

**Centers for Medicare & Medicaid Services**  
**HIPAA ROUNDTABLE CALL**  
**July 31, 2003**

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

Bernice: Thank you, Ms. Hudson. Good afternoon to those of you on the East Coast and good morning to those of you on the West Coast. We hope that you're having a wonderful summer.

This 11th national implementation round table call is being conducted by the Centers for Medicare and Medicaid Services or CMS, which is part of the department of Health and Human Services. Our call today will focus on the Health Insurance Portability and Accountability Act of 1996 or HIPAA and specifically the Administrative Simplification provisions.

My time is flying. There are only 77 days before the October 16 deadline for compliance with the electronic transactions and code sets. On July the 24, 2003, CMS issued guidance, which we discussed at a special HIPAA open door forum. There are some 1,600 persons on this call and I am sure that many of you must have been on that call also.

So to begin our remarks today and our conference, we're going to call on our director of the office of HIPAA standards at CMS, Jared Adair.

Jared: Thank you, Dr. Harper. Good afternoon and good morning as Dr. Harper said. Next she indicated there are in fact 77 days until the compliance date and although many of you may have been on that special open door forum, we thought that today we would like to spend the entire hour really talking about at least in our remarks and potentially in your questions about what the guidance said. And so I will spend a little bit of time going back over it.

I would also like to make you aware that the guidance is in fact posted in its entirety on our website. And for those of you who are not familiar with our website I will spend just a second telling you its address. It is [www.CMS.HHS.gov/HIPAA/HIPAA2](http://www.CMS.HHS.gov/HIPAA/HIPAA2), the number two.

Now when you get there you'll be at our home page for the administrative simplification part of HIPAA. You will notice there that we have highlighted the guidance that was announced last Thursday and in addition I would draw your attention that the website also has a wealth of other information available on it: frequently asked questions. It has an information series. So please take a look while you're there at some of the other services offered on our website.

So let me now go back more specifically to the guidance that we did put out last week. The guidance really talked about our enforcement approach. Most notably having to do with directly after the implementation or the compliance date of October 16. The guidance reiterates that Congress has given us the deadline of October 16, but this guidance goes on and talks a little bit about our enforcement approach. And the enforcement approach notice, which we probably have talked to you about before will in fact be complete drive.

But we wanted to talk a little bit in this guidance about what we would be doing with complaints. The first obviously is that we would take a look to see if in fact we got a complaint if the transaction was first off compliant.

The second what we expound upon in the guidance is that good faith effort. Let me talk for a moment on this and that what we're saying is that folks from now until October 16 have a responsibility to intensify their efforts to become compliant and health plans specifically have more responsibility. They not only have the need to get themselves compliant. They should be working with their provider community to conduct outreach and to insure that they get into tests.

Should after October 16 a health plan decide that, boy, they have done this – they've done all of this intensified work but their

provider community is still not at a place where they believe smooth payments will happen following the implementation date, they can deploy a contingency. A contingency that meets their responsibilities and works for their trading partners. We haven't said what an appropriate contingency is. That's to be decided by the health plan and their trading partners.

But should they have deployed this contingency plan after having done good faith efforts to get people compliant and we get a complaint about them, we would not take enforcement action against them. I think that's really very important and you will be having meetings during – over the summer with the health plans to talk to them, encouraging them to be working with their provider community to get them into test and to understand the contingencies that they would deploy if they found that a large percentage of their providers were not going to be ready and what they would do to avoid a disruption in the payments.

Let's see. I think I believe that that's really the announcement part of the guidance. So I guess I would open it up now to see if there are questions having to do with the guidance we did provide and which is located at the site that I gave you. I wanted to – I guess the other things that I would feel obligated to say at this point is there are 77 days left. We should each be doing what we can to get compliant. We have – we will be working with the health plans to encourage them to be working with the provider community as well as to be thinking about what appropriate contingencies would be if they feel that despite their best efforts that payments might be disrupted.

So I guess that's really the announcement and it's obviously a Cliff Notes version of what is in the guidance material itself. So I would encourage you to go take a look at it and to be copied to assuming that most of the people on the call today are from the provider community encourage you to be talking to your payers about what they're making sure they're aware of this and seeing what they're doing.

The other thing I would encourage people to be doing is testing. They need to be testing with their payers making sure that they can get a transaction through and making sure that they are as ready for

production as they can be. So, Dr. Harper, if we could turn it over to questions, I think that would be good.

