in it, but we would continue to process it - that transaction. We would send that transaction over to the Common Edit and Enhancement Module.

And ultimately that claim would be rejected, but you would get a little bit more information on it once it's processed by the Common Edit and Enhancement Module. You would receive back a 277CA and the STC segment would be included. And the STC would have a data element that got - the content is described in this column 6, the disposition and error codes.

We would like to point out that this is a composite data element. So, these three data elements would be present. The CSCCC, which is a claims status claim category code, would contain an A7, and that would mean to you that the acknowledgement is being rejected for invalid information. It would also have the data element following the CSC, which means claims status code, it would have a 512 value in it and from the TR3, it means - a 512 means that there's a link - an invalid link.

And then finally the last element in this composite is an entity code and - with a value in it of 504, meaning that the entities last name and the entity identifier code is the billing provider. This last entity code would have an 85, saying that it was the billing provider's last name that had - it was too long. So, the composite data element would consist of those three data elements in the STC. And we'll show you a few examples. So, if you're feeling overwhelmed just hang in there for a moment.

Slides 10 through 18

We'll move on to slide number 10, and we will come back to that discussion on the 277 in just a minute. But now we're going to walk through the three transactions that we've been speaking about for our error handling. We're going to go back to the first one, the TA1, and have a little walk through here.

The interchange acknowledgement example or TA1 that we have outlined is one where the interchange envelope that was processed by the receiver's translator discovered that the trading partner's Sender Identifier was incorrectly entered.

And it should have been six capital S's, but it had a seventh S in there. And so it did not find that Sender Identifier when it did its validation in its trading partner management system. So, right up front when the ISA is processed the Sender ID is validated with trading partner management systems. And in this case we discovered we didn't have a match. So, the entire transaction set, the ISA to IEA, will be returned or not returned but it will be not processed. We'll return a TA1 rejection transaction to you.

And you'll see an example of what the submitted envelope would look like. You'll see the capital S is a little lower case s to show you where the error was made and the resulting interchange acknowledgement transaction is the TA1. And it is returned indicating that an interchanged note of 006, that there's an invalid interchange Sender ID. You'll see that on the bottom of this slide, the second row from the bottom, the TA1 and the last value in there is an 006.

So that's typically how a TA1 would be used, identifying errors discovered in the ISA-IEA. If the ISA-IEA is processed successfully, the transaction will continue to be processed. And we have now a couple of examples of 999

situations. So, in our example we're processing an 837 health care claim, but in this situation a functional group had two non-fatal errors and was accepted for further processing. In any situation each error is identified in the IK4 segments.

So, you'll see, again, as I said earlier that we're not trying to do an EDI overview, but you'll see the ST segments of the various segments and their full expression on the left side of this slide and then broken down for you on the right side of this slide to explain what each of the data elements in that segment are meant to be. But you'll see the ST is formatted appropriately and we have an expression for you to see what the AK1 will look like when returned to you.

But I really wanted to draw your attention to the IK3 and 4. The IK3 will indicate that there was a segment error found. It will give the actual segment that contained the error. It will give you 120, the position in this example of the segment within the transaction set that had the error and the value 8, indicates the segment that had the data element error. I'm sorry - that it is - the segment has data element error as a qualifier to mean that the segment has data element errors. But the real value in this is the IK4. That will indicate to you that the 2, is the data element position within the segment, the CLM02 contains the error, and then the actual error that exists.

The 782 is the X12 data dictionary reference for this particular data element and the I12 indicates that the segment has data element errors. And the actual data value that was populated in that segment contained a nine two decimal position 111.

So, the data element 782 is a monetary amount field. And the TR3 Implementation Guides have restricted monetary amounts to be no more than

S98V99. So, in this particular case we have a situation of three decimal positions when the Implementation Guide has reduced it to only two. So, this is a particular error we can't - we don't want to accept this particular error. So, we will return to you in this 999 example. It's a non-fatal error, but we'll continue to process it. But in the 999 transaction that we return to you we'll give you this specific detail.

