

Centers for Medicare & Medicaid Services 13th National HIPAA Roundtable
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Tina

Good afternoon. My name is Tina, 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 Roundtable. 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, simply press *1 on your telephone keypad. If you would like to withdraw your question, press the # key. Thank you.

Dr. Harper:

Dr. Bernice Catherine Harper, you may begin your conference. Thank you, Ms. Jones. Welcome to the 13th National HIPAA Roundtable call, which is being conducted by the Centers for Medicare and Medicaid Services (or "CMS") which is part of the Department of Health and Human Services.

What a difference a week makes. Last Thursday and Friday, we were confronting the devastation of Isabel. Today in Washington, the sun is shining, although last week we were closed on Thursday and Friday. And we hope that you're recovering from the devastation of Hurricane Isabel.

Our subject today is the Health Insurance Portability and Accountability Act of 1996 (or "HIPAA") and specifically the Administrative Simplification Division. The deadline is fast approaching relative to compliance with the HIPAA electronic transactions and code sets. We will begin our call today with remarks from Ms. Karen Trudel, the Deputy Director of the Office of HIPAA Standards at CMS. Ms. Trudel?

Karen Trudel:

Thank you, Dr. Harper. Hello, everyone. Welcome to the thirteenth of these calls and, as Dr. Harper said, we are fast approaching the compliance deadline for transactions and code sets. There are now 21 days until October 16. A number of things have been happening recently, and I think there's a certain amount of awareness of that. I think we've got over 2,000 folks on the call today which kind of indicates that people have something of a burning interest in this topic. One of the most newsworthy items was that CMS announced on Tuesday, the 23rd, that we have made a decision that for Medicare fee-for-service we will be implementing our contingency plan which means that there will be

the ability for providers who are not compliant to be able to find a way to have Medicare claims submitted and paid. And to talk a little bit more about that is Gary Kavanagh who is the Director of the Business Standards and Systems Operations Group at CMS. I'll turn it over to Gary.

Gary Kavanagh:

Thank you. As Karen said, on Tuesday we issued a press statement that said we were implementing our contingency plan, and this is the message that we've asked all carriers and intermediaries to post on their websites which you should be seeing soon if you haven't already. It says:

After careful analysis of Medicare provider, submitter, and other trading partners in HIPAA readiness, Medicare will continue to accept and send standard and non-standard versions and/or formats for any electronic transaction for a limited period beyond October 16, 2003. This is a temporary measure to maintain provider cash flow and minimize operational disruption while trading partners who are not compliant on October 16, 2003 work with Medicare to achieve full compliance. This contingency plan is only for a limited time. Providers who must continue to bill and receive non-compliant formats should test and move into production on HIPAA-required formats as soon as possible or risk possible cash flow problems.

So that was the announcement. I'm sure there's more on our website about that as well, and I'm sure you may have some questions about that that we'll answer in a few moments.

Karen Trudel:

Gary, this is Karen again. I'll just ask I think a few questions perhaps that I've been hearing and that perhaps will answer questions that some of you were thinking about. The contingency means that we are going to be accepting HIPAA-compliant transactions and all of the other EDI ("electronic data interchange") formats that we're now accepting?

Gary Kavanagh:

That's correct.

Karen Trudel:

And is that to include the HIPAA 4010?

Gary Kavanagh:

That's correct. Yes, we will. Including the national standard format as well as that we accept today.

- Karen Trudel: Okay, great. Other people have also wanted us to clarify, are we just talking about claims or do we include things like remittance advices and coordination of benefits transactions?
- Gary Kavanagh: Yes, we do. That's why I included the language "accepting standard and non-standard versions."
- Karen Trudel: Okay, good. Thanks. We're going to go now to Joy Glass for some follow-ups on items that were raised in our previous roundtable. We're starting to institute a provision like the other CMS-sponsored open doors where when we receive questions that we can't answer, in addition to responding directly to the person who asked, we will actually tell people on the next call what the answer was so that everyone has the benefit of that information; and there are several items left over from the last session that Joy will address.
- Joy Glass: Hi. Yes, there is one question that was asked regarding the 834 transaction and I did promise to supply an actual listserv address where you can sign up and pose your questions on particular transactions because we do not have expertise here to answer the questions on the 834. And I would like to provide that address here. It's <http://www.x12.org/x12org/listserve.csm>. And when you sign up to that listserv, there are a lot of various transactions and discussion groups that you can pose your questions. And they're very helpful; you can get a lot of information on a variety of questions and what a lot of people are asking.
- Okay. Another question that was asked concerned a Medicare secondary claim. The question was: If the primary payer has sent a paper remittance and they do not have any claim adjustment reason codes, what would Medicare expect to receipt on the MSP claims? And you can send the electronic claim without the reason codes. The amount fields that we need are not contained in that segment, so you do not need to send reason codes.
- A third question was asked about the Medicare claims on ordering physicians, the tax ID. It was asked that they are having a problem getting that tax ID from the provider. In the 837 implementation guide, the ordering provider tax ID, that data element is situational. It was changed to situational in the addenda version and it's only required if known. So you do not have to supply that for the ordering physician.

Karen Trudel: Okay, thank you. I think at this point we will open it up to questions.

Dr. Harper: Ms. Jones, would you give us the instructions for asking the questions, please?

Tina: At this time, I would like to remind everyone in order to ask a question, please press *1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Your first question comes from Kazoo Sano{phonetic}.

Kazoo Sano: Hi. Are you taking privacy questions during this call?

Karen Trudel: No, I'm sorry. We do not have an OCR representative available.

Kazoo Sano: Okay. When will the next time be that we can ask privacy questions?

Karen Trudel: We'll invite them to the next one.

Kazoo Sano: Great, thank you.

Dr. Harper: Your welcome. Next question, please.

Tina: Next, we have Jane Stafford.

Jane Stafford: Hi. This is Jane Stafford from Care First Blue Cross/Blue Shield. I wanted to ask if the leeway that you talked about in terms of your leniency for other than Medicare claims that has been talked about for the last several months is still in place.

Karen Trudel: This is Karen. I think what you're going back to is the original announcement that was made on July 24 that health plans who exercise good faith efforts can exercise a contingency -- implement a contingency -- plan. That is guidance that is industry-wide. That still is in effect. Medicare, as we just said, has determined that it will implement a contingency and, as I understand it, the Blue Cross/Blue Shield Association announced also on Tuesday that all of the Blue plans will choose to implement a contingency for a short period of time also.

Jane Stafford: Thank you.

Dr. Harper: Next question, please.