Bernice: Thank you, Ms. Adair. Ms. Hudson, may we have the instructions for the questions please?

Operator: At this time, I would like to remind everyone in order to ask a question please press star then the number on your telephone keypad. Your first question comes from Leeza Durska.

Leeza: Hello. Thank you very much. My question is in regarding the guidance, but there was a note approximately a week or two ago relating to Medicare and secondary Medicare claims and the fact that they would be allowed to be placed on paper. Could you define secondary Medicare claims? For instance my question is if a Medicaid provider receives Medicare claims from AdminaStar for those members that are both Medicare and Medicaid, would that be considered a secondary Medicare claim?

Gary: No, it would not. This is Gary Kavanagh. What we're talking about here are situations where a payer has actually gotten reimbursed by another entity and then they're billing – then you need to bill Medicare to get – receive a secondary payment. And the only situations that we're aware of is when there's actually more than one secondary payer, which, you know, again you've already billed the secondary payer. If you've billed more than one of those and they've paid you and then you still, you know, you still want to bill Medicare for additional payment, then in that situation there's an issue about whether you can – you have to bill on paper.

We are in discussions with the X12. I think we're trying to reach resolution. I mean, we thought that had to be submitted on paper, but as the format couldn't accommodate it, we're still in discussions with them about whether the format really can accommodate it or not.

Leeza: Okay. Thank you very much.

Jared: We believe those situations to be pretty rare. Don't we, Gary

Gary: Yes.

Leeza: Okay. Great. Thanks for the clarification.

Bernie: Thank you. Next question please.

Operator: Your next question comes from David Garlinge.

David: Yes. I'm with a payer insurance company and you've got several E-mails from me in the past, but with your concern about the secondary payment from Medicare we are a med sup company and we're reliant on getting the transactions from the – your contractors, fiscal intermediaries. To date we are getting very poor service on testing data from those people. And I'm glad you took my call, but, you know, we've been fighting this for over a year now and still not receiving the test data. Is CMS going to be in the middle of this and give some direction? The second part of the question is the data that we have been receiving is far from compliant and won't even go through. So can I have your comments?

Gary: Yeah. This is Gary Kavanagh again. Let me make a general statement and then respond to your specific question. In terms of testing with Medicare contractors we certainly do encourage all providers and submitters to test with Medicare contractors and they are available to test on the 837 inbound, the 835 and for the most part on the 837 COB. You are correct that there are some issues in terms of, you know, going into product on the 837 and there are some compliancy issues that we're dealing with and trying to work through with our systems maintainers that support the Medicare carriers and intermediaries.

Hopefully the fix is to address those issues, some of them on the intermediary side. In fact the ones on the intermediary side should be in the system by the middle of August. We're hopeful that the ones on the carrier side are in the system by no later than the end of August. But you can continue to test. You're right. You're going to get some data back that is not compliant. You can't go into production yet, but you can test and we would encourage people to test if they feel they want to test at this point in time on the COB.

You can, however, let me stress again the inbound transaction, the remittance advice we certainly – we want everybody be in there accompanying those transactions at the moment. And would encourage COB testers, but that's up to you at this point.

David: Well, we have and there's several, particularly on the part A side, the carriers that are not even willing to send us test data. They're not giving us a date to even you know, start testing with them. So I sent that and I got a response from Karen Trudel. She was going to follow up with some of those, but –

Gary: Yeah. We're working through those issues. I think some of that – you know, we need to get back to you in particular about that. Those – some of those carriers are testing and I'm not sure quite what the issue is there.

David: One other –

Gary: We'll respond to you directly.

David: Okay. One other question I have, there was a notice put out that suggested if compliancy wasn't available for October the 16 that we continue to receive the NSF data, which does still work for us as opposed to not receiving compliant data. Is that being addressed?

Gary: The issue – well, I think this goes along with what Jared said earlier about developing contingency plans and all payers including Medicare are in the process of developing contingency plans if we are in a place, you know, in October where, you know, it could disrupt payments to providers. So that's the kind of issue that we are looking at.