On slide number 4, we're continuing to show that type of validation. We said that there were 2 non-fatal errors and we'll see at the top of slide 12, the IK3 indicates that it's the N4 segment that has the error. And its position 127 within the transaction set and that the segment has particular data element errors. The IK4 will indicate to you that it's the third data element within the segment, N4 segment. So, it's N403 that has the error.

The 116 is the data dictionary reference which indicates it's a zip code and that the value of six indicates that there is an invalid character in the data element. And that would be the dash between the five digit zip and the four digit to make it the nine digit zip. So, we have a copy of the bad data content. So, in this particular case it's the zip code that we've discovered has an error. So, you'll receive this information in the 999. However, we may continue to process those transactions so that we can deliver back to you in the 277CA a more robust set of edits that have been failed.

On slide number 13, we do have an example of a 999 that has been accepted that there are no syntax errors discovered. That's not to say that it's a clean claim submission, however, because this just means that it's going onto that Common Edit and Enhancement Module. There at that point additional business failures may occur resulting in a 277 Claims Acknowledgement. But in this case it's gotten by the envelope edits, the TA1, and it's has gotten by the 999 level of validation. So, you will receive a 999 that will tell you that

the transaction set has been accepted. And we have an example here of what that will look like. We have the ST followed by the AK1. And the AK2 is actually indicating that it's the transaction set response header and the IK5 has the A in it to indicate to you that it is been accepted.

And the second functional group is indicated the same way, the AK2 followed by another IK5 to indicate it's accepted. So, that's - perhaps after the first situation has been corrected the second time it's processed you've got two accepted transactions coming back.

So, moving on to slide number 15, and in this example we're talking about the 277 Claims Acknowledgement example. And here's a little business case scenario. The submitter is a Best Billing Services. The receiver is a clearinghouse, First Clearinghouse. And the provider is Smith Clinic. So, this is just to point out that the sender is the billing service and the receiver is the clearinghouse. This has not gotten to one of our Fee-for-Service Contractors yet. The claim submission date is indicated, the number of claims and total charges. In this scenario the file is going to be rejected in the - by the - Common Edit Module, Logic, as a billing provider who is not associated to the submitter organization.

I guess I need to restate the scenario. This would be a scenario if, in fact, one of the Medicare Fee-For-Service Contractors was having this validation edit performed by a clearinghouse on its behalf or one of its gateways. So, otherwise we wouldn't even expose it to the Common Edit Module. But in this scenario we wanted to get to the point of where the billing provider is not associated with the submitter organization.

I'm on slide number 16, we have the 277 Claims Acknowledgement example. Just to point out a couple of things to you. You'll see the ST and the BHT is

the first two transactions. Then the first hierarchical level indicates that it's the First Clearinghouse. The second hierarchical level is the Best Billing Service and the third hierarchical level is the Smith Clinic. This is what the 277 will be returned - what it would look like being returned to the Best Billing Service.

The STC you'll see within the HL2. It's the third segment within that hierarchical level and then we also have an STC within the third hierarchical level STC. So, this is the data stream. And I'm going to move onto slide number 17 that will give us a little bit of the description of what we're looking at here in the data stream. On slide 17, we'll see the expression of the ST and the break out of what each of those elements are reflecting. We have the BHT which gives us the breakout of the hierarchical structures.

And on slide 18, we have the first hierarchical level and the information source level indicates that it's the - it is the information source and the NM1, the source is indicated that it's the First Clearinghouse. The error was discovered by the clearinghouse.

Slides 19 through 26

On slide number 19, we'll see hierarchical level two and this is the information receiver, who is receiving this error transaction. It's the Best Billing Service is being told why there was an error. And we'll see the STC below that. It is the information receiver status information contains a composite data element as A7 indicates an acknowledgement being rejected for invalid information.

The 23, says that it's being returned to the entity and the status information effective date follows that data element, that composite data element. And finally the U, indicating that the transaction, the claim itself, is being rejected.

So, we still don't know precisely what's going on. So, we'll move on down to hierarchical level three and we'll see the - it's the provider of service level. That's the billing provider name, the Smith Clinic, is pointed out in NM1, but the STC indicates to - that's another two rows down from there - A8, that the transaction is being rejected with a 496. The submitter is not approved for electronic claims submission on behalf of this entity. And the entity being rejected is the billing provider. And the fact that it's a U is a reject. I told you that the trans - the actual claim transaction is being rejected.

