Medicare FFS Implementation of HIPAA Version 5010 and D.0 Transaction Standards
21st National Provider Call

Moderator: Charlie Eleftheriou
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Operator: CMS is hosting its 21st National Provider Call regarding Medicare Fee-for-Service implementation of HIPAA version 5010 and D.0 transaction standards.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. Anyone who has any objections may disconnect at this time.

Thank you for your participation in today's call. I will now turn the call over to Charlie Eleftheriou. Thank you sir, you may begin.

Introduction

Charlie Eleftheriou: Thank you, Holley. Again, welcome to the 21st national call on HIPAA versions 5010 and D.0. Today's call targets vendors, clearinghouses, and providers who need to make changes specific to Medicare Fee-for-Service (Medicare FFS) in compliance with HIPAA version 5010 and D.0 requirements.

We'll also hold a question and answer session giving participants the opportunity to ask questions related to 5010 and D.0 implementation.

As a reminder, today's call is being recorded and transcribed. The transcript and audio will be available on the CMS Web site shortly after the call.

We'll be using a webinar feature as part of today's National Provider Call. The webinar is an added feature that allows participants who have Internet access the ability to follow the presentation online as it's given. This will not have any effect on participants who are dialing in with phone only.

To access the online Adobe Connect Pro webinar, please use the following URL: https://webinar.cms.hhs.gov/medicareffs5010. Sign in as a guest when prompted, by entering your first and last names. Please note that you must also dial in to the call in order to access the audio portion of the presentation.

This webinar's capacity is limited to 1,000 participants, and access is on a first-come, first-served basis. If capacity is reached, you may get an error

message. In this case, we've created a second webinar room for an additional 500 participants, which can be accessed using a URL similar to the previous URL, except it has a "-2" at the end: https://webinar.cms.hhs.gov/medicareffs5010-2. You use the second link the same way you use the first. If you get an error message when attempting to join the second room as well, capacity has been filled. In this case, you may visit the 5010 national calls page located at www.cms.gov/versions5010andD0. Select today's call from the list, download the presentation from the bottom of that page, and you'll be able to follow along manually during the call. You must still dial in to the call in order to access the audio portion.

Finally, if you'd like to ask a question related to today's presentation and do not get an opportunity to do so during this call, please submit your question to the 5010 Fee-For-Service mailbox at 5010ffsinfo@cms.hhs.gov.

Please note: This mailbox will only accept questions for the next 24 hours. Questions and answers from this call will be posted on the Web site in the next few weeks.

I'll now turn the call over to Angie Bartlett, Health Insurance Specialist with the Division of Transaction Applications and Standards [DTAS], in the Office of Information Services here at CMS.

Overview: Implementation Status and MAC Status

Angie Bartlett: Good afternoon. My name is Angie Bartlett. I'm a Health Insurance Specialist at the Center for Medicare & Medicaid Services, particularly on the Medicare Fee-for-Service side of the house as an Electronic Data Interchange subject matter expert.

Thank you all for taking the time out of your busy day to join this call. I appreciate the opportunity to provide you with useful and valuable information about 5010 D.0 as well as general information CMS has been working on related to the implementation of 5010 D.0.

Today I am joined by a panel of our 5010 team as well as staff from Medicaid and the COBC contractor. We hope to provide you with an overview of

current status of 5010, as well as encourage you to begin testing and implementing as soon as possible.

Today's call will be focused on 5010 readiness for Medicare Fee-for-Service and Medicaid, and will include troubleshooting tips as well. In addition, we will be providing guidance on what to do next to prepare for the transition.

Today's agenda (slide 3): We'll start with a general overview and discuss our top operational concerns and the top 10 edits failing for 5010 currently. We'll also address Medicaid readiness. Then we will conclude with a question and answer session.

Slide 4, implementation status, is a quick preview of where we are with the 5010 project right now. The expansion for ICD-10 is complete; all MACs have completed running the certification test programs for 5010; CMS systems are 5010-ready in production; all MACS and legacies are testing with external trading partners; and trading partners are transitioning from test to production as we speak.

We are marching toward the January 1 implementation date for 5010.

Slide 5, Medicare Administrative Contractor Status: This is where the MACs are now. They have completed the certification testing. The full set of certification tests were exercised, and CMS has directed the MACs on resolution of any critical deviations.

External trading partners continue to be notified of deviations related to the translator certification, and those can be found on the individual MAC Web sites. Please look at your local MAC's Web site for additional information related to those types of deviations.

Now we're going to focus on 5010 operational status, our top operational concerns. We're going to have each of our subject matter experts identify themselves and talk about two of these concerns.

The first one is MSP.

Operational Concerns: MSP Claims, Part 835, NDC Codes, P.O. Box, Zip Code, NOC Codes

Brian Pabst: This is Brian Pabst from OSM. Certain MSP claims are not being accepted, or are being rejected on the front end. Based on everything I'm hearing, these issues are well on the way to being fixed. There was an issue discussed Monday about Primary Payer Name, and this is on the list of things to be addressed. That's all I have.

Sumita Sen: Hi. This is Sumita Sen also from DTAS. I actually have three on the list. This is on the 835 on Part A.

The first concern involved the PLB segment: Qualifier QA was being used instead of qualifier OA. This particular issue was on the Part A side, and it was corrected on December 5. So anything produced since December 6 would be OK.

The second concern I have on the list is that the CAS segment was generated without a reason code, causing a translator failure. This actually happened on the DME side. Basically, even if the amount was zero, a CAS segment was being created. Again, this issue has been addressed, and it was corrected in October.

The third concern is with sporadic problems with incorrect SE counts. This happened on the Part A side occasionally. This issue has been corrected, and production started on December 5. Moving forward, we should not be seeing this issue.

Angie Bartlett: About the National Drug Code (NDC) reference used in the CEM: We had several problems with the NDC code file and how it was being used. So effective December 9 for Medicare Part B and effective January 1 for Medicare Part A, Medicare Fee-for-Service will be turning off the current X12 5010 CEM national code set validation edit for Part A and for Part B.

The specific NDC edit will be turned off in Loop ID 2410 LIN03. It requires that the NDC be valid against the Food and Drug Administration's NDC code list.

A replacement NDC edit will be implemented in the Part A and Part B CEM for the January 2012 shared system quarterly release, which will perform only syntactical editing for the NDC submitted in Loop 2410.

Now on to the next slide, about P.O. Box.