David: And that would be a possibility to go forth with NSF or –

Jared: Obviously that – as I indicated in my earlier remarks, each payer needs to come up with a contingency. Obviously one contingency many people would think about was the NSF. It is – nobody is saying right now whether or not they would deploy contingencies. We anticipate that they or not anticipate, we encourage them all to

be monitoring over the summer the metrics that they have available to ascertain provider readiness. Obviously testing people end test and testing results will be one key metric. So people don't know whether or not they will be deploying a contingency, but they should be thinking about what theirs are and as you point out one obvious one would be the NSF.

Bernice: Thank you, Mr. Garlinge. Next question please.

Operator: Your next question comes from Paul Galluko.

Paul: Hi. It's Paul Galluko and actually I've been preempted by the previous question. We are a large payer in the Maryland/DC area and we've established as our biggest risk for implementation the inability to receive good test files from Medicare intermediaries and carriers. What we've received so far is – how shall I be discreet – useless and we are told as just mentioned that we would not be able to get any good files or intermediaries until mid August and for carriers perhaps later on. And that puts us in very, very large risk. I'm not asking for a repeat of the answer. I just wanted to go on record with that.

Jared: Fair enough. I would like to add something there. This is Jared Adair is that I think that Gary is absolutely right. We are working with our carriers and intermediaries to have them get into test and work with their payers. But if there are some particular instances that you would like to make us aware of so that we could have, you know, make some specific phone calls to see where things are, we will be happy to do that.

I ask you to notify us of those particular instances. We have an E-mail address that you are welcome to use. Our E-mail box for this is all one word [ASKHIPAA@CMS.HHS.gov](mailto:ASKHIPAA@CMS.HHS.gov). If you are calling to express concerns about COB training, being able to test, I don't necessarily need to know who you all are, but I do need – we do need to not just have kind of generalizations. If you could tell us the Medicare contractor and if you would like to have a Medicare contractor contact you, you will need to give us specifics about how they can reach you. If you're just calling or wanting us know about that they are not providing good service, we will on a general basis contact them through our regional offices and work

with them. So we can either deal with it generally or if you want to give us a specific and have them call a payer, a state, a whatever, you need to give us the information.

Paul: Thanks very much.

Bernice: You're welcome. Next question please.

Operator: Your next question comes from Ann Cokahan.

Ann: Hi. I'm also concerned about the 835 coming from Trailblazers is who we use as a contractor. I requested the file back in June and they told me that we had been added to a list. Part A said that we'd have the file within a couple of days. Part B said that it was still a manual process. To date I still have not received any file and when I called them back to follow-up, they said that since we get our files from THIN we need to talk to THIN. And when I called THIN they said that they have not even started testing with Trailblazers and they don't even know how they will do this process. Do you recommend that I just send this information to the E-mail or do you have a different way for me to proceed with this?

Gary: Can I ask you a question about the way you do business? Is THIN your clearinghouse or vendor?

Ann: THIN is where we get our remit file from.

Gary: So, I mean, you need to be speaking to them. I mean, we'll – we can investigate it from the Trailblazer perspective, but do you know what's going on with the clearinghouse and what if they've approached Trailblazers and are they in testing with Trailblazers?

Ann: When I talked to THIN they said, you know, we don't know even how we're going to do this with Trailblazers. We haven't even started thinking about testing with them. That's what THIN told me.

Jared: I think that we're talking here is two – I mean, testing is in fact two way communication and it takes two parties to activate and respond to it. And so we are certainly happy to have a conversation with Trailblazers just about the status of where they

are, but you need to be addressing the issue just having your clearinghouse throw their hands up in their air and say we don't even know how we're going to approach it. We – I don't know that there is much that we can do on that aspect, but I think you do need to be sitting down with your clearinghouse and talking to them about expectations and insuring that they are speaking to the, in this instance, Trailblazer.

We're happy to talk to Trailblazer about making sure that they're prepared for testing and potentially themselves reaching out to your clearinghouse to a certain degree. But you – we need to – clearinghouses have some responsibilities here that they need to be stepping up to the plate on.

Ann: Okay.

Bernice: Thank you.

Ann: Thank you.

Bernie: Next question please.

Operator: Your next question comes from Cynthia Korman.

