Centers for Medicare & Medicaid Services
Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0
Transaction Standards
Moderator: Aryeh Langer
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1:30 p.m. ET

Contents

Operator: At this time, I would like to welcome everyone to the Medicare Fee-For-Service Implementation of HIPAA version 5010 and D.0 Transaction Standards Call.

All lines will remain in a listen-only mode until the question and answer session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call.

I will now turn the call over to Aryeh Langer. Thank you. You may begin.

Introduction

Aryeh Langer: Thank you, Holly.

Hello, everyone. This is Aryeh Langer from the Provider Communications Group here at CMS headquarters in Baltimore. I'd like to welcome you to the 20th National Provider Call on HIPAA version 5010 and D.0 transactions.

Today's call targets vendors, clearinghouses, and providers who need to make specific fee-for-service changes in compliance with HIPAA version 5010 and D.0 requirements. Specifically, Medicare Fee-For-Service would like to know the following: What, if anything, is preventing you or your customers from transitioning to HIPAA version 5010 and D.0?

Today's call will feature an open mic session at the end of the brief presentation, which will give participants the opportunity to ask questions related to 5010 and D.0 implementation.

As a reminder, we have posted to the CMS Web site many educational resources that will help with the transition of 5010 and D.0. We encourage you to visit the Web site at www.cms.gov/versions5010andd0 to see all the information available.

One final item: If you'd like to ask a question related to today's call and do not get an opportunity to ask it, please submit that question to the following e-mail address: 5010ffsinfo@cms.hhs.gov.

This mailbox will only accept questions for the next 24 hours after the call is over. Questions and answers will be posted on the Web site in the next few weeks.

Now I'd like to turn the call over to Chris Stahlecker. She is the Director of the Division of Transactions, Applications and Standards in the Office of Information Services, or OIS, here at CMS.

Update

Christine Stahlecker: Thank you, Aryeh. You've done a very nice introduction to the purpose of today's call.

I really don't have a lot to add, except to say that in the past we've had a handout or a PowerPoint you might download in advance, but there was none for today.

We will be sharing today's information as a transcript that will be posted probably 10 or 15 days after the call. You can come back to the Web site Aryeh just mentioned to see the transcript.

Before we open the lines for our open forum, I want to make sure everyone on the call realizes that the Medicare administrative contractors processing the fee-for-service transactions are ready for 5010. They have been testing and transitioning to production for several months now. Everything is working, but it's slow.

We have an issue with the 835 Part A remittance, which is due for a correction in early December. I believe the scheduled implementation date is December 5. You are free to test that transaction and once the fix is in place, all those that are approved can be turned into production remittance receivers.

We've processed nearly 7 million 5010 production claims and crossed over nearly 11 million production claims in 5010 format. Medicare Fee-For-Service is well-established, although, as we've said, the transition to this new format is a little slower than we'd like.

The purpose of today's call is to hear from clearinghouses and vendors serving the providers for Medicare Fee-For-Service—to understand your concerns, the issues you're experiencing, and the reasons we're not seeing a faster transition rate.

With that, we'd like to open the line to your questions and concerns.

Question and Answer Session

Operator: To ask a question or express a concern, 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 before asking a question, and pick up your handset before asking your question to ensure clarity.

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

Your first question or concern comes from the line of Jane Lutz.

Jane Lutz: My name is Jane Lutz. I'm with Charlotte Radiology in Charlotte, North Carolina.

I have a quick question. We are actually testing as we speak. We've not had a big issue, but we wanted to learn more about something we heard about from our MAC, which is the issue of the P.O. Box being in the billing address field.

We were told by the J11 EFT department as well as the Palmetto contractor that this was not going to be enforced by Medicare. They didn't say it would be rescinded, but that it would not be enforced.

I know some providers are inquiring about this because of programming changes in their billing software. As I understand it, they have gone back to Medicare twice, and Medicare has told them both times that, yes, this is not going to be enforced, that we do not need to worry about this particular detail. However, nothing stating this has gone to the clearinghouses, and therefore our clearinghouses have told us that we need to keep processing as if we have to change the P.O. Box.

Can you give me any information?

Christine Stahlecker: That's a very interesting issue, and I do appreciate you bringing it up.

The 837 Professional Claim does require that the Billing Provider address line is *not* a P.O. Box, as you've stated, and CMS has not taken the position that this edit will be lifted at this time.

For now, the edit is in place, and the software we have distributed to the MACs to execute should cause a claim showing a P.O. Box to reject.

That said, we understand there are issues with the P.O. Box address. Many have suggested this edit should be lifted across the industry. Unfortunately, one payer such as Medicare Fee-For-Service cannot make that change unilaterally and still be considered compliant with its implementation. CMS Medicare Fee-For-Service can raise the issue with X12 and see if they want to issue some billing instruction, since this does seem to be an industry-wide problem.

We've learned that in the next version of HIPAA standards X12 is working on, version 6020, the requirement not to have a P.O. Box on the Billing Provider address line has been removed. **[Post National Call Note: After further review, Medicare has learned that the P.O Box requirement**

remains in the 6020 837I and 837P TR3 that is out for public comment, at the current time]

For now, this seems to be an obstacle that's in the way of 5010. We appreciate this difficulty, but it's not just Medicare Fee-For-Service that's experiencing it—other payers may be as well.

Currently, as a payer we are not permitted to ignore such a requirement, so we'll be working within the SDO to see if an errata-like direction will be forthcoming. Without something like that, or some equivalent alternate solution, we would have to think very hard about the impact before making a change across the board to disregard the TR3, the implementation guide direction.

Jane Lutz: I appreciate that. You gave me a lot of information there.

Maybe what is confusing our contractor is the 6020 that's coming out in the future, where it would be removed. **[Post National Call Note: After further review, Medicare has learned that the P.O Box requirement remains in the 6020 837I and 837P TR3 that is out for public comment, at the current time]**

But one other quick question: We don't mind changing our software to make it reflect the street address. We're more concerned about being compliant on the provider enrollment side, where all our enrollment records basically state that our billing address is a P.O. Box. Even though it is a P.O. Box, we can program our software to do a "pay to" versus a billing address, and we can get around it. We don't want to be non-compliant. The question is: Do we need to change things in our enrollment records to reflect this, or is this done more through the claims processing system?