Brian Reitz: Hi. This is Brian Reitz, in DTAS. The P.O. Box issue is one that X12 implemented in order to prevent fraud. It's requiring a physical address for your billing address. We've had a lot of providers contacting us about what they're supposed to put there. Simply, you're going to have to fill in the billing location with a physical address and not a P.O. Box. P.O. Box is in the Pay-To loop.

Matt Klischer: My name is Matt Klischer, and I'm also in DTAS. About the zip code issue: The TR3s require a 9-digit zip code for the Billing Provider, that's a 2010 AA loop, and the Service Facility.

The Service Facility on the 837 professional is in the 2310 C, and on the 837I it's in the 2310 E. For all the other zip codes, you can provide 5 digits or 9 digits. But the two I just mentioned, Billing Provider and Service Facility, require 9 digits.

Brian Reitz: This is Brian Reitz again, about the NOC issue. For those who don't know, NOC stands for "not otherwise classified." When you submit an NOC code, the implementation guide now requires you to provide a narrative description of the service rendered.

We've had many vendors and providers contacting us saying they are getting a zero, and asking what to code in as the description. But you can't code a description, you have to provide one—that is, tell us exactly what was done related to the "not otherwise classified" code you're submitting as your billing procedure.

For example, if you submit a code for a not-otherwise-classified procedure of the hand, you have to put in a description what was done. If you added sixth

finger to the patient's hand, that's what you need to put in there in order for the payer to be able to adjudicate the claim.

We can't use the same CPT or HCPC code descriptor as the description. It doesn't get us to a point where we can adjudicate the claim. You're going to have to put into that field exactly what it is you are billing us for.

Operational Concern: Translator Deviations, Top 10 Failing Edits, TDLs

Angie Bartlett: Our last item on the page: translator deviations continue to be addressed and resolved by the vendors. Several MACs are reporting translator deviation errors, and these can be noted on the MACs' individual Web sites. So for a complete list, please visit your MAC's Web site.

The next slide (slide 8), which you can use as reference, is a brief update on the top 10 edits failing version 5010 for Part A. Some of our top rejections, for example, are for invalid information within the revenue code, such as invalid information within the HCPC, claim is rejecting for invalid information inconsistent with the billing guidelines, and so on. This list gives you a feel for some of the edits we're seeing for Part A.

Next, on slide 9, you'll see the updated list of Part B failing edits. We'll see rejections because "submitter not approved for electronic claims submission," for invalid information in the postal zip code, and for invalid information for subscriber's contract number.

You'll be able to refer back to this after the call and see if you have any similar edits or errors as well.

Slide 10 describes communication technical direction letters issued by Medicare Fee-for-Service as incremental steps in facilitating the transition, rather than waiting till the very end, December 31, and transitioning everyone immediately over to 5010. Technical Direction Letter 11464 announced that as of October 1, all new direct submitting trading partners and 835 health care payment receivers are required to enroll using version 5010–compliant transactions. This is going to be all of your PC-ACE Pro32 features. That's where you're going to fall.

Here we want to mention an important point about PCA-ACE and Pro32: starting on January 1, the current version of Pro32 will only permit selecting 5010 as the outbound format. 4010 will not be an option anymore. This restriction is in all versions distributed since April 2011. Also, the Pro32 software expires every 8 months, so a new version needs to be downloaded and installed. Everyone is on the current version, which means you have to start submitting 5010 as your output starting on January 1.

Next, Technical Direction Letter 12035: As of November 1, all new providers submitting through an existing submitter ID—that would be a clearinghouse or vendor—and 835 payment receivers through an existing submitter ID will be required to enroll using 5010-compliant transactions.

This means that any trading partner wishing to enroll with a clearinghouse after November 1 must do so in 5010. This requirement was also intended to encourage the clearinghouses as well to move into 5010 production so they can take on these new trading partners in 5010.

Note on Additional Processing Guidelines

Chris Stahlecker: This is Chris Stahlecker speaking. I want to take a minute and address as much as possible the OESS announcement that 5010 and D.0 as well as NCPDP version of 3.0 would not be enforced until March 31.

Medicare Fee-for-Service has announced that we will give our MACs additional processing guidelines. However, we have not yet finalized what those guidelines will be. So we ask you to stay tuned, and as soon as we have the guidelines available for industry consumption, we will publish them through our various listservs. We will also address these guidelines at our next audiocast. That's all I have to say at this point.

Our next speaker will be Elizabeth Reed on the Medicaid status. Thanks.

Medicaid Status

Elizabeth Reed: Hello, everybody. I'd like to give a quick Medicaid status update. The slide you may be viewing is a little outdated. I have received confirmation from all

the states. All but seven states will meet compliance for 5010 transactions on January 1. The states that providers need to be concerned about are as follows.

California is having issues with meeting compliancy for their claims, as well as NCPDP, 835, and 270 and 276 transactions. They are capable of doing 837 dental transactions.

Arizona and Hawaii will be able to do all transactions except the 835 remit.

New Mexico is going to have a delay with their 270 series, meaning the eligibility and the 276, but they will be processing claims.

Maine has announced that they will delay up until January 15, and they're supposed to be issuing guidance to their providers as to whether they're expecting continuation of 4010 until January 15, or whether they're going to accept 5010 and hold them till January 15. So if you do business in Maine, please get on Maine's listserv.

Colorado will go live with 837 transactions, which are the claims again, but there will be a delay for all the other transactions, looking like February for them.

New Hampshire is going to go live with 837s, but the 270 series may be delayed by a month or two.

The next slide (slide 12): Communication right now is critical. That's what I advise to the states. They should have been sending communications out to all their providers. I would encourage you to obtain as much information as you can from their Web sites.

As a provider, your testing should have been completed by now. You need to look at your risk mitigation plan as to what will happen if the state you are doing business with is not ready to accept new transactions, or if your system is not capable of producing 5010 transactions.

MAC Jurisdictions and EDI Help Desks

Angie Bartlett: Our next slide, slide 13, I'm sure you have seen before. This slide shows a current map of MAC jurisdictions. If you are unsure of your MAC, please make a note of your jurisdiction number, and on the next slide you can look up the name of your MAC.

Slide 14 gives a very good list of MAC Web sites. You can find a wealth of information on your MAC's Web site: top FAQs, links to their companion guides, as well as useful information regarding the transition.

Slide 15 gives information on MAC EDI help desks. Medicare Administrative Contractors are the administrative arm of Medicare Fee-for-Service. That means any claims or other transactions you submit to Medicare go through them first.

