

Operator: Good afternoon. My name 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 15th 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. Jones. Hello, everyone. Welcome to the 15th national HIPAA roundtable. This call is being conducted by the Centers for Medicare & 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 division. CMS staff will address questions related to the electronic transaction and code sets, security and unique identifiers.

We're joined today by Jeff Zelmanow – Jeff, will you introduce yourself. You're from the Office for Civil Rights.

Jeff: Yes. My name is Jeffrey Zelmanow. I'm with the Office for Civil Rights. I'm a privacy analyst working out of the Washington headquarters office.

Dr. Harper: Thank you. We're happy to have you on the call today to address the privacy questions. We will begin our call with a few words from Ms. Lori Davis, the acting deputy director of the Office of HIPAA Standards at CMS. Ms. Davis.

Lori: Thank you, Dr. Harper. We're now almost 60 days out from the October 16 compliance deadline for the transactions and code set standards. And we believe that a significant amount of covered entities are still not ready despite the best intentions of ourselves and the industry. We recognize that HIPAA compliances are all being processed are we are continuing to work with covered entities to help them move towards compliance.

The Administrative Simplification Enforcement Tool or ASET is

our online transaction code set compliant system and it has been operational since October 16. We are accepting complaints through ASET, which is the electronic version as well as paper complaints. Both the ASET system and the paper complaint process can be accessed through the CMS HIPAA website and I'm going to give you that website now. But it's www.CMS.HHS.gov/HIPAA/HIPAA2 and both of those are under the little headline for HIPAA enforcement.

In terms of upcoming regulations, we expect that national provider identifier rules to be published in the near future and we will send out a notification through the HIPAA reg list serve what's the rule that's been published in the federal register. You can sign up for the HIPAA reg list serve also on that CMS website and I will give you that website again in my closing remarks.

We continue to make resources available to assist covered entities and understanding their requirements in achieving compliance. For example, on our website we have a series of HIPAA presentations or webcasts that can be accessed by the Internet free of charge again through the HIPAA website and that is www.CMS.HHS.gov/HIPAA/HIPAA2. The webcast include presentations on the basics of HIPAA, provider sets to be getting paid under HIPAA, HIPAA security, CMS enforcement, 837 professional claim and the 837 institutional claim. Also on the website we continue to post frequently asked questions and other information on HIPAA administrative simplification issues.

At our call today we're joined from staff in addition to the Office for Civil Rights, from our Office of Information Services, and our Center for Medicaid and state operations that can respond to questions directly related to Medicare and Medicaid.

I'm going to turn the call back to Dr. Harper in a minute, but I thought I would turn the call over to Mr. Gary Kavanagh who could give you some information on the status of Medicare at this moment.

Gary:

Thank you, Lori. Let me just give a quick update on Medicare. Currently Medicare as of about a week ago was receiving just a little less than 50% of its claims and production in the HIPAA compliant format. That's rates for the other two transactions. The

electronic remittent device and the COB is not quite that high. However, we are, you know, pushing very hard and our contractors are working very hard with clearinghouses, states, and providers to make sure that they have the necessary information and the necessary ability to test to move forward into production.

We're also working very hard with the clearing houses and encouraging the clearinghouses that have been able to successfully test and move into production because that statistic of claim in production is very important to us. We know that the contingency plan is not going to last forever. We're trying to make sure that we're in a position fairly soon to end the contingency plan. So let me turn it back to Ms. Harper.

Dr. Harper: Thank you very much. Ms. Jones.

Operator: Yes, Ma'am.

Dr. Harper: Would you give us instructions now for the questions?

Operator: Yes, Ma'am. At this time, I would like to remind everyone in order to take a question, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Your first question comes from the line of David Garling.

David: I have couple of questions for you. One is can you speak a little about the COB where you're talking about the COB transactions being handled by a single Medicare entity? And then can you also give us a better update than you had, Gary, on the COB transactions? We are still – we have yet to receive any more than three sets of good COB data from about 40 different fiscal intermediaries. They are so far behind in quality of data or even sending this data, we're in no position to even go into production anytime soon.

Gary: Yeah. This is Gary Kavanagh, again. Let me rather react to those questions. First off, we are trying very hard and working very hard with the third party submitters with yourself and others and also with the contractors and the shared system maintainers to deal with issues, generally the COB. We don't have a lot of people I production at the moment or we do have some people in

production on the COB, so that's somewhat encouraging.

In terms of the COB contractor there is an initiative in CMS to move to a single entity, which we call our coordination of benefit contract providing the coordination of benefits transactions to third party payers. That facility will probably be available some time in the spring. We're shooting for April. I'm not quite sure we're going to make April, but that should help to facilitate the ease of this transaction working and we're trying to coordinate those two efforts at the moment. The thing that's important though is that we really do need to get the HIPAA COB transaction working at the individual contractors in a better state than it is today before we can move that workload to the COB. So it's very important that COB submitters or receivers still continue to work with us on trying to resolve the problems in these transactions.

David: One other question in that regard. With regards to – you say you're hoping to close out the contingency plans and start enforcement. Again, we're so far behind hopefully the COB transaction will be part of that equation as to when a contingency plans are allowed to end.

Gary: I mean, we don't have a date certain or whatever on the contingency plan. We're just pushing very hard, as hard as we can to end the contingency plan as soon as we can. And certainly, you know, COB and the issues involved there will be considered in any decision to go forward in the contingency plan.

David: Okay. Thank you.

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

Operator: Your next question comes from Lori Sexton.

Lori: Hi. I had a question regarding outpatient claims and the 837 institutional claim regarding dates of service. My question is is dates of service required with every revenue code regardless of whether there's a CPT or HCPCS code associated with it.

Joy: Hi. This is Joy Glass and I believe that's true, but I need to get back to you on that and talk with the analyst that is more familiar with that.

Lori: Thank you.

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

Operator: Next we have Desla Mensella.

Desla: Yes. I just have a question about the tax ID code that we've asked about the last couple of teleconferences. The Tax ID number for a physician is a situational data element. And we were told at a previous conference that if it's unknown you don't have to use it. My question is though one of the issues that we've had, of course, is getting the physician population to want to give us that information. And at the last conference, we were told that there was a FAQ out there on that. However, when you look at the FAQ, it addresses EIN and Social Security numbers, not tax ID numbers. So I'm wondering if there is some change part of what the status is with the tax ID number for physicians.

Stanley: Hi. This is Stanley Nachimson. The tax ID number is either the EIN or the Social Security number.

Desla: Actually they're not. In many cases that's not so.

Joy: This is Joy, look in the implementation guide. The only two valid qualifiers refers to the EIN or SSN and the billing provide ID which is referred to as EIN is required.

Dr. Harper: Does that answer your question?