Christine Stahlecker: As far as we're informed, you do not have to change your enrollment records. We believe enrollment in the Medicare program does not permit you to use a P.O. Box as your legal business address, and that would be the address to be used in claims adjudication or determining where to route payment, information that is related to your legal business entity.

Jane Lutz: Right. We have it listed in our Special Payments address. That's what I was concerned about—whether I had to change.

Christine Stahlecker: No. We understand that. No, you do not.

Jane Lutz: Perfect. Thank you so much.

Operator: Your next question or concern comes from the line of Tim Brousseau.

Tim Brousseau: My question concerns MSP. I'm a vendor in South Texas, Datatel Solutions. We are getting rejected when the primary payer has been submitted via a paper claim. And when we submit the MSP information, we're required to provide in the SVD record the payer ID in lieu of the national payer identifier.

How do we handle this situation? Before, in 4010, we would include just "paper" as the submitter ID, but now this is being rejected.

Brian Reitz: This is Brian Reitz.

Since we don't have a national payer ID yet, I can't really give you a number to put in there. The situation, as Chris alluded to earlier, is we have to follow the rules set in the TR3, and the TR3 is requiring an identifier of some nature for that prior payer.

You could contact that payer and ask them if they have an identifier they use for their own business.

Tim Brousseau: They don't accept claims electronically.

Brian Reitz: The prior payer does not do electronic claims processing?

Tim Brousseau: Exactly. We get a response to be included to go with an MSP, and we're rejected because we don't have that information. Again, before, we would just put down that the prior payer's ID was "paper" and that was accepted.

Brian Reitz: Correct. Well, Medicare has implemented a much more refined editing process now, and that type of data is not acceptable per the TR3.

Christine Stahlecker: We can take this concern that you have and see if we are able to determine a solution for you. It might be helpful if you would send in your details to that resource box that Aryeh mentioned at the opening.

Tim Brousseau: We could certainly do that.

Christine Stahlecker: I would appreciate that. Thank you.

Tim Brousseau: That's my question. Thank you very much.

Operator: Your next question or concern comes from the line of Chandler Kim.

Chandler Kim: Hello. My name is Chandler Kim. I'm calling from a software vendor, HealthCare Synergy.

One of our concerns is that the MACs seem very slow in getting our approval. We waited about a month for one of our approvals, our last one, and we're still waiting on it. That's actually our biggest issue.

My question is: Some intermediaries are allowing providers to sign up for 835s, 837s, and 277s separately. Let's say they only move to production with 837s. Will they be automatically getting 835 and 277 5010 format on January 1, or will they still have to sign up for that? Do you guys know?

Christine Stahlecker: Yes. The process does treat each of the transactions separately. If you, as a trading partner, would like to begin testing the 837 claim, you may do so. Once approved, you may go into production with that 837 claim—a separate action from getting on to the 835 remittance in the 5010 format. When you're ready to do the 835 remittance, that is a separate contact to your MAC's ETI Help Desk to begin to get 835 test 5010 transactions.

So, yes, they are separate requests.

Chandler Kim: Does that automatically change, since the files are being sent to us instead of us sending the files, on January 1?

Christine Stahlecker: Remember, Medicare Fee-For-Service is a payer just like everybody else. We're all under a mandate to have 5010 operational and no more 4010 coming in. The cutoff for 4010 is something that's being discussed and planned with the MACs at this point.

We're expecting that you're taking every step necessary to become 5010-ready by January 1. If you are not 5010-ready, is your question whether you will automatically have your 4010 cut off and have a 5010 delivered? It would be much preferred if you would coordinate that with your MAC and have it be a conscious decision, rather than an unconscious decision, to flip that switch to give you 5010.

Chandler Kim: I think that about answers my questions. Thank you.

Operator: Your next question or concern comes from the line of Missy Parker.

Missy Parker: Hi. My name is Missy Parker. I'm with HealthcareFirst, Ozark, Missouri.

My question is specific to hospice claims (type of bills, 8182xs). For the certifying position, with 4010 this was sent with a qualifier 73, but in 5010 that is now the "other" operating position, which can't be sent unless an operating position is sent.

We're trying to get clarification on where you want it and what qualifier to use for the certifying position when it's different than attending.

Christine Stahlecker: That's essentially a policy kind of a question or a very detailed billing question. We are really focused on transition work to 5010. Are you pointing out the difference in the 4010 to 5010 formats?

Missy Parker: Yes. It's not even there anymore in 5010 for us to send.

Matt Klischer: This is Matt Klischer. I work on institutional billing issues.

Normally, if you will be having data submitted to us, you're going to see a CR as far as how to submit it. Where the "other" was broken out—where you have "other" in 4010 A1 and it was split out into "other operating" and "rendering" and so on—I know of no CRs that say providers should start using those specific loops for 5010.

If we can get your e-mail address, I can get back to you on this question. Would that be all right with you?

Christine Stahlecker: Or you can send your request in to the HIPAA resource box, and Matt can get the question that way and respond to you.

Matt Klischer: That would be even better. Is that OK?

Missy Parker: That's perfect. Thank you.

Matt Klischer: Thanks.

Operator: Your next question or concern comes from the line of Patti Brinkmeyer.

Patti Brinkmeyer: Yes. This is Patti Brinkmeyer with Healthfusion. We are having a large problem with the transition, with our 277 CAs coming back from Trailblazer and Noridian with the A321 status code, which is an "invalid" status code, but without any information about why the claims are rejecting.

I was wondering if you could address that.

Mike Cabral: Patti, this is Mike Cabral. You said A321, or is that an A3 and an A21?

Patti Brinkmeyer: A3 and A21.

Mike Cabral: Because the code you mentioned, there's a different format.

Patti Brinkmeyer: Basically, it says it's rejected for incomplete data and requires a third qualifier—a third status code or a second status code—and we're not getting anything.

Mike Cabral: The third status code or the component in the. . .

Patti Brinkmeyer: The third component in the status code or a second status code.

Mike Cabral: That would probably be like a provider, or a patient, or some kind of qualifier. It sounds like they're not sending back who to identify the entity in the FTC segment.

Patti Brinkmeyer: Right. That is correct. What they're saying is that is a WPC issue. I don't believe that to be, but that's what they're saying.

Mike Cabral: Do you know which entity they should be indentifying for your error?

