Centers for Medicare & Medicaid Services
Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions Conference Call
Moderator: Aryeh Langer
January 25, 2012
2:00 p.m. ET

Contents

Operator: At this time, I would like to welcome everyone to the Medicare FFS Implementation of HIPAA version 5010 and D.0 Transactions Conference 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.

Aryeh Langer: Thank you, Holley. Hello, everyone. This is Aryeh Langer from the Provider Communications Group here at CMS in Baltimore. I would like to welcome you to the special National Provider Call on HIPAA version 5010 and D.0.

The target audience for today's call is vendors, clearinghouses, and providers who need to make Medicare Fee-For-Service–specific changes in compliance with HIPAA version 5010 and D.0 requirements.

We'll be hosting a question and answer session giving participants the opportunity to ask questions related to 5010 and D.0 implementation. As a reminder, today's call is being recorded and transcribed.

The transcript and audio will be available on the CMS Web site shortly after the call. That Web site is located at www.cms.gov/versions5010andd0. I'll repeat that Web address one more time: www.cms.gov/versions5010andd0.

Finally, if you would like to ask a question and did not get an opportunity to do so during the call, or if we ask you to send your message in to the resource box, please submit your question to the 5010 Fee-For-Service Resource Mailbox at 5010ffsinfo@cms.hhs.gov.

Please note that the mailbox will only accept questions for the next 24 hours. Questions and answers from this call will be posted on the Web site in the next few weeks.

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

Updates and Announcements

Chris Stahlecker: Thanks, Aryeh. And welcome, everyone. We're really appreciative that you carved some time out today to attend our call. And Happy New Year, belatedly.

We first wanted to remind folks that on November 17, CMS had announced an enforcement discretion period that would begin January 1 and go through March 31. So, although the compliance date for the new standards remains January 1, the emphasis is that enforcement discretion continues in this first three months of 2012.

So, I wanted to share with you a little bit about our current Medicare Fee-For-Service metrics. The numbers are looking fairly good, and we hope that your experience has been going well, but we'll talk a little bit more about that as our call continues.

On our Medicare Part A claim volume, we are at about 47 – a little over 47 percent on Medicare Part A as of January 16. And on our Part B, and, of course, that includes the irregular heartbeat claims and DME, the number, to date, is at 68.7. On our NCPDP standard, we are over 90 percent and on our eligibility transaction, the 270, over 83 percent are all using the 5010 format.

We have a few metrics to share before I continue on with a little bit of the Medicaid numbers. Let me give you, we are posting on our Medicare site – on our Web site – our CMS Web site the metrics that I just mentioned, and you can find them at the usual http://www.cms.gov/ediperformancestatistics, and the metrics that I just mentioned will be at that Web site.

On the Medicaid side, just a few spot check numbers that we had to share; Washington State is at 80 percent submitting, of the providers that are submitting 5010, Florida is at 90 – over 94 percent, Iowa over 85, Tennessee over 98 percent, Illinois is at 50 percent, trading partners are ready. So, we're making some steady inroads. I do not have a Web site where those numbers are posted, however.

We wanted to also share, because we wanted to make sure we're communicating with industry, that we had a number of fixes that have been implemented over the past, you know, six weeks or so. So, if you haven't had a good experience, perhaps some of these fixes will address that.

On the Part B side, we had some discrepancies with our national drug code set, and we needed to lighten up some of the front end edits, and December 9, we modified our NDC edit in our Part B system. And, although we are still editing for format, we are not doing a direct match with the FDA NDC code set, and that's within the front end systems.

And we did the same kind of lightening on the Part A side, and it was December 21 that the NDC edit code was lightened on the Part A side.

We also had some discrepancies with the "not otherwise classified" code set and we did issue a listserv message about how to interpret which codes might fall into the category of "not otherwise classified."

And the file that we had been using is one that was assembled with various components, review, and input on the – what code should constitute the "not otherwise classified" code set. And that code set was made available and put into our production operations on January 16.

So, some of those fixes are already in place and should be of some relief to those that were experiencing difficulties with the edits.

I'm going to speak about four more edits that are up-and-coming. One is the CAH edit, which is the critical access hospital edit, and we had issued a bit of a conflict in some of our billing instructions, and we have a prepared listserv message that should go out fairly shortly, and it will pertain to how additional information should be supplied on the claim in that it relates to the NPI information that would be in loop 2310 B and C.

So, we'll have – yes just please look forward to a listserv message coming out that will address critical access hospital providers and how they need to use

their NPI and the operating physician loops. So, if you have more questions, we can take them in a bit.

Another edit that should be up-and-coming is the 835 remittances. We had some difficulty with the shared system output and a particular segment called the SVC and we do have a fix for that that should be going in within the next couple of weeks as a workaround while the real permanent fix is – we're still waiting for a delivery date on that.

But, it has been holding up delivery in some cases on the 835 remittances, but we should see relief – so the MACs should be able to be addressing your 835 Part A remittances within the next week or two.

We'd also recently heard about three or four DRG codes that had not made it to a reference file that's being used in our front end systems and we are actively working on correcting that problem. That means getting the three or four code sets added to the edit file that choose in our front end system.

And, finally, an edit that we wanted to mention had to do with Medicare secondary payer claims. Some of them are being – on the party side, being sent to the return to provider process which means that the provider, although having billed the claim completely, the claim does go through the RTP process which requires a correction to be made. And we are actively working on expediting the delivery of that fix although it is currently scheduled for April – our April quarterly release.

Finally, what I wanted to mention, and this is a plea – this is a request that we are making – Medicare Fee-For-Service is making to the - primarily to clearinghouses, and it has to do with how the 837 claim files are being formed.

There is a perfectly sound way to create the transaction and it's not going to fail our translators; however, when a transaction file, and this has to do with a very large transaction file, is formed such that an individual claim is contained in an envelope, an ST-SE envelope, it does create a large burden to the MAC processing environment.

It's a – if I could create an analogy, it's like trying to read a book where every page has its own cover. And, although this style of formatting an 837 might be very appropriate for a real-time claims adjudication system, that is not the case that we have right now with our Medicare Fee-For-Services. We are processing in batch and that style of creating the 837 is creating a lot of overhead and not permitting our MACs to process effectively or efficiently.

We're asking if, especially the clearinghouses, but anyone forming a very large claim file, would be sure to not have more than 5,000 claims in an ST-SE envelope and, also, not have more than 10,000 ST-SE envelopes within an interchange.

We are experiencing bottlenecks and bulletin boards when there are more than 10,000 ST-SE envelopes in an interchange, an ISA-IEA, and we're experiencing severe throughput problems when there are more than 5,000 claims between the ST-SE envelope.

So, we're requesting that anyone needing to submit those very large files to a MAC, that you please have a look at how you're formatting them, and restrict the size of what you're putting in these envelopes.

Meanwhile, Medicare Fee-For-Service is going to be looking very closely at how we might edit those situations to cause claims to return when they are received in that fashion, but, for the moment, we don't have those edits in place and we are asking for your cooperation in how you prepare those claim files.

And, just one more point on the envelopes, and this is an issue that Medicare Fee-For Service expects to take forward and discuss at the upcoming X12 meeting next week. But, it has to do with matching the inbound claims, certain envelopes and pieces of information, with the outbound responses.

