

CENTERS FOR MEDICARE AND MEDICAID SERVICES
12TH NATIONAL HIPAA IMPLEMENTATION ROUNDTABLE

Renee: Good afternoon. My name is Renee, and I will be your conference facilitator. 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. Bernice Harper, you may begin.

Dr. Harper: Thank you for those of you on the East Coast and good morning to those of you on the West Coast. This roundtable call is being conducted for Centers for Medicare and Medicaid Services, better known as CMS. This is part of the Department of Health & Human Services. Our subject today is the Health Insurance Portability and Accountability Act of 1996 or "HIPAA," and specifically the administration simplification provisions. We will provide a Medicare update, give a brief presentation on the Medicare electronic claims submission interim final rule, and will then take questions.

We will begin our call today with a few questions from Ms. Karen Trudel, the Deputy Director of the Office of HIPAA Standards of CMS. Ms. Trudel?

Karen Trudel: Thank you, Dr. Harper. Good afternoon. I'm sure I don't need to remind people that there are 55 days between now and the October 16 deadline for compliance with the HIPAA electronic transactions and code set standards. As I've said on previous calls, I can't stress enough the need for communication and testing and for covered entities to develop any needed contingency plans with our recently-issued guidance in mind. There may be a lot to do between now and October but, by working together, we can accomplish a lot. We have done this in the past, and we need to do it now.

With that said, I'd like to turn the call over to Janis Nero-Phillips from our Office of Information Services and Janis will provide an update on Medicare readiness. Janis?

Janis Nero-Phillips:

Thank you, Karen. Yes, I'd like to provide comments about Medicare and our testing readiness. Open trading partner testing is available at the Medicare fiscal intermediaries and carriers nationwide. Medicare is ready to accept transactions in the required HIPAA version 4010A format. All contractors are testing on the 837 inbound and outbound claims format and the 835 remittance advice transaction. You can obtain information regarding specific contractor HIPAA testing at our website, and that website is located at www.cms.hhs.gov/providers/edi. Now on a biweekly basis our Medicare contractors report the status of submitters in testing and in production. Currently, about 10% of all claims are submitted in the 4010A! HIPAA format. These claims are in production. As of August 1, there were approximately 17,000 submitters in production on the latest HIPAA version of the 837 inbound claim -- out of the total number of submitters -- and that total number of submitters is 155,000; so you see we have quite a ways to go with getting all of the submitters in test and in production.

Tom Scully sent out a letter recently urging you to contact your Medicare contractor as soon as possible to arrange a date to begin testing on the current HIPAA version if you have not tested already on this version. Please contact the CMS Regional Offices, specifically the Consortia Contract Management Offices, if you are having problems with testing with a specific contractor. And I'd like to go over the names that you can contact -- the names of the individuals in the regions. In the Northeast Region, please contact Patricia Volk, and her number is (215) 861-4191. In the South, please contact John Delaney, and his number is (214) 767-6289. In the Midwest, please contact Daly Vargas, and she can be located and reached at (312) 353-9840. And finally in our West Consortia, please contact Lil Calma, and her number is (415) 744-3631. Thank you.

Karen Trudel:

Okay, thanks. Actually, I'm going to ask Janis to repeat those names and phone numbers because you may have been taken unawares while trying to write them down. So we'll just recap those names and phone numbers for a moment.

Janis Nero-Phillips:

Certainly. In the Northeast Consortia, please contact Patricia Volk. Her number is (215) 861-4191. In the South, contact John Delaney, and his area code is (214) 767-6289. In the Midwest Consortia, please contact Daly Vargas. Her number is (312) 353-

9840. And in the Western Consortia, contact Lil Calma at (415) 744-3631.

Dr. Harper:

Thank you. Thank you, Janis. Now we're going to go to a presentation on the Medicare electronic claims submission interim final rule; that's the one that talks about Medicare claims needed to be submitted electronically effective October 16, and our presenter will be Stanley Nachimson

Stanley Nachimson:

Thank you and good afternoon. On August 15, CMS published in the Federal Register an interim final rule with comments regarding the electronic submission of Medicare claims. This rule requires that initial claims submitted by Medicare physicians, practitioners, suppliers, and other healthcare providers on and after October 16, 2003, must be submitted electronically in the standard as specified by the Health Insurance Portability and Accountability Act or HIPAA. The electronic claims submission requirement applies to those physicians, practitioners, suppliers, and other healthcare providers who will be under Part A or Part B of Medicare.

There are some limited exceptions to this requirement. Entities that believe they meet the criteria outlined in the rules, for those who have no method available for submitting an electronic claim, those who consider themselves a small provider, or those who have certain unusual circumstances may not need to comply with the Medicare electronic claims submission requirements. I'll give you a few details about those exceptions. The entities that may be waived from the requirements to bill Medicare electronically include:

- Situations where there is no method available to bill Medicare electronically. This will apply to Medicare beneficiaries since they cannot be expected to have the capabilities to submit Medicare claims electronically. When the electronic transactions standard adopted by the Secretary do not support all of the information necessary to pay claims. There are currently three situations that meet this category. First, the roster billing of vaccinations covered by Medicare. Secondly, claims for payment under Medicare demonstration projects. And, thirdly, claims where Medicare is the secondary payer to two or more primary payers. Medicare will issue further instructions in the future informing entities if these exceptions no longer

apply.

- The second category of exceptions is for small providers. Those entities that are defined as a provider of service with fewer than 25 full-time equivalent employees or a physician, practitioner, facility, or supplier other than a provider of service with fewer than ten full-time equivalent employees. These are considered small providers. Provider of services includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehab facilities, home health agencies, hospice programs, and others defined in Section 1861(u) of the Social Security Act. Again, the providers of service must have fewer than 25 full-time equivalent employees to be considered as small providers; and physicians, practitioners, facilities, or suppliers other than providers of service must have less than ten full-time equivalent employees to be considered a small provider, and those small providers are excepted from the requirement to bill Medicare electronically.
- The third category of exceptions are those in unusual circumstances. The Secretary has the authority to waive the Medicare claims submission requirement in these situations. As of now, three situations meet the definition of unusual circumstances. These are the submission of dental claims, a service interruption -- for example, a provider with electronic breakdown or interruptions in their telephone or communications services -- and, thirdly, upon demonstration to the Secretary of other extraordinary circumstances that preclude submission of Medicare claims electronically.

Now, entities that believe they meet one of these exceptions to the electronic claims submission requirements should not make a special request to receive a waiver to exempt them from this requirement unless they feel extraordinary circumstances exist beyond the exceptions that are outlined in the rule. We expect entities to self-assess to determine if they need an exception. Medicare will not issue waiver certificates or maintain a database of waived providers. Responses to requests for waivers will only be issued to entities with extraordinary circumstances. Entities who fail to submit their claims to Medicare electronically in the

appropriate format on or after October 16, 2003 could experience payment denials unless they are an entity that meets any of the outlined exceptions.

