

## HIPAA ROUNDTABLE TRANSCRIPT MAY29, 2003

Operator: Good afternoon. My name is Kimberly, and I will be your conference facilitator. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Ninth National HIPAA Implementation Round Table conference call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer period. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

I would now like to turn the call over to Dr. Bernice Catherine Harper . Ma'am, you may proceed.

Dr. Bernice Harper: Thank you, Ms. Nelson. Good afternoon to those on the East Coast, and good morning to those on the West Coast. Again, it is my pleasure to serve as your moderator of the round table. This round table call is being conducted by the Centers for Medicare and Medicaid Services or better known as CMS, which is part of the Department of Health and Human Services.

Our subject today is the Health Insurance Portability and Accountability Act of 1996 or HIPAA and, specifically, the Administrative Simplification Provision. There are four administrative simplification provisions: one, unique identifiers; two, privacy; three, electronic transactions and code sets; four, security. We will begin our call with a few words from Karen Trudel, Deputy Director of the Office of HIPAA Standards at CMS.

Karen Trudel: Thanks very much, Dr. Harper. Good afternoon. It's good to be able to speak to all of you again. Between now and October the health care industry, all of us, are going to be addressing the challenge of becoming compliant with the HIPAA electronic transaction and code set standards. The deadline for compliance, as I'm sure you all know, is October 15th, 2003, which is only 140 days from now.

Electronic commerce is like a handshake. It's important for everyone to assure that not only are they able to send compliant transactions but that their trading partners can receive and accept those transactions. Although this is a huge undertaking, the result will be greatly enhanced electronic communication throughout the health care community. Successful implementation will require

the attention and cooperation of all health plans and clearinghouses and of all providers that conduct electronic transactions. That's why communication between trading partners and early testing is so important.

Health plans and clearinghouses need to make sure they explain their testing procedures and schedules to the providers they do business with and to be ready to start testing as soon as possible. Providers need to make sure their software vendors or billing services have made any necessary changes so that they are ready to test in a timely manner. If you're a provider, don't assume that someone is already doing this for you.

If these handshakes, these electronic handshakes don't occur, provider cash flow could be jeopardized, and with that comes the danger of impacting patients' access to health care. This is not an acceptable outcome in our book. Our combined goal should be that on October 17th everyone is operating in a HIPAA world and no one notices any difference. Time is running out, and I urge you to focus the attention and resources necessary to make this goal a reality.

Now we have a lot of information to communicate to you today, so we're going to go ahead and get started. I'd like to introduce some of the people who are going to be speaking. We do have some presentations for you today. We will have with us Stephanie Kaminski, we've had with us Stephanie Kaminski, from the Office for Civil Rights that will be available to answer questions that you might have on privacy. We have Elizabeth Holland who is our team leader for outreach who has some messages for you that has to do with outreach tools and things that can help you become compliant. And we have a representative from our office of information services who appears to be Joy Glass at this point who is going to talk a little bit about Medicare free billing software and the status of Medicare testing. And with that, I will turn it over to Elizabeth.

Elizabeth Holland:

Thank you, Karen. First I wanted to respond to one of the many questions that we keep getting. It has to do with the Medicare waiver for small providers billing on paper. The Administrative Simplification Compliance Act or ASCA included a provision that effective October 16th, 2003 Medicare will not accept paper claims. However, ASCA did provide exceptions for small

providers, that is practitioners with fewer than 10 full time equivalent employees or institutional providers with fewer than 25 full time equivalent employees.

There may also be other limited exceptions. Regulations clarifying the exceptions are expected to be published soon. If you believe that you meet the small provider exception, there is not a waiver for you to apply for at this time. Just continue to bill via paper. We will provide further instructions on how to obtain a waiver after the regulations have been published. If you are not a small provider, we'd recommend that you prepare to bill Medicare electronically using the appropriate HIPAA transactions.

I'd also like to share with you some of the information that's available on the CMS website. That address is [www.cms.hhs.gov/hipaa/hipaa2](http://www.cms.hhs.gov/hipaa/hipaa2). There we have, under "general information", 60 frequently asked questions. We also have covered entity decision tools to help you determine whether you are considered a covered entity under HIPAA. Also under "educational materials" we have a series of 10 informational papers on HIPAA for providers. That's all I have.

Karen Trudel:

Okay. Thank you very much, Elizabeth. We also have a Medicare update on the status of Medicare fee for service implementation activities. And I'll turn it over to Joy Glass.

Joy Glass:

Hi. Our contractors have been working to update the software to include the addenda changes. We expect that the contractors should have completed those changes, tested, and the software should be available to you by the end of May. Contact your Medicare contractor and they will provide you with the addenda free billing software available.

In regard to submitter testing status, we haven't see that much of a change from the previous month. We have about 3% of our submitters that are in production on the claim. We are working on open testing of coordination of benefits transaction, but we haven't moved many in production on that transaction. We just recently polled our contractors to see where they were in testing with the addenda. And the majority of our contractors are ready to test the providers and their COB trading partners. We certainly encourage you to contact them and begin testing. We are aware of some known problems with some translators and we are working with

the translator companies to resolve those issues. That does impact a few contractors, but the majority are ready and willing to begin testing.

Karen Trudel:

This is Karen Trudel again. Let me reiterate that statement that Joy made. It's really critical if you do bill Medicare electronically that either you, if you submit directly, or the clearinghouse or whoever submits on your behalf, contact the Medicare carrier or fiscal intermediary that you do business with and schedule yourself for testing. As time gets closer to October and more and more people get into the queue to test, it's going to be harder and harder to make arrangements and schedule time and to get the attention of the carrier and intermediary personnel. So early testing is the very critical part of a smooth transition.

Thank you, Elizabeth and Joy, for the update. And I think we're about ready to go into the question and answer portion of the call.

Dr. Bernice Harper:

Ms. Nelson, will you give us the instructions for the call please?

Operator:

Yes, ma'am. At this time I would like to remind everyone, in order to ask a question, please press star, then the number one on your telephone keypad. And your first question comes from Patrice Taylor.

Patrice Taylor:

Hey, Karen and everybody.

Patrice Taylor:

We were wondering if the contractors could be required to put their readiness plan in an easy to see format on their website or if you'd be willing to do it in that national arena that WEDI developed with CAQH. But it's very time consuming to track our contractors and carriers and have to call the EDI department, are you ready for this transaction to test, or are you in production? And most payers just have like a little grid with every transaction and this is the date I'm ready to test and then production and then a contact. Think that's something you would consider?

Karen Trudel:

Patrice, that's a good idea. We'll put our heads together with the folks who would have to develop that instruction. And if we are able to do that, we can send out a message on the outreach list serve that would tell people where to go to get it.

Patrice Taylor:

It would be great because we do find -- that we are having a hard

time finding out like what are you planning to do with the 270, 271 or remittances. Claims, you know, you guys pushed a lot, but there's some other things we have to convert also. So we want it for all transactions.

Karen Trudel: Okay. That's fine.

Patrice Taylor: Thank you.

Dr. Bernice Harper: You're welcome. Next question please?

Operator: Your next question comes from Julia Mathis

Julia Mathis: Hi, everybody. This is Julia Mathis with Seimens Home Health. I was attending your last conference call, and at that time I had reported that all four of the home health intermediaries were actually not quite ready for the version 4010 A1 testing, and I'm happy to report this week that as of yesterday two out of the four we've passed testing with, and they were ready for version 4010 A1. I take it from the previous remarks that you expect everybody else to be ready probably by the end of this month. I'm thinking Palmetto won't be because they wouldn't give us -- they wouldn't commit to end of the month, but maybe they're close. UGS also I don't think is ready. But Cahaba and Maine are ready and have passed that.

