FTS HHS/CMS

HIPAA 5010 and NCPDP D.0 COB Testing Call

Moderator: Brian R. Pabst
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****DISCLAIMER:** The following is a transcript of a call between CMS and numerous national commercial insurers. Whenever discussion points or answers given deviate from COBA documentation, such as the COBA Implementation Guide or future 5010 and NCPDP D.0 Companion Guides, please note that the language in these resources should be regarded as the most correct depiction of CMS COBA crossover operational policy.**

Coordinator: Welcome and thank you for standing by. At this time all participants will be in a listen-only mode. At the end of the presentation, we will conduct a question and answer session. To ask a question at that time, please press star 1, unmute your phone, and record your name clearly when prompted.

This conference is being recorded. If you have any objections please disconnect. I would now like to turn the meeting over to Mr. Brian Pabst. Sir, you may begin.

Brian Pabst: Thank you, ma'am. Good afternoon. I am Brian Pabst, the CMS Government Task Leader for the National Coordination of Benefits Agreement (COBA) crossover program, and I welcome you to today's teleconference presentation regarding the HIPAA 5010 and NCPDP D.0 COB testing.

CMS hopes this presentation will be useful to all commercial insurers that currently participate in the COBA crossover process as they plan resources and processes that will ultimately lead towards their full

implementation of HIPAA 5010 and NCPDP D.0 claims transactions with the coordination of benefits contractor.

Before I introduce members of the CMS and Coordination of Benefits Contractor, or COBC, COBA crossover team, I offer a word of caution to our teleconference participants who may have questions: Please note that CMS will not be entertaining any questions it posed that fall outside the scope of 5010 and NCPDP D.0 COB testing. Again, I repeat, CMS will not be entertaining any questions that fall outside of the scope of 5010 and NCPDP D.0 COB testing.

The purpose of this meeting is to discuss, at a high level, what willing testers may expect once CMS makes available 5010 and NCPDP D.0 COB claims for testing.

Callers may obtain an outline of today's discussion topics by referencing their agenda.

Now for some introductions of the CMS COBA team and various members of the COBC COBA team…. With me today here at CMS is my immediate supervisor, Sherri McQueen, who is the director of the Division of Medicare Benefit Coordination, and two of my fellow COBA team members, Rick Mazur and Ann Wood—all of whom are invaluable supports to me at CMS in my role as the Government Task Leader for COBA.

Present with us today from the COBC COBA team are Bill Ford, our COBC EDI manager; Don Fleischman, a Coordination of Benefits Contractor (COBC) EDI technical consultant who works collaboratively on our translator and HIPAA compliance editor with Janis Pollard, one of our more highly seasoned COBC technical specialists who is joining us by phone today.

Charles Collins, a systems engineer and key COBA system architect with our COBC systems subcontractor, VIPS, also known as General

Dynamics, and Billy Haddox, one of our COBA-dedicated programmers and business analyst who is also with our COB systems subcontractor, VIPS/ General Dynamics.

Joining us this afternoon via phone in addition to Janis Pollard are Jim Brady, our COBC project director; Donna Robinson-Raser, a technical consultant with COBC and our COBA marketing director; and lastly John Leo, our COBC EDI supervisor.

For those who are referencing the agenda, the first item we will discuss is testing timeframes for 5010 and NCPDP D.0 crossover claims.

You all should know that, following some detailed internal discussions, CMS has determined that it will be in a good position to offer external testing to its COBA partners during the period from June 1 to December 31, 2010.

CMS would actually prefer that all COBA partners that are willing to test during this timeframe do so concurrently in the interest of stressing our systems and uncovering any potential issues. Thus, there will be no attempt on either CMS or the COBC's part to assign COBA training partners to differential testing windows from June to December 2010.

Without question, all COBA trading partners will be eligible to test receipt of the 5010 and NCPDP D.0 crossover claims with the COBC during the advertised timeframe.