Patti Brinkmeyer: No. We have no clue.

Mike Cabral: You don't know if it's at a claim level or is it a . . . ?

Patti Brinkmeyer: It could be claim, it could be line, it could be anything.

Mike Cabral: I can't have you send PHI over the internet, but send in your contact information. Maybe we can set up a WebEx to look at your output with them.

Patti Brinkmeyer: OK.

We're also having the same situation with invalid diagnosis codes and invalid HCPCs, where they haven't updated the diagnosis codes for the 2012 diagnosis codes and HCPCs and modifiers that are valid in the 4010, but they're rejecting in the 5010 format.

Mike Cabral: We'll work with the standard systems on the diagnosis and the other reference files—i.e., the HCPCs and the modifiers.

I know there are changes coming along for some of these things, but I'm not sure if it was the HCPCs and the modifiers. January 2012, I think, would be kind of early for that.

Patti Brinkmeyer: The diagnosis codes are October 2011.

Mike Cabral: Yes. Right.

Patti Brinkmeyer: These are the HCPCs and the CPT-4 codes, and the modifiers have been valid forever.

Mike Cabral: That comes out of the core system. When you send in your information, we'll do a followup call with you.

Patti Brinkmeyer: Thank you very much.

Operator: Your next question or concern comes from the line of Laurie Holtsford.

Laurie Holtsford: Hi. This is Laurie with Community Health Systems.

We recently went live on the 5010 with WPS Medicare Part A. We're getting a lot of front-end edits, either batch rejections or on our 277, that weren't previously in place and we weren't aware of until we went live.

I was wondering—is there a place where you have published the edits we need to be aware of? They're now validating against NDC codes. Some valid NDC codes are missing from their files, so it's still kicking the claims out. It's erroring if we have a HCPC or procedure code that has "not otherwise specified," "not otherwise classified," anything like that, within the description. Even though it may tell what that procedure was, it wants a more detailed description to be sent.

Also, we have MSP claims that are going and Medicare's acknowledged there's a FISS issue. Once the MSP claim gets into the system, the primary payer information is disappearing, so the claims are RTP.

In addition to the front-end issues, there is the issue with the MSP claims, all of which really makes me hesitant to go live on the 5010 with any other payers since we're having all of these problems right here close to year's end.

My question is: Is there any place where we can find out what those added front-end edits are so we can be prepared?

Christine Stahlecker: Yes, there is. They're on the edit spreadsheets that we use to document our edits, which are always connected to a change request as we go forward, and we have our change requests scheduled for quarterly releases.

Matt Klischer: This is Matt Klischer. You can go to the Medicare Web site, www.cms.gov. Click on Transmittals, and you will go to a page where, on the left side you'll see consecutive years, with the most recent on top. If you click on 2011, you can do a search on 7515, which is one of the CRs you can look for. I don't know the one before that.

Brian Reitz: This is Brian Reitz. If you submit the request for a view of the spreadsheets, we'll e-mail you the link you can use to go directly to them. They are posted, and anyone can view the entire list of edits and what the expectations are for inbound claims submissions.

Christine Stahlecker: We should try to get that URL into this transcript so others on the call will have that information.

Laurie Holtsford: It's really killed us all of a sudden having these edits. I was perfectly prepared for 5010, the format requirements and data requirements, but this is something I was not aware of, and it has really hit us.

Christine Stahlecker: About the NDC codes, I will give you some further clarification.

The edits that have been made available to the Part A front-end process needed to be refreshed, and it took some time to get that scheduled with the release of the file. That should be happening right before Thanksgiving.

The "not otherwise classified" codes with the 5010 version are required to have a description—not just the name of the code, but a little text describing what that code is to be used for.

The MSP claims going to the Return to Provider process also have a fix, which I believe is scheduled for December 5.

Those fixes are coming up. They were identified late in the testing timeframe, and we are responding to them as production support items and getting them fixed as rapidly as we can. Those are all Medicare Part A items.

Laurie Holtsford: Also, is there a place where we can find those items that are being addressed? I've tried to look at different FI, 5010 issues, or anything like that, and I really haven't seen any of this being addressed.

Christine Stahlecker: We can take that as a takeaway from today's call—we appreciate your mentioning it—and see if the CMS Central Office can deliver to the MACs some information regarding that schedule.

It is something that all the MACs are familiar with because we've been meeting as a project team. These items and the scheduling of the fixes have been well discussed and shared with all of the MACs. For consistency of messaging, perhaps the Central Office could be delivering a schedule update for the MACs to post on their Web sites. We can take that up with them. That's a good suggestion. Thank you.

Laurie Holtsford: All right. Great. Thank you.

Operator: Your next question comes from the line of Lorena Moncada.

Lorena Moncada: What happens is that our clinical medical record, that is the clinical, they say they have not already implemented version 5010. So we are very concerned about that.

We are in Texas—Victoria, Texas. We use electronic medical records, e-clinical, but they are not ready yet. They are saying they are going to be ready in December, but we are not sure. In Victoria, we are very concerned because Medicare says they will pay no claims if you don't have the new version.

Christine Stahlecker: Yes, that is our situation today. For Medicare to be compliant and meet the regulatory timeline, we must not accept the 4010 format after January 1.

That's the position all payers are in. We would support you if you're saying that your vendor is not able to test or transition prior to December. So we

share your concern. If you would like any kind of followup with your vendor, we would try to support that effort. But it really is your vendor's responsibility to deliver upgraded software to you.

The other side of that equation is that you can request free billing software from your MAC and use that. This software permits you to bill the 5010 format. You can get a free copy of it from your MAC. Just contact them and ask for it. You could use this free software on an interim basis until your vendor delivers the software upgrade you need.

Lorena Moncada: Where can I get that implementation for my billing?

Christina Stahlecker: Contact your Medicare administrative contractor. That should be on our Web site. Or where you send your Medicare Part B claims to today, contact them.

Lorena Moncada: It is in Dallas. The office for Medicare in Texas is Dallas.

Christina Stahlecker: Yes. You can look through our Web site, which has all the MACs and their contact information posted. I think we have that slide with all the MAC contacts in each of our earlier audiocasts, so that information is on the Web site that Aryeh mentioned earlier.

Lorena Moncada: In which Web site? In the TrailblazerHealth.com, or cms.gov?