Cynthia: Hi. Hi. My question is also about claims where Medicare is the secondary payer. Is it feasible – is it possible for those situations to be excluded from the ASCA mandate for electronic filing? And if I could give you background on why I'm asking, the situation that I see – I consult to healthcare providers and the – but I've worked with payers. The situations that I see where Medicare is the secondary payer often has commercial carriers as the primary payer and the commercial carriers are having challenge in providing the ERA, the electronic ERA that would give the information about the primary payment. So at best the providers will be late in getting well tested electronic files that reflects the primary payment. If they have to submit the secondary claim to Medicare without having a well tested electronic remittance advice from the commercial payers they're going to have a hard time submitting an accurate Medicare secondary claim. While they can drop the paper – while they can use a paper EOB to collect the primary payer information. They will have a challenge and

converting in some cases they'll have a challenge in converting the information on the paper remittance advice –

Bernice: I think we have the question. Who can answer it?

Karen: I'll take it. This is Karen Trudel. There really are two aspects of your question. One is that you need to be aware of the fact that it is possible to submit an electronic claim to Medicare as secondary payer without an electronic remittance advice. So the lack of an electronic remittance advice coming back from the commercial carrier is not necessarily a bar to being able to submit an electronic secondary claim.

The second thing is that the regulation that will establish what the specifics of the electronic billing requirements for Medicare under ASCA is still in the Health and Human Services clearance process and we can't comment as the results on the content of that right now. The question, you know, definitely has been brought up at other round tables and other venues. But it will be – we can't speak to it until the regulation is released.

Cynthia: Thank you very much and your point is well taken.

Bernice: Thank you, too. Next question please.

Operator: Your next question comes from Beth Morris.

Beth: Hi. I'm questioning about the provider identifier in the 837. Our understanding is until the national providers identifier comes out we have either the EIN or Social Security number that we need to use to identify the provider. And we're trying to get that information from all doctors that have patients that come into our facility. And we needed to get some guidance on what are we supposed to put in that field in the event that we can't get either an EIN or a Social Security number from a physician. There's some type of generic value that we can enter in there. That's one question and the second is what is Medicare specifically going to require in that field, the EIN or the Social Security number?

Joy: Hi. This is Joy Glass. Actually we do not process EIN or SSN so whatever, value is entered we don't use it to base payment on. So

we would accept whatever comes in that field as long as is compliant in the syntax format, such as being numeric and it does adhere to the rules. In the secondary segment is where you will put the Medicare provider ID and that's where we would pull the number. We process the Medicare provider ID and not the tax identification number.

Karen: This is Karen Trudel. Generally speaking what plans are going to use as identifiers is what they're using right now. And I believe the 837 format accommodates that pretty well. So it does allow for the use of Medicare provider IDs. It allows for the use of commercial identifier, commercial insurance PINs, Blue Cross Blue Shield PINs for providers. So I'm not exactly sure where the expectation that you needed a tax ID number was.

Beth: Well, because it's in the guide. It's still required. You got to put something there to implement it and apparently from what I've experienced is that providers haven't been willing to give their tax identification number.

Jared: We're trying to understand. You know, again, trying to be compliant with the 837 it's saying either EIN or Social Security number. If that's a value that is needed to adjudicate the claim that's fine on our end. We just need to understand what's acceptable in there.

Joy: As long as it adheres to the guide rules— if you look at the implementation guide I believe it's defined as alpha numeric and it must meet those guidelines will be acceptable.

Gary: Again, we're speaking for Medicare.

Joy: Right. For Medicare.

Gary: You would have to talk to other payers about what their expectation is.

Beth: Not all payers are addressing this in their companion guides, which is making it more difficult.

Jared: As I indicated we're having meeting with the health plan

associations over the summer and that will be a point I will let them know about.

Beth: Thank you.

Bernice: You're welcome. Next question please.

Operator: Your next question comes from Patrice Taylor.

Patrice: Hi. This is Patrice Baylor, regarding Medicare's contingency plan are you planning to issue one on behalf of carriers and intermediaries or will you be expecting each of them to inform the providers what they're able to do. We also have another contingency problem with being able to receive our 835s. My expectation was that these were going to be validated against Claredi ahead of time yet we are finding many errors and in light of the fact that they might not be ready to be compliant by October, right now we're looking at having to hire 40 to 50 staff and I can't wait to train people on October 1. So we would really like to know how you're going to issue this contingency for Medicare and when.