As CMS had mentioned in its earlier COBVA broadcast late this winter, COBA trading partners that take advantage of testing during June to December 2010 will realize two key benefits or advantages. The first is the ability to actualize any internal testing changes that payers have made through testing externally with CMS, a very large payer of healthcare claims in today's health care system. And, second,

you will realize a greater readiness for acceptance of 5010 and MCPDPD 0.claims submitted to Medicare as of January 2011—the timeframe when most providers, physicians and suppliers will begin submitting 5010 and NCPDP D.0 claims in production to Medicare. To realize this latter advantage, the interested COBA partners will, of course, need to move into production on the 5010 and NCPDP D.0 claim format by January 2011. And CMS and the COBC are jointly committed to assisting as many trading partners as possible with meeting this desired goal.

As indicated on the agenda, the next topic that we will discuss is COBA identifiers and contractual changes needed prior to testing.

All COBA trading partners will be able to utilize their current 5-byte COBA identifiers for purposes of 5010 and NCPDP D.0 COB testing, which CMS believes most of you will regard as good news. We certainly do. Only in those situations where a COBA trading partner wants to vary its claims selection criteria while testing would it be necessary for that entity to apply for a unique 5010 or NCPDP D.0 test COBA ID.

In terms of the contractual changes necessary to indicate the desire to begin 5010 or NCPDP D.0 testing, CMS and the COBC are in the process of developing what we will call a "COBA 5010 NCPDP D.0 Testing Assessment" document that interested COBA trading partners will need to complete prior to commencement of testing.

During the testing period, COBA trading partners will be able to test all lines of business. For example, an insurer may test a standard Medigap line, its employer supplemental line, as well as its Federal Employee Health Benefits Program (FEHBP) line if it should desire with the COB contractor; **or** these entities may test certain lines and not others. And they will indicate which option applies to them as part of the testing assessment document. The CMS is targeting the

issuance of the testing assessment document via COBVA broadcast in late July of this year.

As discussed, it is **not** necessary for COBA trading partners to obtain new COBA identifiers for the testing of 5010 and NCPDP D.0 claims. All COBA trading partners that test these claims with the COBC will, however, need to complete an Electronic Transmittal Form (ETF). This will facilitate the establishment of a new dataset name so that the COBC will be able to properly direct the test claims to each trading partner, independent of its
4010 A1 and NCPDP 5.1 production claim. And we realize you wouldn't want to comingle them.

The next topic is, as indicated on the agenda, a continuation of receipt of production claims while you are in testing mode.

The CMS and the COBC want to assure all trading partners that they will continue to receive their production 4010 A1 NCPDP 5.1 batch production claims from the COBC at the same frequency and via the same connectivity methods while they are simultaneously testing 5010 and NCPDP D.0 claims with the COBC. That said, prior to commencement of the testing process, COBA trading partners will need to make some systematic modifications to accommodate the reality of “true parallel production”—that is, receipt of the same exact claim down to internal control number, procedure and diagnosis codes, and service dates in the 4010 A1 production mode and in the 5010 test mode or in the NCPDP 5.1 production mode and NCPDP D.0 test mode. As was true five to six years ago, COBA trading partners should note that they should **not** make payment to providers, physicians or suppliers in association with test claims received, since these claims do not represent “true production.”

The next topic on the agenda, as you'll note, is claim volume expectation, which complements the topic we just discussed.

In a related vein, in terms of claims volumes, COBA trading partners will notice that for the COBA identifiers under which they wish to receive 5010 or NCPDP D.0 test claims, they will receive the same volumes as they do in production under 4010 A1 and NCPDP 5.1. And, again, that assumes that the trading partner's claims selection criteria are identical. It is very important that COBA trading partners realize that every 5010 claim that the COBC generates to them in test will be an exact duplicate of the 4010 A1 claim they receive in production, and they will need to take any actions necessary to allow for this reality during the testing period.

In terms of guidance for helping folks to understand the values that are going to be coming across in COBC test claims and in later as production 5010 and NCPDP D.0 claims, CMS is going to be making available a HIPAA 5010 and a NCPDP D.0 Companion Guide. There will be two separate guides for COBA trading partners' use. The CMS is planning to make these available by late July 2009. And, as part of these documents, you will notice, among other things, a listing of delimiters as well as nonstandard alphanumeric or numeric values—that is, values not specifically defined by the TR-3 Implementation Guides or that are not within supporting source tables or listings; e.g., the NUBC codes—with accompanying 837 data fields (or elements) in association with the 837 institutional and professional claims and NCPDP D.0 COB claims.