Now, we all know that the outer envelope, the ISA, is matched. Information that is responded to comes back to the sender in a TA1. So there is a data element, it's in the ISA13. We're strongly suggesting that the data content

that's in ISA13 is the same data content that would be returned in the TA1 transaction.

This is according to the implementation guide, the Excel implementation guide, so the technical report type 3. We just would like to begin to enforce it or request your, again, industry cooperation making sure that this information is mapped that way.

And the next lower envelope, the ST envelope, the TR3, requires or will stipulate that they return in 999 transaction the same value that is received in the ST02 would be returned in the 999s AK202 element.

And then the last one that I'm going to speak about is an 837 BHT segment, the element BHT03, the value that's placed there will be returned in the 277 claims acknowledgment transaction in the 2200B.TRNO2 data element.

So, if care is given to how the claim is formed coming in, you can be assured that the data elements will be returned to you in the TA1, the 999, and the 277CA to facilitate matching on the part of the sender so that you'll be able to know where the errors are identified.

So, we wanted to cover that in this call as well. So, excuse, please – that got down into some technical conversation and – but that is the information that we wanted to share at the get-go of this call.

Now, we would like to open up the call line and Aryeh will go over that in just a minute, but we're very anxious to have you tell us what your experiences are with your 5010 implementation, and if you are experiencing any difficulties other than what I have talked about, we're very anxious to hear about that. Thank you.

Aryeh Langer: Thank you, Chris. At this time, we'll pause for just a few moments to complete the keypad polling so that CMS has an accurate count of the number of participants on the line with us today.

Please note, there may be a moment of silence while we tabulate the results.

Holley, we're ready to start the polling please.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line.

Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between 2 and 8 of you listening in, enter the corresponding number between 2 and 8. If there are 9 or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between 2 and 8 of you listening in, enter the corresponding number between 2 and 8. If there are 9 or more of you in the room, enter 9.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Aryeh Langer: I'd just like to remind everyone before we start the Q&A session, if you could, please state your name and your organization name that you're calling from, and, in an effort to get in as many questions as possible, if you could try to limit your question to one per caller, we'd appreciate it. Thank you.

Question and Answer Session

Operator: Thank you for your participation, we will now move into the Q&A session for this call.

We will now open the lines for a question and answer session. To ask a question, press * followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the # key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity.

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

Your first question comes from the line of Tim Brosseau.

Jerry: Hello, this is Jerry first, I'm speaking for Tim with DataTel Solutions. We're a software vendor and my question has to do with several things.

First of all, is there a Web site that we can go to where we can see what the future edits are going to be? I've been scrounging through the CMS Web site and have been unable to find a location for that.

And, secondly, concerning ICD-10 that's coming up, the four diagnosis pointers that we have limited in the 5010 specification is going to cause a severe or critical issue when providing that information on a client. It takes four pointers just to identify a reason for a visit.

The commercial vendors are asking that we complete as many diagnoses as possible. Unfortunately, even though the specification allows us for 12, with there being only four per procedure, that's a severe limitation.

Chris Stahlecker: On the first question - let's go back to the first question.

Jerry: A Web site where we can find what your future edits are going to be so we can anticipate what's coming before we get lambasted by our customers on not providing that information or providing that edit.

Jason Jackson: Tim, this is Jason Jackson, and we do post those edits. They are actually posted in multiple locations. They automatically – because we do quarterly

change requests for the edits and whenever our change requests get issued and final, about five months before the release, they are actually posted.

Now, what you're looking at, you're probably looking for the Excel versions. Currently, I'm the one that maintains those on the Web site, and we only post the current, so, right now, it would be the January that's the most recent. With this call, I'll go ahead and I'll post, because April has been issued in final and actually the July spreadsheets will be issued in final probably within the next two weeks.

So, I will get those posted. If you go to our Web site, click on Medicare and then click on Fee-For-Service, 5010 and D.0, it'll be on the left hand side. I, unfortunately, don't have the exact link right now. You'll find that they're under Technical Documentation.

Chris Stahlecker: On your second question, on the ICD-10 question. You could, we have a resource box that Aryeh mentioned at the get-go of our call and we'll get that question over to our ICD-10 contact for them to respond to. Do you need, Tim, for Aryeh to repeat where to send your e-mail question?

Jerry: I think, do we have, did you send in the e-mail?

Aryeh Langer: I'll just repeat the resource box. It's 5010ffsinfo@cms.hhs.gov.

Jerry: OK. And, I'm sorry, your question again to me was…

Chris Stahlecker: Oh, if you would please send an e-mail to that location with your ICD-10 question about your procedure – the number of procedure codes.

Jerry: OK. Thank you.

Chris Stahlecker: OK. Thank you.

Operator: Your next question comes from the line of (Airgee Levito).

Airgee, your line is open.

(Airgee Levito): Oh, OK. Question regarding the description that's required for the unspecified or nonclassified codes. In the most recent memorandum that came out, it stated that for the nonspecific procedure code description, it would not error or be rejected if some of that verbiage was in that description field.

Now, does that mean that the CPT code or the HCPC code, whether it's a 99, if any of that verbiage stating not otherwise classified or unspecified, if we put that in the description field, will it go through and will it actually review for processing for payment?

Chris Stahlecker: Thanks for asking that question. It's Chris. It's a good question and there are two different process steps that we're trying to accommodate in order to pay the claim.

The first one is to get by the translator edit and if you are billing an NOC code, if that's one of the codes that your – you need to bill, then, yes, you do need to enter a description and that will get by the first level of editing and get the claim into the adjudication system.

However, the next step in the process is to actually adjudicate and pay the claim and, if you haven't put in a meaningful description in there, then the reviewer will not be able to understand what the procedure was performed for and not be able to make a reasonable decision about paying the claim.

So, we're asking when you do submit a description, for you to put in, to the best of your knowledge, what the procedure really was that was performed and that should do two things: it'll get by the validation edit, and it'll give the reviewer what they need to know to pay the claim.

(Airgee Levito): OK. Thank you, that answers my question.

Chris Stahlecker: OK, great.

Operator: Your next question comes from the line of Lynda Harstine.

Lynda Harstine: Hi. This is Lynda Harstine, Greene County Home Health, and I had sent an e-mail that requested a submitter ID set-up and it was answered on January 19

saying that I had been set up for the submitter ID, but please allow the 24 to 48 hours.

How do I know when that is done? I've not heard anything else so I'm not real sure what else I'm supposed to do. Thank you.

Chris Stahlecker: Well, I would advise you to call the MAC back and ask if you have not sent in a file and you really want to be assured that the submitter ID is operational before you submit your file, to go ahead and give them a call. Otherwise, after the 48 hours, you may also submit a file and, presumably, it will be processed.

Lynda Harstine: OK.

Chris Stahlecker: If you want to double-check, give that MAC a call back.

Lynda Harstine: OK. I have sent several claims through on it as a test and it's still just testing so I guess that probably is my other question.

Chris Stahlecker: OK, so you were asking them to switch you from test to production?

Lynda Harstine: Right. Yes, ma'am.

Chris Stahlecker: So I would call that MAC back and find out if there's a reason why they have not switched you over to production.

Lynda Harstine: OK.

Chris Stahlecker: If you're not getting any response, then go ahead and send us a note, in that e-mail resource box that Aryeh just read off, the 5010ffsinfo, and let us know the MAC that you're having difficulty with and we'll follow up.

