

**TRANSCRIPT**  
**TOWN HALL TELECONFERENCE**

**SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP**  
**EXTENSION ACT OF 2007**  
**42 U.S.C. 1395y(b)(8)**

**DATE OF CALL: August 11, 2009**

**SUGGESTED AUDIENCE:**

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

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**FTS-HHS HCFA**

**Moderator: John Albert**  
**August 11, 2009**  
**12:00 pm CT**

Coordinator: Good afternoon and thank you for standing by. I would like to inform all parties that your lines have been placed on listen-only until the question and answer portion of today's conference. This call is being recorded. If you should have any objection, please disconnect at this time.

I would now like to turn the call over the Mr. John Albert from the Center for Medicare and Medicaid Services. Thank you sir, you may begin.

John Albert: Thank you. I'd like to welcome everyone to one of the continuing open-door teleconference events to discuss the implementation of the MMSCA Section 111 MSP Mandatory Reporting Requirements call. Today is August 11, 2009. And the call today is to discuss specifically technical implementation issues with the (Non-Group) Health Plan or Workers' Comp Liability No-Fault Insurer Reporting Processes.

First of all for everyone that's on the call, if you haven't received the email notification through the listserv that the latest version of the user guide was posted to CMS's Section 111 Web page, as well as some additional materials including a draft for public comment of what is -- I guess the document itself, "What is an RRE?" Correct? Yeah. And that we've asked for public comments by August 16 on that before we incorporate that into the final NGHP user guide.

So please take a look at those materials. I wanted to also point out that because there have been a lot of materials recently uploaded to the Web page, we've had to move some stuff around from time to time. I know it's been mentioned in the past that we have certain limitations on the number of documents we can post as attachments to each individual Web page.

So when in doubt look at the NGHP tab as well as the "What's New" tab. Also, we continue to release additional computer-based training modules. Again, there is a tab for that as well. You can register and take those courses. We have a few more coming out in the near future depending on what happens with the comments on the RRE, et cetera.

But basically most of the major issues that were under discussion after the release of the March guide have been resolved and the answers to those issues have been incorporated into this version of the user guide. We don't anticipate there being many changes other than to incorporate possibly the "What is an RRE" document into the guide.

But for most intents and purposes that, you know, most of the outstanding issues that you the public have brought up in terms of questions about, you know, who is an RRE and what should be reported (center) have been addressed in this version of the guide. It's much more comprehensive than the one that was issued in March. So please take a look at that.

Another thing that I wanted to bring up is that we have some concern regarding the potential misuse of Section 111 reporter IDs regarding access to Medicare and (Toloman) information. We're receiving information from our Medicare Coordination of Benefits contractor who you work with to implement the reporting requirements, regarding requests for information using those specific RRE IDs.

We're in the process of further investigating and we may actually be contacting some of the RRE ID contacts to get confirmation that the request for such information is valid or not. We're concerned that again with the use of that ID that we assign that parties that have no business essentially accessing Medicare and (Toloman) data are trying to do so above and beyond what they should be allowed to do under the scope of this reporting requirement.

So again, especially for those entities out there using (Asians), please make sure that they understand that they are bound by the Privacy Act and that, you know, the RRE is ultimately held responsible for guarding its RRE ID and making sure that queries are performed as appropriately allowed for under the reporting requirements.

So again we can't stress enough that this is very important because if something happened, there's a very real possibility that we would have to suspend access to query data which I know nobody wants. So please police yourselves and your vendors and make sure they are using the IDs that access that Section 111 (grant you) appropriately.

With that Pat Ambrose is here and she's going to go over a lot of the changes that occurred in the most recent guide and address some of the technical questions that have come in. Again this call is geared toward technical questions and implementation. We have another NGHP call scheduled later in the month. That is a policy call. This call again should be for your technical support and IT folks.

And with that I'll turn it over to Pat.

Pat Ambrose: Okay, thanks John. I'm going to reiterate some of John's comments about recent postings to the Web site. The Mandatory Insurance Reporting Web Site for Section 111 can be found at [www.cms.hhs.gov/mandatoryinsrep](http://www.cms.hhs.gov/mandatoryinsrep).

An update was made to the page regarding reporting dos and don'ts as well as an alert posted there. That information has to do with providing authorized representatives and account manager information during registration which I'll go over later. The alert is dated July 21, 2009 and again this is on the reporting dos and don'ts page of the Mandatory Insurance Reporting Web Site.

John also mentioned that an alert was posted on the -- this alert is actually on the "What's New" page. It's posted July 31, 2009, alert for liability including self-insurance, no-fault insurance and workers' compensation draft language for public comment. That's again in the downloads area of the "What's New" page. It has information, draft language related to the definition of a responsible reporting entity or RRE.

Note that comments must be received on this draft language by close of business August 16, which would be -- is a Sunday. So please, midnight, Sunday, August 16, 2009. Your comments can be sent to the CMS Section 111 resource mailbox. That email address is [pl110-173sec111-comments@cms.hhs.gov](mailto:pl110-173sec111-comments@cms.hhs.gov). You can also find that email address on the Section 111 Web site on the overview page in the third download at the bottom of the page entitled "Revised April 10, 2009 MMSCA 111: Opportunity to Comment on CMS's Plans for Implementing Section 111."

Another brief announcement. If you are developing a process and using some kind of new form to ask an injured party if they are a Medicare beneficiary, in that process that you are implementing, please plan to request the Medicare

health insurance claim number or the HICN, sometimes referred to as the “Hicin” or “Hic” number, if that number is available rather than just the Social Security number of the injured party. The HICN number is Medicare’s official identifier for Medicare beneficiaries and the preferred data element to submit on your claim input file.

I also wanted to provide a brief review of timeframes related to the registration and account setup steps. The new registration step is the first step performed on the Section 111 COB secure Web site. That Web site is [www.section111.cms.hhs.gov](http://www.section111.cms.hhs.gov).

When you first go to that Web site a login warning page will display. If you click on the “I Accept” link, the homepage of that page will display prior to log in and certain information can be found on that page as well as the button for the new registration step.

So when a new registration step is completed and the registration application is submitted online, the information provided will be validated by the coordination of benefits contract or the COBC. Once this is completed the COBC will send a letter via U.S. Postal Service to the named, authorized representative with a personal identification number or PIN and a COBC assigned or EID associated with the registration.

PIN letters are sent to the authorized representatives within ten business days. If you have completed the new registration step and ten business days have gone by, you may contact your assigned EDI representative or the EDI department main number to inquire of the status of that PIN letter. So again the PIN letter should be received within ten business days after the new registration step.

The next step after you have received the PIN letter is the account setup step. The account setup step again is performed off of that Section 111 COB secure Web site by clicking on the account setup button. It must be performed by the account manager.

Once the account setup has been completed on the COB secure Web site and processed by the COBC, a profile report will be sent to the RRE's authorized representative and the RRE's account manger named during the account setup step via email.

The profile report should be transmitted to your authorized representative and account manager within ten business days upon completion of the account setup step on the COB secure Web site.

Another note related to timeframes. Query test file submissions may begin once the signed profile report is returned to the COBC and the RRE ID is updated to a testing status. After a test query file is submitted, the COBC will create a test query response file within five business days or one calendar week. Again if you do not see or receive your response file within five business days, you may contact your EDI representative to determine a status.

I'd also like to point out that we have documented an escalation process for reporting problems to the COBC EDI Department regarding Section 111. The escalation process can be found in Section 18.2 of the recently updated user guide. Please contact your EDI representative first and then follow the procedure provided if further assistance is required to further elevate your issue.

Now I'd like to cover an important point about which we have discussed before, but just to reinforce this concept about what information to provide for

certain individuals during registration. Please note that it is absolutely critical to provide information on your authorized representative during the new registration step on the COB secure Web site. And then provide account manger information during the account setup step.

In fact the account manger must personally perform the account setup step so that they may obtain a login ID and find the user agreement for the COB secure Web site. Note that authorized representatives cannot be users of the COB secure Web site for any RRE ID.

If you find that you entered incorrect information or the wrong person for the authorized representative during the new registration step, then contact your assigned EDI representative or the COBC EDI Department at 646-458-6740. That number can also be found on the Section 111 COB secure Web site.

Please make this contact and have that information corrected before proceeding to the account setup step with your personal identification number. Please see the user guide and the how-tos on the menu of the homepage of the Section 111 COB secure Web site for a description of the registration step and user role particularly the how to get started and how to invite designees that you'll find under the "How-To" menu option of that page.

Again the user guide is posted on [www.cms.hhs.gov/mandatoryinsrep](http://www.cms.hhs.gov/mandatoryinsrep) on the non-GHP tab which is also known as the liability no-fault insurance and workers' compensation page.

And also note that when you're providing an email address for your authorized representative it should be your authorized representative's own personal email address. Only critical emails are sent to the authorized

representative. Most of the email communications go to the account manager related to Section 111 day-to-day processing.

