TRANSCRIPT
TOWN HALL TELECONFERENCE

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SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities- Question and Answer Session.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
December 17, 2013
1:00 p.m. ET

Operator: Good afternoon. My name is (Melissa) and I will be your conference operator today.

At this time, I would like to welcome everyone to the Section 111 NGHP Town Hall Teleconference.

All lines have been placed on mute to prevent any background noise. After the speakers' remark, there will be a question and answer session. If you would like to ask a question at this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Mr. John Albert, you may begin your conference.

John Albert: Thank you, operator, and for the record, today is Tuesday, December 17, 2013 and this is the Section 111 Non-Group Health Plan Town Hall Call.

As I do with every one of these calls, I do mention a disclaimer that on occasion we may say things that contradict within the official user guide and other material that would also, you know, appear in the transcript as well.

Again, if there is a conflict between what we say and what is in the transcript versus what is in the official information on the Section 111 Web site

including user guide. Again, the user guide always takes priority over anything we may or may not say.

Today with me, I have Mr. Jim Brady and Jeremy Farquhar who we've heard from before. As we do we'll provide a couple of presentations that will follow into a Q&A session. We ask that people provide their name and the organization they're with and because especially this call is a little bit shorter than the average, we would ask that you limit your question to one and one followup question so that others can get on the line.

I wanted to remind everyone to please continue to submit your policy and technical guidance question to the resource mailbox. These are used to develop the presentations for this call and to update the guidance on the Section 111 Web site.

If you have more general operational technical questions, please try your EDI rep first rather than use the resource mailbox. If for some reason, you can't get what you need from your EDI rep, there is an escalation process in the user guide.

We've noticed an increase in some rather routine question that your EDI representatives are more than qualified to handle.

I want to go and do some background prior to the call and then we'll jump into it. For those that are newer to this process I want to give a little history in that. In 1999, CMS awarded the Coordination of Benefits Contracts to consolidate activities related to the collection and management of other health insurance coverage information.

In October 2006, we established the MSP Recovery Contract or MSPRC to consolidate MSP debt collection activity. Previous to those contracts all these activities have been handled by each Medicare claims processing contractor on their own and if you've been around this longer than I have, at one time, there were over 80 claims processing contractors.

While the consolidation of the MSP data collection recovery activity has resulted in many benefits for the Medicare program, CMS realized that further benefits could be realized by further restructuring MSP contracting operation.

As you may have heard on the previous calls, CMS is restructuring coordination of benefits and Medicare secondary payer recovery activity. This action will provide improved customer service to stakeholders, consolidated and streamlined data collection of recovery operation as well as value-added efficiencies and enhance resource utilization on part of the government.

CMS has already transitioned all group heath plan recovery activity to a commercial repayment center or CRC effective May 13th 2013.

The purpose of today's call is to formally introduce you to the new recently awarded Benefit Coordination and Recovery Center or BCRC. The new Benefit Coordination Recovery Center will assume all operational activities of the COBC and will perform recovery case work for non-group health plan liability insurance, no-fault insurance and Workers' Compensation insurance.

Group Health Incorporated who was the prime contractor for the COB and the MSBRC is the prime contractor for the new BCRC contract. The BCRC is currently in a transition period and we expect transition to be completed sometime in early February. A specific go live date and additional information will be provided at later date through formal announcements via the Web site.

Now, I'd like to turn the call over to Jim Brady, the project director of the new Benefit Coordination and Recovery Center.

Jim Brady: Thank you, John. Good afternoon everybody. As John flanked it up, my name is Jim Brady and I am the Project Director for the Benefit Coordination and Recovery Center, the BCRC.

BCRC will be assuming the coordination and benefits activities for both group health plan and non-group health plan that is liability insurance including self

insurance, no-fault insurance and Workers' Compensation and recovery activities or non-group health plan.

As the current incumbent for both the MSPRC and the COBC, one of our primary objectives is to insure that the transition be as seamless as possible to our customer. For Section 111 reporters, the following will remain the same. Apparent reporting requirements and processes, Web sites and systems currently used by RREs to report and the EDI hotline numbers.

Changes that will occur include a new consolidated customer service phone number as well as new P.O. box mailing addresses and general correspondence.

Over the next few weeks, you'll be hearing more about the changes to come of our mailing addresses and toll-free numbers, however, please keep in mind that for a period of time mail and phone calls will be forwarded to provide uninterrupted service.

For the most current information of transition activities, there's the coordination of benefits and recovery section on cms.gov. And now I'll turn it over to Jeremy Farquhar who will give you some specific updates with respect to the town hall.

