

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Moderator: John Albert**  
**July 28, 2015**  
**1:00 p.m. ET**

Operator: This is Conference #: 82291119.

Good afternoon. My name is (Stephanie) and I will be your conference operator today. At this time, I'd like to welcome everyone to the Section 111 NGHP Town Hall.

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

I would now like to turn the call over to Mr. John Albert from Centers for Medicare and Medicaid Services. Please go ahead, sir.

John Albert: Hey, thank you, operator. Just for the record today is Tuesday, July 28, 2015. As the operator stated, Section 111 NGHP Town Hall. We have a couple of speakers including myself and also Jeremy Farquhar of the Benefit and Coordination Recovery Center as well. We'll also be doing some Q&A follow-up as well based on what we received through the Section 111 Resource mailbox. The transcript of today's call will be available under the NGHP Transcripts tab which is under the Mandatory Insurer Reporting for Non-Group Health Plans found under the Coordination of Benefits and Recover Section of CMS.gov's Medicare pages.

As I say it, every one of this call's disclaimer that the verbal and the – anything we say here is, as well as on the transcripts i.e. if they contradict anything that is in the official CMS User Guides, Materials et cetera, found on the CMS.gov Web site. The materials on the Web site always take precedence over anything we say or that shows up in the transcript. So, please if there is something that doesn't sound quite right, make sure you check the User Guide first before taking on or making any decisions on what you're doing.

The first thing I wanted to talk about and this is – (has been) generally related to Section 111 but it's the announcements regarding the ongoing responsibility of medicals and mentioned that. On July 1, 2015, CMS announced some of the Coordination of Benefits and Recovery Overview page that CMS is transitioning a portion of the Non-Group Health Plan Recovery workload to the commercial repayment center.

As part of the continuing efforts to improve Coordination of Benefits and Recovery Program and Claims Payment Accuracy and the MSP – and MSP situation, the Centers for Medicare and Medicaid Services will be transitioning a portion of the Non-Group Health Plan Recovery workload from the Benefits Coordination and Recovery Center to its Commercial Repayment Center. CMS will also be closed – working closely with its claims processing contractors to make sure that Medicare pays correctly in the MSP situations described below.

Effective October 2015, BCRC will assume responsibility for the recovery of conditional payments where CMS is pursuing recovery directly from a liability insurer which include the self-insurer entity, no fault insurer or workers' compensation entity as the identified debtor and that's the key and they – as they are the identified debtor. The following should be noted regarding the plan workload transition. The transition only includes those cases where CMS is pursuing recovery from – directly from the liability insurer, no-fault insurer or workers' comp entity.

Beneficiaries and their attorneys will continue to work with the Benefit Coordination and Recovery Center where CMS is pursuing from the beneficiary and this is your typical settlement situation. Webinars and town

halls will be scheduled on the coming months to provide additional information. CMS will be hosting two webinars to provide information. Dates of the webinars are Tuesday, August 25th at 2 pm Eastern Standard Time and Thursday, September 25th at 2 pm Eastern Standard Time.

The webinar information will be posted this week on the COB&R Overview, what's new page which is <http://go.cms.gov/cobrwhatsnew>. Again, <http://go.cms.gov/cobrwhatsnew>. I guess there are critical thing with this transition is that when in doubt because this is a transition of only perspective cases is that you should continue to follow what the official correspondence she received on a particular cases in terms of who to work with. It's only the new (staff) that's going to be going to this – via BCRC not the old (staff).

So, when in doubt, always look at the letter that came with whatever correspondence you receive from CMS and contact to it. That's the contact. It's not like we're going to be switching open cases to different contractors (that there's) –so that the work will continue under the old contractors or what – as well as the new (staff) or the new contractors. So, again, follow the correspondence in terms of what to do. And speaking of ORM, the same July 1st announcement also discussed that CMS will be implementing an additional limitation to Medicare claims payments where insurers or workers compensation entities have reported to CMS that they have ORM or ongoing responsibility for medicals.

In situations where an insurer, workers' compensation entity has reported to CMS that it has ongoing responsibility for medicals for specific care. CMS with claims processing contractors will use this information provided by the insurer or workers' compensation entity to determine whether Medicare is able to make payments for this claim. Insurers and workers' compensation entities that notify Medicare that they have (RM) are strongly encouraged to report accurate ICD-9 and ICD-10 codes after the October Go Live for ICD-10 which we'll talk about more later.

Medicare claims processing contractor will use this information to pay accordingly and BCRC will use this information to recover accordingly. So,

again, accuracy is absolutely critical. Please continue to visit the CMS.gov Web site regularly for updated information related to these activities.

With my apologies to Jeremy if I go over something he will be discussing and with apologies to the more experienced Section 111 submitters. I wanted to mention the Section 111 mailbox has seen a lot of very basic questions reflecting that we have a lot of folks who are new to the Section 111 process. The first thing I wanted to mention is that as we've mentioned before, there is an escalation clause where for some reason, you are a registered – responsible reporting entity who's registered to report Section 111, you're not able to get a hold of your EDI rep under sub-Chapter 8 which is within the introduction and overview chapter of the NGHP User Guide, there is an escalation clause that allows you, which tells you who to go to if you can't get the information, you're looking for. You can't get a response from your specific EDI rep.