Christina Stahlecker: The information we've been talking about is posted on cms.gov. But if TrailBlazer is where you send your Medicare Part A claims, they are the ones you should contact to get the free billing package.

Lorena Moncada: Thank you.

Operator: Your next question comes from the line of Renee Yeager.

Renee Yeager: Hi, yes. I am with ZirMed. We're a clearinghouse. We received a copy of last Friday's CMS presentation regarding encounter transactions from one of our trading partners. Slide 9 of this presentation stated that CMS was permanently turning off the 2010AA N3 validation for street address, which of course is the P.O. Box. I hate to bring this question up again, but this trading partner is

actually asking us to turn this off across the board, based on this CMS slide presentation for encounters. I want to know how you would respond to this.

Christina Stahlecker: Thank you for bringing that up. It sheds some light on the original question a minute ago. Because it is encounters, there is a separate project under way that is not between a provider and a payer. It is something that's being handled separate from a HIPAA-compliant activity. This does not involve HIPAA-covered entities. This flow is going from a payer to a payer. The standard format is being used as the foundation, but because it is not an exchange between covered entities, it does not need to be HIPAA compliant. So in that exchange, Medicare can turn off the edit on the P. O. Box and still not be at risk for being non-HIPAA compliant, because it's an exchange between two non-HIPAA-covered entities. Does that make sense, I hope?

Renee Yeager: It does make sense except that this particular trading partner is kind of interpreting that slide presentation as meaning that maybe this is going to extend into the rest of the claims processing fee-for-service, commercials, and the other claims. So they have actually asked us to turn it off across the board.

Christina Stahlecker: We'd welcome an e-mail from you with some of the particulars here so we can do some followup, because that's not our understanding right now.

Renee Yeager: I did send an e-mail to the 5010 e-mail address that you provided. I sent that yesterday, so you should already have that in your inbox.

I have a followup question. On the zip code, we just need some clarification. Are you or are you not accepting the 9998 extension where the four-digit can't be identified?

Brian Reitz: This is Brian Reitz. I believe that the 9998 would be acceptable. We are not doing a comparison of the plus four to the core five, so it would meet syntax for the implementation guide and be accepted.

Renee Yeager: Super. Thank you.

Operator: Your next question comes from the line of Jim Mechan.

Jim Mechan: Yes, this is Jim Mechan from Emdeon, and I apologize, but I'm going to take you back to the P.O. Box again.

What we hear when we outreach the providers is most of them, unfortunately, do not yet have 5010 software, and the legacy software only has room for one billing address.

No matter how much you tell the providers that payers are going to pay out of the enrollment and the payment system, they say, "No, I need to put my P.O. Box in there or I will no longer be paid in the correct place." So they're saying, "No, I'm not going to stop sending the P.O. Box because I have no option but to send it because I can only have one address in my system."

What I think we're going to find on January 1 is not just Medicare and not just Medicaid, but many, many other health plans are going to say, "No, the guide says, it must be, so therefore, I'm going to reject for that." We're going to have a huge number of rejections that the provider may not be able to do anything about, so they're going to keep resubmitting. We're all going to get caught up in the timely filing situation, and people going to their state Prompt Pay boards.

All of this over a change to one field that the X12 Co-Chair admitted, at the WEDI meeting, had been requested by one payer (that is, the billing address in the P.O. Box). Also, there was not real provider outreach done to figure out the impact, and as Chris just stated there, we're now recognizing that the SDO and X12 and the 6020 are not going to have that requirement, which will help us all greatly three or four years down the road, but will not help in the least on January 1.

So, because of this thing that is now being acknowledged as a mistake, we're heading for a bad situation, but we're going to keep this hard, strict attitude and cause a huge number of rejections and frustrations for providers who can't properly deal with it.

Christina Stahlecker: Jim, please let me interject that we will be having a followup. CMS Medicare Fee-For-Service will be taking this issue up with X12. We agree

with everything you've said, but we're still not positioned as a single payer here to make that much of an industry-wide decision.

Jim Mechan: I understand and appreciate that, but payers are asking us what Medicare will do, because if Medicare will accept this, we'll accept it.

So you actually have unbelievable influence across the whole industry and an opportunity here, a leadership opportunity, to help the industry over this unfortunate circumstance that we find ourselves in.

Christina Stahlecker: I appreciate your comments, and we'll take that into some internal discussions. We will be taking it up with X12 as well. But thank you for raising it, Jim. We could hear that loud and clear at WEDI as well.

Operator: Your next question or concern comes from the line of William Hawes.

William Hawes: Hello. I'm calling from WellCare. My call is also related to the P.O. Box issue.

I submitted this question. It's actually tied to the instructions that the NUBC provides on the paper claim form for CMS-1500, which recommend that the box 33 information be a physical address so it can be mapped over to the 2010AA, which has to be a physical address.

In doing so, you don't have the ability for a provider to communicate a P.O. Box if you make a physical address, because there's no "pay to" box on a CMS- 1500. I was wondering if there is any guidance from CMS to the providers that I haven't been able to find on the CMS Web site.

Brian Reitz: This is Brian Reitz. As far as we're concerned, providers are perfectly welcome to put a P.O. Box in on the 1500. There are no issues, and we don't have instructions that say that you have to put a physical address there. What the NUCC recommends is just that, recommendations. There's no force of law behind them.

William Hawes: OK. Thank you very much.

Angie Bartlett: Hi, this is Angie Bartlett. I want to say something about the resource mailbox. If you sent your question in before yesterday, it went to an automatic inactive box, so those of you who say you sent in your questions, make sure it was within 24 hours before this call. If not, please re-send it, as it went to our inactive box. Thank you.

Operator: Your next question comes from the line of Jaime Hebert.

Jaime Hebert: Hi. My name is Jaime. I'm with a software vendor, Acadiana Computer Systems, and we submit to three different MACs.

WPS is the first one. We're 5010 production for the 837, for Part B, but we are having difficulties getting 835 in production. I'm thinking that that's probably a MAC issue we'll need to bring up with them again, but we wanted you guys to be aware of the issues we were having in going completely 5010 production.

Our second MAC is TrailBlazer, and it's taking an unusually long time. I think there was a vendor named Chandler on the phone earlier who said he was having the same issues. It took us 3½ weeks after an e-mail to get forms to fill out, and now it's been 3 weeks since we filled out the form to be on approval. I just don't know how much longer we can wait on this.