Lynda Harstine: OK. Thank you.

Michael: This is Michael, your acknowledgment indicated the claims were clean, correct?

Lynda Harstine: Yes, the claims were all clean.

Michael: Probably just sounds like you need to inform the MAC that you're ready to switch them over. They may have already done it for you, too. We don't know that – that's each MAC can do that.

Lynda Harstine: OK. Thank you.

Operator: Your next question comes from the line of Amy Stoller.

Chris Stahlecker: Amy, you there?

Operator: Your next question comes from the line of Amy Stoller. Amy, please go ahead.

Chris Stahlecker: If you're talking Amy, you might be on mute.

Aryeh Langer: Go ahead and take the next caller.

Amy Stoller: Hear me now.

Aryeh Langer: Yes. We can.

Amy Stoller: OK. I had actually sent in a question back in December and listened to the call then, too, and never got a response with that e-mail box.

My question is that we're having issues with Indiana Medicaid and they're wanting proof that if it's a requirement of 5010, that the NPI number has to be the same when it crosses over, because Medicare and all of our other insurance companies we file, because we're a sole proprietor, but Medicaid is demanding that we file as a group so we're having an issue there.

And I don't know how to prove to Indiana Medicaid that what we're doing is right and that they need to adjust. Any suggestions?

Chris Stahlecker: Well, it is a Medicaid question that you have and today we're focused on Medicare Fee-For-Service, so go ahead and send the e-mail question in to that resource box and we'll get it to the Medicaid folks.

Amy Stoller: OK. Yes, I did. I sent it in already yesterday because you could do it the day before the call and I also did it last December – December 7 and never got a response.

Chris Stahlecker: OK. I apologize for that and we'll look specifically, we have enough of a description here. I think you're saying that – you're questioning whether or not the same NPI value has to be on the claim you send to Medicaid or to Medicare Fee-For-Service as you want to have – be on the crossover claim to Medicaid?

Amy Stoller: Right, because Medicaid wants us to file it with a group NPI number because their definition of a group and what Medicare and other insurance companies are two different things and they're arguing back and forth.

Chris Stahlecker: OK. Well, we do have a point of contact here at central office …

Amy Stoller: OK.

Chris Stahlecker: … that handles the crossover and another contact that handles Medicaid so we'll be on the lookout for that question and get those two areas to respond to you.

Amy Stoller: OK, great. Thank you very much.

Chris Stahlecker: All right. Sorry, Amy, that we didn't …

Amy Stoller: That's OK.

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

Rena Yeager: Hi. This is Rena. I'm with ZirMed. I've got a couple of people in the room with me. We are having trouble with the responses that we are receiving from a couple of the MACs. The 277s that are coming in from Palmetto, Trailblazer, and Cigna are coming in with a line feed every 35,000 bytes.

And this is causing these files to fail intake, and when we talk to Palmetto about this, they are telling us that the problem is not on their end; however,

Cigna has acknowledged that the problem is on their end. And so we're wondering if this is an issue that you have heard of, if you're aware of it.

And, secondly, we also are having rejections from Trailblazer for NPI not registered, but when we enroll the providers, we enroll the providers at the group level, but the rejection is at the rendering level. Can you help with either one of those questions?

Chris Stahlecker: Well, frankly, we haven't heard the level of detail that you just gave us on the line feed with the 277 claims acknowledgment. Actually, I'm not so sure that we've heard about 277 claims acknowledgment issues at all. So, if you want to send us the details on that, we can definitely follow up.

And, in terms, of the rejections for NPI not registered, this is a ticklish – if there's several uses of NPI, you know, we all realize and, first of all, you register for the Medicare program and you receive back an NPI, then that's the next – your next step is that you register to perform EDI processing and so your submitter ID may be connected to the EDI – or it's the NPI number that you are – that you supply when you enroll for EDI and it is that NPI that would be expected to be interrogated on the EDI transactions.

So, there may be a disconnect in where the NPI is being used versus how you have enrolled, either would – to perform EDI or in the Medicare program and then using an NPI on the detailed level of the claim.

So, if you have some specific examples, we could look into that and, again, not to get into the specific examples during this dialogue, go ahead and send that in an e-mail to us.

Rena Yeager: I'll be happy to send the e-mail, but part of the issue is we, of course, are a clearinghouse and so we assist our providers with the enrollment process, and the current process does not allow us to enroll those providers at the rendering levels.

So, and these – our customers, long-time customers, that have been submitting claims in 4010 and now it's suddenly rejecting in 5010. So, we were just

basically asking: is there a registration process that's separate from your enrollment process?

Chris Stahlecker: Yes, very much so. When you enroll in the Medicare program, that's something that you do with a MAC – oh, actually, both features or functions are preformed with a MAC, but you are not able to engage in receiving reimbursement from Medicare until you're enrolled as a Medicare Provider and, then, similarly, until you are enrolled for EDI, you're not able to exchange electronic transactions.

So, many of the electronic transactions are – your EDI enrollment is often performed at the group level, not at the rendering level, and that is an edit that was made more strict with 5010 over 4010 in that the provider number that was on the actual 837 claim, for example, is linked to the submitter ID.

And although as a clearinghouse, you want to perform a service for your providers, many times a MAC will require the provider to tell them which clearinghouse they are going to be using. So, it often does require the provider to engage in, not re-enrolling for EDI, but modifying their EDI registration to include a clearinghouse.

Vinia: This is Vinia with ZirMed. My question – I think what we're trying to get at is these transactions have been going through to the MACs and being processed in the 4010 format. It's not the 5010 where they're submitting the same NPI in the same loop and now they're saying they're not enrolled.

So, it seems to be a 4010/5010 issue. They were enrolled in 4010 and, now, all of the sudden, in 5010, they're rejecting and telling us the NPI needs to be enrolled.

Chris Stahlecker: We'd like to see the real edit number – or rejection number that you're getting back. That would be helpful for us to see, but we're suspicious that it's the intended tightening of the edits that perhaps we didn't, in 4010, compare the NPI with the submitter ID that we are now doing in 5010.

Vinia: Ok, I believe that rejection code was A7486. So, if we provide you with specific examples via e-mail of each of these issues, then we will get a response back? Because I have to echo the previous caller that said that she had sent questions to your e-mail box for previous calls and had not received responses either on the call or via e-mail. So, we do want to make sure that if we send the e-mail, that we will get an answer back.

Chris Stahlecker: For the most part, we've been able to respond to directly from this component. When we do need to go outside, we will coordinate better on this set of questions and my apologies on the earlier set of questions.

Angie Bartlett: This is Angie Bartlett, as well, and if you go out to the – next to the national call where the transcript is, we also list an FAQ document with all of the questions that we respond to from the national calls.

It doesn't answer specific questions really, but anything general that we think a group of people would like to hear, we do have that posted out there to the Web site as well.

We do try to respond to each individual question. Sometimes, like Chris had said previously, some of the policy questions have to get sent out and we have to wait until we get responses back.

Chris Stahlecker: And so to Angie's point, if there is a general trend in a question, we may not individually respond back, but put an entry in an FAQ list. So, but if you're going to give us this specific information, please don't send us PHI, that – yes we will get you some information back.