We've had some request to change authorized representative email addresses to something other than their own personal email address and that is not appropriate. In certain cases, important situations, the authorized representative must be notified in addition to the account manager.

The new user guide has a list of the emails that are generated by the system and includes the recipients so you can see that there are a very limited number of emails that would go to your authorized representative and again most of them go to your account manager.

Some other notes related to the Section 111 COB secure Web site include that we had a problem with the response date that was posted erroneously for certain files that had actually not completed processing. A response date with the year 2003 was showing up erroneously for response files that actually had not yet been generated but the file had been processed.

So the status of the file showed that it was in process and actually the response file was not created. However, there was an incorrect response date showing up on the secure Web site. This problem has been cleared up for any files that have been transmitted and will complete processing in the future.

But I just wanted to mention that if you see a strange response date related to your response file, that problem has been addressed. You again will see that the file is still in process. Once the file has been completed and the response file generated, the correct date will show.

We are also addressing some performance issues related to the secure FTP file transmission process particularly related to login IDs that are associated with a large number of RRE IDs. If you experience problems such as being timed out during your secure FTP attempt, please notify your EDI representative and they'll work with you on this process.

The other thing that I wanted to remind you related to secure FTP is that passwords associated to login IDs are exactly eight characters long. If you for some reason provide a password that is shorter or longer than eight characters when you're attempting to do your secure FTP file transmission, your log on to the secure FTP server will actually fail.

So please make sure that as you're setting up your secure FTP file transmission that you use the correct password associated with the login ID of exactly eight characters.

Also note that the HIPAA eligibility wrapper software, the software that is available free of charge for you to develop the (ANC) X12 270 and 271 files for the query process, is available in a Windows PC server version and in a Mainframe version.

The Windows version is available as a download on the COB secure Web site after logging in to the Section 111 application. Or you may obtain it from your EDI rep if you're having trouble downloading it from the secure Web site. The Mainframe version is also available. It is only available from an EDI representative who will physically deliver that to you.

Also note that the input files to the HEW software, the H-E-W software, which I also refer to as the HIPAA eligibility software, these files must be in an MS-DOS text format, not a Unix-based text file at this time. We are

looking to add a save-as file type for the query downloads. However, in the meantime a work around is to open the file in Word Pad, not Text Pad but Word Pad, and save the file selecting the MS-DOS text as the file type.

John mentioned that we have computer-based training modules available and you're highly encouraged to enroll in these courses. To sign up go to the mandatory INF REP Web page and on the left-hand side of the page click on the link or the tab for MMSCA 111 computer-based training and follow the instructions on that page.

You will receive an email invitation to the CBT shortly after you provide enrollment information. There is no charge for the CBT courses. You do not have to be a registered user of the COB secure Web site in order to enroll in these courses. Once you are enrolled you'll be automatically notified of any new courses or updated courses as they are rolled out.

The courses currently available -- there's a curriculum posted on that CBT page but the courses currently include a process overview, registration and account setup, the query process, file format, file transmission methods, and courses on the Section 111 COB secure Web site. New courses related to the claim file submission will be released very soon. And again once you're enrolled for the CBTs you'll be automatically notified when those new courses are available.

As you should know the query test and production files are now being accepted for non-GHP or EIDs in a testing status. To get in a testing status you must have returned your signed profile report to the COBC.

Claim input file testing begins January 2010. Claim input files are due during your assigned file submission timeframe in the second calendar quarter of -- which is April through June of 2010.

Now I'm going to go through some of the changes that were made to the non-GHP user guide Version 2.0 which has been posted out on the Web site. John already mentioned that no changes were made to Section 7.1 which defines what is an RRE or responsible reporting entity for Section 111. Please see the alert that we discussed previously on the "What's New" page for proposed language related to "What is an RRE."

Other information which is not included, certain outstanding issues, include write-offs particularly related to hospital stays. Several questions have been submitted regarding that and CMS is working on an answer to that question still. And also no additional information has been added at this time related to product liability and mass tort but as you know CMS has requested people to ask to participate in a work group related to product liability and mass tort reporting.

Section 2 of the updated user guide provides a fairly complete list of the changes and the additions that were made but you really need to reread the entire guide from start to finish due to the number of changes that were made.

When this guide was initially posted last week, Page 198 was out of order in the PDF file. It mistakenly appeared between Pages 213 and 214 due to a formatting problem. That has been corrected and the pages are now in order and everything looks good to me.

That Page 198, the information on it was correct, it showed part of the error code table and again the correction has been made and the document reposted. No other change was made to the guide other than that formatting issue.

Note that no changes were made to the field requirements related to the representative first and last name and the representative firm name as we previously announced on these calls. So please see the field descriptions for those particular fields related to representative first and last name. Those fields are always required. The firm name is required as of a certain date if the representative is a member of a firm.

Note that some changes were made to the reporting thresholds and a new section was added to the guide for that. The dates for the reporting thresholds have been modified to extend the period of time the thresholds will remain in effect. And the threshold for workers' compensation ongoing responsibility for medicals was raised to \$750. Again, see that section in the guide for those changes.

Sections 11.7 and 11.10.1 were updated to note that a process will be added to the Section 111 COB secure Web site application that will allow a user associated with the RRE ID to indicate that the RRE has nothing to submit for a particular quarter in lieu of submitting an actual empty file.

We've had several reports that it was somewhat burdensome to repeatedly send an empty file for those RREs that have very little to report quarter to quarter. And so now you will be able to log on to the Section 111 -- well as of January you will be able to log on to the Section 111 COB secure Web site and indicate that you have nothing to report.

Of course files are not due, production claim input files are not due until the second quarter of 2010. So you won't have to perform this process until that time.

Some new fields were added that were named Claimant 1, 2, 3 and 4 entity/organization name. These were added as a redefinition of existing claimant last name and first name fields in order to allow for submitting a claimant name other than that for a specific individual.

All subsequent fields on the record were renumbered accordingly. However, these fields are in a sense overlapped each other. The entity organization name takes up the same area in the record as the first and last name.

So these fields are meant to redefine the fields prior to them. In other words you use the first name, last name and middle initial Fields 106 through 108 for Claimant 1, first, last and middle initial name or the entity name in Field 109. Again they take up the same positions in the record. Fields 106 through 108 start in Position 1647 and end in Position 1717. Field 109 starts in Position 1647 and ends in Position 1717.

So you use Fields 106 through 108, the first name, last name and middle initial if the claimant relationship code is E, F or O. If the relationship code is X, Y or Z, we ask that you use Field 109. In other words you're providing an entity or organization name rather than an individual's name.

It's a little unusual but we did it because often times the claimant being reported is not an actual person but rather the estate or trust of the deceased beneficiary. We are trying to make it more flexible but still maintain essentially the same record layout. So again all the Claimants 1 through 4

entity organization, last name, first name and middle initial fields work the same way.

Note that we updated the requirements for reporting of ICD-9 diagnosis codes. We will provide downloadable files for test beneficiary information. The ICD-9s that are referred to as (in suspicion), ICD-9 codes that are found in an appendix of the user guide and also a downloadable file of error codes and their descriptions, these files will be posted to the Web site at a later date.

Note that there is already a downloadable file available for what CMS considers to be valid ICD-9 codes. Take a look at the user guide and the link provided there for that file which can be found on the CMS Web site.

And one other note that I wanted to make about the updates to the user guide is to point out that the claim response file record has been increased to 460 bytes from 400 bytes.

I'm now going to go through some of the technical questions that were submitted to the CMS Section 111 resource mailbox and attempt to answer those and then we'll open it up to a question and answer session.

A question was submitted related to whether parentheses can be submitted particularly in the illness or injury description Field 57. Actually the answer is yes. Parentheses can be included in there. And we have an update to make to the user guide to indicate that that is possible.

The question also went on to ask about what to do with suffixes related to last names. For example, John Smith, Jr., we recommend that you remove any suffix included in your last name field and certainly do not include a period

punctuation mark in that last name field. This will ensure that you will more likely get a match on that last name field.

Some of the other names other than for the injured party we might be able to be a little bit more flexible with and we'll update the user guide accordingly. But specifically when reporting the last name for the injured party whether it's on the query file or on the claim input file, we recommend that you remove any suffix and the period punctuation mark. Later on I'll address other formatting related to the last name. So we'll get to that shortly.

We had another question about an RRE who is very small and is having, only has a few production claims that they can convert into test data and the testing requirements state that you must submit at least and post at least 25 add records indicating 25 new test claims.

What I recommend that you do in this case where you only have a limited number of production claims to use for your test files is that you change the dates on some of your claims to create additional claim examples. You can submit the same injured parties on multiple claims using different dates in order to pass the test criteria.

And you may also overlay your injured party information with the test beneficiary information which we will supply sometime around October 1. So that might provide you some additional help in creating your test data. So you may use production data for testing but you may also modify and create your own test data in order to manage to submit at least 25 claims to pass that testing requirement.