Currently our administrative contractors are being consolidated by jurisdiction. Most consolidations have already occurred, but some of you may be in states where your consolidation has not been completed. If you send your transactions through a Fiscal Intermediary for Part A or a carrier for Part B, you have yet to be transitioned to a MAC jurisdiction. The links on this page will help you find the EDI help desk in your state where you will want to go to begin.

Next, on slide 16: What has Medicare Fee-for-Service developed in terms of communication resources to date? Medicare FFS has established central Web pages on the CMS site where you can find a wealth of information, and it is growing every day.

You'll find resources such as fact sheets, readiness checklists, resource cards, FAQs (these have been posted on the CMS main page in a searchable database), and technical resources such as 4010-to-5010 side-by-sides, MLN articles, and other previous national calls.

The final slide tells how to get help with some of your questions. You will be able to access the transcript for this call online, as well as an FAQ list and the recording. If you have a question and aren't able to ask it during this call, or if

you think of a question after the call, please note that you can submit your questions to the Fee-for-Service resource mailbox shown at the bottom of this slide, which is 5010ffsinfo@cms.hhs.gov. This is only available for 24 hours before the call and 24 hours after it, so please get your question in quickly.

Thank you very much.

Question and Answer Session

Charlie Eleftheriou: Before we jump into questions and answers, I'd like to pause for a few moments to complete keypad polling so CMS has an accurate account of the number of participants on the line with us today. There may be moments of silence while we tabulate the results. Holley, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line.

We would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If nine or more of you are in the room, please enter 9. Please hold while we poll the results.

That concludes today's polling session. We will now open the lines for the question and answer session.

To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization before asking a question, and to ensure clarity, pick up your handset before asking your question.

Charlie Eleftheriou: I'd also like to remind callers that this call is being recorded and transcribed, so please speak clearly and give your full name and location before asking your question.

We can now take our first question.

Operator: Please note that your line is going to remain open during the time you are asking your question, so anything you say or any background noise will be heard.

Your first question comes from the line of Inna Bender.

Inna Bender: Good morning. Inna Bender from Mt. Sinai Hospital. Can you please clarify your statement about the NDC edit being turned off and something being turned on again?

Brian Reitz: Hi, this is Brian Reitz, from DTAS. We've been receiving feedback regarding the amount of editing against NDCs, and the difficulty providers have in getting claims in. What we're doing based on this feedback is deactivating the current edit for validation of the submitted NDC code against the FDA's code list.

The deactivation on Part B will occur sometime this week. For the Part A side, deactivation will be effective sometime in January.

We are going to replace the validation against the code source edit with a simple syntax validation of the submitted NDC, so basically the system will just check whether the code has the amount of digits that an entity is supposed to have.

Inna Bender: Is NDC considered a mandatory field or not?

Brian Reitz: It depends on who you're submitting to. From Medicare's perspective, we do not believe it is mandatory. We have only been able to identify a few policy situations that actually require an NDC be submitted on a Medicare claim.

Maybe Elizabeth can speak to this, but we think the Medicaids are big on asking for the NDC code. Since we're CMS—Medicare and Medicaid—we have a lot of dual eligibles, so providers may be giving us the NDC on the Medicare claim, expecting we will cross that over to Medicaid after we're done with it. So that may be why this is happening.

Inna Bender: Another quick question: For the nonspecified code, is there a minimal type of description you're looking for? A minimal number of bytes, or basically a lay type of description?

Brian Reitz: There is not a minimal size description we're looking for from you. We need you to give us as much of a description as you can in 80 bytes, because the limitation on what you can send to us in that particular field is 80 bytes.

So you may have to get a little creative if the procedure performed is a nontypical, very difficult one.

Inna Bender: OK. Thank you.

Operator: The next question comes from the line of Kathy Sites.

Kathy Sites: Hi, this is Kathy Sites from RealMed.

I'm interested in the NOC codes. We're getting a lot for anesthesia, and we're wondering if the actual surgical CPT code could be used in sort of a narrative in that description area.

Brian Reitz: That is likely a policy question, and I don't know that we have anyone in this room who can say what would be an acceptable description in order to get that claim adjudicated. If Claudette wants to step in. . . .

Claudette Sikora: I can look into it. Could you repeat the question? Are you asking if a particular CPT description will work for an NOC?

I believe it's going to really depend on the individual service. I thought what Brian was saying earlier was that we weren't looking for on the technical side, for an exact. . . . The CPT codes have unique descriptions, so if it's not an

otherwise classified code, it strikes me that what you're talking about is something that's really going to be different. If it winds up being the same as a CPT code, it doesn't seem like we'll be able to do it.

Kathy Sites: Well, there are several anesthesia codes that say "not otherwise classified," but they're not specific enough. Let's say they say abdominal surgery or something. Would you consider accepting the surgical CPT code as a description for the anesthesia codes that are NOC?

Claudette Sikora: Here's what I would recommend. You can e-mail me at xxxxxxxx@cms.hhs.gov and give me the examples of what you're thinking of doing, and I will refer the question to our policy folks. I don't believe their focus would be so much on the 5010 implementation. They would not be aware that this is what you're thinking of doing, and I would need to get a sense of whether it would fly or not.

So if you could send me the question with specific examples, I'll refer it on.

Brian Reitz: This is Brian Reitz again. Just to clarify, the NOC is not a new concept for 5010. It has been around a while. I would ask how you have you been billing your 4010 claims in order to get them adjudicated. Were these NOC anesthesia codes you are referring to adjudicated without any sort of description in 4010?

Kathy Sites: We have not been requested to provide the detailed description on this on the 4010.

Brian Reitz: Well, I can guarantee you we have not changed policy in processing, so it may be a case that, although the particular NOC code contains the keywords we're honing in on, there may actually be pricing on that specific code.

As an aside, I spoke to X12 yesterday or the day before, and there's a physician in the X12 meetings who has raised some concerns regarding anesthesia and how it is affected by this not otherwise classified situation.

So it's something overall that Medicare is going to have to monitor, as

every other payer is going to have to monitor this implementation and do a little tweaking as we go along.

If there are codes that don't belong on this list, they will be taken care of over time, but we have to implement what we think is the valid list of NOCs right now.

Kathy Sites: Thank you.

Brian Reitz: You're welcome. Thanks, Claudette.

Operator: The next question comes from the line of Karen Sedunov.

Karen Sedunov: Hello, this is Karen from Omnicare. My question concerns the patient's signature source code. You have an option of leaving it blank or placing the code "P" there.

First of all, I think in the 4010 that element was required, but now it's situational. It's required when an entity executes a patient's signature on the patient's behalf.