- Tina: Next we have Patrice Cup.
- Patrice Kuppè: It's Kuppè{phonetic} now. Hi, Karen. We're wondering if CMS is going to provide any guidance for providers in situations where the primary payer requests that transactions be on an institutional claim and then CMS wants those services split out to a professional claim, or vice versa. How are we able to reconcile that with electronic remits and 837s?
- Karen Trudel: I'm going to ask Stanley Nachimson to respond to that.
- Stanley Nachimson: If you're talking about, Patrice, what should a provider do or are you talking about a coordination of benefits situation?
- Patrice Kuppè: The COB piece. I mean, I don't really have a choice is Payer A it's got to be institutional, I've got to do that. Right?
- Stanley Nachimson: That's correct.
- Patrice Kuppè: I don't know how I'm supposed to do it.
- Stanley Nachimson: You will have to recreate the claim in the format that the secondary payer asks for. We are working with -- or at that Wedi organization is putting together -- a group to work on selecting the appropriate implementation guides for different situations; so hopefully at some time in the future there will be industry agreement on every type of claim, whether you use the institutional or the professional, but {unintelligible; both speaking}.
- Patrice Kuppè: What if we can prove to you like it's not, we can't do it? {Laughing} I mean, we can't do this.
- Stanley Nachimson: If you're talking about a Medicare situation
- Patrice Kuppè: Yes, I mean with other payers, I can just say, "Forget it. I'm dropping the second one to paper." But I can't for you guys.
- Stanley Nachimson: I'll leave that to the Medicare folks to explain how they can do it for Medicare; but according to the rules, a payer is still free to choose the appropriate implementation guide and type of claim that they require for each situation.
- Dr. Harper: Anyone else in the room want to comment?
- Gary Kavanagh: Well, we want to make sure -- this is Gary Kavanagh -- we want to

make sure we understand the situation. You're saying that you bill a primary payer who's not Medicare and you're billing them, for example, as inpatient and then you come to Medicare and Medicare's telling you that you need to bill that as an outpatient service. Is that the situation that you're talking about?

Female Speaker: I would assume, Onesta{phonetic}, if that's correct -- and I'm not sure; maybe you can't get back to the mic -- but if that situation were corrected, it seems to me what you would have to do is create an electronic claim that be an outpatient claim for secondary payment.

Patrice Kuppè: I know. But I just billed it using all the institutional codes.

Female Speaker: I guess we'll have to follow up.

Karen Trudel: Why don't we take your contact information and someone will call you back?

Patrice Kuppè: Stanley has it, thank you.

Karen Trudel: Okay, thank you.

Female Speaker: Was that Patrice?

Karen Trudel: Yes.

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

Tina: Your next question comes from Jean Dowling.

Jean Dowling: Hello. My question, today, is in regard to ICD-9 codes on outpatient claims. Is it my understanding that Medicare no longer wants to see ICD-9s on outpatient claims?

Joy Glass: No. This is Joy Glass. That is not true. There are specific volumes of the ICD-9 that only apply to outpatient.

Karen Trudel: The ICD-9 diagnostic codes are to be provided in all settings.

Joy Glass: Yes, uh-huh.

Karen Trudel: But ICD-9 is the adopted code set only for inpatient claims.

Jean Dowling: Okay. So ICD-9s as a general rule should still remain on outpatient claims. There's been a lot of emails flying around based

on some information that came out from a company called ABC Monitors, and they've made some I guess claims that they should no longer be submitted on outpatient claims, and it's very confusing.

Stanley Nachimson:

This is Stanley, and let me see if I can at least explain the situation. And we need to maintain the distinction between diagnosis codes and procedure codes. For diagnosis codes, the ICD-9 code set is the adopted code set for all types of claims and should be continued to be used on any claim. However, if we're talking about procedure codes, the ICD-9 procedure codes are only to be used for hospital inpatient procedures. Any other procedures, you need to use either the HCPCs or the CPT-4 code sets as appropriate. So this was a discussion perhaps on outpatient procedures where, my understanding is, some hospitals were putting in the appropriate HCPCs or CPT-4 codes, but then providing additional information in the form of the ICD-9 procedure codes. The ICD-9 procedure codes are not the recognized or adopted HIPAA code sets for outpatient procedures, so those should not be used.

Karen Trudel:

Right. This is Karen Trudel. We're aware that there's some confusion. We've gotten a number of calls asking the same question on our hotline, and we are tracking it back to the source. But the answer that we've provided here is authoritative.

Jean Dowling:

Okay. Thank you very much.

Karen Trudel:

Thank you.

Dr. Harper:

You're welcome, Ms. Dowling. Next question, please.

Tina:

Your next question comes from the line of Jim Ricker{phonetic}.

Jim Ricker:

Hi, this is Jim. You just answered my question. I was going to ask the same thing about the procedure codes and outpatient claims. But as I'm talking with the people that are doing coding and as we've been testing with both commercial payers and with Medicare, we're submitting ICD-9 procedure codes on the claims and that's been the practice from day one in doing UB92 billing. And I think a lot of us are being caught off guard that we're no longer going to be able to do this. This is a major change for us coding-wise.

- Karen Trudel: I'm kind of at a loss to explain that because this was very clearly stated in the regulation in 2000 and hasn't been affected by any of the modifications.
- Jim Ricker: I guess what I'm saying is, there was an assumption on a lot of our parts -- I guess we didn't understand as we read the regulations and so on -- that by saying it would be used in inpatient it excluded the use of procedures for the outpatient coding. And so there's a lot of us that are going to be scrambling to try to figure out how to meet this requirement when it wasn't -- even though you are correct, it does say that; I've looked it up in the regulations -- but I think there's why there's so much concern about it.
- Karen Trudel: Okay. Well, this is again one of those unforeseen situations where contingency planning can possibly go a long way to keep payments flowing; and we'll continue to sort of monitor that situation. I'd be interested to hear more about it. Next question.
- Dr. Harper: Thank you, Mr. Ricker.
- Tina: Your next question comes from Ed Golgahon{phonetic}.
- Ed Golgahon: Good afternoon. My question is related to the patient relationship code and specifically the NUBC{phonetic} directive that the UB92 be changing with statements showing service dates after October 16. Essentially, that has an impact that, first of all, I don't think has been brought out; and I'm curious what guidance you're issuing to the fiscal intermediaries about that and what CMS's own contingency plans are based on the fact that its own contingency software -- for example, the PCS Pro 32 -- is not even supporting that directive.
- Joy Glass: This is Joy. We will get back to you on this.
- Ed Golgahon: All right.
- Dr. Harper: Thank you. Next question, please.
- Tina: Your next question comes from Mimi Raulette.
- Mimi Raulette: Hello. I have a question that I'd like directed to those involved in the PCS Pro 32 software application for Palmetto, please. Is there a multiple user version of this PCS Pro 32 software?
- Joy Glass: When you say multiple users --

Female Speaker: Do you mean for use on a network?

Mimi Raulette: Yes, for use on a network.

Joy Glass: We'll have to have someone get back to you on that.

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

Tina: Next we have Sherry Cullen{phonetic}.

Sherry Cullen: Yes, we were wondering, is CMS gong to issue a directive to all their contractors on how they're going to conduct their crossovers? Or are you going to allow each contractor to do their own thing?

Karen Trudel: I guess I need to ask you to clarify what you mean by how they're going to do crossovers. The contingency guidance that we issued said that for any crossover partner that is ready to accept HIPAA formats, we will send a file in a HIPAA format and in fact we have many in several in production today. And if a crossover partner is not ready to receive the HIPAA format, we will continue to send the current format.

Sherry Cullen: That answers that question. Thank you.

Dr. Harper: You're welcome, Ms. Cullen. Next question, please.

Tina: Next we have Sal Golubcau{phonetic}.

Sal Golubcau: Yes, I'd like to follow up on the previous question. We're a secondary payer and we have a relationship with 23 CMS contractors: A and B. You said pretty much that it is when the secondary payer is ready, but is there no standard approach to this? Do we need to work out the arrangement one by one? We haven't been able to test successfully to this point with any of the 23 contractors. Can we insist on a full testing process or is there a standard approach, directive, that you will giving on this and how long can this go on?