Jeremy Farquhar: OK. Thanks, Jim. First off, in case there might be any listeners who aren't already aware, since our last call an updated version of the NGHP user guide has been published.

New version is available for download from the CMS, NGHP mandatory insurer reporting page at go.cms.gov/mirnghp. That's go, there's no www, it's just http://go.cms.gov/mirnghp.

From that page click the NGPH user guide's link on the left hand side of the page. It's version 4.0 and it's dated 10/07/2013. The changes are primarily just the addition of the information published to be three out of four most recent alerts which should cover the transition from ICD-9 to ICD-10, ICD-10 testing and standard excluded codes for ICD-9 and ICD-10.

The September 30th alert regarding newly excluded ICD codes specific to no-fault reporting didn't make it into this version in the guide but should be included in the next revision.

Based on numerous e-mails received via the CMS resource mailbox it would appear that there may still be some confusion regarding the aforementioned alert topics. And so I'd like to take a few minutes to try and provide a bit of clarity.

For starters, I'd like to reiterate the timeline for the transition to ICD-10. As of 10/01/2013 we've been accepting ICD-10 codes on test files. Although not technically required, we highly recommend that all RREs perform ICD-10 testing to ensure that they're prepared once the transition occurs.

All RREs reporting the file submission may presently submit ICD-10 codes via test files. Test files may be submitted at the same time as your standard production files and we'll process simultaneously so it shouldn't disrupt your regular schedule in anyway.

ICD-10 codes will be accepted on production files beginning 10/01/2014, that's production files, 10/01/2014.

Any ICD-10 codes submitted on production files prior to 10/01/2014 will be rejected.

Now it's important to remember that the distinction as to whether a claim will require ICD-9 versus ICD-10 is based on the date of incidents. For dates of incident between 10/01/2014 and 03/31/2015 we will accept either ICD-9 or ICD-10 codes. However, if a claim is submitted with ICD-9 codes and the data of incident between 10/01/2014 and 03/31/2015 it will receive an 02 compliance log.

This compliance log is simply a remainder to RREs that ICD-10 codes will soon be required. For any date of incident 04/01/2015 or later, only ICD-10 codes will be accepted.

If ICD-9 codes are submitted for dates of incident after 04/01/2015, they will be rejected.

ICD-10 codes may contain from 3 to 7 digits as opposed to ICD-9 codes which contains 3 to 5 digits. That being the case, some minor changes to the claim input file layout are necessary. However, this is taken into consideration originally when the claim input file layout was designed. You may have noticed that in the old file layout, there have been separate fields consisting of just two filler spaces following the alleged cost of injury field and each ICD-9 fields.

In order to accommodate the use of ICD-10 codes, those two white filler fields should all have been combined with their preceding fields. So each ICD field is now seven bytes rather than five.

A combination of these fields has necessitated updated to the field numbers within the layout and this seems to have caused a bit of confusion. Rest assured that although the field numbers have changed within the layout, the data elements have not actually been moved.

Aside from the expansion of the alleged cost of injury in ICD fields, there's only one other layout change. And that change is the addition of the new ICD indicator fields.

The ICD indicator is a one by field located at displacement 168. This also used to be a pillar field and in the old layout it was field 18. With the aforementioned renumbering of fields, the ICD indicator is now field 17.

There's a little bit of confusion surrounding those, the differences in field numbers. Eighteen is where it would have been on the old layout but the new renumbered fields it is field 17, same place in the actual file.

The purpose of this field is simply to indicate whether the ICD codes within the claim are ICD-9 or ICD-10. Value of space or nine indicates ICD-9 and a value of zero indicates ICD-10. There's also a new error code which relates to these ICD indicator fields. The new error is CI31 and it will be generated if a value other than space 9 or 0 is populated within the ICD indicator fields.

It's important to understand that while within a single file, you may have some records containing ICD-9 and some containing ICD-10. You may not mix ICD-9 and ICD-10 records within a single claim.

If you mix ICD-9 and 10 codes within a single claim record the codes which do not match the type linked to the ICD indicator provided will reject with errors. And there's one last thing which I'd like to make clear regarding ICD-10.

We received questions for numerous RREs looking for information regarding new ICD-10 related error codes. In actuality with the exception of the aforementioned CI31 error, there are no new ICD-10 related error codes. If an invalid ICD-10 code is submitted on a file, the error generated will be the same error that would have been generated for an invalid ICD-9 code in that position.

Range of errors for CI05 through CI23 will be utilized for ICD-10 just the same as they presently are for ICD-9.

