This transcript has been edited for spelling and grammatical errors.

Centers for Medicare & Medicaid Services
CMS audio conference call: HIPAA Version 5010 – What you need to know!
Moderator: Aryeh Langer
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2:30 pm ET

Operator: Welcome to the CMS conference call: HIPAA Version 5010 - What you need to know. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed for Encore replay purposes. If anyone has any objections, please disconnect your lines at this time. I will now turn the call over to Mr. Langer. Please go ahead, sir.

Aryeh Langer: Hi, good afternoon, everyone, and good morning to those of you on the West Coast. I'm Aryeh Langer from the Provider Communications Group here at CMS and I'd like to welcome you to the first HIPAA Version 5010 National Provider conference call. This is the first national call specifically dedicated to 5010. CMS appreciates your participation in today's call and we look forward to a very informative session.

Before we begin, there are several important items that I would like to mention. For anyone that did not yet get a chance to download the materials for the call, you can go to the 5010 web page and download the presentation now and go to the download section towards the bottom of the page. The web address is www.cms.hhs.gov/electronicbillingeditrans/18_5010d0.asp . I hope you got that all.

As a result of feedback CMS received regarding NPI, we are currently working on developing a new 5010 web page that will distinctly differentiate between information for Medicare Fee-For-Service providers and the healthcare industry at large. Our new web page will be the central source for

all CMS 5010 information. This website will include federal regulations and manual instructions, outreach and education, listserv messages, information on Medicare's implementation of 5010, links to ICD-10, and other useful information. This web page will be available by the end of the month and will be announced via the listservs used for today's call. Additionally, you'll be able to download an audio version and transcript of today's call at that soon-to-be announced web address.

I would like to bring to your attention the release of MLN Matters Special Edition article SE0904. This article is an introductory overview to Version 5010 and is the first in a series of MLN Matters articles that will be developed. To access this article, please visit www.cms.hhs.gov/mlnmattersarticles . Once you're on that site, you can click on the left-hand side of the page on 2009 articles. If you have not yet subscribed to the MLN Matters listserv, you can do so there. This article and other educational materials will be available on the new 5010 web page.

There is another message that CMS would like to relay today. Did you know that your local Medicare Contractor - that is carrier, Fiscal Intermediary, or Medicare Administrator Contractor or MAC - is a valuable source of news and information regarding Medicare business and your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area such as local coverage determinations and local provider education activities.

If you have not done so already, you should go to your local contractor website and sign up for their listserv or email list. Many contractors have links on their home page to take you to the registration page to subscribe to their listserv. If you do not see a link on the home page, just search their site for listserv or email list to find the registration page. If you do not know the web

address of your contractor's home page, it's available by going, again, to the CMS website - that's www.cms.hhs.gov/mlnproducts/downloads/callcentertollnumdirectory.zip - which is, again, located on the CMS website.

Finally, there will be a question and answer session following the presentations, enabling participants to ask questions of CMS subject matter experts. As has been the case with other national provider calls, we have a very large number of participants on today's call, so we ask that you limit your questions to one per caller. Without any further delay, I'd like to introduce our first speaker for today, Kyle Miller, Health Insurance Specialist from the Office of E-Health Standards and Services here at CMS. Kyle will be followed by Chris Stahlecker, Director of the Division of Medicare Billing Procedures in the Office of Information Services. Kyle.

Kyle Miller: All right, thanks Aryeh, and I'm going to begin with regulation requirements and that's in the PowerPoint that was distributed to everyone.
Okay, to start off, what was adopted under the HIPAA Modifications Rule? And first and foremost, we added Version 5010 of the X12 standards suite for administrative transactions. We also added Version D.0 of the NCPDP suite for retail pharmacy. We also added Version 3.0 of the NCPDP suite for Medicaid pharmacy subrogation. And for retail pharmacy supplies and services, it is up to the covered entities to choose either Version D.0 or Version 5010 and that's going to be based on trading partner agreements.

Okay, so why 5010? And put quite simply because Version 5010 is outdated and it's going to continue to be more outdated as time moves forward. More specifically, the industry relies extensively on companion guides, which severely limited the value of the 4010 standard. Version 5010 is an improvement because it brings many things to the table. Structural and

content-oriented changes will be implemented; it will incorporate more than 500 change requests; it will also resolve ambiguities in situational rules and it will provide more consistency across transactions and most rules are the same throughout the suite.

So on top of that, why Version D.0? Again, put quite simply, Version 5.1 is outdated. It's been more than 5 years since the initial implementation and 8 years since balloting of the current version. Since then, business needs have changed, since 5.1's implementation and D.0 incorporates the appropriate changes to meet these new needs. And Version D.0 is an improvement for numerous reasons, but it incorporates change requests submitted by the industry to accommodate changing business needs, as I mentioned and it incorporates changes necessitated by the requirements of the Medicare Prescription Drug Improvement and Modernization Act.

Policy features of HIPAA Modifications Rule - these are very important - we want to be clear on these - the compliance date for 5010 and D.0, mandatory compliance is on January 1, 2012, for all covered entities. Internal testing should begin on or after January 1, 2010, and external testing should begin on or after January 1, 2011.

The second point here is very important. No entity may require another entity to use the new version of the standard without agreement between the two parties for testing and implementation. You must be on the same page as your trading partners. And as mentioned earlier, the ability to use X12 or NCPDP for retail pharmacy supplies and services is available, so it will be your choice.

The benefits of converting to 5010, D.0, and 3.0, most importantly, there is less ambiguity in the guides for all three and due to that, it reduces reliance on

the guides, which currently is a huge problem. There is enhanced usability and usefulness of certain transactions, such as referrals and authorizations and that's both X12 and NCPDP versions. And 5010 and D.0 and 3.0 will support increased use of EDI between covered entities, which is a goal, as we all know.

So, to sum up that small section, for additional information that anyone may have, I'm going to give you individual websites. For X12 and obviously 5010, which they developed, please see www.x12.org; and for the X12 portal, www.x12.org/portal; and for D.0/3.0, please see NCPDP at www.ncpdp.org. And for all other inquiries or questions, please see the CMS website at www.cms.hhs.gov. Okay, right now I just concluded slide number 9, we will be moving on to who is affected and I'll turn it over to Chris.

Chris Stahlecker: Thank you, Kyle. Hi everyone, just to reiterate, we are on slide 10. We thought this was a pretty good transition slide, although we've been speaking from a regulatory perspective; Kyle is presenting from a regulatory perspective regarding who is affected by the regulations. It is all HIPAA covered entities, as he said. It will focus on providers who are the primary target audience of today's first educational forum and it will affect all health plans. Of course, Medicare Fee-For-Service is just one and that is what I'm focused on for the rest of this presentation.