My question is, if other ones are not ready in June, do we have any contingency plans, or you just don't expect that to happen?

Janice Nero-Phillips: Hi. This is Janice Nero-Phillips. We don't have a contingency plan, but we are pushing our contractors to get their translators delivered and be on 4010.A.1 as soon as possible. So I would suggest that you keep checking with the contractors that you just mentioned about their 4010.A.1 readiness.

Dr. Bernice Harper: Thank you.

Julia Mathis: Okay. Thank you.

Dr. Bernice Harper: Next question please.

Operator: Your next question comes from comes from Fundi Procrasia.

Fundi Procrasia: Yes. I was just calling to see if you all have any information -- I haven't received any e-mails about the video that's supposed to be coming out for the security implementation for April 2005. I know it's kind of early to test that, but I was just checking on the status of that.

Elizabeth Holland: This is Elizabeth. We are planning to do a number of security informational materials. We have not yet decided whether we will produce a video or whether we will instead produce some sort of webcast package. But we're expecting we will have something available probably early next year.

Fundi Procrasia: Next year early. Okay.

Karen Trudel: Right. We are working on informational content at this time. And we had initially thought that we would do a video because they have been so well received. We're also finding that webcasting is proving to be a very successful tool also, so still looking at our options for one versus the other.

Fundi Procrasia: Could I ask what webcasting is specifically? Is that like a conference via the Internet?

Elizabeth Holland: Essentially you can see the whole program on your computer screen, and you can click on different aspects of it. So you can repeat a section if you need it repeated. You can see all the graphics, you can print them out. It's just an easier way to view a program than via video.

Fundi Procrasia: Oh, it sounds like it probably would be even better.

Elizabeth Holland: Uh-huh. That's what we're hoping.

Fundi Procrasia: Okay. Thank you very much. I appreciate your feedback.

Dr. Bernice Harper: You're welcome. Next question please.

Operator: Your next question comes from Brian Ross

Brian Ross: Hello. We have three questions. The first two are kind of related to each other. First question -- the first two questions are, what was CMS's reaction to the AHA letter, and do they have any type of comment to the comments made about the system wide

implementation plan?

Karen Trudel: We're still doing analysis on the AHA letters. We haven't provided a response yet.

Brian Ross: Okay.

Dr. Bernice Harper: Next question.

Brian Ross: And we've got one more question.

Dr. Bernice Harper: We realize that.

Brian Ross: Oh, I'm sorry.

Dr. Bernice Harper: Thank you.

Female Speaker: Linda Peppa

Linda Peppa: Since the National Provider ID has not been implemented, the feedback that we're getting from payers is that they are warning providers to use payer specific IDs. For a large clinic, 200 plus physicians, doing business with only 10 payers, this means 2000 separate ID numbers. Is there any way to resolve this situation?

Karen Trudel: Well, as I understand it, that's the situation that we've been faced with for a number of years, which was the impetus behind the national provider ID. Again, the regulation is nearing the end of the clearance process, and it's scheduled to be published when?

Stanley Nachimson: September.

Karen Trudel: September. And until we are able to roll out identifiers and actually get them implemented into planned systems, I don't see how we could require plants to do anything else that but use the identifiers that they've been using for years now. I understand your frustration, and we're moving as quickly as we can, but these are not easy things to do. And as always, the devil is in the details.

Dr. Bernice Harper: Mr. Ross, did you have another question?

Brian Ross: Yes. I guess the problem there is between not having the provider IDs and not having the payer IDs in place, we've got a number of

gaps that are required of your all's components to the 837s. And so here we're trying to submit and move to that format, whereas before we kind of lived with it, now we've made these required elements, so we're going to move forward and implement these transactions in the absence of several of the pieces that support those transactions. We're just kind of stuck with this gap here.

Karen Trudel: Well, I wouldn't call it a gap as much as I would call it a timing issue. But the transactions are at this point engineered to take a national provider ID when ready and any number of payer specific IDs until that time. And so it is perfectly possible to implement the 837 without having a provider identifier.

Brian Ross: I think you get back to the limitations of your SAR [PHONETIC] systems again where if I look at an HIS [PHONETIC] system, I don't have somewhere to put, you know, that number of potentially different ID numbers. And before, again, it was not necessarily required in all circumstances. Now we've moved to the point of requiring it, and there lies the difference.

Karen Trudel: Okay. Point well taken.

Dr. Bernice Harper: Thank you, Mr. Ross. Ms. Nelson, the next question please.

Operator: Your next question comes from Darlene Hamblen.

Darlene Hamblen: My question is the Internet address that we were given, she went so fast that -- could you repeat that.

Karen Trudel: Elizabeth will do the Internet address again along with some updates at the end of the call.

Darlene Hamblen: Thank you.

Dr. Bernice Harper: You're welcome. Next question please.

Operator: Your next question comes from Shawn Wilson.

Shawn Wilson: This is Shawn Wilson with Wayne Care. My question is on the NCPDP companion guides, I was told that it was released Friday the 24th. I can't find it on any website at CMS. Where can that be located?

Janice Nero-Phillips: Hi. This is Janice Nero-Phillips. That HIPAA document should be out on the Medicare/provider/EDI website momentarily. You're correct that it was released last Friday, May 23rd, and we will check to see if it has been posted. But it should be going up momentarily.

Shawn Wilson: Thank you.

Janice Phillips: You're welcome.

Dr. Bernice Harper: Next question please.

Operator: Your next question comes from Steve Kaplan.

Judy Komido: Yes. Actually, it's Judy Komido from Trinitos Hospital. My question is that we have contracted with a clearinghouse in order to provide us with these electronic transactions. However, we're finding it very difficult to get this company to move ahead with all the transactions and the testing. Now we do have a contract with them. What is your suggestion if they don't come through for us?

Karen Trudel: Is the clearinghouse having problems with all the transactions or just specific ones?

Judy Komido: Right now I believe it's specific transactions.

Karen Trudel: Is it the claims?

Judy Komido: No, it's the payment transactions and authorizations.

Karen Trudel: Okay. It is -- I can't speak to your contractual obligations that they have, but it is my understanding that in some cases clearinghouses and vendors are choosing to roll out transactions in the order of the WEDI recommendations on sequencing, which essentially put the money transactions, the claim and the remittance and the coordination of benefits towards the front and some of the other transactions a little bit towards the back of a sequence. And, therefore, you may find that they're not ready to implement them all at once.

I think what you need to do is to talk to your clearinghouse, find out when exactly they're going to be ready, and begin to look at contractual issues. Decide if they aren't prepared to do those

transactions on October 17th, what is the impact on your business operations and what other contingencies could you put in place.

Judy Komido: Thank you.

Karen Trudel: You're welcome.

Dr. Bernice Harper: Next question please.

Operator: Your next question comes from Kelly Wibbenmier.

Kelly Wibbenmier: Hello.

Karen Trudel: Yes.

