

Operator: 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 14th National HIPAA Implementation 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 star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. Dr. Bernice Catherine Harper, you may begin your conference.

Dr. Harper: Thank you, Ms. Tina Shawn. Good afternoon to those on the East Coast, and good morning to those on the West Coast. It is my pleasure again to serve as your moderator. And welcome to the 14th National HIPAA Roundtable, 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.

Our subject today is the Health Insurance Portability and Accountability Act of 1996, or HIPAA, and specifically the administrative simplification provisions. My, my, my, how the time is going. There are only eight days before the October the 16th deadline for compliance with the HIPAA electronic transaction and code set standards. As we promised during our last roundtable, we do have a representative from the Office for Civil Rights, Stephanie Kaminsky. And now we will begin our roundtable with a few words from Ms. Karen Trudel, the Deputy Director of the Office of HIPAA Standards at CMS. Ms. Trudel.

Ms. Trudel: Thank you, Dr. Harper. I think, as you mentioned, the important thing here is that we have only eight days left until the transaction and code set compliance date. And as a result, time is short. I am sure you all have a lot of questions, and I'm not going to take up a lot of time with a presentation. We'll start out with a short report from Cathy Carter as to status of Medicare's implementation activities and then we'll go right to questions and answers. Cathy?

Ms. Carter: Thank you, Karen. I'm not going to take up a lot of time either on the Medicare update. I think many of you know, I'm sure most of you know, that on September 23rd we announced that Medicare was invoking a contingency plan, and so that is now in place, or

will be in place on October 16th. So Medicare will be not only receiving and sending out HIPAA compliance claims and other transactions, but will also be receiving and sending legacy claims and other transactions as well. We are getting reporting on a bi-weekly basis at this point from our Medicare contractors as to the status of their testing and the production reports on each of the submitters that are working towards submitting HIPAA compliant claims. In every reporting period we're seeing the numbers increase. We are at the point now where many of our contractors are reporting to us that over half, or somewhere near half, of their electronic claims are coming in the HIPAA format. We are spending a lot of energy at this point working on our coordination of benefits transactions and what we send out not only to trading partners, the commercial trading partners, but also the Medicaid state agencies. As we increase the number of entities that we're testing with, we are working on the issues that are coming up as a result of that testing, making sure that those issues are being worked on and are being resolved. So as I said, the incoming claims we're reporting, we're seeing a real good increase in the number of claims, and we are working on the other transactions as well, and are really at the point right now of increasing the number of trading partners that we're testing with, and we're assuming that's going to keep increasing as the waning days go on.

Dr. Harper: We're going to use that maximum time today for questions. So, Ms. Shawn, would you give us the instructions for the questions please.

Operator: At this time I would like to remind everyone, in order to ask a question, please press star, then the number one on your telephone keypad. And your first question comes from the line of Jeff Perber.

Mr. Perber: Hello. My question is in regard to the Social Security numbers or Tax IN numbers for referring physicians. It was mentioned in the last call that that was a situational field, but it wasn't really explained what we're supposed to do in order to encourage physicians to provide that information when it is required, for instance, on inpatient claims. And that's one of our big issues here, and I'm sure the issue of many hospitals around the country who have to have that information.

Mr. Nachimson: Hi, this is Stanley Nachimson and I'll try to answer that question.

First, what CMS is doing is putting a frequently asked question on our site that recognizes this situation, and reminds physicians that in order for hospitals to get paid, they need that information from physicians. And I've been told that it has been posted on our website. So the instruction to physicians is there and you can certainly feel free to refer physicians and others to our website if they need some sort of an explanation as to why you're asking for that number. I think the only thing that you can really do is explain to your partners that you need this information in order to get paid, although some plans may continue for a short period of time on a contingency basis to process claims without this information when they move to a HIPAA compliant state. You will need to have that information or you will not be able to get paid.

Mr. Perber: Is CMS accepting dummy numbers? I've heard that CMS has said they will accept all nines.

Ms. Glass: This is Joy Glass. We do not use the SSN or EIN number for processing so we validate for the syntax of that data element to insure it is numeric and it is the correct length, but we do not have a file to edit to see whether it is a valid EIN.

Mr. Perber: Okay. Thank you very much.

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

Operator: Your next question comes from the line of Mary Bartow.

Ms. Bartow: Good afternoon. Thank you for taking my questions.

Dr. Harper: You're welcome.

Ms. Bartow: My first question is can – and this has to do with the former roundtable. There was a discussion about outpatient bills having both ICD-9 codes and CPT codes after 10/16. And I'm just looking for clarity. Will CMS accept both ICD-9 and CPT codes on an outpatient claim?

Mr. Nachimson: This is Stanley again. And let's start at least with the requirements and then I'll let the Medicare folks talk about how they're implementing it. The regulations and the implementation guide require that to indicate a procedure on an outpatient hospital claim,

you have to use the CPT or HCPCS code, and you cannot use an ICD-9 code. So claims with ICD-9 – outpatient claims with ICD-9 procedure codes would not be considered compliant. We will have a frequently asked question on our site in the near future explaining that. We do understand that this issue was only brought to light fairly recently and does involve contracts between providers and certain health plans, and may cause a problem. We are working actively with the industry to figure out what a temporary solution will be, and move the industry towards a more compliant state.

Dr. Harper:

Are there comments from other members of the staff?

Ms. Glass:

This is Joy Glass. On the outpatient claims we will expect to see the HCPCS or CPT-4.

Ms. Bartow:

Right. But on 10/16 if we also have the ICD-9 code, are you going to reject the claim?

Dr. Harper:

We're having a little consultation. Just a minute.

Ms. Bartow:

Thank you.

Ms. Glass:

Can I get back with you, take your number. I'm not positive at this point.

Ms. Bartow:

I have another question.

Dr. Harper:

All right.

Ms. Bartow:

And this also was from a former roundtable, and I never got a clear answer. There was some discussion about a batch being rejected when it's sent out through either payor or clearinghouse if there was a syntax error in the batch. In other words, if my clearinghouse sends a payor a batch of data that has multiple provider claims in it, and one claim in some provider's batch had an error, that the whole batch would be rejected, therefore, my claims would be rejected along with all the other providers in that batch. Am I to understand that that's the case?

Ms. Glass:

This is Joy Glass again. Currently some of our contractors do in fact reject the entire batch, however, we are issuing instructions to them which they are to implement by January that they will start

rejecting at the claim level and not the batch level.

Ms. Bartow: But by January? So between October and January we could have that experience?

Ms. Glass: Yes, you could.