Just to conclude that point, though, it will affect all clearinghouses acting on behalf of either the providers or a health plan and any billing service agent who is performing these EDI transactions on behalf of providers or health plans or engaged in the workflow will also be affected. But before we move off of this slide, I just wanted to reiterate that from this point forward in the presentation, I'll be speaking on the Medicare Fee-For-Service implementation

of these new transaction sets. So everything Kyle said is about a regulatory effect and now I'm talking about Medicare Fee-For-Service.

Here at CMS, just to reiterate again, we have two different areas that are responsible, Medicare Fee-For-Service and the Office of Information Services that I'm with is more of an operational leg and implementation aspect of this regulatory requirement. And so we're looking at the implementation issues just as you are. So we wanted to share this information today.

On to slide 11; when are you required to have your systems changes implemented? And as we just heard Kyle say, January 1, 2012, is the cutoff date for the old format of the current 4010 and 4010A1 format. So Medicare will be turning off its use of those forms - formats, those versions, on that date.

Medicare will be ready to begin transitioning off of those current formats on January 1, 2011, and we'll make this point a couple of times in today's presentation. So Medicare will have a full year to transition away from the current formats and onto the 5010 format.

On to slide 12; what must be changed? Well, as Kyle said, the formats are changing. The formats currently used, that you're currently using to bill Medicare or perform Medicare eligibility inquiries must be changed from the 4010A1 format to the 5010 and also from the NCPDP 5.1 to D.0. And just as Kyle said for all health plans, Medicare is required to change as well.

So systems that submit claims, receive remittances, exchange claim status inquiries and responses or eligibility inquiry and responses must be analyzed and during that analysis identify software and business process changes.

We want to make sure everyone realizes that the new versions of these standard formats have different data element requirements. In some cases, existing data elements in the 4010 format are no longer present in the 5010 and in some cases, the 5010 formats have requirements where maybe in the 4010A1 format it was a situational; now that data element may be required in the 5010 format. So there are real changes in these formats.

Medicare has performed a comparison of the current 4010A1 and the new 5010 and D.0 formats and we have listed - we have put this side by side comparison up on our website and we have that listed in our presentation materials on slide 12.

Everyone should realize that the software that's used today to produce these EDI transactions must be modified to produce and exchange the new formats. And in addition, you may discover that your business processes may need to be changed, especially if there is a requirement to capture the new required additional data elements. So you may have business processes that are required to be modified.

And then the transition to the new formats must take - it's going to require careful coordination. From a Medicare perspective, our contractors will be accepting the 4010A1 formats all during that transition year, so you, the provider or service agent on behalf of that provider will have that full year to conduct your systems testing with your MAC contractor and complete that transition work. So you will continue to use the current format, likely with Medicare you may begin to get on to the 5010 format, but for other payers, you may stay on the 4010 format for a period of time. Or perhaps your market mix of transactions does not place Medicare as your primary concern; you may start with a different payer and bring Medicare up later in the year. But at

some point, you'll need to start with one trading partner and then transition from that current 4010A1 to the 5010 format.

On slide 13, how did Medicare get started? Well, first of all, realize that Medicare processes this list of X12 transactions. Medicare Fee-For-Service does not process all of the HIPAA transactions. We do process the institutional claim or the 837-I and its Coordination of Benefit format. We do process the professional claim, the 837-P, and its Coordination of Benefit format. The claims status inquiry and response is part of the Medicare Fee-For-Service program, along with the eligibility inquiry and response, 270/271, the remittance advice, the transaction acknowledgement, TA1, and a functional acknowledgement, 997.

Those last two, please be reminded that those are not really HIPAA standard formats. They are in place today with Medicare, but they were not part of the original HIPAA requirements.

Medicare also processes the DME claims in the NCPDP Version 5.1. But there are other HIPAA transactions that Medicare Fee-For-Service does not process, such as the subrogations that Kyle mentioned and there are the authorizations and referral transaction or the enrollment transaction that’s not part of Medicare Fee-For-Service today. So we don't have some of those side by side comparisons available for those other formats.

On to slide 14; Medicare Fee-For-Service is very well entrenched using electronic data interchange or EDI. In fact, we’re high - over 99%, nearly 100% of our Medicare Part A claims are received in the 837-I format and over 96% at this point of our Medicare Part B claims are received in the 837 professional format. We've listed on slide 14 another URL for where you may

go to our website if you're interested in additional metrics on Medicare Fee-For-Service use of EDI.

It's also important to note that the Administrative Simplification Compliance Act or ASCA does require the use of electronic claims in order for providers to be reimbursed by Medicare. There is a waiver. There are some provisions for waivers and so some providers have requested the ability to continue to bill on paper. But Medicare Fee-For-Service is very interested in moving toward electronic data interchange.

It is critical to us that the transition from the 4010A1 formats to the 5010 and D.0 formats is really a smooth and seamless implementation. We're just not prepared to go back to any amount of paper and even in a very horrific situation if we had to implement something like that, we really would not want to have that be a very lengthy process.

On slide 15, "Getting Started". Again, Medicare started very early. Our project work began in 2007. We did this analysis that I've been mentioning, this side by side comparison. We looked at the claims, both the original claim and the Coordination of Benefit claim. We looked at the remittance advice, the claims status inquiry/response, the eligibility inquiry/response. An analysis also included the NCPDP 5.1 and D.0 formats. And then we also looked at the paper claims, the UB04 for paper institutional billing and the professional billing, the CMS-1500, and compared those to the Coordination of Benefit use of the 837 claim formats. These side by sides, again, we've mentioned are available on the CMS website and you can pick that URL up off of slide number 15.

We did want to make mention that we had initially posted these side by side comparisons in a PDF format, but industry had asked us, many, many areas

had asked us to post them in the native Excel versions so that they could be used for a head start as every covered entity needed to do an analysis and they felt that they would benefit from the work that Medicare had done. So those forms, those side by side comparisons, are up in both the PDF and an Excel format.

On to slide 16, the scope within Medicare. We have treated this project as a major infrastructure expansion, primarily because the new 5010 format is making way for the ICD-10 code set values to come in, and as you may realize, the ICD-10 code set values represents a larger size data element than the current ICD-9 format and there are also additional iterations. So we've referred to this as a Y2K-like expansion of the claim record.

So we needed to go through all of our Medicare systems from the very point of receipt as providers will exchange with our MAC contractors, all the way through our claims history files that researchers may draw data from, all of that is being expanded as part of this project.

We are also implementing new standard - non-HIPAA transactions, but new ASC X12 standard acknowledgement and rejection transactions and we'll speak more about that on the next slide. And we have also identified some selected enhancement processes that we want to implement now in our Medicare Fee-For-Service application systems to move us toward modernization.

On slide 17, we want to make note that the new ASC X12 standard transactions - these are the non-HIPAA transactions - include the functional acknowledgement; we are actually replacing the 997 transaction with a new 999 transaction to be a part of the 5010 implementation. We will be implementing as well, the 277 claims acknowledgement transaction, not to be

confused with claims attachments, but it is claims acknowledgement, 277-CA, claims acknowledgement. We'll be using that transaction to replace our proprietary error reporting. So this is important for you to hear about today and we have more discussion on it a little bit later in the presentation. The TA1 transaction is also an acknowledgement transaction that is in place today and it will be upgraded for 5010.