Kelly Wibbenmier: Actually had a question that piggybacked off of the one that was just asked. I'm with a children's hospital, and I'm having the same exact problem. One of our clearinghouses we actually started testing back in October by sending them files. And we had done the same thing, we had contracted with them to put our 837 in a HIPAA compliant transaction standard format, and we're still getting 100% error files back from them. And I've called and talked to them and talked to them, and I've talked to them about contingency plans, and I've talked to them about what will happen, you know, if they don't in fact get that HIPAA compliant 837 transaction, and I really don't get any answer really. So I was just wondering what would your recommendation be once I've actually gone that step and asked, you know, what are contingency plans, what do we do if you are not prepared, and they really have kind of been passing the buck. And a lot of the other hospitals around here use the same -- it's a big clearinghouse. I mean, it was -- I got certification from Claredi, and they're not -- a lot of people are not happy with them.

Karen Trudel: Well, the first thing, again, is really trying to pin the clearinghouse down. I would suggest that if there are a number of providers that are having a similar problem with one organization, if you have a regional SNIP affiliate in your area, which is an offshoot of the Workgroup for Electronic Data Interchange or WEDI, it might be helpful to try to bring that to the attention of the organization because many voices, you know, are likely to be more effective. As far as contingency plans, if it becomes obvious that they're not going to be able to make it, again, that's something that you have

to think through from your business perspective, whether that's seeing if you need an arrangement with a backup clearinghouse that is already one that is in better shape. You can find out, for instance, which clearinghouses have successfully tested with Medicare contractors by looking at the contractors' websites.

You know, I hate to suggest to anyone that they revert to paper because it's such a draconian solution. And I would say that would have to be a last resort to keep cash flow going. But I would suggest though that you potentially think about alternate arrangements.

Stanley Nachimson: This is Stanley Nachimson. Let me just add a couple of other things. I mean, first, you need to find out if it's the same problem that they're having with you as the other hospitals in your area, if the problem is on the clearinghouse side or if the interface between you and the clearinghouse, what the specific errors are, if it's that you're missing information or they're not able to understand your information or they're just having problems producing the HIPAA transactions for anyone.

Kelly Wibbenmier: Well, they're having -- they were certified under Claredi, so we know that they've actually done the 837 and have been certified, and it's gone through. But I'm actually the chairperson on one of our main boards in our area for TCS certification, and it seems like everybody on this board is using this company, and there's been nothing but bad things said about this company. So it's kind of like, yes, Claredi has certified them, but what does that actually mean also?

Stanley Nachimson: That means that -- sounds like that means they're able to produce transactions from some files, but they may not be able to produce the transactions from the files that you're sending. Again, I think you need to identify the particular errors and see if it's the same error for all the providers or different errors for different providers.

Kelly Wibbenmier: Oh, we've already done that, and it's very -- there's many global errors, and there are some errors that are specific to certain types of hospitals because we're a children's, whereas some of the other hospitals are adult hospitals in this organization, so they have different types of information that's running through. So I think it's a lot of hospital specific. We even have a VA that's in our organization, and they're having extreme problems. So it's been a

nightmare.

Stanley Nachimson: I think you just need to get as high up in that organization as you can.

Kelly Wibbenmier: Okay.

Dr. Bernice Harper: Thank you very much.

Kelly Wibbenmier: Great. Thank you.

Dr. Bernice Harper: Next question please.

Operator: Your next question comes from Victoria Albert.

Victoria Albert: Hi. I have a question for Stephanie.

Stephanie Kaminski: Okay.

Victoria Albert: Stephanie, I'm sorry to do this to you, but you're from the Office for Civil Rights, if I understood the introductions correctly, and I've tried to get this question answered for several months, and I'm having a hard time. Our organization distributes, in the past at least we did, what we called Care Cards for our patients. They're little plastic cards like you get for a grocery chain or a pharmacy chain. It has Heritage Family Health System on it, it has a bar code, patient name. The bar code allows an authorized employee of the hospital to quickly access demographic information only when the patients come in. The whole idea was that you swipe for registration eventually so that you don't have to sign in -- so you don't give the same information over and over again. What we don't know is if that card in and of itself, which only has a patient name, our name, and bar code on it is PHI.

Stephanie Kaminski: And you are a health insurance plan?

Victoria Albert: Oh, I'm sorry. I missed that part. Now, we're a two hospital health care system. We have 105 owned physicians and satellites. And the card, no matter where you present in the system, if they have the swiping capability, you can register with minimal questions and what have you. And again, the goal was ultimately to eliminate things like sign in sheets and -- but what we don't know is if that card is PHI because it has patient name on it. We're about

to print 70,000 more of them.

Stephanie Kaminski: Well, it doesn't just have the patient name on it, if I understood you correctly, it also has your name on it, right?

Victoria Albert: Yeah. It has the hospitals name.

Stephanie Kaminski: Yeah. I think that definitely falls in the category of PHI.

Victoria Albert: So we can't use that anymore?

Stephanie Kaminski: Not necessarily -- no, that's not necessarily the case.

Victoria Albert: Oh, Stephanie.

Stephanie Kaminski: I wouldn't necessarily say that. I guess it would be -- it's -- some thought would have to be given to the types of uses and disclosures that you're using it for. I haven't dealt with this kind of situation before, but off the top of my head it sounds like a health care operations use.

Victoria Albert: Yeah, definitely.

Stephanie Kaminski: Or even a health care operations disclosure, although it sounds more like a use. And so it's possible if the analysis were, you know, done to completion to come -- I wouldn't necessarily say that it can't be used anymore, but I would pretty definitely say that it is PHI.

Victoria Albert: It is PHI.

Stephanie Kaminski: Uh-huh.

Victoria Albert: And we in the past haven't requested people to sign an authorization form to give them these cards so, you know, I guess that could be problematic too.

Stephanie Kaminski: Well, I mean, it sounds like though -- would each individual who's using it be -- would a family member hold it for multiple people, or would they be just using it themselves?

Victoria Albert: Just themselves.

- Stephanie Kaminski: Each individual.
- Victoria Albert: And that's why we have everybody's first and last name on it so that when, if I'm the mom, I've got mine and my kids, and I can tell the difference when I go to a hospital or a doctor's office to use it, you know, so I wouldn't have four purple cards that don't have any identifier on it.
- Stephanie Kaminski: You know, it's a little tricky to try to do an analysis on the telephone, you know, on the phone.
- Victoria Albert: I know, Stephanie. So tell me who I can call please. Or call me back.
- Stephanie Kaminski: Yeah. Certainly I can do that. I guess so I wanted to say it does sound very similar to a situation where somebody would walk in and voluntarily give their PHI, demographic information or whatever to register or sign in, in which case it's not a question of authorizing the use of PHI for a third party. They're using it themselves, so I'm not sure that the authorization line of analysis is quite right either. It sounds like something that maybe -- you know, it sounds like it's a health care operation and may be some -- you know, it may be perfectly permissible. If you -- maybe there could be a way afterward that we could exchange information and we can follow up about it.
- Victoria Albert: Oh, thank you because -- and we can't get the demographic information unless somebody has given it to us first, so it isn't like we go in computers and weed this stuff out. You had to have had a visit at one of our facilities.
- Karen Trudel: Right. This is Karen. What we normally do in these situations is if you're willing to part with your phone number, and I have to tell you that there is no privacy on this call, there are 1600 people listening to you, if you're willing to give your first name and phone number to Stephanie, she can give you a call back.
- Dr. Bernice Harper: Next call please.
- Operator: Your next question comes from Sylvia Bernstein.
- Sylvia Bernstein: Hi. Just a question. We've contacted CMS with some issues we're having with payers about interpretation of the implementation

guides, and we're wondering what the turnaround time for us to get a response back.