So, that is an example of what the 277 will look like when a transaction is being rejected - when an individual claim transaction is being rejected. I tend to use the term transaction not to mean the ST to SE because this is an individual claim found within that envelope, but it is a claim unit of work.

So, moving on to slide number 21, and just to review the purpose of these three unique transactions. And when you receive a TA1 what you will need to do to correct it is to find the problem within the ISA-IEA interchange, correct it and resubmit the entire ISA-IEA. So, we have not returned all of that data. We just did not retain it at our site. We're telling you that the envelope was bad and you need to resubmit that entire transmission.

When a 999 is received that can tell you a couple of things. It may tell you that there are syntax errors and that you need to begin an investigation and correct and resubmit a particular claim transaction or if it's an A, a 999-A, you may be assured that all of the transactions were accepted. And you may actually use the - may put a look out for the 277 Claims Acknowledgement.

When you do receive that Claims Acknowledgement, you may recognize that business rule errors have occurred and you can begin a correct and resubmit of

that particular claim that was found to be rejected or you may recognize that all the claims were accepted. And you may look and retrieve out of that 277CA the claim numbers for subsequent use, for example, on claim status inquiries. So, these three transactions do work together to convey to you whether or not your transmission had errors in it and the nature of those errors or whether or not everything was fine. And you should expect to be able to submit claim status inquiries or receive an 835 remittance.

On slide number 22, there were a couple of special situations that we wanted to point out. And when we are moving through the validation process we wanted to point out that we don't continue on in all cases. When a billing provider loop is discovered to have an error in it and either in that hierarchical level if we have difficulty with the NM1, we're not going to continue on and process at a detailed level all the claims that are submitted for that particular billing provider.

We'll indicate to you that an error is encountered and that you will need to resubmit. We're treating that billing provider hierarchical level as a little mini envelope, if you will. So, you'll need to resubmit all of the claims for a situation where there is difficulty with the billing provider.

But we do want to be able to process the maximum number of transactions that come to the carrier, the intermediary or the MAC. So, we are trying to define a fine line between whether we reject a transaction and when we continue on to validate it. But this is one unique situation that we wanted to point out to you. When a fatal error is encountered with data of the provider we don't continue on with a specific claim editing.

On slide number 23, just to recap for you on how you can use the TA1, we did expect that once received at the provider location there were likely two

different audiences that would receive these transactions or would attend to receiving these transactions. We felt that the TA1 and the 999 did reflect technical problems that might be addressed by the software that was preparing the EDI transmission. So, likely you'll need to create trouble tickets to be addressed by your technical resources that would be able to fix an outer envelope or a syntactical correction for the reasons why you were receiving a 999 rejection.

However, when you receive a 277 Claims Acknowledgement, that can just be a billing data content error and perhaps the resources that would be fixing those problems will be coming from your billing area. The billing staff will likely need to have reports produced for them and those reports would be drawn from the data that's returned in this 277 Claims Acknowledgement Transaction.

So, we are expecting that when Medicare Fee-for-Service issues a 277CA, that the receiver - and that would be the providers on this call, so your technical representatives - would receive that 277 Claims Acknowledgement and produce for you a readable - human readable error report so that you can understand how to fix your billing error and resubmit that particular claim.

On slide number 24, we wanted to point out that currently each Medicare Administrative Contractor is producing customized error reports that can vary somewhat by jurisdiction. And by moving to the use of the standardized edits and the accompanying EDI error and acknowledgment transaction that Medicare is enabling the production of standardized reports across all jurisdictions. Please note that Medicare is not producing the error report or producing the error transaction. So, clearinghouses and software vendors will be able to use these transactions to produce the reports on behalf of their customers.

So, I'm moving on now through slide 25, to slide 26, because I have concluded a majority of the points needed to be made in today's presentation, but I did want to point out on slide 26 where you can obtain additional information. Again, to reiterate that Implementation Guides or Technical Report Type 3s, now need to be purchased. And we've given the location of where you can obtain them.