Additionally, the Companion Guides will highlight new placement of information in specific situations where they have been previously provided either in the "NOTES," or NTE segment, or the K-3 segment. These two resources should prove extremely valuable to COBA trading partners not only in association with 5010 and NCPDP D.0 testing but also when they move into production using these claim formats. Once completed, the Companion Guides will be released via our COBVA broadcast system and will also be made available on CMS's COBA web site.

If you're following along on the agenda, the next topic is future availability of a revised COBA Implementation Guide.

The CMS and the COBC are retooling their ever-popular COBA Implementation Guide at present and are planning to finalize work on it also by late July 2009. Updates will be specific to HIPAA 5010 and NCPDP D.0 as well as current COBA test and production processes. The revised guide will be accessible on CMS's COBA web site. Due to its size, CMS believes that the sending of this document via COBVA broadcast may not be viable. But, we will take a closer look at that.

A lot of you have raised a concern over the many months about differences between the two claim formats—837 4010-A1 versus 5010. And we ourselves have been taking note of those differences. As early as last summer, CMS issued a COBVA that featured a 4010 A1 and a 5010 side-by-side comparison document. That document highlighted, even at those early intervals, some of the key differences between the two formats. Indeed, it illustrated that certain elements were changing from situational to required or disappearing altogether. It also illustrated that certain loops were being completely reordered and confirmed that several elements were introduced within 5010 that had not previously existed. To assist our callers with identifying some of the more noticeable changes, I will draw upon some of the information conveyed in the very recent OIS presentation delivered at CMS. Then, I will present some of the observations that the CMS and COBC COBA teams have made concerning differences between the formats.

First, the 5010 claim format allows for separate diagnosis code reporting by principal diagnosis, admitting diagnosis, external cause of injury, and reason for visit. Indeed, as we are all discovering, the 5010 format serves as the foundational transaction for the robust reporting of morbidities and co-morbidities and co-morbidities in the format of the ICD 10 code set. The same cannot be said of the 4010 A1 format.

Second, the 5010 claim format adds a new element for present on admission (or POA) indicator within the 837 institutional claim format. Most of you are aware, I'm sure, that in the current production 4010 A1 version this element has been afforded a default placement in the K-3 segment.

Third, unlike the 4010 A1 format that supports reporting of anesthesia time in both minutes in units, the 5010 professional claim only allows for the reporting of anesthesia services in terms of minutes. This will doubtlessly be a welcome change for a great many COBA trading partners we are sure. The biggest adjustment is our end in terms of this new practice. .

The 5010 claim creates new required pickup location elements in association with ambulance supplier claims. Now if incoming electronic ambulance claims do not have both pickup and drop-off address locations, they will not be considered HIPAA compliant and thus would never reach COBA trading partners for crossover purposes.

These are some of the items discussed by our Office of Information Services in a recent presentation. Now I wanted to move on to what we've observed and what we suspect you too have observed about the transactional differences.

The CMS and the COBC COBA teams have additionally observed that the 5010 claim removes almost all “AMT” segments, with the exception of those that reflect payment by Medicare or by a payer that is primary to Medicare. In other words, all approved or allowed amount AMT segments are disappearing with 5010. Why? The thinking is that all payers, including Medicare, will be able to approximate another payer’s approved or allowed amount by taking the total amount billed and subtracting any reported CAS*CO*45 monetary amounts. Again, this is one of those changes that we ourselves are becoming used to, and we know the same is true of you

as well. Even so, this is one of those growing pains that is not necessarily painless. So hopefully we'll all get through it together.

One important change from 4010 A1 to 5010 is that Medicare will now insist that all 837 institutional and professional claims balance, just as all financial information must currently balance in association with the 835 ERA transaction.

Lastly, though not of huge importance to commercial payers, many of the previous restrictions concerning the reporting of taxonomy codes in various PRV segments that once appeared in the 837 professional implementation guide are now removed. Happily, the present 837 4010 institution Implementation Guide never imposed any such restrictions. And the new TR3 Implementation Guide for the 837 institutional claim poses no new change in this regard.

I thank you for giving me your undivided attention this afternoon as I, on behalf of CMS and my team, outlined for you various topics that will help you better appreciate how the 5010 and NCPDP D.0 COB claims testing process will unfold beginning in June of 2010.