Desla: Well, it's in opposition to the answers that we were given the last two teleconferences, I guess, that's why I'm getting confused. Because it was specifically asked about the tax ID number.

Dr. Harper: Would you like to talk with us off line.

Desla: Yes, please.

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

Operator: Next we have Michael Lisamel. Sir, your line is open. Please go ahead.

Michael: Good afternoon. I'm in a little bit of confusion about the contingency plan. It is still in effect. Is that correct?

Gary: Yes, it is. For Medicare. I assume that's what you're talking about.

Michael: Yes. And you're still accepting paper claims. Is that correct?

Gary: We're accepting paper claims from entities that are allowed us to send us paper claims under the Administrative Simplification Compliance Act.

Michael: I have in my hand a Palmetto GBA information dispatch informing us that they disconnected their server in region C and will no longer accept DMERC claims. Is this part of the – is this against the contingency plan. I don't understand how you could have the contingency plan and we would have it in place and then be told that we have to migrate. I'm a little confused if you could clarify that. It's dated December 3, 2003.

Gary: You would need to fax that to us and we don't have that document right here and maybe we could explain – maybe we could find out exactly what they're meaning, because I don't think that means what you believe they mean.

Michael: Well, as a matter of actual fact on December 24, I'm sorry, November 24 they unplugged their server and we have neither been able to upload or download through that telephone number and they have said that that is no longer in existence.

Joy: Okay. And we'll check into this, because that's –

Michael: It's quite serious and the reason I asked about paper claims is I hate to send you 5,000 paper claims because they've unplugged their server.

Gary: Have you spoken to Palmetto?

Michael: We've been on the phone 11 times and the wait time has been

beyond our time that our hours are open.

Dr. Harper: Thank you. Next question please.

Operator: Next we Samantha Haygood.

Samantha: Hi. My question is regarding NCPDP's transactions for retail pharmacy. Is there someone there today that can address these for me?

Joy: Yes. This is Joy. Go ahead.

Samantha: Okay. Hi, Joy. We are currently testing with region D. One of the rejects that we received on the error report was 66072, which is service date not within NDC range. My question is where does the drug information come from? Is it first data bank information? How do we know what dates will be good for these claims, for these NDCs?

Joy: Yeah. We get these NDCs from a contractor that's responsible for updating NDC from the FDA list. If – I'd have to really call you back on this and get somebody that works in our area that could address that. They do have the tables, you know, I believe it's on a quarterly basis.

Samantha: Okay. Okay. Well, I just want to make sure that we have our information correct here on our end because we are a billing service. So we want to make sure that keep our providers compliant and not send in claims where there are bad dates. Because my next question is the NDC inactivated on 7/22/02. The date of service on the claim was 6/24/03. We do billing for retail pharmacies so it's not unlikely that a pharmacy can have a drug on their shelf and bill it after that NDC number has been inactivated. So I did not know what to do in that situation.

Joy: Yeah. If I could have your phone number I can have somebody call you back.

Samantha: Thank you.

Dr. Harper: Thank you. Next question please.

- Operator: Your next question comes from Nancy Armitous.
- Nancy: This is a question – I have a privacy question although it may have some implications for security and transactions as well. I represent a client who is an EAP and they actually provide services to US companies who have ex-patriots in other countries so they perform assessment services for these individuals who are living in other countries. And I have been at a loss on how to advise them in terms of the information that they get overseas when it is sent, transmitted electronically back into the United States. And I'm wondering if there's been any guidance on that or if there is any place that I could go to get some more information about how that might be covered under HIPAA.
- Jeff Zelmanow: I don't think we have any – we've issued any guidance on that. This is pretty – a little bit different than what we normally deal with, but I will be more than glad to talk to you off line and get whatever information I can to you.
- Nancy: That would be great.
- Dr. Harper: Thank you. Next question please.
- Operator: Next we have Joan Alediberry.
- Bob: Hi. This is Bob Perlits working with Joan at New Jersey Medicaid. I have two questions. One is pertaining to the statistic you gave Gary about 50% approximately of claims coming in in HIPAA format. I'm curious to know what percentage of submitters are coming in in HIPAA format?
- Gary: It's about 40% at the moment.
- Bob: So 40% are submitting 50% of the claims.
- Gary: Right. About
- Bob: And my second question is related to COB is there a plan to not require payers to take the new format until such time as the mutually agreed upon trading partner agreement has been developed with respect to identifiers and so forth.

Joy: This is Joy. Are you talking about the single contractors?

Bob: No, I'm talking about either. Right now we get proprietary format, you know, old format COB claims from a number of contractors. Our concern is we can't change over to COB until such time as those contracts are sending us our identifiers, which right now most of them, if not all of them are not. And so our concern is getting the world that we are going to turn off proprietary, send you identifiers that you aren't expecting and you have to live with it.

Gary: Are you talking about the ISAA segment?

Bob: Yeah.

Joy: Okay. Yes. And we do have a fix for that, but so, you know, until that time they would still be sending me the old number, but we do have a fixed –

Bob: Okay. So you do that fixed. We'll get proprietary.

Joy: Yes.

Bob: Thank you.

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

Operator: Next we have Grace Uplegger.

Grace: Hi. Yeah. I'm just wondering about secondary Medicare claims, when we think they might be required to be electronic instead of paper.

Kathleen: This is Kathleen Simmons. Actually I've been working on the instructions for the mandatory electronic filing for Medicare. As far as the secondary claims are, we've got a lot of different practices around the country and you could continue following whatever instructions you have been issued by your individual Medicare carrier intermediary regarding secondary claims until you receive notification otherwise and then that should be shortly after the first of the year that you'll be getting some further guidance from contractors on that.

When that guidance comes out it will also give you a little bit of time to be able to make any local changes that you might have to make in order to be in compliance. There are some types of secondary claims, but systems or the X12 format just aren't able to handle it at this particular point as in the case when Medicare is maybe like a tertiary payer, there's more than one payer primary before Medicare. In those cases we need claim level or a line level information for each service and there is no ability to report that in the 837 format. So those will probably continue to have to be on paper for some time. But other than that if there's only one payer primary to Medicare we should have finished internal system changes fairly soon so that all of those could start coming in electronically.

Grace: All right. Thank you very much.

Kathleen: You're welcome.

Dr. Harper: Next question please.

Operator: Next is Penny Grover.

Penny: My question is regarding the NDC codes. It was our understanding that the NDC codes we were dismissed from the HIPAA and taking out of the HIPAA regulation for – just for regular providers and now our software company is telling us that they are putting in an upgrade for NDC codes for all of our 837s and we wonder if you're going to be accepting both the NDC codes and the J codes or how that's going to work or if our software company is out of line in asking us to use the NDC codes.