It's the X12 store location and also NCPDP. And the location for where you might want to go to look for responses to technical comments, as well as other interested parties might look at the HIPAA.DSMO, Designated Standards Maintenance Organization, for a location to receive requests for changes to the transactions and then additional CMS website locations for keeping your eye open for additional information from CMS on this implementation.

And with that Sarah, I think we're ready to take questions if there are any.

Question and Answer Session

Operator: We will now open the lines for a question and answer session.

To ask a question, please press star followed by the number 1, on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question. So, anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Gloria Davis. Your line is open.

Gloria Davis: Hi. This is Gloria Davis, with NextGen Healthcare. With the usage of the return claim number in the 277CA will there be a requirement to send a corrected claim with that return claim number?

Chris Stahlecker: No. That claim is not considered a received claim at that - I'm sorry. Let me ask you that - let me ask you to repeat that question. So, you're going to get a claim number back. So, that says to you that we've accepted that claim. I'm sorry I focused on the rejection part there for a moment. So, if we're returning a claim number to you, we've accepted that claim into our process. So, what's the next part of your scenario?

Gloria Davis: Well, will the requirement be to send it as a corrected claim and note that returned claimed number on the corrected claim?

Chris Stahlecker: No. We're not accepting corrected claims in that fashion, although, you know, we realize the transaction can be used in that manner Medicare Fee-for-Service has not implemented that process.

Gloria Davis: Okay. That's all right.

Chris Stahlecker: Corrections need to be made on the Medicare Part A side. It would be through the direct data entry process and - at this point anyway.

Gloria Davis: Okay. That's all right. I just wanted to clarify whether it would - you were going into that direction of using that claim number for any resubmitted claims.

Chris Stahlecker: Not at this time. It's interesting you asked the question but not at this time.

Gloria Davis: Thank you.

Operator: Your next question comes from the line of Nancy Horn. Your line is now open.

Pat Tye: Yes, this is Pat Tye. My question is purchase of Implementation Guides and access to technical questions. Once that's purchased is there - will there be publications available with any updates or changes to that information?

Chris Stahlecker: I believe when you speak to the store representative that you would be permitted to engage them in that discussion. We've been successful for negotiating, you know, reissuing the publications when errata occurs and the correction is made to those TR3s. We've been able to receive that at no additional cost. So, it is something for you to discuss with them when you are purchasing those TR3s.

There's a portal where you can ask questions. There might be a Frequently Asked Questions list there that might address that for you. So, on the X12 website you could look for that Frequently Asked Questions. It might help you out additionally.

Operator: Your next question comes from the line of Deborah Graham. Your line is now open.

Deborah Graham: This is Deborah Graham from the U-Mass Memorial. What happens in the 999 if there are accepted with errors and totally rejected errors?

Chris Stahlecker: You'll have...

Deborah Graham: Like in two separate SC-ST or ST-SE segments?

Chris Stahlecker: If the ST to SE is rejected, you won't have the 999E. You'll have a 999R.

Jerry Batey: You would get two 999s, one with an R and one with an E in that situation as she described it.

Deborah Graham: Okay. So, there - it's a possibility that we will get more than one 999?

Jerry Batey: You'll get one 999 for every ST to SE. It's how we're planning the implementation here at CMS.

Deborah Graham: Oh, cool! So, if I send you five ST-SEs I'm going to five 999s back even though there in the- I send them in the same file? If I send you five, I get five?

Jerry Batey: The concept is that if you have a functional group that has five transactions set inside you get one 999 with multiple transactions sets identified within 999 and each of those will identify whether that transaction set was accepted or rejected. It goes to how you package it. I mean if you take - if you have a functional group of one transaction set, then you have a second functional group with another transaction set, then you indeed would get one 999 per - it's one 999 per functional group regardless of how many transaction sets you put inside.

Deborah Graham: Okay. So, for each GSGE I get one 999?

Jerry Batey: Correct.

Deborah Graham: All right. What if one of my ST-SEs in there was totally rejected because I did something really bad and one was accepted but with errors?