Operator, we are now ready to take questions from those on the phone.

Coordinator: Thank you. And, again, if you'd like to ask a question, please press star 1 at this time. Please unmute your phone and record your name clearly when prompted.

We do have one question queued up and it comes from Nelly Childress. Your line is open.

Please check the mute button on your phone, Nelly. Your line is open.

We'll take the next question from Christol Green. Your line is open.

(Christol Green): Hi Brian. One thing I'm looking at the final rules state that no payer, including Medicaid or Medicare, is permitted to mandate a transition to 5010 prior to this January 2012 compliance date unless there's a mutual agreement between both parties. And I'm hearing, or if I heard correctly, you are stating that we need to move by January 2011. Could I obtain some clarification around that?

Brian Pabst: Thank you, Christol, for your question. The CMS is trying to encourage as many folks as possible to move to that date. And the reasoning behind that is when the actual claims will begin flowing into us with 5010 content, we wanted payers to be able to accept complete throughput, as originated at the provider billing office and as moved through until the point of claims cross-over. But, we are not mandating transition to HIPAA 5010 before January 1, 2012. We are just making a testing window available between June and December of 2010. If folks are not available to test at that time, they may test during 2011.

The one thing that's a definite constant, however, is we all have to cut over by January 2012 to the new format. The CMS is just letting everyone know that we're opening up a window. We envision folks may take us up on it and we hope they will, but we are not compelling anyone to test and cut-over early.

(Christol Green): Thank you, Brian.

Brian Pabst: Sure; you are welcome.

Coordinator: The next question is from Sabrina Freeman. Your line is open.

And please check the mute button on your phone. The name is not recorded. Sabrina?

(Sabrina Freeman): Yes this is Sabrina. Hi, Brian. How are you?

Brian Pabst: Hi, Sabrina.

(Sabrina Freeman): I just needed you to restate the information on the 5010 concerning removing the approved amount.

Brian Pabst: Yes.

(Sabrina Freeman): Would you restate that for me? I want to make sure that I'm understanding that correctly. Would this apply to institutional and professional? Could you just go over that again briefly please.

Brian Pabst: Very good question; thank you. We have noticed here at CMS that the allowed amount, which always has been qualified by a B6 or AAE, is going to be removed for both institutional and professional claims. And the only amount segments that will remain will be those that qualify payment via a payer, whether it be Medicare or a payer that is primary to us. The X-12 Committee thought that that would be okay because, through usage of CAS*CO*45, one could derive what Medicare would have allowed. Also, in terms of getting to what Medicare paid, the balancing formula normally is that you take the amount billed, minus all CAS segments, and you realize the amount Medicare paid. Now that's not always true, particularly in cases such as the inpatient prospective payment system, or IPPS, methodology, where you end up adding the differential amount between billed and allowed to the incoming billed amount before subtracting any applicable CAS*CO*45 amounts.

(Sabrina Freeman): Right.

Brian Pabst: This happens because often under IPPS the approved amount is greater than the charges submitted. But, as a general guiding principle, the balancing formula is useful. But, again, the AMT segments that are being removed are those that convey the approved and the allowed amounts on the claims, not the “AMT” that would qualify Medicare or another primary payer’s paid amount.

(Sabrina Freeman): Okay, thank you very much.

Brian Pabst: I can tell you're having the same reaction that we had at first.

Brian Pabst: One thing, too, and before we go on to the next question, Sabrina, is that my understanding is that when Medicare applies IPPS, where we allow more than is charged, the difference is almost always reflected as a CAS*CO*94 in association with Part A claims.

(Sabrina Freeman): Okay.

Brian Pabst: So that would probably help you in terms of getting ready for that.

(Sabrina Freeman): Okay. Thank you.

Brian Pabst: You're welcome.

Coordinator: Ronnie Coleman, are you there?

(Ronnie Coleman): Yes. I just wanted to know if the longer version of the agenda is available. I'm a slow typer, so I was listening, but I can't key as fast as you were talking. That's all I wanted.

Brian Pabst: I'm sorry; I tried to talk slowly. I believe a transcript is being made available for this call. Becca, can confirm that?

(Ronnie Coleman): Okay; thanks, Brian.

Brian Pabst: Sure.