There was a question submitted regarding ongoing responsibility for medicals. I'll read the question and then I'll ask Barbara Wright to correct me if I get

this wrong. The question said, "I have a question about auto-policies and states with low-limit medical (unintelligible) coverage. First party benefits in Pennsylvania with a \$5000 limit. Sometimes the limit is exhausted in one payment but sometimes several payments are made. Would that coverage be reported as ongoing responsibility for medicals or as a TPOC amount?"

From my read of this question you're referring to a no-fault insurance benefit and that should be reported as ongoing responsibility for medicals. And even though -- you know, those payments that are being made are for specific medical services, not a settlement judgment award related to that claim but rather being paid to reimburse for specific medical services. And so the information should be reported as ongoing responsibility for medicals and not a TPOC amount.

And the same goes with another example of a Florida personal injury protection with a \$10,000 limit. Again one payment or multiple payments could be made. Again, personal injury protection is considered no-fault and would be recorded as ORM, or ongoing responsibility for medicals.

Note that the actual dollar amounts related to payments for these individual medical services are not reported. The TPOC is specifically for those settlement judgment award or other payments other than reimbursement or ongoing responsibility for medicals.

And so you're just reporting with an ORM indicator equal to a Y. You're reporting the date of incident and if the -- and any applicable no-fault insurance limits should also be reported, the date the limit was reached as well as an ORM termination date if that applies.

And then there was a third question about states with a \$1000 (med-pay) limit. Again, usually one payment but can be multiple payments. Again, (med-pay) is considered no-fault and reimbursement for individual medical services and not reported as a TPOC but reported as ORM.

Woman: Yes, this is precisely the type of situation we need reported as ORM. The point of the reporting as ORM is so that our records are current. And if we mistakenly receive a claim, we can reject payment for that claim until we know whether or not it's covered under the no-fault. So these should routinely be reported as ORM and you should have an open record until you have no further legal obligation or until it's exhausted.

Pat Ambrose: Okay, another unrelated question, this has to do when an entity has both a department that handles group health plans and a separate department that handles non-group health plan claims. Would these two departments handle each -- handle their own plan type separately and therefore register separately?

And the answer is yes. If you have group health plan information to report for Section 111 and liability insurance including self-insurance, no-fault insurance and workers' compensation, you need to register for two separate RRE IDs. One RRE ID would be GHP and the other RRE ID would be non-GHP and the reporting is handled completely separately and different file types and reporting assigned file submission timeframes.

Another question was submitted related to if we spend more than one TPOC date and amount and the payment on the claim detail record is then deleted, are we to continue to send the other TPOC amounts in their original location on the detail and auxiliary records? And yes that is correct.

So if you have reported multiple TPOC dates and amounts and then need to remove one of those, you would send an update record zeroing out the appropriate TPOC amount. And all the other TPOCs should stay in their original locations.

Now if you have then made that update and in a sense deleted or removed a certain TPOC amount, the questioner went on to ask if they could reuse that slot if another payment was added later. And the answer is actually yes. You could reuse it. The COBC and other Medicare contractors will essentially treat it as a correction but we'll accept that information.

So if you've used up all five of your TPOC fields, then subsequently zeroed one out because it turns out it wasn't applicable or wasn't accepted but then later have a sixth TPOC amount to report, you could use that slot that had been taken up by the payment that you actually deleted.

Another question was submitted related to the HEW software and whether it can be used in an automated process whether it would run in a Unix environment. So please note that at this time the HEW software or the HIPAA eligibility wrapper software will not run on a Unix platform nor can the Windows version be invoked automatically.

We are working on changes that will allow things like this but a release date for that has not been determined. So if you're using the HEW software, the PC server Windows version of the HEW software, you're going to have to run it with user intervention and set up a process to do that in the meantime.

Another alternative would be to not use the HEW software and to use your own translator and there are mapping documents, a companion guide for the

X12 270, 271 out on the Web site that can help you with that mapping process.

Some questions, numerous questions, were submitted related to what -- TPOCs of what dates must be reported. And in this particular example, suppose a \$100,000 liability settlement in favor of a Medicare beneficiary involving money for past medical bills and future medical, is concluded and paid on August 2009. So without getting too technical let's say the TPOC date is August 2009. Does the RRE have no duty to report the TPOC? Or does the duty to report still exist but the date for reporting postponed?

Please see the updated user guide which states that only TPOCs with TPOC dates of 1/1/2010 and subsequent are required to be reported. The date for ORM, ongoing responsibility for medicals, that is unchanged. So any ORM that isn't in effect as of 7/1/2009 and subsequent must be reported.

Your initial files are not due until the second quarter of 2010. However, you are to report any TPOCs meeting the appropriate thresholds retroactively to January 1, 2010 and you are to report any ORM retroactively to July 1, 2009. Again, see the updated user guide as there is an explanation of these reporting date requirements for TPOC versus ORM in the guide.

A question was submitted regarding how ICD-9 codes would be used and whether it's better to submit as many ICD-9 codes as possible or to for some reason limit the number of ICD-9 codes. You know, what would actually result in a better process for Section 111 reporting and subsequent potential recovery efforts?

CMS is of the opinion that the more inclusive, the better when it comes to the reporting of ICD-9. And that will focus the recovery efforts only on the

applicable claims that Medicare may have paid erroneously and prevent Medicare from paying any claims that it should not.

So in other words please supply all applicable ICD-9 codes, as many as possible that are related to your particular claim. The more accurate and complete the report, the more accurate and complete the recovery effort will be.

Another question was submitted related to the secure file transfer file transmission process about -- and it has to do with the login IDs and passwords related for that. To answer that question, let me say this that the secure FTP is done via the Section 111 secure FTP server and not actually the COB secure Web site.

Secure FTP can be automated. However, credentials including a login ID and password are needed for secure FTP. And those credentials that are used are the same as those applicable to a COB secure Web site login ID associated with the RRE ID.

So the secure FTP process is going directly against our secure FTP server. A user does not have to be signed on physically to the COB secure Web site in order to transfer a file via secure FTP, instead they are in a sense signing on to the secure FTP server. However, the same login ID and password is used.

So when you're performing secure FTP you need to use an account manager or an account designee's login ID and password. And again remember that password is exactly eight characters long. You need to use the account manager or account designee's login ID and password when signing on to the secure FTP server in an automated fashion in order to transfer files.

Another questioner was asking for some more information related to the special reporting extension for ongoing responsibility for medicals and the special qualified exception for reporting and the delay that is allowed until third quarter of 2010. See Section 11.9. This section has been renumbered in the new user guide.

Examples have been added there too that should help you when you're going to create your initial claim input file in the second quarter 2010. And that section also describes the extension that you have to report certain claims with ORM where ORM was assumed prior to July 1, 2009.

Those claims can be reported in the third quarter 2010 file submission if you're having difficulty obtaining the appropriate information for those claims. So again I point you to the updated user guide and the additional examples that we added there that should help you with that process.

Another questioner back to the ICD-9 codes -- I'm sorry I'm jumping around here but I'm just answering these questions in the order that they were sent in essentially. One questioner pointed out that they often update their claims in their internal system with new or different ICD-9 codes and do we want to receive updates related to those?

And the answer is yes. Changes or additions to ICD-9 codes do trigger an update. We want those updates submitted whenever an ICD-9 is changed or added on a claim in your regular quarterly claim input file submission.

Another questions asked, stated that they need to designate their third party administrator for workers' compensation as a reporting agent, how do they go about doing this?

You will name you TPA as the agent during the account setup step on the COB secure Web site when you perform that step during registration. After that step is completed your account manager will invite individuals from your TPA as account designees. See the registration section of the user guide and the how-tos on the Section 111 homepage which is again [www.section111.cms.hhs.gov](http://www.section111.cms.hhs.gov).

Another question was submitted regarding reporting of ongoing responsibility for medicals. If you have the acceptance of ongoing responsibility for medicals on August 1, 2009 and settle the case on December 1, 2009, does that have to be reported in 2010?

By settling the case I assume that means that ORM was terminated on December 1, 2009. And the answer is yes. Any ongoing responsibility for medicals assumed as of or that was effective as of 7/1/2009 and subsequent must be reported.

You will include this particular claim in your first file submission in the second quarter of 2010 with an ORM termination date of December 1, 2009 if that's when the ORM was actually terminated. And then you'll never need to report that claim again unless it reopens for some other reason subsequently.

Woman: If they're reporting ORM and they have TPOC that's prior to 1/1/2010, they have the option of reporting that TPOC but they're not required to, is that correct?

Pat Ambrose: Yes, that is correct.

Woman: The other thing is the question came in and said it's settled as of December 1, 2009. For any TPOC you need to make sure you're looking at our definition of that TPOC date.