Karen Trudel: Was that question sent to the askhipaa mailbox?

Male Speaker: It was actually to file a complaint concerning a particular health plan.

Female Speaker: To file a complaint --

Male Speaker: -- remittance advice. You know, they're saying that the remittance advice is not covered as far as requiring the health plan to accept that transaction at a very minimum or no cost in exchange. They're wanting us to pay a transaction fee.

Karen Trudel: Okay. Well, the first thing you have to understand is that unless this is the plan that did not file an extension, the deadline for compliance is not until this coming October, so --so we can't accept complaints until October.

Male Speaker: -- paid for a clearinghouse to receive the 835, and we're saying that we can accept [UNINTELLIGIBLE] or they can accept the clearinghouse, but we shouldn't be required to pay that fee.

Karen Trudel: That is correct. If the health plan wants to select using a clearinghouse as their way to achieve compliance, they have to pay for it. They can't make you do it.

Male Speaker: And that's our situation. In order for us to be ready for October, this is one of our major payers, and they're saying they're not, and so we're at an impasse.

Karen Trudel: Right.

Female Speaker: Why don't we get that interpretation in writing.

Karen Trudel: I would suggest that you send an e-mail to us at askhipaa, A-S-K-H-I-P-A-A --

Male Speaker: It was done.

Karen Trudel: -- it was?

Male Speaker: Yes.

Karen Trudel: Oh, okay. All right. We'll go back and see if we can find it then. Do you know when?

Male Speaker: First of May.

Karen Trudel: Okay.

Dr. Bernice Harper: Thank you.

Karen Trudel: I would say that in general the more complex the questions are, the more time it takes us to research and respond to them.

Dr. Bernice Harper: Next question please.

Operator: Your next question comes from Bill St. John.

Bill St. John: I've got a question on taxonomy code. What plans will Medicare have in utilizing those?

Karen Trudel: Medicare will not be using the taxonomy.

Bill St. John: Okay. Even for part B?

Karen Trudel: Yes.

Bill St. John: Okay. Also another question on that. We're a hospital based system here, and we have physicians that work in the hospital, and they have more than one taxonomy code. If the hospitals select a single taxonomy code that goes on the bill, and the physicians select a different one than that one, do you see anything that could happen that could be a problem with that?

Karen Trudel: No, I don't believe so.

Bill St. John: Okay. Thank you.

Joy Glass: Let me explain for a moment why Medicare is not using the taxonomy codes as they come in on the claims. It's because we have an in house provider file with information that we obtain from the providers when they enroll in the Medicare program as

providers. And rather than take the information from each and every claim that comes in, we simply use that file to get specialty and taxonomy information on the claim as we receive it for adjudication.

Bill St. John: Okay. Thank you.

Dr. Bernice Harper: You're welcome, Mr. St. John. Next question please.

Operator: Your next question comes from Joel Grubber.

Joel Grubber: Hello. Can you hear me?

Dr. Bernice Harper: Yes.

Joel Grubber: Okay. Very good. I just have a question regarding the payer readiness portion. You were very good at quoting Medicare statistics. I was wondering if CMS would have any information regarding the readiness of the Medicaid agencies in testing their HIPAA transactions.

Marie: Hi. This is Marie Margiottiello state agencies regarding their testing status. We do not have this compiled and put together yet in a format we can release, but if you want to -- is there -- if you want to contact me off-line, I can probably help you with whatever it is you specifically need to know.

Joel Grubber: That just seems to be the end of the spectrum that has little or no movement on it.

Marie: Are you concerned with more than one specific state Medicaid agency?

Joel Grubber: Absolutely.

Marie: Okay.

Joel Grubber: Yes. If I could follow up with you, could I get your demographics again please?

Marie: Yeah. My e-mail address --

Joel Grubber: Uh-huh.

Marie: -- is mmargiottiello@cms.hhs.gov.

Joel Grubber: Okay. Thank you.

Karen Trudel: If you can't get that, try askhipaa@cms.hhs.gov.

Marie: And they'll forward it to me.

Karen Trudel: We'll forward it to Marie.

Joel Grubber: Thank you.

Dr. Bernice Harper: Thank you. Next question please.

Operator: Your next question comes from Ava Purdy.

Kendrick McDonald: This is actually Kendrick McDonald. I'm sorry. I have a quick question about 4010.A.1 testing. I've been told by one of the regions that testing is not required. Of course, the 4010 is required. I was just wondering, could you give me any information on that?

Janice Nero-Phillips: Yes. We require testing of every one of our submitters on the 4010, and we did leave it as an option to our contractors whether, you know, they felt -- if you have passed testing on 4010 and then moved into production, we left it up to their discretion as to whether they would have to retest somebody on 4010.A.1. I do believe most of our contractors still really want to retest on 4010.A.1. But you have had to at least test on 4010 and have moved into production.

Kendrick McDonald: Okay.

Dr. Bernice Harper: Does that answer your question, Mr. McDonald?

Kendrick McDonald: Yes, it does. I have one more question. My next question is we have a product called a Woundvac, and right now on certain billing cycles we have to send in wound measurements. And, of course, there's no CMN that we could use, so I would imagine we'd still have to drop that to paper in order to send that in with the wound measurements. Is that still an option in October, or will we still have to send in those wound measurements?

Karen Trudel: You're talking that these are currently submitted on the NSS [PHONETIC] and the CMN?

Kendrick McDonald: No, we send them on HCFA 1500 with the attachment. And my understanding is in October that won't be an option as far as sending the HCFAs. And the information that we send on this [UNINTELLIGIBLE OVERLAPPING CONVERSATION] progress report that we send in. And the information on there can't fit -- there are no [UNINTELLIGIBLE] for it on a CMN.

Joy Glass: What you're saying then, sir, is that you're sending in a paper claim because there's a paper attachment that goes with it.

Kendrick McDonald: Exactly.

Joy Glass: Right. Well, you can still send the 837s electronically, and there is a segment there, the PWK that you would indicate if you're mailing that attachment, faxing it, or e-mailing it. You still can submit --

Karen Trudel: You can send in a claim electronically and the attachment on paper.

Kendrick McDonald: Okay. And that won't result in a denial?

Karen Trudel: No, no, no, no.

Kendrick McDonald: Okay. All right. Thank you.

Dr. Bernice Harper: Thank you, Mr. McDonald. Next question please.

Operator: Your next question comes from Karen Billingsly.

Karen Billingsly: Hi. I hate to ask these questions but have just come on board with the company. We are durable medical equipment company, not loaner but sale. I have about 30 claims a month, but we supersede the number of employees [UNINTELLIGIBLE] manufacturer. A couple of questions, I don't have a problem with 837, 4010, but I'm still not clear if I understand what other EI documents I'm supposed to have done by October 16th. Is the 835 required for the October 16th deadline, or is it strictly the 837?