Mr. Kavanagh: This is Gary Kavanagh. Let me add to that. We've done some checking in terms of the testing that's been done up to this point and even in production with contractors that are rejecting at the batch level, and this has not been a significant problem for the vast majority of submitters. So we don't really think it's that big of an issue, however, recognizing that it is a concern, we're trying to change it in the future.

Ms. Bartow: Can you tell us or do you have on your website the providers that might do that to us so we can know what to look for?

Mr. Kavanagh: Do you mean the contractors?

Ms. Bartow: Well, whoever it is that's going to reject the batch because it's got a syntax error? Is it one of the big payors or how do we know? Can we know up front that this is going to happen?

Mr. Nachimson: This is Stanley again. Gary was just talking about the Medicare contractors. We could probably make available the list of Medicare contractors that are doing that, but we do not have a nationwide list of all payors that would be doing that.

Ms. Bartow: Okay. And where would I find this list of Medicare contractors?

Dr. Harper: We're having a consultation.

Ms. Bartow: Okay.

Ms. Trudel: This is Karen Trudel. We'll develop a frequently asked question on that. And as part of the response we'll include the information about which carriers or fiscal intermediaries that the issue could arise with in the short-term.

Ms. Bartow: Okay. Thank you.

Ms. Trudel: That will probably take maybe a week.

Dr. Harper: We're going to another question now from someone else.

Operator: Your next question comes from the line of Ann Kocian.

Ms. Kocian: I more just wanted to make a statement in regard to Texas Medicaid. Their contingency plan is to go to either paper or 837 claims. And we're having a hard time testing all the way through to get an 835 format filed. And I was wondering if you had any recommendations because they are going live on 10/16.

Mr. Friedman: This is Rick Friedman at CMS. I think the best thing to do is just to work closely with the folks of the state of Texas, the HIPAA coordinator and others. I know that they're working on a variety of contingency plans, and they're trying to make sure that their solution fits everybody's needs. So if you need contacts, I'd be happy to provide it to you if you give us your phone number.

Dr. Harper: Thank you. Next question please.

Operator: Next we have Alan Goldberg.

Mr. Goldberg: Good afternoon, and thank you for taking my question. My question has two parts, but it relates to somewhat of a similar subject. That is in electronic transactions, there are small health plans, 5.0 million dollar or less gross receipts, that occasionally will communicate electronically, for example, to pass along premium payments to an insurance company providing healthcare, and not have the resources or need since the communications occur sporadically, possibly once or twice a year, to think in terms of PCS compliance. The second part of the question is there are funded health plans that indeed use third-party administrators and self-fund the plans that provide healthcare who deal with their third-party administrators, and again, maybe once or twice maybe monthly during the year provide funds to the third-party administrator for purposes of funding a bank account or other resource used to pay claims by the TPA for the health plan that is more than a 5.0 million dollar health plan. In either or both instances, is adherence to the TCS transmission requirements or premium payments implicated, or is what I described not truly within the TCS compliance requirement?

Ms. Trudel: Alan, hi, this is Karen Trudel.

- Mr. Goldberg: Thank you, Karen.
- Ms. Trudel: I know there was a question in there somewhere, Alan. I think we may need to do a little bit of legal research before we can answer it. And I know where I can find you, so I will give you a call back.
- Mr. Goldberg: I sure do appreciate it. And a pleasant afternoon.
- Dr. Harper: Thank you very much.
- Operator: Next we have Julie Mathis.
- Ms. Mathis: Hi. Thank you very much for taking my question. First, I also want to thank you. I had a question at the last roundtable and you indicated you would follow-up, and indeed I did get a follow-up phone call. That was on the items where the regional home health intermediaries are not quite in agreement on their edits. I haven't heard back from that follow-up, but I do expect to. My question today is actually on just your remark on – California Medicaid's companion guide indicates that the claim separators, the element separator, the component separator and the segment separator, they're actually looking for unprintable text characters. There are two issues that concern us with this. One is it certainly was easier when people were taking colons, asterisks, and tildes. That's easily explained. It's hard to even tell customers or our users how to insert a text character as the separator when you parameterize that value. But the second issue is it makes it difficult to break the claim down. We often tell our users that when they're trying to look at a claim in a text editor, to break it on the tildes because then it's easier to see the segments and loops laid out. And I was just wondering if Medicare has a comment. Did you expect any of the Medicais to use non-printable text character separators, and do you mind if we're doing this? This is fine with you, or any comment?
- Dr. Harper: A consultation going on in the room. We'll be with you shortly.
- Ms. Mathis: And just as a comment, I've examined 23 state Medicaid companion guides. So far California's is the only one that I've come across that is doing this for the separators.
- Ms. Glass: This is Joy Glass. And in the implementation guides it does

specifically state that any characters used in the stream of data have to be – they can be part of the special character set, but they're all printable characters. It does not appear that there are unprintable characters as you describe them would be valid.

Ms. Mathis: Well, maybe I'm incorrect there. On printable they're saying hex 1C, hex 1D and hex 1F. And our translation of that is that they're unprintable. Maybe I'm wrong and I'd love to be wrong, but I don't think so.

Mr. Friedman: This is Rick Friedman. Perhaps the best thing to do is just to put folks together on a call involving the state of California and Joy, and anybody else that's interested in this. And if we take your name and number, we'll try to set that up and connect you with California to make sure that to the extent that what they're doing comports with what's required, and that it solves your problem as well.

Ms. Glass: Just as an FYI, Julie is also the person working the regional home health issues. I have passed that information along and we do have somebody checking on it. And as soon as I get a response, I'll be back in touch.

Ms. Mathis: Thank you very much.

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

Operator: Next we have Delpha Mansilla.

Ms. Mansilla: Hi, this is Delpha Mansilla. We would like to expand on the question of the ICD-9 code on outpatient claims. We've been sending compliant claims for a month and a half now with Med A, and we're sending the ICD-9 code on the outpatient claims in the HI segment, and these are being accepted and they're being paid. Why would there be a possibility on October 16th that these would be rejected all of a sudden?

Dr. Harper: Just a minute please.

Ms. Carter: This is Cathy Carter. I do believe that for Medicare, and we weren't absolutely certain which is why we didn't answer before. We believe that there are – we do not have an edit in place that would reject a claim for the ICD-9 codes coming in on outpatient.

And I guess you've just proven that that's true if you're talking about that being an 837 claim. We were just going to verify that and get back with the other person who asked the question. But I think that probably answers that for them, that there's not an edit in place to prevent those codes from coming in on an outpatient claim.