On slide 18, some of the enhancements, I had mentioned enhancements a moment ago, some of the enhancements that Medicare Fee-For-Service is implementing with the 5010 project are that we are improving our claims receipt, control, and balancing procedures. Our objective is to have although we have multiple MACs with individual systems; we want each one to perform as if it were a virtual single system so that you the provider no matter which MAC you are exchanging transactions with should experience very similar processing results. So we're going to be improving our claims receipt, control, and balancing. We'll be increasing the consistency of claim editing and error handling. We'll be providing common edit definitions to be used by all systems and in all jurisdictions.

We'll be returning claims, those with errors that need correction, earlier in the process. We'd like to move our returned as unprocessable or denied as unprocessable to be an earlier-in-the-process function. We'll be adding edits for common mistakes that are - have been made in billing to the front end of each MAC system rather than waiting to do these edits in our adjudication systems. We'll also be assigning claim numbers closer to the point of receipt and we expect that you'll be able to receive the claim number in the 277 claims acknowledgement transaction and therefore have it available to you to be used in your claims status inquiry transactions.

On slide number 19, we want to really draw a line between what Medicare Fee-For-Service is achieving with our 5010 project and what you can expect will start off the ICD-10 project. We don't want to speak at length about the ICD-10 project, but it's important to know where the 5010 project sort of begins and ends. We know that the 5010 project is a prerequisite for the ICD-10 project. This new 5010 format permits the ICD-10 code set to be exchanged on the claims and on the claim status transactions.

As I mentioned a moment ago, the differences in the diagnosis code data values are that ICD-9 has a maximum position of 5 bytes and the ICD-10 code values have a maximum length of 7 bytes, 7 characters, 7 positions. However, we want to recognize that both of the - excuse me - code set values, both ICD-9 and ICD-10, have a minimum length of 3. So you can't just look at an ICD value and know if it came from the ICD-9 code set or the ICD-10 code set.

So Medicare Fee-For-Service is adding a one-position version indicator that will travel with the diagnosis codes to indicate whether that code value was drawn from the ICD-9 code set or the ICD-10 code set.

The 5010 format also increases the number of diagnosis codes that are permitted on a claim, at least on the 837 professional claim it's being increased from 8 occurrences to 12 occurrences. And on the institutional claims, although the 837 institutional claim has always permitted - well, in 4010A1 anyway - permitted 25 occurrences, the Medicare Fee-For-Service application system was limited to process only 9. And part of this 5010 project, Medicare Fee-For-Service will be processing all 25 instances of a submitted diagnosis code.

There are some other additional data modifications in the standards, as I've mentioned earlier, additional data elements that are required and so this is part

of the Medicare Fee-For-Service upgrade as well. However, what 5010 does not do within the Medicare Fee-For-Service system, it does not add any processing needed for the ICD-10 code values. We are not including the crosswalk at this time between the ICD-9 and ICD-10 codes and we are not requiring the use of ICD-10 codes. All of those facets of the ICD-10 project will be made clearer by CMS in the future.

We want to recognize that the 4010 format does allow both the ICD-9 code set and/or the ICD-10 code values in a transaction. So please know that we have an edit right at the very front door of receipt of these transactions that will return and reject back to you any ICD-10 code values that may be inadvertently submitted prior to the time when the ICD-10 project says that you should begin to bill them. So the business rules for processing the ICD-10 code set values will be defined with the ICD-10 project.

On to slide 20; just a little transition to set the stage for you - What can you expect from your Medicare Administrative Contractor? On slide 21, each MAC, Medicare Administrative Contractor, has its own unique front end system they run that at their own local data center and they use that system to exchange all of the HIPAA EDI transactions with their adjudication system that runs at a CMS Enterprise Data Center.

So the MAC is the point where the upgrades will take place in the front end system. The upgrades will take place to the translators, and any trading partner management that performs authentication of trading partner and submitter IDs and does the validation of the each and individual transactions and the provider relationship between the provider as it's identified in the transaction that matches the submitter, and then performs the actual exchange of the standard transaction with the Enterprise Data Center.

The MACs must also plan for and implement this new software that's being developed by the Fiscal Intermediary Shared System and the multiple carrier system vendors that will actually provide common software to the MACs to be used for processing these detailed claim editing the claim numbering that I spoke about - the receipt, control, and balancing for the exchanges with the enterprise data centers. So there is a piece of the software that the MAC will use in their environment that is being supplied by our shared system maintainers.

The project approach for Medicare Fee-For-Service is to work with current MACs that are up and operational, have completed their transition of their current workload and those are identified as jurisdictions 1, 3, 4, 5, 13, and CEDI or a common EDI for the DME process. And then subsequent to bringing up those MACs, we, CMS will address an implementation strategy for the remaining MACs.

It is important for you all to know that each MAC will be required to exercise a certification test package before CMS will permit that MAC to begin their transition phase. So according to the schedule, this certification testing - we'll speak more about that in a minute - will be required to be completed prior to December 31, 2010.

On to slide 22; again, the MACs will coordinate an information exchange within each of their jurisdictions. They will be disseminating information regarding whether a new trading partner or submitter ID will be required for the 5010 transactions or if their trading partner management system can accommodate a provider or a biller using their current submitter ID for both 4010A1 production and 5010 test and eventually 5010 production.

The MAC will also identify the steps that the provider will undergo to transition away from the current format and on to the new format. They'll identify the requirements, if any, for testing each transaction. Or if you're using a clearinghouse, perhaps the MAC will indicate that it wants the clearinghouse tested and certified or your vendor software tested and certified. Individual testing may not be required. But that information will be coming to you from your MAC.

And then the clearinghouse and vendor test support that the MAC will offer, CMS expects that early trading partner testing will occur prior to the transition testing phase. So during the latter stages of calendar year 2010, we expect the MACs to outreach to clearinghouses and vendors that are ready to begin some integrated systems testing so that both sides - the clearinghouse and vendor, as well as CMS, can assure that their systems are working correctly and completely. Finally, we'll continue the posting on our MAC websites of a list of vendors who have completed their testing for the new 5010 format.

On slide 23, we have a timeline that we'd like to review with you. This timeline is something that Medicare Fee-For-Service has been working towards. It does comply with what Kyle had mentioned earlier as a requirement for all covered entities.

Medicare Fee-For-Service actually began their Y2K-like expansion implementation in the October of 2008 time frame. There have been quarterly releases implemented since that time. And we are well underway with our development activities for the 5010 implementation. We expect that we're going to begin our integrated systems testing on January 1, 2010 of these installed components and complete that systems testing by January 1, 2011.