I feel like we're going to be ahead of the deadline, and we're waiting on them, but we're not getting what it seems like should be a quick two- or three-day response. Do you have anything to enlighten us on that?

Christina Stahlecker: No, but if you do want to send those particulars to the resource box, we're happy to do some internal followup.

Jaime Hebert: OK.

Our third MAC is Palmetto GBA, and it's for our Louisiana Medicare Part B claims. My co-worker Steven is going to ask you the questions we have on that.

Steven Burrel: We tried submitting a file to them, and we got back some errors for NDC units. We were submitting the number correctly, because in X12 they don't want you to submit trailing zeros (that is, it should be 0.5, not .500).

We were getting an error for our numbers, and it seemed like they didn't want to help me, like I should submit it incorrectly, because they tested the incorrect way and it passed. I had to get in touch with Arkansas Blue Cross, which is our actual MAC right now, and they told me the problem was a bug in the system. We tried submitting another file, and we didn't get that error, but we never received the 277 CA, and we need that information to go production.

I tried e-mailing Arkansas Blue Cross twice. We never received the 277, we never received a response, so we still couldn't go production based off of that test.

Then I submitted another file, and it had somewhat the same information as our previous tests as far as the billing provider taxonomies, and now all of a sudden the 999 is kicking all of that out.

I started a ticket with Palmetto again, and it took them a week. Actually, I waited a week and I never got anything back from them, so I submitted another test file, and I'm still getting the same errors.

I called them and said, "I've been waiting a week. I'm still getting the same errors." They said their technical team was still looking at it. It's been almost another week, and we still haven't heard anything. We still can't go production, because we keep having issues with the translator or the claims processing kicking out our files.

We can't get timely responses back from them as far as what the actual issue is, and whether it's an issue on their end, or something we need to fix.

Jaime Hebert: We're a vendor for thousands of providers. We're a billing service as well, so this is affecting all 2,000–3,000 of our doctors.

Christine Stahlecker: These are the kinds of issues that we were hoping we would hear today, and we would appreciate a resource box entry.

Angie Bartlett: When you submit that resource box entry, please include the names of the contacts you've been talking to at these MACs, so we have a resource to follow up on.

Jaime Hebert: Absolutely. Would you mind giving us that resource box one more time, please?

Matt Klischer: Sure. It's 5010ffsinfo@cms.hhs.gov.

Jaime Hebert: Thank you.

Operator: Your next question or concern comes from the line of Kristen White.

Michelle: Actually, this is Michelle from J & B Medical Supply. Kristen is the one who called in. I have a question regarding how to verify that my software provider has completed testing.

Christine Stahlecker: Each of the MACs has been maintaining a list of the tested vendors on their Web site. You should be able to go to that Web site and see your vendor listed if they are approved.

It has been brought to my attention that some vendors have requested not to have their software product listed on that list. When you contact your MAC's EDI Help Desk, they may be able to share information with you in the event that that's what your vendor has done—that they truly are approved but have requested not to be listed.

Michelle: Would information also be available there if they have not been approved yet as to what sort of issues they're having?

Christine Stahlecker: I don't believe that the Medicare administrative contractors (or in your case, if you're a DME supplier, that would be the common EDI contractor) are maintaining that level of detail about the issues that the individual vendors are having. But, anecdotally, they may be able to share some information if you contact their EDI Help Desk.

Michelle: Thank you.

Operator: Your next question comes from the line of Karen Howard.

Karen Howard: Hi, this is Karen Howard with Cardiology Associates of Princeton in Princeton, New Jersey. We have not transitioned yet to the 5010 format, but in some of our meetings they were discussing the zip plus four and that that would be mandatory. They did not say whether it would be mandatory in the Patient field, or the Provider Referring field, and so forth, and this is my question.

Brian Reitz: This is Brian Reitz. The nine-digit zip is only required for the Billing Provider and the Service Facility Location. Any other zip codes submitted in your electronic transaction can be submitted as five-digit only.

Karen Howard: Great. That was an easy question and an easy answer. Thank you.

Matt Klischer: The resource box address, again, is 5010ffsinfo@cms.hhs.gov.

Operator: Your next question or concern comes from the line of Melissa Landers.

Melissa Landers: Hello. Our FI is First Coast Service Options in Jacksonville, Florida. I'd like to ask if they are ready to accept live 5010 claims. Our billing software vendor has told us they are not ready to accept live 5010 claims.

We've tested, we've been given the thumbs up and told that our claims look good. We want to take a proactive approach and get some claims out there to make sure we don't run into the same problems some of the callers have described today. So are they ready?

Christine Stahlecker: Yes. They are ready.

Melissa Landers: OK. Thank you very much.

Operator: Thank you. Your next question or concern comes from the line of April Caldwell.

April Caldwell: Hi. This is April Caldwell with Accu-Med Technology Solutions, and I have several questions.

The first one concerns Highmark. Our line of business is nursing homes, skilled nursing facilities. The occurrence code 50 is being rejected when it's outside the statement covered dates.

Christine Stahlecker: You have a particular occurrence code that's being rejected?

April Caldwell: Yes, because it's a date of the assessment that's required for skilled nursing facilities on their claims. When that date is outside the statement covered dates, it's a front-end rejection of the claim, and that date is more than likely going to be outside the statement covered dates for that line of business.

Christine Stahlecker: Are you getting a rejection as in a 277 Claims Acknowledgment or an 835 Denial?

April Caldwell: It's being rejected on the 999, so it's a front-end rejection of the claim.

Christine Stahlecker: The 999 is a syntax rejection, and that would imply that the 837 is not formed correctly. It would not necessarily have anything to do with the data content, as you're indicating.

It may be that when a particular date is populated, there are other data elements that are also required but are not present. You'd need to look at that 999 because that really tells you there's a syntax problem or it's not a well-formed 837.

April Caldwell: Well, when we use Clarity or Ingenix it shows as an error as far as line of business, but then if we send it to one of the MACs it gets rejected up front.

Highmark recognized this as a problem on their end yesterday. They informed payers, as far as providers who are in production, that these claims will reject but that they are aware of the issue. They say any claims that don't have this problem will be processed, but until the issue is fixed, claims that do have this problem will continue to be rejected.