- Ms. Mansilla: There will not be in the future or it will stay the same as it is?
- Ms. Carter: If there's no edit in place now, there will not be one on October 16th.
- Ms. Mansilla: Okay. Thank you.
- Dr. Harper: You're welcome. Next question please.
- Operator: Next we have a question from Gracie Wheeler.
- Ms. Wheeler: Hi. We're just wondering if we could submit retail pharmacy drug claims using the 837 until everyone is ready to test with the batch 1.1?
- Ms. Glass: This is Joy Glass. You were on the last HIPAA call, and the number I called was somebody else's voice mail, but I did leave a message. But just to let you know that the DMERCs are all testing. And we've actually checked this past week and they all have said they are sending out – they are testing on the NCPDP.
- Ms. Wheeler: But what do we do in the meantime? If we're sending 837 in production that we have retail pharmacy claims, until we go into production with the 1.1, can we send those in an 837?
- Ms. Glass: Until you go into production, you can continue using the other formats.
- Ms. Wheeler: So we should send that in until the production of 1.1?
- Ms. Glass: Until you move into production, yes.
- Ms. Wheeler: Okay.
- Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from the line of Gray Utledger.

Ms. Utledger: Hi. Thank you for taking my call. My question has to do with code sets. And I'm wondering on October 16th, with the contingency plan in place, will you still expect code sets that are valid at that time and from the various updates that have been applied in the last few quarters to be consistent and to be compliant at that time? And also, are we also going to have to make sure we have the code sets in place on the effective date, such as 1/1/04, or will we still have that 90 day grace period?

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

Ms. Utledger: Thank you.

Ms. Glass: This is Joy Glass again. We shall continue to have our grace period. I do understand there is a work refunder, electronic data interchange, that is looking at this issue. But as it stands, Medicare will still continue the grace period.

Mr. Nachimson: And this is Stanley just to expand a little bit on what Joy said. While Medicare has had a grace period for certain code sets, not every health plan has had the same grace period. What we're attempting to do is work with the industry to standardize grace periods among all health plans so providers are aware of what the grace period is and can plan the same grace period for every health plan that they deal with.

Ms. Utledger: Thank you.

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

Operator: Your next question comes from the line of Monica Kennedy.

Ms. Kennedy: Thank you very much for taking my call. My question has to do with privacy. Do you have a privacy person there today?

Dr. Harper: Yes, we do.

Ms. Kennedy: Okay. I'm the new HIPAA privacy officer, and got that by default. And the reason that I'm calling is I am told that there is somewhere on the Internet that one can go and do education documentation for all of the people who have had the HIPAA

privacy guidelines, etc., given to them. I was wondering if you could tell me where that was, and what steps I need to do to make sure that everybody is educated, and it's all compliant, and all that good stuff.

Ms. Kaminsky: This is Stephanie Kaminsky from Office for Civil Rights. And I am not personally familiar with the website that you're talking about, nor if I understand you correctly, does it have anything to do with HHS or the Office for Civil Rights. There is a requirement in the privacy rule to train staff who will have a need to know and be using and disclosing protected health information of a covered entity, and there is a requirement to document that that training has occurred. But in terms of a comprehensive sort of how to train kind of information source, that is not something that is required by the rule, nor is it something that HHS or the Office for Civil Rights sponsors. Does that answer your question if I'm following you correctly?

Ms. Kennedy: I believe it does. Thank you very much.

Ms. Kaminsky: Sure.

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

Operator: Your next question comes from the line of Dawn Walden.

Ms. Walden: Thank you. My questions have been answered.

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

Operator: Next we have Barbara Kitt.

Ms. Kitt: Hi. Thanks for taking my call. I come from a retail pharmacy who provides home infusion products. And I have some concerns – two concerns I guess – because at one point in time when I was contacting the d-merc regions, they did not have a vendor that they had passed testing with. And we currently use the 837's to submit claims on. So based on your answer to Gracie, I guess we can continue to do that until we can find a vendor who can submit batch and NCPDP claims to the DMERCs. Is that correct?

Female Speaker: That's correct. And actually the home infusion claims can be continued.

- Ms. Kitt: But we're a retail pharmacy. We do drugs and home infusion.
- Joy Glass: I know we have at least – I know there's one of the d-mercs that have several vendors that have tested their software in production. Maybe if I could have your number, and I'm not sure which region.
- Ms. Kitt: We do all four regions.
- Joy Glass: Okay. If I could have your number, I could put you in contact with them, and maybe they could get you in contact with the vendors.
- Ms. Kitt: Okay. And then I do have another question regarding PBM's versus major medical. I guess if we bill a drug, are we supposed to do one format or the other because when we're talking to our commercial plans, if they have a PBM, they'll say submit it on the NCPDP format. If it's major medical, submit it on the 837.
- Mr. Nachimson: This is Stanley. As a retail pharmacy, you should be billing your drug claims according to the regulations only on the NCPDP format, not the 837. We would expect when you move into compliance and the health plans also move into compliance that all the billing would be done on the NCPDP format. We understand that that's been an issue for the retail pharmacy industry, but the regulations –
- Ms. Kitt: We can do it. We have the ability to do it in the NCPDP, but a lot of the insurance that handles major medical can't.
- Mr. Nachimson: The health plans should be accepting retail pharmacy drug claims on the NCPDP format.
- Ms. Kitt: Okay. And then that brings me to my last question. When you say home infusion product, besides the SRD and nutritional, is it any and all home infusion products? If it's just the drug and it's infused by the patient, is that considered home infused? Let's say the first visit the nurse comes out so she does have a service, and then after that the patient infuses it by themselves. So is that an 837 type of transaction or an NCPDP transaction?
- Mr. Nachimson: If you are a retail pharmacy and billing the drug, whether the nurse infuses it or the patient infuses it, your responsibility is to bill the

drug on the NCPDP format. The service that the nurse provides, assuming it comes from a home infusion therapy provider, will be billed on the 837.

Ms. Kitt: Okay. And we were told – and I can't say who told us because it's come down a lot from various people from my side who have contacted Medicare, and said, no, you can't do that because you have to show the whole claim together or they won't be able to put the drug and the service together or they'll deny one or the other one.

Dr. Harper: We're having some conversation.

Mr. Nachimson: Let me first say that we have a slightly revised frequently asked question on our website that we believe provides further guidance on who is the home infusion therapy provider and when clients should be billed for home infusion on the 837 and when they should be billed on the NCPDP transaction.

Ms. Kitt: And I have all three of those Q&A's, and I'm still not really quite sure that it does answer the question because it's again, generic and it doesn't get into specifics.

Ms. Kitt: Okay.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from the line of Tina Barstow.

Ms. Barstow: Hi there. I have two quick questions. As far as contingency plans go, when we talk about CMS a lot of times we focus on CMS and Medicare only, but CMS is the Centers for Medicare and Medicaid Services. So when you're looking at the contingency plan that you put out, and here in Wisconsin Medicaid has also put a similar contingency plan saying they'll accept the old format, my question is – and I'm assuming that because Medicaid is a separate care that they can end their contingency plan even if Medicare – or they can continue the contingency plan even if Medicare decides to end theirs. Or does the state Medicaid have to follow kind of the same timeline that Medicare will follow with the CMS guidelines?

