Centers for Medicare & Medicaid Services
Eleventh National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0: NCPDP Version D.0
Moderator: Aryeh Langer
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Contents

Welcome

Operator: Welcome to the Eleventh National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0: NCPDP Version D.0 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 objectives – or – sorry, if anyone has any objections, you may disconnect at this time. Thank you for participating in today's call. I will now turn the conference over to Aryeh Langer. Sir, you may begin.

Aryeh Langer: Thank you, Simon. Good afternoon, everybody. Once again, this is Aryeh Langer from the Provider Communications Group here at CMS. And I'd like to thank you for joining us for the Eleventh HIPAA Version 5010 National Provider Conference Call. Today's session will focus on the National Council for Prescription Drug Programs, or NCPDP, Version D.0 Transaction.

To download today's presentation; please go now to the 5010 website to access the presentation. The web address is www.cms.gov/versions5010andd0. Again, www.cms.gov/versions5010andd0 and click on the 5010 National Calls link on the left hand side of the screen. You can then scroll down and access today's presentation.

As with all of our other 5010 national calls, there will be a Q&A session following today's presentation. Without further delay, I'd like to introduce

our speaker for today. Jason Jackson is a Health Insurance Specialist with the Division of Medicare Billing Procedures here at CMS. Jason.

Slides 2 thru 12

Jason Jackson: Thank you, Aryeh. All right, for all those on the phone, my name is Jason Jackson. I'm a Health Insurance Specialist with the Centers for Medicare & Medicaid Services specifically on the Medicare Fee-For-Service side of the house as an EDI subject matter expert. I'd like to thank you all for taking time out of your busy day to join this call. I appreciate the opportunity to provide you with useful and valuable information about the HIPAA D.0 transition as well as what CMS has been working on related to its implementation.

All right, we'll start off on slide two of the deck. For the purpose today's call, we're going to highlight the significant differences between the Versions 5.1 and D.0. I'll provide you with an update on Medicare Fee-For-Service activities related to this implementation of Version D.0 for the Part B drugs. We will discuss the Errata that has recently been issued. We'll provide guidance on what needs to be done for D.0 and finally we'll have a Q&A session.

And just to set a little bit on expectations. This presentation is focused on the D.0 implementation activities related to the Fee-For-Service providers. This presentation does not address the Medicare Advantage, Medicare Part D insurers, or Medicaid implementation.

All right, on slide three, the agenda for today. It kind of goes over what we just talked about on slide two. On slide four, we'll get into the general overview. What exactly was adopted under HIPAA? Well, for instance, for

the NCPDP, it was – it was adopted – was the Telecommunications Standard Implementation Guide, Version D, Release 0, also known as D.0, and equivalent NCPDP Batch Standard Implementation Guide, Version 1, Release1.2. Again, Medicare Fee-For-Service does only accept the claim batch – the claims in a batch format. Also adopted under HIPAA was the Data Dictionary and new for D0, the External Code List.

The NCPDP code values - this is for the ECL,or External Code List - are now part of an External Code List instead of being listed directly in the Data Dictionary. This allows the flexibility of implementing changes to the value codes as they are updated by the NCPDP organization, while remaining within the scope of the guidelines named under HIPAA. Medicare's initial implementation will be based on the June 2010 version of the ECL. Updates will be made on a recurring basis for new versions of the ECL as they are published by NCPDP.

And there's also – adopted was the Telecommunication Version D and Above Answers and Editorial Updates. This is really – these are the changes that were made into the NCPDP telecom standard D.0 until April 2009 and are noted in the Appendix A which can be found on the NCPDP website and we'll actually pull out the link deeper into the slide deck.