When you're looking at an assignment from a patient, there are numerous times when somebody else signs for the patient on the patient's behalf. If that is the case, would you then use that P code, or is that something entirely different?

Brian Reitz: This is Brian Reitz, and again I don't think we actually have anyone in the room who would be able to speak to that, I mean from a Medicare perspective.

Once again, I don't want to put Claudette on the spot, but I know she has been involved in these discussions quite a bit. There are situations where assignment is pretty much a foregone conclusion based on the provider status with Medicare.

So we would be expecting certain values. I mean, the P certainly would seem to apply in that particular case.

Claudette Sikora: This is Claudette Sikora. When we were drafting the 5010, the issue of what to do in a situation where the patient can't sign did come up.

Once again, I think I'm going to need an example. I will need to look at some of our notes and talk to some of our policy people, because there's a difference between accepting assignment, and services being paid on assignment, and whether or not a beneficiary has assigned benefits to the provider, and that sort of thing. We actually had our general counsel craft some wording on this for the guide. But I need to see your example.

Chris Stahlecker: Could you submit your example to our resource box, which Charlie mentioned earlier in the call? Then we'll get that question to Claudette.

Karen Sedunov: Sure.

Brian Reitz: And you should be seeing that e-mail address on your screen right now, on the bottom portion. It's 5010ffsinfo@cms.hhs.gov.

Chris Stahlecker: The earlier question we were going to seek Claudette's advice and support on, that should also be submitted to the resource box, if you would, please.

Karen Sedunov: Yes, because whenever we print the 1500 claim form, we were wondering if we then say "signature on file"? Or do we not print anything when we print the 1500? How we use this is a little confusing.

Chris Stahlecker: Go ahead and get those examples in the resource box e-mail you're going to send in. Thank you.

Karen Sedunov: OK. Thank you.

Operator: Your next question comes from the line of Chandler Kim.

Chandler Kim: Hello, my name is Chandler Kim from Healthcare Synergy. I joined the call a little late, so I'm not sure if you have answered my question. How will the 90-day grace period be implemented for the MACs? According to the MACs, they don't seem to have an answer to this. And when will we have a better understanding of what's going to happen?

Chris Stahlecker: Alright. Just to repeat, the effective date for the 5010 compliance remains January 1, 2012, and we have issued a listserv message saying that Medicare Fee-for-Service will be giving additional guidance to the MACs, but we haven't received approval to release that message yet. So we've asked folks to stay tuned, and we will be supplying that guidance and direction as soon as we possibly can.

Chandler Kim: There no timeframe as yet?

Chris Stahlecker: Well, the compliance date remains January 1, 2012. So we're operating with a sense of urgency to get our transition work completed as soon as we can. I would stay focused on that date, and the guidance the Medicare FFS MACs will receive should be forthcoming as soon as we have our message approved.

Chandler Kim: Sure. Thank you very much.

Operator: Your next question comes from the line of Katie Bruner.

Katie Bruner: Yes. I have a DME question. We are doing some test claims in different scenarios, and our DME claims came back with a rejection, looking for a rental code, a rental price, and the links/duration. These are not rentals, they're purchased. They're things such as back braces and that type of thing. How do we do that?

Brian Reitz: This is Brian Reitz. My suggestion would be for you to deal directly with the entity you're testing with. If that's the EDI NGS, then you should be speaking with them about your rejections. They are the subject matter experts with regard to DME processing, and they could address what was in your file and what may have inadvertently triggered this error. It sounds like you're saying it's an incorrect error. But I think you definitely need to work with them first.

Katie Bruner: OK. Thank you.

Operator: Your next question comes from the line of Joy Warner.

Joy Warner: My question concerns the P.O. Box issue. My issue is not with putting a physical address into the area, it is: Am I still going to get paid, based on credentialing? How is a match made? Are you looking at the NPI, and you don't care what that address is? Or how does that work?

Chris Stahlecker: This is Chris Stahlecker. The payment determination is not affected by the presence of the billing address on the claim. That determination is driven by internal processing logic. The change, where P.O. Box is no longer accepted, or the presence of a valid address, really does not affect how pricing and payment are determined, which remains as it currently is, within the adjudication system.

Joy Warner: So it won't matter that the address is different from the address we've been sending in the past?

Chris Stahlecker: I can't guarantee it won't matter. You are not billing the same address you've always billed? Is that what you're talking about?

Joy Warner: We were sending a remittance address in there because there was no loop for the Pay To. So we were putting in a remittance address, and now we'll have to put our physical address there, and we're concerned because it's the same NPI but a different address.

Chris Stahlecker: All those reference files are billed internally within the adjudication system to direct payment, so we don't use the data that comes in on the claim in terms of the street and address to send a payment. There's the rule that you cannot send in the Post Office Box, and we do have an edit that would prevent acceptance of a claim if there was a P.O. Box on the address line for the Billing Provider, according to the implementation guide. So we won't accept those claims, but when you put your valid address there—honestly, we are not using that to route payments.

Joy Warner: So it should not affect our ability to get paid, just we have to make sure there's a physical address.

Chris Stahlecker: Right.

Joy Warner: OK. And I have one other question. Your slide with the A/B MAC and CEDI Contacts [slide 14]—we're jurisdiction 8, but I don't see it listed.

Chris Stahlecker: You are still continuing to use a legacy contractor at this point, so that part has not yet been finalized. You'll continue to contact your legacy contractor, and that legacy contractor has a partnering arrangement with one of the other MACs to process your 5010 transactions. You can become 5010 capable, but you need to work through your legacy contractor to get the appropriate contact information.

Joy Warner: OK. Thank you.

Chris Stahlecker: I believe we have one more add-on to your earlier question.

Brian Reitz: This is Brian Reitz. We don't have anyone in an enrollment capacity here in the room, but from what I've been told, related to claims being processed, the information you submit on your claim, along with what we have in internal records, is what is used to match up the right internal processing provider number. Contractors follow a process, and I've been told none of the steps of that process involve denying your claim. If they can't figure out what the right NPI is to use to what legacy PTAN to process your claims, they will ask, they will develop.

So denial of your claims, from what I've been told, is not going to be happening. We will do everything we can as the contractors to do a match to find out which NPI we're supposed to be using to process your claim.

Joy Warner: So basically it's NPI driven.

Brian Reitz: Correct.

Joy Warner: As long we're still sending the same NPI, you should be able to match us up.