Mr. Friedman: Hi there. Indeed the states are allowed to use their own rules in terms of contingency plans.

- Ms. Barstow: Okay. That was my first question. My second one is I know that we've gone back and forth on taxonomy codes, and I was looking at a companion guide from our Part A contractor, Medicare contractor, and I don't have it in front of me unfortunately. I was looking at it on a computer and didn't print it out. But it said something along the lines that when a taxonomy code is submitted that it will be validated, and if it's not a valid taxonomy code, then the claim would be rejected. However, from my understanding of the addenda, taxonomy codes are not required anymore. So if we don't submit the taxonomy code, then there should be no validation and we should be fine on that line. Obviously there are other reasons why a claim could be rejected. Is that true?
- Ms. Glass: Yes, that is true.
- Ms. Barstow: Okay. Thank you very much.
- Dr. Harper: You're welcome. Next question please.
- Operator: Next we have Peggy McCloskey.
- Ms. McCloskey: Hi. Thank you. I just wanted to know if there was an update from the last roundtable. Someone had brought up the issue of indemnification clauses, and how carriers are requiring us to sign things that have nothing to do with HIPAA. I believe the person who asked the question, you took their number and went offline, and I was interested in the result as well.
- Mr. Nachimson: This is Stanley. And based on the analysis that we did, based on looking at certain contracts, health plans are allowed to include in their trading partner agreements things like indemnification clauses and other items that are part of their normal business. The only thing that cannot be included are clauses that would change the standards or the implementation guides, or unfairly cause harm to the providers just because they're using a standard. But normal business clauses like that could be included.
- Ms. McCloskey: We're a billing company and that's where we feel like we're getting caught because we're indemnifying them, all of our business associates, which would include our clients. We're a billing company, now defined as a clearinghouse, but –

Mr. Nachimson: And I think our analysis is that's not a HIPAA issue, but a business decision that needs to be worked out between both parties to the contract.

Ms. McCloskey: Okay. Thank you.

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

Operator: Next we have Nancy Rudolph. Ma'am, your line is open.

Nancy Rudolph: Thank you. My name is Nancy Rudolph and I'm calling from Jackson Memorial Hospital in Miami, Florida. My general question is about payor ID requirements. We're mainly commercial payors. We've had a lot of recent information coming from payors saying I have a vendor number, a payor ID number, this number or that number. And we were just wondering do you have some general terminologies that we can count on when people tell us that this is a vendor number which would be interpreted as a payor ID number?

Ms. Glass: This is Joy Glass. When you're communicating with your commercial health plans, you need to get the number that they will accept in the payor ID segment.

Nancy Rudolph: Is there a standard format for that payor ID number, such as six characters, five characters?

Ms. Glass: No, not at this time.

Mr. Nachimson: Aside from the general requirements that are in the implementation guide, which are probably fairly broad, there are no national standards for health plan ID numbers. And that's a proposed rule that we hope to publish sometime next year.

Nancy Rudolph: Thank you.

Dr. Harper: Next question please.

Operator: Next we have Roland Blake.

Mr. Blake: Thank you for taking my question. We operate skilled nursing facilities throughout the United States, and are working with each state to make sure that they're ready to accept electronic billing

information for Medicaid. However, there are two states, and I could name them, Arizona and Nebraska, which have – they only deal with paper. And their contingency plan is only to deal with paper and not electronic, although we recently heard that they're implementing some state software, but it's really far down the pike. So my question is with these two states, as long as we and other facilities are willing to go paper, I assume that there's no problem with that if it's a contingency plan. And secondly, if we want to nudge them to go toward electronic, first of all, is CMS the agency that enforces that? And what can we tell them to get them to move along? For example, could we say that you have plans to announce an end to the contingency plan at a certain time, or does that only apply to the Medicare part of it?

Mr. Friedman:

This is Rick on the Medicaid side of CMS. Clearly the whole point of HIPAA is to move toward an electronic environment and standardization. So it's in CMS's best interest, regardless of where one sits, to try to foster that. It's interesting you mentioned both Arizona and Nebraska as being problematic in that they are not ones that are truly on our radar screen as being a problem. But we're happy to get in the middle between you and them to see what we can do to try to make sure that they are moving in the right direction that comports with where you want to go, and also where they really want to go. So I really wasn't tracking that they were resorting to paper, but if that's what you say, then that's what they're doing. But we're happy to get involved in a conversation with them and see what we can do to move the ball along.

Mr. Blake:

Well, do you expect us to initiate then either with them or with you some kind of query or how will that work?

Mr. Friedman:

The way it will work is that we'll call you and we'll set up a call with them.

Dr. Harper:

Next question please.

Operator:

Next we have Trudy Solomon.

Ms. Solomon:

My question pertains to the ICD-9 on the outpatient claims. I have a copy of an e-mail from a Gladys Wheeler and, Stanley, I think you were copied on that. She said that they're going to have a fax out there clarifying this issue. But basically using ICD-9 for future codes to report hospital outpatient services at the line level or

claim level would not be HIPAA compliant. Now we have a problem in this state. Our Medicaid agency is requiring that to be on the outpatient claim. That's how they pay their surgery claims. However, the clearinghouses say that's not HIPAA compliant. The hospitals who have converted to 837 software internally cannot physically put that in there. The software won't let that go in on an outpatient claim. And we need some help because, as you said, that's like eight days away. And our Medicaid agency says that only applies to Medicare, so help, help.

Dr. Harper: We hear you.

Mr. Nachimson: Once again, why don't we get your name and number and contact the specific state Medicaid agency to see how we can work that out.

Mr. Friedman: And obviously it's the state of South Carolina that you're having difficulty with?

Ms. Solomon: Yes.

Mr. Friedman: Okay.

Dr. Harper: Thank you.

Ms. Solomon: Thank you.

Dr. Harper: Next question please.

Operator: Next we have Sandy Cenon. Sandy, your line is open.

Ms. Cenon: I'm calling from New Jersey. Currently we're submitting our claims in the 4010A1 format to Medicare. On October 16th should we expect to receive the 835 back in the 4010 or will they, because of the contingency plan, send it back in the current format of the 3050?

Ms. Glass: This is Joy Glass. Are you currently receiving the 835?

Ms. Cenon: Yes, because what we were told is that they wouldn't be switching over to the 4010 format until October 16th.

Ms. Glass: I thought you said you were currently receiving the 4010 835?