On slide five. We get into the significant differences in D.0 from 5.1. Under the specific segment changes, the AM12 Prior Authorization segment is no longer valid for use with the telecom billing transaction. The AM14 Additional Documentation segment was added. However, this is not been used with Medicare implementation as there are no longer any valid CMN formats for the drug claims allowable to be billed in the NCPDP format. The AM15 Facility segment was added which encompasses all of the facility-

related fields that were previously recorded in version 5.1 via the AM04 Insurance and AM12 Prior Auth segments.

The Medicare facility information will continue to be required when the place of service reported is other than patient's home. And the AM16 Narrative segment was added which allows for narrative text to be recorded as deemed necessary.

And finally, only one batch header and trailer record must exist per physical file sent in to Medicare. Well, those cover the segment changes and then we'll get into the significant field changes.

First off is the location field or Patient Location field, also known as the 307-C7. This has been redefined as the Place of Service field and uses the 2-digit CMS POS code to convey where the services were rendered. A new Patient Residence field was added to convey where the patient resides. Therefore, Medicare will no longer convert NCPDP location codes to Place of Service codes for claim processing. Instead, they'll be explicitly reported on the claim.

Let's see, the Compound Route of Administration fields, the 452-EH. This is in the AM10 Compound segment. This has been removed. The Route of Administration fields in the AM7 segment is to be used for conveying the route of administration for compound claims. This field uses the new code set SNOMED to convey whether the route of administration was for inhalation or oral.

Then on slide five is the Prescriber First Name and address information changes. This information was previously reported on AM12 Prior Auth

segment which will be recorded in the new added fields within the AM03 Prescriber segments. However, the presence of these new fields will not be required by Medicare.

All right, on slide six. We have some more of the significant field changes. Starting off with the Prescriber First Name and address information changes. These were previously reported on the AM12 —oh, that carried over. Sorry about that. Number five is the number of procedure codes increased. They are increasing from four to 10. There is the Compound Ingredient Modifier changes previously reported on the AM12 Prior Auth segment. These will be reported in the new fields in the AM10 Compound segment.

Number seven is the Incentive Amount Submitted field. It was previously optional but is now a qualified requirement. The field is required with the value, if the value has effect on the gross amount due calculations. In Medicare, the field does have an effect on the gross amount due calculation and therefore will be required even if the amount reported is zero. That's an important one to take note of.

Number eight is code values 08 and 99 in the Other Payer Amount Paid Qualifier field, these have been deleted. These values were previously viewed by Medicare in Version 5.1 to identify other payer amount paid and other payer allowed amount for Medicare secondary payer, also known as MSP, claims. For MSP processing under D.0, code value 07 should be used to report the other payer amount paid.

All right, number nine is the addition of several new fields to aid in the Coordination of Benefits process such as the IPN field 993-87, Medicaid indicator 360-2V, and the Medicaid ID number. Also, we have some other new fields which are the Payer Accepts Assignment field was added and this

will be required by Medicare. And the finally the Patient Assignment Indicator field, this was also new and will also be required by Medicare.

All right, moving over to slide seven, we'll now get into kind of what exactly Medicare Fee-For-Service is doing to implement D.0. As I mentioned before, for the External Code List effective January 2011, CMS will be on the June 2010 version of the ECL and will probably switch over to the next version. We'll be on quarterly releases after January.

For standardized error handling, for D.0, we will be using the NCPDP Transmission Response. The Transmission Response will be used to acknowledge acceptance and rejection of the entire batch file and/or each claim within the batch. The Batch Number from the inbound submission will be returned as the Batch Number in the response. And the Transactions Reference Number for each claim will be returned back as the Transaction Reference Number on the response.

Some of the primary elements for matching the response back to the initial submission are the Batch Number and the Transaction Reference Number which I just mentioned. Due to the use of the Transmission Response, Medicare will enforce the Transaction Reference Number. The 880-K5 must be unique for each claim within the same batch in order for the response to be matched back to the original claim.