If you consider a case settled in December 2009 but it's one that requires for example Court approval and that Court approval isn't until on or after January 1, 2010, then the TPOC date would be on that Court approval date and you would have to report that. So when you're looking at dates be sure you look at the definition that's in the file layout.

Pat Ambrose: Okay, next question had to do with formatting the Field 57 description of illness or injury. First it was pointed out that the field is limited to 50 characters and would we consider increasing that field size.

Since this is only a temporary field, we're not at this time planning to increase the length of that particular field. But in order to provide you some suggestions as to how best to fill that out until you are able to submit actual ICD-9 codes here's some additional information.

So when examining this text description in Field 57, the COBC will define each word provided as an action, an adjective or a noun and tables are being built to map combinations of those to specific ICD-9 codes for the interim period. So we are attempting to take your text provided and convert it to an ICD-9 code. However, that text will also be examined manually in many cases during any recovery effort as well.

A suggested format would be something like, automobile accident, fracture of two ribs. So obviously very brief but basically giving a cause and then a body part and the actual what happened to that body part in a sense. You could

remove any extraneous words such as uhs, at, the, and any punctuation to save space. Of course separate words need to be separated by spaces.

So hopefully that provides a little bit of guidance as to what you keep in that field to best help us map it to an ICD-9 code and then subsequently also use it in any recovery effort.

Another question, back to the COB secure Web site. What happens if an account manager or account designee fails to update their password within 60 days? Can the password be updated after the 60-day timeframe has expired?

If you do not log on to the COB secure Web site and update your password yourself within 60 days, then you must contact your EDI representative to have it reset if 60 days has transpired.

So obviously what I recommend is that you make a habit of logging on at least once a month the COB secure Web site and keeping your password up to date to avoid any delay in that process of resetting it if you fail to do so within the 60-day timeframe.

The other question was submitted saying we have a self-insured workers' compensation plan and pay all the hospital, doctor, et cetera, bills through the company to the entity not the employee. Would we have anything to report?

Yes. These are considered payments of medicals and constitute ongoing responsibility for medicals or ORM. You do not report the actual amounts for these medical payments for ORM but rather report the claim with the ORM indicator equal to a Y and the applicable date of incident and ORM termination date if one applies.

Woman: Remember that the whole purpose of ORM, at least in large part, is so that CMS's common working file, CWF record accurately reflects this ongoing responsibility so that if the bill is inappropriately submitted to us first, we can reject that bill and ask for workers' compensation to make a determination before we're billed.

If we don't have the ORM out there, that doesn't happen. So the simple fact that you only pay entities doesn't help us take care of the part that we need to make sure that we don't pay inappropriately.

Pat Ambrose: Another question was submitted related to if an individual's name that is associated with their HICN number can be different from the name associated with their Social Security number.

And the answer is no. Medicare gets name, date of birth and gender information from the Social Security information. So both CMS, Medicare and the Social Security Administration use the same name information for the individual. Use whatever name is found on the individual's Social Security or Medicare insurance card if available, that will provide you the best match on the name.

Another question was submitted related to submission of multiple claim input files. This particular individual was stating that they will -- they plan to submit two files, one with their RRE ID for in-state business and one is being submitted by an agent for out-of-state business.

Please note that you will need two RRE IDs for this situation. If you're going to submit more than one claim input file per quarter, you need two RRE IDs or as many RRE IDs as claim input files that will be submitted. Only one claim input file is accepted per quarter per RRE ID.

If you need to send two different files, you will need to register for two RRE IDs. You can use the same TIN to register both RRE IDs. Add the agent information to the one RRE ID that reflects the agent file submission and you can invite the agent as an account designee to that RRE ID.

Woman: The example came in talking about the RRE submitting one file directly and another file through an agent. But the rule holds true, even if the company was going to submit both of them directly, there can only be one file per RRE ID per quarter regardless of whether or not agent (unintelligible).

Pat Ambrose: Yes. That is true. Another question was submitted related to the HICN number that is returned. So suppose a claim input file record is submitted with only an SSN and the COBC matches the information using the SSN and the name, date of birth and gender of that injured party matches that person to a Medicare beneficiary. On the response file record you will be returned the Medicare health insurance claim number or the HICN number.

Later on if you need to submit an update to that record we do ask that you include that HICN number if possible on your update. You do not -- I realize that the user guide says a change in SSN or HICN number triggers that situation where it's not just an update but an add/delete. That's not really the case in this scenario.

It's still the same person and actually the same SSN but what you're doing on your subsequent update if you submit the HICN number is just supplying some additional information. I realize that technically the HICN number is changing from spaces to the HICN number that we've provided back. But in that scenario that does not trigger that delete/add situation.

They may send an update record with either the SSN submitted previously or the HICN number you got back from the COBC or both the SSN and the HICN number and just submit that record as an update if you have something additional to report. And that does not require the delete/add transaction that's described for changing key fields.

The only time that you would need to perform that delete/add is if you actually submitted the wrong person, the wrong SSN or the wrong HICN number originally.

Another question was submitted related to setting up RRE IDs. This particular RRE has a holding company as the ultimate parent with 64 licensed insurance company subsidiaries beneath the ultimate parent. They intend to register the parent as the RRE and establish approximately ten individual RRE IDs to support their reporting due to different file -- claim file systems and the like.

So the question went on to ask about what to supply for an NAIC code. When you're setting your RRE ID using the parent, do not -- you are to supply any one of your NAIC company codes -- five-digit NAIC company codes. Do not supply the NAIC group code.

That's actually a four-position field and technically would not be accepted. Just supply any one of your NAIC company codes with each of your registrations for each of your RRE IDs and we'll be able to map that particular company code back to the other company codes and group codes that is applicable. So you do not -- while you're registering for your RRE ID, you do not supply group codes.

The questions also went on to ask about what to provide for subsidiary information. Under these RRE IDs if you are going to list your subsidiaries for

each RRE ID, you must provide different TINs for each subsidiary. Their TINs must be different from each other and different from the TIN used for the RRE ID.

If this is not possible because not each subsidiary has its own unique TIN, then you can skip that subsidiary page or only add those that are possible and unique. We'd like you to provide as much information as possible but there are certain limitations.

So all the TINs that you're providing during registration, the TIN for the RRE ID on the first page and the TIN supplied for your subsidiaries on the subsidiary page all must be unique while you're filling out the new -- while you're performing the new registration step.

What is more important is that you report the proper TINs on the claim input file and the TIN reference file that reflect the actual company that is responsible for the claim payment for your individual claim record.

So don't get too bogged down in the registration, the TINs provided at registration. What is far more critical are the TINs that you provide on your claim input file and associating the proper TINs for those subsidiary companies with their applicable claims.

You may also include data for one subsidiary under multiple RRE IDs. Possibly you're using one RRE ID to report all your worker's compensation and another RRE ID to report your liability. The same, you may submit subsidiary information for - under multiple RRE IDs; obviously different claims under each and that's perfectly fine.

When you submit the claims for those subsidiaries under the different RRE IDs, you can use the same TIN for that subsidiary under each RRE ID. In other words, the TINs only have to be unique during registration under the RRE ID. Once you're submitting your claim files, you can submit whatever TIN is applicable to that particular claim.

The question also went on to ask if they were registering for multiple RRE IDs, may they assign a different person to be the authorized representative for each RRE ID. And yes you may, as long as that person has, you know, the appropriate responsibilities to play the role of the authorized representative. You may use a different person for the authorized representative for each RRE ID or you could use the same.

Another question went on about - asking about updates and what triggers an update when changes are made to TPOC dates and amounts and Claimant 1 information and whether changes to TPOC fields number 2, 3, 4 and 5 trigger updates and, as well as, changes to Claimant 2, 3 and 4 trigger updates.

This is defined in the user and the event table. All the TPOC date and amount field for all five TPOCs - TPOC Fields 1 through 5 trigger updates if any changes are made to any of those five TPOC - sets of TPOC fields. Now only changes to Claimant 1 information triggers an update; not changes to Claimants 2 through 4 but you may send updates for changes to information for Claimants 2 through 4. If you choose to do so, it's just not a requirement. Please see the event table.

Again, if you send an update for Claimants 2 through 4 that will be accepted and processed but only changes to Claimant 1 information actually triggers the update requirement.

Another question was submitted in a situation where a file has already been closed administratively and that's in quotation marks and the RRE is not currently paying for any medical expenses. Do these cases need to be reported?

Please see Section 11.9 and the newly added examples for the initial reporting requirements of claims with ongoing responsibility for medicals; ORM. The extension and exceptions defined in that section only apply to claims where ORM was assumed prior to 7/1/2009; not claims where ORM was assumed 7/1/2009 and subsequent. And also see the special exception in Section 11.8 as to when ORM, you know, can be actually - an ORM termination date can be submitted.

The only time that CMS in a sense allows not reporting a claim that is, in quotation marks, administratively closed, are those claims that where ORM was assumed prior to 7/1/2009 and the claim was administratively closed prior to January 1, 2009.