By the way, before moving on to the more specific mailbox questions, I'd like to touch upon the 09/30/2013 alert regarding newly excluded ICD codes for no-fault reporting.

This is another topic which seems to have generated a fair amount of questions coming through from RREs. This alert contains a new list of ICD codes both 9 and 10 which will be considered excluded codes effective January 6, 2014.

These exclusions are a bit different as they pertain only to no-fault clients. Examples of the type of codes being excluded include diagnoses such as hypothyroidism and diabetes. There are nontrauma based codes which should never be related to a no-fault claim.

The inappropriate inclusion of these types of codes will often result in claim denials for beneficiaries. It's important that be avoided whenever possible.

The alert contains a table which lists the excluded ICD-9 codes along with their equivalent ICD-10 codes. One thing which seems to have caused a bit of confusion is the fact that there are two different sets of dates referenced.

On the first page of the alert it indicates that these ICD-9 codes will be excluded as was previously beginning 01/06/2014. That date is specific to the ICD-9 codes. The alert then goes on to address the equivalent ICD-10 exclusions. On page 2 it indicates that these codes will be excluded in test as of 01/06/2014 and in production as of 10/01/2014.

That's simply because ICD-10 codes are presently only accepted on test files and will not be accepted on production files until end of 2014.

The reality is that you simply won't be able to successfully report any of these codes whether ICD-9 or 10 at any point after 01/06/2014.

Now moving on to some more specific questions received via the resource mailbox. First off we received the question from an RRE asking whether CMS will be publishing an updated version of ICD-9 codes which would become effective January 1st, 2014.

The RRE was uncertain whether to expect to one file updated version of ICD-9 codes or if version 30 would be the last in the implementation of ICD-10. As we receive that question, ICD-9 version 31 has been published and is presently available for download via the CMS Web site.

The current version of the user guide contains the URL from which you may download the new version 31 located in Chapter 4 on page 6-14.

The same individual also had a second question regarding ICD-9 code 9599. As you may be aware, ICD-9 codes 9598 and 9599 are no longer accepted for any coverage type as of 10/01/2013.

These are extraordinarily vague codes which provide no information about a specific injury. It will almost always result inappropriate claims files.

Question was regarding accidents involving a fatality. The RRE referenced situations where the beneficiary may have perished at the scene of the accident or on the way to the hospital.

The RRE (inaudible) accident was often simply reported to them with a cause of death indicating multiple injuries due to auto accident. And they wanted to know what code they should use now that 9599 was no longer accepted.

Unfortunately, RREs will need to investigate further to determine the specific injury sustained which led to the beneficiary's death. Those are the codes which we expect to be reported under such circumstances.

Next, we received a question from another RRE regarding claims which they indicated that they are reporting to the COBC since they have confirmed Medicare, HICNs for those beneficiaries.

You go onto indicate that approximately 1 in 10 individuals on whom they are reporting are experiencing troubles with denied claims. However, they also indicate that they are writing letters to the MSBRC to deny any responsibility for medical payments coverage because there's a pending third party lawsuit. That there is the crux of the problem.

An RRE should not be reporting a claim prior to the point in time the responsibility for medical is assumed. When posting an ORM record an RRE is indicating that they have responsibility for medical payments associated with injuries or illnesses sustained as a result of the reported incident.

The beneficiary seeks treatment for an injury or illness which appears to be linked to their reported ICD-9 codes then Medicare is going to appropriately deny primary payment.

That record reported to the COBC indicates that the primary payment is the responsibility of the NGHP insurer. If there is pending litigation and the RRE is yet to assume responsibility for medicals then they should not report the claim into the lawsuit itself.

Another RRE wrote into the drop box with a question regarding appropriate ORM termination date reporting. They indicated that they may often have a med pay provision indicating that they will pay the necessary medical expenses that are incurred or medically ascertains within three years of the date of action.

The question was whether it would be acceptable to report that future ORM termination date prior to the point in time the benefits had bene exhausted. In this situation, the answer is no, although, it may turn out that the ORM will terminate as of that date three years into the future. We cannot accept the termination date that far in advance and the claim will be rejected.

Technically, our process can only accept termination dates up to six months into the future. However, as the circumstances regarding the case may always change it is preferable that you're referring from reporting an ORM termination date until that ORM termination actually occurs.

As some of you may recall, if you're listening in our last town hall call, we previously indicated that there is a current issue where occasionally in situations where beneficiary has been deceased for greater than 27 months, the COBC may not have received an update with the beneficiary's appropriate entitlement information.

In almost all cases the beneficiaries for whom entitlement information is missing have been deceased for at least a decade if not longer.