Jared: I'll answer the first part of your question and then Gary – this is Jared Adair. Gary Kavanagh will address the second part of your question. The first part of it had to do with Medicare contingency. We like other health plans will in fact come up with our contingency plan and share it with our Medicare contractors in the ear future and we'll have a date in there where we would say at what point we would let them know whether or not we would be deploying our contingency. So that will be coming out in the near future and we will have – it will be a Medicare wide, but it will not be – we will not determine whether or not we need to deploy it until later on in the summer.

Gary: And in terms of your statement that you don't believe the transactions coming back to your complaint because we need specific information on that. So if you could send that in from which contractors or intermediary carriers that you're dealing with and what the specific problems are we can follow-up on that. You could send it to the ask HIPAA site.

Patrice: And we're happy to do that. I guess what I'm starting to hear is, you know, there's many of us who are having these kinds of problems and we're all, you know, hounding you one by one to "askHIPAA". You know, maybe there's a way that we could, you know, through this kind of posting information help move those people along. We don't like to be the reporters. They're trying but they're just not ready. They're not doing it right.

Jared: Well, we have forums with our Medicare contracts where we bring this up. We do have information on our website where we had got their testing status and we will take a look at if we should be putting more annotation on there for people to be aware of and – but your point is well taken. We are having conversations with the Medicare contractors about what people are expecting from the.

Patrice: Were these supposed to be validated before they start testing?

Joy: This is Joy. I was just going to ask that question. Are you saying you're running these 835s through Claredi prior to your translator?

Patrice: Correct.

Joy: So you have not tried to run these –

Patrice: Through a validator, a different one, but the same edit and they're – you know, they're not balancing. They're missing mandatory data elements and there's no way they would have passed the Claredi validation engine.

Joy: I mean, we did require all of our contractors to certify through Claredi a year or so ago. I know they revised their tools but we have not required them to do that again this year.

Gary: And we also have – I mean, we are in communication with Claredi and providers that are working with Claredi in particular and, you know, there are some issues, you know, even though the guide is supposed to be –

[INAUDIBLE – SEVERAL SPEAKING AT ONCE]

Patrice: -- mandatory elements, not the situational gray area. So I was surprised at how it showed up. But thank you for your help. We'll submit the information directly.

Bernice: You're welcome. Next question please.

Operator: Your next question comes from Ann Marie Helstrom.

Ann Marie: Hello. I'm calling from a durable medical equipment supplier and I'm rather new here and our HIPAA compliance officer has been on vacation probably the whole time I've been here. So I just have a general question. Sorry if it's too naïve, but I do all the Medicare billing. And we're currently transmitting our claims electronically and, you know, then we go and we download our rejections. We actually submit to the region A DMERC because that's our population. But nonetheless we're receiving, you know, the rejections if anything, you know, no date of birth, doesn't match. And then we download our payments, you know, by electronic remittance. Can I assume that if we're – I'm sorry. Did I step on what you were saying?

Jared: No.

Bernice: No.

Ann Marie: Okay. Can I assume that if we're submitting our claims electronically we're getting our rejections, you know, when we download the receipt to make sure it went through or that the prior one went through and that we're downloading our ERN payments, but we're HIPAA compliant or is that too general a statement?

Jared: This is Jared Adair and I'm sorry to tell you I believe that's a little bit too general of a statement. I'm sorry to do that to you, but I figured you wanted the – it could be possible, but I rather doubt it right now. People have been billing electronically in different formats as – that were payer driven. By October 16 what we've been talking about is new electronic transaction rules if you'll allow me having to do with formats and data content go into effect. And so although it is maybe a slim chance that before your friend went on vacation he had gotten all the way through and was in

production is not really feasible.

I would suggest that you go to our website and – that I mentioned before although I'm sure at the end of the call we'll mention it again as well as the HIPAA web – yeah, E-mail address so that you can see what the alterations you need to be making in order to be HIPAA compliant.

Ann Marie: Because all I see is the raw data that we're putting in. For example just real basic, you know, location 12 home is our place of service code. I'm hoping and I'm assuming that it's working right because I don't see the – I don't know what that translates to in our file, you know, our data file when we transmit it.

Bernice: Thank you for your comments and –

Karen: I just want to add one thing and this is Karen Trudel. What I would suggest you do is speak to whoever is the vendor for the software you're using, if you have internal IT people, if you work with a clearinghouse. You need to talk to some of those folks and find out where you are in the process. Because the ability to submit electronic claims today does not guarantee you anything in October.