Cathy Carter: Yes, the process is supposed to be standard and we have had -- there are, I believe, some fixes that are still being made or should be in the final stages of being made at this point -- but every contractor should be able to send a test file to trading partners at this point. I understand there are some issues of maybe where we don't necessarily agree on interpretation, and I believe there are meetings that are going to take place here at Central Office talking

about some of those issues. But every contractor should be able to send a test file at this point and, as I said, we do have some in production. To answer your question about whether you need to deal with each and every contractor, yes, you do. That is the way the process is currently set up. That's the way your current process works absent HIPAA. And that's the way it will work at this time. You have to be able to attach the file you receive from each of those 23 contractors that you mentioned that you currently have arrangements with.

Sal Golubcau: Has it come down to the satisfaction then of the secondary payer with each contractor, with the files of each contractor?

Karen Trudel: This is Karen. Perhaps I'm understanding what you're saying. As you test with each one of them, you make the decision about when you want to move over into the HIPAA-compliant format, assuming that you have done so before the contingency period ends because at that point Medicare will make a decision to completely move over to HIPAA and all the contractors will do that on the same date.

Sal Golubcau: Right. So do you have any idea when that period will end?

Karen Trudel: No, we don't. And the reason that we don't is that we're going to be looking very closely over a period of weeks at production numbers to see how people are doing, and that will have a pretty big impact on our decision.

Sal Golubcau: Thank you.

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

Tina: Next we have Gracie Wheeler.

Gracie Wheeler: Thank you for taking my call.

Dr. Harper: You're welcome.

Gracie Wheeler: I have a few questions, but they're all pretty related. First, I was wondering if we're allowed to send both A and B 837 and NSF production claims at the same time?

Several: Yes.

Gary Kavanagh: To Medicare? Is that the question?

- Gracie Wheeler: Yes, Okay. Well, if we do that, what will our remittance information be like? Would we get 835s in response to the 837s and another format in response to the NSF? Or is it going to be all mixed together?
- Joy Glass: It would be whatever you're currently receiving.
- Karen Trudel: Right. My understanding is that each contractor works with their providers, and my understanding is that a provider can only receive either an 835 or another format of the remit. They can't receive a multiple. You could send in multiple formats, although certainly we're encouraging that once you've tested and moved to the HIPAA format we'd like to see all the claims moved to that format. But I believe that the remit can only be one version.
- Gracie Wheeler: Oh. Well, okay, because for reason D{phonetic}, we've been getting both the old style ERAs and the 835s. I don't think the 835s are correct, so I'm not sure what those are that we're getting exactly from them. But I was just wondering what would happen if we start to fully go into production. So I guess it's not a 1:1 relationship. You're supposed to just get one type of remittance information.
- Joy Glass: Right.
- Karen Trudel: That was our understanding; but if you think you're getting multiple formats, I guess we would need to follow up to see.
- Female Speaker: Well, no. Frequently during a testing period, a contractor will send out the new format and the old format just for comparison purposes, but that's typically only for about 30 days or something.
- Gracie Wheeler: Oh, okay. Yeah, we are in the testing mode, so that's probably why. But once we start going into production, then we'll just get one type of remittance?
- Female Speaker: Right.
- Dr. Harper: Thank you, Ms. Wheeler.
- Gracie Wheeler: Oh, wait. I have a few more.
- Dr. Harper: You have another question?

- Gracie Wheeler: Okay, thank you. We have a question about submitting retail pharmacy claims. Since most of the DMERCs are already with the NCPDP 1.1 batch, how will we submit? Will it be in an 837 transaction?
- Joy Glass: This is Joy. Actually, all our DMERCs already -- in fact, In know we have one of our DMERCs actually has some vendors that are already in production. They've successfully passed testing. So they are ready to test.
- Gracie Wheeler: Well, the only two DMERCs that I've been able to get to say that we could test is the Regions B and D. A and C, whenever we contact them or try to look on their webpage, it stays they're not ready.
- Dr. Harper: Okay,I'll get back to you. Thank you, Ms. Wheeler. Next question, please.
- Tina: Next we have Julia Mathis.
- Julia Mathis: Hi. Thank you for taking my question. I really am looking more for a contact rather than an answer to the exact question. We're seeing some differences between the four RHHIs in home health -- Palmetto, Cahaba, Associated Hospitals of Maine, and UGS -- and these are sort of what I would call grey area differences. The companion guide says the same thing, but we get error reports back where one wants one thing and one wants something else. And we were wondering is a body that we can go to with a question to get a single, standard answer because half the time we're not sure if perhaps UGS is answering and their answer applies to all the others, or if their answer applies only to them. But now that we have customers sending production claims to all four intermediaries using our software, it's becoming critical that when we get reports, like after being in production for four weeks, we get an error that a new edit is going to be put on and then we'll have to change our software for this new edit. We're concerned because these are coming in I'd say two a week now where the intermediaries, now that they're seeing more claims, they're starting to I guess tighten up their demand and they're not in agreement. Is there a way to make one contact to get a firm answer?
- Joy Glass: What we will need is really as many specifics as you can give us: specific edits, specific RHHIs. And then if you'll give us your

contact information, we'll have somebody get in touch with you, go over the information, and see what we can do with it.

Julia Mathis: That's excellent. So you're going to take my information?

Joy Glass: Right.

Julia Mathis: I can give you the specifics.

Dr. Harper: Great. Thank you.

Julia Mathis: Thank you.

Dr. Harper: Next question, please.

Tina: Next we have Christopher Fehr{phonetic}.

Christopher Fehr: Yes, hi. Thanks for taking my question. This is Christopher with OptiServe. In a situation where the payer has announced they're not quite ready to accept the standard for a particular line of insurance but the provider is ready to submit it, would you like the provider to take any particular action in terms of informing CMS or should the provider just wait for instructions from each payer regarding when they can accept the standard?

Karen Trudel: Well, first of all, if a plan is not able to conduct a transaction in a HIPAA format as of October 16, they are technically out of compliance and the provider is within his rights to file a complaint. That being said, we do encourage providers and plans to be talking to each other about any areas where there might be compliance problems, where there might be potential cash flow interruption, to talk about whether contingencies are appropriate and to try to work things out. And I think that's what I encourage people to do first before filing a complaint. I would suggest that the provider talk to the plan and say, "Okay. When are you expecting to be ready? What are you gonna do in the meantime?" And take it from there.

Christopher Fehr: Thanks. I'm actually assuming that there would be a lot of conversation between the provider and the payer and that a reasonable contingency would have been worked out and a provider was able to submit the old format and everything was working well. My question was more whether CMS would want to be informed in some way. I don't think providers are going to want to submit complaints -- that sounds like a lot of trouble -- but do you want to be informed or should we just keep this between

the provider and the payer until it's worked out?

Karen Trudel: I think it needs to be between the provider and the payer. I think as long as people are working things out, if there isn't a sense on someone's part that there should be a complaint filed, I'm not sure what we would be doing with the information.

Christopher Fehr: Well, my thought was that you might want to record it for your information just in terms of what's happening so that you understand the state of the industry. But if you don't want it; that's fine. I just was curious to whether you would want it.