And there are various levels of accept and reject status. Therefore, Medicare will be using the Response Message segment to clearly denote the acceptance or rejection of each claim. And we do ask that you consult your vendor for specifics regarding how error reports will be displayed to the end-user. And finally, the claim number assignment. The ICN will be included when sent back within the Response transaction.

All right, moving on to slide number eight on the Errata. The Errata came out about two weeks ago or so. The Errata are technical corrections or modifications that the industry requested to be made to the implementation justifications and are contained within the August 2010 publication of the NCPDP Editorial Document posted on their website. The comment period has already closed as the Errata has been posted, and we do not feel that there was any significant changes to the NCPDP standard as they have it locked down since April of 2009.

Moving on to slide number nine. It just shows our timeline and deadlines. For those of you that have attended the previous national calls, you might notice the timeline looks a little bit differently. For D.0 we've been a little bit later to get started on our work for the implementation. As you can see on the timeline, the final rule was originally published on January 15, 2009. We began our development November 1st of last year and that actually wrapped up in February 1st of this year and we're currently going through system test. And then beginning January 1, 2011 we will begin external Trading Partner testing. And then that will span until January 1, of 2012 which is when 5.1 will be turned off and then we'll be looking forward to the ICD-10 cutover on August 1, 2013.

All right, on page 10. These are some important websites that we feel will be needed. Some are – under bullet number two, these are all internal CMS websites from directly for our 5010 and D.0 web page which is the first bullet under number two, down to the more technical one, bullet number three which is the actual Medicare Fee-For-Service directly where we have a lot of our technical documentation posted.

Under number five, this is where you can find the NCPDP website and also the Version D Editorial Guide which is posted for the public, you don't have to be an NCPDP member to get the editorial guide. But you do need to be a member in order to access the Implementation Guide.

And slide 11. What you need to do to prepare. You need to contact your software vendors. The license for your practice management systems- does that include regulation updates and will these upgrades include a readable error report produced from the Transaction Response? You need to inquire with your vendor or clearing house if they're planning to do – to do an upgrade of your system, if they are one of your vendors. And evaluate the impact to your practice and begin planning for training and transition. Again, transition period starts January 1st of 2011.

And on to slide number 12. Test early and test often. January 1st, 2011 through December 31st, 2011 is the full transition period from 5.1 to D.0. Direct submitters, you should contact the MAC help desk to coordinate testing procedures. CMS indirect submitters will need to contact their respective vendors for their testing process. And prior to be granted access to submit production D.0 transactions, direct submitters will be required to be 100% compliant for structuring syntax and 95% compliant on Medicare business rules. And submitters will be in test status until they've been approved for production.

All right, that brings us to our Q&A session.

Question and Answer Session

Operator: We will now open the lines for our question and answer session. To ask a question, press star followed by the number one on your touchtone phone. To

remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity.

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

Your first question comes from the line of Jackie Clark. Your line is open.

Jackie Clark: I'm sorry. Can you hear me?

Jason Jackson: Yes.

Jackie Clark: OK. My question is how does the 5.1 to D.0 5010 upgrade impact institutional billing?

Jason Jackson: The institutional billing, they're actually going from 4010A1to 5010 …

Jackie Clark: Right.

Jason Jackson: And they're following the same timeline of the transition period from January to December.

Jackie Clark: Right. So – I guess what my question really is, the D.0 is specifically for pharmacy billing?

Jason Jackson: Correct.

Jackie Clark: So, as far as pharmacy charges, were – are there any implications of pharmacy charges on our bills? Does that make sense?

Jason Jackson: Pharmacy charges on your Institutional?

Jackie Clark: Yes. Are there any new requirements for those charges reporting like NDC number or whatever you need to report? That I know.

Jason Jackson: OK. For that, you'll want to refer back; I believe it was probably our 8th national call which is on the Institutional. So, that – on the website that Aryeh mentioned earlier, that's where you can find the Institutional one with changes.

Jackie Clark: So, the D.0 upgrade is only for pharmacy systems?