That systems testing will include an October of 2010 through January 1, 2011, will include that certification test package that I had mentioned earlier. So on January 1, 2011, Medicare Fee-For-Service will begin accepting the 5010 transactions. Now that will be in a transition mode. The 4010A1 will be the format that you will continue to submit your productional workload in until you have completed your transition or startup processing with your MAC contractor.

So please be - you know, we're already making - trying to make it obvious to you that there's no room to delay, we can not possibly convert all of the Medicare trading partners at the 11th hour or January 1, 2012. So we'll be looking at very active encouragement of trading partners to begin their transition phases early in 2011, as early as possible, because on January 1, 2012, Medicare Fee-For-Service will be ending the receipt and exchange of the 4010A1 format. On this same timeline, we do have the startup date indicated for the ICD-10 cut-over. But, again, that's just to frame it. More will come to you from our ICD-10 project team.

On slide 24, we would like to share with you some upcoming communications. CMS will be developing and disseminating educational material, as we usually do. We have several methods of doing that, our MLN letters or news articles and associated newsflash, we have some information. Aryeh had mentioned earlier, we're going to have a new location on the CMS website that will be the highest level location for all 5010 information. From there, you will be able to branch to regulatory information or to detailed documentation as Medicare Fee-For-Service completes its implementation. There'll be some materials that you can download to print from our CMS website - frequently asked questions - we'll share our PowerPoint presentations.

On slide 25, our upcoming communications continues with our national provider calls, such as this first one that we're holding today. We do expect to hold a second with similar agenda topics and that'll be in the early July time frame. We'd like to mention our multiple listservs, and please come to our website and subscribe if you have not already. And our provider partnership network is a wonderful way to stay connected to Medicare Fee-For-Service implementation news.

On slide 26, we have multiple provider web pages on the CMS website. Also our bulletins and newsletters please look for IVR messages. We'll be exhibiting at national provider conferences. That has already begun. There will be regional office outreach activities and the Medicare Fee-For-Service provider newsletter.

On slide 27, we wanted to speak a little bit about okay, now we understand what the scope of change is and it's pretty big, what are some actions that the provider community could be taking now? And, again, the first step is we would encourage you to contact your system vendors right away. We'd like you to be assured that whatever licensing agreement you have in place that you know whether or not it includes regulatory updates because if it does, you may have a shorter path toward your implementation. But if it does not, you may have a longer path, procurement path to follow.

We would encourage you to find out if your license does include a regulatory upgrade. You should find out if it's going to include the 5010 version of the TA1 transaction, the 5010 version of the 277 claims acknowledgement, and the 5010 version of the 999 transaction. Remember I stated that these are not HIPAA transactions.

Medicare Fee-For-Service is a little - a step ahead because it just makes good business sense to use these standard transactions for the benefit of increasing EDI and reducing the complexities of proprietary error reporting. We would encourage you to also find out if you're going to receive a readable error report. If your system will accommodate the 277-CA and the 999, you may also want to ask whether or not that software vendor will produce a readable error report from those transaction exchanges. It's one thing to have a system interface built, but it's another to have the user-friendly aspect of it made available to you.

Next we would encourage you to inquire when your system vendor is planning to upgrade your individual system and then to assess that response to find out where you are in the pecking order or where the deployment activity falls in the calendar from your vendor's perspective - what your vendor is planning for deployment to figure out where you stand, how you feel confident with your implementation, to make sure that you're going to be ready and not have any negative effects to your business or your transaction flow knowing that Medicare needs to cut off the current format on January 1, 2012.

So you can leverage your, you know, concerns and anxieties with your vendors to make sure that your transition will be completed well before the cut-off. And then we would finally encourage you to evaluate after you've done your analysis and looked at the new formats using those side by side comparisons we suggest, evaluate any impact to your routine operations and begin to plan for any kind of training or transition activities you may need to put in place.

And overall, just essentially to wrap up, we're hoping - not hoping - we're adamantly planning with every mitigation, risk mitigation activity we can

possibly address at this point for a smooth and seamless transition. And we're encouraged that we'll be working with you as trading partners to achieve that, both you the provider and your service vendors and your software vendors. And at this point, that is essentially the end of the presentation, the planned presentation, and we would open it now for any questions or concerns you may want to bring up.

Operator: At this time, we will now open the lines for the question-and-answer session. We ask that you please limit yourselves to one question. To ask a question, please press star-1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Today's conference is being recorded and transcribed for Encore replay purposes. So please say your name and organization prior to asking a question.
Our first question comes from the line of Gary Smith.

Woman: So if I have a clearinghouse, Office Ally is actually my clearinghouse, they are the ones that are actually I need to be in touch with to make sure that they are transitioning to this and where they're at, as well as my Medisoft vendor?

Chris Stahlecker: That would be very wise. Your Medisoft vendor needs to take the first step to deliver the new format to your clearinghouse, but if your clearinghouse has not shared its timeline, you know, it all links in this electronic exchange chain need to be working seamlessly, so your Medisoft vendor and your clearinghouse...

Woman: But as a billing company, it is going to be ultimately the clearinghouse's responsibility to have this format set up to send to you folks.

Chris Stahlecker: Well, the clearinghouse is a covered entity. So yes, they must comply...

Woman: Okay.

Chris Stahlecker: ...with the HIPAA regulatory update. But it doesn't do any business any good to just know that you're served by that clearinghouse. It's most prudent for you to be assured by that clearinghouse that they're working actively and that they can accommodate your transition timely.

Woman: Okay, thanks.

Operator: Your next question comes from the line of Leslie Whitkin.

Leslie Whitkin: Yes, I was wondering...

Aryeh Langer: Leslie, are you still on the line? Can we take our next question?

Operator: Your next question comes from All Script.

Shay: Hi. This is Shay with All Script. I just wanted to get a little clarity on the statement about CMS being ready for the transition on January 1, 2011. Does that mean that you'll be ready to begin testing with vendors and clearinghouses on January 1, 2011, and once they've passed testing with the various MACs they can begin sending 5010 claims? And also does that mean that they're required- what is the requirement for testing? Is that testing for all clearinghouses or all trading partners?

Chris Stahlecker: Those are good questions. Let me see if I can peel the onion a little bit.

Each MAC will specify what its testing criteria will be. CMS will require that MAC to have their application software productionally ready by 2011, January 1, 2011. So we will have assured that the 5010 software is

productionally ready by January 1, 2011, knowing that that opens the door for trading partners to begin their transition activities.
Likely that transition activity would begin with testing and results coming back to the clearinghouse or provider from the MAC. And then as that provider or trading partner becomes assured that their system is ready to swing over to the new format, working with that MAC, the trading partner ID will be turned into a productionally submitting 5010 trading partner. I hope that helps. Do you have any additional questions about that?

Shay: No, that's great. I would love to have those details in writing maybe in a change request or something. But thank you so much for providing that additional information.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Ann Gardner.