Brian Reitz: Nothing really changes internally for CMS because we use internal files, as Chris alluded to. We're not using the data on the claim. So it really doesn't change for you, you just have a requirement you have to meet because of

X12's change in the implementation guides to use a physical address instead of the remit address.

Joy Warner: OK.

Brian Reitz: Hopefully that helps. A lot of people have the same question.

Joy Warner: I think so. I think the main concern is that people are worried about the address being different, and what's on their enrollment forms doesn't match, and that sort of thing, so they would get denials.

Operator: Your next question comes from the line of Lyn Kohler.

Lyn Kohler: Lyn Kohler from PeaceHealth. I have a question about the 9-digit zip code for the Service Facility loop. If the services were rendered at home, and I don't have a 9-digit zip code, what do I do?

Brian Reitz: This is Brian Reitz. People need to understand that this is not a requirement that CMS is implementing just because we want to. This is an overall industry requirement that was set up by X12. We have to follow this requirement, and there is nothing else I can tell you to do, other than try to get that plus-4 to add to the 5-digit zip.

Lyn Kohler: I bill from Ketchikan, Alaska, and some places do not have a 4-digit. They just don't have it. They live on an island. Do we just put in a bogus number?

Brian Reitz: Well, you can't put a bogus number in. It has to be a valid plus-4. And from CMS, I can tell you we will not do a comparison of the 5-digit zip to the plus-4 to make sure they're supposed to go together. Wink, wink.

Many zip-plus-4s are being used. When Medicare receives a paper claim and processes it, we have to convert that into an electronic claim for crossover when we're done with it. When there is no plus-4 on the paper claim, we use a 9, 9, 9, 8 as the plus-4 to add to it, and that is acceptable to the trading partner.

Lyn Kohler: OK. Thank you.

Operator: Your next question comes from the line of Linda Gatto.

Linda Gatto: I'm going over to the payment side. On the 835, the claim status for Denied, the definition of that has changed to "Denied—patient is not in the payer's system" versus "Denied for other reasons." How will that come back? Those other reasons, how will they come back to us? Will it still be in the 835? Would it be under a different status? Would it still be a 4?

Sumita Sen: You are talking about the PLB segment in 835? (This is Sumita Sen, by the way.) It will come back as denied because we cannot identify the patient here, but the other ones haven't changed, and it will be still in those—that 1, 2, 19, 22, the way we have been using for 4010—that will continue.

Linda Gatto: OK. Thank you.

Operator: Your next question comes from the line of Cindy Alexander.

Tuanna: Hi, this is Tuanna from CompuNet Clinical Laboratories in Dayton. The question I have is in regards to the Washington Publishing Web site. I want to know what process legislation has in place, if a payer isn't using the correct category or claim status code, for us to know why our claims were rejected.

Chris Stahlecker: That would be an opportunity for you to file a complaint with our OESS office, if you have a payer that is not using the appropriate or valid codes as listed by Washington Publishing.

Angie Bartlett: This is Angie Bartlett. That information can be found on the question and answer slide, the very last slide (17), under "CMS HIPAA Enforcement Process.

Tuanna: OK. Thank you.

Operator: Your next question comes from the line of Denise Oviatt.

Denise Oviatt: Thank you for taking our call. This is Denise Oviatt with Relay Health. My question is for Elizabeth Reed, in regard to Oklahoma Medicaid. Oklahoma was not one of the states referenced, but we have not been able to obtain any

testing information regarding Oklahoma Medicaid. So we're somewhat questioning their ability to be ready for the January deadline.

Elizabeth Reed: If you could send your contact information to the 5010 FSS Info e-mail, I will work with you in coordinating a meeting with Oklahoma so you can get your answers.

Denise Oviatt: OK. Thank you very much.

Operator: Your next question comes from the line of Susan Owens.

Susan Owens: This is Susan Owens with Novant Health. My NDC question I believe has been previously answered. I'd like to know if there are any MACs there with the panel. We were trying to go live with—we're a J11, Palmetto GBA, and we're in some sort of queue. They are processing e-mail forms, I guess, in a fashion. I wondered if all the MACs were doing that. Will all the MACs have us confirmed and all before January 1, or could it flow over into the 90-day grace period? We really don't want to go into this 90-day extension. Do you have any information about how they're processing providers to go live?

Chris Stahlecker: It's Chris Stahlecker. The MACs may have many similarities and common software, but trading partner management is one area where each MAC still has a unique solution. And so many of the MACs have to get into their trading partner management systems and update them per submitter. I imagine at this point many of the MACs are experiencing a real bottleneck in turning around updates, although we haven't really been told they have a bottleneck.

We have been asked by some MACs for permission to do a blanket approval of their trading partners for 5010 processing, and we have not given them that approval just yet because we're trying to measure the transition of the industry Medicare FFS claims, especially submitters and claims, and other transactions, too. We're trying to measure the rate of progress towards transitioning to 5010, and we feel that if they blanketly flip all their trading partners to be 5010 capable, we will not have that information to understand the rate of change.

We're rapidly approaching deadlines, so we may be rethinking that. We'll take your point into consideration when we are making those decisions.

Susan Owens: That would be great, because we're a large hospital system, and we have several pieces that have to be coordinated over several days before we can go live. And I can confirm for you that J11 MAC definitely has a bottleneck. I waited almost two hours yesterday at two different times, a total of two hours, to try to get through to a rep. They are absolutely swamped, which again concerns us as a large provider in getting approved in time to coordinate our other pieces to make a live date. So anything from your end you could do to expedite or to consider other options would be great. Thank you.

Chris Stahlecker: OK. Thank you for your comments.

Operator: Your next question comes from the line of Patricia Morris-Cunningham.

Patricia Morris-Cunningham: Good morning. My question is: In the CL1 segment we have a problem with the data element being too long. We're an FQHC [federally qualified health center], so I wanted to find out who I can talk to regarding FQHCs?

Chris Stahlecker: Would that be an institutional claim?

Patricia Morris-Cunningham: Yes.

Chris Stahlecker: We're looking through documentation now to help answer your question, but it would be more helpful if you could send your question in to the resource box, and then we can do a better job of research for you.

Patricia Morris-Cunningham: OK. I'll do that.

Operator: Your next question comes from the line of Tracilynn Rodrigues.

Tracilynn Rodrigues: Hi. This is Tracilynn Rodrigues with Dr. Michael Catapono's office. I have been trying to do testing directly in-house, but I have a couple of questions. One, the Rendering Provider information it says must be different

from the Billing Provider. We're a small office; our Billing Provider *is* the Rendering Provider. Why is that an error?