Coordinator: Yes, that is correct; a transcript is being made of the call. And the next question will come from Deborah Johnson.

(Deborah Johnson): Yes, I know you had mentioned that we will have to complete a transmittal form when testing the 5010. Is there any plan to update our current contract for the 5010 in production?

Brian Pabst: And, Deborah), when you say that, are you asking whether CMS in the short term would actually change the COBA Attachment to incorporate 5010 elections?

(Deborah Johnson): Correct.

Brian Pabst: In the longer-term, the answer is yes. But, for the immediate short term, the earlier referenced Technical Assessment document that would serve as a COBA Addendum of sorts that would convey your desire to utilize 5010 claims for testing purposes.

(Deborah Johnson): Okay.

Brian Pabst: And that's what we're going to go with for the immediate future. Because changes of that nature are kind of large for everybody, including CMS and the COBC. All commercials just finished re-executing the COBA Base Agreement and Attachment, and I do not believe that they or we want to go down that formal path again this soon.

(Deborah Johnson): All right, thanks.

Brian Pabst: Sure.

Coordinator: If there are any final questions, please press star 1 at this time.

And the next question I believe comes from Guy, with Blue Cross Blue Shield.

(Guy): Yes, Brian, one question is when will that Technical Assessment document be available for us?

Brian Pabst: We are planning to issue it via COBVA in late July 2009. As far as when you complete it, really anytime between now and June of next year would work.

(Guy): Okay, what would the timeframe be from the time we submit it to you till we can begin testing?

Brian Pabst: The earliest you can test is June next year. And we at this point have no indication that this date is changing. If that ever did change, we would let everyone know through our normal communication channel. You could get the ball rolling in terms of signing the Technical Assessment document as soon as it goes out or as late as June next year. But you wouldn't see any results, in terms of test date, for about 11 months.

(Guy): Well, I'm saying if I submitted the completed form on June 1 of next year, how soon would it be before it gets approved and I can start testing?

Brian Pabst: I see, okay. Bill, any input regarding this?

Bill Ford: I would think it would probably be no more than a couple of weeks, maybe three weeks tops, before you could start testing.

(Guy): Okay. The other question I have is that I just want to make sure I understood. The COB testing in 2010 is not required. And we could test in 2011 if we chose to.

Brian Pabst: Yes. We're going to be ready to test by June 2010, and we just wanted to offer COBA trading partners the opportunity to test with the COBC as soon as possible. We know some folks are already gearing up for 5010. Everybody is at a different stage of readiness for this. And for those who feel like they're going to be ready by then, there's no mandate that you start in June. We're going to make it available in

June. And, as I have said in my presentation, we'd love to put as many people into the testing mix as possible because then it will hopefully unloose any problems that may be there.

(Guy): Okay, if our plans don't test with you until say 2011, when would you start sending us 5010 production claims?

Brian Pabst: Whenever you tell us when you're ready to cut over. And if you've been with us for a while, you that that there is a standard process for cutting over with the COB contractor. We change what we call the COIF to move COBA trading partners into COBA production. .

(Guy): Right. Okay, thank you.

Brian Pabst: Guy, just to be clear we really would want folks to test in the 2010 timeframe and in 2011. But if folks haven't started to test by July of 2011, we're going to get nervous because we want to give people at least 30 to 90 days and possibly longer depending upon what they would need to realize in terms of satisfactory testing results.

(Guy): Right.

Brian Pabst: So if folks have not begun to test by July 2011, CMS is going to be sending out something that states, in essence, that CMS is concerned that your organization has not begun to test and inquire as to the reason why an organization has not begun testing.

(Guy): Okay; thank you.

Brian Pabst: You're welcome.

Coordinator: (Rich), your line is open.

(Rich): Hi. I was concerned about the test files and the naming conventions. Will we be able to identify the files as a test file because of a different

naming convention as compared with our normal production claims file?

Charles Collins: Just as it true today for your 4010-A1 claims transaction, you'll be able to name it whatever you choose to on your end.

Now, of course, your BHT-03 indicator will identify the claims as test. You may want to choose to go with what you would actually have in terms of dataset names for your current production files once you cut over to 5010.

So from the perspective of establishing your file transfer and receiving your files, you wouldn't realize any changes. But whatever the naming convention is on your end is what we'll transmit claims data to as part of the COBA process.