And, just a reminder, that comments for this interim final rule will be accepted up until 60 days after the publication of August 15. So a reminder that if you do feel that you meet one of the exceptions, you do not need to contact Medicare except in the very unusual circumstance that is not detailed in the rule. Again, if you meet one of those exceptions, you can continue to bill Medicare on paper on and after October 16. If you do not meet one of the circumstances, you must bill Medicare on your initial claims electronically on and after October 16, 2003.

Thank you.

Dr. Harper: Thank you, Mr. Nachimson. Now, Mrs. Cameron, would you give us the instructions for asking the questions and the answers, please?

Renee: 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 Gracie Phillips.

Gracie Phillips: Hi. Thank you for taking my call. I have three questions. The first one is, when diabetic insulin is administered via the pump, would it be considered a drug, therefore we would bill it with the NCPDP1.1; or is it not and we would bill it with the 837?

Joy Glass: Hi. This is Joy Glass. Actually, we just had a meeting yesterday regarding this issue and we were thinking that these drugs are actually considered part of the home infusion products, and those would be billed on the 837. But formal instructions will be provided to actually clarify, because we do understand there was some confusion on which format to use.

Gracie Phillips: Okay, thank you. My second question is --

Dr. Harper: Just a minute, please. The gentleman wants to add something.

Gracie Phillips: Oh, okay. Thank you.

Stanley Nachimson: And if that drug is provided by anyone other than a retail

pharmacy, it clearly goes on the 837.

Joy Glass: Right.

Gracie Phillips: I was speaking about retail pharmacy.

Stanley Nachimson: If it's a retail pharmacy and it is providing that as a drug in a separate situation, not as a home infusion therapy provider, then it would probably bill it on the NCPDP.

Gracie Phillips: Oh, okay.

Dr. Harper: Your second question, please?

Gracie Phillips: The second question is, do you plan to publish a drug list with NDC numbers since those will be required for the October 16 deadline?

Karen Trudel: The FDA approves the NDCs.

Dr. Harper: Right. The Food and Drug Administration on their website does publish a list of national drug codes.

Gracie Phillips: Who does? I'm sorry.

Dr. Harper: The Food and Drug Administration.

Gracie Phillips: Oh, okay. My last question is, is there any documentation out there that would tell me what data elements in the 837 segments are needed for doing centralized influenza billing?

Joy Glass: This is Joy again. The 837 does not support the roster billing function, and that was one of the exceptions that Stanley had mentioned.

Gracie Phillips: Yeah, I did hear that mentioned but I was wondering. Okay, so --

Dr. Harper: Thank you very much. Just a minute, please.

Stanley Nachimson: Just to explain that. If you want to bill those claims on paper, you can continue to do that. If you want to bill those claims electronically, you would have to use the full 837 format appropriately to bill that on an individual by individual basis, not

as a roster.

Gracie Phillips: Okay. And then -- okay.

Dr. Harper: Thank you very much.

Gracie Phillips: Thank you.

Dr. Harper: Next question, please.

Renee: Your next question comes from Brian Shoenover{phonetic}.

Brian Shoenover: Hello. My question here is that I'm actually representing someone else in our organization, but they had a question on if one of our intermediaries or carriers are not able to accept the current format for whatever reason, when is Medicare going to publish whether or not they will accept old formats after October 16?

Karen Trudel: Well, first of all, as far as we know, all of the carriers and fiscal intermediaries will be able to conduct HIPAA transactions as of October 16. So that's my first part of the answer. However, our recently-issued contingency guidance does permit health plans to make a decision as to whether they want to implement the contingency to assist providers that may not be compliant in time, and Medicare is indeed looking at the testing statistics that we've been getting which Janis discussed to determine whether we need to implement a contingency and, if we do, what that contingency would be. We know that we need to give our carriers and intermediaries advance notice as to what to do, and we anticipate that we will be making a decision as to what contingency and whether it will be exercised by about the middle of September.

Brian Shoenover: Okay, thank you.

Karen Trudel: You're welcome.

Dr. Harper: Next question, please?

Renee: Your next question comes from Jill{phonetic} Fazio.

Marjorie Wilkes: Yes, this is actually Marjorie Wilkes, and I have two questions for you. The first question is I just wanted a clarification on the applicability of the Administrative Simplification Act to overseas components of a covered entity or a business associate or a subcontractor of a business associate. Does it make any difference

whether or not services are actually performed overseas?

- Karen Trudel: Well, I think that's an issue that there is no one in the room able to answer. We do not have a representative from the Office for Civil Rights with us, and they generally handle most of the questions as to whether an entity is a covered entity or not. We would need to take the information down and get back to you, if you are willing to supply us with your name and phone number, keeping in mind that there are 875 other people on the call.
- Marjorie Wilkes: Okay, that's fine. And they'll probably also need to get back with me on the second one too because it relates to a privacy question.
- Karen Trudel: Okay.
- Marjorie Wilkes: My second question was we had a situation come up where a deaf individual was wanting to use a relay service, and we wanted to know if we needed to get an authorization form signed first before we can use a relay service for the deaf.
- Karen Trudel: Okay. Thank you, Marjorie.
- Marjorie Wilkes: Thank you.
- Renee: Your next question comes from Lois Bayton{phonetic}.
- Lois Bayton: Hi. We're a healthcare payer and our question is in reference to the use of taxonomy codes on 837P. I understand from the implementation guides that in the addenda version that the taxonomy codes are not required. Is this correct? And in your experience does the provider community use them?
- Joy Glass: This is Joy. The segment is now situational. For Medicare, if the provider submits the code, we do not process them. I can only really speak for Medicare. I believe state Medicaid's do process the taxonomy codes because they would require that. You'd have to read the note in the implementation guide. I believe it says required if necessary for adjudication.
- Lois Bayton: Who decides if it's necessary for adjudication, the provider?
- Joy Glass: The payer.
- Lois Bayton: The payer?

Joy Glass: Yes.

Dr. Harper: Thank you very much. Next question, please?

Renee: Your next question comes from Debra Kimler.

Debra Kimler: Good afternoon. I have a question about the national provider ID, the NPI. Can you give us an update on the progress of that database and also how will the IDs be disseminated to the providers?

Stanley Nachimson: This is Stanley Nachimson. The final regulation on the national provider identifier is now in the clearance process, and we expect to publish it by the end of this year. That regulation will detail not only the structure of the ID but how we're going to maintain the database and how it will be sent out to providers. So all that information will be provided by the end of this year.

Debra Kimler: Okay. How will we be notified of those decisions?

Stanley Nachimson: Along with the information on the CMS website, we'll be sending out information through contractors and sort of our normal sources of communication. We'll be working with all of the industry organizations to make sure all the information gets out to the necessary places.

Debra Kimler: Okay, thank you.

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

Renee: Your next question comes from Cindy Inya{phonetic}.

Cindy Iniya: Actually, it's Cindy Iniya{phonetic}. I have a question on your remittance advice remark codes. I was out on the website and we're building our databases for these codes, and I noticed that the last update was as of February 28. Has there been anything updated since that time or are you planning to update that before October?

Janis Nero-Phillips: This is Janis Nero-Phillips. Yes, we are planning to update that website before October. Hopefully, in mid-September.

Cindy Iniya: Thank you.

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

Renee: Your next question comes from Carl Russell.