Jason Jackson: Correct, Yes. Yes, and in the Medicare Fee-For-Service, it's only for the inhalation or oral cancer and immunosuppressive. So, those are the only two drug types that are processed.

Jackie Clark: Oral cancer, and what?

Jason Jackson: Immunosuppressive.

Jackie Clark: OK. Thank you.

Operator: Your next question comes from the line of Jennifer Kaiser. Your line is open.

Jennifer Kaiser: Hello. My question is whether there will be a call similar to this to address Medicare Part D billing?

Chris Stahlecker: Hi, it's Chris Stahlecker. I can inquire whether or not our Medicare Part D folks would be interested in hosting an audiocast, but at this time, that is not planned. But we will look into that.

Jennifer Kaiser: All right. Thank you very much.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of James Castroconio. Your line is open.

James Castroconio: Yes, this is James Castroconio with Evolving Technologies for the Military Health System. On slide 12, you mentioned Medicare business rules that we need to be 95 compliant with. Do you have a website where these business rules are presented?

Jason Jackson: Yes, they will actually be there. They're not currently out there, but on slide 10, under number two, the third bullet there, where it's www.cms.gov/mffs5010d0 that website. We will actually be posting our edit spreadsheets out there for these claims and that contains, you know, any Medicare-specific business rules.

James Castroconio: OK, thank you.

Jason Jackson: Yes.

Operator: Your next question comes from the line of Kim Dufrain. Your line is open.

Kim Dufrain: Hi, this is Kim Dufrain with LSU Healthcare Services. On slide 10, you had mentioned, I think under bullet five, that you must be a member. I wasn't sure of what, but I think I found my answer, National Council for Prescription Drug Programs?

Jason Jackson: That's right, yes. In order to download the full Implementation Guide, you need to be a member of NCPDP, but you can get the Version D editorial without being a member.

Kim Dufrain: OK. Thank you.

Jason Jackson: You're welcome.

Operator: Your next question comes from the line of Cathy Sykes. Your line is open.

Cathy Sykes: Yes. This is Cathy Sykes from RoMed and I'm wondering how the testing for the HETS system is going to work for the 4010 and the 5010 and will there be availability for testings with all of the issues that have been going on with the system at this point?

Chris Stahlecker: Hi, it's Chris Stahlecker. The HETS applications system that you referred to is the system that processes our eligibility, inquiry, and response transactions or the X12 270/271 transactions for Medicare Fee-For-Service. And it will be upgraded similarly to the timeline that was mentioned here. It's to be available for testing, the 5010 version, January 1st, but that's not – that's the base version, that's not the Errata. So, no one will be promoted into production until after the Errata has been tested and that will be available after April next year. That's the same timeline as the other 5010 transactions for the X12 suite of HIPAA transactions.

Does that help?

Cathy Sykes: Yes. Thank you.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Jenny Hughes. Your line is open.

Jenny Hughes: Hi, this is Jenny Hughes, from Dr. Phillip's office. I unfortunately turned in a little bit late so I did not get the website that you're on.

Jason Jackson: To – the website to download the presentation?

Jenny Hughes: Yes. Or the – with – the one where you're – that you're going through all this stuff. You're talking about bullets and 10 and – or, you know, slide 10 and …

Aryeh Langer: Yes. The presentation is available on the 5010 website. It's www.cms.gov/versions5010andD0. That's versions 5010 and D0.

Jenny Hughes: OK. Thank you very much.

Aryeh Langer: Sure.

Operator: Your next question comes from the line of Maria Cabeza. Your line is open.

Maria Cabeza: Hi. My name is Maria with MYD Homecare here in Florida. I'm just wondering how this 5010 conference call – how all of this is affecting the Part A and B providers?