You know, I just want to make sure that we're speaking on the right topic here that providers, even if they're using a clearinghouse, may have a responsibility to contact their MAC and inform that MAC of the clearinghouse that they are using so that when the provider – when a claim comes through with that provider's NPI on it, it will pass the edit that we now have in place for 5010, that we didn't have in place for 4010, that matches the NPI with the clearinghouse submitter ID.

Betty: So, this is Betty. So, am I to understand that we – when we convert from 4010 to 5010, we were not asked to re-enroll all of these providers? They were already in your system. We did the testing, we passed, and we were approved for 5010. And so I would assume that they would have linked that – both NPIs to our submitter ID and so maybe they didn't and that's why we're experiencing these rejections?

We understand the process of enrolling the new provider and getting that linked, and we do have our providers do that work for - you know, we instruct them to do that, but these were already providers that were already live, and it was during this migration, this transition from 4010 to 5010, that we're now experiencing these types of rejections.

Chris Stahlecker: Hi, Betty. This is Chris. The – it does seem unusual, but – and I can't explain it without seeing some of the details, but we would have expected that if a provider was using the same clearinghouse and using the same NPI, that if you have gone through the test with that MAC using that particular provider's NPI, perhaps you tested and didn't use that provider's NPI, I don't know …

Betty: Yes. We were not required to test with every single one of our providers.

Chris Stahlecker: Right, right. So…

Betty: I mean, if we have need to re – I mean if we need to re-enroll, it would be nice for us to know that, then we would have done so, but that was not a requirement.

Chris Stahlecker: Right. I think some of the terminology is the blanket statement called "re-enroll." We would not have termed it "you need to re-enroll," we would have said "you may need to update your EDI enrollment information," or not even the clearinghouse would need to update it, it is the provider that needs to update their EDI enrollment information.

So, it's an update, not a re-enrollment, and that may be semantics to many on the call here. We don't mean to be using vague terms, but that is a very different process as a MAC.

Betty: Correct, correct. So, we will send you the example, and then I don't think it's every MAC, but we are having trouble with, particularly, maybe one in particular. So if you could assist us with who we – you know, we just want to resolve it for our providers.

Providers are experiencing a lot of pain in claims not being paid, and so we're faced with a wall where we can't reach anybody at the intermediary, you know, at the MACs, and so maybe that's where we want a little bit of assistance.

Chris Stahlecker: OK. We'll look for that e-mail from you. Thank you for bringing it up.

Betty: We sure appreciate it.

Operator: Your next question comes from the line of (Patty Brinkmeyer).

(Patty Brinkmeyer): Hi. I actually have a statement and then a question.

I have a statement in regards to missing 277CAs for institutional claims, and it's all over the place with that.

And then I have a question in regards to the newest MedLearn Matter that came out yesterday, MM7557, in regards to the attending physician ID on institutional claims. It says in part 2, "For claims with dates of service on or after April 1, 2012, Medicare will assure that only nonemergency trips require an NPI in the attending physician field."

According to the TR3, the only time that you need to have an attending physician is on nonscheduled claims: "Required when the claim contains any services other than nonscheduled transportation claims."

Chris Stahlecker: OK. Well, hey, it's Chris and I have to first let you know that we don't have our claims expert in the room with us. So, Patty, we might come back to your – we were unable to get them onto the line where he can speak and answer this question, but he is on the call.

So, he has heard your question, and he may take a moment and text us a message. We have a sort of a media gap here.

(Patty Brinkmeyer): OK.

Chris Stahlecker: Oh, he's back on?

Female: Matt, are you on the line?

Matt Klischer: Yes. Can you hear me?

Chris Stahlecker: All right, go ahead, Matt. Can you handle that question?

Matt Klischer: Because I need her to repeat what the MedLearn said. I think it was 7557, you said.

(Patty Brinkmeyer): Yes. It just came out yesterday. It says, "For claims with dates of service on or after April 1, 2012, Medicare will assure that only nonemergency trips require an NPI in the attending physician field. Emergency trips on institutional claims do not require NPI in the attending physician field."

Matt Klischer: That sounds exactly right.

(Patty Brinkmeyer): OK, then you go to the TR3 and it says, "Required when the claim contains any services other than nonscheduled transportation claims."

Matt Klischer: OK.

(Patty Brinkmeyer): Nonscheduled would be emergency transportation claims. Nonemergency trips are scheduled trips like to and from the nursing home to the hospital for treatment. Is that correct?

Matt Klischer: Right. So, you'd need an attending for those.

(Patty Brinkmeyer): But, that is not what this is saying. The TR3 says, "other than nonscheduled transportation claims." That means they want an attending physician …

Matt Klischer: For anything other than nonscheduled, that's correct.

(Patty Brinkmeyer): OK.

Matt Klischer: From what you just said was, right …

(Patty Brinkmeyer): Nonemergency …

Matt Klischer: Right. In fact, it's almost for everything. Everything except nonscheduled transportation needs an attending.

(Patty Brinkmeyer): OK. Right now, if you send any attending physician to the MAC with a revenue code 540, they're rejecting it whether it's emergency or nonemergency, saying you cannot have the attending physician on the claim if there's a 540 on the claim even though there's other revenue codes on the claim.

Matt Klischer: OK. What I'll need to – if you could please, send the actual 277CA error message, like the A7 or A6 or followed by the code because it's supposed to be more than just a 540, it's a 540 as well as other key things.

(Patty Brinkmeyer): No, if we have 540, a 270, a 450 on the claim, it rejects saying that you cannot have the physician on the claim.

Matt Klischer: OK. Just please send – you can send to me or send it to Angie Bartlett to send the actual …

Angie Bartlett: Send it to the – send it to the resource box please.

(Patty Brinkmeyer): OK, I can send …

Matt Klischer: OK, resource box with the actual error code that you're getting, please, ok?

(Patty Brinkmeyer): OK, and then can you address the 277CAs missing from processing when we get a good 999?

Chris Stahlecker: Or, hey, it's Chris, we're looking into that. We're – we've heard from clearinghouses, we've heard from MACs that, on some occasions, that even

though the 277 claims acknowledgment is returned from the MAC to a clearinghouse – now, Patty, are you with a clearinghouse or …

(Patty Brinkmeyer): Yes.

Chris Stahlecker: Or are you an individual provider?

(Patty Brinkmeyer): I'm with a clearinghouse. We work with about six or eight different MACs.

Chris Stahlecker: And you're not getting the 277 from the MAC?

(Patty Brinkmeyer): We're not getting it from WPS, Trailblazers, Noridian; those are the ones, right now, it's Noridian, PGBA, NHIC and these are all institutional. We also have the problem with professional with Trailblazers and with Noridian.

Chris Stahlecker: To some degree, I can understand where you may be getting back the 999 because that can come – if it's in a – there are no formatting problems, then that file can continue to be processed through – you can get a 999 that says everything's fine.

But, we're having some difficulty, as I said at the outset of this call, getting certain formed 837s has created a bottleneck in getting through our processing. So, if you're sending in very, very large files, there may be some problem like in which it would cause a delay in the return of the 277, maybe not a no return, it may create a delay.

(Patty Brinkmeyer): Some of the 277s have less – I mean some of the files have less than 300 claims in it. None of our claims have over 5,000.

Chris Stahlecker: I can appreciate that. However, those clearinghouses that are submitting the very large ones may be in front of you in the processing queue and nevertheless causing a delay in the entire stream of process.

So, we – it is an urgent request that I made at the outset of this call. Those clearinghouses that are sending in the very large files can have a negative effect on our overall throughput.