Bruce Saunders: Hi. I've got two questions here. These are both regarding 834, not the 837. The first one is the ISA-14 loop{phonetic}, if you have that marked as zero, do they expect no response whatsoever? And if it's a one, is the appropriate response a 997?

Joy Glass: Yes. This is Joy. Actually, the ISA is the envelope which is wrapped around all the transactions. I don't have the implementation guide with me, but I know if your choice is "yes" you will receive a 997 or "no" you won't receive the 997 because that's what it does relate to, the 997.

Bruce Saunders: Okay. So if they say zero or no, then they get no response whatsoever?

Joy Glass: Correct.

Dr. Harper: Do you have a second question?

Bruce Saunders: Yeah. What's the purpose of the BGN or BGN08 segment? It's a verify; it's basically the action code. What's the purpose when they send a verify, and does that require a response?

Dr. Harper: We're having a little consultation in the room. We'll be with you just in a minute.

Joy Glass: We don't have anyone in the room who is familiar with the nuts and bolts of the 834 because it's not a transaction that Medicare uses. We will do our best to research that and get back to you or --

Karen Trudel: There is actually a listserv that you can subscribe to where you can ask questions of this nature to the different X12 workgroups, and the quickest link to that is you can go to www.x12.org and that'll take you to the X12 web page and then there will be some listservs that you can subscribe to depending on the transaction that you have questions on. And that will probably be your best avenue.

Bruce Saunders: Okay.

Dr. Harper: Next question, please?

Renee: Your next question comes from Mike Cochran.

Mike Cochran: Yes, I was wondering if you had any plans or discussions on

establishing a standard method to use for encryption of email.

Bill Schooler:

No, there will not be -- there is not -- any standard {for encryption,nor are we planning to adopt one.

Mike Cochran:

The reason I ask is the majority of the United States gets their health insurance through group insurance through their employers, and in that process you have the employer, the employer's broker, a TPA possibly, or an insurance company all involved and the communication of material back and forth amongst those entities often involves email anymore; and if there's no standard, it gets very -- it almost eliminates the possibility of using email to use to communicate PHI between all those entities.

Stanley Nachimson:

I think if you'll refer to the Security Rules, we have encryption as an addressable specification.

Mike Cochran:

Yeah, our attorneys have said that with the size of our organization, they don't see any other method but to do encryption.

Stanley Nachimson:

Okay. Then the choice of encryption technology is up to you. We stayed away from --

Mike Cochran:

Yeah, but that doesn't mean then the brokers might choose something different and the employers might choose something different.

Stanley Nachimson:

That's absolutely correct.

Dr. Harper:

Thank you {several speaking}.

Karen Trudel:

Let me add something to this. This is Karen Trudel. The issue of security is always a double-edged sword. When we think about the flexibility that we've provided the healthcare community -- and I've been in many meetings where people have debated this -- half the people in the room step up and say, "We didn't do enough to standardize," and the other half of the people tell the first half to sit down and be quiet. {Laughter} The security standards were meant to provide a floor, and what we are encouraging industry members to do is, in the course of implementing those standards, to begin to come together and try to come to some consensus themselves as to what would be appropriate technology. And I encourage you to do that. I'm sure that the employers' association -- and I've forgotten the name of it as this point -- the Workgroup

for Electronic Data Interchange, there are any number of places where those discussions can take place and we do encourage that you do so.

Mike Cochran: But that would mean the employer association and the insurance industry and the broker industry would all have to come and arrive at the same encryption method.

Stanley Nachimson: But their encryption methods have to be interoperable.

Mike Cochran: Right.

Karen Trudel: Right.

Dr. Harper: Thank you very much. Next question, please?

Renee: Your next question comes from Gerald Taniguchi.

Gerald Taniguchi: Hello. I have a question -- I guess it's to Karen or those people. We've been testing with one of the FI's since April of this year and we haven't been able to get a compliant transaction done yet. And another one of our FI's hasn't even started yet and they're saying they're going to start in September. We're very concerned and I think CMS needs to do something and not keep saying that, yeah, people are testing when we haven't got any compliant transactions on the FI's.

Karen Trudel: Is this on a 837 claim or --

Gerald Taniguchi: 837 COB.

Karen Trudel: COB, okay. Again, we will reiterate that there have been problems uncovered in the course of testing with the COB transaction. We make system changes only every quarter, and we have been working those corrections into quarterly releases. There are a number of changes that will be coming up in August --

Joy Glass: And September.

Karen Trudel: -- and September.

Joy Glass: We are fast-tracking these changes.

Karen Trudel: Okay. And the issues are being handled as quickly as we can identify them and correct them. We do have, however, some

carriers and FI's who have been able to get COB clients into production. So I guess what I need to tell you is that the changes are being found as a result of the testing process. The problems are being addressed as quickly as we can. They're being put into place as quickly as we can get them there. And we are hoping to get where we need to go by October. Now I realize that that cuts down on the ability to test -- the time is short -- but I do encourage you to stay in touch with your FI's and get a sense of where they are with the changes that they need to make.

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

Renee: Your next question comes from Carrie Asher.

Carrie Asher: Hi. Thank you for taking my call. I have a question about Medicare secondary. When you send the claim electronically when Medicare's secondary, how does Medicare know what the primary paid?

Joy Glass: This is Joy. The provider gets the remittance back from the primary payer and then it places that information on the claim and then submits it to Medicare. All the payment information has a particular place.

Janis Nero-Phillips: There's a particular place that primary payer information goes.

Carrie Asher: Okay. So, I mean, if the provider doesn't get the payment posted correctly, it's very well then incorrect information to be sent to Medicare.

Janis Nero-Phillips: That's a possibility.

Carrie Asher: You don't get anything from the primary payer, you know say Aetna or Anthem.

Janis Nero-Phillips: No, we don't.

Carrie Asher: Okay. And my next question is on NDC numbers for a physician's office, do you see any time in the future that Medicare would require say an oncologist to bill using NDC numbers?

Janis Nero-Phillips: Currently, the only requirement that Medicare has are on oral cancer drugs, and those are billed NDC. I do not know of any plans where physicians would bill Medicare with NDCs. Yes, I

forgot about that. Several retail pharmacies, of course, as you know they're --

Carrie Asher: Right.

Janis Nero-Phillips: -- but for professional pharmacy drugs --

Carrie Asher: Okay.

Janis Nero-Phillips: -- the only ones actually that we do require the NDC are the oral anti-cancer drugs.

Carrie Asher: Okay. And one more question. I understand that Medicare needs to know that we're testing with our software vendor as far as our claims going through their clearinghouse. When I go to the Medicare seminars, they're telling me somehow the vendor needs to let them know that I am testing with the vendor; but when my software company is saying I'm covered under them, I don't quite understand how Medicare knows then that my practice is testing and that we'll be ready October 16. I've been told at a seminar that even though we're ready October 16 and we're compliant, if that vendor did not notify Medicare that we were ready that our claims will not be paid.

Dr. Harper: We're having some consultation in the room. Just a minute, please.