Stanley: This is Stanley Nachimson. Let me address that from a HIPAA perspective and then I guess we also need to know if you are asking that question from a Medicare perspective. We did remove the NDC code set as the required drug coding set for providers that are other than retail pharmacies. But the implementation guide for those professional institutional claims allows the reporting of NDC codes as well as HICPIC codes. NDC codes when they are state or federal regulations or laws that require them so some health plans can ask regular providers for non-retail pharmacy providers for those NDC codes. It is possible that for example a state Medicaid

program might ask a physician or a hospital to report NDC codes as well as HCPCS codes. So it sounds like their software company is up to date and doing what they need to do to keep on top of the HIPAA requirements. But whether or not a health plan asks for the NDC code as well as the HCPCS code will be up to the health plan allowed only if there's some federal or state laws requiring.

Penny: And then the answer for the Medicaid accepting the – is Medicare going to accept either one then?

Joy: This is Joy. We use the J-codes for all drugs except for oral cancer and then we do need the NDC for that.

Penny: Thank you.

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

Operator: Your next question comes from Donna Madison

Donna: Yes. I represent a long-term care company. And we're having problems with our batch transactions. As you know in the 837 when you have multiple claims – for example, we submit about 2000 claims in a batch. If there's one error on one claim the entire batch gets rejected. And we're wondering if – as we understand it there have been multiple companies that this is happening to and if you are looking into that and if there's a way we can get around it.

Joy: This is Joy. You know, according to the implementation guides that is allowed. However, at least for Medicare we have directed our contractors those that we're rejecting the entire transmission to stop and only reject the individual claims and that fix will be made. Now for the other health plans –

Donna: Well, our issue is with our FI, so how would we get that communication to our FI who is still rejecting our entire batches on our Medicare side.

Gary: This is Gary Kavanagh. What Joy was saying is we've directed them to do that and they have not done it.

Donna: I'm sorry. You cut out. I can't hear you.

Gary: I'm sorry. I wasn't speaking directly into the microphone. We have directed our intermediaries to do that. However, they have not all been able to schedule that. So they'll be doing that over the next few months. They should know, however, that this is going to be happening. So it should be happening in the next few months.

Donna: So they'll put the fix in place, but from now until they have the opportunity to do that, we should anticipate that our batches would still get rejected with one claim having an error.

Gary: That's correct.

Donna: Okay. Thank you.

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

Operator: Next we have Sissy Wasinott.

Sissy: Hello. I was going to ask regarding the 81A notice of election. In the past prior to the implementation of 837 we were able to send those as electronic claims. And with the implementation of 837 we now have to send them paper or dial up directly to DDE and enter them by hand. I was wondering if there was anything in the works to get that back to being an electronic file to being sent.

Joy: This is Joy and the notice of election is – it can't be sent on the 837. The 837 does require services and other elements that are just not supported and it is not really a HIPAA transaction, not covered under HIPAA.

Sissy: Is there going to be a time where it can ever be sent electronically then through some other type of format instead of us having to key it in by hand. Because we do quite a lot of those at our organization and it's actually taking almost a full time person now to do that where in the past it would take me 15 minutes to do it.

Joy: I guess that's something that we could look at in the future of establishing an electronic transaction under HIPAA for that.

Sissy: That would be much appreciated.

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

Operator: Mary Ellen Johnson.

Mary Ellen: Hi. My question's concerning electronic standard data set. And I was wondering if the new data sets include the ability to handle the ICD-10 as far as space requirements. Because right now your ICD-9 diagnosis codes are only up to, you know, the five digits and then IDC-10 is six digits and this is the question I'm getting from several different people.

Stanley: From a HIPAA standpoint at the moment the ICD-9 is the required code set for diagnoses and for inpatient hospital procedures. The ICD-10 code set cannot be used – if the ICD-10 code set were to be adopted as a HIPAA standard we would make sure that the transactions would be adjusted to be able to accept them. My understanding is that there are some adjustments that do need to be made to the claims and other transactions and we would be working with the X-12 and other standard developing organizations to make sure that the transactions could handle ICD-10 if it was accepted as HIPAA code set.

Mary Ellen: Okay. Part of this concern is that they're going to make this decision to go to ICD-10 and our internal systems are not going to be ready to accept ICD-10. So by knowing that the X-12 transactions can't handle it either yet that gives us a little bit more time to know that we can work on our internal.

Stanley: Let me just give you a process to check on that. If we were to decide to adopt the ICD-10 as a HIPAA code set we would first publish that in a proposed regulation to give the public an opportunity to comment. And part of that proposed regulation would also talk about a suggested implementation time period and we would use both our own knowledge and the comments we get from the public to determine what the implementation time period would be. I think – and then a final rule would have to be published. So you should have plenty of time and plenty of notice before ICD-10 or other code sets were changed.

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

Operator: Next question comes from Donna Wiles.

Donna: Yes. I don't have a question. I just have a request. If you could boost the volume on Gary and Joy. Were having trouble hearing them.

Dr. Harper: Thank you. We will bring them closer to the microphone. Next question please.

Operator: Your next question comes from Nancy Make.

Nancy: My question is on the oral cancer comment you made earlier where it requires NDC codes, its there a bulletin about that?

Joy: I think that's been for some time, quite, I don't know, five more years that we've always required the NDC for oral cancer for Medicare.

Nancy: On hospital billings?

Joy: No, this is part B.

Nancy: Okay. Okay. That answers that question. And then as far as the report you said it's rejecting – we're having the issue also where in production where rejects the whole file for like one claim.

Joy: Right. And we have instructed the intermediaries to change, you know, their systems so they would only reject one claim that will, as Gary stated it might take a – within the next few months. We expect, you know, that they should start rejecting –

Nancy: Could we submit multiple batches of smaller size? Would that present an issue? Breaking it up into like size of one or two or –

Joy: You would really have to talk to your intermediary to see the specifics whether, you know, their translators are set up to handle, because you know, you have to wrap those into each – you know, in an envelop and some may not accept that, so I would talk with him first before proceeding.

Nancy: Okay. Because we have the capability of breaking them into smaller batches, but if – causing problems to –

Joy: Why don't we just talk – I mean, they may – their transmitter may

be able to handle it. I couldn't, you know, say off hand here. But if you talk with them –

Nancy: Do you know the schedule for Adminastar Federal? What their implementation date on the claim level rejection reports is?

Gary: I think Adminastar Federal is very close. They may have already done it.

Nancy: They haven't as of today.

Gary: Oh, really? Well, they're very close. I don't know the exact date, but they're very close.

Nancy: Thank you.

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

Operator: Your next question comes from John Prindigas.

John: Hello.

Dr. Harper: Yes.

John: Oh, I'm sorry. Coincidentally enough I might have an answer to the previous question. My understanding is the new HIPAA2 report from Adminastar Federal is supposed to go into effect on December 15, the best of my knowledge. Anyway, my question was in regard to the joint signature memo regarding 30 days. I'm wondering if you might speak a little bit to that and what that means towards the contingency plans.