Jerry Batey: Within the 999 there's a pair of segments that you'll get back that will identify the transaction set and whether it was accepted or rejected. That would be the

AK2 and the A - the IK5. That pair will then tell you what happened to a particular transaction set. Each transaction set will have its own AK2, IK5 pair.

Deborah Graham: That's basically like it does now with the AKs and the 997s?

Jerry Batey: Yeah, it's just like - yeah, the 999 is almost the same as the 997. It's just a different per business scope a few other segments and elements.

Deborah Graham: Okay.

Jerry Batey: I'm sorry. I'm being reminded to give you my name. My name is Jerry Batey, working with CMS.

Michael Kabroff: And I'm the other speaker, Michael Kabroff, and I work in Chris Stahlecker's area in Medicare billing procedures.

Deborah Graham: Okay.

Michael Kabroff: We apologize for that.

Deborah Graham: Oh, that's okay.

All right. One 999 or yeah, one 999 for every GS-GE I send you which I think we only send you one?

Michael Kabroff: Correct.

Deborah Graham: Okay. All right. Thank you.

Operator: Your next question comes from the line of Jim Blood. Your line is now open.

Jim Blood: Yeah, this is Jim Blood, with AHDS. My question is, are you - with the 270/271, can you ask a question about that?

Chris Stahlecker: Yes, you can. Go ahead.

Jim Blood: Okay. In the current TM3270 DDE, process a corrected date of birth is returned with it. The current 270/271 doesn't do that. Will the new 5010 270/271, return a corrected date of birth?

Chris Stahlecker: Good question and we'll have to take that question offline. I don't have the answer for you today.

Jim Blood: Okay. Can I send you an e-mail with that question?

Aryeh Langer: Do you want to give us your contact information? We'll have somebody get back to you.

Jim Blood: Yeah. xxxxxxxx@xxxx.

Aryeh Langer: Can you repeat that, I'm sorry?

Jim Blood: It's xxxxxxx@xxxx.

Aryeh Langer: Okay. Great. We'll get back to you. Thank you.

Jim Blood: Thanks. I appreciate it.

Operator: Your next question comes from the line of Mark Finisey. Your line is now open.

Bonnie Cybert: Hi. This is Bonnie Cybert, at Atlantic General. I was just wondering if you could tell me first of all if the PCAs billing software that we go directly through Medicare will also produce those reports that you were speaking about.

Chris Stahlecker: Yeah, the PCA software, also known as Pro32, is being upgraded for the 5010 process. We'll be able to send 5010 transactions and receive back the TA199 and 277 Claims Acknowledgement, yeah.

Bonnie Cybert: And also are the reports for the billing department that you were talking about?

Chris Stahlecker: It will receive back a 277 Claims Acknowledgement Transaction and produce for you something that's viewable. And then I believe you have an opportunity to print from that.

Bonnie Cybert: Okay. How about - also, I wanted to know when you speak about that claim number are you speaking about the tracking number that they used to refer to in the HIPAA transactions?

Chris Stahlecker: No, we're talking about the actual claim number that's assigned for use within our claims processing system. So, it's the claim number that's used to retrieve a claim for claim status inquiry response.

Bonnie Cybert: Okay, so how about the tracking number? It has nothing to do with that?

Chris Stahlecker: There are several tracking numbers. So, I guess I'm not quite sure which one you mean. There's a patient account number, medical record number, clearinghouse claim number. There are several tracking numbers and...

Bonnie Cybert: I thought within the HIPAA transactions though when you send in a claim it's actually assigned a tracking number that follows that claim all the way through until it is adjudicated?

Male: Are you talking about a document control number on the Part A claims system? There's some terminology differences between professional and institutional. On both they end up with what can be turned into a legal claim number where data - that will go through the whole adjudication system and basically show up on your remittance advice.

Chris Stahlecker: That is the claim number that would be returned to you on a 277 accepted claim. That's the claim number, but if you're looking for something else you'd have to give us a little bit more to go on.

Bonnie Cybert: Okay. I'll go back to the manual.

Chris Stahlecker: Okay.

Bonnie Cybert: Thank you.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Denise Smith. Your line is now open.