But please go ahead and send us some details on that. Again, don't send us PHI, but you can send us the day and the number of claims that you had sent and which MAC you had routed them to. That would be helpful for us to follow up and your submitter ID number.

(Patty Brinkmeyer): I can do that.

Chris Stahlecker: OK.

Operator: Your next question comes from the line of Lee Stickney.

Lee Stickney: Hi, this is Lee Stickney with HCRnet in Las Vegas. We're a clearinghouse and we've had a great experience so far with our MACs that we're dealing with. No problems.

Female: (Light laughing.)

Lee Stickney: Hello?

Chris Stahlecker: Yes. It's good to hear. Thank you, Lee, for saying that.

Lee Stickney: You're welcome. It's been a lot smoother than I expected it would be last September.

Anyway, we are experiencing one issue and it's kind of similar to what I've heard in a couple previous calls, and that is we've stopped sending the rendering physician loop when it's the same as the billing provider, and we're getting some rejections. Not all, but some providers are rejecting, saying missing, incomplete, or invalid rendering provider when there is no rendering provider loop in the claim.

Is there some sort of distinction that's made when it must be there, even if it's the same as the billing provider?

Chris Stahlecker: I'm not aware of any requirement to have the rendering be present when it is the same as the billing.

Lee Stickney: I wondered if maybe it had something to do with the billing provider using a group NPI and that's the only NPI he has or…?

Chris Stahlecker: I'm really not – Mike, I don't know.

Mike: I was going to say, if you can get us those, not the NPI, but if you could get us the MAC, the date, the 277 information …

Lee Stickney: OK.

Mike: We might be able to get the MAC track that – because if we're seeing that they're not performing exactly right, we'd like to know.

Lee Stickney: It's not being rejected in the edit or the 277; that's all going through clear, it's in the remittance advice coming back that's saying it's being denied for payment.

Mike: Oh, oh, oh, oh, that's in the adjudication system then. That definitely has to go to the MAC, but send us some information and we'll try and track the MAC down and see if there's a policy thing that we need to follow up with another component on.

Lee Stickney: OK. I can do that.

Chris Stahlecker: Thank you, Lee.

Mike: Yes. It's good we had that clarification.

Lee Stickney: Yes. Thank you very much.

Operator: Your next question comes from the line of Paul Grossman.

Paul Grossman: Hello, good afternoon. Earlier in the call, you had mentioned about an 835 remittance error – I'm sorry, 835 remittance edit. At this time, are the 835 remittances being transmitted, or are we going to need to wait until the next week or so when these edits have been resolved?

Chris Stahlecker: Hey, Paul, it's Chris. Unfortunately, this is an "it depends" answer. We have some MACs that have not turned the 5010 on in production, and it depends on

which MAC you are exchanging transactions with. So, for the most part, our MACs are returning 835s, both Part A and Part B, but we have some that are not sending Part A out at this time.

Paul Grossman: OK. How can I find out, you know, which MACs are sending and which ones aren't?

Chris Stahlecker: If you want to send us an e-mail, we will respond to you and we'll follow up with the individual MAC and find out how soon they will be turning – you apparently have already received your test 835s and asked that MAC to turn on production?

Paul Grossman: I think we have gotten one 835, yes, and we're actually looking to test with Medicare, and I know that it's out of scope here, but also with commercial providers as well, but I think we may have gotten an 835 already. I have to double-check that with one of our customers, but I know that that's one of the issues that I'm working on right now is testing with 835 remittances.

And, you know, that kind of – you know, and, also, with the edits, I mean, the ones that are coming – the ones that are transmitting, does that mean that they are going to be changing, or if they're not really correct right now? I mean, are these ones really, even if they are transmitting, are they even worth using at this point?

Chris Stahlecker: I think – I don't want to confuse the 837 claim edit with the 835 remittance situation.

Paul Grossman: OK, well, then I apologize …
Chris Stahlecker: Are you trying to do …

Paul Grossman: I thought I had taken a note that said that there was an edit for the 835 remittance and that it would be addressed within the next week or so.

Chris Stahlecker: It's not so much an edit as the formatting situation that exists right now in the claims system output to the 835 remittance. It doesn't affect every single remittance, so the MACs that are experiencing it at a higher volume have decided to hold back on sending out those remittances.

Some MACs are not experiencing it, and they are sending out the remittances, and some MACs have decided to go forward and send out the remittances and if they experience a problem, they have a workaround. So, we are moving forward with the workaround across all the MACs while the permanent fix is put into the shared system. We're trying to expedite the delivery of that.

So, the workaround solution should be operational in a week or two. So, if you're currently trying to – are you trying to test with an 835?

Paul Grossman: We're trying to test them, yes.

Chris Stahlecker: Are you productional with 4010?

Paul Grossman: We're trying to process them.

Chris Stahlecker: You process production 4010 835s?

Paul Grossman: 5010.

Chris Stahlecker: But you don't have any 40 – usually when you test, for the most part, folks have been productional on 4010, and then they request to receive 5010 test file equivalent of what they have in production for their 4010. But if you're just starting from scratch and trying to come up with 5010 – is that the case here?

Paul Grossman: No. We are in production with 5010, just during our testing process, you know, we were getting 999s and 277CAs, but we were not getting 835s during the testing process. So, we had to wait until now to start looking at processing the 835s.

Mike: Let's clarify. This is Mike. Let me clarify what you're stating here. The MACs weren't doing a "round trip" for every 837 claim they were going to send to the corresponding 835 transaction.

What they were doing was testing the claims acknowledgment model on the front end, and then it was up to you as a trading partner to request the parallel

835, which took your 4010 production live data and created a 5010 test transaction.

Once you were comfortable with that, you notified the MAC that you could begin receiving the 835 5010 production. They were flipping a switch for that. So…

Paul Grossman: OK.

Mike: Does that help clarify what – some of the confusion?

Paul Grossman: I think so – I mean, we're in production with 837. We're not – we're really not in production with 835 yet.

Mike: OK. And that's normal.

Chris Stahlecker: Yes, that's normal.

Mike: It's just when, you know, you can request, if you're the remittance trading partner for that set of claims, for the production parallel 835 to be created.

So, you'll still get your 4010 835, and then you'll get a copy of the same claims information in a 5010 format, and you'll be able to look at that in your system, translate it, figure out if you can do your postings or pass it off to your customers if you're a clearinghouse. And then when everything – you're satisfied with that part of it, you can tell the MAC I wish to get off the 4010 production 835 and switch to the 5010 835 in production.

Paul Grossman: All right. Well, let me ask this then. If I'm in production with 837, can I still get 4010 835s?

Mike: Yes.

Paul Grossman: Oh, OK. That's probably the case, and I'll have to double check that.

One last point then, where can I find the procedures for requesting this production parallel to the 5010 835?

Mike: Each MAC EDI Help Desk will just flip that switch for you. You just call your EDI MAC Help Desk, they'll do it.

Paul Grossman: OK.

Mike: They'll know what you're talking about when you want to run parallel.

Paul Grossman: OK. Alright. Thank you very much.

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

Chris Sermon: Hi, this is Chris Sermon from CBIZ MMP, and I just wanted to reiterate, somebody already called on this, 277CA. This past week, we are getting carriage return line feeds periodically within the files, and this was especially coming from Palmetto GBA.