- Stanley Nachimson: There are actually two different sets of requirements I think that we need to clarify. For Medicare purposes, you've indicated that you're not a small provider, --
- Karen Billingsly: Well, we are a small -- we're a manufacturer, and we bill for durable medical equipment that is sold to the patients based on scripts and letter necessity from a physician.
- Stanley Nachimson: -- assuming you're not a small provider, you'll be required to bill Medicare electronically.
- Karen Billingsly: Right.
- Stanley Nachimson: But no -- for Medicare purposes, no other transactions are required to be done electronically at this time.
- Karen Billingsly: Just the 837?
- Karen Trudel: Just the 837, right. And I know that based on the number of claims, you view yourself as a small provider, but unfortunately the law defines a small provider in terms of full time equivalent employees.
- Karen Billingsly: And that's fine. We are in-house, so I will -- we'll do our own in-house into the [UNINTELLIGIBLE]. But the question that was just asked about the PWK, are we required to also send in the letter of medical necessity. We've heard from some of the [UNINTELLIGIBLE] that we don't have to do that anymore, like the prescriptions. We'll get a prescription for the device, it's a single device that is sold to the patient, and we bill it, bill you all for that.
- Karen Trudel: I mean, that is not part of the transaction, but -- We're trying to see if someone sitting in the room is familiar with the issue. Let me give people a chance to rev up their brain cells a little by repeating what I think you said.
- Karen Billingsly: Well, what I'm trying --
- Joy Glass: The issue was after October, is there still a requirement for certificates of medical necessity and prescriptions to be sent to the DMERC.

Karen Billingsly: -- right. And we have them, and I understand on the PWK as far as EDI, I think there's an HR for health records as a qualifier that's mandatory, but I didn't know if that is equating to expect it in the mail.

Karen Trudel: We don't seem to have anybody in the room who can answer that which is not unusual.

Karen Billingsly: Can I send this then to askhipaa?

Karen Trudel: Certainly.

Karen Billingsly: Okay. Okay. I guess the only other question I have is there was an organizational change in the company that I am with -- we're obviously behind the eight ball, but I think we could make it. My only concern is they had never put in a for submitter ID, and I understand that's a six to eight week lag time which, in a way, bothers me. Is there absolutely positively no other option around that?

Karen Trudel: To get a submitter ID from the contractor?

Karen Billingsly: Yes. They're telling me no, and I understand that but, you know, I just -- I'm going to ask.

Karen Trudel: I would contact your contractor.

Karen Billingsly: I have, and they're telling me six to eight weeks, and I'm not sure if I can get past the level I'm talking to. What level do I need to go to at a contractor? I'm an EDI person, so --

Karen Trudel: Have you --

Stanley Nachimson: What's the problem with the six to eight week time period?

Karen Billingsly: -- well, to make the October 16th, I can't test, and we just sent paperwork in yesterday.

Karen Trudel: I'm at a loss to be able to answer the question. At this point because of the ASCA legislation it may be that contractors are being swamped with additional requests for submitter IDs because people realize that they need to convert from paper to electronic. And I guess maybe one of the things would be to give them a call

and ask if there's any way to give you a temporary ID just for testing.

Karen Billingsly: Okay. Well, I have and that's why I was asking. I've been there, and I can't seem to get through. But that's okay. I appreciate your information. I will subsequently send to the askhipaa on do we still need to send in a letter of medical necessity and how do we, other than the PKW, identify that that will be coming?

Joy Glass: Are you talking about the actual certificate of medical necessity?

Karen Billingsly: Well, we receive a letter from a physician and a prescription that prescribes the durable medical equipment.

Karen Billingsly: And we have all that here, and normally that is attached paper to HICFA 1500.

Joy Glass: Because the 837 does support reporting your certificate for medical necessity.

Karen Billingsly: Okay. I guess I --

Joy Glass: The FRM segment.

Karen Billingsly: -- the FRM?

Joy Glassr: FRM, look at that.

Karen Billingsly: Oh, thank you so much. I'll look at that, and if that doesn't clear it up for me, I will send an e-mail.

Dr. Bernice Harper: You're quite welcome. Next question please.

Operator: Your next question comes from comes from Ola Johnson.

Ola Johnson: My question has already been answered. Thank you.

Operator: Your next question comes from Chris Apgar.

Chris Apgar: My question is related to the conversations that are ongoing right now between WEDI and NCVHS, that American Hospital Association and others around creating what some have called an

amnesty period around October because of the concerns that there are a fair number of providers that are not ready. And I also note from previous discussions that there are some legal issues around on one side it would be a violation of HIPAA to accept nonstandard transactions, on the other side it would be a violation of ERISA and Medicare and a whole host of other things, and was wondering where CMS was in that discussion with NCVHS and WEDI and so forth.

Karen Trudel: There's not a lot I can tell you right now, Chris. The NCVHS did do hearings, that's the National Committee of Vital Health Statistics did have some hearings I believe a week or so ago and talked about a number of possible recommendations, but they have not provided any recommendations yet to the secretary and likely will not do so until some time next month. We are still looking at some of the proposals that WEDI suggested. As you stated, there are a number of legal issues to look at. And at this point, if you want to know what is on the books right now, what the law says, October 16th is the deadline. That being said, you know, everybody needs to be thinking a little bit about, as several people said before, what kind of contingency plans they might need to put into place as plans go awry, if the clearinghouse can't deliver, etc., etc. I'm sorry to give you sort of a bureaucratic response, but we aren't in a place to have an answer right at this point.

Chris Apgar: That's fair. Thanks.

Dr. Bernice Harper: You're welcome. Next question please.

Operator: Your next question comes from Louise Anderson.

Louise Anderson: Yes. We are a small -- well, we're a medium size health department, and the only billing we do at all is electronic to Medicare for flu and pneumonia shots. Are we going to have to bill electronically? We did call Medicare, and they said we would have to. And we -- you know, since it's the only thing we do, we just wanted to double check.

Karen Trudel: I'm assuming when you say medium that you already know that you exceed the size limitation in the ASCA legislation, which in the case of an institutional provider is 25 full time equivalent employees and for a practitioner 10 full time equivalent employees. I'm just assuming that. Essentially, if you do exceed

that, you do need to bill electronically. How are you billing electronically now for those things?

Louise Anderson:

We don't.

Karen Trudel:

You don't.

Louise Anderson:

We have never billed electronically.

Karen Trudel:

You haven't?

Louise Anderson:

No.

Karen Trudel:

You send them in on paper.

Louise Anderson:

Correct.

Karen Trudel:

Okay.

Louise Anderson:

Well, this would have been the first year. They told us last year we could still bill on paper, which we did. And then we were told we'd have to bill electronically this coming year, and we have -- we tried to get the free software, which didn't work. So we don't even have anything to test with at this point.

Karen Trudel:

Are you talking about actually the roster billing or --

Louise Anderson:

Roster billing. That's all we do. That's the only billing we do at all in the health department.

Joy Glass:

Right. WWe're looking at this issue and we do know that they do not currently have the free 837 roster billing software.

Louise Anderson:

They have not?

Joy Glass:

No, but we are aware of this.

Louise Anderson:

Okay. So if it's not developed, we could still get by with doing paper this coming fall?

Stanley Nachimson:

You'll have to wait until the regulation that requires electronic billing is published to see whether the situation applies.

Louise Anderson: Is that what -- I came on the call a little bit late. Is that what you were talking about when I came on, or when will that be published?

Karen Trudel: We expect that will be published in about a month.

Louise Anderson: Okay.

Karen Trudel: And it will include not only the items -- the requirements for an exclusion based on the size of the provider.

Louise Anderson: Right.

Karen Trudel: There will be some other limited exclusions that would allow paper claims to be submitted in certain cases, and we're looking into very specific issues. You know, roster billing may turn out to be one of those.

Louise Anderson: Okay. Because we don't have -- we have clinics, but we don't charge our patients. They're all public health. We don't bill Medicaid or anything like that, so it's the only billing we do at all.