Jason Jackson: Excuse me. Part A and B providers – well, this one is aimed towards the prescription drugs. We've had several previous ones on the Part A and Part B claims. They're following the same timelines; they're going from version 4010A1 to now version 5010A1. Medicare, you know, we're going to start testing in January 1 of 2011, but nobody will be promoted to production until after we've installed our Errata version in April of 2011.

Maria Cabeza: OK, wonderful. And my last question could be can you repeat that email, the www.cmsversion5010? I didn't get the rest of it, I'm so sorry.

Aryeh Langer: AndD0. A-N-D-D-0.

www.cms.gov/versions5010andD0

Maria Cabeza: So it's cmsversion5010?

Aryeh Langer: It's www.cms.gov G-O-V /versions5010andD0.

Maria Cabeza: OK, wonderful. Thank you so much. That's all.

Aryeh Langer: And the previous calls are listed there as well, so you can access them there.

Maria Cabeza: OK. Wonderful, thank you.

Operator: Your next question comes from the line of Barbara Hollerung. Your line is open.

Barbara Hollerung: Thank you. We have a couple of questions. One is you've listed Part B drugs on NCPDP as oral cancer and immunosuppressive. What happened to inhalation, oral antiemetics, and epoetin? Are you billing those? Are they supposed to be billed with HCPCS on a professional claim only?

Chris Stahlecker: We're going to have to look into that one. Hey, it's Chris Stahlecker.

Barbara Hollerung: Hi.

Chris Stahlecker: We're going to have to look into that one and get back to you. So, would you be willing to give us your email address?

Barbara Hollerung: Sure. It's xxxx.xxxxxxxxx X-X-X-X-X-X-X-X-X @xxxxx.xx.xx. Another question. The medical supplies on the NCPDP, that – in the final rule that we're given an option of billing medical supplies on NCPDP or the Professional claim, have you addressed that? And its Trading Partner agreements, blah-blah.

Chris Stahlecker: So, I think we're going to – it's Chris again, we're going to have to get back to you on that one.

Barbara Hollerung: OK, great. One other question.

Female: Hi. There was somebody else before that mentioned business rule and you had referenced them to page 10, in the number two, the third bullet?

Jason Jackson: Correct.

Female: Is that the same as the Companion Guide?

Jason Jackson: No, it's not. The Companion Guides were currently working on – we're hoping to have those posted by January 1st of 2011. No, these are the edit spreadsheets - that exact website- that is where we'll be posting the edit spreadsheet that our Front End System will be using to edit inbound D.0 claims.

Female: OK. But you said January 1st of 2011 you anticipate both to be done?

Jason Jackson: Yes. We're actually working on them this week and then we have a quite lengthy internal approval process to go through before those can be posted for the public.

Female: OK.

Barbara Hollerung: Thank you.

Female: Thank you.

Jason Jackson: You're welcome.

Question and Answer Session continued

Operator: Your next question comes from the line of Elizabeth De Armas. Your line is open.

Elizabeth De Armas: Good afternoon. This is Elizabeth De Armas from Sheridan Health Corp in Florida. We had been told that there might be an extension to the timeline dates for the D0 HIPAA 5010? And we just wanted to confirm that.

Jason Jackson: As of right now, no, we're still marching by the timeline that was set forward in the final rule.

Elizabeth De Armas: OK. Thank you.

Operator: Your next question comes from the line of Amanda Lawson. Your line is open.

Amanda Lawson: Hi. We have a question in regards to slide 12 when you say test status until installed with approved software. And I understand you said that also April 2011 is when the Errata will be released. So, when we're in the test – if we pass all the certifications or pass all the structure syntax and the business rules …

Jason Jackson: Yes.

Amanda Lawson: We then can go into production after April 2011?

Jason Jackson: Well, are you talking about for D0 submission or one of the claims, like the Institutional or Professional?