Chris Stahlecker: Were you not getting it prior to this week?

Chris Sermon: Yes, that's correct. We've been doing 5010 for like probably since September, with Medicare getting everything switch over and not too bad of a transition, and we just ran into this issue.

Chris Stahlecker: OK. Thank you for mentioning that. That helps us do some troubleshooting. It may be a recent fix broke something else.

Mike: Is it on institutional or professional claims?

Chris Sermon: Professional.
Mike: OK.

Chris Sermon: And that's all I had.

Chris Stahlecker: Thank you for mentioning it, Chris.

Operator: Your next question comes from the line of Amanda Ashmore.

Amanda Ashmore: Hello.

Chris Stahlecker: Hello, how are you doing?

Colleen: Good. Hi, my name is Colleen, I'm talking for Amanda, and I have a question. We are calling from a provider's office, and we're getting our Medicare remittance advice, whereas they have these two particular codes, and we don't know why exactly. It's MA112 and N290, and we have the whole remittance advice that has the same denial code for all these patients.

What is that?

Mike: Those are two remarks codes that are probably on the 835s, I believe you're seeing.

Colleen: Yes, the 835s, that's correct.

Mike: I don't have an internet connection with me right here, but if you can look – if – I'll try and look them up while we're on the call.

Colleen: OK.

Mike: Off the Washington Publishing Web site and, from the description, we may be able to tell you that that's probably a policy reason why those claims were denied.

Colleen: OK.

Mike: And if – you know, there have been instances where some of the provider enrollment in the core system relative to NPI needs to be adjusted, and this is kind of what we were talking about earlier when Chris was talking with the clearinghouses, that there are actually updates to the 835 enrollment that had to be performed.

So, we'll try and look up the code from the Washington Publishing site while we're in the room to see if that sheds any light, but send your contact information to the PMO mailbox and which MAC you're getting it from – I'm sorry.

Colleen: I'm sorry. What is a MAC exactly. I'm sorry.

Mike: The Medicare Administrator Contractor; that's who adjudicated the claim. You have Medicare claims, correct?

Colleen: That's correct.

Mike: Yes, the MAC is the contractor that you send them to. You may be sending them to a clearinghouse, but they're the ones…

Colleen: Yes, we are.

Mike: …that sent you the explanation of benefits which has these codes on it.

Colleen: Yes.

Mike: And these are electronic claims, correct?

Colleen: Yes, that's correct.

Mike: OK.

Colleen: OK. So do we have to do the update, or does the clearinghouse have to do the update to fix this problem?

Mike: What we'll do is we'll look at your particular situation, we'll call you. These are remarks codes, and we'll try and have the MAC or one of our staff get back to you.

Colleen: OK. Thank you very much.

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

Genevieve Davis: Hi, this is Genevieve Davis with the Texas Medical Association. I just wanted to make a general question/comment. We're hearing from a lot of physicians in Texas who are not receiving any Medicare payments, and it's causing a huge financial burden for them.

We have been engaged with several of the clearinghouses and a couple of the practice management software vendors, and it seems to me that there's just a lot of finger-pointing as to who's responsible, but really no action being taken.

Several of the clearinghouses are telling physicians that it may take up to 30 days to get these issues resolved. We have concerns because practices cannot go 30 days without payment, especially if a large portion of their patient population is Medicare-based, and because Medicare prohibits them dropping their claims to paper, they're kind of stuck in this loop of trying to get their electronic claims out.

Is there any chance that CMS might go change that reg. temporarily to allow these practices to drop their claims to paper while the clearinghouse and CMS and other payers try to get these issues resolved?

Chris Stahlecker: That is something that we can take under consideration, not an activity, not a direction that we'd really like to go in without a lot supporting detail. So, you know, I appreciate …

Genevieve Davis: Well, I mean, you can easily, like for instance, Availity, who's a very large clearinghouse, they sent out a mass e-mail message to all providers that use them that said they are having problems getting their Medicare claims submitted, they're working on the issue, but that it could take several weeks for them to get the issue resolved and that they just asked for physicians to be patient.

And physicians will be patient, but when it's impacting their cash flow and they're talking about having to close their doors because they're not getting their Medicare payments, we want to know if there's something else that can be done.

Chris Stahlecker: Well, we certainly would appreciate your sending us a note to that effect. We have been in communication with that specific clearing house, Availity. We had a detailed conversation with them earlier this week, and we have a meeting with them tomorrow to go over some of the issues between the exchanges, and it's something that, you know, we are – as I said in the

beginning of this call, anxious that we have a different forming of the 837 transaction set other than very, very large submissions of claims and bundled up as if they were just interactive one-by-one.

So, we have some work to do, as any large system implementation might have expected to, in working through some of these start-up issues, but to your point in particular, we'd like to know exactly what you're facing, and so please give us the details in that follow-up e-mail.

You're saying, Genevieve, that your providers would prefer to go to paper.

Genevieve Davis: Well, not all of them would, but several have approached us and said, "We know paper claims will get paid, and we're being told by our clearinghouse that it could be 30 days." Well, when you have a practice that a third of their practice is Medicare, it's a cash flow issue.

It's really becoming a cash flow issue, and the providers really don't have any play in all of this. This is really a clearinghouse, software vendor, payer issue, and we are definitely not singling out Medicare, because we've heard that there are plenty of issues with several of the commercial payers, but in those, the practices that have gotten desperate have just dropped those claims to paper because they can. But with Medicare, they can't do that.

Chris Stahlecker: So, if you give us the specifics, again, who – which MAC it is that you're exchanging with and if you're Texas …

Male: She's the association.

Chris Stahlecker: I know you're the association so I don't know if all of the providers you're speaking on behalf of go to one of our MACs.

Genevieve Davis: They do. They use Trail – it's Trailblazer.

Chris Stahlecker: OK, so we can certainly discuss some options with Trailblazer.

Genevieve Davis: Thank you.

Operator: Your next question comes from the line of Leann Lewis.

Leann Lewis: This is Leann Lewis, and I'm wondering – for the most part, it's been a relatively good experience except in dealing with MACs and paperwork issues. I've been waiting for Noridian to put us in 835 production for nearly two months, and when you try to call to get a status on it, you call them and they say, "We're too busy to take your call at this time, please call back at a different time."

I've held for up to two hours and have been unable to get a hold of them recently. So, I'm wondering if anything is being done to address some of those issues.

Chris Stahlecker: Well, it's interesting that you mention the call volume, and we have looked at the metrics reports just earlier today, and our MACs are experiencing triple call volumes in some cases.

So, the fact that – we believe that it is linked to the claim file formatting problem that we spoke about at the get-go of this call, and that in order to get claim files through that …

Leann Lewis: This is 835, not 837.

Chris Stahlecker: No, no, no, I understand, but it's only one call center so if there are a number of calls coming in related to 837s, the 835 questions are not really – you know, we're not sorting them out to get to just those.

Leann Lewis: But when I activated the 835, they said it would be 7 to 10 business days, which was too months ago.

Chris Stahlecker: Two months ago. Again, if you give us the details. You're talking about Noridian, I hear you, but if you could send us your submitter ID and some return information in that e-mail, if you would send us an e-mail through the 5010ffsinfo resource box, we would be able to follow up on your behalf and get back to you.