Dr. Bernice Harper: Thank you. Next question please.

Operator: Your next question comes from Mike Cochran.

Mike Cochran: Yes. I have a couple of questions. Must a payer respond with an 835 when a claim is received via an 837?

Stanley Nachimson: If the provider requests an electronic remittance advice be sent, yes, the payer, assuming it's a health plan defined under HIPAA, is required to send an 835.

Mike Cochran: Okay. My second question is if the payer is using a clearinghouse, does the payer just have to test with the clearinghouse, or should the payer also be testing with providers?

Stanley Nachimson: What is the payer using a clearinghouse for?

Mike Cochran: For our electronic transactions.

Stanley Nachimson : Are you the payer or --

Mike Cochran: Yeah, we're the payer.

Stanley Nachimson: -- there is certainly no requirement in the regulation for any type of testing. However, one would suggest that you want to make sure they can process work correctly. So I would certainly suggest testing with as many providers as you possibly can to make sure that the communications can be done.

Mike Cochran: Even though we won't be -- our plan is not to be communicating with providers once we're up and running, just going through the clearinghouse.

Karen Trudel: The clearinghouse is essentially primarily responsible for making sure they can communicate with their providers. And so your primary responsibility is to make sure that you can communicate with them. But some end to end testing is often a good idea. We had someone earlier on the call who said that the clearinghouse couldn't communicate with the plan. It may be that in some cases it's because the clearinghouse can't communicate with the provider.

Mike Cochran: Okay.

Dr. Bernice Harper: Thank you. Next question please.

Operator: Your next question comes from Jennifer Kroeger.

Jennifer Kroeger: Hi. Thanks. I have two sets of questions actually. The first one is how providers are handling the different EDI implementation dates for the small health plans because we're finding from some of our TPAs that their business is really a mixed bag, and so some will be affected this October, some the following October.

Karen Trudel: I have to stop you right in your tracks. That's not correct. Small plans were not permitted to ask for an additional year to implement the transaction and code sets under ASCA because they already had an extra year. So at this point, this October, small plans are supposed to be compliant.

Jennifer Kroeger: Okay. All right. And that's helpful because that's what we had understood, but our TPAs and their attorneys are differing on that.

Stanley Nachimson: All health plans are required to do the HIPAA transactions by October 16th, 2003.

Jennifer Kroeger: Okay. Wonderful.

Karen Trudel: You could refer them to our website. We do have information on there where they can see it in writing if they want to.

Stanley Nachimson : Yeah. They may be confused with the privacy implementation dates. Small health plans did have an additional year for that.

Jennifer Kroeger: Okay. Thank you very much. And then the second set of questions really have to do with the 278. And you had mentioned earlier the recommended sequencing by WEDI. If you could just address, you know, where folks are at in that sequence for the 278.

Karen Trudel: I'm not sure anybody in the room is familiar off the top of their head with where the 278 falls in that cycle. I believe it's towards the end.

Jennifer Kroeger: Okay. Because we're just finding difficulty finding someone to test that with on the provider side.

Karen Trudel: Right. And I sympathize with that. But when you really stop and think about things -- and I also think it's great that people are looking for opportunities to implement the 278 at some of the lesser used electronic transactions. Between now and October, an awful lot of people are thinking about primarily cash flow and --

Jennifer Kroeger: Yes.

Karen Trudel: -- and the claim is sort of foremost in people's minds. And, you know, while I'm not saying it's the ideal situation, I can't really fault people for, you know, working on the claims first when they know that there's so much at stake there.

Jennifer Kroeger: Right. Okay. And then the last part, and thanks for your patience with all the questions, the 278, any updates on ways to include more of those disclaimer statements and additional information that we're required by our different state department of insurances to include with any type of authorization? For example, you know, we have one state where there's a six page external review appeal option that we have to send.

Karen Trudel: I don't think we do have an update on that. I guess I would say the way to

go about making a change to the 278 is certainly to submit a request to the designated standards maintenance organization for a DSMO process.

Jennifer Kroeger: Okay.

Karen Trudel: And that's got to be your first step.

Jennifer Kroeger: Okay.

Dr. Bernice Harper: Thank you.

Jennifer Kroeger: Thank you.

Dr. Bernice Harper: Next question please.

Operator: Your next question comes from Noel Paulson

Noel Paulson: Hi. This is Noel with Blue Cross/Blue Shield of Florida. We're calling to try to get direction from CMS on how the 837 COB [PHONETIC] transaction, which will be replacing crossovers, are expected to be handled in terms of acknowledgments, TA1s and rejects, etc.

Joy Glass: Within the transaction there is an indicator whether or not the sender wishes to receive an acknowledgment. And we, for Medicare, have left it up to our contractors as to whether they do want to receive that acknowledgment back from the COB trading partner.

Noel Paulson: Okay. Thank you very much.

Dr. Bernice Harper: You're welcome. Next question please.

Operator: Your next question comes from Tina

Tina: Hi there. I actually have two questions, and I hope you'll pardon my ignorance on the first one. I'm actually not from a billing side of things. I'm from the IS side of things. What's the difference between a Medicare intermediary and a Medicare contractor?

Karen Truel:: They're sort of interchangeable in a way. Contractor is the term we use to cover all of the insurance companies that we contract with to pay claims. Medicare contractors can be fiscal intermediaries who

handle the institutional claims. They can be carriers who handle the professional claims, or they can be DMERCs or durable medical equipment carriers who handle DME claims. So the term Medicare contractor is an umbrella term that encompasses FIs, carriers, and DMERCs. Was that clear?

Tina: Yeah. I'm just writing it down.

But I have another question.

Female Speaker: Sure.

Tina: My other question is about the free software. The only free software that I know of right now through Medicare is the FISS system. Is that being replaced by a different free software, and does that work for both Medicare part A and part B?

Joy Glass: That is Medicare part A. And the software they have available now should be in the -- support the mission of the addenda, the 4010 A1. But that is for part A only.

Karen Trudel: When you say free software, are you talking about PC software, or are you talking about the mainframe direct data entry system?

Tina: I'm talking about the direct data entry. I didn't know there was a --

Karen Trudel: Huh-uh. Okay. The free billing software that we've been talking about is PC based, and basically you load it onto your PC, and you can key the data in and it creates an electronic claim. The Florida mainframe system, which is direct data entry, you can sign on at the terminal and key information, will also be maintained in addition to Florida accepting electronic data interchange files.

Tina: -- and does the FISS, is that part A only as well, or is that --

Joy Glass: Yes. That's part A only.

Tina: -- and is there any plans for software or direct data entry for part B?

Stanley Nachimson: There is free billing software or will be free billing software on the PC side for part B.

Tina :           Yeah. We do not really have any business -- I think the only DDE that is supported by the carriers is, of course, some correction to the claims. That -- you know, we've never had the -- it wasn't necessary --

Karen Trudel: So there won't be direct data entry software on the carrier side, but the PC free software will be available.

Tina:           And where do we go to get both the Part A and the Part B software?

Joy Glass:       Yes. The website at [cms.hhs.gov/providers/edi](http://cms.hhs.gov/providers/edi). And if you scroll down the page, there will be links to Part A and Part B for the free software. And then you call that number in the state, and they will send that out to you.

Tina:           And just my last question, and maybe this will help us with our contingency plans, could this free software be used as part of our contingency plans then if our vendors don't come through?