That's one of our reasons for not going into production with our clients. The other issue we're seeing involves those who take our file and put it into the offered software PC-Ace. When that file is re-created into PC-Ace and uploaded to the MAC, it is wiping out the room and board, one of the service lines, and it's being rejected.

People are getting rejected because we have put them into production for 5010, and they're being rejected I guess because in that MAC system they're still listed as 4010 production.

I didn't really see anything on any of the Web sites about a process of a provider deciding to upgrade to the current PC-Ace software who has not been put into 5010 production. When I talked to Palmetto, they offered dual production of both 4010 and 5010. Is it possible that all the MACs offer that until some of these issues are resolved? That way, if they have a problem that is clearly on the MAC side, one that we have no control over, they are able to at least revert back to sending 4010 until it's resolved.

Christine Stahlecker: As was indicated on earlier conference calls where we had a panel of MACs, each of the MACs has the capability for dual processing, so you should contact your MAC and request that.

April Caldwell: We would just contact each one of them and request that. If we are refused, should we come back to you?

Christine Stahlecker: You can, yes.

April Caldwell: I mean, so far the form requests are very stringent, such as: "give us a list of your submitters to move into production." There are no questions. It's not like you can say, "and 4010 as well."

Christine Stahlecker: Right. This is not a process that is marketed by the MACs, because it's very complicated to set up. We are not saying to industry, "Go ahead and send in and expect to be able to do dual processing."

It is almost a workaround solution. Each MAC does have that capability, but they're not going to be setting up all of the trading partners for that capability.

So you'll have to stand in line, you'll have to make your case, and the MAC will attempt to deal with your requirement at their capability.

April Caldwell: I feel, from what I've heard on this call about the problems of rejection, we're talking money as far as these providers go. The MACs are all using the same edits, so if you're going to have claims rejecting in production, it should be across the board that they be able to do 4010 or 5010. I think it has to come from CMS, because if it's going to be hard to do, they are not necessarily going to offer it just because I say it's an issue. I think CMS has to say it's an issue.

Christine Stahlecker: Well, let me be clear. You can contact the MAC and request it and make your case with them. You can contact us to say the MAC is not being responsive to your needs. But for industry-wide recognition of dual processing capability, each MAC is not set up exactly the same. For some MACs it's more problematic than for others. Yes, we have consistent edits, but that is a software component.

What you're talking about is a totally separate front-end function called Trading Partner Management. Each MAC has a separate system for that, and it's more complicated for some MACs than for others. That's why it's not one of the features CMS requires. We require the capability, and each MAC has the capability, but they're not marketing it across the board because it's not always easy for them to handle it.

To belabor the point a bit more: If there are, say, 53 calendar days until cutover to 5010, that really boils down to about 32 working days. So at this point CMS is not going to require each MAC to have the capability to easily do dual processing. There are simply not enough calendar days remaining.

Again, please contact the MAC and make it known how very critical dual processing is for your ability to do billing. They will do their best to satisfy that need, and if you're not feeling it is adequate, please contact me.

April Caldwell: If that's not practical, the other option is to resolve the problem, to fix what's broken, in that same amount of time.

It wouldn't be a need for dual production. I wanted more information about what happens for people who are using PC-Ace, the free software. When we use PC-Ace, all the MACs are saying we as vendors have to put them into production. Is this true, and what is the process for PC-Ace users?

Christine Stahlecker: Most PC-Ace users are direct billers. They get the free product and connect directly to the MAC, and the MAC coordinates with that provider. Any kind of conversion or software upgrade activities that the user performs are coordinated between that provider and the MAC.

The provider contacts the MAC and obtains the free billing package.

Are you a nursing home?

April Caldwell: No, we're a software vendor. We have clients all over the U.S.

Christine Stahlecker: Then you probably need to work with your provider clients to understand what the instructions are for the upgrade of the PC-Ace product.

April Caldwell: Well, the problem is that they've already upgraded. They have submitted files that are in 5010 format and they're being rejected. We're being told this is because they are not in 5010 production.

Christine Stahlecker: That's because the MAC doesn't understand that a provider wants to transition to 5010 if your individual customer has not contacted the MAC. That's what your customers need to do.

April Caldwell: *They* need to do that. OK, we can relay that information. Thank you for answering all my questions.

Operator: You're next question or concern comes from the line of Kathryn Simon.

Kathryn Simon: Hello. I am Kathryn Simon from American Ortho Tech, and this is my question: The software I'm using stated to me that they are not going to update to 5010, but the clearinghouse I use is, and that would suffice. Is that correct?

Christine Stahlecker: This is one of those maybe-yes, maybe-no answers. It depends on whether the file you are sending from your billing package to your clearinghouse (and I don't know what format that's in) is data rich enough, if you will. Does it have all the data content that is required for your clearinghouse to make a compliant HIPAA 837 on your behalf? The answer is maybe, I'm sorry to say.

If your vendor is indicating they can do that for you, I would say the proof is in the pudding. Find out from your vendor if they are taking your workload, your claims, today and sending them to your Medicare administrative contractor.

Kathryn Simon: I asked my vendor, the vendor I send my claims to, and they said they have tested with Medicare. My question is: Doesn't the software company have to be compliant as well?

Christine Stahlecker: You are talking about your billing software, right? Are we talking about claims?

Kathryn Simon: Yes.

Christine Stahlecker: Let me just back up for a second.

A clearinghouse as a covered entity under HIPAA, by definition, takes a proprietary format and creates a standard, or it takes the standard and creates a proprietary format, or it can pass through a standard format.

In your example, if your billing package has not upgraded to produce a 5010 837 output file, if the file it *is* putting out to the clearinghouse has all the data elements in it, then your clearinghouse can take that file and create an 837-compliant format. Does that make sense?

Kathryn Simon: Yes. Absolutely. Thank you so much.

Operator: Your next question comes from the line of EllieAnn Marchese.

EllieAnn Marchese: Hi. This is actually EllieAnn Marchese. I'm calling from Suffolk Anesthesiology Associates here in New York. I have several questions.

The zip code, I understand, is not going to be mandatory in the patient fields. In the event that we are unaware of a facility's four-digit extension, is it enough to use four zeros in that field for the time being?

Matt Klischer: We checked with the Postal Service, as far as their code source, and that is not acceptable. Four 9s are not accepted either.