Brian Reitz: This is Brian Reitz. Are you are a solo practitioner?

Tracilynn Rodrigues: Yes.

Brian Reitz: Then don't submit anything in the rendering.

Tracilynn Rodrigues: OK. And it says the Place of Service code at service line level is the same as the Place of Service code at claim level. What is that?

Brian Reitz: It's Brian Reitz again. In general, you are not to submit additional data unless it's different. There are two levels to a claim submission, the claim level and the line level. X12 is currently rethinking their stance on redundant data at the claim and the line, but at this point, a claim with the same Place of Service at the claim level and the line is noncompliant. You would find that not just Medicare, but many other payers would take that same approach. So simply don't submit the Place of Service at the line level.

Tracilynn Rodrigues: Alright. So when it asks for a Place of Service when we're billing, wouldn't we fill that in? I mean, I'm not understanding where the second one is coming from, I guess, because all I ever see is one spot.

Brian Reitz: Right. That's a question you would need to pose to your software vendor.

Most of what is done in your software program, how your claims are created, is behind the scenes within your software program. So although you're entering one number, your software may be creating both places and putting that same number. They may be creating this problem for you. You would want to start with them first.

Tracilynn Rodrigues: OK. Great. Thank you very much for taking my call.

Operator: Your next question comes from the line of Craig Seaman.

Craig Seaman: Hi. My name is Craig Seaman calling from WellCare. I have a question about the J-Codes with the NDC for drug rebates. I'd like to know if you guys are

rejecting the claim up front if there is a J-Code with no NDC, or if you are rejecting or denying the claim in your auto adjudication system?

Brian Reitz: This is Brian Reitz. Are you asking Medicare or Medicaid?

Craig Seaman: Medicare.

Brian Reitz: From my understanding, the Medicaid rebate situation on a paper claim is that the NDC is populated in the narrative field of the actual detail line. So there's no editing involved with that particular situation. If you're submitting the J-Code and then you're putting the NDC in the LIN segment referenced earlier in the presentation—that is the requirement that the submitted NDC must be valid against the FDA code set, and if not, this is now leading to rejection. We're not denying the electronic claim. We're rejecting the electronic claim, which will change this week on Part B and in January for Part A.

Craig Seaman: I understand that. But if you receive an electronic claim that has a J-Code and no NDC, because the law says if you have a drug rebate, you have to have an NDC, are you rejecting that claim at the front end, or are your denying the line in your auto adjudication system?

Brian Reitz: I think the answer is neither. We are not denying or rejecting, because from what I've been told—and like I said, we have no policy folks in the room to back up what I'm saying from a policy processing point of view—Medicare doesn't need the NDC to adjudicate the J-Code, assuming it's not a not-otherwise-classified J-Code. If you submit one of those, you're going to have to give us some description of the J-Code drug you have been providing.

I have been told Medicare does not need an NDC to adjudicate the claims. This rebate situation you're referring to is purely a Medicaid issue. After Medicare is done with the J-Code piece, they will use that information to get any rebates they are due from the manufacturers. That, I assume, is based on the NDC, the quantity, dosage, and so on, of the drug. So it's really not a Medicare issue or concern. It's just because there are many folks dealing with dual eligibles—Medicare, Medicaid. As a courtesy, we'll take that

information, we're now required to validate it, and then we pass it on. The rebate situation is between Medicaid and the manufacturers.

Elizabeth Reed: This is Elizabeth Reed. I deal with the Medicaid agencies. Their edits will be a little different for each one, specifically on how they manage missing or invalid NDC codes once the claim is received. I know the majority of them have edits in place stating that a code is missing or invalid. So you would have to contact your specific state agency.

Craig Seaman: OK. That was very helpful. Thank you very much for the information.

Operator: Your next question comes from the line of Amy Davis.

Amy Davis: Hi. This is Amy Davis. I'm a provider also, and I had another question about the P.O. Box. Several of us in this area have P.O. Boxes that have a street address associated with them as the first line. Is that acceptable, or does that too need to change?

Brian Reitz: No. The street address is perfectly acceptable. It has to be a physical non-P.O. Box/lockbox-type address.

Amy Davis: Great. Thank you very much.

Operator: Your next question comes from the line of Ursula Mercer.

Ursula Mercer: Hi. This is Ursula Mercer with Data Systems Management. We're a software vendor. I have a question about the POA indicator for 837I. I need to know how to report for one of our IPPS hospitals. Instead of the one that was formerly acceptable on the 4010A1, how do we report the blank that is specified in one of the transmittals I'm looking at? We've been trying to test, and we've been submitting just a blank, and it's coming back they're not wanting the information like that.

Matt Klischer: This is Matt Klischer. You're correct. You cannot submit a blank, and unfortunately, the wording is very specific. It has to be a *null*. In other words, if you're familiar with the string of data in a transaction for a segment, the examples use an asterisk to delimit between data elements. When you don't

have data to put in an element, it's like an asterisk followed by another asterisk. That's how you need to code it.

Ursula Mercer: So what you're saying is "no" between the asterisks?

Matt Klischer: No. When you have an asterisk followed by an asterisk that means you have no data at all for the element. That's called null.

Female: Right. If you type in an asterisk and then type an asterisk again, that's what it would appear like.

Ursula Mercer: I think that's how our programmers have been submitting it, and the entity we're testing with is sending it back saying they don't want it like that. Are you getting any reports like that from any other sources?

Matt Klischer: No.

Just make sure they're not putting an asterisk, a space, and an asterisk.

Ursula Mercer: So just an asterisk, asterisk.

Matt Klischer: Correct.

Ursula Mercer: OK. Thank you very much for the information. I do appreciate it.

Operator: Your next question comes from the line of Dan Voss.

Dan Voss: Hi. Dan Voss calling from TriTech Software. We're a software vendor. I was going to ask about MAC backlog, but it sounds like you don't have any information on that, but you are looking for information. I can tell you we know of submitters that use our software, which has already been certified with the trading partner in question. They've had requests to go to production out for over two weeks, and those still haven't been acted on. So there does seem to be a significant backlog with some of the MACs.

Chris Stahlecker: Thank you for that comment. This is Chris Stahlecker. Please send a comment to the resource box, and we could get a tabulation of how many folks on the call are sensing that problem out there. We'd appreciate that.

Dan Voss: OK. Will do.

Operator: Your next question comes from the line of Janet Meives.