Karen Trudel: I know. We're always happy to hear what any information that people have, so if you'd like to provide that, certainly feel to do it, Chris.

Christopher Fehr: Okay, thanks.

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

Tina: Next we have Sharon Flanagan.

Sharon Flanagan: Yes. I'm a durable medical equipment dealer and we bill power wheelchairs hard copy because we send physical therapy reports with the claims. We currently have tested, and we're on the correct format right now, for other electronic billing; but we have not started billing power wheelchairs electronically because of these physical therapy reports. Will we have to transmit these electronically, and how will we get those physical therapy reports to Medicare? Or will each claim just go into a suspended and then they'll requested a hard copy of it?

Joy Glass: Yes. Currently, you will be able to continue to bill those on paper. We are going to have a process in place that the Medicare contractors will be able to associate the paper attachments with the electronic, but that is not in place yet. So until that is in place, you may continue to bill those claims on paper with the attachments.

Sharon Flanagan: Okay, great. Thank you.

Gary Kavanagh: You also need to check with your regional carrier to make sure that the process we just described is a process they're using.

Sharon Flanagan: Are you saying that they might deny our claims?

- Gary Kavanagh: No. I'm saying that they may be able to accept your claim electronically and associate the attachment with it; so you would want to check before you bill on paper.
- Sharon Flanagan: Okay. Would we check with the EMC Division or with Provider Relations? Who would be the proper person?
- Joy Glass: You would check with your EMC Division.
- Sharon Flanagan: Okay.
- Joy Glass: Just to see if they -- because some of them need to have that process in place, but not all do. Okay?
- Sharon Flanagan: Okay, thank you.
- Dr. Harper: You're welcome, Ms. Flanagan. Next question, please.
- Tina: Your next question comes from Rick Navarro.
- Rick Navarro: Hi. I appreciate the opportunity to get an answer to my question. HIPAA clearly allows a carrier to define its requirements for conducting an electronic transaction within the scope of HIPAA's definition of a trading partner agreement. However, many carriers and clearinghouses acting as portals for carriers are refusing to conduct standard transactions with trading partners unless the trading partner signs a contract with them that sometimes contains contract language dealing with indemnification, extra security requirements, requirements to protect non-PHI data, etc. My question, under HIPAA, can a carrier or their clearinghouse demand these kinds of contracts be signed as a precondition to accepting standard transactions even if a trading partner strongly objects to some of the terms? Thank you.
- Karen Trudel: I think we're getting into a legal area where I don't feel comfortable making a statement off the top of my head. There may be a grey area here that we need to look into. The things that I can say are that, yes, health plans have the ability to require trading partner agreements. I don't know of any health plan, except for instance claims from providers that they don't know, or clearinghouses where they don't have a sense that they have a business relationship with them. Health plans further have the ability to limit the ways in which they accept electronic claims.
- Rick Navarro: Yes, but, are we to exclude those items that are covered under

HIPAA's definition of a trading partner agreement which are all those electronic setup issues --

Karen Trudel:

Right.

Rick Navarro:

-- how to send, giving the IDs, etc. I'm speaking just of those issues that HIPAA doesn't speak to such as the contract language dealing with, you know, "You agree to indemnify us if your trading partner ever does such and such."

Karen Trudel:

Uh-huh.

Rick Navarro:

"And pay our legal bills" and all those kinds of things which are -- I would never sign those kinds of terms otherwise, but if I don't, if I can't send standard transactions.

Karen Trudel:

I understand that. Because we have a number of people listening, I was trying to respond to the parts of the question that I could answer specifically in case that information was of use to any of the other listeners. Where we do have a certain grey area is whether the requirements of the trading partner agreement are so onerous that they basically disadvantage people who are submitting HIPAA transactions; and I would have to ask for some language to take a look at. And if you can give us your name and number, we'll get back to you.

Rick Navarro:

Yes, and I've already sent things to CMS and HHS about this over a month with the exact contracts and never got a response.

Stanley Nachimson:

This is Stanley. We are looking at that and are in the process of putting together a response to those requests.

Karen Trudel:

Okay, good. Thanks.

Dr. Harper:

Thank you. Next question, please.

Tina:

Next we have Becky Ostralski {phonetic}.

Becky Ostralski:

Will Medicare continue to accept primary and MFP claims on paper from providers if they submit electronically as well?

Gary Kavanagh:

No. Beginning October 16, they must submit electronic bills to Medicare.

Becky Ostralski:

So that will not come under the contingency plan at all?

Gary Kavanagh: No.

Becky Ostralski: Thank you.

Kathy Simmons: We do have one exception.

Gary Kavanagh: There is one exception.

Kathy Simmons: If Medicare is secondary and there's more than one primary payer, those claims can continue to come in on paper. But if there's only one primary payer, they are supposed to come in electronically.

Karen Trudel: This is Karen. You've raised a very good point and, again, something that we've heard some potential widespread misunderstanding about, and that is that the Medicare fee-for-service contingency only has to do with electronic claims. It doesn't have anything to do with the provisions that require people to bill electronically and not on paper. What we're talking about in terms of the contingency is providing the ability to use those HIPAA-compliant and non-HIPAA-complaint electronic formats for submitting claims.

Becky Ostralski: Okay. Will you reject or deny these claims if they are transmitted or sent on paper?

Karen Trudel: If they are sent on --

Kathy Simmons: Initially, we're going to accept the claims because there are a number of exceptions to the paper prohibition. And we're going to initially assume that whoever is submitting the claim has made an evaluation to determine that they meet one of the exception criteria for submission of claims. For instance, somebody could be a very small provider that's entitled to send all of their claims on paper if they choose. But what we're going to be doing is on sort of a post-payment basis, we're going to be doing some evaluation of the levels of paper claims being submitted and on a certain case-by-case basis we'll be doing further investigations to determine if somebody actually met any of the exception or waiver criteria. But up front we are going to pay those claims and then deal with it after the fact.

Stanley Nachimson: When we deal with it after the fact, if we identify a provider who is inappropriately billing on paper, we will likely set up some kind of system edits that will prospectively deny claims. Our intentions at this point preliminarily are not to go back and reopen claims and

recover overpayments.

Becky Ostralski:

Thank you.

Dr. Harper:

You're welcome. Next question, please.

Tina:

Your next question comes from Carol Alevodos{phonetic}.

Carol Alevodos:

My question has been answered. Thank you.

Dr. Harper:

You're welcome. Next question, please.

Tina:

Your next question comes from Keona Newland{phonetic}.

Keona Newland:

Yes, my question I think has been addressed by several individuals. We have some concerns as to have information is going to be transmitted to the carrier in regards to attached and primary EOBs and such. We've yet to be given any information as to how to get this information to the carrier, and have asked several times and been told that this will be shared with us at a later date.

Kathy Simmons:

Actually -- this is Kathy Simmons -- we have an instruction that we're preparing and hope to get out to the carriers and intermediaries very soon, and that does also include directions that they're supposed to give to the providers about information to put in their websites as well as in the provider newsletters. So once you receive some sort of formal notification from your carrier or your intermediary, you should follow the instructions that they give you at that time; but those instructions will talk about things such as when paper claims can still be submitted in an attachment situation or talk about the secondary payer situation and other sort of unusual glitches here that may in some cases only apply to certain carriers.