Ann Marie: I gotcha. Thank you.

Karen: You're welcome.

Bernice: You're welcome. Next question please.

Operator: Your next question comes from Richard Pico.

Richard: Hello. I'm really interested in seeing the results of your study and modeling study that is in impact analysis of how the complaint driven system is going to work such as how many complaints per year do you predict what the response time, how many resources do you have assigned, how many steps, what will you do when the accused challenges back and says and denies it? When you look for a transaction compliance a two-way problem becomes an in-way problem very rapidly if there's other vendors, intermediaries involved. So I – we really need to see the study of how this system

will work when it starts up in October.

Bernice: We're having a little consultation in the room here. Just hold on please.

Karen: This is Karen Trudel, you've kind of asked an awful lot of questions there. I think we have outlined in a number of round tables that the general – the generalities of the enforcement process and talked about the different steps that we were talking about. You do need to keep in mind that no matter how many vendors or billing agents are in a process, really we are talking about enforcement between, among, and against covered entities. And what we are trying to do first and foremost rather than to take action immediately is to obtain voluntary compliance. So the first part of our process will be to determine whether there's a valid complaint, who the covered entity is and whether there's a valid complaint. And then to go to that covered entity, find out, you know, what the situation is. We are working on some tools that we will be using in the course of that process and those are not built yet, so I can't speak to them.

Richard: Well, no, I understand all the steps. I guess my – the first part of the question – I was just delineating some of the questions that – in terms of the study that you've done to predict what the – I mean, this is a – the large social impact of how many complaints are you going to get – how many people do you have to handle the complaints, how many feet on the street? What is your average response time? What will you do with – when the accused pushes back? I mean, we'd like to know – and how do you predict how – what's going to happen? And do you have any data or analysis around what's going to happen? Or is it just going to start from day one?

Jared: No, it is not. Sir, we can – part of this we're not in the position because it has to do with some pre-regulation type of activity that we're not at liberty to share right now, but I think that what you've told me is that when we're in a position to share that we will make it available and it'll be part of publication. It'll be part of published regulations having to do with enforcement.

I would, however, like to remind people that our involvement only

starts when a complaint is levied and that it is anticipated that this supposed to be an industry process where people are working together to make it. And so we would hope that prior to ever a complaint coming to our door that the trading partners have tried to work it out amongst themselves and rectify the situation and that – I mean, if you take a look at the old benefits of HIPAA and how standards are developed, where they come from, it truly is an industry process. The enforcement is a last resort activity and we view it as that. The attentions and intentions is on the industry working together to make sure the process is working for them.

But as we publish the regulation you will see the information in the impact analysis.

Bernice: Thank you, Mr. Piceo. May we have the next question please?

Operator: Your next question comes from Steven Banks.

Steven: Good afternoon. Thanks for taking my call.

Bernice: You're welcome.

Steven: I have a concern from another meeting that we attended that some payers are basically stating procedurally at the time that October 16 comes forth that they turn a switch and claims are either compliant or they're not compliant. If some items are missing, they may consider it at that point not compliant and reject the claim. And my concern is that most of the payers are basically stating, you know, as long as they have what's needed to pay the claim, you know, they will go ahead and pay the claim and process it, which is great.

But I'm concerned about the ones that done when we have to start doing rebuilds on old claims that were prior to actually going live on October 16 from the standpoint that the extra additional data fields may not be present with data just due to the fact that we didn't have systems up at that time to capture that data and what are the payers going to do with that data. Are they going to be rejecting these old claims because they're going to consider them non-compliant like we've been told, that some payers are going to do it? And what would be CMS's lock on that?

Bernice: We are getting consultation in the room.

Karen: This is Karen Trudel. First of all that does speak to the issue of the guidance and establishing contingencies and it may be that some health plans that initially felt that they were required to do that in order to maintain their own compliance will reconsider and decide if there is a necessity to implement a contingency and a contingency may be to accept an incomplete HIPAA transaction and incomplete 837. That's a perfectly acceptable contingency to implement. I think the other question has to do with just the issue of cross over pre-HIPAA to post-HIPAA and I think that issue will come up not only with that kind of rebuild, but there any measure of other situations where you will find yourself submitting whether it's because of an appeal that's reversed or whatever, a claim post October 16 for services that occurred earlier.