Denise Smith: Yes, we - since the last call we have been reviewing the TR3 5010 for the 837-P and in the sheet that we are looking at that was - that has been available thus far the CLM05-1, says that the POS code indicates that they're deleted in the 5010 standards? Out to the side on the spreadsheet it indicates that that code has been deleted and we just wanted to see if we could get some clarification on that?

Male: I believe what that is they are no longer able to print in the TR3, the code source where the CLM05 comes from for those place of service. If it's the NUBC maintaining that that NUBC that's what it really means is they've deleted it out of the Implementation Guide. And you should be getting that from the code source maintainer itself.

Denise Smith: So, we're still going to report the POS though?

Male: Correct. The adjudication rules haven't changed. It's just the way X12 dealt with the POS codes and removing them from the guide.

Denise Smith: Okay. Thank you.

Operator: Your next question comes from the line of Andrew Ortlett. Your line is now open.

Chris Stahlecker: Andrew, if you're talking to us, you're on mute.

Aryeh Langer: Will you take our next call for us?

Operator: Yeah. Your next question comes from the line of Deb Cogdon. Your line is now open.

Deb Cogdon: Good afternoon. I have a question about the 277CA. The current H99 actually returns our reference number. So, I don't know if this is going to the same question of the tracking number and I don't see that in the 277CA. So, we're trying to figure out how our claims - how we can trace our claims. Will anything be returned that will be returning our internal claim reference number?

Chris Stahlecker: Deb, are you a clearinghouse?

Deb Cogdon: No, we're an internal - we have an internal system.

Male: There's two different identifiers with an 837 that will get returned to you within the BHT of 837 there's - if you will, a batch control number that will come back with the 277, as well as, you know, if the error does get down to the patient level, you will also get your patient account number which is a value that went in on CML01.

Deb Cogdon: Okay. Thank you.

Operator: Your next question comes from the line of Mr. Emmit. Your line is now open.

KB Emmit: This is KB Emmit with Multicare Home Health. And what I'm trying to find out is I use the Express Plus how does that affect me? One and the second thing I couldn't find the slides so I could follow on the computer.

Chris Stahlecker: Sorry about the - you couldn't find the slides. It must have been difficult for you to participate today. The Express Plus Project or application software, we're unclear whether or not that will be updated at this time. We do know that the PCAs or Pro32 Version will be updated for the 5010 transaction set, but Express Plus at this point - is that used by you for DME processing?

KB Emmit: Yes.

Chris Stahlecker: For DME? We'll have a DME product, but we'll have to confirm which version is going to be updated. We were, CMS was looking to have a single product for each line of business. So, PCAs or Pro32 for Medicare Part A and B and there will be a product for DME. I'm just not clear today as I'm answering you whether or not that's Express Plus.

KB Emmit: And will it be implemented you think before the implementation date for the 5010?

Chris Stahlecker: That's our objective, yes. We need to have the software for the DME processing available for providers to transition on January 1, of 2011. So, we would expect the software, the free software, supporting DME processing to be available in advance at that date.

KB Emmit: Thank you very much.

Aryeh Langer: Sir, do you have the website that I gave out at the beginning of the call, the web address where the presentation is available?

KB Emmit: I tried accessing it, but for some reason it gives me a strange message, not accessible or something, but anyway...

Chris Stahlecker: Do you want to give us your contact information and we can give you a return call on the software name that will be updated for DME?

KB Emmit: Yes, ma'am. That would be xxx-xxx-xxxx is the telephone number. And shall I give my e-mail address as well?

Aryeh Langer: We'll contact you and then we can also hopefully help you get the presentation from today.

KB Emmit: Yes, sir.

Aryeh Langer: Thank you.

KB Emmit: And thank you.

Operator: Your next question comes from the line of Deb Ribson. Your line is now open.

Deb Ribson: Yes, this is Deb Ribson, from University of Rochester Medical Center. And my question really has to do with documentation on the 837 and the 835. I understand that the Implementation Guide will be replaced by the TR3, but will there be a separate Companion Guide issued by CMS?