Ms. Cenon: No. We are currently sending the 837 in the 4010 format, but we are receiving the 835 in the 3050.

Ms. Glass: Okay. You need to test, and they will send the 835 4010 if you're ready.

Ms. Cenon: Okay. I guess my question is with the contingency plan.

Ms. Glass: If you're not ready, they will continue to send whatever you were receiving before the 3051.

Ms. Cenon: Okay. So I have to contact them at this point then?

Ms. Glass: If you wish to receive the 4010, yes.

Ms. Cenon: Okay. Because we were told prior to the contingency plan that it was just going to be automatic, that they were going to switch over to the 4010 on October 16th.

Ms. Glass: I would suggest that you contact them.

Ms. Cenon: Okay.

Dr. Harper: Thank you.

Ms. Cenon: Thank you.

Dr. Harper: Next question please.

Operator: Next we have Keith Poblis.

Mr. Poblis: Hi, do you hear me?

Operator: Yes, sir, we can hear you. Please continue.

Mr. Poblis: Thank you for taking my question. In the state of California there is a new regulation that requires payors to communicate specific reasons why a claim may be denied, for example. And also we have to communicate how a provider can issue a dispute of how a claim was resolved if the provider feels that they don't agree with that. So we need to start looking at the 835, the electronic remittance advice. If payors in California fulfill requirements as

far as HIPAA is concerned with the 835 specification, do you have an issue if we try to find ways to use fields within that spec, fields that are not being used or maybe try to input some free text information in there. Is there that kind of flexibility?

Mr. Nachimson: This is Stanley. There's not a flexibility to allow individual states or other health plans to customize transactions and use fields in conflict with the implementation guide. We have a couple of suggestions that you might follow. Try to get the appropriate code sets on the 835, perhaps updated to the code setting committees, to reflect the information that you have to provide. Number two, you could ask through the DSMO process for a change to the standard to give you the capability that you need. I'm a little concerned that state regulations – I'm not an attorney, but my understanding of the HIPAA regulations is that the state regulations cannot override or ask for information that is not present on the standards. So that's something that we would have to resolve.

Mr. Poblis: I thought, at least in the privacy portion, that if there were requirements that were more stringent on the state side, they would take effect over the HIPAA –

Mr. Nachimson: That may be on the privacy side, but there's a specific section of the regulations that talks about having federal standards for transactions preempt any state requirements, and that the state could ask for an exception.

Mr. Poblis: And so the state itself would have to ask the CMS for an exception?

Mr. Nachimson: Yes.

Mr. Poblis: Okay. And is that what you were saying with your second idea of either try to update the codes to the committee? What was the second?

Mr. Nachimson: Ask for a change to the standard through the designated state maintenance organization process if you need some new data elements or parts of the 835 remittance advice.

Mr. Poblis: That, of course, is a much slower process. This new regulation takes effect on January 1st.

Ms. Trudel: This is Karen Trudel. What I suggest that you do is to look at the – compare any potential gaps in legislation to the reason or remark codes that are already in the 835, and which really are very extensive, and see if there's a need to add new codes, which can be done fairly expeditiously. And then as Stanley said, there may or may not be a need to expand other data elements or functionality in the transaction. I'm sure that you have a WEDI/SNIP affiliate in your state. And I think that might be an appropriate organization to undertake some of that effort, maybe in concert with the state.

Mr. Poblis: I also participate in an organization out in California called ICE, which I believe Stanley may be familiar with, but it's with provider groups and health plans that collaborate together to standardize requirements for new regulations and statutes. And so we are looking at this disposition codes and other requirements that are indicated in the new regulation here. But our initial thought is that the 835 will not fulfill the regulatory requirement. What I could do is feed this response back to the Department of Managed Healthcare out here and see what they say.

Ms. Trudel: Thank you. And we'd be interested in getting information on that bill.

Mr. Poblis: If you contact me, I can get that to you.

Dr. Harper: Thank you very much.

Mr. Poblis: One more question, a quick one. The Medicare contingency, I've been hearing, but I can't get confirmation, is that ending on November 1st or there's no end date identified.

Ms. Trudel: This is Karen Trudel. I'll answer it because I happen to be sitting here in front of the microphone. There is no specific end date that we have published. What we intend to do is to continue monitoring very closely the progress towards compliance, the percentages of claims that are in production, the numbers of submitters that are in testing. And when we feel that we've achieved an appropriate critical mass, we'll then make an announcement as to when the contingency will be turned off. And it will not be done with just a few weeks notice. We would provide more lead time than that.

Mr. Poblis: And other health plan payors, do they have a specific end date that

they're required – are they going to follow suit with what CMS decides for Medicare?

Ms. Trudel: That depends on each plan. Each plan is free to do what they wish.

Mr. Poblis: For an indeterminate time?

Ms. Trudel: Not for an indefinite time, but for a as yet unspecified period of time. It may be that one plan has many, many more or many, many fewer claims in production than another plan, and so each plan really has to look at its own situation to see whether there's a need to continue the contingency.

Dr. Harper: Thank you. Next question please.

Operator: Next we have Stacy Nalley.

Ms. Nalley: Hello. Thank you for taking my call. I'm trying to check on the status of my company's submitter ID application for DMERC region C, and I'm having no luck getting a response. Do you have a suggestion for me?

Ms. Glass: Yes. This is Joy Glass. If you could just give me your number.

Ms. Nalley: Thank you.

Ms. Glass: You said you submitted the application?

Ms. Nalley: Yes, I did.

Ms. Glass: Okay.

Dr. Harper: Thank you. Next question please.

Operator: Next we have David Whitman.

Mr. Whitman: Hi. Thank you for taking my call. I have a question. I'm looking for guidance on Medicare as a secondary payor. I called in late on the last roundtable when that issue was just wrapping up. I've been looking for any kind of guidance document on how to handle Medicare as a secondary payor to commercial insurances when those commercial insurances do not have 835's in production.