And a number of plans Medicare as well, I think, are trying to come up with ways to be able to handle those situations, gap fill the data if that's necessary in order to be able to process those claims. And I would suggest that you may want to look in the companion guides from the plans that you do business with or call them up and ask how they're expecting you to handle those situations, because those claims need to be paid.

Steven: But CMS's position is that it's totally acceptable to have an incomplete E837 on old claims.

Karen: What CMS's position is is that for this period of transition because what we're trying to do after all is to get people compliant as soon as we can and not disrupt health care payment flow and operations that if a plan exercises due diligence as Jared mentioned earlier, that they can implement a contingency and that that is an acceptable one.

Steven: Okay. Thank you very much.

Bernice: You're welcome. Next question please.

Operator: Your next question comes from Caroline Price.

Caroline: Hello. Thanks for taking my call.

Bernice: You're welcome.

Caroline: Last month I asked about a discrepancy between the agenda and the original 4010 and you were going to call me back and I have not heard anything. It deals with loop 2310C other provider information. If the service is inpatient, outpatient, or home health that data was removed in the agenda. However, the agenda kept the 2310C other providers specialty information as a required field. And it doesn't seem to make any sense. I – my question is do we have to put this in as a required field now and get it reported as an error in trying and try and get it fixed. Can we send a dummy number out for people to use? How are we supposed to handle this?

Joy: This is Joy and I do remember this call and I'm sorry. I really did think somebody had returned your call. Could I have your number again and I will make sure the analyst calls you that –

Caroline: Okay. It's getting really imperative because we're trying to get everything resolved very quickly in our software design and this is really holding us up. I have one other question.

Joy: Could I have your number? When I get back after this call I'll have the analyst get in touch with you.

Caroline: Thank you so much.

Jared: The number.

Caroline: 707-738-6873.

Joy: Okay.

Bernice: Now your next question please that you wanted to ask.

Caroline: My next question is who may I speak with regarding some web page content that is required for enrollment and authorization?

Jared: Web page content. Could you be a little more specific please?

Caroline: Well, in the regulation you state that the web page must contain the content – I'm sorry – the content not the format.

Jared: Okay. So you're talking about a web based enrollment.

Caroline: Web-based enrollment and web-based authorization and what I want to discuss with someone at CMS is the content of those two formats.

Jared: When Joy calls you back with the other one, we will have a context for instance on the DDE.

Caroline: I appreciate that. Thank you so much.

Bernice: You're welcome, Ms. Price. Next question please.

Operator: Your next question comes from Mary Highland.

Mary: Yes. I have a question regarding providers who have self-pay patients seeking eligibility status. Currently as they do business now if a client comes in and self-pay the provider normally comes in and checks that the Medicaid status of that client to see if the by chance have Medicaid as an insurance carrier. They also now are checking other insurance carriers as well to see if that client has coverage under those carriers. By the privacy act, I believe that is – should no longer be acceptable. Am I correct on this?

Jared: The privacy rule doesn't distinguish between self-pay and other patients. The process that you're describing does have to do with treatment payment and healthcare operations so that it's appropriate to request that data but the provider who's requesting the data will need to have enough information about the patient, the patient's name, the patient's Medicaid number or Medicare number of whatever that they can – that the plan can be assured that they actually are checking on behalf of the patient.

Mary: Okay. Thank you very much.

Bernice: Next question please.

Operator: Your next question comes from Lori Valentine.

Lori: Hi. I want to give you a little background before I ask my question. Back in August when the final privacy rule came out I submitted a DSMO request stating that I thought there was a conflict between the privacy rule and the transactions rules regarding the release of information. The 837 indicates whether the provider has a signed statement by the patient to authorize the release of data.

Final privacy rule said that you don't need a patient's signature for treatment. However, the 837D was already out and it said that it was still required - CLM09. Anyway last November the DSMO] request was approved. The work around was outlined. I guess they got everybody involved. CMS also some civil rights lawyers, office of general counsel, obviously.

At that time when they responded back to me they had said that they were going to send out some kind of public advisory. And to my knowledge, which is obviously limited and there's 10,000 things out there to read, which I haven't read them all. So I put in another DSMO request because just to ask about this. HIPAA implementation that's so quickly coming we just want to make sure that the claims aren't rejected because there wasn't a signature collected. Does CMS plan to publish any technical guidance for the industry on some of the known discrepancies? I mean, is there a process to advise the public when one federal rule says something and one federal rule says something else?