And there are specific examples given in the user guide in Section 11.9 related to that. Otherwise, if ORM is assumed 7/1/2009 and subsequent, that ORM must be reported and an ORM termination date cannot be submitted, should not be submitted until ongoing responsibility for medicals has truly ended which is not equivalent to administratively closing a claim.

Another question - it is our understanding that the account manager sending information via secure FTP must update the password every 60 days or less. Does this also mean that account designees who are transferring files via secure FTP must update their passwords every 60 days or less? And the answer is yes. Any log in ID that you're using for the secure file transfer process must be - the password must be updated every 60 days.

And in fact, any log in ID or password associated to a log in ID on the Section 1111 COB secure Web site should be updated every - within every 60 days in order to keep that log in ID and password current.

Another question which - some of which we've answered previously related to formatting the name field. Again, please do not include suffixes with last names such as Jr., Sr., the III, that sort of thing. Remove those suffixes from your last names when submitting the last name.

If an individual has an imbedded space in their last name, keep that space. If possible, try to format the last name the way that that last name appears on the individual's social security card or Medicare insurance card. And so if an individual's last name is la space Rosa, then it should be submitted that way with the embedded space in that last name field.

That also goes for names with hyphens in them such as O apostrophe Brien. Please keep that apostrophe punctuation mark in the last name field. You'll see in the updated user guide that those name fields allow for certain embedded spaces and apostrophes, as well as hyphens in between two parts of a last name.

Another question was asked. Is it possible for one RRE to send a claim file via secure FTP and then under the same RRE ID, but a different reporting agent, provide or submit a file for other claims through the HTTPS process?

Again, I go back to only one claim input file may be submitted per quarter, per RRE ID. And you must use the same file transmission for each of those claim input files. If you're submitting more than one claim input file per

quarter, please register for more than one RRE ID and submit the claims under each RRE ID.

So if you want to submit one claim input file via secure FTP and another claim input file via HTTPS, then create two different RRE IDs and select the appropriate file transmission method for each.

It is possible, however, to submit a query file via one file transmission method and the claim input file via another method. So you may submit the query input file via secure FTP and your claim input file via HTTPS or via Connect Direct over the AGNS. So the file transmission type or method that you use is by file type. And you can use different file transmission methods for different file types but again, you can only submit one claim input file per RRE ID per quarter.

Another question was submitted. How do organizations handle reporting from several different departments within the same organization? We have a third party administrator that handles our worker's compensation that will report on behalf of worker's comp. However, I will also need to report on behalf of our risk program. In particular case, it sounds like you will need two RRE IDs again, if separate claim files need to be submitted.

Will Medicare return a 51 disposition code on the query response file when someone returns to work and is no longer entitled to Medicare benefits? So I presume they're talking about an individual who might be entitled to Medicare due to disability. The answer is no. You will get an 01 disposition code on the query file in this case because the individual will be matched to a Medicare beneficiary who was or is covered by Medicare so that once someone is set up on our Medicare beneficiary database, as a Medicare

beneficiary, they remain their indefinitely regardless of the actual dates of their Medicare coverage.

So when you submit this individual, they will get an 01 back on the query file. When submitting the claim file, if the claim dates do not overlap the Medicare coverage, you'll get an 03 disposition code. And that's described in the claim response file section of the user guide indicating that the individual was matched to a Medicare beneficiary but the information supplied on the claim does not overlap or does not have any bearing on their Medicare coverage.

Barbara Wright: Also keep in mind that disability for social security is different than disability for worker's compensation where most, if not all states, provide for some partial or percentage disability. For Medicare, you're either totally disabled or you're not.

For social security, you're either totally disabled or you're disabled at all. And you essentially must be disabled for approximately 30 months before you're entitled to Medicare. So it's relatively rare that someone loses their Medicare because they go back to work. Social security also provides certain provisions for trial work periods, et cetera.

Pat Ambrose: Okay. And so note that a 51 disposition code is only returned if we cannot match the submitted information to someone who is or was a Medicare beneficiary.

Another question was submitted - if a person is receiving Medicare benefits based on a spouse's eligibility, which person's social security number do we use to query for eligibility? You are to submit the actual injured party; their information, not their spouses. Everyone gets their own unique HIC number

assigned by Medicare, although it might often be based on the spouse's social security number, it will have a different suffix.

For example, a B at the end of the HIC number versus an A. So you always submit the information related to the actual injured party regardless of why they may be entitled or eligible for Medicare.

Another question was submitted - if an attorney represents the injured person for a liability claim arising from an accident but does not represent the injured person for a no fault claim arising from the same accident, should they report the attorney information and attorney's name and TIN on the no fault claim report. And the answer is no.

Only include the attorney as the injured party's representative on the report for the liability claim if that's all the attorney is involved in. Do not include or do not put the attorney information on the no fault claim which was reported under a different insurance type and the ORM indicator equal to why.

Since the implementation date for the worker's - I'm sorry. Since the implementation date for reporting for non-group health plans, worker's comp, liability and no fault, has been pushed back to April 1, 2010, will we still have to report as of 7/1/2009. Yes and please see the user guide for that retroactive reporting.

Again, ORM is reported retroactively for ORM that was open as of 7/1/2009 and subsequent and RREs are only required to report TPOCs dated January 1, 2010 and subsequent. So some retroactive reporting is required in your initial claim input file submission.

Another question related to TPOC dates and reporting when a first TPOC occurs before January 1, 2010, and the second occurs after January 1, 2010, that takes the total TPOC amount over the threshold amount. Do you report upon the second TPOC or do you have to total the TPOC over the threshold amount occurring after 1/1/2010 to trigger the reporting requirement?

You do not have to include the TPOC with a TPOC date prior to 1/1/2010 at all. So you just have to look at TPOCs dated January 1, 2010 and subsequent, and the total of those TPOC amounts when you're checking to see if the claim meets the reporting threshold. However, you may include TPOC amounts prior to 2010 in your threshold calculation and reporting. If you choose to do so, if it's easier for you to do so, but you are not required to do so.

Woman: Let me clarify. If they include it in their calculation and it's what makes it go over the threshold, then they also have to report it.

Pat Ambrose: Yeah. Yeah. I, you know, we're going to take your claim, add up all the TPOCs and then take the latest TPOC date reported and apply the threshold that applies to that latest date.

Now if you are reporting all TPOCs that are prior to January, 2010, we'll use that initial reporting threshold. So it's anything up until those dates and I think that's specified in the user guide. So again, though anything that you're using to calculate your TPOC threshold, any TPOC amount that you included in your total, must be reported on the claim because we're going to add it up and if it does not exceed the threshold, we'll reject the claim and if it does, we'll accept it.

There was another question submitted related to recommendations for disaster recovery and reporting delays that might be incurred because of a catastrophic

situation in your system. The first recommended step would be to report your disaster recovery effort and your problem to your EDI representative to keep them informed of your status and then work out the details with your EDI representative as to when to send your file. Most likely, your representative will request that you send your claim input file as soon as possible after your recovery is successful. However, you know, you do need to work with your EDI rep on what is an appropriate file submission.

The questioner went on to ask if they could submit a file limited to only certain critical fields and the answer is no. Any claim input file will be held to the same edit requirements or, you know, standards so a fully formatted file would have to be submitted so you would not be able to submit a claim input file until you're able to completely format that file.

There are no fines automatically imposed by the system related to a situation like this. Again, if you keep your EDI representative, you should be completely covered.

When the file does get processed, it may end up having some compliance - some records flagged for compliance. But again, since you'll have an explanation for that, there should be no problem with that either.

So that does it for the questions that I went through and was able to cover and I guess we'll open it up to a live question and answer session at this point.  
Operator.

Coordinator: Thank you. Our first question comes from (Teresa Felino). Please state your affiliation.

(Teresa Felino): Hi. I'm with AAA Auto Club Group and my question is you did mention the fact that now you are requiring firm name and representative name where earlier you said that in this user's guide you were going to not require. You were just going to require one or the other. Is there a reason that you changed that because we actually programmed based on what you had said previously.

Barbara Wright: Two things. One, we've asked you during the calls to wait until something comes out in final in the user guide and, you know, we've tried to be very cautious about reiterating at that time. But yeah, we do need both information in part because of all the matching activities that go on in the back end once information is submitted because we have information coming in through other avenues as well such as self identification by the beneficiary or their attorney.

And without having both of those fields completed, they're much more likely to have to re-contact you which is something you don't want.

(Teresa Felino): Oh, I guess I'd prefer a phone call versus having to make my claim representative enter it in all the time.

Barbara Wright: Well, we don't have the resources and staff to do repeating contacts when we can get the information to start with. So the, you know, the suggested change was not made.

(Teresa Felino): Okay. Thank you.

Pat Ambrose: Before we go to the next person Operator, I'd like to add what John usually interjects at this point. We'd like to limit it to one question and one follow-up because we do only have a limited amount of time left. Operator.