- Ms. Glass: This is Joy Glass. And on the last call I believe the concern was some of the codes you were getting are not the same codes that you would get normally on the 835.
- Mr. Whitman: Correct.
- Ms. Glass: Right. And for claims submitted to Medicare with Medicare as secondary, the segment that contains the reason codes, we don't need those segments. There are certain amount fields that we need, which are in the 835, so it is not necessary for you to send any of those types of code or try and crosswalk them in the CAD segment. That's where you would put those codes.
- Mr. Whitman: Right. So we would just need to put that there is a primary payor to Medicare, but we would not need to include the adjustment reasons or the adjustment amounts?
- Ms. Glass: Yes.
- Mr. Whitman: Okay. There are several fields like contract amount, obligated to accept amount, and approved, allowed, but there are separate fields for those. But when will something come out that I'll be able to actually hold in my hand and view and take guidance from?
- Ms. Glass: Actually your contractor – Medicare contractor should have provided that information. There was an instruction that was released describing how to bill MSP. I can certainly provide you with that.
- Mr. Whitman: Everything that I've gotten – that would be great if you could – if it's everything that I have gotten both from CMS and from our local provider is that when Medicare is a tertiary payor, you may put Medicare on paper, but everything – if Medicare is only a secondary payor, you need to have it go electronic. There was no specific guidance as to what to do when the primary payor does not have a functioning 835 so that coordination of benefits cannot occur.
- Ms. Glass: But I can certainly provide you with a copy of the instruction that our contractors received on how the MSP claims would come in on the 4010.
- Dr. Harper: Thank you, Mr. Whitman.

Mr. Whitman: Thank you.

Dr. Harper: Are you through? Next question please.

Operator: Your next question comes from Michael Licamell.

Mr. Licamell: Thank you for taking my call. I have two questions. One, we're trying to develop in-house an SQL database, taking the code sets that you would send down to DME payors, and I can't get the code set anywhere because we're not a software provider. Is there somewhere you could send me for that code set information?

Mr. Nachimson: Which code set is it that you're looking for?

Mr. Licamell: A DME claims upload and download, specifically the inhalation therapy claims and denial codes.

Mr. Nachimson: Is this in general or only to Medicare?

Mr. Licamell: No, just to Medicare. We're trying to develop this and I'm going into a roadblock with anybody really sending those to me.

Ms. Trudel: You're talking about procedure codes?

Mr. Licamell: I'm talking about the actual file that you're going to download or upload to us as a provider. We want to take that file and map it. And no one can give us the map or the code set. Could you give me some direction as –

Ms. Trudel: Could you tell me what file you're talking about? We're still not clear.

Mr. Licamell: Sorry. The download file of payments made to a provider by Medicare coordinated with an electronic fund payment.

Ms. Trudel: Electronic remittance advice. And the specifications for the electronic remittance advice are found electronically for download on the Washington Publishing Company website. And I'm sure someone at this table knows the URL, but I don't.

Ms. Glass: www.wpc-edi.com. And the specifications are there.

- Mr. Licamell: Thank you. My second question is particularly with HCPCS crossover codes for the new code sets. There was initially no way to code a KO, KP or KQ. They addressed a KP and a KQ, but nowhere is it addressed if it's a compounded KO – how you would indicate that in a code set situation.
- Ms. Glass: This is Joy Glass. We are updating our companion guide. I don't have that with me, but I do believe that it is addressed in that – about the compound segments.
- Mr. Licamell: Because they did address it with a release, but they only addressed the KQ and KP in the release that was made up to now. I think they've forgotten the KO in that particular case.
- Ms. Glass: I can check that for you.
- Dr. Harper: Thank you.
- Mr. Licamell: Thank you very much.
- Dr. Harper: You're welcome. Next question please.
- Operator: Next we have Kelly Wibbenmeyer.
- Ms. Wibbenmeyer: Hi, and thanks for taking my call. I had a few questions. I still have questions on the ICD-9 and CPT codes. From this call I did understand that there was no edit in place for the ICD-9 on 837 outpatient claims, but is that strictly only for Medicare?
- Ms. Glass: Yes. That comment was just Medicare.
- Ms. Wibbenmeyer: Okay. So we don't know about the rest of the world because that's a huge issue in our Greater Dayton Area Hospital Association.
- Mr. Nachimson: This is Stanley. And if I could just interrupt here for a moment. I think it's important to remember that whether or not there's an edit in place at any particular health plan, the ICD-9 procedure code is not a HIPAA compliant code. And you certainly run the risk of a claim being rejected by any health plan at some time in the very near future.
- Ms. Wibbenmeyer: But we're sending both.

Mr. Nachimson: I understand that.

Ms. Wibbenmeyer: Okay. So basically we should be taking the ICD-9 out, even though we've been told by other payors that that needs to be in there to pay the claim.

Mr. Nachimson: Certainly they could say on a contingency plan basis to continue sending that code until you both move into a compliant state.

Ms. Wibbenmeyer: Okay. Because we kind of wanted to move over all at once, but it doesn't seem like that's going to be happening, and it's very hard with our software to say yes to this one, but don't send it to this one. I'm sure a lot of other people are having that same problem. But we just need to get some I guess clarification if it's going to be required or if we send both, if it will be rejected. Or I guess the reason why they don't want to send both is a privacy issue. Is that what everybody else –

Ms. Trudel: This is Karen Trudel. I think because this question has come up so many times, it's worthwhile to take a few moments to explain the genesis of the issue. Apparently this is something that has been in place for quite some time, that no one quite noticed. It appears that a number of health plans have been using for years ICD-9 codes at the claim level to explain, for instance, the type of surgery that occurred so that you could pay anesthesia at the line level. And apparently the notion of ICD-9 codes at the claim level kind of passed over everyone's head. So this has just come up within the past few weeks. It was raised, actually for the first time that we were aware of, at the last roundtable, which I think says to us that we're very glad that we're doing these because it caused a fairly significant issue to come up. That being said, we are eight days from implementation. We have several ways to deal with this. One is obviously contingencies of some sort. And the other, as Stanley mentioned, was to work, and we will, with industry groups, work groups for electronic data interchange, state Medicaid HIPAA coordinators, anybody that we need to try to get a sense of who actually needs this data at the claim level. What business impacts it's causing, and are there any short-term solutions that we could put into place.

Ms. Wibbenmeyer: But we've been told by many of our insurance companies that they need both to pay the claim. So that's why if we take that out, we

know we're not going to get paid. Are we going to have a HIPAA violation if we do have it in there?

Ms. Trudel: I understand that. And I guess what I have to tell you is that this is going to be something that you'll have to determine almost a payor by payor basis. Presumably you know the payors that do require it because apparently they've already told you so.

Ms. Wibbenmeyer: Right.

Ms. Trudel: And you know that Medicare is not editing that field because we've told you so. And then the question is what other payors have built their systems to edit that piece of data, and potentially reject the claim if it's there. And that's the imponderable. I can't answer that, but that's something that you'll need to check with various plans on, or plans who continue to submit claims of that type in legacy formats or in any other way that you can use to take advantage of a contingency plan.

Ms. Wibbenmeyer: Okay. I have one other quick question. In Ohio, for home health care, Ohio states that we need to send the 837 for infusion drugs instead of the NCPDP 5.1 format because I guess Ohio has stated that all home health are classified as retail pharmacies, even though – when we look at our home health, we are definitely not a retail pharmacy. So what should we do in that aspect?