Karen Trudel: No. This is Karen Trudel. That's really not the case. If your vendor or clearinghouse has successfully tested with the carrier or fiscal intermediary, you in essence are already in production and your claims are being paid in a HIPAA compliant format right now. We're accepting them right now. We don't need to know anything about you particularly for October 16. What we do want is, in the case where a provider may need to implement a contingency themselves -- for instance, the provider is compliant but the health plan that they're trying to send claims to isn't compliant, and in order to get paid the provider is sending claims in an old format -- then we would want to know what you had done in advance to try to finish up that handshake before October 16. But, if you or your vendor are submitting compliant claims on your behalf, that is proof of your compliance right on the face of it and you don't need to worry.

Carrie Asher: Okay. Thank you.

Karen Trudel: I would like to add one other thing to your question about the National Drug Code.

Carrie Asher: Uh-huh.

Karen Trudel: And if used in physician claims, we did actually step back when we published the modification regulation in February and say that the National Drug Code was not the standard for institutional and professional claims for a variety of reasons. Those two sectors of the public said that the NDC did not work well for them. So we would really need to have the industry come back and pretty much do a complete about-face for us to go back and reconsider that judgement.

Carrie Asher: Thank you.

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

Renee: Your next question comes from Betsy Clore.

Betsy Clore: Yes, I had a question about the Medicare secondary. If our primary payer has sent us a paper remittance advice and we do not have the claim adjustment reason codes in the way that is standard, what does Medicare expect us to send?

Dr. Harper: We're having consultation in the room. We'll be with you shortly.

Janis Nero-Phillips: I think we want to clarify something. Are you saying that when the primary payer sends back the remittance advice, he's sending non-standard codes?

Betsy Clore: Right, on paper -- which is allowed, from what I've understood. They can continue to use proprietary codes on paper and I have heard that a number of payers are going to do that.

Janis Nero-Phillips: I'm rather surprised by that.

Betsy Clore: Well, I've been told that by the payer.

Janis Nero-Phillips: Okay.

Betsy Clore: And I do have another question too about the PWK segment and sending our claims that require attachments electronically. We will not be able to produce a PWK segment because we don't have a way of entering the type of attachment; and also I've been told

by our regional CMS that they will not have any way of handling a PWK segment until possibly October, so we couldn't test it if we did have a way to do it. Therefore, the only way I can think of to comply is to just send the claim knowing that it needs an attachment without the attachment or saying anything about it and then letting it be rejected and then sending it on paper. I don't know what else to do. Do you have any suggestions?

- Joy Glass: This is Joy. The Medicare carrier can accept a PWK segment, although they don't have the process in place right now to match up the control number with the paper attachment.
- Betsy Clore: Right. I understand that part. They're not going to reject it because I would send one.
- Joy Glass: Right. They wouldn't reject. When you send your claim electronically, they would actually further develop it and probably send you a letter saying you have to send the paper attachment. They would not reject it.
- Betsy Clore: Okay. So it wouldn't come back on the remittance as a rejection; it would just be asking for more information?
- Joy Glass: You'd probably get a development letter.
- Betsy Clore: I'm sorry. I couldn't hear you.
- Joy Glass: You would get some type of development letter --
- Betsy Clore: Okay.
- Joy Glass: -- requesting that you send the paper attachment.
- Betsy Clore: Okay. So that would be okay to do it that way until we get a method of doing that?
- Joy Glass: Yes.
- Betsy Clore: Okay, thank you.
- Dr. Harper: You're welcome. Next question, please?
- Renee: Your next question comes from Arlene Peak.
- Arlene Peak: Hello. I thought one of the reasons that HIPAA was HIPAA was

so that everybody's doing the same thing. Basically, I've been doing a HIPAA survey with all the plans and am trying to find out what kind of eligibility file they're going to send us. I'm getting that member rosters do not have to be HIPAA-compliant. I'm getting 271 unsolicited, which is not even on the Washington Publishing site. And then I'm also getting the 834, but I've also been told 834 is only for people that are paying for the insurance which would be the health plans not for -- I'm an MSO. Can you help me understand this?

Stanley Nachimson: Yes. This is Stanley Nachimson and I will certainly give it a try. The eligibility transaction we've defined in HIPAA would be the eligibility inquiry -- that is the questioning from one health plan to another or a provider to a health plan -- about the status of an individual beneficiary and an eligibility response, a response to that particular inquiry. In the situation where a health plan is providing an eligibility roster, that is not one of the HIPAA standard transactions and there's no requirement for health plans to send that in any particular standard format. At this time, they're still free to send it in a proprietary format, in unsolicited 271s, or any other type of format that they choose. So we have not yet standardized the eligibility roster transaction. If you are inquiring to a health plan as to the individual beneficiaries or a group of beneficiaries, you should be using the 270 transaction and they must respond with the 271 transaction, but only in that situation.

Arlene Peak: Okay. But if that's the only situation, how do I know who the new members are? They send us a membership roster with new members and terminated members monthly.

Stanley Nachimson: Then it's up to the health plan to determine in which format to send you that information. Arlene Peak: Okay. And what about the 271 unsolicited; have you heard of that?

Stanley Nachimson: Yes, I've heard of it but it is not one of the transactions that we have adopted as a HIPAA standard, so health plans if they choose can use that as a transaction to send you eligibility information on an unsolicited basis.

Arlene Peak: Okay.

Joy Glass: But, again, the point here is that while there are other transactions that are not included under HIPAA, there is a requirement that you may send a 270 to a plan and they must respond in a 271.

Arlene Peak: Okay. The only thing -- and I understand that -- I was doing part of the testing when I worked at Blue Cross for 270/271. But my thing is unless I become psychic by October, I won't know who the new members are. So there has to be a different form for the eligibility file.

Stanley Nachimson: Yes. I mean, one would assume that whatever file they send to you has some sort of markings that indicate the old members and the new members.

Arlene Peak: Yeah, there's a -- I mean they have their own text Excel access, but then they're saying now with HIPAA 271 unsolicited and 834. So I just thought maybe you knew one or the other. Thank you for your time.

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

Renee: Your next question comes from Louise Anderson.

Louise Anderson: Mine's already been answered, thank you.

Dr. Harper: Thank you, Ms. Anderson. Next question, please?

Renee: Your next question comes from Cindy Miller.

Cindy Miller: Hi, this is Cindy Miller. I have a couple of questions dealing with the NCPDP format. We are a Medicare supplemental payer and we do have contracts with all four of the durable medical equipment carriers, and we're curious when will we be able to get an NCPDP test file? We've been waiting rather patiently. The format is very, very confusing, and we're hoping that the test file can help us ensure that we handle these claims correctly, especially the COB part.

Joy Glass: Hi, this is Joy, and they were ready to test August 1. Are you saying that they're now telling you something else?

Cindy Miller: That is correct.

Joy Glass: Which of the --

Cindy Miller: All four.

Joy Glass: -- all four DMERCs? Okay.

Joy Glass: Okay. I'll get back to you.

Dr. Harper: Do you have another question?

Cindy Miller: Yes, I do, with the NCPDP there's a program memorandum -- it's B03057 -- and it explained a little bit in detail how COB will be handled on the NCPDP format. However, I haven't really seen a good guideline, and that includes the companion guide that was released in May, on how COB is going to be handled between October and January on NCPDP.