Coordinator: Thank you sir. Our next question comes from (Suzanne Jordan). Please state your affiliation.

(Suzanne Jordan): Hi. I'm calling from (Broadstyer) and I had a question related to registration. With the deadline being September 30, if we have a client who completes their preliminary or their initial registration step but has not completed the account setup, is that sufficient for purposes of the September 30 deadline.

Pat Ambrose: Unfortunately John isn't here right now. He had to step out but keep in mind that registration stays open. It's not a matter of closing and our biggest concern is that everybody have at least a full quarter to test before they actually have to start doing things.

So there is a little bit of wiggle room there as long as you're keeping up-to-date on all other steps. But what will help us in terms of registration is assignment of the reporting window and the sooner we have people registered, the more we can even that out and make sure that you, as RREs, are getting better and smoother service.

(Suzanne Jordan): Okay. Thank you. And this question is just related to the alert that you had mentioned early in the call. Once you receive the comments or feedback on August 16, does CMS expect to have a final determination made in regards to the draft that you had put out?

Pat Ambrose: Yeah. We will put final language out. I doubt that we will put out a second draft. Frankly, although we may end up adding more, I'm not sure that the basic rules will change that much unless someone gives us a very compelling reason.

Remember that a lot of what's in here is driven by what's in the statutory language and our best effort to accommodate that. For example, when we are looking at the deductibles and the fact that when an amount is paid in excess of the deductible, we've said that the insurer can report both of that regardless of who's making the actual payout.

In that case it arguably doesn't impose an additional reporting burden on the insurer because they already have to report or already have reporting responsibility and they already know that something below the deductible has been paid otherwise they wouldn't be paying above the deductible.

So we've tried to avoid imposing reporting responsibility where there would be none but condensed the number of RREs where possible.

(Suzanne Jordan): And do you expect that to come out in final form by September 30?

Pat Ambrose: That would certainly be our aim. You know a lot of it will depend on how many comments we get in. Several we've received so far seem to be more requests for specific review of their tiny factual situation, as opposed to questioning of the actual rules or requirements that we have in the draft.

(Suzanne Jordan): Thank you.

Coordinator: Thank you. Our next question comes from (Leslie Trembly). Please state your affiliation.

(Leslie Trembly): Good afternoon. I'm from Crawford & Company. I have a question related to update and add record action types. As a TPA, we often handle a claim which will be under a deductible or self-insured retention and then above a

deductible or self-insured retention where the responsibility switches from a client to a carrier.

When we have that situation on a claim, should be submitting an update with an ORM termination for the party under the deductible and then another add for above the deductible?

Pat Ambrose: It sounds like, if I'm understanding you correctly, that there are two different RREs.

(Leslie Trembly): Yes.

Pat Ambrose: Yes. And that is exactly right.

(Leslie Trembly): Okay.

Pat Ambrose: Now you would be submitting them under different RRE IDs as well.

(Leslie Trembly): Yeah. We would be.

Pat Ambrose: Yeah. That would make sense that one party is - if one party's ORM has ended, that you're sending the termination date for the first RRE ID and then on the other RRE's file, you're sending an add record with the date of - well, the date of incident is going to be the same but you'll leave the ORM open and...

Barbara Wright: I guess - this is Barbara Wright. I'm going to ask if you would send that in a separate note, because I believe the way we have the draft right now the situation you identified, if I heard you correctly, it would be reported by the insurer in either case. And we've said when the insurer is reporting both under

the deductible and above the deductible, that they don't report it as self insurance at all. They report it just under their insured number. So there would be no reason to terminate and start on the same record.

(Leslie Trembly): Great. I will send that in as part of Crawford's response.

Barbara Wright: But I do think that based on the draft, it probably would be a single submission.

(Leslie Trembly): Okay. Thank you.

Coordinator: Thank you. Our next question comes from (Sam Coon).

(Sam Coon): Hi. Yes. I'm affiliated with State Compensation Insurance Fund in California and my question is concerning the query input and query response file. Basically, according to the COB's system interface spec that I noticed in the 271, you have a capability of receiving back a tracking number which seems to be a, you know, a user assigned value that helps you correlate or tie back to the 270 transaction.

So my question is kind of two-folded. Where in the 270 would I map segment and element value - that user defined value and just also then to confirm the field - the segment value in the 271.

Pat Ambrose: Okay. Currently it is not possible for you as the submitter to submit your own DCN or document control number or tracking number and receive that back. However, we are planning a change to do that. We don't have a release date for it just yet.

The current format that returns a DCN is returning just one that's developed internally at the COBC and could only be used by you when talking to your EDI rep about a particular record and you're trying to locate a particular record on a file. It's just there to help resolve issues.

So again, it's not possible for you to submit a DCN and get it back but we are making that change in a future release. I don't have a release date for it yet.

(Sam Coon): Okay. And if I had another question, you know, is that okay to do that now or should I...

Pat Ambrose: Yeah. Sure. Sure.

(Sam Coon): Okay. The other question is related to the triple A segment in the 271 response. And according to the same guideline, it specifies that if you receive a triple A segment, that that acknowledges the fact the claimant is not a Medicare beneficiary. So I just wanted to confirm that in the absence of a triple A segment, does that confirm that it is a Medicare beneficiary?

Pat Ambrose: I'm not entirely able to answer that question.

(Sam Coon): Okay.

Pat Ambrose: You should have a field that you can interrogate for a disposition code of the 01 or 51 and that would be absolute confirmation but I'm afraid I don't have the expertise on the 270 - 271 to answer you specifically. What I recommend is that you submit that question to an EDI representative and if we need to make an update to that companion guide, we will do so. But I also would recommend that if there's a field that you can interrogate where the

disposition code of 01 or 51 is present, that that is a more definite confirmation.

(Sam Coon): Okay. Sounds good. I'll do that.

Pat Ambrose: Next question please.

Coordinator: Thank you. Our next question comes from (Robin Pack).

(Robin Pack): Yes. I'm sorry. This is (Robin Pack) with Sedgwick CMS. I was wanting to - it was more of a suggestion more than a question. I was noticing, we've gotten a couple of example of the profile report or actual profile reports from some of our clients.

And I was wondering if you guys could publish an example of a profile report that actually contained every single field that you guys are going to be providing in these reports. For example, I haven't seen anything with any kind of subsidiary information.

There's some information underneath the file transmission method that I mean it's kind of vague looking. If there's anything that you guys could provide on the Web site as a - just something for us to look at and kind of help anticipate what we're supposed to be getting in these reports.

Pat Ambrose: Yeah. I'll take that under advisement and we'll either add something to the user guide or possibly the COB secure Web site user guide or somewhere provide some clarification on that.

(Robin Pack): Thank you.

Pat Ambrose: I see your point.

(Robin Pack): Appreciate it.

Coordinator: Thank you. Our next question comes from (Scott Umsted).

(Scott Umsted): Hi, this is (Scott Umsted) with Sedgwick CMS. I have a question about something you mentioned a little bit earlier. You mentioned some sort of natural language type translation between a description field and ICD-9s.

Are we going to be - I mean are there going to be like new rejection kind of error codes associated with that so you don't find a match.

Pat Ambrose: No.

(Scott Umsted): How's that going to be handled. Okay.

Pat Ambrose: No. You know we are doing our best to take the description provided and map that to an ICD-9 code for posting on our Medicare internal files.

(Scott Umsted): Okay.

Pat Ambrose: Also keeping the text in that will be manually reviewed as required as well. The, you know, if you look at the user guide, that is a free form text field; alpha numeric. It does not currently indicate that parenthesis would be accepted but they will be accepted. I need to make an update to the user guide related to that.

So if we're unable to map it with our cross walk process, that doesn't result in a rejection. There may be additional follow up as needed if the description is

not complete enough and another Medicare contractor is looking at it and needs more clarification.

(Scott Umsted): Okay. Thanks.

Barbara Wright: Hang on just a second.

Pat Ambrose: Yeah. Let me also note that what I was trying to do when I went - when I covered that topic was just to provide suggestions as to how best to fill out that field if you're able to, you know, change the formatting; like getting rid of extraneous words. And also using standard abbreviations like auto instead of automobile might be a good idea as well to save space.

But again, there's - if we're unable to map it internally to a valid ICD-9 code, we're not rejecting the record outright but it may require some individual follow up subsequent.

Barbara Wright: And that is just an internal mapping. That's not any type of mapping system that's available to the outside or anything.

(Scott Umsted): All right. Thanks.

Coordinator: Thank you. Our next question comes from (Taneka Louis).

(Taneka Louis): Hello. My name is (Taneka Louis) and I'm with (Neutral Insurance Company of Arizona). We have a question on the FFTP. We logged on. We checked our user name and password and we can log onto the COB Web site just fine.

But when we log on to FFTP we get access denied.