Leann Lewis: OK. If possible, one more question. There was an issue where on crossover claims going through (inaudible) states like Washington, the taxonomy code was not being translated as they had to downgrade it to 4010 for the Medicaid crossover. Has that issue been resolved yet?

Chris Stahlecker: Since taxonomy code is not necessary in the Medicare claims…

Leann Lewis: It is required for Medicaid to pay for it.

Chris Stahlecker: Yes, I understand that. This is an old problem, and I'm not going to recall its resolution. When you send us that note, include this please.

I apologize, we don't have our – some of our experts on the call with us today.

Leann Lewis: OK. Thank you.

Chris Stahlecker: Thank you.

Operator: Your next question comes from the line of Vanessa Hunt.

Male: Vanessa, are you there?

Chris Stahlecker: Might be on mute, Vanessa. Check that out. Can't hear you.

Operator: All right. That question has been withdrawn.

Your next question comes from the line of Wanda Lilly.

Wanda Lilly: Hello?
Chris Stahlecker: Hello.

Wanda Lilly: Wanda Lilly from CHS Professional Practice. We're a provider's office.

Chris Stahlecker: OK.

Wanda Lilly: And we've just run into what appears to be a new edit that's kicking in. I have a Medicare remittance advice here for the DME MAC Jurisdiction A. And on the PECOS edit, the N544 – I spoke to a young lady today, her name was Lou.

She's telling me that the CEDI edits are a little different than the edit in the CMS system. And what it did is it took our physician's last name with the MD behind his name and it kicked it where the CEDI edit will just take the four – first four letters of his last name.

Are you aware of this yet?

Chris Stahlecker: No, actually. We hadn't heard about this one yet. You – so you're saying that although it – the bills came through CEDI with the name forms with MD. Once it got into the claims system, it kicked it out because it had MD at the back end of it.

Wanda Lilly: Correct. And when I spoke to Lou, she said I was – they've had a lot of providers call – she had a lot of providers calling with the same rejection. However, I was the first one who called in and could give her an example that on the same remittance advice I had the same provider as a referring ordering and they passed through. They got paid.

Chris Stahlecker: So, paid is when this name is used as the referring or ordering physician but not when they are the billing physician?

Wanda Lilly: No. What I'm saying is the same information went through on two different claims. One rejected. One didn't. Same physician. It's our physician, and he, you know, we went through the big exercises of making sure all of our docs were in the PECOS system.

And then the other thing I did do, and maybe there was more to this from our end, I pulled up our on-line the ordering/referring report that's available that we can go look to see if our clinicians are listed. This particular one's no longer there. So, we're also talking to provider enrollment.

But the fact that I have two claims here with the same physician as the ordering/referring/rendering. Everything's identical except for the patient name and the service line item. One passed and one didn't. And it's all because it picked up the MD in the physician's last name field.

Chris Stahlecker: OK. We can take a look at that if you get the details.

Wanda Lilly: OK.

Chris Stahlecker: Add it to the component to have her look at.

Wanda Lilly: Where shall I send it?

Chris Stahlecker: That resource box that was mentioned earlier. Do you need that again?

Wanda Lilly: No. That's – you have it listed on your paperwork.

Chris Stahlecker: OK. Great. Thank you.

Wanda Lilly: Thank you.

Operator: Your next question comes from the line of Jeremy Smith.

Jeremy Smith: Hi. This is Jeremy Smith from Emdeon. A couple of things I just wanted to touch base on, the error that a lot of folks are mentioning with providers no longer being linked to a submitter. We are also seeing that. And what we found, of course I'm working with the different MACs on this issue, it's just a simple matter primarily of providers that were linked in 4010 didn't get transitioned to our submitter number that they were linked to in 4010 when we went to 5010.

So, you know, we're trying to identify best we can to help minimize the impact for providers and get them set up. Which is, you know, can basically be done with a list of NPI and PTAN, but the issue does definitely exist. It does seem to be across all MACs, the Trailblazers, Railroad, and some of the Palmetto J-1s, we've noticed the heaviest impact. But of course, we have a larger client load in some of those states, too, so that's why I think we see that. But I just wanted to mention that just for everybody's information.

Additionally, in talking about the batching of claim files, I just want to make sure that I understand, because we are making efforts to give you what you want. I mean, right now I think the bulk of our payers are 1-ISA to IEA with multiple ST to SDs in them, with each ST to SD reflecting one billing

provider. And that seems to be a problem, and it seems to be sort of what you're requesting here.

So, actually what end we're working towards is 1-ISA to IEA per billing provider. And in some instances what will happen if we change our batching to that is – and of course, it'll be a smaller case of this happening – but if a provider sends us one claim, we're going to batch it up as 1-ISA to IEA, but that, of course, has an ST in it, an ST to SE, but that ST to SE is going to have one claim in it.

So, I just want to make sure, you know, I understand clearly what you understand the preferred method of delivery to be given that I'm currently pushing efforts to have us send 1-ISA to IEA per billing provider because really, that's the only way that ISA 13 even can be the same value as what you guys are requesting, be the same value in the STL2 and the BHT03 if we had multiple STs inside that ISA to IEA, that ST value and the BHT03 won't match up to what the ISA 13 is.

So, does what we're pursuing sound like it's right?

Chris Stahlecker: Actually, no. It doesn't. It sounds like it's going to be even worse than what we have on our hands today.

Jeremy Smith: You're going to end up with probably a larger amount of files.

Chris Stahlecker: Right. We're not…

Jeremy Smith: Number of files.

Chris Stahlecker: We're anxious for fewer but reasonably sized files. We've had some MACs tell us that, you know, they had 75,000 claims, but each of those claims was within a separate ST to SE and that is just killing folks.

We had another MAC that the bulletin board went down when there was more than 9,999 ISA-IEAs received in a day. So, you know, we have a balancing act that we need to get through while, you know, the sizing of these new files is accommodated.

So, we're told that a reasonably sized number of claims between an ST and SE would be in the ballpark of 5,000 claims.

Jeremy Smith: Yes.

Chris Stahlecker: So, if you need to have the ISA ST, you know, bundled up and packaged for 5,000 claims, that would be reasonable.

Jeremy Smith: Well, we're doing that now and we're not seeing the performance, that's why that, you know, for example NGS initially was the biggest culprit of delays. Of course they still have a published one, you know, that they're working through. But what they've asked us to do is just that: send one ISA to IEA per billing provider.

And you know, basically the only down side to doing that – of course, that means we're going to be sent at least one file per provider per day. So, if we had 100 providers in that – in that particular region, we're going to see 100 files. But if that provider sends to us multiple times throughout the day, you know, we're not waiting for one particular time in the day to send. We'll send hourly because the volume, it dictates that we do so.

So, that, you know, that provider may have three files on any particular given day, so it could bring it up to 300 if you had 100 based providers in that region.

So, and it seems to be OK. NGS seems to be responding better with that. I guess I – I guess I'm just wanting to understand.

Chris Stahlecker: Yes. Let us take your question and – under advisement and our direction, and we will be issuing some instruction to our MACs, and we'll put out a very clear message as a listserv. So just hold tight on it and we'll do some backtracking and make sure that we are – what I articulated earlier in the call is exactly what our MACs are telling us.

So, from what you're telling me is it may not be. So, I need to backtrack and get some more input.