Joy Glass: The NCPDP companion document was revised - the companion document was just released today.

Cindy Miller: Oh.

Joy Glass: Yeah. That should be up on our website shortly.

Cindy Miller: Okay.

Joy Glass: So take a look at that, and also the DMERCs should be working with you.

Cindy Miller: They have been trying to work, but they've expressed frustration themselves in trying to get test data in and that's been apparently --

Joy Glass: Right. I know one of the DMERCs; they do have some testing and I know the others have not so that presents a problem. But I'll get back to you.

Janis Nero-Phillips: Joy, would you mind repeating the website for Medicare EDI?

Joy Glass: Yes, it's www.cms.hhs.gov/providers/edi.

Dr. Harper: Did you get it, Ms. Miller?

Cindy Miller: Yes. I've been out to the website many times.

Joy Glass: It's just that I would say check it maybe middle of next week and that should be posted up there.

Cindy Miller: Okay.

Joy Glass: The companion document.

Dr. Harper: Thank you very much. Next question, please?

Renee: Your next question comes from Olanga {phonetic} Fitzgerald.

Olanga Fitzgerald: Hi, this is Olanga. I am with Richmond Ambulance Authority. I have a question about Medicare when we file it as a second payer. I know that question's come up a lot during this discussion. The question that I have is when we file it now, if I don't include the explanation of medical benefits from the primary payer, my claim is rejected stating that they need the EOB. Now how would that work with us having to file electronically come October 16?

Joy Glass: Well, I'm really surprised to hear that because the current Medicare format works very similar to the HIPAA transactions for MSP and there are the data elements that have the primary payment information. So I'm surprised to hear that those are being rejected.

Olanga Fitzgerald: Yeah, they're actually being rejected if the EOB is not sent. The claim is rejected. And I don't know if it makes a difference that we are an ambulance provider vs. a physician provider.

Joy Glass: It shouldn't. Could you tell me which contractor you're dealing with?

Olanga Fitzgerald: We're dealing with Trailblazer's Medicare here in Richmond, Virginia.

Dr. Harper: Anything else, Ms. Fitzgerald?

Joy Glass: I just would say with the HIPAA transactions, they are not to reject your claims. The elements are there and you need to populate your primary payer information.

Olanga Fitzgerald: Okay. So those should not be rejected come October 16 when we go live?

Joy Glass: No.

Olanga Fitzgerald: Okay. All right, thank you. That's all I have.

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

Renee: Your next question comes from Pauline Osborne.

Pauline Osborne: Hi. My question has to do with a follow-up to a conference call I listened to. Lori Davis from the CMS -- I think the Enforcement Division -- was on a call sponsored by the American Hospital Association back on August 8. And there were a lot of questions on the conference call relating to the physician's social security number/EIN issue. What Ms. Davis said was there was a meeting scheduled I think for that week or the following week with the Designated Standards Maintenance Organizations to try to find a solution to the problems of people not being able to get the physician numbers. I wondered if you had an update from that meeting.

Karen Trudel: This is Karen Trudel. I'm familiar with the issue, but I'm not familiar with that meeting. I'd be willing to get back to you and talk about this offline.

Pauline Osborne: Oh, okay.

Pauline Osborne: And I did have another question to do with taxonomy codes. We're a rehabilitation hospital and we have some outpatient therapy clinics, and we're struggling to find out what taxonomy codes we should use on our claims say if we bill -- can we use one taxonomy code for everything, or do we have another code we need to use for our provider-based clinics and another code to use for our agency clinics?

Pat Peyton: You'd have to use the taxonomy code that most closely represents the services that the clinic performs; and if you have the code set and can't find the right one, I could call you on Monday and talk to you about it.

Pauline Osborne: Okay.

Pat Peyton: But I don't have the code set here with me.

Pauline Osborne: Okay.

Dr. Harper: Would that help?

Pauline Osborne: That would help, thank you.

Dr. Harper: We have your number.

Pauline Osborne: Yeah.

Karen Trudel: Okay, right. And that was Pat Peyton who's our taxonomy code expert.

Pauline Osborne: Okay, thank you.

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

Renee: Your next question comes from Jim Burkes. Mr. Burkes, your line is open.

Jim Burkes: Good afternoon. The question that we had was Part A filing. Is the DDE from Florida Shared System considered compliant?

Karen Trudel: Yes.

Jim Burkes: It is?

Karen Trudel: Yes.

Jim Burkes: Is there a statement stating that?

Karen Trudel: Yes. And I believe there's actually an FAQ regarding the DDE as well as adherence to the data content.

Jim Burkes: Okay. That's all I had.

Dr. Harper: Thank you, Mr. Burkes. Next question, please?

Renee: Your next question comes from Robert Fenlow.

Kathy Whitbeck: Hi, this is Kathy Whitbeck{phonetic} for Robert. I just wanted to clarify that in the exceptions in the interim final rule, the exception that everything listed there is all inclusive. In other words, if somebody wants to interpret no known method available than what is listed there, is that going to be an option?

Dr. Harper: We're getting an answer for you. Just a minute.

Janis Nero-Phillips: That is an exhaustive list.

Stanley Nachimson: The only place where there is some flexibility, if you want to call it

that, is the unusual circumstance situation where the Reg actually says on demonstration satisfactory to the Secretary of other extraordinary circumstances precluding submission of electronic claims. So in the rare extraordinary circumstance that precludes your submission, you could apply to the Secretary and ask for a determination.

Dr. Harper:

Does that answer your question?

Kathy Whitbeck:

Yeah. Stanley, do you have some examples of what that might be -- what some of those extraordinary circumstances might be?

Karen Trudel:

No, actually we don't. This is Karen. If we had known what they would all be, we would have listed them all. We were trying to maintain some flexibility to be able to handle situations that we were unable to think of in advance.

Kathy Whitbeck:

Thank you.

Dr. Harper:

Thank you very much. Next question, please?

Renee:

Your next question comes from Ruth DeShavins{phonetic}.

Ruth DeShavins:

Hi, we're in Kansas and we've been advised that the Cahaba through which all our home health clients for Medicare go is not ready for testing, and I was wondering if you knew anything more about readiness at the state level for these Medicare clearinghouses for home health.

Joy Glass:

Are you talking the claim or a coordination of benefits?

Ruth DeShavins:

I'm talking about the claims. I'm talking about testing in general - - any kind of testing -- they are not currently ready to test anything.

Stanley Nachimson:

This is the Medicare intermediary, the Medicare regional home health intermediary?

Ruth DeShavins:

That is correct.

Janis Nero-Phillips:

Okay. It is our understanding -- we're getting reports -- that they are testing.

Joy Glass:

They have told us specifically recently that they are not ready to test.

Karen Trudel: Okay. I'll get back to you on this.

Ruth DeShavins: All right. Thank you so much.

Dr. Harper: Next question, please?

Renee: Your next question comes from Christine Lee.

Christine Lee: Yes, thank you for taking my call. The question I have is, who would we contact at the office of CMS if we have questions on waived entities?