Gary: Yes. This is Gary Kavanagh. We did issue a directive to our intermediaries to move submitters that have already tested successful in the production within 30 days. What we're trying to do here is augment the number of people in production. This is not – it doesn't really change the contingency plan. What it does is allow the contractors to engage in dialog with submitters that are – should be ready to move into production and get a date certain from them when they can move into production. Thirty days is a goal. It's not an absolute deadline.

- Dr. Harper: Thank you. Next question please.
- Operator: Your next question comes from Chris Acevedo.
- Chris: Yes. Actually I'm going to tie into that last question that was asked for some clarification. You said it was to open up some dialog, however, I'm looking at a posting which is a Pennsylvania carrier and according to them, if you've successfully completed testing prior to December 1, you must be in – have your entire workload, and again it says must, move your entire workload into production for 4010A1 by December 31 and if you're testing – if you've completed testing after December 1, you must move your entire workload to 4010A1 within 30 days. It doesn't appear to be a conduit for dialog. It appears to be a directive to – almost like an order to the submitters. So if you could clarify.
- Gary: Well, what I would encourage you to do if HGSA doesn't contact you before hand is for you to contact them and give them more specifics on when you can go into production and they should be willing to work with you. If they're not, then let us know.
- Chris: And that's –we're not in Pennsylvania, but that's on a per carrier basis you're suggesting that.
- Gary: Correct.
- Chris: Okay. Thank you.
- Dr. Harper: You're welcome. Next question please.
- Operator: Your next question comes from Mikey Williams.
- Mikey: Hello. My name is Mikey Williams and I have a question. We have a – we're a health plan and we wanted to know can we – can our health plan require the use of the ICD-9 codes on our outpatient forms in the situational field for the purpose of processing electronic claims?
- Stanley: If that's in direct violation of the implementation guide, no, you cannot require the ICD-9 for procedure codes for outpatient claims. Certainly it's required for the diagnosis code, but not for procedure codes.

Mikey: Thank you.

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

Operator: Next we have Brett Ward.

Stan: Hi. This is Stan Havock at NCHICA. My question is related to the 835. When a hospital wants to compare the payments that are made under the 835 with those sent in via the 837 with the actual claim that was made, is there a way in the 835 to refer the payment information to an actual reprice schedule or the schedule that's actually used by the plan.

Kathy: No, this is Kathy Simmons. There is no provision like that in the 835 implementation guide.

Stan: Okay.

Dr. Harper: Thank you. Next question please.

Operator: Next we have Debra Lalinski.

Debra: Hi. Mine is just a comment. Frequently you say you'll get back to an individual caller, but those questions are vital to all of us and I'm wondering if you could commit to not only getting back to the caller but posting a question answer as a follow-up to each of the webcasts or the, excuse me, these audio conferences. That would be a strong request because what I've been doing is taking down phone numbers and then I call those individuals to find out what your answer is. Thanks.

Lori: Hi. This is Lori Davis. We'll certainly take that under advisement to the extent that we could either come back to the next question and give answers, you know, to then next roundtable and give answers to some of the questions we gave out. In the past we looked at posting them on our website as kind of like a frequently asked question. We'll take that under advisement. That's an excellent suggestion. Thank you.

Dr. Harper: Next question please.

Operator: Your next question comes from Sandra Slater.

Sandra: Hi. I was just wondering if you could give me an update on the requirements for the taxonomy codes.

Male Speaker: For Medicare or in general.

Joy: The taxonomy – this is Joy. The taxonomy code maybe – there’s a website you – that download those and the website’s www.WPC/edi.com and that has the most current list of taxonomy codes.

Sandra: Oh, okay. Thank you very much.

Dr. Harper: Next question please.

Operator: Your next question comes from Eva Purty.

Eva: Hi. We were just making a request similar to the one right before the last question regarding posting the answers to the questions maybe on your website from today’s teleconference.

Dr. Harper: Yes.

Eva: And if that’s not feasible would it be possible to at least maybe post the phone numbers of the individuals that asked the questions that asked you to give them a call back so that we would be able to contact them to get the answers to their questions.

Lori: We cannot post a phone number publicly of the folks who answered questions, but we will very seriously look into the issue about whether or not we can post answers to questions that we’ve taken into our office, you know, to do further research and call the individual back. We’ll come up with an alternative.

Eva: Okay. The gentlemen that asked the question regarding DMERC C and he referenced the December 3 Palmetto newsletter. Can we – could we please have him, if you’re listening give – you could give me a call. We’re interested in finding out the answer to your question.

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

Operator: Next we have Eric Sidelove.

Female Speaker: Hi. I have a question that goes to enforcement for Medicare health plans. We are almost exclusively Medicaid health plans in about 10 states. We are very much at the mercy of the state agencies in each of these instances and we cannot be compliance until they are in compliance. We have several of our agencies who have indicated to us that they are not going to be ready to move to standard transactions until perhaps the end of first quarter, beginning of second quarter of 2004. My question is what – can you speak to the enforcement for the health plan in these kinds of situations.

Lori: This is Lori Davis. To the extent that they are running a contingency plan and they've demonstrated good faith effort they certainly can continue to accept whatever their contingency plan is, whether or not that's like C-systems, paper claims, whatever their contingency plan choose to be.

To the extent that you wish to convert over yourself and to file claims that are HIPAA compliant to that entity and they're unable to take them, you are within your perview to file a complaint to the Office of HIPAA Standards and we would investigate it in that regard.

Female Speaker: Okay. I guess my basic question is that I'm looking for whether or not we as the health plan are going to be protected from any sort of complaint that speaks – that's coming down stream because of our inability to be fully compliant because we're so dependent on the state?

Lori: To the extent that you should be individually ready in your own practice to be HIPAA compliant, you know, to the extent that you can document your efforts as a good faith effort to kind of work with your health plan, in this case it would be the state Medicaid agency, to become compliant. That is within the perview of the document that the Department of Health and Human Services put out in July. You should be documenting your efforts to become compliant to the extent that that is contingent and kind of dependent on the state Medicaid agency. They're supplying you with some sort of billing software or supplying you to the poll to

send in your electronic claims. I would document that as well.

Female Speaker:

Okay. Great. Thank you.

Dr. Harper:

You're welcome. Next question please.

Operator:

Net we have Sydney Tilton.

Sydney:

Yes. Was I correct in hearing earlier that we can't send paper claims anymore? I believe it was Gary that was talking about the –

Gary:

Yes.

Sydney:

-- Railroad Medicare.

Gary:

I wasn't specifically talking about Railroad Medicare. This is Gary.

Sydney:

Right.

Gary:

I was talking in general about the legislation that Congress enacted which precludes billers of a certain size from –

Sydney:

Right.