An RRE who had been made aware of this issue via their EDI reference sent in some questions which I'd like to address. First off, they had asked whether the issue have been resolved yet and the answer to that question is no, not yet, but it should be very shortly. The fix is currently slated for a January release, that's January 2014, so next month.

They went on to ask that if you haven't been fixed, should they follow up with their EDI rep in all situations where they receive a beneficiary not found disposition on response file or via an online beneficiary lookup.

And the answer to that question is no, we would not expect that they follow in every situation where the beneficiary is not found.

However, if an RRE is attempting to submit a claim for a deceased individual and they have reason to believe that the individual has been entitled to Medicare, yet they received a response indicating that the beneficiary was not found, then they may wish to reach out to their ER to request that they investigate.

We are able to determine that the individual was in fact entitled to Medicare then we can perform a manual update in our system in order to add their entitlement information.

After we've done so the RRE will be able to successfully post the claim via the section 111 process. That said, our query process is a means by which most RREs are aligned on determining Medicare entitlement status.

If an RRE queries an individual and they're certain that the personally identifying characteristics are accurate, yet, they received a response indicating that the beneficiary is not found and we can't reasonably expect it didn't make a determination to the contrary and somehow manage to report.

We couldn't really hold an RRE responsible for not reporting on an individual in such a situation if our process has essentially indicated that the report is not necessary, regardless this issue should very shortly be a thing of the past.

Another RRE had contacted us with the question related to the Workers' Compensation exclusion. That exclusion indicates that if all of the following circumstances have been met for a particular Workers' Comp claim then the RRE would be exempt from reporting that claim.

Those situations are that the claim is for medicals only, the associated lost time is no more than the number of days permitted by the applicable Workers' Compensation law for medicals only or seven calendar days if applicable law has no such limit.

All payments have been made directly to the medical provider and total payment for medical does not exceed $750. So the RRE in question had indicated that they occasionally encounter situations where all these circumstances have been met but eventually at some point down the line, the beneficiaries claims end up exceeding $750 threshold making it reportable payment at that point in time.

Since the claim initially qualified for the exclusion, it wasn't immediately and by the time the medical expenses exceeded $750 when they had additional treatment further down the line it's past the point in time where new claims submission would be considered timely based on the database.

It had indicated that they had received compliance flags in such a situation and they didn't feel that they were appropriate. In this case the RRE should be safe to ignore that compliance flag, unfortunately, there isn't currently a way to indicate that this claim wasn't initially reported to the aforementioned Workers' Comp exclusion.

Our system will simply read the date of incident and compare it with the receipt data of the file and then tag it with a late submission compliance flag. The RRE should simply retain documentation regarding the situation and they should have nothing to worry about.

Please remember that compliance flag is simply a warning and not a concrete indication that a penalty will be assessed.

And one last question was submitted by an RRE who had indicated that the beneficiary was being denied care due to the fact that an open OR claim links to their organization was likely on their records.

They subsequently determined that ORM should have actually terminated and they were questioning about what they could do to immediately terminate that ORM rather than waiting for their next file submission period.

Now there are two important things to note here. First, in a situation where it's imperative that an ORM record be terminated as expediently as possible,

an RRE may always contact the COBC call center at 800-999-1118 to request the manual update.

The call center representative will look at their organization and after doing so successfully will take and apply that ORM (inaudible) over the phone.

It's also worth noting that quarterly reporting restrictions have long since been removed for claim and for file submissions. The primary reason those quarterly restrictions were removed was so that RREs could report ORM terminations in a more timely fashion should the need arise. Therefore, it isn't necessary to wait for the next quarterly submission timeframe then to update electronically.

Once the RRE's prior file submission has completed processing, they may submit a subsequent file, off schedule file, in order to post update to this nature.

And with that all, I'll turn it back over to you, John.

John Albert: All right. Thanks Jeremy and Jim. Operator, I think we're ready now to go into Q&A with folks on the phone.

Operator: At this time I would like to remind everyone in order to ask a question press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Your first question comes from the line of Lisa Maynard from Harmlin Burton. Your line is open.

Lisa Maynard: Good afternoon. We have two questions regarding loss of consortium claims reporting those for Section 111 requirement.

Assume the person signing the release is a family member of the injured party and this signing family member is either a representative of the state of the injured party or has the power of attorney for the injured party and there are no individual lawsuit consortium claimed or alleged, however, the release releases any and all claims.

Must we report the signer of the release as a lawsuit consortium claim if he or she signs his or her name but only signs with a designation of or in the capacity as the personal representative of the state? That's the first part of the first question.