Bernice: We had the question.

Karen: Lori, this is Karen Trudel. I'm afraid we're all drawing a blank on this particular issue. We will go back and check it out and see if we – the process that we would use if we need to clarify that would be to develop a frequently asked question.

Lori: Oh, okay.

Joy: And this is Joy. I can at least – I can assure that as long as you put a valid value in that segment we're not going to reject the claim. Okay.

Lori: Well, but if the value is “no”. The guide says that you don’t allow release of information..

Joy: It wouldn’t cross over to another payer.

Lori: But some people are saying no means that they would reject the claim.

Joy: At Medicare we’re not doing that.

Lori: Okay. And when the work around came out, they said to not do that.

Joy: And I understand that the element has been changed to situational but unfortunately it is required now.. You have to put something in there.

Lori: It’s required now .Joy: Right, right.

Lori: Yeah.

Bernice: Thank you, Ms. Valentine. We have time for one more question.

Operator: Your next question comes from Linda Kruger.

Linda: Yeah. Hi. Thank you for taking my call.

Bernice: You’re welcome.

Linda: I have a pretty generic question and it may sound silly to some of you, but just coming into this process recently, we’re looking at the situational data elements and we’re trying to determine when we’re looking at the file sent to us by our computer software company, which items are required and by payer and it sounds to me at the beginning of this conversation that maybe the answer to this question lies in the companion guide, which is, you know, a new term for me. But perhaps on a CMS or a Medicare level can you answer the question, you know, if I looked at these list of things that say that they’re required, are they truly required for Medicare or is it Medicare not required requiring some of the

items just because they're saying it's part of the new companion guide?

Joy: Okay. This is Joy. You need to look at the implementation guide first and anything that is absolutely required must be there and then of course you need to look at the situational note for the data elements. Medicare issued companion guides and they are available on our website that note particular things that, we don't need or --

Jared: To find tough situations.

Joy: Right. And particular elements that, you know, may need clarification.

Linda: Yeah. So as an example we just throw this out there if you would. On the situational data elements we have the date of accident. If that accident – if there is a data of accident within the file it's saying that the city – I'm sorry, the state, the country, and the related causes are required. So we're looking at this thing – it says it's required based under this situation, but is that true for Medicare or does it matter of the payer, that everything is listed as a situational data element is required regardless of payer?

Joy: It's irregardless of the payer. If you still have that date then there's other situations that must be followed based on the guide. It really is for all payers.

Jared: There may be some situations where one payer would require a data element while another one would not. But in many cases if the situation is met then the data must be there for all payers.

Joy: Because the example that you are pointing out t the data element is based on the presence of another data element regardless of payer.

Jared: True. And I guess that's what we were struggling with because I'm hearing from some people that while, you know, some payers don't require it, some payers might. Well, that's – again we're struggling with that. I mean, it needs to be all or nothing, I think, for –

Joy: The implementation guide states that the date is required if that date is present and that's what needs to be followed.

Karen: I know – this is Karen Trudel. I know we need to wrap up at this point, but I would say that companion guides do play an important and an appropriate role here. We're trying to standardize data transmission. We're not standardizing business practices in the healthcare industry. So there are inevitably going to be some situations where plans do things differently and that's not necessarily a bad thing.

Bernice: Thanks so much. We're now going to have a few announcements by Elizabeth Holland. Ms. Holland.

Elizabeth: Hi. I just wanted to remind everybody of the website. Our website is [www.cms.hhs.gov/hipaa/hipaa2](http://www.cms.hhs.gov/hipaa/hipaa2). On that website we have information about our next round table, which will be held on August 22 at 2:00 Eastern time. All the dial in information is on the website. And as we mentioned before if you have a specific example of things you want to point out to us, please send those to our E-mail mailbox. That address is [askhipaa@cms.hhs.gov](mailto:askhipaa@cms.hhs.gov).

Bernice: We want to thank you for participating in the round table today. We want to thank the staff and all of you who called in today. Ms. Hutchins, can we have the number of people who were on line today please?

Operator: Yes. 1,900.

Bernice: 1,900. Thank you very much.

Operator: Thank you, Ma'am. This concludes today's Centers for Medicare and Medicaid Services HIPAA implementation Round Table. You may now disconnect.

[END OF REPORT]