Karen Trudel:    It could be used as part of your contingency plans for assuring your continued Medicare cash flow, but it's not likely to be of use to bill anyone else.

Dr. Bernice Harper:    Next question please.

Operator:         Your next question comes from Rose Healy.

Rose Healy:        Hello. I have a question about payer ID. Can you hear me okay?

                  This was addressed just a little bit ago, but we would like some clarification. Our understanding is that if a rule on payer ID is not issued by October 16th that we would continue to pass whatever number to a particular payer that we currently are passing to that payer. Is that correct?

Stanley Nachimson:        Assuming that number meets the requirements of the implementation guide, yes.

Rose Healy:        And when you say meets the requirements of the implementation guide, can you elaborate a little bit?

- Stanley Nachimson:                    There is a space in the implementation guide for a payer identification number that has a certain width associated with it assuming that payer identifiers that you're using at least are between the minimum and maximum width or less, you can continue to use them.
- Rose Healy:                            And so, for example, if we are now passing a physician's [payer ID for the referring, would we continue to do that?
- Karen Trudel:                        Yes.
- Rose Healy:                            Okay.
- Dr. Bernice Harper:                Thank you.
- Karen Trudel:                        Yeah. Most of the identifier fields are I think, what, 15 characters?
- They're considerably large. So the likelihood that a number that you're now using won't fit into the space is extremely unlikely.
- Rose Healy:                            I'm sorry. I didn't hear that. Could you repeat it? I apologize.
- Karen Trudel:                        Sure. The field space for the identifier, the plan ID, the provider ID, in the transaction currently it can hold up to a 15 digit field. So the likelihood that whatever you're using now would be too big is pretty slim.
- Rose Healy:                            Is remote. Okay.
- Rose Healy:                            I appreciate it. Thank you.
- Female Speaker:                    All right. Can I ask another part of that please?
- Dr. Bernice Harper:                Go right ahead.
- Female Speaker:                    Some of our payers are not telling us because we have never had numbers to put in a payer ID field so they're not sharing companion guides, and they're not telling us what numbers to place in that field. What are we to do then come time for testing and we're getting rejections back for that file because we have no payer

ID number in that field.

Karen Trudel: You're saying the Medicare contractors are not giving you their number?

Female Speaker: Not necessarily Medicare contractors but one of them in particular we know had not, but there's also other payers that we're attempting to do this as well, and they have not shared a payer ID number to put in that field for the testing purposes. So then we send out the information, and it automatically is going to come back because that payer ID field was empty.

Stanley Nachimson : Because the payer ID field is blank?

Female Speaker: Yes.

Stanley Nachimson: Then for testing purposes I would -- certainly you could put some sort of dummy number in there at least to get your transaction tested. However, certainly for production purposes, it would be a good idea for them to give you what number they expect to see in there

Female Speaker: That's what we would hope you'd say because that's the way we're going to present it back to them. They need to give us something that will be acceptable in order for that claim -- I mean, for that file to make it into production.

Stanley Nachimson: Let's hope.

Dr. Bernice Harper: Thank you. Next question please.

Operator: Your next question comes from Diana Balwe

Diana Balwe: We have a question with regard to an internal clearinghouse. We're going to use that as an option for entering when we receive the proprietary transactions. If we determine that we don't have all of the required or situationally required data elements, can we supplement that so that we can create a standard transaction?

Stanley Nachimson: This is an internal clearinghouse?

Diana Balwe: Yes.

Stanley Nachimson: So you are the health plan and receiving the transaction?

Diana Balwe: Yes.

Stanley Nachimson: The provider is required to send you a HIPAA compliant transaction, and you should be -- if you are acting as the payer, you should be rejecting that. Now that being said, you could have your internal clearinghouse sign a contract with the provider to do that necessary supplementation.

Diana Balwe: Okay. So we can -- if we determined that the proprietary transaction does not have all the situationally required data elements, we could have our unit, that is the internal clearinghouse, supplement the proprietary transaction so that we can create a valid HIPAA compliant transaction?

Stanley Nachimson: Oh, yeah. I mean, again, you have to be very careful that -- this internal unit has to have a separate contract with the provider to be serving as the provider's business associate to produce that compliant transaction.

Diana Balwe: Okay.

Stanley Nachimson: The provider is responsible for sending you or making arrangements with someone to send you a compliant transaction. It's not up to you as the health plan to take a proprietary transaction and then convert it into a HIPAA standard or supplement it. It's absolutely the requirement of the provider to do that.

Diana Balwe: So in order for this to work, we would need to -- that unit would need to be a business associate of the provider?

Stanley Nachimson: Yes.

Dr. Bernice Harper: Thank you. Next question please.

Operator: Your next question comes from David Garlinger

David Garlinger: Yes. We're a med soft carrier. With regards to the testing you're talking about, we deal with fiscal intermediaries for Part A

and Part B nationwide. We have yet to get compliant data from them for testing, and we just had a notification from Part B carriers that use the MCS system that they will not be able to send any transactions for testing until July of this year because of deficiencies in their systems. What is CMS doing to alleviate this problem with our contractors?

Joy Glass: Yes. Actually we have received your email[in the askhipaa mailbox, and we're in the process of responding that to you. Could you wait? We expect to get that response out directly to you via e-mail, and we will be in touch.

David Gallant: I would, but --

Joy Glass: We need some more specific information from you.

David Garlinger: -- it's getting worse because we just received this letter from Blue Cross/Blue Shield of Montana saying that we won't get anything until July because the MCS system is so deficient. You know, we've been trying to testfor months and haven't been able to get any HIPAA compliant testing yet.

Joy Glass: Okay. We have completed a survey and the results from the survey in Montana said that they have been testing.

Karen Trudel: What Joy is saying is that we need to do -- we have your inquiries that came in via the mailbox. We need to do some more research before we can respond, and we should be in a position to do that shortly.

Dr. Bernice Harper: Thank you. Next question please.

Operator: Your next question comes from Kris Owens.

Kris Owens: Yes. I've got a couple of questions. In regards to the code sets, the nonmedical code sets,things like remittance advice codes and so on, --

they potentially can change once a quarter. And we were wondering what the anticipated requirement is for getting those implemented. How quickly do we have to have those in place each quarter?

Karen Trudel: We're thinking.

Stanley Nachimson: You're talking about the remittance advice codes or the remark codes?

Kris Owens: Remark codes or either. I mean any of those codes that could potentially change frequently.

Stanley Nachimson : We're working with all the coding organizations for them to put effective dates on their code sets. So hopefully we'll be able to provide guidance on a code set by code set basis.

Kris Owens: So I understand the effective date, but it takes us a little while to implement.

Stanley Nachimson: We're trying to work with them so that the effective date will be at some time after the publication date --

Kris Owens: -- oh, that would be great. That would be very helpful.

Stanley Nachimson: Again, we're in the process of working with the different code set maintainers to come up with at least what they feel are reasonable implementation time frames.

Kris Owens: When do you anticipate having that in place?

Stanley Nachimson: I can't give you a particular date.

Kris Owens: My second question has to do with when the gentleman was asking about the NPI, there was something about a September date, something to be released in September, and we missed it.

Stanley Nachimson: Again, we expect to publish the final regulation on the national provider identifier by September.

Karen Trudel: This coming September. You didn't miss anything.

Kris Owens: 2003.

Stanley Nachimson: 2003, yeah. With an effective date, a compliance date at some time in the future.