Ann Gardner: Yes, we are opticians in Pennsylvania we actually are currently using your Express Plus software. Needed to find out if your Express Plus is going to automatically updated to accept this or if not what do we need to do?

Chris Stahlecker: We're working with the free billing software vendors to make sure that their packages are ready and available to accommodate, to produce the new formats. Express Plus versus PC-ACE, I can't speak to directly now if both are going to be ready or not. We've been assured by the Systems Development, Inc. vendor that the PC-ACE product will be available. So I don't have that assurance yet from all of the vendors that maintain free billing packages that CMS is using.

So either we will have assurances from the vendors or we will need to swing over to those vendors that can meet our timeline. But more information will be disseminated at future dates.

Ann Gardner: Thank you.

Operator: Your next question comes from the line of Thelma Carver.

Aryeh Langer: Go ahead, your line's open.

Can we take the next caller, please?

Operator: Your next question comes from the line of Kelly Yori.

Kelly Yori: Hi, yes, I just had a question. I did see in the slides that there's a provider partnership network. I'm curious about what kind of outreach is going to - what type of outreach will CMS have with other payers and the state programs to make sure that they are compliant by your date as well?

Chris Stahlecker: This is Chris and I can take maybe the first crack at that. There was an earlier meeting, an audio cast today that was hosted by our Coordination of Benefits area for the crossover aspects of our work and there is another - and that was with the commercial payers only, not the state Medicaid. But I think within the next two weeks, the Medicaid conference call is scheduled. So those are working meetings that've already started so that we can coordinate our implementation timelines. But I think that there is additional aspect to your question on the provider work.

Kelly Yori: So you think that that'll eventually be covered? I know that one area of concern is the crossover piece, but then we do have payers that we deal with

right now that can not at present time accept 4010 format. So while we're moving to 5010, I'm just curious what's going to happen with those payers. Is there any enforcement for that?

Nicole Cooney: This is Nicole Cooney. Unfortunately our representative from the Office of E-Health Standards and Services, he had to leave. So he's not able to address this question. But OESS, that entity of CMS that has responsibility for enforcement of the HIPAA standards, they are planning to work with a contractor to do more of the industry outreach and we should have more information on that in the future. But there is some discussion of that at this time.

Kelly Yori: Okay.

Nicole Cooney: Unfortunately I don't have the details.

Kelly Yori: Is there somebody that you can recommend I coordinate with just to get information? We're also looking at how - with the states, with all of the budget shortfalls - how we can educate some of the states that we're dealing with to take advantage of some of the IT initiatives in the stimulus package. Is there someone I could work with at the OESS department?

Nicole Cooney: If you can give your name and number, I can pass it on to them and someone will return your call later this week.

Kelly Yori: Okay, great. Do you want it now?

Nicole Cooney: Yes.

Kelly Yori: Okay, it's Kelly...

Nicole Cooney: Okay.

Kelly Yori: ...last name Yori, Y-O-R-I.

Nicole Cooney: Okay.

Kelly Yori: Phone number's XXX...

Nicole Cooney: XXX.

Kelly Yori: ...XXX...

Nicole Cooney: XXX.

Kelly Yori: ...XXXX.

Nicole Cooney: XXXX.

Kelly Yori: Thank you.

Nicole Cooney: Okay, thank you.

Kelly Yori: You're welcome.

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

Gloria Davis: Hi. Just a query, well, I noticed UB04 and CMS-1500 does not fall under this. Do you foresee a plan of any changes on that platform as well?

Chris Stahlecker: Well, CMS has requested that the National Uniform Claim Committee expand the number of diagnosis codes on that CMS-1500 to match the number of diagnosis codes that the 837 can accommodate. Right now, there are I believe 4 locations for diagnosis codes. And, of course, we need to go up to 12 to match the 837 professional in Version 5010.

So we do have a request we've submitted several months ago to the National Uniform Claim Committee. That's chaired by the AMA. And each - I think they meet three times a year. We've been asking for some indication for when that work will be undertaken. So we are actively proceeding to try to get that accommodated, but that is an industry-maintained form at this time. So we'll be working with them closely to try to encourage that activity to take place but, we would be limited to use the paper claim form as supported by the NUCC.

Gloria Davis: Thank you.

Operator: Your next question comes from the line of Tina Lyons.

Tina Lyons: Hi. Yes, I'm kind of getting on the beginning stages of this, so hopefully it isn't too much of a stupid question. But just to understand because we bill on the CMS-1500, then this 5010, is a paper form change?

Chris Stahlecker: No, the 5010 is the electronic data interchange, the electronic format change for electronic billing and providers are required to bill electronically and billing services do not have any exclusion. Just let me say that.

Under the ASCA provision, a provider has exclusion, but not a billing service, not a clearinghouse. No one other than a provider doing direct paper billing, direct billing, has a - an exclusion under ASCA. So we are looking to have the 5010 upgrade is for electronic billing. The paper claim billing, the CMS-1500,

for those providers that under the ASCA waiver provisions do qualify for one, we believe that the paper claim forms can accommodate sufficient data elements without iterations that as I just mentioned with the diagnosis codes. But there is room enough if you will, white space enough, where the diagnosis code and is housed to indicate whether or not it's drawn from the ICD-10 or the ICD-9 code set.

Tina Lyons: I guess I'm not - I mean, you know, we bill electronically on a CMS-1500, so I'm just - so in that case, it at this time doesn't apply to us.

Chris Stahlecker: Well, that's interesting because our MAC contractors are not accepting any electronic formats other than the 837, well, professional in your case format. We're not accepting an electronic equivalent of the CMS-1500.

Tina Lyons: Okay. Thank you.

Chris Stahlecker: Yep. No such thing as a silly question. Now is the time.

Operator: Your next question comes from the line of April Ford.

April Ford: Hi. Can you repeat the website where today's presentation was so I can print out copies of that?

Aryeh Langer: Sure.

April Ford: I got it up to electronic billing and then it was too fast.

Aryeh Langer: Okay, I apologize. It's - I'll start over again.
It's www.cms.hhs.gov/electronicbillingeditrans/18_5010d0.asp.

April Ford: Okay, thank you.

Aryeh Langer: You're welcome.

Operator: Your next question comes from the line of Diana Shaw.

Diana Shaw: Yes, my question is does this make any difference to a critical access hospital? Or are there any changes?

Chris Stahlecker: This would apply to a critical access hospital as well. Any billing that that hospital performs, any eligibility inquiries that it's performing, the actual formats would need to be upgraded to replace the 4010A1 format with the 5010 format. So, yes, it applies.

Diana Shaw: Thank you.

Operator: Your next question comes from the line of Diane Larson.

Diane Larson: Hello. If we go to that online comparison of old versus new, will that give us the new required data elements that will be with this new 5010?

Chris Stahlecker: It will show you where there are changes between the two formats and where the 5010 format has a new required element, yes; it will indicate that to you.

Diane Larson: Thank you.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from the line of Tammy Johnson.