Male: Hold on just a second. You know, we're going to have to go back and discuss this internally because this is something we'll provide an answer to later date just because we're just – I'm not sure at this order right now.

Lisa Maynard: OK. Yes, so …

Male: Did you send a specific question to the resource mailbox?

Lisa Maynard: We haven't sent it yet.

Male: (inaudible) mentioned in the subject line, you know, like (inaudible) non-GHP town hall call or something like that.

Lisa Maynard: Yes. The second part of that question was we wanted to know that must we report the signer of the release as a loss of consortium claim that if he or she just – if he or she just signs his or her name without a designation or in the capacity as a personal representative. So that was the second part of that question.

But I wonder if you could address this second question regarding loss of consortium claims, assume a family member is not entitled by law to a loss of consortium claim in this particular venue or state, however, the family members signing the release releases any and all claims. When any and all claims language exist in the release, CMS has directed us to report the signing family member as a loss of consortium claimant.

Would we have to report the signer as a loss of consortium claimant even when we know that a loss of consortium claim is prohibited by the law in that particular venue or state?

Male: Yes. They have to be reported.

Lisa Maynard: OK. So, we would record loss of consortium claims even if the venue said they weren't entitled to it.

Male: Yes.

Lisa Maynard: OK. OK. So we'll send in the first question to the Web site, to the e-mail address. I appreciate it. Sure.

Female: Operator?

Operator: Your next question comes from the line of Keith Bateman from the PCI. Your line is open.

Keith Bateman: Well just to – I just wondered whether at some point you could post together something like a flow chart that shows the old process and the new process so people can see that in a visual form?

Male: When you say the old process and the new process, what are you referring to?

Keith Bateman: I mean when you had a separate MSBRC?

Male: Yes. The process from a perspective of everyone working outside of here (inaudible).

Keith Bateman: Yes. Yes. Outside or in there. From the outside.

Male: You should see no change. There is no change to the process.

Keith Bateman: OK.

Male: So.

Male: Right, I mean, you know, aside from some of the stuff we mentioned before, the one phone number instead of two is largely just a consolidation we already know and hopefully love.

Keith Bateman: OK. But, you know, you have some hats on the stuff where people don't know that they can get a manual change, you know, ORM termination, you

know, ORM termination. Things like that. Some way to visually handle this to reduce the confusion, just give some thought to it.

Male: OK. Yes. I mean, you know, as part of this transition, I mean we're looking at all of the outreach and, you know, cycle activity that we're doing and part of this process is to consolidate a lot of the information at single point sources and you know, and use lots of different media for conveying that information. So, sure. OK. Hey, operator.

Operator: Your next question is from the line of Katelyn Miner from Faegre Baker Daniels. Your line is open.

Katelyn Miner: Thank you. Hello. Thanks for taking my call. We're monitoring Section 111 issues for a number of RREs and are looking for guidance regarding short-term travel policies. We're aware that the user guide classifies such policy doesn't go full insurance. However, we have some unique hypotheticals that we believe do not fit squarely with the user guide's definition and may not trigger a reporting obligation.

So, for example, suppose the company offers a travel insurance policy that provides accidental death and dismemberment coverage only. Payments are mainly scheduled either for loss of a body part or death. The policy does not provide medical expense coverage and the schedule of payments is computed without regard for medical expenses and/or whether medical expenses are actually incurred.

The product provides the claimant with no right to claim medicals and the company does not seek a release for medical. In this situation the company under an obligation reports the lump sum indemnity only payments. I know a similar hypothetical was presented on a teleconference in the fall of 2012. And you had indicated that you would take it under consideration and possibly issue an alert on that reporting treatment of lump sum indemnity only payoff. I mean I haven't seen any subsequent guidance so I thought I'd bring it up on this call.

Male: Yes. I mean I know this has come up in the past. I know there's someone who's not with us right now who is working on that issue so I don't really have

an update to give you unfortunately but we are aware of that issue and are looking to address it.

Katelyn Miner: Do you foresee that that – it was nothing. Do you foresee that that will come up as an alert or?

Male: Yes, definitely.

Katelyn Miner: OK.

Male: Definitely will come out as an alert just because it is a topic of interest to – you know a very specific topic of interest to many.

Katelyn Miner: Right, right. I have a quick followup. There was also a question raised on that same teleconference about the definition of no-fault and I believe an example was presented where the injury sustained did not occur on the premises of the insured property and it wasn't during the user occupancy of an automobile that should be the regularity definition of no-fault.