Gary:

-- anything other than electronic claims after October 15th.

Sydney:

So if you're saying they won't accept paper anymore, if our systems are not working properly, especially for DMERC, how do we submit the claims?

Kathy:

This is Kathy Simmons. Are you talking in a situation where maybe a DMERC has asked you to submit certain attachments with the claim.

Sydney:

No, this is just filing the claim straight away just like a HCFA 1500.

Kathy:

Well, I don't know if we'll have to get back to you on that because we're not aware of any DMERCs that aren't able to accept claims electronically.

Sydney: Yes.

Kathy: We know that in some situations where there is attachments involved there were some problems, but that's all that we're aware of.

Sydney: No. We have problems. I cannot file electronically.

Dr. Harper: Ms. Tilman, give us your number please.

Joy: Oh, you're saying – this is Joy. You're saying that you're having a problem on your end.

Sydney: Yes. And – yes, I cannot send electronically and I'm wondering if my paper claims are going to be denied.

Joy: Well, before we even get into it, do you have like a large practice? I'm not sure of the size of –

Sydney: Yes.

Joy: --your operation.

Sydney: Yes. There are ten doctors here.

Joy: All right.

Sydney: We are optometry.

Joy: Okay. Well, then you've got a problem.

Sydney: Uh-huh. Can somebody get back to me then?

Joy: I'm not quite sure how much relief we'll be able to give you though. It's been technically – unless you meet one of the requirements for a waver situation. The law is fairly clear that you be expected to file electronically.

Sydney: Okay.

Joy: I mean, have – this is Joy. Have you requested the free billing software?

Sydney: We have that. It's not working. Hello. Did you hear me?

Joy: Yes. Yes, I did. Yes. It's not working or you're not able to make it work –

Sydney: It is not working.

Joy: -- other places in the country.

Sydney: No. They are telling me it's not working and I can't get anybody to help me that seems to know anything about it.

Joy: Could you tell me which DMERC?

Sydney: It's – the software provider it's Express Plus.

Joy: Well, the Medicare contractor that you're dealing with.

Sydney: Adminastar Federal.

Joy: Okay.

Gary: Have you been in touch with them?

Sydney: Yes, I have many times. I get nobody – I get no help.

Joy: Okay. We'll look into this and get back in touch with you.

Sydney: Thank you very much.

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

Operator: Your next question comes from Shay Vaughn.

Shay: Question. One I had was for Stanley. I believe at the beginning of the broadcast there was a message regarding a national identifier that was going to be coming into play really soon, but I – because of the volume issues on the phone I haven't really been able to hear which identifier that was, if it was a payer ID or the plan ID or what.

Stanley: Okay. Again, this is Stanley. The final rule that will adopt a national provider identifier is scheduled for publication in the very near future.

Shay: Okay. And also I wanted to speak to the issue of secondary claims, MSPs. We have been trying – attempting very diligently to test secondary claims with various providers, I mean, various carriers and running into one issue kind of after another, are there any known MSP issues out there or should – who should we be speaking to if we’re running into kind of brick walls with the carriers on MSP testing?

Joy: This is Joy. Shay, how are you? I can take your number. I mean, yeah, we’re not aware of any outstanding MSP issues at all so if you’re having problems, you know, we can look into that.

Shay: Okay. Recently there was a – we had a problem with the MSP claim being required to contain information at a line item and claim level, which may not be sent back by the primary carrier in a remittance file and for that reason we can’t – we couldn’t supply it. But I did speak with Kathleen on that. Kathleen has had the carrier – I’ve been working with the carrier on that particular issue, but we’re running into little things like that that take weeks to get it resolved. So my concern is that if the contingency plan is going to be listed or goes away in the very near future and we’ve been, you know, and their issues – individual issues based on the carrier or based on the particular type of claim, in this instance MSP we’re trying to get it all done, but it takes time to work through all those issues with each individual carrier.

Kathy: Shay, this is Kathy. Because if I recall the details the issue was that you weren’t getting electronic remittance advices or even paper remittance advices from some other primary payer that included the claim adjustment reason codes that typically appear on an 835. And so you were confused about how you were suppose to bill those claims to submit them to Medicare electronically if we’re the secondary payer. And that there actually were situations where if you had not gotten that code from the primary payer, since they’re not required under HIPAA to send you electronic remittance advice, an 835, that you’re not actually required to submit those claim adjustment reason codes when the secondary claim comes into us. And in fact, I had checked with

our processing people here and we don't even use that information even if it was submitted to us. We use other information about what the primary paid at the – for the individual services, but we don't need the claim adjustment reason codes at all for the Medicare adjudication.

Shay: Right. You're exactly right. And that did help to open up the conversation with the carrier regarding that, but I guess what I'm saying is that like that particular issue is still not resolved on the carriers end, so we've halted testing sort of until that came – until that issue has been resolved, but things like that are coming up with each and every carrier that we're testing with. So if the compliance – I mean, if the contingency plan is lifted in the midst of all this – I won't call it chaos, but in the midst of the testing and the effort to get all of this resolved, we all might have some issues. I'd just like CMS to keep in mind that there are some individual issues about – in testing that are slowing down the compliance.

Kathy: And as I recall again, I think that our regional office was working with the carrier and may have been in touch with you also about trying to get that straightened out at least in this one instance.

Shay: Yes. And that carrier is attempting to straighten it out, but it's just delayed the testing. But thank you.

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

Operator: Next is Kevin Mahoney.

Kevin: Good afternoon. I represent a company that develops practice management system software for physician practices. My questions have to do with the security rule and specifically I haven't seen it yet, but is the CMS scheduled to release a guidance on the security rule and if so when?

Stanley: This is Stanley and I can certainly talk to that. During the next year we do intend to publish some additional guidance on the security rule both in papers and through a series of frequently asked questions. We're working with the National Institute for Standards & Technology on using some of their references and cross referencing the security rule standards to already published information. That's one set that you can look at. There are also a

number of papers that we've seen published by the work group for electronic data (WEDI) their strategic national implementation process that provides some interesting implementation guidance on securities so we would certainly point you to those sites as well as some of the other organizations that have already done some work on securities.

Kevin: Okay. And just a related follow-up question more specific with the security rule, some folks who interpreted the final rule as requiring physicians or covered entities let's just say to be able to track any and all instances when people within their organization access PHI and therefore they've looked to us as being able to fulfill that requirement by implementing, you know, perhaps some kind of internal auditing by which anytime somebody were to access PHI within the software that some log would be implemented to track who and when, you know, such access was provided. Is it your interpretation that that is a requirement under the security rule or not?

Stanley: Let me look. There is a particular standard that does talk about access control.

Bill: I'd be glad to answer. This is Bill Schooler. No, there's not a requirement in the security rule to go into that detail in the auditing area.