Tammy Johnson: Yes, this is Tammy Johnson with Home Oxygen Care. And I was wondering if this would apply to me - I have - I bill through a Medicare software, I bought the Medicare from, I mean, the software from Medicare and it's the PC Pro32 and, of course, it does bill on the HCFA 1500 form.

Chris Stahlecker: The PC - well, that particular software product has two names that are widely known. One is it's the same product, but the latest version of Pro32 that you mentioned; it can produce the electronic formats. And we have an assurance from that vendor that it will be ready and available to send and receive the 5010 format. So that vendor has been up front with us about it - their readiness - and so you should be okay with that product. You will need to have an upgrade. The current version of it does not accommodate these formats.

Tammy Johnson: Okay, right. So they will probably notify us through a listserv or something that there is an upgrade.

Chris Stahlecker: You typically get your notifications from your MAC that an upgrade is available. Is that not true?

Tammy Johnson: I think that's right.

Chris Stahlecker: I'm not quite sure how you are using this Pro32 software. Did you receive it as a distribution from your carrier as a free billing package? Or did you actually go to the vendor and purchase a copy?

Tammy Johnson: Actually I asked the vendor about it when I went in business and I've just been using it ever since. And I think it was like $25 or $50. It wasn't - I mean, it wasn't pricey at all. But I just use it because that was the one Medicare sold or...

Chris Stahlecker: Okay. The Medicare Contractor can recover up to $25 of its distribution costs, so it may appear that you paid $25 for it, but that was really a distribution fee from that Medicare Carrier.

Tammy Johnson: Okay.

Chris Stahlecker: So that Medicare Carrier will advise you when the new format is readily available for you to obtain a fresh copy of that package...

Tammy Johnson: Okay.

Chris Stahlecker:...with the updates in it.

Tammy Johnson: Okay. And will it - is it supposed to be an update to that? Or will it be whole new learning software to learn?

Chris Stahlecker: We'll have more information on that at a future education call. Some of those details we just don't have yet.

Tammy Johnson: Okay, thank you so much.

Chris Stahlecker: You're welcome.

Operator: Your next question comes from the line of Kathy Parks.

Kathy Parks: Yes, thank you very much for the information. It was very helpful today. My question refers to the Clearinghouses and Billing Agencies. Do you have training calls in process as you did for providers so that they will be alerted to all of these changes? Or how are you getting this information out to them as far as guidelines and deadlines?

Chris Stahlecker: Well, in our routine distribution methods, we work with our carriers and Fiscal Intermediaries and MACs to distribute information as they need to maintain the software vendor list on their websites. So we communicate information through our MACs. However, we've taken some extra steps with this major implementation, with this major upgrade to 5010. I'm not sure if you have ever heard of the HIMSS, H-I-M-S-S organization.

Kathy Parks: Un huh-.

Chris Stahlecker: The - yes you have?

Kathy Parks: No, I have not, sorry.

Chris Stahlecker: Well, the hospital information system society - Hospital Information Management System Society.

Kathy Parks: Mm-hm.

Chris Stahlecker: And it -

Woman: Health.

Chris Stahlecker: Health information.

Woman: Sorry.

Chris Stahlecker: Thank you so much. Health Information Management System Society and it's a dot-org if you go to their website.

Kathy Parks: Okay.

Chris Stahlecker: H-I-M-S-S.org. And their primary audience and maybe this is changing recently, but over time their primary audience had been for provider software vendors and they have an annual conference. They usually feature new development work in a demonstration mode. And at this last conference that was held, their annual conference was held in April in Chicago, several CMS members did speak at that conference, well attended by vendors.
And we did announce - we have a MAC - I'm sorry, a 5010 presentation that we delivered there, that CMS had delivered there. Cathy Carter from CMS, she is the group director for the Business Applications Management Group, my boss. And she did deliver the presentation at HIMSS and spoke at length to the vendors about the schedule that Medicare Fee-For-Service has for their targets for meeting the regulation, as well as the non-HIPAA standard transactions. We've done other outreach at industry forums. At the recent WEDI, Workgroup for Electronic Data Interchange that was held in April.

Kathy Parks: Mm-hm.

Chris Stahlecker: We spoke at that conference as well. And we do maintain several listservs that we have a clearinghouse listserv that vendors and clearinghouses subscribe to. And we also use the HIMSS listservs as an extended outreach. And we have put all of those mechanisms into play for extending this outreach.

Kathy Parks: It would still behoove us to make sure that the people that we are working with individually, though, are not just getting the information, but implementing things it sounds like.

Chris Stahlecker: Absolutely. Absolutely, I mean, they may have not subscribed to some of these recognized communications posts.

Kathy Parks: Mm-hm.

Chris Stahlecker: And so when you contact them, it may be the first that they're going to hear of it. So it's very prudent for you to make that contact.

Kathy Parks: Thank you very much. I appreciate your information.

Operator: Your next question comes from the line of Bonita Beers.

Bonita Beers: Yes, thank you. I wanted to know if there's somewhere on CMS' website that we could get examples of the new 999 and 277-CA reports.

Chris Stahlecker: Interesting term, 999 reports. The 999 will be a transaction, not a report and that's why we're encouraging you to find out if your vendor will accept that transaction and produce a report for you to see and be able to read it.

Bonita Beers: ...I'm actually a software vendor. That's why I'm asking.

Chris Stahlecker: Mm-hm. We will be sharing the - as much information as we can. We're still in somewhat of a design mode for the translator vendors working in our project team, are meeting with our shared system vendors. And that is an activity of design that's currently being developed. So as soon as we have that information, we would be more than happy to share that.

Bonita Beers: Thank you.

Operator: Your next question comes from the line of Nita Loy.

Nita Loy: Hi. I have a couple of questions. It's interesting that we have to go through these changes. We are in a very small town and one of my questions I have for you is how would we know what vendor is ready - does Medicare have something that we can go and look at and pick from? Because right now we went ahead and went to the electronic medical records and all that, but we seem to having a lot of problems between our billing and our vendors and trying to make everything work. How - or what suggestions do you have? Is there a system?

I mean, I understand that you want everyone to move to all this stuff, but do you - does Medicare have a program that we as providers can go ahead and purchase or use to make sure that we are in compliance with what Medicare wants?

Chris Stahlecker: Well, we have a couple of tools.

Nita Loy: Mm-hm.

Chris Stahlecker: One is if you need free billing software, we can supply that to you.

Nita Loy: Okay.

Chris Stahlecker: Usually that's not suitable for any, you know, midsized organization. You know, a free piece of software is really aimed at the, you know, the smaller-sized business. But we do have our - a requirement for our contractors, the Fiscal Intermediaries, carriers, and MACs...

Nita Loy: Mm-hm.

Chris Stahlecker: ...to maintain on their website, their individual website, so whoever you send your claims to...

Nita Loy: Mm-hm.