Keona Newland:

In regards to the secondary claims, if we continue to send in paper, right now the challenge is getting all the data to the carrier in an electronic format that meets the HIPAA standard. We've been trying to test our HIPAA format and I think we're ready to go, but the piece has not yet been tested and completed. Therefore, if we continue to send these in a paper format, are we going to be penalized later when they do a retrospective review?

Kathy Simmons:

Well, we would encourage you to keep testing this, including testing each particular data element. If you continue to send these claims on paper six months from now, chances are you would be

detected in some sort of evaluation investigation. But if this is something that you for just a relatively short period of time and within a few more weeks or so you're able to submit these claims on paper, I don't imagine that you'd probably come up in a post-payment review.

Keona Newland:

Thank you.

Kathy Simmons:

But you can't continue this forever.

Dr. Harper:

Thank you, Ms. Newland.

Keona Newland:

Thank you.

Dr. Harper:

Next question, please.

Tina:

Your next question comes from Linda Crawford. Ms. Crawford, your line is open.

Linda Crawford:

My question's been answered already. Thank you.

Tina:

Thank you. Next we have Chris Owens. Chris Owens, your line is open.

Chris Owens:

Yes, thank you. Two questions. If in Loop 2010-BB in the destination payer we put a Medigap provider number, will that automatically be treated as a crossover?

Joy Glass:

Yes. This is Joy. Yes, if you indicate in that loop that there are secondary payers and if the Medicare contractor does have an agreement with that other payer, they will forward that on.

Chris Owens:

Okay, thanks. And my second question is, you indicated with the contingency that you'll determine based on volume and so on when to cut that off. Can we assume there will be some sort of announcement letting know that the contingency will be discontinued?

Gary Kavanagh:

Yes, there will be.

Chris Owens:

Okay. Thank you very much.

Dr. Harper:

You're welcome, Ms. Owens. Next question, please.

Tina:

Next we have Martin Morrison.

- Martin Morrison: Yes. My question is in relation to crossovers as well. Most of my questions have been answered regarding that, but I'd still like to know your position on code sets as used in crossovers. I can give you a specific example and something that we're finding in the testing with the intermediaries. Let's say a CMS contractor receives a YB modifier on either an existing electronic format or a paper claim, processes that information, and then forwards the crossover claim over to us as the secondary. We're seeing the YB modifier in the data. So are the code sets a separate entity or part of the HIPAA specs for outbound transactions?
- Joy Glass: The code sets are part of the transaction, the medical code sets.
- Martin Morrison: So we would expect, then, not to see any non-standard codes --
- Joy Glass: Correct.
- Martin Morrison: -- in any of our crossover data?
- Joy Glass: Correct.
- Martin Morrison: Regardless of your original source?
- Joy Glass: Correct. They'd be original source if they were not a standard part of the standard code set would be denied. They wouldn't make it through. We shouldn't see those.
- Kathy Simmons: There is a situation sometimes when somebody may submit a procedure code, for instance the HCPCS codes, and that HCPCS code is obsolete. When the last update or something came out, this HCPCS would no longer be effective and that this other HCPCS code is supposed to be used instead in that situation. I mean, there are situations when we will get an old code like that and we may even deny that service because somebody did submit an obsolete code. Now that type of information might be included in
- Joy Glass: crossover information you get. Yeah, that would only be included if you request that. And we do understand that some trading partners want to see the denied claims as well and that they could in fact contain invalid codes; but that would be up to your agreement with the Medicare contractor.
- Martin Morrison: And is this effective October 16, or will those --
- Joy Glass: This is how it works today. As part of your trading partner

agreement, if you wish to receive denied claims then you would --

Martin Morrison: Oh, no, no, no. Not the denied claims. I'm just asking --

Joy Glass: Okay. If you're not receiving denied claims, then you should not be receiving invalid {unintelligible; both speaking}.

Martin Morrison: We're concerned about Medicare paying a claim and us having to reject it under HIPAA. And the same applies to the grace period for procedure codes, which we've made adjustments for.

Joy Glass: You should not be seeing the invalid codes then.

Kathy Simmons: Well, you could have a situation with multi-line claims and one of the codes is invalid and the other lines are fine. So we're actually paying some of the lines of the claim, but {unintelligible; two speaking}.

Joy Glass: But that would be noted.

Kathy Simmons: Right.

Martin Morrison: Well, thank you for clarifying the fact that the code sets are part of the HIPAA specifications on both in-bound and out-bound.

Joy Glass: Correct.

Dr. Harper: Thank you, Mr. Morrison. Next question, please.

Tina: Next we have Keith Aglease {phonetic}.

Keith Aglease: Hi. Thank you for taking my question.

Dr. Harper: You're welcome.

Keith Aglease: When a provider sends a standard electronic 837, if there's a specific data field or loop that doesn't really pertain to them -- and it's a required field, let's say -- is it all right that they could auto-populate it in a way that if it's a date field they could put zeros all across? Is that considered okay? It has to do more with business needs pertaining to a specific trading partner as opposed to interpreting the standard specifications literally field for field.

Joy Glass: Yeah, this is Joy. No. If you're sending in the claim and there is a required data field, the value in that field must meet the implementation guide syntax. So, for example a date, you could

not submit all zeros. It would have to be a valid date.

Keith Aglease: And so the date, if they don't really have that value, for instance, many providers will have the patient's date of birth, but they don't have the subscriber's date of birth -- the subscriber who holds the contract with the health plan, but say a dependent is the patient -- if they don't have that date, could they put in that default date?

Joy Glass: You would have to get that date from the patient.

Keith Aglease: So they would have to have that date.

Joy Glass: Yes.

Keith Aglease: Because I thought I heard in the prior roundtable that payers are allowed to have some room in terms of the business requirements between the two trading partners that's in the specification of the standard.

Karen Trudel: No.

Joy Glass: But only with respect to situational data elements. If a data element is required, then it is required.

Keith Aglease: So situational, there's some flexibility?

Joy Glass: It depends on the actual situation that is in the implementation guide and the health plan interprets that to see how it fits in with their business needs.

Keith Aglease: And can we, for the most part, is the billing provider responsible for identifying situational data?

Joy Glass: No, the health plan will do that and provides it, generally speaking, in a document called a companion guide.

Keith Aglease: Okay. And one question about clearinghouses. My understanding is that if a provider wants to submit claims through a clearinghouse and they send a non-standard, the clearinghouse -- and the recipient at the other end, the payer, is okay with working with a non-standard -- still in the step in between the clearinghouse has to make a conversion to standard and then convert back to non-standard? Is that correct?

Stanley Nachimson: Yes, that's correct.

Keith Aglease: They just simply, Stanley, they can't pass it through without converting?

Stanley Nachimson: That's correct.

Keith Aglease: Thank you.

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

Tina: Next we have Lisa Roth.

Lisa Roth: Hi. Thanks for allowing me to ask my question. I have a couple of questions regarding coordination of benefits claims or what people refer to as crossovers.

Dr. Harper: Could you talk just a little louder, please?

Lisa Roth: Sorry.

Dr. Harper: Thank you.

Lisa Roth: I have a question regarding the crossover or coordination of benefits claims. It's my understanding there's a payer ID that we need to complete or put into one of the data segments; I forget the exact data segment right now. But my question is, where do we get that? I know eventually it will be the NPI, but where do we get that today?