Kris Owens: Okay.

Dr. Bernice Harper: Thank you.

Kris Owens: And just one last comment. The very first person on the call asked about a schedule for readiness with the fiscal intermediaries. We would certainly appreciate that as well. We are having trouble getting communication back, particularly on when our FIs are going to be ready for the 835 testing.

Karen Trudel: Okay.

Kris Owens: And I assume the reason they're not communicating with us is because they're not ready. But it would be very helpful to have that kind of a schedule.

Karen Trudel: Thank you.

Kris Owens: Thank you.

Dr. Bernice Harper: You're welcome. Next question please.

Operator: Your next question comes from Lolita Jones.

Lolita Jones: Yes. My question is about the American Dental Association codes, the CDP codes. Is there anyone there who can speak to when the outpatient perspective payment system will reflect those codes because we do have an APC just for dental services, but right now that APC isn't necessarily populated with those dental codes. And I guess my other question is about the national drug code. When will those be incorporated into the outpatient PPS?

Karen Trudel: It doesn't look as if there's anyone here who could speak to your dental code issue. As far as the national drug code, the NDC is, for Medicare purposes, only going to be used for retail pharmacy transactions. The addenda regulation, the modifications, rescinded the NDC as a standard for institutional and professional claims. And so the use of whether to use NDC or HCPCS is up to the payer. And Medicare intends to continue to use HCPCS codes instead of converting to national drug codes for institutional and professional claims. So basically the NDCs will only be used in retail pharmacy, and they will not impact any of the PPSs.

- Lolita Jones: On that note, is there any reason why the fed or Congress didn't mandate that an implementation guide has to be prepared by each payer because it would really help if they had to submit or prepare implementation guides because there are certain fields and certain data elements where it's really optional, and that's becoming a nightmare?
- Karen Trudel: Right. I understand that. I can't speak to why Congress didn't do it. I think what you mean is companion guides that go with the implementation guides --
- Lolita Jones: Yes, yes.
- Karen Trudel: -- that contain the specifics of how a plan is going to conduct its business function within the HIPAA standards. And I guess that when Congress passed the law, they at that point weren't aware of what the standards would be at all. They did not mandate companion guides so while we don't have legal authority to require companion guides, we certainly do recommend them.
- Lolita Jones: You can't even require them from your contractors? That's still not within the law?
- Karen Trudel: No, we're -- yes, we can require them from the Medicare contractors, and we have provided information to them as to what's to go into a companion guide.
- Lolita Jones: My last comment is I can tell you right now some of the FIs have already stated that their attorneys have told them that the regs stated optional, so they may not understand that.
- Karen Trudel: Well, the regs make it optional, but Medicare tells the contractors what we want them to do.
- Joy Glass: Right. And we -- actually, we have instructions that are pending for the Medicare intermediaries that -- they're pending release from CMS, and it's in the language that they are to include a companion guide.
- Karen Trudel: Right. There is a particular instruction that is awaiting publication that sets out essentially what our priority companion guide will look like.

- Stanley Nachimson : Let me speak to the issue of your comment about the nightmare of the myriad of companion guides. And I think the original intention probably from Congress was that the standards would be so clear and precise that there would be no payer by payer variation. Obviously the experience that we had to date and the fact that different plans have different business rules at the moment make that impossible. As we get more and more experienced with the standards, hopefully the industry will be able to come together and eliminate much of the variations among the health plans. And I think our experiences on October 16th and beyond will help move us towards that.
- Dr. Bernice Harper: Thank you. Ms. Nelson, we'll have one more call please, one more question.
- Operator: Your last question comes from Cindy Mayer.
- Cindy Mayer: Hi. I had a question regarding the sending of secondary claims after October 16th with Medicare and the intermediaries ready to accept secondary claims. We also heard discussion about the PW case segment. Is that where we would put information that we would have an attachment with some type of additional info coming via mail?
- Joy Glass: Yes.
- Cindy Mayer: And when we send this attachment, is there specific info that needs to be on the attachment so that our intermediary could match the electronic claims with the paper attachment?
- Joy Glass: Yes. There is a control number, and you would have to, you know, talk with your intermediary to see what number that they would want you to put in that element that they could link those up. For a claim where Medicare is the secondary payer, there are fields on the 837 to include the information from the primary payer's remittance advice. So essentially a secondary claim is possible to do completely electronically just using the 837. The fact remains that an awful lot of people still do like to send those claims in on paper with the remittance advice stapled, and that's an additional issue. But you can actually conduct the entire transaction electronically.

- Dr. Bernice Harper: Thank you. We have final remarks from Karen and from Elizabeth.
- Karen Trudel: Actually, I don't have final remarks as much as I have a question that came in on our hot line. We've been getting a number of these questions just in the last few days. Apparently -- and this has to do with privacy so, Stephanie, I'm going to put you on the spot I'm afraid. We've been getting questions from people who have been to a seminar, generally physicians' offices, and they're being told that privacy does not allow loose papers to be in a patient's medical record. Stephanie, can you speak to that at all?
- Stephanie Kaminski: Yeah. I'm a little confused about the context, who's going to these seminars, but it's physicians who are going to these seminars or --
- Karen Trudel: Yeah. It's office managers, and they're being told that they have to do something with their patient records because you can't have loose papers in them anymore.
- Stephanie Kaminski: -- got you. Well, as many people who have grappled with the privacy rule know, there is a very broad requirement at 164 530C], which talks about safeguards. And in that requirement the privacy rule states that a covered entity must have in place appropriate administrative technical and physical safeguards to protect the privacy of PHI, protected health information. And so in this case I think that the issue on the table is what's an appropriate physical safeguard for a medical record, and is a bound medical record or somehow a sort of tightly encapsulated medical record better safeguarded than loose papers. That's an interpretation, and each covered entity needs to take a look at the regulation and make it's own interpretation about what appropriate safeguards are for the nature of the PHI at issue.
- Karen Trudel: But there's no outright requirement in the privacy rule that would take someone in that direction?
- Stephanie Kaminski: No. Just what I had stated.
- Dr. Bernice Harper: Thank you.
- Karen Trudel: Okay. And then Elizabeth is going to give some outreach updates.
- Elizabeth Holland: I wanted to remind you of our website. That website is

[www.cms.hhs.gov/hipaa/hipaa2](http://www.cms.hhs.gov/hipaa/hipaa2). Under upcoming events on our website, we will have listed information on our next round table call. That will be on June 25th at 2:00 Eastern time. We also have information about a series of provider workshops we're sponsoring. The next one will be June 5th in Tacoma, Washington. The one after that will be in Syracuse, New York on June 12th. And we're also planning one in Las Vegas, Nevada later in the month of June.

We're also hoping to satellite broadcast our basics of HIPAA simplification program some time in the month of July. We will have information about that coming soon on our website. We also have under the educational materials heading on the website information on how you can join our HIPAA outreach list serve.

Dr. Bernice Harper: Thank you very much.

Karen Trudel: Stephanie, is there anything you'd like to add?

Stephanie Kaminski: For more information on HIPAA privacy, visit the OCR web site located at [www.hhs.gov/ocr/](http://www.hhs.gov/ocr/) Dr. Bernice Harper: We'd like to thank everyone for participating in the round table today, and we thank those on-line. The conference is now closed.

Operator: This concludes the Centers for Medicare and Medicaid Services Ninth National HIPAA Implementation Round Table. You may now disconnect.

[END OF CALL]