Woman: Okay. I'm not sure what the problem may be, but you need to report that to your EDI representative. And if you've already done so and for some reason not received a satisfactory response, take a look at the escalation procedures that are in the user guide in Section 18.2 but I'm sure your rep will get right on that problem and figure out what the problem is and resolve it.

It's not a global problem as far as I know. We have had RREs who have successfully transmitted test query files via secure FTP and test response files have been posted to the secure FTP server for download. So we do have it working.

(Taneka Louis): Okay. And just one follow up to that regarding the EDI rep. We've used the escalation procedures on a couple of other issues we had with just the Web site. Our EDI rep is no longer there. How soon should we expect to be - to get another one?

Pat Ambrose: I can't answer that. I'm afraid I'm not aware of the procedure. I'm sure there is one but I will follow up on that for you and in the meantime, you may contact the, you know, the department number and the contact information provided in the escalation process and those individuals would be able to let you know when a new rep would be assigned.

(Taneka Louis): Okay. Thank you.

Pat Ambrose: Operator?

Coordinator: Thank you. Our next question comes from (Jose Ruiz).

(Vanetta): Hi, this is (Vanetta) from State Fund. My question is that State Fund has submitted query test file via the FFTP method and it's been about three - three

and half weeks and there has been no resolution. When should we expect a resolution of the problem?

Pat Ambrose: And I assume you've been in contact with your EDI representative.

(Vanetta): Yes. We have been in constant contact with our EDI representative.

Pat Ambrose: Okay. You said you're with State Farm?

(Vanetta): State Fund. State Compensation Insurance Fund in California.

Pat Ambrose: State Compensation Insurance. Okay. I, you know, just keep checking with your EDI rep and we here can also follow up and try to get a status for you.

(Vanetta): Okay. Thank you.

Coordinator: Thank you. Our next question comes from I believe it's (Ellen Hansel). It did not record well. Ma'am, your line is open.

(Ellen Edsell): Hi. This is (Ellen Edsell) from Chubb Insurance. As far as the claim reply and the disposition code, the Disposition Code 50 as it's described in the manual says that you didn't get to process all the records and they should be resubmitted. Would they be resubmitted as an add record the following quarter?

Pat Ambrose: You would resubmit those - could you mute your phone please? I'm getting some feedback. You would resubmit the record with whatever you submitted originally; add, update or delete, as the case may be. And that should - and then it will reprocess. I do want to remind everybody that that disposition code of 50 should be returned only in very rare circumstances. However, of course,

you do need to code for it and you should put a process in place to just submit the same record again.

You may submit it with any updated information. The action type should be the same as what you submitted originally.

(Ellen Edsell): Okay and just one quick follow up. Actually more of a suggestion. Just having sat on these calls for several months, I'm thinking that maybe the whole registration topic could be a separate meeting because that seems to take up most of the technical time and that really has nothing to do with the query and the claim file.

Pat Ambrose: Yeah. We'll take that under advisement and consider splitting up the topics on these calls going forward.

(Ellen Edsell): Great. Thank you.

Coordinator: Thank you. Our next question comes from (Kathy Cather).

(Kathy Cather): Yes. We just had one question involving the new model form. There's a group health provider model form that you guys have on the group health page that is available for use when you want to get the information such as the social security number and the HICN number from the claimant. Are you saying in your statement that if we are to develop a form that we want to make sure we include a field for the HICN, that you're not going to provide such a model form for the non-group health providers.

Barbara Wright: We are planning to provide such model form for NGHP. It's in the process of review right now.

(Kathy Cather): Okay. Thank you.

Coordinator: Thank you. Our next question comes from (Norman Reese).

(Norman Reese): Yeah. On a worker's compensation case, if we've got ORM - I know we report that. But subsequently if we settle that case, settle the indemnity and medical, do we report that as TPOC?

Pat Ambrose: Yes. If there is a settlement amount, you would then - and if that also terminates your ongoing responsibility for medicals, you'd send an update record with the ORM indicator equal to Y still, the ORM termination date and then also include the applicable TPOC amount end date on that same update record.

(Norman Reese): Okay. Would you include the indemnity payment or just the medical payment in your total?

Pat Ambrose: Well generally with a settlement amount - hold on a minute please.

Barbara Wright: Normally you'd be reporting the total. You can look at the language that's in the updated user guide about reporting indemnity payments but if you've got a settlement, we don't accept allocations. We're not bound by it and we don't accept allocations by the parties. So normally you are going to be reporting the total.

(Norman Reese): Okay. When some of these cases - we're involved with Medicare set asides, where you know they dictate to us what we have to pay on medical.

Pat Ambrose: That is future medicals. That's not current, past medicals and it is part of the settlement.

(Norman Reese): Right.

Pat Ambrose: So it is reportable.

(Norman Reese): Okay. Thank you.

Pat Ambrose: Thank you.

Coordinator: Thank you. Our next question comes from (Nikki Lahand).

(Nikki Lahand): Yes. We've read the July 13 alert but we're still not sure if our particular circumstances allow us to exclude our weekly indemnity benefits from the TPOC. And we say that because our claim system technically will not allow us to merge a medical payment with a weekly indemnity benefit.

So is that enough for us to exclude regular weekly temporary partial and temporary total benefits from being considered TPOCs. And we especially have this concern because by the time we submit in the first - in the second quarter, all of our weekly indemnity claims will have exceeded the allowable five fields for TPOC payments. So we want to exclude them obviously if we can.

Woman: Can you hold on for a minute so we can confer on this question?

(Nikki Lahand): Thank you.

((Crosstalk))

Woman: Okay. We're back.

(Nikki Lahand): Okay.

Woman: You need to be guided by the language that's in the alert. If your state law allows you to pay medicals out of indemnity and you're simply arbitrarily allocating them, then you need to report those. If you fall under what's in the alert, then you don't need to report the indemnity.

The fact that you've set up your system in a certain way is not by itself controlling.

(Nikki Lahand): Okay. All right. Thank you.

Pat Ambrose: Operator?

Coordinator: Thank you. Our next question comes from (Sara Christianson).

(Sara Christianson): Hello. I am with Mitsubishi Motors and I just have a question that I think I may have the answer to but I just need clarification before we send our IT department off on this.

As far as the query files go, is Medicare supplying software for us to use for that function only?

Woman: Correct. You may - you have a choice of using some software supplied by the COBC called the HIPAA Eligibility Wrapper where you would create a flat file input to the HEW - H-E-W software and it would create the X12 270 file for you to transmit for the query. It doesn't, you know, you still have to create that flat file input yourself.

(Sara Christianson): Okay. And that...

((Crosstalk))

Woman: And then it would translate the 270 coming back - 271 coming back for your back into the flat file response format. And we do not supply software for the claim input file.

(Sara Christianson): Okay. All right. Thank you so much.

Coordinator: Thank you. Our next question comes from (Donna Buschard).

(Donna Buschard): I am with Farm Bureau Insurance of Michigan and my question is related to the ICD-9 codes. We're looking at the codes off of the Web site and there's actually two files out there; a DX and a SG file. And I see the same numbers in both those files; specifically 0010 is in both files. I don't know what they are.

Woman: Which Web site file are you looking at specifically?

(Donna Buschard): I'm at the diagnosis and procedures codes and their abbreviated titles. It's the hyperlink in the user guide. It takes you out there and I pick up the effective October 1, 2009 zip file.

Woman: Right.

(Donna Buschard): There's two files in there. One is called (CMS27BEFC short DX) and the other one is the same thing only it's SG.

Woman: Okay. Hold on just a minute.

(Donna Buschard): Thank you. The E codes are in the DX file. They are not in the SG file.

Woman: Yeah. I just have to look at the specific file name. I'm looking it up right now.  
I'm sorry. I didn't have it handy.

(Donna Buschard): That's okay.

Woman: You should be using a V26 I-9 diagnosis.txt. Do you see that file?

(Donna Buschard): No. Can you say it again?

Woman: Yeah. It should be V26 I-9 diagnosis.txt.

(Donna Buschard): Okay. That's in the zip file that's effective October 1, 2008.

Woman: Right.

(Donna Buschard): Which is the current one?

Woman: Right.

(Donna Buschard): But by the time we get there, we're going to be effective October 1, 2009.

Woman: Yeah. We'll issue some...

(Donna Buschard): Okay.

Woman: I'm not exactly sure when the 2009 will be out there.

(Donna Buschard): Okay.

Woman: Right now that's the current file.

(Donna Buschard): Okay. So I want the one with the diagnosis and then I just want to make sure I understand how to use these. Field 15 - I can use any E code that's in this file that's not in Appendix H.

Woman: Right.

(Donna Buschard): And then for the odd field numbers - 19 through 55, I can use any of these in here that are not in Appendix H including the E codes?

Woman: Yes, you may.

(Donna Buschard): Okay.

Woman: But...

(Donna Buschard): But...

Woman: You must...

(Donna Buschard): And that's if I don't...