Stanley Nachimson: I'm sorry. What do you mean by waived entities?

Christine Lee: Well, we're a small employer and we have some questions about whether we are going to be waived if we are a covered entity -- if we aren't -- and if we are a covered entity, are we going to be waived for those submissions, the electronic submission of the Medicare claim?

Karen Trudel: If you're an employer, that doesn't apply to you. The electronic submission of claims has to do with healthcare providers.

Christine Lee: Okay. We are a small employer. We are a provider of services. We are a physical therapy office.

Karen Trudel: So you are? Okay. You're a provider. Okay.

Christine Lee: But we are a small employer. There are fewer than ten full-time employees.

Stanley Nachimson: If you have fewer than ten full-time employees --

Christine Lee: Correct.

Stanley Nachimson: -- then based on your assessment, you will have a waiver and there's nothing that you need to do, nobody that you need to contact.

Christine Lee: Okay. Even though we may check on claims via internet? You know, we check on different payers' websites to see if our claims have reached them.

Karen Trudel: I think you're confusing several different concepts. If you are a covered entity which is what I'm assuming because you conduct

some transactions electronically, then you are required to comply with the HIPAA privacy and security. However, that said, if you do some of your transactions on paper, you submit Medicare claims on paper, you can continue to do that based on your size. But the electronic billing Reg only affects Medicare billing of claims. It doesn't affect whether or not you are determined to be a covered entity under HIPAA.

Christine Lee: Okay. Well, that answers my questions then because that's basically what we were wondering about, whether we had to comply with it, because right now we are not submitting claims electronically.

Karen Trudel: But you are doing electronic --

Janis Nero-Phillips: Sounds like claim status transactions

Christine Lee: Claims status is what we're doing; we check status electronically, but we do not check any Medicare electronically.

Karen Trudel: But that makes you a covered entity and the Medicare electronic billing regulation then doesn't make any difference in your case.

Stanley Nachimson: But you are not required to submit claims to Medicare electronically.

Christine Lee: Okay. Thank you very much. That answers the question.

Karen Trudel: Okay.

Dr. Harper: You're welcome, Ms. Lee. The next question, please?

Renee: Your next question comes from Rhonda Kinneman.

Rhonda Kinneman: Hello. Part of my question was already asked and answered concerning the PWK field and how to handle the additional documents that will accompany an 837. My first question, though, is where will the CMN be returned? Is it on the 997 after the 837 submission, or would it be on a 271 from a 270 transaction?

Janis Nero-Phillips: Once you submit the claim, I'm not sure that if it's returned back on the 835. I believe that's where it returns, but I would have to get back to you on that. It would not be on the 997. It would be

on the proprietary report that you get from your Medicare contractor, but not on the 997.

Rhonda Kinneman: Okay. Because I thought the 835 was the payment advice.

Janis Nero-Phillips: Right.

Rhonda Kinneman: Right, so is that going to have what was paid on the claim or is that going to be the --

Janis Nero-Phillips: Show what's paid on the claim.

Joy Glass: There are three different things that you could get back depending on how far through the process we've been able to take your claim. If there's a significant problem on the front end in terms of the envelope or something like that, we will send you a 997. If we can take it a little bit farther but the claim still is not compliant, we will send you a proprietary format that tells you what the issues are. If we can actually get the claim into adjudication and process it, then the results will come to you on the 835.

Rhonda Kinneman: Okay. So if this documentation is required in order to pay the claim, then I would get a remittance and it would have the CMN on it?

Joy Glass: No. If you needed documentation with the claim, the contractor would -- I think their normal process is to -- send you a development letter requesting the paper attachment. They would pendthe claim until they get that attachment and then they would process it.

Rhonda Kinneman: Okay. And how close are y'all to issuing guidance regarding this method?

Joy Glass: Well, this is currently how Medicare contractors perform this function. They will be supporting the PWK, and we are in the process of writing instructions for them to implement that. We are anticipating April and there will be guidance sent out to the providers on how to use the PWK.

Rhonda Kinneman: Okay. I'm sorry?

Karen Trudel: I'm sorry. I'm hearing a common theme here that this is something that people would like some more information about.

Rhonda Kinneman: Absolutely.

Karen Trudel: So I think that after the call we will put our heads together and see if perhaps we could develop a frequently asked question that we could post on the web.

Rhonda Kinneman: Okay, that would be great. And I have just one more question and it's regarding, you mentioned contingency guidance. Could I view that somewhere?

Karen Trudel: The contingency guidance is available on the CMS website, and actually it's in a headline on the home page. The URL is www.cms.hhs.gov.

Dr. Harper: Thank you very much.

Rhonda Kinneman: Thank you.

Dr. Harper: Next question, please?

Renee: Your next question comes from Sherrilyn Somerski{phonetic}.

Sherrilyn Somerski: {No response}

Renee: Sherrilyn, your line is open. She withdrew her question. Your next question comes from Jill Wills.

Jill Wills: {No response}

Joy Glass: Hello? Operator?

Renee: She withdrew her question. Your next question comes from Patrick Flynn.

Patrick Flynn: Yes, hi. Thanks for taking my question. Actually, I have two questions. The first question is, everybody in the industry pretty much agrees that the testing process takes about 45 days and so if payers or clearinghouses are not testing by September 1, they're obviously not going to make the October 16 deadline. Is there any way or will CMS accept reports of payers that have not started testing by 9/1 after 9/1, or do we have to wait until October 16 to file a complaint?

Karen Trudel: The regulation does not go into effect until October 16, so we can't accept complaints for action prior to October 16. I can assure you

that we've been working as hard as we can with the industry groups. We have already met with representatives of the health plans and the clearinghouses. We've encouraged them to step up their testing efforts and, to the extent that they can, we have encouraged them to consider putting contingencies in place in the event that their systems are compliant effective October 16 but their providers have not been given adequate time to test. I can take any anecdotal information that you like, but I do have to say that CMS does not have any legal standing until October 16 to take complaints.

Patrick Flynn: Okay. My second question is, in talking with the clearinghouse, pretty much if they have tested with let's say Medicare/Medicaid and some other commercial carriers, they've indicated that all they're testing for is 837 and that 835s, 270s, 271s, 276s, 277s, 278s are not even being discussed at this point in time and that the effort is all going into the 837 to have that ready by October 16.

Joy Glass: Uh-huh.

Patrick Flynn: Is there not a requirement that all of these be tested and compliant by October 16 or do they have more time for the other ones?

Stanley Nachimson: The regulatory requirement is for all transactions at the same time; by October 16, health plans, providers, and clearinghouses must be able to use all of the HIPAA standard transactions. Certainly, that being said, we understand that health plans and others are setting certain priorities in the testing of transactions as more important transactions for providers especially the claims and remittance to allow the payment to contingent.

Karen Trudel: This is Karen. I would take that one step farther and say that indeed we're aware that attention has been focused primarily on the claim, but if a plan chooses to do so, they can put contingencies in place for the other transactions too where, for instance, until providers have adequate testing time, they could continue to, for instance, accept proprietary transactions.

Dr. Harper: Thank you very much.