Chris Stahlecker: Yes, there will be. We're not that far along yet, but yes, there will be - it will essentially have references to the edit document that we're going to have on our website though. So, I think even if we don't have a published Companion Guide for the next several months, you should still be able to use the edit spreadsheet from our website to get your work underway.

Deb Ribson: Okay. So, is there a target date in mind for that to be published?

Chris Stahlecker: Probably first or early second quarter next year.

Deb Ribson: Okay. Thank you.

Chris Stahlecker: Did you mean the Companion Guide or the edit spreadsheet? The edit spreadsheet we expect to post on our website within two-and-a-half to three weeks.

Deb Ribson: I meant the Companion Guide.

Chris Stahlecker: Yeah, the Companion Guide is out there a little bit. We have some work to do on that - just a we would like to have - our thinking on this is that the Companion Guide will follow the CAQH Core Template for Companion Guides and so that we will have only a section that will be standardized by CMS that each of our MAC contractors will use.

But each of the MACs, of course, have their own unique front end for telecommunication and EDI help desk contacts. So, there's many chapters in that template that would be unique per MAC contractor, but the essential parts of where we want to get to consistent processing and error handling, CMS would supply the language in that template before the MAC customizes it for their site.

Deb Ribson: Okay. Thank you.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Ryan Harkins. Your line is now open.

Ryan Harkins: This is Ryan Harkins, with CPSI. You guys may have gone over this. I was a little late coming in. Going back to the 999, say we receive a 999E that has a single claim rejection on it. Would that claim rejection also show on the 277 or is the 999E the end of the road for that claim?

Chris Stahlecker: No, it's not the end of the road for that claim. The 999E is sort of an early heads up that there's trouble with it, but we're continuing to process.

Ryan Harkins: Okay.

Chris Stahlecker: And the 277 would be the final story on that.

Ryan Harkins: So, if the claim rejects on the 999E, expect to see it rejected on the 277CA whenever that's available?

Chris Stahlecker: Yes.

Man: Yeah, there is only - there is one exception to that and that is if somebody uses a not used element within a transaction set that will only be reported within the 999E.

Ryan Harkins: Okay.

Man: All others will have a 277 associated with it.

Ryan Harkins: So, the vast majority, if it rejects a 999E it would also be reported on the 277CA?

Man: That's correct.

Ryan Harkins: And was I right in hearing that the 277CA is not going to be human readable and that software vendors would need to come up with some ways to make that readable for providers?

Chris Stahlecker: That's correct.

Ryan Harkins: Okay. Thank you.

Operator: Your next question comes from the line of Betty Gomez. Your line is now open.

Mike: Hey, this is Mike unintelligible.

My question was in relation to the 277CA. It's been asked already about the - about a claim trace number and we were wondering in regards to the Ref D9. It says it will return the DHPO3 and the patient control field. What about the Ref D9?

Chris Stahlecker: Clearinghouse control number, if that's what you're referring to, is going to be returned to you.

Man: We're making a difference Mike, and we're making arrangements with our internal system so that when it comes to our front end MAC and it goes through their translator and through the CEM module, the 277 would then spit back that D9 Ref segments so that the clearinghouse claim control number gets returned to the clearinghouse as soon as assuming they were the trading partner sending in the file at that point and time.

Mike: Okay...

Man: ...before it got to our MAC. I don't know what to tell you there.

Mike: Okay. Thanks.

Operator: Your next question comes from the line of Bill Anderson. Your line is now open.

Bill Anderson: Yes, this is Bill Anderson Advocate Health Care in Chicago, Illinois.

Could you give us the link again? We were not able to find the documents as well.

Aryeh Langer: Sure. It's www.cms.hhs.gov/versions5010andD0.

Bill Anderson: And D0?

Aryeh Langer: And, a-n-d, versions5010andD0.

Bill Anderson: Okay and a second question if I may. Will there ever be an education call summarizing the changes to the 835?

Chris Stahlecker: Yes, that is a good suggestion and we'll take that under advisement. We can happily do that.

Bill Anderson: Okay. Thank you.

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

Pamela Smith: Yes, earlier in the call the speaker made reference to an 837-C0B?