Chris Stahlecker: ...you can go to their website and look at list of vendors that are authorized for these transactions.
Now please know that they're not there yet. This is the beginning of this project and - but just keep an eye out and as vendors become to be - to complete their testing with those Fiscal Intermediaries and carriers and MACs that this vendor list will be updated to show that they have completed that 5010 task. So I think that that is the extent that Medicare Fee-For-Service is able to support at least availability of vendor products for you to select from.

Nita Loy: Where would I go to find out where this list would be for vendor products?

Chris Stahlecker: You would go to the website for the Fiscal Intermediary or carrier that you are sending your claims to.

Nita Loy: Okay. Thank you.

Chris Stahlecker: You're welcome.

Operator: Your next...

Aryeh Langer: Go ahead.

Operator: Your next question comes from the line of Jeanne McFillian.

Jeanne McFillian: Hi.

Chris Stahlecker: Hi.

Jeanne McFillian: Thank you for a great presentation today. My question may be premature. It's regarding ICD-10 and training and is any - is there going to be any links or anything on the website that have to do with that as that approaches?

Aryeh Langer: Yeah, we will have links from the 5010 website to the ICD-10 website. I actually have the ICD-10 website in front of me if you would like it. But we will have links. The answer to your question is yes.

Jeanne McFillian: Yes, if you could give me that link, that would be great, or the website.

Aryeh Langer: Sure. It's the CMS website. It's at www.cms.hhs.gov...

Jeanne McFillian: Right.

Aryeh Langer: .../icd10.

Jeanne McFillian: Thank you.

Aryeh Langer: Sure thing.

Operator: Your next question comes from the line of Bonnie McLaughlin.

Bonnie McLaughlin: Hi, this is Bonnie McLaughlin and I'm calling from Meditech. We're actually a software vendor. This kind of ties in to one of the earlier questions; I may be in the wrong area - we have some HIMSS participation here at Meditech, but it tends to be more on the marketing side of things. I am actually in the software development aspect. And so where we have customers all across the nation and our customers are actually the providers. We as a software vendor don't have a direct relationship with any specific MAC. And

what I'm interested in is the - slide 22 where you were talking about testing support for clearinghouses and vendors and that there would be outreach through the MACs for that.

But, you know, without a direct relationship with any specific MAC, is there another way that we can proactively jump onboard with that process? We've actually been trying to put feelers out in that direction because we're currently developing this software and we're almost at a point where we're ready to do some external testing now, not wanting to wait until 2011 and have the software deploy to our couple thousand customers. We want to be doing the testing with the external entities before that. So what do we do?

Chris Stahlecker: Well, first of all, nice job on getting ready early. That's incredible. You know, good job there.

Bonnie McLaughlin: Thanks.

Chris Stahlecker: And you're a little bit ahead of where our Medicare Fee-For-Service MACs are right now. And during 2010, we expect that some of our MACs would be looking for vendors such as yourself to exchange the 5010 transactions with. So we would call that, you know, the early implementers, the early adopters. And we would be doing an outreach at that point, likely through some of the software vendor outreach mechanisms that we talked about earlier.

Bonnie McLaughlin: So as long as we're on like a CMS clearinghouse listserv, would that reach us? I mean, I guess I - we haven't heard anything yet. So what's going to be the avenue through - how are they going to reach us if we don't have - subscribe to a specific MAC?

Chris Stahlecker: You know, we're going to have to give some thought to that and line ourselves up so that we have a really good answer for that need. And thank

you for raising the question and we're all taking notes here to make sure that we don't omit addressing that. So thank you. We'll have to make an announcement at a future call about how we can address that.

Bonnie McLaughlin: Very good. Thank you so much.

Chris Stahlecker: Mm-hm.

Operator: Your next question comes from the line of Linda Reyes.

Linda Reyes: My question was already answered. Thank you.

Operator: Your next question comes from the line of Marie Aaron.

Marie Aaron: Hi. This is Maria Aaron from Kaleida Health in Buffalo. I'm excited to hear about the 277 claims acknowledgement transaction. Where can I get the guide or the TR3 manual for that? I can't find it anywhere. And what version are you using?

Chris Stahlecker: Well, that one we are working with X12 and DISA, D-I-S-A, the...

Marie Aaron: Mm-hm.

Chris Stahlecker: ...you're familiar with them?

Marie Aaron: Yes.

Chris Stahlecker: DISA.org, and to find out where they are going to place that. Right now, we are using working copies made available to us from X12C, communications group. And also WEDI, the Workgroup for Electronic Data Interchange, has a

technical advisory group, or they have a workgroup focused on identifying how this transaction can be used. So CMS is planning on using it, but the industry is moving in that direction as well. So you may be able to obtain a copy or at least a - the working version from them.

Marie Aaron: Okay. Because it's new it's not quite published yet?

Chris Stahlecker: Yes. I believe that's the status, yes.

Marie Aaron: Okay. Is that the same for the 999? Or can you direct me where to get that?

Chris Stahlecker: I believe that's the same situation there as well.

Marie Aaron: Okay. Thank you.

Chris Stahlecker: Mm-hm.

Operator: Your next question comes from the line of Damon Carter.

Damon Carter: Yes, how're you doing? This is Damon Carter from Americom. I had a question in reference to slide 21 where you speak of the front end edits for the MAC. I noticed that you did list this software would be for FISS and MCS. I wanted to know if you would make it a standard business practice and then also include VMS in this implementation.

Chris Stahlecker: Good question. VMS is essentially already ahead of the game here in that the common EDI is performing as a single front end system to the VMS applications. So these edits have already been worked out and are operational in CEDI for the 4010A1 format and NCPDP 5.1. CEDI will be implementing

the 5010 version and the D.0 version, so the software for VMS is already upgraded.

Damon Carter: Thank you.

Chris Stahlecker: A little bit ahead of where the FISS and MCS systems are.

Operator: Your next question comes from the line of Leona Brown.

Leona Brown: Hello. I have one question about on one of your slides, you spoke of that a MAC may require us to apply for a new submitter ID, and I'm kind of wondering why we would need a new submitter ID if your transmissions aren't changing.

Chris Stahlecker: Well, your transmissions will be changing, definitely. So you need to be able to submit your current 4010A1 format for production while you start to send 5010 in test mode. So that's kind of a unique situation. Once a biller becomes productional, they do not necessarily fall back and start to send test transactions. This is a unique situation where we want to be able to send test transactions in 5010 and production in 4010. So your formats are definitely going to change.

Leona Brown: The formats I understood, but you're saying so I will get two separate transmissions. And so the 4010 will have the old submitter and possibly my 5010 will have a new submitter ID.

Chris Stahlecker: Possibly.

Leona Brown: That's what you're telling me. Okay.

Chris Stahlecker: Possibly. Yes. And, you know, be on the lookout for that. We're working through those details with the MACs now.

Leona Brown: Okay, I have one more question. What if we have variances in - while we're testing the 5010 file? Who is our contact? Or is there going to be some contact information out - posted out on a website for us?