Charles Collins: Are you currently utilizing SFTP for connectivity?

(Rich): Yes.

Charles Collins: Okay.

(Rich): Well, we're actually using SFTP via https right now.

Charles Collins: Okay, but you do have a test and production filename, correct?

(Rich): We just go right in and all we see is the production files. Though, am I correct that there will eventually be another mailbox that we will be able to flip to obtain the 5010 files?

Charles Collins: Incorrect. How long have you been in production on the 4010-A1 format?

(Rich): Since the inception of COBA.

Charles Collins: Okay. Well that's probably why. There will be a production and a test filename.

(Rich): Okay.

Charles Collins: So when you do your ETF, it's important that you designate that you do not currently have a test mailbox.

(Rich): Okay.

Charles Collins: Just know that this can be addressed.

(Rich): That sounds great. Thank you.

Coordinator: Your next question is from Ted Sewell.

(Ted Sewell): Yes, hi, Brian. I have a question regarding the claims that will be ready to cross over on January 1, 2011 in the 5010 format in production. Where will those come from? Will the providers be encouraged to be ready for 5010 by 2011 or will the Medicare contractors be converting the claims?

Brian Pabst: Ted, CMS is encouraging providers to start sending in 5010 claims in production by January 2011. But, prior to that, if you are testing with us, the Medicare contractors would be converting incoming 4010-A1 claims into the 5010 claim format for COB testing purposes.

(Ted Sewell): Okay. So once we've completed testing for 5010, any 4010 A1 claims would be converted to the 5010 format once we're ready?

Brian Pabst: Yes.

(Ted Sewell): Could we be potentially be receiving claims in both 4010 and 5010 for a period of time?

Brian Pabst: Not in production.

(Ted Sewell): Okay.

Brian Pabst: Right.

(Ted Sewell): Okay; thank you.

Brian Pabst: You're welcome.

Coordinator: Michael Sauer, your question…..

(Michael Sauer): I actually had the same question as the previous person. I was wondering if it would ever be possible to ever receive a 4010 and 5010 in production at the same time?

Charles Collins: If a 5010 claim comes in from the provider and you're not in 5010 production mode yet, the shared system will convert it a 4010-A1 "skinny" format. During the transitional period, you would systematically not be able to receive both a 4010-A1 and 5010 claim in "production" mode.

(Michael Sauer): All right, thank you.

Coordinator: (Deborah Johnson)?

(Deborah Johnson): Hi. Sorry, I should've asked this question at the beginning of my previous question: What is going to be the turnaround time for the testing to get the results back?

Brian Pabst: Deborah, it would be the same as it is today. You will be receiving real claims that are labeled as test. They're live claims just as your production claims are live. So assuming you get a copy of claim A and it's in the 4010-A1 production format, you will get claim B in a 5010 test format at the exact same frequency. Also, there is no holding of

claims at the COBC. Your claim files will come through just as they normally do when submitted to Medicare from the provider after all payment floor requirements are met.

(Deborah Johnson): Okay, great.

Coordinator: (Marianne Singaro).

(Marianne Singaro): Yes, I was wondering if there will be any changes to this dispute process or the file layout for that process?

Brian Pabst: Certainly not in the immediate future. And, again, the reason we maintain the format we do is because we do require a certain amount of detail for disputes, and we find that the 999 and 997 transactions do not allow for reporting enough detail as to reason for rejections/disputes for our purposes.

(Marianne Singaro): Yes.

(Marianne Singaro): Okay, so here is my second question: Will you, outside of the dispute files, be accepting any 999 as acknowledgment to the files?

Brian Pabst: We are not planning to do so.

(Marianne Singaro): Okay.

Coordinator: Sabrina Freeman, check the mute button on your phone please.

(Sabrina Freeman): Yes, I had the same question as the previous question about the 4010 and 5010 coming in. So you answered that; thank you.

Brian Pabst: Thank you, Sabrina.

Coordinator: At this time there are no other questions.

Brian Pabst: Thank you very much, Becca, and thank you, everyone.

And, Becca, does that mean we're done?

Coordinator: Yes, you can all disconnect at this time. Thank you all for your participation.

Brian Pabst: Thank you.

Coordinator: You're welcome.

END