Amanda Lawson: All. I mean, here you're talking about D.0 but I'm interested in all the claims that you are …

Jason Jackson: All right, for the NCPDP formats for D.0. We'll actually – you can – we'll be into production with them once you've passed all of your testing with Medicare. So, you could – if you start January 1, 2011, you could be into production by the end of January to February depending upon how long it takes. For the X12 transactions, those are the ones that are going to have – you can be approved but you won't be moved into production until April which is when the CMS systems will be upgraded to the Errata version.

Amanda Lawson: OK.

Chris Stahlecker: And – I'd just like to add on a little bit there. Because the software that we will have ready to support your testing in the January till the end of March timeframe will only be the base version. Any testing that you do there is good for you and you'll get a lot of benefit from doing that testing. But once our Errata version is installed, you will need to test using the Errata version of the transactions before you can be promoted into production.

Amanda Lawson: OK. And how does that promotion to production work? Is there like a timing that we – you kind of say, ~~–O~~K, you've been approved and then you give us time to let us promote our code to production" and then say, ~~–O~~K, now we're both in production. Go." Is there some sort of approval process and timing for that?

Chris Stahlecker: Yes. It's Chris. See, our individual Medicare Administrative Contractors will coordinate how they conduct their test with you. And then when you've been given affirmation that, you know, you are accepted, you are able to submit

clean test files, you will need to ask them how to get promoted into production. It's nothing that they do that dovetails necessarily with what you're doing with your own software, but they will coordinate when they can promote you to be a production Trading Partner so that when you send in your 837I or P that it has a production indicator in it and it will be processed accordingly.

Amanda Lawson: OK.

Chris Stahlecker: You need to really work that out with your MAC.

Amanda Lawson: Got it. OK. And then – but that's not – do we also go through MAC for the D.0 transactions as well?

Jason Jackson: For D.0 it's – the kind of MAC, it's actually our CEDI contractor. They're the front door for all of our DME MACs. So, there is a MAC entity out there for D.0, yes.

Amanda Lawson: OK. And then – sorry, the last question is in regard to the Remittance Advice. During the testing from January to – or, you know, during the testing phase, will we be getting a Remittance Advice with- corresponding to our test transactions?

Chris Stahlecker: It's Chris again. When you are ready to be receiving a test 835, again, you will need to contact your MAC and they will set you up in their system so that you will receive a test file of 835 5010 format.

Sumita Sen: And – this is Sumita Sen. This is not automatic, because you are sending a test 837 file, that doesn't necessarily mean that you will receive an 835. You have to manage that with your MAC.

Amanda Lawson: But, my question is, we need to send basically what – real patient information to the test system in order for us to get a 835 back once we've passed all the syntax and the business rules. We would receive an 835 that would correspond to that test transaction?

Jason Jackson: I believe that the way that MAC generally handle that is they have a production parallel system set up, so that when you're ready to test with 835 they would take a 4010 835 and essentially run it through the 5010 side and send that one out. So, you'd be getting real patient data but it would have been on a 4010 claim that they would send out on the 5010 version out for test.

Amanda Lawson: OK, so it's actually going off of our real production claims that are 4010, they would submit back to us a test 835 5010 version …

Jason Jackson: Correct.

Amanda Lawson: That is corresponding to our live production claims, not our test claims?

Jason Jackson: Correct. That's correct.

Amanda Lawson: Thank you. Thank you for the clarification. So, that's also from the D.0 remittance information would also be – is there – that was the only …

Sumita Sen: It would be the same thing for D.0 too.

Jason Jackson: Yes.

Amanda Lawson: OK. Thank you so much.

Operator: Your next question comes from the line of Chris Gilbert. Your line is open.

Chris Gilbert: Actually, my question was just answered – it was part of the last caller.

Jason Jackson: OK.

Chris Gilbert: Thank you.

Jason Jackson: Thanks.

Operator: Again, to ask a question, please press star followed by the number one on your touchtone phone. Your next question comes from the line of Yvette Martinez. Your line is open.

Yvette Martinez: Hi, yes. I was just wondering if there was any impact or any changes on the CMS-1500 forms with these changes?