Ms. Glass: This is Joy. And you are not considered to be a retail pharmacy. Are you thinking of Medicare?

Ms. Wibbenmeyer: Ohio Medicaid has stated that all home health agencies for the state of Ohio are classified as a retail pharmacy, therefore we need to send our information on the NCPDP 5.1 format instead of the 837. So the state is telling us one thing, and then CMS is telling us something else. So we need to get some clarification on that also.

Mr. Nachimson: And in general, home health agencies are not retail pharmacies. And this is something we can follow-up with the state of Ohio. Can I have your name and number, and we'll make some sort of contact with them.

Ms. Wibbenmeyer: All right. Thank you very much.

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

Operator: We have a question from John Landrigan.

Female Speaker: Hi. Our question is about the CMS and whether they have a speakers bureau or some number that we could call to get in contact with someone who could possibly come to Memphis and speak to a group that we're putting together.

Mr. Nachimson: You're in our Region 4. I would suggest calling our Atlanta regional office and making a request. And if they can't fulfill it, that we could possibly work with them.

Female Speaker: Can you give me that number?

Mr. Nachimson: I don't think we have it.

Female Speaker: Okay. Thank you.

Dr. Harper: Next question please.

Operator: Next we have Charlotte Valdez.

Ms. Valdez: Hi. I am just asking about the NOE's of admission. And I'm understanding that with the new HIPAA requirements, they will no longer be able to be done electronically through our vendor's software, that they must be done through EDI. Can you explain that please?

Ms. Glass: This is Joy Glass. The NOE's cannot be submitted in the HIPAA format because the NOE's do not have service lines associated with them, and service lines are required on the 837. So you would continue to use the format you currently do to submit to the Medicare contractors.

Ms. Valdez: The way that we currently send them is through our vendor software, like we send a claim or 81A's, notices of admission.

Ms. Glass: That process isn't going to change because that's not a HIPAA transaction.

Ms. Valdez: Okay. Our vendor is not even allowing us now to send notices of admission because they said that CMS is not allowing them to go through that way.

Ms. Glass: That's not true.

Ms. Valdez: Okay. That's nice to know. Thank you.

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

Operator: Next we have Heather Olson.

Ms. Olson: My question has already been answered. I guess I would just like to make one request. There are many questions being raised here that are similar in every state. So if some of the answers here could be posted so that everyone gets to see the results of this, that would be very much appreciated.

Ms. Trudel: Yes, we'd be happy to do that.

Operator: Next we have Mary Yarn.

Ms. Yarn: Thank you. My question has to do with paper claims and whether or not CMS's contingency plan to accept legacy claims includes any opportunity for providers to continue to submit some paper claims.

Ms. Glass: This is Joy Glass. Unless you need to ask the definition as a small provider, you must send these claims in electronically.

Ms. Yarn: So even under the contingency?

Ms. Glass: Even under the contingency as of October 16th, you must submit your claims electronically.

Ms. Yarn: Okay. Thank you very much.

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

Operator: Next we have Jeannie Avery.

Ms. Avery: Thank you for taking my call. My question is kind of similar to the last caller, but my question is there are times when we need to send the op report, for instance, if it's a modifier that's used that needs explanation in the op report, or an unlisted CPT code is used. And we would need to send the op report with the claim.

Can we submit a paper claim under those circumstances?

Ms. Glass: This is Joy Glass again. And we are in fact preparing the instruction that at this time we will allow an exception to submit those claims on paper. We are working with our systems, and we're going to have a system change where those claims can be submitted electronically, and then the paper attachment mailed or faxed. But at this time, you will still be able to continue sending those in paper.

Ms. Avery: Thank you very much. Have a nice afternoon.

Dr. Harper: You too. Next question please.

Operator: Your next question comes from Charles Poglioli.

Mr. Poglioli: Hi. Thanks for taking our question. This is Chuck Poglioli, Doctors Community Hospital. And I think you've covered our questions. Estelle?

Estelle: It has to do with the outpatient CPT codes so many people have asked you about. And if you can either call us with the answer or post it. Currently our vendor, our electronic vendor, has interpreted for outpatient hospital claims that on the claim line level that the ICD-9 is no longer valid. So we're like many other providers. We're in crunch time here, and somewhat in a panic.

Mr. Nachimson: That is clearly a correct interpretation according to the regulations and the implementation guide, but you obviously will have to work with your health plans and vendors to work out at least a temporary solution.

Estelle: Everybody is taking – we've only had your standard edits here, so we haven't been able to fully test Medicare yet. We've tested every other payor and we have not had a problem. We've been putting ICD-9 codes there.

Ms. Glass: Right. This is Joy Glass. And as we stated earlier, you shouldn't have a problem with Medicare either.

Estelle: At least not initially. Thank you.

Mr. Poglioli: Okay. Thanks.

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

Operator: Next we have Rhonda Kinneman.

Ms. Kinneman: Hello, can you hear me?

Dr. Harper: Yes.

Ms. Kinneman: I have several questions, and some of them surround the issuance of supplier numbers and guidance on changes that have occurred within the – or the recent process of obtaining supplier numbers. I know they've asked us for a lot of additional information surrounding our applications and haven't published guidance on that. And I know they're scrutinizing the claims. Will CMS be issuing these supplier numbers soon – giving supplier numbers soon, or is there a projected date that that freeze will be removed?

Ms. Glass: This is Joy Glass. We don't have anybody here from our supplier group that can answer that. But I'll get your number and I can have somebody from our supplier group that works directly with the contractor who issues those numbers to contact you.

Ms. Kinneman: Okay. And then I have some additional question regarding the attachments. I know that in I think it was the 12th HIPAA roundtable discussion, you mentioned that you would try to put together something in regards to the paper attachments that need to be used in determining payment on a claim and guidance on how to submit those, but I still haven't seen anything being published. I was wondering where you all were with that, and if we would see something soon.

Ms. Glass: This is Joy Glass. As I stated to the previous caller, you will be able to continue to send paper as you do today. We're working with our contractors to automate that process. That will take some time, and once we do, we will be issuing instructions on how to do that, perform that function. You will have to submit the claim electronically. We will provide notification once we've completed that.

Ms. Kinneman: Okay. So I didn't miss it. It hasn't been posted yet.

Ms. Glass: No.