Chris Stahlecker: You'll be working with your MAC.

Leona Brown: So we will just - whatever our MAC gives us as far as contact information, those are the people that we will talk to?

Chris Stahlecker: Yes, mm-hm.

Leona Brown: Okay. I will assume that there will also be a new version of PC Print. Is that correct?

Chris Stahlecker: That's correct.

Leona Brown: Okay. Thank you very much.

Chris Stahlecker: Okay.

Operator: Your next question comes from the line of Betsy Clor.

Betsy Clor: Yes, when will you be publishing which claim edits, the new ones, will be moving to the front end?

Chris Stahlecker: We should be able to be publishing that probably within about three months. We're working through those details. We don't want to publish anything

prematurely. And we're still working through understanding exactly which edits are going to be part of this common edit module developed by the shared system maintainers. We feel that we're very close, but getting that in a publishable format might take us a little bit longer.

Betsy Clor: Thank you.

Operator: Your next question comes from the line of Cheryl George.

Cheryl George: Hi. I had a question on the implementation guides for the 5010. Do we really have to purchase those or are they going to be available for free on the like WEDI or CMS websites?

Chris Stahlecker: Oh, excellent question. I'm glad you asked it. And the answer is you will really need to purchase them. OESS in the past had taken that step to make documentation readily available, but at this - that was the first year and startup issues and it was brand new to everyone, and at this point, everyone is using the 4010A1, so we feel that that's - not we feel, but the understanding is that - that's part of your routine operation, so the upgrade should be something that is not necessarily funded by this agency.

Cheryl George: Do you know how much possibly that it will be?

Chris Stahlecker: Yeah, the prices are on the website. You can see them. I believe they're - you can get to the website through the disa.org or www.wpc-edi.com.

Cheryl George: Okay.

Operator: Your next question comes from the line of Chris Carnez.

Chris Carnez: Hi. I had a couple of questions. Are the MACs then going to be required all to follow the same front end processing standard?

Chris Stahlecker: For the translation process?

Chris Carnez: Yeah. I mean, was...

Chris Stahlecker: and the edits?

Chris Carnez: ...could we expect that, you know...

Chris Carnez: ...our MAC would handle it the exact same way as another MAC might?

Chris Stahlecker: The translation and the edits, yes.

Chris Carnez: Oh

Chris Stahlecker: Each MAC has its own telecommunication capability. CMS has a number of requirements that each MAC must live within. But it does depend upon that MAC's individual trading partner mix - who wants to have dedicated lines versus dialup, that kind of thing. So we are dependent upon the MAC to maintain that relationship with what the trading partners would request in terms of telecommunication capability within the CMS requirements.
But CMS has some security requirements and so we arrive at a finite number of options and each of the MACs can operate within those finite numbers of options. But beyond the sending and receiving through the telecommunication bulletin boards if you will, the actual process of the transactions, the translations and the editing of those transactions should be the same. There will be local medical policies supported. We do have that issue to be realistic about. But…

Chris Carnez: Regarding edits potentially..

Chris Stahlecker: …wherever possible, we are standardizing the edits. So where an edit's performed the same, it's going to use the same error code and be returned in a TA-199 or if it's a detailed claim-level edit relationship, procedure code, modifier kind of thing, it will be a 277 claims acknowledgement.

Chris Carnez: Okay. Will this revision, this format revision, encompass Medicare secondary claims as well? Because right now they are so different from Medicare primary, that it's very difficult to submit secondary claims electronically without a lot of special handling.

Chris Stahlecker: We are - that is almost the second pass of our edit review. And we are looking at some of those issues now. So we are making every attempt to address those.

Chris Carnez: Yeah, because it seems like the vendors have difficulty with that, too, you know, when it's two different issues. And one more real quick question - how does all of this certification process with the vendors, how does it interact with the certification that's supposed to be happening for electronic medical records?

Chris Stahlecker: So I want to be clear about that. The certification testing is not with the vendors. This is something between CMS and the MACs.

Chris Carnez: Okay. But you said you were going to be listing vendors who would be tested or would show that they can, you know, generate these new formats and be successful with these new formats.

Chris Stahlecker: That's correct. And that's an existing requirement that CMS has with its FI, carrier and MAC. But each of those entities maintain on their own website, a list of vendors that are successfully using EDI transactions. So we're going to enhance that list, if you will, and make sure that each vendor has indicated that when they complete their 5010 testing with the MAC.

Chris Carnez: They may do that and yet still not qualify to be an electronic medical record vendor, right?

Chris Stahlecker: Possibly yes because what we're looking at are the EDI transactions that we mentioned - a claim, a remittance, eligibility inquiry/response, claim status inquiry/response - not electronic medical records. That is a separate project from what we're focused on.

Chris Carnez: Okay, thank you.

Operator: Your next question comes from the line of Savannah Fillman.

Savannah Fillman: Hi. Basically you had mentioned that each MAC will decide what the testing criteria would be. Will they also decide when we could start testing?

Chris Stahlecker: CMS is requiring each MAC to be ready by January 1, 2011.

Savannah Filliman: So there's no like early boarding or like we did with the transition from one contractor to the other?

Chris Stahlecker: Well, each of the MACs if they are ready and interested in engaging industry early adopters to test with them would be doing that kind of an outreach.

Savannah Filliman: Okay.

Chris Stahlecker: So as we get a little closer to it, we might have more of a process around it about doing that outreach, but I would say stay close to your MAC.

Savannah Filliman: Okay. Okay. Thank you very much.

Aryeh Langer: And we have time for one final question, please.

Operator: Your final question comes from the line of Diana Harvey.

Aryeh Langer: Diana, are you there?

Diana Harvey: Yes, I am. I was just wondering if the - you released flat file formats for the 4010 and the 4010 addenda for the transactions that you used. I was just wondering if you were going to be doing that for the 5010 transactions.

Chris Stahlecker: We do have those flat file formats completed. We will be, quite frankly there was an earlier point made about change requests, they'd like to see something official in change requests. The change requests that we have been working from to date have not been made generally available to the public until we, you know, get a little bit further in our design and development and implementation. But we will be making them available. So yes, we can make our flat file formats available.

Diana Harvey: Okay, do you have any idea when that might be, the time frame of those?

Chris Stahlecker: Now the flat file formats, of course, please remember, I just want to make sure you know what you're going to see is the format that will be delivered from our MAC front end system to our shared system.

Diana Harvey: Yes.

Chris Stahlecker: That’s what you’re - okay. We probably would be able to make that available within two months. I think our flat file formats are probably ready within a couple of months.

Diana Harvey: Okay, thank you.

Aryeh Langer: Thank you very much. At this time, I would like to thank our staff here at CMS, as well as all of you on the lines for participating in today’s call. We'd like to remind you to be on the lookout for the availability of the new website, as well as announcements of any future calls and other important educational information. Thanks again and have a great day.

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

END