Patrick Flynn: Okay, thank you.

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

Renee: Your next question comes from Whitney Coverdell.

Whitney Coverdell: Hi. Thanks for taking my question. It's regarding CPT codes and ASA codes for anesthesia billing. Will insurance companies be ready to accept one format, either the CPT or the ASA code, and, if so, when will that occur?

Gladys Wheeler: Hi, this is Gladys Wheeler. The ASA codes are not really an adopted standard, although many of the ASA codes are identical to the anesthesia section of the CPT book, which is the adopted standard for anesthesia reporting. So there is the question of whether or not in CPT other codes are used, but CPT codes is the adopted standard to be used for reporting anesthesia services.

Dr. Harper: Anything else, Ms. Coverdell?

Whitney Coverdell: Well, some payers want us to use the surgery code when we do the billing and others take the anesthesia code.

Gladys Wheeler: Well, in CPT, the surgery codes and the anesthesia codes are part of the adopted standard CPT code set; so this is a reimbursement decision that's part of your trading partner agreement with the health plans as to whether or not they want you to report the surgical or the anesthesia CPT codes.

Dr. Harper: Thank you very much.

Whitney Coverdell: Wait. Will that be standardized, or will they always have the option of picking what they want?

Gladys Wheeler: Well, the code set -- the CPT code set -- is standard. Which codes in that particular code set are in part negotiated among your trading partners.

Whitney Coverdell: Okay, thank you.

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

Renee: Your next question comes from Ethel Mackey{phonetic}.

Ethel Mackey: Hi, it's Ethel Mackey{phonetic} and thank you for taking my call. My question is in regards to the employer identification number and the social security number that's required, we've had a problem of submitting some of our Medicaid claims for non-staff positions where we just receive an order for lab work. Is there any

contingency for those two numbers?

Dr. Harper: We're having consultation in the room. We'll be with you shortly.

Stanley Nachimson: Can you explain a little bit more of the situation? Are you saying that you're unable to get the EIN or the SSN for those particular providers on those claims?

Ethel Mackey: Correct. We may not have any relationship with the provider himself. We are a lab service. A patient appears at our door with an order for a lab test. We do the lab test. We try to submit the claim. We have no EIN or social security number for that physician, and sometimes no way to contact him.

Joy Glass: For the referring physician?

Ethel Mackey: He's not -- well, yeah. He may be a referring physician.

Joy Glass: The ordering physician.

Ethel Mackey: Correct, the ordering physician. He may be out of our area, a non-staff physician. For example, we may have someone come from another state with an order for a test.

Dr. Harper: We're having further consultation.

Joy Glass: We're going to have to do some research. We would need to check with implementation guides and I just need to get your name and phone number.

Dr. Harper: Thank you very much. Next question, please?

Renee: Your next question comes from Mary Yarn.

Mary Yarn: Yes, thank you. I have a question regarding the element for last menstrual period in the professional guide, and a question on the element for reporting patient weight for patients receiving EPO. My question on the last menstrual period date element is, is there a definition -- is there a defined ICD-9 code set -- that the provider should use to know when to report the last menstrual period date? I think the guide says if the claim is related to a pregnancy condition. But is there a definition that we can go to and know that our definition will be the same as the payer's definition?

Joy Glass: That should be something that the payer would communicate to

you in their companion guide.

Mary Yarn: Okay. So it could differ by payer?

Joy Glass: It could.

Mary Yarn: Okay. We could make that determination between trading partners as to when we would submit that.

Joy Glass: Exactly.

Mary Yarn: Okay, thank you. And then the other question was regarding the patient weight of the PAT element and it's indicated as situational but it's required on claims and encounters involving EPO -- erythropoietin -- for patients on dialysis. And my question is, are we still compliant if we sent patient weight for some patients who are not on dialysis in this segment?

Joy Glass: Yeah, you're still in compliance. There's nothing prohibiting -- you have to submit the patient weight under that situation -- but the guide doesn't say you can't supply the patient weight for another situation. You'll be fine.

Mary Yarn: Thank you very much.

Dr. Harper: You welcome, Ms. Yarn. Next question, please?

Renee: Your next question comes from Kim Adler.

Kim Adler: It's a question about your specialty codes. The current listing on the website, is that the most updated?

Stanley Nachimson: I'm sorry. The Medicare specialty codes?

Kim Adler: Yes. Is that the most updated list that's on the website?

Joy Glass: I would think it is, yeah.

Karen Trudel: That's not a standard code for us, so the Medicare specialty codes may be posted somewhere on the website but they won't be used on HIPAA compliant claims, the use of provider taxonomy codes to describe the specialty.

Kim Adler: So the specialty codes, they don't have to be put on the referring physician's info when you're submitting the claim?

Joy Glass: No

Kim Adler: Now the taxonomy codes, they have to be put on the referring physician's info also?

Joy Glass: That is a situational element and it depends on the payer. Medicare does not require that, but Medicaid does.

Kim Adler: Okay.

Dr. Harper: Thank you, Ms. Adler. Next question, please?

Renee: Your next question comes from Nick Rommell.

Nick Rommell: Yes, hello. I have two questions. First, just verifying earlier -- I think Stanley said that the national provider ID would be published by the end of the year and not by September.

Stanley Nachimson: Our current schedule calls for it to be published by the end of the year.

Nick Rommell: Okay. Also, getting back to the TCS guidance in July, is there going to be anymore guidance or any memos or anything coming down the pike to further define what good faith or due diligence constitutes? I know there's a lot of confusion out there about sort of what good faith really means in terms of timetables of external testing. Is there going to be any additional guidance coming out about this?

Karen Trudel: We've gotten a number of questions of that ilk, and we're taking a look to see what kinds of guidance or frequently asked questions we might want to put out that further define some of these concepts. Although, I must say that sometimes you don't necessarily want us to be more specific.

Nick Rommell: Right. Yeah, I know you don't want to lock in because I know it's a case by case basis, but will there be some sort of maybe examples that you could post on the FAQ section to get some basic guidance on what that means?

Karen Trudel: As I said, we're trying to figure out how much of that we can and should do. I'm hearing your point.

Nick Rommell: Okay, great. Thanks.

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

Renee: Your next question comes from Steve Cooper.

Steve Cooper: Thanks. With CPT as the standardized code set for outpatient procedure coding, is it going to be inappropriate to submit the ICD-9 procedure code along with that as has really been done historically?

Stanley Nachimson: The answer is yes that would not be a compliant claim if the ICD-9 code.

Joy Glass: Wait a minute. There should be an ICD-9 diagnosis code along with the CPT procedure code.

Steve Cooper: Correct. Yeah, but the ICD-9 procedure in the past we've submitted that due to pay requirements and for data capture.

Joy Glass: No.

Steve Cooper: Okay, we wouldn't. Okay. That's all I had. Thanks.

Dr. Harper: Thank you, Mr. Cooper. Next question, please?

Renee: Your next question comes from Jodi Peterson.

Lisa Giancomo: Hi, this is actually Lisa Giancomo{phonetic} instead of Jodi. You had previously answered a question regarding the fact that if we have a clearinghouse who is already certified that apparently that's all that we really need to do is make sure that they're certified. I guess my specific question is, as a hospital entity, don't I need to be certified?