- Ms. Kinneman: Okay. And also, we are having some trouble and wanted some guidance from you all in getting responses from the d-mercs regarding EDI concerns that arise pertaining to our claim. And I wanted to see if there was any suggestions you all might have on how we could get answers faster from them or answers at all when they do not respond to our inquiries since I know that you won't be taking complaints until after either the contingency plan is lifted or after October 16th. If you could clarify that as well.
- Ms. Glass: This is Joy Glass. If you have specific problems with any of the d-mercs, you can certainly contact us, and we can have somebody in the regional office follow-up, and that's how we usually handle that here.
- Ms. Kinneman: Okay. Thank you very much.
- Dr. Harper: You're welcome. Next question please.
- Operator: Your next question comes from the line of Richard Laverty.
- Mr. Laverty: Hello?
- Dr. Harper: Hello.
- Mr. Laverty: Hi, this is Dick Laverty from Vermont. I'm with the Department of Aging and Disabilities, and I've got a question about the HCPCS codes and the modifiers. We have services that are provided through Medicaid for our waiver services. And I was wondering, I have not been able to find any modifiers where we could distinguish surrogate directed or group directed or consumer directed personal care or respite services like that. Do you know if there's any additional modifiers available that would cover that kind of a thing?
- Mr. Friedman: Dick, you've obviously talked to the Medicaid folks about this?
- Mr. Laverty: Right, yes.
- Mr. Friedman: And they haven't been of much assistance?
- Mr. Laverty: No, we've talked to them and we've talked to EDS, which is our billing provider. And all I've gotten is that HCPCS books and a

website with modifiers, and I haven't found anything to create the distinctions that we need for our reporting requirements. I've got all the HCPCS codes that would fill the categories, but we have reporting responsibilities where we've got to report this stuff out for our reporting requirements on the waiver and for budgeting. And there doesn't seem to be a way to make those kind of identifications.

Dr. Harper: Any comments in the room?

Ms. Trudel: This is Karen Trudel. I want to clarify whether the reporting you're talking about is separate from submitting a claim or an encounter.

Mr. Lavery: Yes. I think in terms of the claims, I think we can get the claims submitted, but it's going to hinder our management for auditing the processing in terms of following the money and if it's being spent properly according to the plans of care.

Ms. Trudel: Right. Any use of modifiers is not part of a HIPAA transaction. It's really somewhat outside our purview, and I'm afraid there's not a lot we can say about it in this venue.

Mr. Nachimson: This is Stanley. Just to clarify a little bit, for internal purposes if you want to put your own local modifiers on there and keep track of the information that way, you can certainly do that. But in using the HCPCS codes on any of the standardized transactions, you can't use your own local modifiers.

Mr. Lavery: Well, we're using the HCPCS codes for the transactions, and they're all identified. We're going to use the HCFA 1500 as the billing form. We were told there were only a limited number of modifiers, state modifiers, that could be used, and our Medicaid department has used most of those, so there are not any available for us. So I'm trying to find modifiers that could be used that were published in the modifier list that's at the Appendix of the HCPCS codes. And I can't find things that are appropriate.

Ms. Trudel: This is Karen again. What I was trying to convey was that if you are talking about using modifiers on something that is not a HIPAA transaction –

Mr. Lavery: But it is a HIPAA transaction.

- Ms. Trudel: It is a HIPAA transaction?
- Mr. Lavery: Oh, yes.
- Ms. Trudel: You mean a claim?
- Mr. Lavery: Yes.
- Mr. Nachimson: Then you need to use the official modifiers.
- Ms. Trudel: You need to use the official modifiers, and if modifiers aren't available that suit your needs, then there should be a request for an additional code or modifier.
- Mr. Lavery: Okay. So how do I go about doing that?
- Mr. Nachimson: If you look at the CMS website, it has a HCPCS page that will explain how you put in a request for additional codes or modifiers.
- Ms. Trudel: However, if this is – again, I'm having trouble grasping the concept here. Because if this distinction is not germane to the state, then I'm not understanding why it needs to go on the claim. If the distinction is germane to the state, then the state should have asked for additional codes in order to convey the concepts that were of interest to them.
- Mr. Lavery: Right. And it is, and I don't know that a request has been made from the state. My feeling is they haven't done that yet, but it is a necessary modification that we need. And what would the timeframe be there? I know it's late in the game here. If we were to put a request in, does it take a long time to get a response?
- Ms. Trudel: There's no one here from our coding group to answer that. I'm sorry. But if you go to the CMS website and you search on HCPCS, you will find a website that you can use to get information about that process of requesting additional codes. And again, if the state needs that code, then the state needs to request the codes. Normally that's the way the process works.
- Mr. Lavery: Right. So when you say the state, are you talking about the Medicaid agency?

- Ms. Trudel: Yes.
- Mr. Lavery: Okay. So that has to come from them?
- Ms. Trudel: It certainly should. It doesn't seem to make sense for a provider to request.
- Mr. Lavery: No, we're not a provider. We're the Department of Aging and Disabilities, which is part of the state, but we are not the Medicaid agency. We are the management agency for Medicaid waiver services.
- Ms. Trudel: I would suggest that you consult with your compatriots at the agency and coordinate that process.
- Mr. Lavery: Okay. So if we give them a list of things that need to be added, they'll have to make the request?
- Ms. Trudel: That would be a good place to start, yes.
- Mr. Lavery: Okay. Thank you.
- Dr. Harper: Ms. Shawn, we have time for one more question please.
- Operator: And your final question will come from Pat Gallagher.
- Mr. Gallagher: The question we have is with respect to COB's. New Jersey Medicaid requires specific submitter and receiver ID's on their 837's, including COB's from Medicare where they're secondary. And Medicare – apparently our contractors are not putting the required submitter and receiver ID's in those COB claims, but rather their own self-determined submitter and receiver ID's.
- Ms. Glass: This is Joy Glass. We are aware of that situation, and we have an instruction that is – currently it's in the process of being issued, and they will change that process and will use the numbers that the receivers need.
- Mr. Gallagher: Okay. And my only other follow-up to that is we were told that that was the case and it probably would be – or could be as long as six months before we saw that. I guess until such time as we could get what we need, we can continue in the old format?

Ms. Glass: Yes.

Mr. Gallagher: Okay.

Dr. Harper: Thank you. Now we're going to have some brief updates from Ms. Elizabeth Holland.

Ms. Holland: Hi. I'd just like to remind everybody that as we mentioned earlier, we have posted many new frequently asked questions on our website. Our website is www.cms.hhs.gov/hipaa/hipaa2. We will in addition be posting a transcript of this roundtable, as well as the last roundtable that we held two weeks ago. And if we do schedule additional roundtables in the future, we will publish notification of them on our website as well.

Dr. Harper: Thank you, Ms. Holland. And I want to thank all of you for participating in the conference, in the roundtable call today. I want to thank those of you who are online, and I want especially to thank our staff members. The conference is concluded.

Operator: Thank you, Dr. Harper. Ladies and gentlemen, this concludes today's teleconference. You may all disconnect. [END OF CONFERENCE CALL]