Joy Glass: You need to get that from your health plan.

Lisa Roth: From our health plan?

Joy Glass: Yes.

Lisa Roth: So do you guys, does Medicare, keep a list of all those? So like if we put something in there that you don't recognize, what happens to our claim? Does it get rejected? Does it just not get forwarded on to a secondary?

Joy Glass: If there was an invalid contractor or the Medicare contractor's correct identifier was not there, they would reject that claim. They wouldn't know that it actually should have been sent to them. You have to have the valid number Medicare contractor number. You know, the carrier or intermediary number.

Dr. Harper: Does that answer your question?

Lisa Roth: Well, I guess what you're telling me is that I need to get that carrier number from the payer that one of my patients may have and that could be thousands?

Dr. Harper: We're having some consultation in the room.

Lisa Roth: Okay. I mean, we're a dialysis service --

Gary Kavanagh: Today, to bill Medicare, you have to be enrolled in Medicare and be issued a provider identification number by your local system and your carrier.

Lisa Roth: Okay.

Gary Kavanagh: And until a national provider identifier is available, you will continue to use that.

Female Speaker: Payer ID.

Gary Kavanagh: Oh, I'm sorry. I keep hearing provider.

Joy Glass: Yeah. And so you need to contact -- your Medicare contractor will provide you with that number. They each have a specific number that identifies them.

Kathy Simmons: And they always have.

Joy Glass: Yes. And this is how -- it's not a new identifier, right.

Lisa Roth: Well, I guess my question is that we currently -- we're a dialysis services firm. We send our claims -- the majority of our claims are Medicare primary. Medicare right now does some crossovers to secondary payers for us. My understanding is we need to complete the coordination of benefits segments, which I think are like 2320 and 2330.

Joy Glass: Yes. If you're aware that there are other payers that are involved in the payment of the claim, then you do complete those loops.

Lisa Roth: Right. And in one of those loops is a payer ID which will eventually be the NPI, which I know is not --

Joy Glass: No. It will not be the NPI; it will be the plan ID.

Lisa Roth: Okay.

Joy Glass: The NPI is for providers.

Lisa Roth: Okay. And that plan ID, I have to call each and every individual plan to get that ID?

Dr. Harper: We're having consultation in the room.

Lisa Roth: Okay.

Kathy Simmons: The national plan ID doesn't exist right now.

Lisa Roth: Correct.

Lisa Roth: But this is a required field.

Female Speaker: It is a required field?

Lisa Roth: Yes.

Helen Dietrick: Provider ID and plan ID will be required when it becomes available. But there is a list in the implementation guide I believe that says you should use what you use currently.

Joy Glass: Wait. I mean, how do you currently send and the number that you provide today is the same number you would use.

Karen Trudel: And so the beneficiary would provide a card showing any other insurance that he or she has besides Medicare and you would copy that information in that section.

Dr. Harper: Did you have another question?

Lisa Roth: Well, my question was, if we send you a claim and you don't recognize that ID that's in that field, what happens? Do you reject the entire claim? Or do you pay the primary and it doesn't get forwarded to the secondary and we need to do it ourselves?

Joy Glass: Yeah, I think it would get plaid and then we would not forward it. Your remittance would not show that the claim was forwarded.

Karen Trudel: I think also in some cases the Medicare contractors have information about a particular beneficiary and where their claims get crossed over.

Karen Trudel: Maybe that's what you're referring to.

- Karen Trudel: And the numbering system that's currently used is kept by each individual contractor, and that may be why you're not knowledgeable about what that number is. So if they have something on their files that shows where that claim should be crossed, it will automatically be sent as under the current procedure.
- Joy Glass: And then on your remittance, you would see whether it was crossed over. That would tell you.
- Lisa Roth: Right. But I mean I guess what I'm saying is I understand right now that if I go to one of our intermediary's UGS website, they have a list of crossover payers and it has IDs for those payers. So I go to a different intermediary, such as Trailblazer, they also have a list of crossover payers and for the same secondary payer the ID may be different. And my concern is, what I'm trying to figure out, is what do I need to put in this field -- and I'm actually looking through the implementation guide to find the exact segment -- and then, if so, how do I get it? Because is it something that you are, as the primary payer, you're expecting a certain code for that secondary payer because right now that national plan ID is not out there?
- Karen Trudel: I think what we're saying is you continue to do what you would do now, which is each FI or carrier, you would use whatever codes they have in place now.
- Lisa Roth: Which would mean it varies based on the primary and secondary.
- Karen Trudel: Yes, because there is no standard yet. Exactly.
- Lisa Roth: Okay, thank you.
- Karen Trudel: You're welcome.
- Dr. Harper: Next question, please.
- Tina: Next we have Catherine Ostapina{phonetic}.
- Catherine Ostapina: Hi. My question is regarding the Loop 2010-BA, subscriber addressed specifically. The notes on the specs from pages 121-25 specifically say required if the patient is the subscriber; so that if in Loop 2000-B to SBR-02 equal 18{phonetic} which is "self," we're interpreting that to mean that the subscriber's address, date of birth, and gender are only required if the patient is the subscriber. Is that

correct?

Joy Glass: Yes, that is correct.

Catherine Ostapina: So the only time -- and so if I'm the subscriber and my child is the patient, you would only need my name and then all the patient information in the patient hierarchical --

Joy Glass: Oh, I'd have to check on that. I can get back to you. I don't have the guide with me.

Catherine Ostapina: Okay. And then just a follow-up to that. Let's say that's the case. If we're interpreting that note that specifically says it's only required when the SBR-02 is 18 or self, if then a payer individually says that they want or require the subscriber's date of birth, if it's not truly required in the implementation guide -- an earlier caller had asked about filling in a valid date; we do have a payer that has told us that it is a required data element and that if we don't have the subscriber's information, they want us to fill it with the patient's date of birth. What I thought I heard you say is that that's really not appropriate and they should not and cannot be doing that?

Joy Glass: Right. And if this is not required, they should not be requiring it anyway. I really need to get back and look at that first. And I'll talk to you about that as well. Okay?

Catherine Ostapina: Okay.

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

Tina: Next we have Robert Wald. Sir, your line is open.

Robert Wald: I believe our question's been answered.

Tina: Thank you.

Dr. Harper: Next question.

Tina: Next we have Marsha Cuma{phonetic}.

Marsha Cuma: Hi. Can you hear me?

Several: Yes.

Marsha Cuma: Okay. I am calling from a single physician's office in North

Dakota, and we've been getting some contradictory information about business associates agreements. Is this something that is appropriate for this conference?

Karen Trudel: Well, why don't you ask the question and we'll see if we can answer it?

Marsha Cuma: Okay. We need to know if we need to have a business associate agreement with facilities that run tests for our doctor, such as blood tests or any other similar test.

Karen Trudel: That is a privacy question, I'm afraid, and we will have to take your name and number and get back to you on that. I'm not going to hazard a guess.

Dr. Harper: Thank you, Ms. Cuma.

Tina: Next we have David Whistler{phonetic}. Sir, your line is open.

Female Speaker: Hi, good afternoon. I'm just wondering if you wouldn't mind just to review the guidelines that you had talked about earlier for the PWK segment and claims that require attachments and what that process is going to look like during the contingency period.