So in a travel insurance policy, there's suppose a mountain climbing accident that occurs during a trip and the injury obviously doesn't occur in the premises of the insured or during, you know, in an automobile, do you have any further guidance on how to handle that since it doesn't fit squarely with the statutory, the regulatory definition would not be still considered no-fault for Section 111 reporting purposes.

Male: People here are kind of not sure.

Katelyn Miner: OK.

Male: I apologize for not being able to give you more specific answers but this is again, I mean if you – have you sent those into the resource mailbox because we're looking for a very detailed write up, that way we will make it sure we understand one another.

Katelyn Miner: OK. I can – yes, we can definitely do that.

Male: I don't want to shoot from the hip and then, you know, end up giving conflicting information.

Katelyn Miner: I understand. Thank you. I will submit a question to the resource mailbox.

Male: OK. As Jeremy said we look at every single one of those.

Operator: Your next question is from the line of Suzanne Jorgan from (inaudible). Your line is open.

Suzanne Jorgan: Hi. This is Suzanne from Broadstire. We have a couple of questions and it just kind of relates to the re-certification process in one case. In the other case, some of the data that we're being asked to kind of review and look at. And these have to do with – primarily with looking at information that seems to be old.

So, for example, in the re-certification process and we manage a lot of RREs, we're having a lot of instances where when they're going through the recert process rather than looking at the most recent profile reported, let's say, from the prior year, they're going back to the original profile report sending the recert request to the wrong context.

So, could be the wrong authorized reps, the wrong account manager and some cases, you know, goes to the old person and both cases, and then when you try to correct it you run into a catch-22 because they are not showing that you're the most recent account managed profile report. Is there something that we should be doing differently?

I'm not sure why we keep running into this but we've got a lot of recerts and they're starting now because the beginning of the year come in and we've already run into this, you know, three times in the last week. So, we're trying to figure out what to do to avoid, you know, going in circles trying to get these recertified.

Jeremy Farquhar: Hi Suzanne, it's Jeremy. Yes, we knew that we had an issue with that early on this year, you know, when we first started to roll things out and that's why there was a bit of a hiatus in the recert process, but we restarted the recert

process back beginning in September it was our understanding that that was resolved and every example I had seen, you know, it was generating the work fresh when the recert e-mail went out it was taking just what we had on file in our system at the present.

So, if you have examples to the contrary, could you please send them to me directly and I'll take a look at it. And if there is a problem we'll certainly work to get that resolved ASAP. I wasn't aware that that was currently an issue.

Suzanne Jorgan: Yes, it actually just started again this quarter for some reason and I thought it was resolved too, but we didn't know if something else might perhaps be going on. So, yes, I'll send those to you directly.

Jeremy Farquhar: OK.

Suzanne Jorgan: And then that leads me to my second question, we're getting request to review like (TPAC) data for instance, but what we're finding when we're going through and reviewing it is the (TPAC) data that is it – we're being asked to look at it is (TPAC) data that was submitted unclaimed maybe two years or more ago that have since been updated with, you know, new (TPAC) information. When we see that, do we still need to go through the process of looking at that old data? Or do we simply respond back and say, you know, all these claims have since been updated, you know. How should we handle that because we feel like...

Jeremy Farquhar: I suppose the latter, you know, just let us know. If you see something like that say, "Hey, you know, we've updated this already, you know, we know these were actually (TPAC) values and we've corrected them." I'm assuming you're talking about low (TPAC) value investigation.

Suzanne Jorgan: Yes, yes.

Jeremy Farquhar: We're focusing now hopefully moving forward on more recent data, so I hope you don't see too much of that and, you know, moving forward, I do know that we add, you know, some of the stuff. You know, we had a pretty broad query that we pulled our data from and so some of that data was old. So, I apologize if, you know, you had already corrected some of the information

that got pulled at query, but that's perfectly accessible if you know that you've corrected these.

You look at a few of the examples and you say, "Yes, these are all things that we basically knew. This was an issue we made corrections." That's basically what we're looking for. We want to just make sure that people understand the, you know, what constitutes an appropriate (TPAC) report and that we're not getting information that isn't really a (TPAC) information, you know, because when we see these very low values we tend to look at stuff that's under $500.

It's very uncommon for us to see actual (TPAC) amount, settlement amounts and such under $500 and, you know, even under $100, you know, that something looks fishy to us and that – and usually it is a misunderstanding of the – what constitutes the (TPAC) usually but yes, all you need to do is just respond and say, you know, we've corrected this, we are aware, and it's not a problem, and that's OK. Yes, yes.

Thank you for following up with us and I apologize for any inconvenience if there is some older data.

Suzanne Jorgan: OK, great. All right, thank you.

Operator: Your next question is from Marci O'Brien from the Texas Association, your line is open.