Jeremy Smith: Yes. I mean, I can see it being that but my, you know, especially the initial comment of don't send one claim per ST to SC. I can see that. But typically, that's not what we're doing, and we're seeing, you know, some of the delays. Of course, it can be backlog from others as well.

But I guess – and then the other general question I had is I'm not a super biller here so, anything you can kind of explain to me as to what are some of the significant changes providers should make note of as it relates to reporting zip plus four in some of the real heavy loops, whether it be the billing provider or your service location, or maybe even the SBRs. If you could kind of just give me a general overview of what needs to, you know, what needs to happen to make sure they don't see failures at that level, I'd really appreciate it.

Chris Stahlecker: So, what you're asking is when is the zip plus four required?

Jeremy Smith: Well, in some regard, yes. Was the zip plus four required? And moreover, you know, what does that data contact need to be, and kind of what's it being used for? So, you know, if a billing provider in 4010 sent a five-digit zip and they don't send a nine-digit zip and so – let's say, for example, our system may default to zeros or 9998, or whatever it might be to try to help satisfy that edit.

What, you know, you know, when is it needed, I guess, you know, maybe what loops, and then how is it used? You know, does – and the billing provider loop, it says send four zeros, you know – why is that going to reject? Is it looking up against something? Or, why they reject type of thing?

Chris Stahlecker: For – what you're speaking of, for professional claims, the zip code plus four is required in the billing provider zip code field, and the service facility is zip code field for 5010 only. So, those are the only two fields that are going to require your nine-digit zip code.

And I think if you put – it'd be really helpful to you to go back and look at our earlier presentations that were done about this time – January, February timeframe of last year. And look at the 837-I MD Professional and know (inaudible) related to the exact billing, and we did address the zip code.

But you know, we are using it for some matching purposes, and that's why back-filling it with zeroes isn't going to – necessarily going to work in all cases.

Jeremy Smith: Sure. And, you know, what would be like some of those – you know, are we validating the last four on that for some reason? Or, I mean, in other words does it – I'm assuming it has to be a valid zip code or it's going to reject for USPS you know, invalid.

Chris Stahlecker: Well, all zeroes is – are not a valid numeric. It's not a valid zip code. So you can't just fill it…

Jeremy Smith: Sure.

Chris Stahlecker: …but we are just looking for a zip code that will pass, you know, United States Postal System zip code in it. That is what the requirement is in the TR-3.

Jeremy Smith: OK. Yes. That's the answer I'm looking for.

But yes, and then going back on that enrollment thing, I mean, it's definitely an issue, and I don't know what you can do on the outreach there, you know, because providers are being told basically, you know, as they call front levels, EDI setup forms, zip and, you know, if they send in updated ones. We'll, of course, correct the problem, but the reality is, you know, these are providers that were linked to the submitter. I – you know, in this case it's Emdeon, but linked to a submitter number 4010, and that slip of linkage was supposed to be transparent to the provider based off that submitter.

And we're just finding it isn't, and for sure TrailBlazer and Palmetto seem to have the biggest volume, but I have seen it with MGS, WPS, High Mark, Pinnacle– well no, of course Pinnacle– no, I shouldn't say that, because they have their own onboarding site that providers have to control. They have their own unique submitter number they assign to those providers. So, they're …

Chris Stahlecker: It is a function of trading partner management, and although 4010 had a submitter ID, and the providers who were submitting through a clearinghouse using that submitter ID were all authorized, of course.

As you swing over to 5010, you have to realize that we went through a test process, and then that provider needed to be set up for production. So, it is a multiple step process, and it's not just a blanket approval.

We have been – Medicare Fee-For-Service asked for dual processing capability 4010 and 5010, and you know, it wasn't a cut over. It wasn't a blanket setup, so providers do have to take a step there. It's not a re-enrollment. It's an update.

Jeremy Smith: Well, that's the thing. There is no such communication from any MAC to that regard. That definitely does not exist. I mean, there are instances where, you know, a provider truly needs to enroll. But if they were linked in 4010 to a submitter number, that link, from every MAC was supposed to be transitioned based off that submitter number, and there are plenty of reasons that are justifiable it's missed.

But when that call is made from the provider or the folks supporting them, you know, the answer they should be receiving is: oh yes, we see that they're linked in 4010; we'll link them in 5010, you know, thank you. Have a good day.

And if there's any reason they need some additional information for – from that provider – whether they've changed PTANs, NPIs, or tax IDs or what have you – you know, they can certainly and it should request that they get updated enrollment forms, but to just immediately start denying them and not allow for that linkage to be restored, even if it's only restored temporarily as they get updated information, is really going to impact the small providers. The big providers, you know, they have the cash flow to back themselves up.

But as it's been stated, you know, those small providers, they're in dire straits, and pulling out their kids' college tuitions and stuff to make payroll. You

know, it's just something that needs to be looked at. And I think the contractors I'm having fairly good success with, you know, Trailblazer and …

Chris Stahlecker: Jeremy, I think we have – I think we have the essence of the – of the issue…

Jeremy: Sure.

Chris Stahlecker: ...If you can go ahead and send us something more to that resource box if you – if you need to, but I think we have the essence of the issue. Thank you.

Jeremy: OK. Sorry.

Chris Stahlecker: OK.

Aryeh Langer: We have time for one more question, please.

Operator: Your final question comes from the line of Jessica Roe.

Jessica Roe: Yes. I had a question regarding the Medicare crossover claims that crossover automatically. We're having our payments sent from the secondary insurances to what's listed in the billing provider address loop instead of what the "pay to" address loop is when we transmit claims to Medicare.

And the secondary insurances are telling us that what they're getting from Medicare is just a billing provider address. And I wasn't sure if there was a way to make sure that when things crossover that our "pay to" address is sent to the secondary insurances also?

Chris Stahlecker: I think I'm confused with what the flow is here. So, are you billing Medicare secondary claims and crossing over to a tertiary payer?

Jessica Roe: No. They're Medicare primary claims.

Chris Stahlecker: Medicare primary. OK.

Jessica Roe: And we're sending our physical location in loop 2010AA and our P.O. Box in 2010AB, and when those claims are crossing over from Medicare to secondary insurances, supposedly the "pay to" address loop is not going over.

It's just the billing provider address loop that is. So, we have payments going to office locations instead of the P.O. Boxes.

And in some cases, we have insurances that are paying them to whatever it seems Medicare has listed in their system as our primary practice location.

And not even any address that's on the claim we're transmitting.

Matt Klischer: This is Matt. Is this happening mostly on your professional claims or institutional or both?

Jessica Roe: Professional.

Matt Klischer: OK.

Chris Stahlecker: Why don't you go ahead and submit that to our resource mailbox, and I can get someone from our…

Jessica Roe: OK. Yes. I already did this morning but I didn't – I thought that maybe if I could get a chance, and maybe you guys might know.

Chris Stahlecker: Well, thank you. I'll look into a response on that.

Jessica Roe: OK. Thank you.

Chris Stahlecker: Good question. Thanks.

Aryeh Langer: Well, thank you, everyone, for joining us on the lines today. I'd like to thank our staff here at Medicare Fee-For-Service here at CMS who've graciously been here to give an update and answer questions, and, as always, look out for listserv messages, eNews messages, that we plan on sending out.

And please frequent the 5010 Web site for more information.

Thank you so much for joining us today.

Operator: Thank you for your participation in today's conference call.

You may now disconnect your lines. Speakers please hold the line.

END