Joy Glass: Right. For Medicare, if you're currently sending in paper claims with attachments, you may continue to do so, although you should contact your contractor to make sure that that's how they wish to receive them. Some contractors are able to receive the claim electronically and associate that paper attachment. And in the future we will have that process in place that will be able to accept the electronic claim and the separate paper attachment.

Female Speaker: So are you looking to standardize this across all your carriers --

Joy Glass: Yes.

Female Speaker: -- because quite frankly, we've talked with 15 of them.

Joy Glass: Yes. Yes, we are going to standardize.

Female Speaker: They all have different requirements and there's really no standard across them. Okay. So for this first -- for a short period of time -- if they have not said so or if they've not said otherwise, we can continue to submit paper with the attachments?

- Joy Glass: Correct.
- Female Speaker: But if they have said otherwise, we need to follow their guidelines?
- Joy Glass: Correct.
- Female Speaker: Okay. Will these claims -- I mean, you were talking earlier about submitting paper claims during this contingency period being subject to an audit or some type of post-payment review or post-payment audit somewhere down the line to see, I don't know, if we met the exception criteria. Are these going to be included in that, or will these claims be excluded from that post-payment review?
- Kathy Simmons: No, because this will be part of the exception, the temporary exception.
- Female Speaker: Okay. So any claims that require an attachment that are waived and can go on paper?
- Joy Glass: Correct.
- Kathy Simmons: As long as your payer has indicated to you that they're not able to accept those electronically yet. There are some Medicare contractors that perhaps have already told their people that they are able to accept claims electronically and separately submitted attachments and re-associate them after receipt. If they've given you directions like that, then you should submit the claims electronically. But if in the past they've always told you to submit them on paper, then you should follow whatever directions you have until you receive different directions from your carrier.
- Female Speaker: What about if they're mandating a non-compliant use of the HIPAA transaction? For instance, we have one {unintelligible} who was telling us to use the NTE segment as opposed to the PWK segment and what it was intended for. I mean, do we need to go along with that and following those guidelines or --
- Joy Glass: No. They should not be requiring you to --
- Kathy Simmons: But this is part of what we're trying to standardize.
- Female Speaker: Right. No, I know. I mean, it's frustrating. They've taken -- they're just trying to jam it into their system electronically, and rather than use PWK they're saying, "Use NTE. Send me Op Report two weeks prior." It's very --

- Kathy Simmons: Right. And we're actually putting together a work group with the contractors in order to resolve this.
- Dr. Harper: Thank you.
- Female Speaker: Thank you.
- Dr. Harper: Next question, please.
- Tina: Next we have Roland Blake.
- Roland Blake: Yes, the HIPAA transaction code set regulations require electronic transmission of transactions to Medicare, and they must be HIPAA-compliant. Do the regulations require that state Medicaid transactions also be electronic and HIPAA-compliant?
- Stanley Nachimson: This is Stanley. Let me address that. There are actually two sets of regulations, and we need to keep those distinct and separate. First are the HIPAA regulations that we published the transactions and code set regulations that required that all health plans and clearinghouses be able to do electronic transaction using this standard; and providers have the option of either continuing to do paper or doing electronic transactions. But if providers do electronic transactions, they must use the HIPAA standards. The second set of regulations -- the ASCA regulations -- required that claims sent to Medicare must be done so electronically except for certain situations. So taking those two together, Medicaid state agencies, if you're a provider, you're not required to send your claims electronically to Medicaid state agencies. However, if you do so, you must use the standard electronic transactions and Medicaid state agencies must be able to accept the standard HIPAA transactions.
- Roland Blake: We have nursing homes in many states, and we've contacted states and many of them cannot do this. They have software, but it's not been tested. Or they have software that is not HIPAA-compliant. And there are some states that do not -- they only accept paper. Now are these states in non-compliance with HIPAA?
- Stanley Nachimson: These are state Medicaid agencies that you say are not yet able to use the standard electronic transactions?
- Roland Blake: Right.
- Stanley Nachimson: They certainly should be working on contingency plan as they

move towards HIPAA compliance. But technically if they cannot accept the HIPAA standard transactions on October 16, they would be out of compliance.

Roland Blake: So it's not a question of us being out of compliance because we use paper or we have electronic transmissions; but the burden is on them to accept them, correct?

Stanley Nachimson: Yes. And the burden is on you to be able to produce them.

Roland Blake: Yes, but if we do produce them, must ours be HIPAA-compliant?

Stanley Nachimson: Yes. If you're doing electronic transactions as a provider, you must be doing them according to the HIPAA standards.

Roland Blake: Okay. And in terms of a backup plan, as long as we can work out something that they and we agree with, that is okay until everything else gets in place?

Stanley Nachimson: In general, yes.

Roland Blake: Okay.

Dr. Harper: I think we have another comment in the room.

Karen Trudel: I was just going to reiterate that you need to work it out with that particular state Medicaid agency. They're in various stages of readiness, so if they can accept it and you can produce it, go for it. If they're not quite ready and they ask you to continue submitting them on paper or however you're doing it currently, then you just need to work it out with them.

Roland Blake: Is this principle more broad than just state Medicaid agencies? In other words, any time we try to have a transaction with another organization, if we choose to submit electronically they must be HIPAA-compliant, and if we submit electronically, they must be able to accept it? I mean, it's broader than just Medicaid or Medicare?

Stanley Nachimson: Yes. These requirements apply to every health plan in the United States.

Roland Blake: Okay.

Dr. Harper: Thank you, Mr. Blake.

- Roland Blake: You bet.
- Dr. Harper: Next question, please.
- Tina: Next we have Desla Mansella{phonetic}.
- Desla Mansella: Hi. Thank you for taking our call. We have three quick questions. The first one is, we are -- and have been for the past month -- in live production with the 4010-A1 with our intermediary. And we have all through that period of time been submitting both the HCPCs CPT-4 codes, as well as the ICD-9 procedure codes. We've not received any kind of error or rejection. So I'm a little at odds how that can be non-compliant if we've been in live for this period of time and have had no problems. So I'd just kind of refer back to the discussion we had earlier about procedure codes, or ICD-9 procedure codes, on outpatient claims. Can someone clarify that for us?
- Joy Glass: I'd have to call back to you. We don't have anybody here that can answer that right now.
- Desla Mansella: Okay.
- Kathy Simmons: We would need information about who the contractor is, etc.
- Desla Mansella: Okay. So the other two are, earlier in the discussion today there was discussion about the physician tax ID number being situational, and it was mentioned that if we didn't know it we didn't have to submit it. However, again, in our live communication process, we are required to put something in that field; we've been using the hospital tax ID number rather than the individual physician ID number. Is that acceptable?
- Joy Glass: If your health plan accepts it, yes.
- Desla Mansella: Okay. That's good. And then the third and final thing is that is there any kind of assistance that CMS can somehow provide for the situations where your secondary insured birth date is needed and we don't know it, is there something that can be done -- like rules that it should be printed on the insurance cards or something - - so that we are able to get that information? Oftentimes it's emergency situations where that information is just not known. Is there anything that CMS can do to facilitate that process?
- Dr. Harper: We're having consultation in the room.