Janet Meives: Yes. I need a little more clarification on the address. We have a corporate office that registered our NPI with their address, but the billing is done at a different location. We previously used the P.O. Box, but now if we use that address, I'm still concerned about how we're going to get paid.

Brian Reitz: This is Brian Reitz, and as I said, what you have credentialed yourself with internally is what Medicare will use. The only thing you need to do is to make sure what comes in on the electronic transaction as your billing address is an actual physical address.

Janet Meives: But the actual physical address we want our remits or whatever to come to, we still want those going to where we are located, not to the corporate address. Do you think that will happen?

Brian Reitz: Nothing you submit on your inbound claim changes anything we have in internal records. So whatever you have in your internal records today, if it's acceptable to you where payments are going, they will continue to go to the same place. We don't use the inbound data to make changes to our internal provider files. Medicare credentials you one time up front, and we've got you set in the system. This is purely an X12 electronic requirement—or hurdle, for the lack of a better term—that people have to get over right now. You can't put a P.O. Box in there. It needs to be a physical address.

Janet Meives: But if that internal address is the corporate address, then that's where things are going to go?

Brian Reitz: If that's where you wanted it to go and you set it up that way, it won't change. If you're not happy with where things are going right now, then you need to do some other credentialing with Medicare to get it straight. But is everything going well for you right now in 4010?

Janet Meives: Right. We have no problem right now.

Brian Reitz: You won't have any problems. Just don't put a P.O. Box in the billing address, and it will all be fine.

Janet Meives: OK. Thank you so much.

Chris Stahlecker: On the earlier call, the question just before this, when we said go ahead and send information to the resource box—if you could let us know which MAC you think may be a bottleneck, that would be helpful information to us, too. Thank you.

Operator: Your next question comes from the line of Joanne Moser.

Joanne Moser: Yes. I had a question about the CLIA licenses and the mammography licenses. We are effectively a payer; we're an IPA, so we send encounter data to Medicare. We don't receive payment from Medicare. But is it required for CLIA waive tests as well as CLIA non-waive tests?

Angie Bartlett: This is Angie Bartlett. Why don't you submit that question to the resource mailbox? We aren't prepared here right now to answer questions on encounter data, but I can get that over to the appropriate team.

Joanne Moser: OK. The mammography is the same. We still get paper claims. Can the facility put that FDA license in a certain box on the paper claim, and can they also put it on the CLIA license on the paper claim? And if so, which box?

Angie Bartlett: That's a policy question. We're going to have to refer that to our policy team as well.

Joanne Moser: OK. I will submit it through the e-mail then. Thank you.

Operator: Your next question comes from the line of Kristy Gomez.

Kristy Gomez: Hi. I bill for a Part B group practice, and I just had a question about the loop 2410 segment CTP pricing. After listening to other questions, I realize this probably won't affect how we get paid, but when it asks for NDC or unit price, do you break that down by how many units you bill for a drug?

Brian Reitz: This is Brian Reitz. As I said earlier, we don't have anyone in the room from a policy point of view. I'm not really sure the CTP is even going to come into play. As I said, for Medicare claims, we haven't come up with many, if any, situations where an NDC is utilized for Medicare Part B.

Kristy Gomez: Well, I did have one rejected by a Medicare payer through my clearinghouse, saying they needed a unit price, or the unit price was invalid, and I think I had just left it at zero. I realize it may not affect how my claim gets paid, but it does seem they do want some kind of information in there, and I would just like to be filling it out correctly.

Brian Reitz: This is Brian Reitz again. That may not be the case. If you submitted invalid data in there that you probably shouldn't have, you may have created this rejection inadvertently. The best thing I would suggest is to submit this to the resource box, and we can take a look at what you are actually producing in the 2410 loop. Sometimes if you start a loop, you have to complete it, and you may have gotten yourself in a situation you may not have needed to be in.

Chris Stahlecker: Just please be careful not to give us protected health information in the resource box examples that you're going to send in. Please don't do that.

But you can give us the example of the drug code and the kind of rejection you received.

Kristy Gomez: OK.

Brian Reitz: There are some situations where zero is not an acceptable value, so if you put a zero in there, that may be the reason why it's being rejected. You can't have zero quantity.

Kristy Gomez: Right. I understand that.

Brian Reitz: Take a look at your data, and go back and make sure of what you submitted. Generally, for Medicare Part B, as long as it meets the requirements in the implementation guides, we'll accept it and we'll pass it on, because that data would probably be useful to the second payer down the road after Medicare.

Kristy Gomez: Right. OK.

Operator: Your next question comes from the line of Helen Law.

Helen Law: This is Helen with Stanford Hospital. For the NDC reference files, I understand the fix is not going to be in until January 1, by turning off the edits. As a provider already submitting live 5010 files, we are seeing our claims rejected against a gate wall. We're under J-1 on their gateway. So everything is coming back rejected referencing that, so in the meantime, until January 1, how do we get those claims paid? If Part B is going effective February 9, why can't Part A be turned on as well?

Chris Stahlecker: It's Chris Stahlecker. We are working with our shared system maintainers to have an emergency correction made to eliminate the reference file lookup. We have had a lot of difficulty with the FDA file and getting matches on it. Structure that's available on the FDA site, as compared to what's required in a TR3, has presented some difficulties to us in getting exact matches.

Helen Law: So is it a possibility that it will be turned off before January 1?

Chris Stahlecker: We continue to work with our shared system maintainer to get the earliest, an ASAP date.

Matt Klischer: You may want to check with your local MAC. There was actually a staged fix put in on the December 5th batch. I just worked with someone in another jurisdiction, and we looked on the MAC's NDC codes, and those were there. So you may want to call your MAC. I think you said you were J-1.

Helen Law: Right. We have been, and they have been very helpful. They're keeping us up-to-date, but the last I heard, yesterday, was they did not have the CMS release they needed to put the fix in place. So they had asked for an emergency release from CMS, and they were expecting to have it in their jurisdiction by this week I think, so they can make it and put it in live on December 12th. I haven't heard anything different since yesterday, but you're saying that release was sent to the J1?

Matt Klischer: There's a release that the reference file for the NDC was corrected, and the MAC I was working with installed it on the December 5th release. So, again, call up your specific NDC codes to see if they can look them up on their internal reference file. That's what we did yesterday, and the hospital where I was working had a large number of their claims under two NDC codes which were on the list but weren't on it the week before.

Helen Law: Question regarding the standard coding (I think it was Brian who mentioned this): What we're seeing is these standard codes are being rejected, back on the gateway, with the current correct description. Except for the end of the description, it does say not otherwise classified. So are we to understand because those words are part of the standard coding and language, these claims are going to be rejected, and we will have to pull that description off each of those codes?