Kevin: Okay. Thank you very much.

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

Operator: Next we have Tina Barstow.

Tina: Hi, everyone. I just had a question about – I wanted to get some guidance from CMS on whether or not an issue that's come up between us and a trading partner would be something that you would consider a business requirement rather than a HIPAA requirement. We have a trading partner – we're in this specific instance I'm referring to a DME claim. And we sent a claim with, you know – it was for more than 100 units of a product. And the trading partner said, well, we don't accept more than 100 units of a product. You have to split that into two different service lines. And in the HIPAA implementation guide for professional claims it

actually said that in that particular field they can have, you know, up to 15 characters so obviously we could have more than 100 units according to the implementation guide, but would that be a business rule or would you consider that a business rule that the trading partner can put on us.

Stanley Nachimson: If the health plan's policy is not to pay for more than 100 units at a time, then this is a business rule and appropriate.

Tina: Okay. Thank you. I had one other question. Are you going to be publishing transcripts to this conference call?

Stanley: Yes.

Tina: Okay. Thank you very much.

Dr. Harper: You're welcome.

Operator: Next we have Teresa Prefountain.

Teresa: Yes. I had a question regarding a new definition of diabetes. Is CMS coming out with a new definition?

Lori: This is Lori Davis. First of all, I don't know the answer to that question. Second of all I don't believe anybody in this room, because this question is not specifically related to HIPAA could have an answer to that question and your better bet is probably to check either the coverage and analysis group or Center for Medicare Management who would make those decisions.

Tina: Thank you.

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

Operator: Next we have Lisa Kibbe.

Lisa: Hi. I work for a software vendor and we need some clarification regarding where the NDC number goes. I guess specifically I wanted to know if a payer requires a HCPCS code and an NDC number should the NDC number go in the 2410 loop in the LIN segment?

- Joy: This is Joy. Yes. That's where it would be.
- Lisa: Okay. Now my other question is I see that you – there's a new segment, an SV5 segment which looks like it pertains to DME equipment only. When we are transmitting a claim for a piece of DME equipment, does the HCPCS code just – and all the information specifically go in an SV5 segment or do they go in SV1 and SV5?
- Joy: This is Joy again. It goes in the SV1. I'd have to double check on the SV5. Can I have you number and get back – you definitely have to submit that information and SVI I have to look at the – I don't have the guide here with me.
- Lisa: The only reason that came up is because we're having a problem with, you know, getting claims to payers with HCPCS and NCD numbers and their companion guide tells us to put the NCD number in the SV5 segment. So, you know, DME equipment doesn't have NCD numbers. So now I'm confused.
- Joy: Okay. I'll get back to you.
- Dr. Harper: Thank you.
- Operator: Next we have Jonathan Ellis.
- Jonathan: On, yeah. I'm with American Renal Associates and I have a question in regards to the acknowledgements and the 997s that come back from the FI. Some of the FIs send back reports that are, you know, clean and simple and easy to read. They show you that a number of transactions, the batches, the number of claims, the dollar amount, whether it was accepted or rejected, individual claims were rejected so forth.
- Another FI just sends back a 997. If the whole idea is to simplify this process do you -- can you comment at all on whether there's going to be any directive from CMS on whether FIs should produce simply reports that just basically anybody can read.
- Joy: This is Joy. And yeah, at least to our knowledge all of the contractors do, you know, provide a supplemental report besides a 997.

- Jonathan: That's not the case. I transmit 30 4010A1s institutional files to, I think, eight different FIs. And –
- Joy: The 997 – I mean, if your errors are so severe that it's not going to get into the processing system, then you would only receive a 997. However, once it makes – if it passes all the syntax and such and once it gets into the processing system then they would regenerate a separate report.
- Kathy: Joy, this is Kathy. Because I think that this subject's come up on some of our institutional shared system calls and I think at least the shared system anyway they had a bit of a problem in that the messages that they were sending back were more designed to be interpreted by intermediary staff rather than providers staff. And they will mean it.
- Jonathan: I have the issue where I manage all the EDI operations here. I can read a 997. But when I go back to management and they want confirmation that claims were transmitted and accepted I, you know, I can't –
- Kathy: Right. Some of these messages that were going out they were proprietary messages and like I said they really weren't written for a provider audience so much and I know that we are looking to modify those messages to say be more receiver friendly.
- Joy: This is Joy. If you're talking about – if your file is clean then all you're going to get back is I think a 997.
- Kathy: Right. You wouldn't give proprietary messages unless there were implementation guide edits that weren't detected during processing. Otherwise you'd just get an acknowledgment.
- Jonathan: Some of the intermediaries like United Government Services, Trailblazers they actually produce a report that along with the 997 and a TA1 they actually produced a simple one, you know, maybe even five lines long report that just says, whether the claims were accepted or rejected. Other ones like Adminastar Federal or – I can't remember the ones off the top of my head. They just send back an 997 and, you know –

Kathy: Well, actually Medicare doesn't have any requirements that they send out that report. They must have chosen to do it on their own. Maybe they're already doing it on the corporate side or something that was easier to do it from Medicare also, but there is no requirement and I think as you know that even HIPAA doesn't require – doesn't say anything about use of a 997 or other types of error reports. That's something that I know X12 has been looking in to developing a new implementation guide. It could be nominated as the future HIPAA standard, but it's not at this point.

Jonathan: But it is under consideration.

Kathy: Yes. There's been an 824, for instance, implementation guide that was developed by X12 that could get proposed, but it would be up to this standards development organization to do it and that would have standard messages for implementation guide level at it's – for all the different types of errors that couldn't be handled by 997.

Jonathan: Okay. Well, as long as it's under consideration, you know, that's great.

Kathy: Yeah. Well, we're certainly looking at it as a tool that would be used by Medicare to try to standardize what we're doing with these messages across the country. Because we're not particularly happy either that we've got all these different proprietary messages that are being used and we would like to standardize.

Jonathan: And my – I actually have two other questions, if I may.

Dr. Harper: Go right ahead.

Jonathan: One is in terms of the 835 ERA. I have one intermediary that is – still has proprietary format that's not in the 835 standard and I cannot get an answer from them as to whether when they're going to change over.

Joy: Actually they haven't been allowed to do that for a number of years. So who's the intermediary?

Jonathan: It's Blue Cross Blue Shield of Georgia.

Joy: Because we actually prohibited intermediaries from sending out

local format electronic remittance notices well over five years ago. So we're going to have to look into this. And it's – is it a case where they're not using the 835 at all or they're using the 835, but they're putting some sort of local codes or something into it?

Jonathan: I believe they're not even using the 835.

Joy: Okay. Well, we'll be in touch with them and get back to you.

Dr. Harper: Thank you.

Jonathan: All right. Thanks.

Dr. Harper: Next question please.