EllieAnn Marchese: It's not. Then we will have to do some investigating.

My next question: We are an anesthesia group. Is it true, as I'm hearing through the grapevine, that all our claims will be going over in minutes instead of units? To some of our insurance companies we send claims with units rather than minutes. Only the MACs, the Palmetto GBAs, want minutes.

Brian Reitz: You have to understand: This is not a Medicare requirement. We're following the TR3s that were written under industry consensus. Changes to the TR3s were made requiring anesthesia claims to be billed using minutes. We're following what has been set forth by the X12 committee.

Christine Stahlecker: So we're implementing the HIPAA national standard. The change is not being driven by Medicare policy by any stretch. We're just trying to implement the standard.

Brian Reitz: It's very likely that when we receive your submission of minutes, we will convert them into units. We'll process the claim the same way as always, but we're required to follow the regulation and the standards that are in law.

EllieAnn Marchese: Right. I see.

My second question: Since we've begun testing 5010, we're having some issues with MSP claims as well on the Part B side. The claim is being sent, and it's being stopped at the ZirMed level for information missing like "working aged" and such.

Is that something that's going to be fixed, or is that something that we will continually have to manually enter once it hits the clearinghouse and sits in that queue, denied?

Brian Reitz: This is Brian Reitz again. Pretty much my same answer applies for ZirMed too. They're required to follow the legislation and the standards that are laid out.

They are pretty much editing ahead of us to make sure your claims data is as clean as possible when it gets to Medicare, or to whatever payer. These are things that are required per the TR3.

EllieAnn Marchese: Do you think it's something our vendor needs to address, to fix in our software?

Brian Reitz: I think it could be one or the other. It could be your issue or it could be your vendor's issue. If you don't have the capability to submit the reason for MSP, then that's a vendor thing. They need to create that for you, the ability to say a patient is working aged or they are ESRD. If you have that capability, then I think the responsibility falls on you, since you're seeing the patients, to make sure they identify themselves and their situations.

EllieAnn Marchese: In some instances, we're just given the information from the hospital, and they may not always get the MSP information right away. We're entering that information after the fact, after data entry, after it's been submitted to the first insurance company. Once we've entered that MSP information, it gets rejected as well.

Brian Reitz: Unfortunately, that's an age-old problem for folks in your situation, where you're not necessarily enrolling the person. Clinical labs, which only get a specimen of blood coming to them, don't have access to information that is needed for the claim.

I can't recommend how you handle this. It's a business process flow that needs to be addressed between you and your associates.

EllieAnn Marchese: My last question concerns the P.O. Box. Today I'm hearing that many people have issues with that. Is there some place online where I can read more about it?

I might have heard about it through an e-mail or two or a listserv. I wasn't really sure it is going to impact us, because our testing of claims went through without a problem. We have a special "pay to" address, which is a lockbox.

We have a P.O. Box with the MAC. Would that have to be updated? Our enrollment forms have our physical address, but they send correspondence to us through a P.O. Box. And then we have that 3rd lockbox.

Brian Reitz: This is Brian Reitz again. The situation with P.O. Box: The current 4010 standards allowed for submission of an actual P.O. Box address. The new 5010s in certain places are not allowing for P.O. Box to come in. If you submit your billing location as a physical street address, you're fine. If you were trying to submit your billing address as a P.O. Box, your claims would be rejected.

It sounds to me like you don't have this issue, and you are billing a physical street address as your Billing Provider location.

EllieAnn Marchese: I have to look into that. I thought it was a P.O. Box, but we're not getting rejected on the test claims, so maybe it's something our software vendor has overridden in the system.

Brian Reitz: The simple fix is to put a physical address in your Billing Location because Medicare credentials you up front. We already know where your payment is supposed to go once you put that in there, so we will send the check to the right place, we promise. Put the physical address in, and your claims will be fine.

EllieAnn Marchese: OK. Thank you, Brian.

Operator: Your next question or concern comes from the line of Brenda Ding.

Brenda Ding: Hello. A lot of people have already addressed the issue on the P.O. Box, but just to clarify: It's not an exact match; it's just whether or not P.O. Box is in? If a P.O. Box is in the Billing Provider address field, you would reject that, right? It's not that you would be doing an exact match.

Brian Reitz: This is Brian. The editing is looking for various combinations of P.O. Box along with the word "lockbox." We've addressed as many possible versions of these as we could think of in the edit logic.

Brenda Ding: But not an exact match. Also, you guys are just one payer. One of our colleagues said some of the payers at the WEDI conference were saying they were doing an exact match. We were concerned that this meant possibly having to go back and do enrollments and make sure our addresses that we send from our systems are matching.

Brian Reitz: When you say "exact match," are you saying that if you enroll with Medicare as P.O. Box 123 and we see P.O. Box 123, that's why we're rejecting? Is that what you mean by an exact match?

Brenda Ding: No, what I mean is we enroll as street address 123 Spring Street, and we spell out the whole word "Street," and in the enrollment form or on your adjudication system, it shows 123 Spring "St." as the address. You would be doing an exact match of those two addresses and rejecting because it's "Street" instead of "St." But you at Medicare are saying that the edit is only looking at whether or not you have P.O. Box or a combination of those things in that field, and not necessarily trying to determine if it's the right exact address.

Brian Reitz: That's correct.

Brenda Ding: Thank you.

Operator: Your next question or concern comes from the line of Robert Beckner.

Robert Beckner: Good Afternoon. This is Robert Beckner from HealthLogic Systems Corporation in Atlanta, Georgia. I noted at the first of the call you said y'all had crossed-over 11 million claims, 5010 claims.

My question is: There are three Medicaid payers that have said they are not going to be ready for 5010 conversion. I need to know how Medicare is going to handle doing crossovers with a non-compliant Medicaid.

Christine Stahlecker: Hi, this is Chris. In today's world, and until December 31, we're prepared to take in whatever format comes in—4010, 5010—and deliver it to the crossover receiving trading partner in the format they can handle.

If you can send in 5010 to one of the Medicaids that cannot take in 5010 yet, the crossover plan they receive is a 4010 format. Right now we are all marching toward January 1 as a cutoff date. Our counterpart component here within CMS has had extended outreach to the Medicaid states that are saying they are not ready. I know that they're working very diligently at coming up with a date by which they can be ready.