- Karen Trudel: I think the first thing -- this is Karen Trudel -- the first thing is, again, the ability for plans to implement contingencies can get us through that in the short term. If there is a sense that there is a data element that is being required that should not be required or that there's a data element that's situational but the situation is too broad, then I encourage you to submit a modification request with the designated standards maintenance organization. And if I'm not mistaken, you can find out more about how to do that on our website.
- Kathy Simmons: But on the birth date, are you talking the patient's birth date? Because that's always been required.
- Joy Glass: Subscriber birth date.
- Kathy Simmons: Subscriber. Okay.
- Dr. Harper: Thank you very much.
- Desla Mansella: Thank you.
- Dr. Harper: Next question, please.
- Tina: Your next question comes from Jackie Blazer.
- Carl Cunningham: This is Carl Cunningham with the American College of Physicians. Karen, I wonder if you would talk a little more about how you expect the enforcement to play out now that we have this contingency plan in place? And specifically we can see that for the first -- on October 16 and 17 -- all Legacy claims are going to go floating straight through there; but then you expect to base the enforcement on complaints. Do you expect those complaints then to come from the payers as they see non-compliant claims coming through from the providers? And, if so, then you would go back to the provider -- or in my case the physician practices -- and start a process? You had done them a couple of times before you would impose financial penalties on them and how many times would you hit them and how long would you wait for them to get their act together? And I guess, finally, would you at some point order a cutoff in payments or would the payments continue while this enforcement process is going on? I'm trying to get some better sense of how to advise our physicians as to what to expect in the coming months so that we can encourage them to not just sit on their hands but get active and compliant.

Karen Trudel: Good questions, Carl, and some of which we're still talking through internally. What I can tell you is first of all, as you know, what we're trying to do here is to encourage compliance and not get ourselves into a situation where we're primarily processing complaints. I think it's not terribly likely that a health plan that implements a contingency to keep cash flow going would then turn around and file complaints against all its non-compliant providers. Medicare doesn't intend to do it, and I don't know of any other plans that are intending to do it. So I think what we're talking about is the situation where what the plan is really likely to do instead of filing a complaint is at some point they will make the determination that they need to cut off their contingency, as we talked about earlier, based on the readiness of the trading partners and, at that point, would say, "You have a month or two months or three months, and then we're gonna cut off and begin to reject non-complaint claims." That's the more likely scenario that I see. Does that answer your question?

Carl Cunningham: Yeah, I think it helps. I was fearful that we would see a situation in which the contingency would look, from the perspective of a physician practice that was distracted by a zillion other things, that the contingency would look like a de facto delay in the implementation date, which might lead them to just continue doing nothing; and what we need is a progressive process that would make them aware that they're out of compliance and then gradually move them towards compliance. And I guess if they were hearing from their payer, the health plan, that are not in compliance and then finally were given a warning with enough lead time to be able to do something about it, that would help. I'm concerned that you've done a wonderful thing by providing this grace period; but if we don't get the physicians to make use of it, we could be replaying the whole scenario all over again where there won't be enough time for them to fix it by the time they get focused on it.

Karen Trudel: Right.

Carl Cunningham: So I guess the question is how do we all work together in getting them to pay attention to this and do what they have to do? And the testing is not easy to do so it's not like a trivial kind of thing we're asking them to undertake.

Karen Trudel: I understand that. And keep in mind also that plans who implement a contingency need to continue to exercise their good faith effort and keep doing the provider outreach and keep pushing

the testing and so that's part of what's already on the health plan's plate. And also understand that we will be continuing to meet with organizations that represent the major group of health plans and that we'll also continue to meet with major provider groups and be trying to work with both of those organizations to sort out how we can all best work together to make that goal happen. Thanks, Carl.

Carl Cunningham:

Thank you.

Dr. Harper:

Thank you, Mr. Cunningham. Ms. Jones, we'll have two more questions.

Tina:

Your next question comes from Grace Upliger{phonetic}.

Grace Upliger:

Yes, regarding secondary Medicare claims, do all of these have to -
- can we send all of those on paper or just those with attachments?

Karen Trudel:

You cannot send ones on paper where there's only one primary payer. But you can send the ones on paper that require attachments if your carrier has asked you to send those on paper with attachments.

Grace Upliger:

No, I understand. Okay. And y'all had mentioned the contingency plan. What we're wondering is, are all payers required to have a contingency plan and, if they don't, are they required to accept compliant transactions on the 16th?

Karen Trudel:

That's actually two different questions. No, payers are not required to have contingency plans and, indeed, some of them may decide based on the readiness of their partners that they do not need one. There's no requirement that a plan has a contingency in place. There is a requirement that health plans be able to accept compliant transactions effective October 16.

Grace Upliger:

And our last question is, say that we encounter a payer who cannot accept a compliant transaction on October 16 and all we can send are compliant transactions? We can't do both. What recourse will the provider have at that time?

Karen Trudel:

The provider is, again, as I said, free to file a complaint against the plan, and we will receive it and assess it and get back to the plan, talk about what they're hoping to do, and try to resolve that.

Grace Upliger:

Thank you.

- Dr. Harper: Last question, please.
- Tina: Your final question comes from Mary Evans.
- Mary Evans: Hi. I actually had two questions, more just clarifying questions. And it kind of built on that last question that was asked if the payer is not ready but the provider is. As far as the recourse that CMS would take on that, is there any sort of reimbursement that we would expect from the payer as far as operationally? If we have to start submitting like all our claims to paper or use a clearinghouse, that would be extra cost to the provider in that case. What are you planning to do for that?
- Kathy Simmons: We have under HIPAA the ability to collect civil monetary penalties, but we do not have the authority under HIPAA to require non-compliant health plans to reimburse providers for their out-of-pocket expenses. There's just no authority to require that they do that.
- Dr. Harper: Did you have a second question?
- Mary Evans: I think my second question was just answered before, but again just to clarify. If we decide as a provider to utilize a payer's contingency plan and submit in an older electronic format, or to use your contingency plan even to submit to Medicare, I'm assuming that if we do that for a couple of weeks there's not going to be any problem; but if it continues on for longer than that, that's when we would get contacted by Medicare to work through those issues?
- Karen Trudel: As I said, we're not able at this point to put a specific time frame on it, whether it's a few weeks or few months or whatever. But I think we can assure you that when we get to the point where we are about ready to turn off the contingency, we will provide the provider community with ample advance notice.
- Mary Evans: Thank you very much.
- Dr. Harper: You're welcome. Now we're going to have some closing remarks and comments and updates from Ms. Holland.
- Ms. Holland: Right. I just wanted to remind everyone that we will continue to post new information on our HIPAA website. That website address is www.cms.hhs.gov/HIPAA/HIPAA2. We will be posting a transcript of this roundtable probably in the next week or

so. We also have additional information on there, including announcements of future roundtables. The call-in information for our next roundtable which is scheduled for Wednesday, October 8, is on our website presently. We will also be posting additional answers to frequently asked questions we have receive. I apologize to everyone who was waiting on the line. We understand there was a lot of people who had questions that we did not get to. If you have questions, you can send them to our email mailbox which is AskHIPAA@cms.hhs.gov.

Dr. Harper: Thank you, Ms. Holland. Ms. Jones, could you tell us how many people we had online today?

Tina: Approximately 2,600.

Dr. Harper: Thank you very much. We want to thank those of you who participated in our discussion today and I'd like to thank the members of the staff. The conference is concluded.

Karen Trudel: Thank you, Dr. Harper.