Woman: Actually that's not true. So for the diagnosis codes let me clarify.

(Donna Buschard): Okay.

Woman: For the diagnosis codes, they must be on that list of valid codes that we just talked about. They must be on the file V26 I-9 diagnosis.txt.

(Donna Buschard): Okay. And those are Fields 19 through 55.

Woman: Yes. And we will accept them even if they're on the insufficient list. However, at least one Diagnosis Code Field 1 through 19 - at least one of them must not be on the insufficient list. In other words, at least one of them that you provide must be sufficient.

So if you only give us Diagnosis 1, then it has to - it must be on the valid list and it must not be on the list in Appendix H of the insufficient code. But if you gave me Diagnosis Codes 1 and 2, 1 or 2 could actually be on that list of insufficient codes and be perfectly acceptable as long as the - and as long as the other one is not on that list, you're good to go.

(Donna Buschard): Okay. Great. And then if I could do just one more quick question.

Woman: Sure.

(Donna Buschard): You were talking about the updates that were coming through and what's going to happen if we sent an update but there really were no changes from the prior action; whether that be an add or an update.

Woman: Not really anything.

(Donna Buschard): It'll be okay?

Woman: As long as it passes the edits, we'll accept it and process it.

(Donna Buschard): Okay. Thank you so much.

Woman: On the ICD-9 codes, could you confirm Pat one way or the other, if they have one valid ICD diagnosis code, the second one could in addition to being one that was on the insufficient list, it could also be an event code?

Woman: Yeah. It's going to be an E code because those are on that list of valid codes. All the diagnosis codes submitted have to be on that list of valid codes. Again, that file - so that the file downloaded from the CMS Web site. That V26 I-9 diagnosis.txt. They all have to be on there and the E codes included...

Woman: There are instances where you may wish to submit more than one event code in which case, although it's beyond the one event code would have to be included in the other diagnosis.

Woman: Right. Right. So you can put an E code in the cause - the alleged cause Field 15 and you may also put additional E codes in those diagnosis codes, fields 1 through 19.

(Donna Buschard): And then do I have to have something that's not an event code in the diagnosis code?

Woman: Yeah. You've got to have at least one diagnosis in field - in diagnosis Fields 1 through 19 that is not on Appendix H.

(Donna Buschard): And is not an E code.

Woman: Right.

(Donna Buschard): And is not - okay.

Woman: Yeah. And not a V code as well. Yeah. Yeah, yeah, yeah.

(Donna Buschard): Okay. I think I got it. Thank you.

Coordinator: Our next question comes from (Brenda Smith).

(Brenda Smith): Hi. Thank you. I have a question about claims which were administratively closed prior to 1/1/2009. I know they don't need to be reported, but as far as reporting them subsequently, if the insurance carrier gets an allegation from a claimant say 10 years later that they have additional treatment that needs to be paid and is related, would it get reported just based on the claimant's allegation? Or would they be allowed to investigate it and only report it if they deem it related and actually decide they're responsible for that service?

Woman: It's if you're reopening it and paying something. If you've decided that there is no ongoing responsibility with respect to that claim, then you don't need to report it.

(Brenda Smith): Thank you.

Woman: Operator, could you tell us how many questions we have in the queue because it's a couple minutes short of 3 o'clock.

Coordinator: At this time we have four.

Woman: Okay. Let's see how quick we can go.

Coordinator: Okay. Our next question comes from (Sabrina Funican).

(Goulden Lamb): Actually the question is from (Goulden Lamb) and you've got (Sabrina Funican) and (John Miano). We just had a quick question with regard to the model language form. I know that before you had indicated to the fact that this was still under review. However, it's been under review for quite some time. Is there any date as to when we might expect that to be available?

Woman: We hope to have it out shortly but you know there's been a lot of conferences we've been attending, as well as people being out of the office and it does have to go through the complete review.

(Goulden Lamb): And one other question. With regard to the escalation process in 18.2, or just a recommendation that you might want to add like a tracker number or the ability to actually be able to determine where an issue is with the process before we - you know like say for instance go to the next level.

Woman: In the sense that you would have like a tracking number or a ticket number or something like that to - as you're escalating it and so that you can refer to the next person in the chain refer them to that issue. Is that what you mean?

(Goulden Lamb): Yes.

Woman: Okay.

(Goulden Lamb): Thank you.

Woman: Operator?

Coordinator: Thank you. Our next question comes from (Mary Jo Argalis).

(Mary Jo Argalis):Hi. This is (Mary Jo Argalis) from (Everest National) Insurance Company.

And my question is, is CMS considering revising the implementation timeline given the request for the industry to comment on what is an RRE?

Woman: I mean we - you know, you're test period is not until 1/1/2010.

Woman: And first filed due starting in April, 2010 in your file submission in that second quarter.

Woman: We took into account the delay with this RRE information when we revised the timeline last time.

(Mary Jo Argalis):Okay. Thank you.

Coordinator: Thank you. Our next question comes from (Chris Kelliher).

(Chris Kelliher): Hi. Yes, this is (Chris Kelliher) from Sedgwick. I'm trying to use the new software I downloaded from the COBC site to take the file that we created according to the CMS specifications in the user's guide and the software is failing because there's differences between the user's guide and what the software is expecting.

And then when I finally was able to get it to work and submitted a test beneficiary file, it was rejected by the - it was rejected because of an invalid header.

Pat Ambrose: Well, I'm not familiar with what your particular problem is. That's one that will have to be referred to an EDI representative; either your assigned EDI representative or the main COBC EDI department number. I'm sorry. I don't know what that problem might be.

(Chris Kelliher): Okay.

Coordinator: Thank you. Our next question comes from (Chris Narsch).

(Chris Narsch): Hi. This is (Chris Narsch) from Hartford Insurance Group. I have a question regarding the TPOC and ORM. Do we report the TPOC and ORM completely like separate from each other even if there is no lump sum settlement in addition to ORM?

Then, in that case, can we report ORM for ORM claims and the TPOC for liability claims?

Woman: We're not sure that we understood your question exactly but if you have a case that has only ORM, you report only ORM. If you have a claim that has only TPOC, you report only TPOC. If you have a case that has both, then you report both the ORM and the TPOC and they can be reported on the same record as long as it's the same type of insurance.

If you're talking one is no fault and one is liability, then you're submitting two separate records because you have to submit a separate record for each insurance type.

(Chris Narsch): Okay. Thank you. I have one more question.

Woman: Okay. Yes. Please go ahead.

(Chris Narsch): If the same policy covers both med pay and PIP, can we report them separately in two different records as they would be considered as two different claims in our systems.

Woman: Did you say if you have the same policy that covers no fault and med pay and PIP.

Med pay and PIP - I think we gave you instructions that those are both considered no fault and if they're in the same policy, then you need to report the total of the two. When you just report ORM once and only report it as terminated when you've exhausted the total of the two amounts together.

Woman: Yes. That's in the updated user guide.

(Chris Narsch): Oh, okay. Thank you.

Woman: Operator. I think that does it. Can you tell us how many people we had on the call and also how many questions we have in queue right now; although we did get through all four?

Coordinator: At this time there is one additional question in queue and we've had a total of 539 parties in conference.

Woman: Okay. We'll take the one call, but don't anybody else get in queue, because we're not going to take it.

Coordinator: Okay. Thank you. Our final question comes from (Stacy Boling).

(Stacy Boling): Yes. This is (Stacy Boling) from OptiCop and it's a very quick question. I'm wondering how soon you feel you'll be able to lock down the data field changes. Unfortunately the IT departments are in a position of waiting for clarification until we finalize development activities and requirements or else

moving forward, and going back and changing those. When do you think the data fields will be locked down?

Woman: I need to ask you what specific fields you're referring to. The only change that I currently have pending is to allow parenthesis in that description Field 57 and possibly just add some more clarity. But essentially they are locked down. But is there a particular field you have in mind?

(Stacy Boling): Okay. None, except that just form format. There were several issues that you described today that were actually published within the new user guide that, you know, represented just some restructuring and some re-data mapping and those types of things. And at this point do you feel like that with very few exceptions represents the final state.

Woman: Yes ma'am.

(Stacy Boling): Okay.

Woman: Yeah.

(Stacy Boling): All right. That's it.

Woman: Pretty much we've only been adding changes when the industry has brought an issue to our attention that no one has mentioned before.

Woman: There was one in the (unintelligible).

Woman: Yes. But I would consider them final and that you could go ahead and proceed and we will - if we make any updates, they'll be minor. Like I said, allow

parenthesis in that Field 57 and those updates will be issued when we update the guide with the definition of the RRE in Section 7.1.

(Stacy Boling): Thank you.

Woman: We appreciate everyone's participation. And there is - for those of you that have both GHP and non-GHP, there is a GHP call tomorrow and there's a second non-GHP call later this month. So thank you.

Coordinator: This concludes today's conference. Thank you so much for joining. You may disconnect at this time.

END