Karen Trudel: Well, first of all -- this is Karen -- certified is not what I was talking about. There are certification authorities that you can go to -- there are a number of them -- and have your transactions tested and certified as being HIPAA compliant. That does not substitute for actually testing between the clearinghouse and the individual payers, and that is what is really important. If you can send the necessary information to the clearinghouse and the clearinghouse has tested with a Medicare carrier or fiscal intermediary or any other payer, that is information and that's the process that you need to go through to make sure that the flow of your claims continues uninterrupted after October 16. I would not put too much

emphasis on the issue of certification because, as I said, it's not a substitute for actual clearinghouse to plan testing.

Stanley Nachimson: There are two procedures we are talking about. First, you certainly have to make sure that the clearinghouse can submit compliant claims to the particular health plan. Then you, as a provider, would have to make sure that the clearinghouse can produce a compliant claim from the information that you provided. So as long as both of those processes are tested and found to be operating correctly, you're okay.

Karen Trudel: So from your perspective, the question that you would want to ask your clearinghouse would be, am I sending you all the information that you need to build a compliant claim and have you tested with all the plans that I send claims to to make sure that both the clearinghouse and the plans have the same concept of what compliance is?

Dr. Harper: Thank you very much. Ms. Cameron, we'll have only two more questions.

Renee: Your next question comes from Bruce Rodman.

Bruce Rodman: Thank you. I just want to thank you all for holding these forums; they're extremely helpful. And my question has to do with the August 15 publication of the waiver for submission of Medicare electronic claims. As I'm sure you know, there are many, many cases where Medicare issues multiple provider numbers to the same organization. There might be a provider number for a hospital. There might be a provider number for a number of alternate site businesses that a hospital has. In other cases, a large national organization may have multiple locations for service where they are providing services covered by the DMERCs under various benefits, and each one of those locations will have a different provider number. Can you tell us in these types of accommodations and probably lots of others whether the limit of less than ten FTE's or, if it's I guess a hospital or whatever less than 25, whether it applies to the entire organization, just to the provider number? What happens if there's various subsidiary business setups? That sort of thing. And perhaps, if that's available on the web somewhere, can you tell us all where to find it?

Joy Glass: I think we can give you a general answer and then say that more

specific language will come from the folks who are writing the instructions to the Medicare contractors. But I think in general it depends on the Medicare provider number. Stanley, do you want to --

Stanley Nachimson: It's whatever Medicare considers the definition of provider. If Medicare considers part of the organization a provider, then the definition of small would apply to that part.

Bruce Rodman: I realize this is a general answer, but to make it more real, if I had an organization such as a home infusion organization that had two pharmacy sites, they are in fact assigned two provider numbers, and each one of them had nine employees working out of each site so to speak, would they be therefore eligible for the waiver and not be required to submit electronically?

Stanley Nachimson: In general, if Medicare considers each of them a separate provider, they would be eligible for the waiver. And I say in general because I'm sure there are certain ownership situations where that might not possibly apply.

Bruce Rodman: Okay.

Stanley Nachimson: But I think the general principle would be to --

Dr. Harper: It's probably a good rule of thumb anyway.

Stanley Nachimson: -- you know, look at the Medicare provider number.

Bruce Rodman: But in any event there will be more guidance on that issued by the contractors, correct?

Stanley Nachimson: We will make sure that the instructions to the contractors address that issue.

Janis Nero-Phillips: But CMS will be writing instructions and providing more detail.

Bruce Rodman: At a WEDI teleconference yesterday, Michael Phillips did say that the enforcement of the requirement for electronic claims submission will be done on an audit basis and that he was pretty certain of, if you will, the Medicare side of CMS that there would be no direction provided to the contractors to actually deny those claims simply because they are submitted on paper. Can you all confirm that?

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

Janis Nero-Phillips: I think that's another one of those things that will be handled in the provider instructions.

Dr. Harper: Thank you, Mr. Rodman.

Bruce Rodman: Thank you.

Dr. Harper: Operator, this is the last question.

Renee: Your next question comes from Roland Blake.

Roland Blake: Hello. In working with our payers, we'd like to submit them questions to ask them -- I know that you have such a thing on your website, but it doesn't work. Is there any other place I can go, or how do I get those questions to make sure that we can be assured that they will be compliant?

Karen Trudel: Well, I have to tell you first of all it does work but, based on the nature of the question, you may not get a response in the period of time that you might desire. We do monitor the Ask HIPAA box so the questions are triaged and provided to the various experts, and some of those experts -- especially the ones where you're asking very specific questions about very specific transactions, loop segments, etc. -- I don't doubt that the folks who are answering them are pretty bogged down. If there are questions about a transaction in general, the website that Joy Glass mentioned earlier at www.x12.org is a good place to go because that's where you can get in touch with the experts who actually work on the x12 transactions. If there is a Medicare-specific question, I encourage you to talk to your carrier or fiscal intermediary first and then if there is a problem where you feel that the answer you're getting is not appropriate, then you can bring that up with us. But I would suggest that you try those other alternate locations first.

Roland Blake: Secondly, do HIPAA regulations require that we have business associate agreements with payers as opposed to other providers if we are a provider?

Karen Trudel: If you're a provider, then you are not a business associate of your health plan. That's simply a misconception. A business associate would be if you're a provider, your billing agent or your clearinghouse who works on your behalf would be a business

associate. The health plans that you submit claims to are not business associates. Some plans -- many plans -- do require what's called a trading partner agreement between themselves and their providers, but the content of those trading partner agreements is very, very different from what you would find in a business associate agreement. So I hope that answers that question.

Roland Blake: And we would certainly not need an agreement with states who provide Medicaid funds for our patients?

(Medicaid person): No, but you need to be a participating provider to provide and serve Medicaid beneficiaries.

Janis Nero-Phillips: You would need to be enrolled as a Medicaid provider and recognized as a Medicaid provider.

Roland Blake: Yes, okay. Thank you.

Dr. Harper: Thank you, Mr. Blake. Now we'll have a few announcements from Mrs. Trudel.

Karen Trudel: We are augmenting our current webcast with two additional presentation segments, which include PowerPoint slides which viewers can download, concerning the 837 professional and institutional claims transactions. We're also supplying the Medicare contractors with additional funding to supplement their HIPAA outreach activities as the October deadline approaches. We have placed advertisements on HIPAA focusing on providers' cash flow testing and CMS resources in a number of large trade journals. Those are scheduled to appear in September publications. And, again, if you're interested in finding out more information about the webcast, you can go to our website at www.cms.hhs.gov/hipaa/hipaa2. Thank you.

Dr. Harper: Thank you. Ms. Cameron, can you tell us how many people we had online today, please?

Renee: There were a total of 920.

Dr. Harper: Thank you very much and we'd like to thank those of you online who participated in this conference today. And we also thank the members of our staff. The roundtable is concluded.

Renee: Thank you for your participation in today's Centers for Medicare

and Medicaid Services HIPAA Roundtable. You may now disconnect.

Dr. Harper:

Thank you.