Marci O'Brien: Our question is, are you all going to deny or reject claims that have both ICD-9 and ICD-10 on the same claim during the period where you're allowing both of those ICD codes?

Jeremy Farquhar: Yes, it's a technical functional type of reason, you know, that they would have to be rejected, it's – during that timeframe which was referenced in my preamble from 10/01/2014 to 03/31/2015, we will accept both ICD-9 and ICD-10 codes for dates of incident that followed in that timeframe. But whenever you report a claim, you have to choose whether you're sending ICD-9 or ICD-10 codes on that claim and there's that ICD code, ICD indicator code which I had referenced previously as well.

And so that ICD indicator that you have to fill out, you have to tell us, "OK. These are ICD-9 codes on this claim or these are ICD-10 codes on this claim." And what will happen is if you say, "Oh, ICD-9 by populating that field with a space or a nine and then you have both nine and 10." The system is going to see those ICD-10 codes but it's going to be looking to be validating ICD-9 codes not ICD-10 codes because your indicators says ICD-9 and it's going to kick those ICD-10 codes out with ICD errors because it doesn't recognize it as a valid ICD-9 code.

So you can – during that timeframe, you can do either ICD-9 or ICD-10 but you got to choose one or the other for any particular claim. Within that particular file submission, you can have records. One record has all ICD-9, the next has all ICD-10 but within one record it has to be either or.

Marci O'Brien: OK. That answers our question. Thank you.

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad. Your next question is from Marcia Nigro from Sedgewick. Your line is open.

Marcia Nigro: Hi. Good afternoon. I really have two questions or comments and I know awhile back we – it was discussed whether CMS would allow ORM termination after a certain amount of time passed on lifetime stage where we have ORM that can go on forever and we have a 20 year old who wants to query them for the next 45 years. Is that then considered? Is that still on the table to be considered because it really is a burden on the system?

And number two, my other comment or question is on med pay claims. Is there any way we can extend that six months to even a year or even three years where most of your contractual med pay provisions, you know, they end at a certain – a specific time and you may have a, I know, we have lots of claims where we pay med pay and they have the ability to continue or to make the claim up until a year. But the medical bills are so – they're not being treated. But we have to lead it over. Any way we can extend that for a year or even up to three years?

Male: I think the answer to your first question regarding like the lifetime medicals that it's still under internal discussion here, unfortunately. I have to admit that I don't understand what the question was.

Marcia Nigro: OK. Well, let me explain again because I probably didn't explain it very well. Our med pay claims, they're contractual oftentimes in an insurance policy, someone falls in the premises, they have – no-fault claim of sorts, there's someone to recover their medical bills up until – for a year. It ends up a year, but it may have a $5,000 limit. We report it and we close the claim because they went to the emergency room, it's $300.

They still have the right to come back if they have additional medicals. But after a year, there's no, you know, they – the claim itself ends. Terminated. But because we have a closed claim, we have to monitor until that ORM terminates in a year because that's when the contractual obligation ends. Where we closed our claim, you know, eight, nine months ago and we're still monitoring the claim because we can't put ORM termination in past six months.

So what's happening is in the industry itself and maybe this is a question we need to write something in more detail. We have a med pay policy on commercial general liability process. Yes, we have a provision and it allows for the medical payments that it does terminate after a set period of time, to six months. ORM requirement, you can't do any time beyond the six months. It requires the industry to have the monitor claims that normally we shouldn't be, you know, we should be able to say, "OK. ORM will terminate a year from today when the incident occurred."

John Albert: You're saying because a claim could still come in after that termination period?

Marcia Nigro: No. If they had any medical bills on or after that year, it's not covered under the med pay portion of a policy. And there'd no coverage for it. And it really is a little bit of a burden for the industry to have to monitor these med pay claims on commercial general liability policies.

And sometimes in fact the previous caller, I think they had a three-year term for theirs. But, you know, three years is probably the max but certainly, you know, you can – CMS, we consider that six month provision because it really has to pay burden on the industry.

John Albert: Can you hold on just for a second?

Marcia Nigro: Right …

John Albert: So you're talking about basically just the extent, you know, the six-month limit on the ability to put a future ORM term date? Is that what you were asking?

Marcia Nigro: Correct. So when we closed the files, I don't have to go back and monitor closed files, you know, when they're – that year is up where they no longer have ORM available to them. So that I – yes, the ORM termination needs to be expanded.

John Albert: Yes. There are maybe – are there limitations on common work followup. Yes. Unfortunately, we have other CMS systems that have those limitations in them so they – those records would not post anyway when they're around. Jim or Jeremy, if you've…

Marcia Nigro: Well …

John Albert: You have that. Actually that's great.