Brian Reitz: Actually – this is Brian Reitz and the National Uniform Claim Committee is currently looking at the 1500 form and how to address it moving ahead. And they haven't made a determination as of yet on how they're going to proceed. There most likely will not be any physical changes to the form. They may just come up with instructional changes and repurposing of existing fields. But there will not be – it doesn't appear as if there is support for a complete revision of the paper form for 5010 uses.

Yvette Martinez: OK. Thank you.

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

Patrice Coop: Hello, good afternoon. I'm just wondering how we can learn the answers to some of the questions that you get emails from people? The one we're interested in is the medical supply, which version format are we going to be using?

Aryeh Langer: If you'd like to supply me with your email address, I can copy you on the response.

Patrice Coop: I appreciate that offer, but I think generally on these calls I always feel like there's really great questions and part of this collaborative call that you do for us.

Aryeh Langer: OK.

Patrice Coop: If we could get it into the transcript or something? I mean, I think that's part of the reasons we're all here, to learn from others.

Chris Stahlecker: Hey, Patrice, it's Chris.

Patrice Coop: Hi, Chris.

Chris Stahlecker: Hi. You know, we have scripts of all the questions and answers and we can review that and consider posting something as an FAQ. Quite frankly, you know, we have a combination of very meaningful questions and some that are, you know, there's no bad question, but some of them are kind of novice questions that we really don't have the need to post as an FAQ.

So, we haven't used that full scripting of all of our prior audio cast question and answer sessions. But today …

Patrice Coop: I get – I get to have reason what you're saying now because I know some of them are pretty 101. So, maybe just with your knowledge you could decide at least for a start which ones look more like this is something the industry doesn't know the answer to yet.

Chris Stahlecker: Yes.

Patrice Coop: And I would like to be copied on the answer, I think it was Barb Hollerung who had asked the questions I was interested in.

Aryeh Langer: OK. All right. We will copy you on that one.

Patrice Coop: Thanks so much.

Operator: And once again to ask a question, please press star followed by the number one on your touch-tone phone. And your next question comes from the line of Carmen Strickweather. Your line is open.

Carmen Strickweather: Hi – excuse me. We just have a question on slide 11 where you referenced the readable error reports being produced from the Transaction Response. Is that error report something that's going to be mandated or no?

Jason Jackson: No. That is really that we're hoping that vendors out there would be taking a look at the transition error response and converting it into a human readable format. On the X12 side we're doing the 277 CA and that coming out in EDI. It's no really conducive to someone in your – in a provider office knowing exactly what is being said back then, which is similar to the Transaction Response. So we're really kind of pushing them. And some of them just have come to us, asking for examples so we've been supplying them with those so they can start programming their systems to produce a human-readable format of the responses.

Carmen Strickweather: OK. So, there really isn't like an industry-specific format, it's just kind of up to the vendor to come up with what kind of format that they're going to use.

Jason Jackson: That's correct.

Chris Stahlecker: In the NCPDP world, in the X12 world, there is a standard format, that's the 277 Claims Acknowledgment format.

Carmen Strickweather: Right. OK, thanks.

Chris Stahlecker: Just want to be clear.

Operator: There are no further questions at this time. Mr. Langer, I turn the call back over to you.

Aryeh Langer: Thank you. At this time, I'd like to thank everybody on the line for joining us for today's call, as well as our staff here at CMS. Our next call is early in the month next month due to Thanksgiving holidays. The date that is scheduled right now is November 17th and the focus of that call will be on COB or Coordination of Benefit. We plan on sending out the listserv message announcing the call details and information how to register in the next day or so. So, keep your eye out for that.

And we'll also be sending out some listserv messages that are planned for the remainder of the year, as well as some future products on 5010. So, once again, thank you for joining us on today's call and have a great day.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect. Speakers, please remain on the line.

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