Operator: Next we have Suzanne Soutard.

Suzanne: This is a hospital. My question is our Missouri Medicaid requires us now to have J-codes on all our injectable drugs. Will this bother the Medicare claim if the J-code is now on all our injectable drugs?

Joy: This is Joy. For Medicare all the drugs have to be submitted on the NCPDP format using the NDC.

Suzanne: But like in the past, you know, my Medicare hasn't required, you know, the actual specific J-code for an injectable. You know, you could just bill it underneath a 250 and then the cost. You haven't had to have the J-code. But now our Missouri Medicaid is requiring us to have a J-code. So I'm wondering if that's going to, you know, have a problem with my Medicare claims.

Joy: I miss – I was thinking that you were on the professional side, but you're –

Suzanne: No, this is a hospital.

Joy: Yeah. Because our hospitals and one of the – wonder if they pay on the J-codes so.

Suzanne: Will it bother if it's there though?

Joy: I'd have to look at the implementation guide. I couldn't tell you off the top of my head here.

Dr. Harper: Thank you.

Suzanne: Thanks.

Dr. Harper: Next question please.

Operator: Linda Davis.

Linda: We're an insurer and had a request from a bank for electronic 835 remittance advice. It's on all claims from a provider who is not and does not plan to file any of those claims electronically with us. Are we required to comply with that?

Stanley: Yes.

Linda: Okay. That's all I needed to know. Thank you.

Dr. Harper: You're welcome.

Operator: Next we have Tracy Salarski.

Tracy: Hi. I am calling because I have a question regarding the submission of the substantial documentation that is required in order to support the medical necessity for certain initial claims. If we're submitting those claims electronically how are we to attach that documentation?

Joy: This is Joy. On the 837 professional – I'm assuming you're sending these to the DMERC.

Tracy: Yes. Correct.

Joy: Okay. There is a segment that's supports this CMN. It's the FRM segment.

Tracy: Okay.

Joy: And that's where all the various CMNs are submitted.

Tracy: I'm not specifically talking about the CMN. I'm talking about the packet of information that we put together regarding patients medical history in order to support the need for the TPN or the inotropic drug.

Joy: Right. And currently those will have to be submitted via paper.

Tracy: Okay. Until they develop a mechanism in order –

Joy: Correct. And we are looking at that, yeah.

Tracy: Okay. So TPN and anything else that requires that documentation would still need to be sent via hard copy.

Joy: Correct.

Tracy: Okay. Thank you very much.

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

Operator: Next we have Cindy Shaski.

Cindy: Hi. I actually have a question in regards to a previous question that was asked about the batch rejection and having one claim being rejected in the whole batch going. I'm having difficulty understanding what my errors are. Is there a tool I can use to view my 837 file and see which claims have the rejections?

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

Lori: The Administrative Simplification Enforcement tool (ASET) was set up specifically for enforcement. It is not set up as an industry compliance test. So the answer to that is no. To the extent that you file a complaint because you believe that you have a valid complaint and you wish to attach a transaction to support as documentation to support your complaint you're welcome to do that and we will in fact use our compliance tool, as a kind of a one step in the diagnostic process, but it is not set up to be an industry kind of testing standard. To that end, there are a number, of compliance testing software packages out there that are available for entities to use. But the ASET tool is not one of them.

Cindy: Okay. Is there – can you give me a reference who I could go to? You said that there were some.

Lori: I mean, there are a number of really large ones, out there. I mean, there are a number of three very, national testing organizations all of which are on various web pages and list serves so I'm in an uncomfortable position, quite frankly, recommending them on a national call because it looks like I'm giving sort of preference to one company over the other and that is certainly not my intent.

Cindy: Okay.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Stacy Smith. Stacy, your line is open.

Stacy: Okay. Well, actually I have two questions. First off we are a small pharmacy and we're sending out batch claims electronically and through that we also use Medicare on assigned claims. And I'm wondering do we need to send those electronically or can those be sent hard copy?

Kathy: This is Kathy Simmons. I mean, we have a couple of different rules here. Are you talking about retail pharmacy claims? Because I know in many –

Stacy: Yes, I am.

Kathy: -- DME and such.

Stacy: Yes, I'm talking about a retail pharmacy that uses DME equipment.

Kathy: Well, because there's different rules that apply to DME billing than retail pharmacy prescription drug billing.

Stacy: It would be DME.

Kathy: Well, I don't know if that only applies to physicians though. Actually we don't have the right people here and I think we're going to have to look into that and get back to you. I know that

there are some rules that apply across the board to all physicians, but I'm not quite sure if it also applies to retail pharmacies, which don't accept assignment. Okay. We'll look into that and get back to you.

Stacy: And I also had another question.

Dr. Harper: Go right ahead.

Stacy: And when will the Regency ERN switch over to ENC format? We have been sending our claims in ANSI format, but yet we are still retrieving those in NSF. And I'm wondering when that switch will be made.

Joy: I mean, have you requested testing on the 835?

Stacy: We are in full production.

Joy: And you've told your DMERC that you want to get these in the 835 format instead of the NSF?

Stacy: Yes, Ma'am. We had – we converted over a long time ago. We converted over in October.

Joy: But did you tell your DMERC that you did finish the conversion for the 835 and you want to start getting 835 transmissions now? If they don't know that they wouldn't start sending it to you before they realize that you're equipped to handle them.

Stacy: Okay.

Joy: So you may just have to give your EDI contact there a call and ask if they switch you to 835. All of the DMERCs are supposed to be equipped and able to do that and have been for some months to the best of our knowledge.

Stacy: Okay.

Gary: Just in general for everyone, if you submit an 837, you don't

automatically get an 835. You have to work with your intermediary or carrier to request that and then they may set up some testing with you make sure you can accept.

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

Operator: Your next question comes from Mary Blane.

Mary: I have three questions. I'm a professional provider of oncology in Mississippi. And I need to find out if there are any state laws stating that we have to provide NDC numbers generally upon request. Can you hear me?

Dr. Harper: Yes.

Stanley: Yes. State laws requiring you to provide NDC numbers to whom?

Mary: Well, y'all had mentioned earlier in an answer to another question that there could be a state law stating that you have to provide the NDC number rather than the J-code.

Stanley: Oh, for claim submission. Yeah. It's – yeah, and I don't know if in your state there are those laws. Generally if the Medicaid program is requesting the NDC code number, you would need to be submitting it.

Mary: Okay. You've also said that y'all for five years that y'all required NDC numbers for oral cancer drugs. Can I get a transmittal or a charge request or something regarding that?

Joy: Yeah. It's been a number of years. I'd have to take your number and see if I can get the person that wrote that instruction and direct you to where that is.

Mary: And then forgive me for my ignorance on this question, but do we have to include tax identification numbers of referring physicians on our claims?