Chris Stahlecker: Yes.

Pamela Smith: Maybe I misunderstood. Oh, I did understand?

Chris Stahlecker: Yes.

Pamela Smith: How is that different than just the regular 837? Is a separate claim file going to have to be submitted for secondary claims?

Chris Stahlecker: Oh, no, no, no. That is information for you. It was in our background area of the slides and we're just referencing the scope of change for 5010. And there...

Pamela Smith: Okay.

Chris Stahlecker: ...is a format, the Medicare Fee-for-Service Coordination of Benefit Contractor will be sending out to all of its trading partners. And that will also be upgraded for 5010.

Pamela Smith: Okay.

Chris Stahlecker: So, it is the 837-COB format.

Pamela Smith: Okay. Thank you.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Patrice Coopen. Your line is now open.

Chris Stahlecker: Patrice, if you're talking to us, you're on mute.

Patrice Coopen: Thank you, Chris.

Chris Stahlecker: Okay.

Patrice Coopen: And thank you for the very detailed presentation. I can tell you have the X12 experts on this. Will the C0B Contractor be using acknowledgement so that we can avoid losing our claims as they do crossovers?

Chris Stahlecker: At this time we're - we do not believe the C0BC Contractor is implementing acknowledgements as the Fee-for-Service program is. We can take that under advisement for future discussion with enhancing that process, but at this time we're not expecting it to.

Patrice Coopen: All right. We appreciate that.

Operator: Your next question comes from the line of Gloria Davis. Your line is now open.

Gloria Davis: Hi. This is Gloria Davis with NextGen Healthcare again. Real quick question. Just understanding is that with the file being sent I will be able to balance from end-to-end all the way through the 997 - I mean 999 to the 277CA the number of claims that I sent within my transaction set?

Male: Yes, ST to SC is how the 277 will respond to an 837 inbound claim transaction.

Gloria Davis: Perfect. Thank you.

Male: So, if you sent 500 claims and 450 of them are accepted, you would get claim control numbers on those 450 claims and then for the 50 that were rejected you would get the rationale for why it was rejected if it's a business rejection.

Chris Stahlecker: In the STC segment?

Male: Right.

Gloria Davis: Perfect. Thank you so much.

Operator: And your last question comes from the line of Susan Ward. Your line is now open.

Susan Ward: Yes, on the question earlier or the comment about the CMS Companion Guide being published, perhaps, in the first or second quarter of next year - is that federal fiscal year or calendar year?

Chris Stahlecker: That will be calendar year.

Susan Ward: Thank you.

Chris Stahlecker: We hope that that's not going to affect your ability to get started because we really believe you need to have our Edit Worksheet to get started honestly. And the companion guide will probably simply have a reference to that material.

Susan Ward: Absolutely. Thank you.

Conclusion

Chris Stahlecker: Okay. Just as - if there are no more questions in the queue just a couple of pointers to make sure folks are looking for the right version of the TR3 we give out the identification for the acknowledgement transactions. The 999 and TA1 you should look for Version 005010, 0-0-5-0-1-0, X231 and for the

claims acknowledgement the 277CA is, again, 0005010X214, to make sure you're getting the correct versions. And they're both available at store.x12.org

So, in terms of wrapping up today's presentation I just wanted to remind folks that the spreadsheets will be posted in our estimate of two weeks. And I just want to reiterate to you please be aware it's going to remain a working document. For the most part we believe 80, 85% of it's finalized. We're still working on a way to identify the changes.

There will be a versioning aspect to this spreadsheet, but the individual changes - because there are many, many rows to these spreadsheets - we want to be able to have an update document to pinpoint where the changes are made. And also how to, for CMS to disseminate a notice that an update has been applied and you should go out there to look for a new version.

We would request that you continue to subscribe to the listservs that you receive notice about today's presentation and for any clearinghouses or vendors to ask them to participate by registering with the CMS clearinghouse and vendor listservs. And please get started. Get those TR3s and come back for future opportunities to dialogue on our progress and to share your ideas or concerns with us. Thank you so much. Bye.

Operator: This concludes today's conference call. You may now disconnect.

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