Brian Reitz: This is Brian and yes, the list of not-otherwise-classified codes was built from the standard procedure code list for any code that had in its descriptor words such as "unspecified," "unlisted," "not classified," "not otherwise classified." There's a whole list of them, and they were used to create the list of NOC codes. So if you submit a procedure code containing those words, it is likely to be on the NOC code list, which will require you to submit the description. It's not an automatic rejection if you submit the description.

Helen Law: But it is. Right? It's coming back as rejected against the gateway.

Brian Reitz: Because the description is not also submitted. There's a separate place in your electronic transaction where you are supposed to put the description of what it is that is being billed. It's a separate element. So the procedure code is one piece, the description is another. If you have one and not the other, your claim will be rejected. If you have both, your claim will go right through to adjudication.

Female Participant: Is a list of NOC codes that are affected published anywhere?

Brian Reitz: We have not officially published one, but we have heard that some of our contractors have compiled a list and put it on their Web sites. This is probably something CMS may need to get in front of.

Jason Jackson: This is Jason Jackson. CMS will be publishing our NOC list next week. It'll be up on our Web site, and the MACs will be directed to post a link on their sites going to that. It's the same list that's being used in our front-end systems.

Helen Law: Thank you.

Operator: Your next question comes from the line of Tonia Infantino.

Tonia Infantino: Thank you. My question is threefold. As we hear, a lot of people are not getting any response from the Medicare FIs. We did a 1-day production run last month, and we ended up with missing claims and no response from the payer. Because of all this, we're wondering if there's any consideration to accept 4010 after the January 1st deadline?

Chris Stahlecker: It's Chris Stahlecker again. As I said earlier, we have formulated some suggestions for an internal document that is going through an approval process at this time. So the direction we have is that January 1 is the compliance date, and we're all working aggressively. We thank everyone out there who has been working aggressively toward meeting that date, and would request a continued sense of urgency toward that date.

We don't have approval to release to the MACs any further guidance at this time. Once we have that approval, we'll be attempting to issue that guidance.

Tonia Infantino: Do you have an ETA on when that approval will be achieved?

Chris Stahlecker: I'm sorry. I don't. Meetings are happening this week, and conversations continue to happen, but I don't have a real ETA.

Tonia Infantino: OK. The last part of my question is about 835s. If we do not enroll to receive 835s, will we automatically start getting them on January 1 in the 5010 format?

Chris Stahlecker: I think that's part of the 90-day strategy. So we would want to not respond to that question until we get the approval for our strategy.

Tonia Infantino: OK. And I'm assuming the crossover claims will be included in that strategy for the Medicaid?

Chris Stahlecker: Yes.

Tonia Infantino: OK. That's all. Thank you.

Operator: Your next question comes from the line of Linda Piegols.

Linda Piegols: Hi. This is Linda from Michigan Pain. I have a question about compound drug billing in regard to 5010. Currently we bill with J-3490, and I was told by Medicaid that for 5010 we can bill it line-by-line, with the NDC number attached—bill each drug separately. Will that be the same for Medicare?

Elizabeth Reed: This is Elizabeth Reed and when you say Medicaid, there are 50-plus states out there, which tend to do things a bit differently. So which Medicaid agency are you?

Linda Piegols: It's Michigan. Also, I've been told by some other carriers that they want the compound drugs billed line-by-line. Because of how 5010 is set up, we can do that, and I just wondered how Medicare wanted that done. I guess there's a place to put a prescription number and things like that?

Brian Reitz: This is Brian Reitz again, and are we talking about Medicare Part B claims or some other type of claims?

Linda Piegols: Medicare Part B.

Brian Reitz: OK. As I said, we don't have a policy person in the room, so we can't talk specifically on how to bill certain procedures. But what I can say is for the most part, the 5010 transition didn't change billing that much. So I don't believe you should be doing anything different in 5010 than you're doing in your 4010 submissions.

Elizabeth Reed: This is Elizabeth again. I would encourage submitting that question to the mailbox so the policy people on the Medicare side can take a look at it to see whether there is any impact, because if the claim crosses over to Medicaid, there may be potential impacts from that.

Linda Piegols: OK. Thank you.

Operator: Your next question comes from the line of Ken Allaire.

Ken Allaire: Hi. Ken Allaire, Fresenius Medical Care. I'm just curious if you could explain how these edits are pushed out to the different Medicare MACs. The front-end edits are what I'm referring to. It's my understanding that all the Medicare MACs are using the same front-end edits, that NDC code edit being an example. But is that a central place that those edits are hit, or are they pushed out to each MAC? We submit to almost every MAC, so we want to understand how these changes are being pushed.

Mike Cabral: Hi. This is Mike Cabral. Each MAC will have an individual policy they have to go through to update their software book. The question you're asking is if there's a central set of software that comes from the CMS standard system maintainer to each of the MACs. They should be employing them on the same day, but there may be scheduling changes. I was working with two of them this week that have different timeframes for posting their approvals to change their production systems. But it should be within the same release period. In other words, this Friday the NDC codes should be pushed out to all the MACs for the end of day Friday, so your first cycle on Monday will relax that NDC edit on the Part B side.

Chris Stahlecker: Does that answer your question?

Ken Allaire: Yes, it did.

Charlie Eleftheriou: Holley, we're going to take one more question. Any questions left over can be answered through the 5010 fee-for-service mailbox.

Operator: Alright. Your final question comes from the line of Christine Pfeffer.

Male Participant: We just have a quick question. We submitted our questions for our organization yesterday afternoon to the Web address provided. We're just wondering if we'll get a direct response, or if everyone will get a response when these are posted somewhere?

Angie Bartlett: This is Angie Bartlett. Just to let you know, I will be responding back to e-mails individually to whoever asks the question, as well as creating FAQ lists of the pertinent questions to post to the Web site. If it is a provider-specific question, I will not include that on the FAQ list. If it's a general question, it will be included on the FAQ list.

Male Participant: Then will that be e-mailed out to the participants?

Angie Bartlett: Yes. But it's not instant. It may take some time.

Male: Right. Absolutely. Thank you.

Male: Well, this is the end of the call. Thank you, everyone, for joining us today. I'd like to thank our Medicare subject matter experts here at CMS who joined us as well. As always, be on the lookout for additional messages, especially upcoming messages announcing the next 5010 call, which will take place Wednesday, January 25.

Thank you all once again. Have a great day.

END