Some of them are saying that they can't be ready, but it's not that they will not be ready with all transactions. Some are ready with claims but not with remittances, and they're reporting that they are not ready. It depends on the state as to what level of "not ready" they really are.

I can't really answer the detailed part of your question. If you would like to name the states that you're interested in and send us a note, we can follow up with our other component in-house and have a statement to be shared with you if that's something you're interested in.

Robert Beckner: I'm particularly interested in California Medicaid, Medi-Cal, because they're one of the largest Medicaid populations in the United States. They are transitioning to a new vendor as well. They are refusing to test, particularly in remits. I have providers who are concerned that they will not be ready January 1, and they will be forced into paper submissions. That's the biggest issue I've found with them at this time.

I'll take it up directly with Palmetto and see what their status is with California Medicaid.

Thank you.

Operator: Your next question or concern comes from the line of Ken Bradley.

Ken Bradley: Hi. I'd like to follow up on the previous call. We are greatly concerned as well about the Medicaid plans that have already announced to the provider

community that they will not be ready on 2012. So it would be nice to have a CMS statement about what will happen should those Medicaid plans not be ready on January 1.

I'm guessing that's something you'll work on preparing a statement for. From what we understand, Medi-Cal, for example, has already put out a statement saying they will not in fact be ready on January 1, 2012.

Christine Stahlecker: Yes, our CMS component that handles Medicaid is addressing this, and I can't really speak on their expectation of making a statement or not, but we will definitely take this comment back to them.

Ken Bradley: That'd be great. I guess what we would be looking for, in that case, is what would be the suggested plan to handle those claims if CMS decides they cannot handle that.

I'd also like to comment on the NDC codes. We process primarily Part B claims, and we are having a significant issue with the NDC codes under the Part B plan. We have not been able to get an update, and we transmit to Medicare plans in all 50 states.

You mentioned Part A would be refreshed, possibly around Thanksgiving, and I was curious if you knew of a similar refresh for the Part B plan NDC values.

Christine Stahlecker: It's a good thing you brought that up because we're not aware of a Part B NDC issue right now. We know there are formatting issues with the NDC code itself, that there are now 10 positions for this particular format that's required—542 format. I'll let Brian speak to that.

Brian Reitz: This is Brian Reitz, and I want to ask, just out of curiosity, why you are sending NDCs to Part B.

Ken Bradley: We get that on a significant number of claims—for oncology, orthopedics, injections, things like that.

By the way, I'm at NaviCure and we're a clearinghouse, so we're really not a billing agent. We really format and forward what we receive, so the practices believe they must submit this or. . . .

Brian Reitz: That's what we're trying to assess here because, from a Part B perspective, in order to adjudicate a Medicare claim, I'm only aware of a limited number of situations where NDCs are payable under Medicare Part B. We've been trying to figure out why we would be getting such a large rejection rate of NDCs when we don't really pay those. I have a sense that it's for rebate purposes after the fact.

Ken Bradley: Well, if CMS would be willing, we certainly would participate in educating the provider community if they're not filing correctly. We are having a significant issue with that, really, across the country.

Brian Reitz: We are as well. NDCs, in general, have been very difficult for us to get a handle on. We have heard that there are different maintainers of a code source, and we're trying to work with what we get from FDA, and then there's the frequency with which new drugs are added.

From our point of view, there's little value for Medicare in freshening up a code set on a daily basis when we're not adjudicating those. So it's a difficult situation we're trying to work through right now, as Chris alluded to, and we've gone down the road of making sure that we can freshen the code set—I think, twice a month? Is that where we're . . . ?

Christine Stahlecker: On the B side it's daily.

Brian Reitz: B side is daily, so I'm not sure we can get much better than that.

Ken Bradley: Well, the problem is, we're communicating to our provider community when we're moving claims to 5010 on their behalf, and the rejections are pretty stark. They happen almost directly when we move to 5010. These claims apparently were OK in the 4010 world. So there's definitely something with the fact that they're being submitted in the 5010 format.

Brian Reitz: Well, it's not so much the 5010 format as it is Medicare's *implementation* of 5010—that we also built a Common Edits and Enhancement Module. We have, basically, a new front end, and that front end functions according to the guidelines in the TR3s, as I stated earlier.

The code sets have to be maintained, and the values have to match the code set, which, for NDC, has to come in as the 542. We don't believe the FDA actually publishes the list that's 542, so that's something that has to be looked into as well—that what we have matches what the implementation guide requires to come across.

Ken Bradley: One more point of clarification: The 5010 remit—on January 1, 2012, will Medicare in fact only return 5010 835 data, or will it still be optional to receive 4010 past January 1, 2012?

Christine Stahlecker: At this time Medicare must comply with the regulatory requirement to only produce the 5010 format.

Ken Bradley: And just one final comment: I don't want to take on anybody, but with Noridian, they apparently have to switch every single practice to 5010 on their side, and we are frankly concerned. We attested many months ago and have attempted and are trying to move our practices, but they will not accept a spreadsheet of practices; it must be done each side at a time. We're concerned that it's going to happen in time by January 1, 2012, quite frankly. That's just a comment on that particular implementation from Noridian.

If they claim they can get it done, that's fine, but we are concerned because they have to go through the process of switching each individually.

Christine Stahlecker: We appreciate that comment and we'll take that into consideration.

Ken Bradley: Thank you for your answers. This has been very helpful.

Christine Stahlecker: Well, I think we're closing on our opportunity to hold our information forum today. We think this has been incredibly helpful. We appreciate the frankness and open discussion that took place today.

We have notes galore here. All of us have been taking notes, but we do have the transcript so they will be prepared shortly.

If Medicare is able to take action on many or any of these suggestions, and there have been many, we will certainly be publicizing that information. We have a couple of action items. We have a lot of internal discussion to do and a couple of external action items. We'll be getting in touch with X12 about the P.O. Box for sure.

Again, I would like to thank everybody who took the time to be in our call and for your open communication with us.

Aryeh Langer: I want to let everybody know we're planning on hosting our next call on Wednesday, December 7, at 1:30 p.m. As always, if you can look out for the listserv messages and e-news messages, whatever different messages you subscribe to for your CMS information, we'll be announcing the details on the registration for that December call shortly.

So thank you for participating, and we look forward to speaking with you next time. Have a great day.

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

END