Joy: This is Joy. No, that is a situational data element.

Mary: Okay.

- Stanley: Just – this is Stanley. One comment on the state law issue suggested that you contact state medical or state hospital association who might have some knowledge about that.
- Mary: Okay. The other question is we – our vendor is telling us that the hold up for us submitting MSP claims electronically is that Medicare and Blue Cross and several of the other carriers are telling us that there are two different ways to submit them like they can't agree which way they're supposed to be submitted. Is that covered in the law or how is that going to be resolved?
- Joy: This is Joy. The implementation guide, you know, they need to follow – you need to follow the implementation guide and CMS has released, you know, our own instructions in how you file MSP.
- Mary: So it's universal.
- Joy: Yes. Yeah, you as a provider after what primary has paid, yeah, it's universal among all of our contractors.
- Mary: Okay.
- Joy: Medicare.
- Mary: Okay. Thank you.
- Dr. Harper: Thank you for your four questions.
- Operator: Your next question comes from Brook Novaine.
- Brook: Hello. We are a data processing service, excuse me, for home care agencies. We help process their OASIS data. And since to the state and – we have one of our corporate entities that is an off site call center and they were wanting to know if it would be within HIPAA compliance for them to handle our after hours and on weekends, data collection and verification processing or would that be out of HIPAA compliance because it's out of the United States?
- Jeff: Are you asking in terms of compliance with the privacy law whether you can send your information overseas?

Brook: We have scannable forms and they come in – it gets optically recognized and those people would be doing data verification on those forms and then the electronic stuff would still be housed by us, but we are wondering if that verification process would be within HIPAA compliance.

Jeff: I'm not sure I follow this specifically, but in general if you had a business associate arrangement with that entity, it seems like it would be permissible disclosure.

Brook: Okay. Thank you.

Dr. Harper: Ms. Young, we'll have one more question.

Operator: And your final question will come from Monica Turry.

Monica: Hi. Can you hear me?

Dr. Harper: Yes, Ma'am.

Monica: Thank you. I'd like to go ahead and ask you a question related to the HGSA memo that someone else had referenced earlier in the call. We are a provider in the State of Pennsylvania using both HGSA and Veritas. And additionally we also submit claims to Palmetto and Cahaba and other Medicare intermediaries. Based on the information that we've talked to HGSA about and also have talked to Veritas about they seem fairly firm about the December 31 deadline if your submitter was approved.

We're a provider who goes through NDC. NDC is classified as our submitter. We're wondering how this law or this change or this new directive from CMS, the JSM memo 20 is going to effect us if in fact we can't become totally compliant with our total workload by December 31.

Gary: Well, again, we're trying to use the 30 days as a goal. If there's specific instances you need to be talking to HGSA and to Veritas if that, you know, if there's an issue there that you believe you can not resolve you should go to the CMS regional office in Philadelphia and have a conversation with them, because there is not an absolute hard and fast deadline although there – I can tell you they're going to push you pretty hard to try to get you to

become compliant because we need people to become compliant.

Monica:

And I think we understand and respect that, however, we're in a position where we're going through our submitter which is NDC and we're somewhat at their mercy as well in trying to coordinate all of the information and data elements from us as a provider through NDC, who probably has hundreds if maybe not even thousands of other providers that they're trying to meet some of these deadlines with. So it's a very aggressive time frame for us learning about it on December 2 through and HGSA web master update that flashed across my e-mail to realize that oh, my gosh, on December 2 we only have until December 31 and we were not clear how all that would effect us since we are not necessarily the quote unquote end submitters that we are relying on NDC.

That's our concern and if push comes to shove on December 31, if there are issues with receiving cash, what is our recourse? And I hear you saying that we need now to maybe talk to CMS the regional office in Philadelphia to obtain clarification if in fact it's necessary. We're hopeful that through all of our efforts it won't be necessary.

And trust me we have called NDC high level people. We have talked to our management. We have talked to our vendor. We have talked to a lot of different people in trying to address this to make sure we're going to continue with our cash flow. But as a provider I can tell you it was high anxiety here learning this so soon or so late depending on your perspective in the game.

Gary:

We appreciate that and I – we appreciate the fact particularly that you're pushing your vendor and your vendors are talking to you. I mean, that was really a major intent of this instruction that went out to the contractors to get people going and get people back on track and not thinking that this contingency plan is going to go on forever. But certainly if there are, you know, specific issues with specific clearinghouses or providers, you know, we're going to have deal with those. So that's the process we're doing it that I described.

Monica:

So if I went back to HGSA and said it is my understanding in listening to this conference call today that the December 31 date is a goal and if it is achievable we should make it, but if it is not

achievable then our recourse is to contact Philadelphia. Is that an appropriate process?

Gary: I think what you should do is try to have them understand, you know, what is your ability to become compliant, when you can do it, you know, the conversations that you've had with your vendor and, you know, if that isn't successful then I would think you should go to Philadelphia.

Monica: Just to be clear we have talked with HGSA and Veritas if not once twice if not three times. So I'm just kind of letting you know to us and we were made aware of it and I think caught a lot of other facilities off guard. So I just kind of wanted to make you aware of some of the level of frustration here particularly when I listen to a conference call that Karen Trudel kind of coordinated through the American Hospital Association on November 17 saying that we'll be there as long as you need us, the contingency plan will be in place for as long as it takes as reasonably necessary recognizing that we all should be in communication with our clearinghouses and so forth. And then to learn on November on the 25 CMS issued this JSM 20 memo which then in turn we learned about on December 2 frankly through HGSA's efforts, which I give them a lot of credit for sharing it so quickly.

Dr. Harper: Thank you very much. We're going to have an announcement by Ms. Holland.

Ms. Holland: Okay. I'd just like to remind everybody of our website, which is www.cms.hhs.gov/hipaa/hipaa. On that website we will be posting a transcript of this call. We will also see if it's possible for us to post some sort of question and answers of the questions that we're getting back to people on as well. We will also post information on our next roundtable.

Our next roundtable is not expected to be until late January, early February. And so we probably won't have any more information posted on the next roundtable until early next year. And we are working to constantly update the website so I urge you to check it on a weekly or bi-weekly basis.

Dr. Harper: Thank you, Ms. Holland. We'll have closing remarks by Ms. Davis.

Lori: Thank you very much for logging on to the call today. We very much appreciate your interest in HIPAA compliance as it relates to the Medicare/Medicaid and other programs in general and thank you very much for your time.

Dr. Harper: And Ms. Young, could you tell us the number of individuals that were on the call today.

Lori: Approximately 1400.

Dr. Harper: Thank you very much and everyone have a wonderful holiday.

Lori: Thank you, Dr. Harper.

Dr. Harper: Bye-bye.

Operator: Ladies and gentlemen, this concludes today's teleconference. You may all disconnect.