Male: Yes.

Male: These are …

Marcia Nigro: And there's no IT to work around on that or possibility? Maybe Jeremy or I can't certainly send in a good example and you could see …

Male: Well, I believe …

Marcia Nigro: … what is there …

Male: We've got the examples. We understand what the scenario. It's just that, you know, CWF is the external national database where all the information is stored and it's not our own process here at the COBC future, BCRC.

I mean don't get me wrong. It's like I don't necessarily have a problem with that and we can certainly look into it. You know, it's a lot easier to build a record once and then not worry about it. You know, we've built all of this systems based on CMS apparel systems that have like you said, we do, you know, some things behind the scenes with the data before that actually goes to the official like, you know, CMS data center systems of record. So we definitely can take a look at that so.

Marcia Nigro: Yes. I appreciate that because the efficiency for all these are either IDRREs to have to monitor it versus just, you know, one system would be a tremendous help for us quite frankly. So I appreciate that.

Male: One thing to keep in mind though and this is one reason why it may not be, you know, why change like this might not occur is that, you know, just because you have that statutory period where coverage may terminate, you know, you – benefits can be exhausted prior to the point in time that you reached that ORM termination date that you've …

Marcia Nigro: Correct.

Male: … perspective.

Marcia Nigro: That happens (inaudible) …

Male: (inaudible).

Marcia Nigro: If that happens when my file is open and I put my exhaust date in. So that really happens on a closed file. But my big problem …

Male: Well that – I mean you're telling us that though from what I understand that you're determining that this file is going to close in a year so you want to give us an ORM termination date that's a year out. How can you close, you know, from the onset, you basically sounds like you want to close this claim but …

Marcia Nigro: No.

Male: … How is it that you monitor to determine whether benefits are exhausted …

(Marsha): Just like way …

Male: … can you monitoring and if the benefits exhaust then you can send the ORM termination and the exhaust.

Marcia Nigro: It's not that simple. It's not quite that simple. What happens is you have – your house. So you stuff someone's file in your print yard. They go to the hospital they have an emergency room visit. It costs $300. You have a $500 med play linen on your homeowner's policy and we need to get that home because that's something everybody can identify with.

Same with commercial policies. That person may never treat – they may never treat again. But legally, they have the ability to treat again and go back and get more treatment. It may be over. They may have no other treatment. But legally, we have to keep that opportunity for them open for a year because that's when the med pay provision ends.

For us to look closer, fop, because everything is resolved, they went the hospital, they're fine. But still, if they ever came back, I would have to reopen my file which would reopen ORM by the way if that happen and I would continue payments. What you're doing now by allowing – only allowing us that six months is it's causing to close those type of files because that's what we'll do, we will keep it open for a year, a year and a half, three years, whatever the case may be. We'll close the file but then we have to go back and monitor closed files. It's not efficient for the industry.

So is there anything you can do on your end? And I'll be glad to, you know, discuss it further without some other folks if we need more explanation. But that's just, you know, the reality is because of one IT system, the rest of us out here kind of, you know, having to go back and look at old files over and over and over again.

So that's it. I'm done. I'm sorry. But it's a little frustrating from our end. I'm sorry to say.

Female: Operator?

Operator: Your next question is from Senora Warren Hurtt from Global Indemnity Group. Your line is open.

Senora Warren Hurtt: Yes. Hi. This basically is not even a question. This is more of a followup of what the first caller just laughed. In our company here, when there was a med pay being paid. Once we paid it, when they exhausted the (inaudible) on that or they done treatment. We go ahead and close out the files. We go here and report it to ISO, what my weight used to be.

Did they happen to continue treatment based on all the equal standards and all we do is reopen it. Go ahead and make the payment of data ISO reports. We all need to go back in, over report, update it and close the day out. We do not monitor closed files. We will go back and reopen if we have to to make the additional payment but we don't monitor it. That is all I have to say.

Male: OK. Thank you.

Operator: There are no further questions at this time.

Male: OK. Well it's about almost 2:00 and I'd like to thank everyone for their participation in this call again as I've mentioned in the past. Please continue to send your questions for the resource mailbox, also your (EDI) rep can help you with many of the issues that have come up in the past as well. We'll – and please let's look out for additional information concerning the transition to the benefit coordination recovery contract coming in the next few weeks. Thank you everyone and have a good holiday.

Operator, if you could stay on the line on the pre-conference?

Operator: Again, ladies and gentlemen, this does conclude today's conference call, you may now disconnect.

END