Since we're getting a lot of basic types of questions in the resource mailbox, again, these are better answered by your EDI rep if you're already registered, or if you're not registered yet and looking for more information, just contact the Benefits Coordination and Recovery call center at 855-798-2627 and, again, the CMS web page is under Coordination of Benefits as well the subpages for Mandatory Insurer Reporting for NGHP has all this information in it. I want to remind folks, too, that if you used the resource mailbox to not expect direct responses to these questions.

The original purpose of the resource mailbox was to solicit more general opinion or feedback regarding CMS policy or more broad (busting) not get answers to specific cases or questions about specific cases or beneficiaries. It will – and since you're not going to be necessarily getting that direct response, again, work with the contractors that you're told to in any correspondence you received from CMS. Questions about this – so this would included also please refer to the, you know, other materials on the CMS Web site, as well as if you need, you know, if you're – before you actually try to contact to a contractor directly.

That being said though, we still want to encourage people to use the 111 mailbox as we do review the questions and use the feedback to improve the

Section 111 process. I wanted to also briefly touch on the ICD-9 to ICD-10 transition. There's been a lot of I guess, misinformation out in the Webosphere regarding the transition to ICD-10 and I want to confirm that come October 1 everybody will be using ICD-10. We've published through Section 111 alert October 1st, April 8th and January 28th of 2015, as well as back in May 13th of 2014 information about the coming transition. Every provider will be using this. CMS continues to send out readiness notices to the provider community that the Go Live date is October 1st.

So, please ignore the rumor mail or other publications, blogs, et cetera. Many of them are wrong. You don't, you know, you don't go to Apple to fix your android phone or GM to fix your Chevy or your Ford. So, you know, use the official CMS publications, and for those that are looking for more information, again, under CMS.gov, there's a section called coding that has all the official information regarding the ICD-9 to ICD-10 transition from high level to a very long key coding information. So, again, please use that information.

There's a lot of publications coming out from the folks who are doing the ICD-10 transition. But again, in short, if a case is established on or after October 1st, you're going to be using ICD-10 because that's what's everybody else will be using and related to that, again, with the specificity of ICD-10 versus 9, again, I can't stress enough just like I did back when I – when I talked about BCRC ORM recovery that it's very important to use complete ICD-10 codes when you're entering them so that we have accurate information and can pay correctly the first time in any recovery they're handled quickly and smoothly.

Another thing I wanted to touch on too is that we've seen as there's been some failures to recertify and maintain contacts regarding Section 111 reporting. I mean, the law was passed in December of 2007 and so we were entering a more mature phase of this process. I realized that for many especially the larger entities, this may be a fairly turnkey operation, you know, solve through I.T. processes and then for others who are using agents as well, but it's very, very, very important that if there's an issue, we'd be able to get a hold of the contacts that you provide us. And even more important to ensure that we can process your files that if you're annual recertification is due that

you please recertify. Because right now, we are rejecting files where there's been no recertification.

So, it's important that RREs and their agents keep in touch with one another and, again, as a reminder, the RRE is ultimately responsible for compliance with the Section 111 reporting requirements and if we're not getting files and not able to process files, then you're basically out of compliance. So, again, please keep on top of that. It's become a kind of a big problem and this is especially critical when we have incorrect information that results in us inappropriately denying claims that affects everybody but especially the Medicare beneficiary.

Also, I also wanted to touch on a recent June 18th alert that relates to the partial – the use of partial versus full SSNs for query and reporting. Again, that alert was published June 18th. We had the June 18th basically states we had to modify the matching criteria slightly because we found that when we're using the five digit SSN that we are still finding some false positives. So, we have to tighten up the matching criteria. If you use a full SSN or HCN, we only look at three of the four personal characteristics which is the first initial of the first name, first six character of the last name, date of birth and gender.

Using the partial SSN, we are requiring a four out of four match that ensures that we're finding the right people. The problem is, of course, is if you require four out of four, there's no room for error on those personal characteristics, and it's very, very important that if you get information back that it's not found and you strongly suspect they are in fact the Medicare beneficiary that you research that information to see what may or may not be, you know, correct in terms of the four characteristics. It increases the risk that, you know, you won't identify somebody to us that is in fact the Medicare beneficiary and if you're not able to do that, then it also increases the risk of noncompliance with the reporting requirements.

So again, as we stated in the announcement, as well as I'll state here, we strongly encourage our RRE system with full SSNs and HCNs, it helps to – that it compensates for the problems that we've seen occasionally from people providing incorrect dates of birth or the last name, initial – name is different

or there's different surnames et cetera. So, while we do crosswalk all the information on a beneficiary, again, (if hasn't) be perfect, it's possible that somebody (that thing) or something somewhere and you missed something. So, again, the rule of thumb, of course, is if there's 65 and older and you don't find them as a Medicare beneficiary, I can pretty much bet that they are and you probably had the wrong matching criteria.

So, with that, I will turn the call over to Jeremy who's going to go over a few of the things I talked about probably provide a little bit more in depth detail (at all). OK, Jeremy?

Jeremy Farquhar: OK. Thanks, John and I apologize in advance for any redundant information but I think some of the stuff there is mentioning twice just to make sure that everybody keeps that in mind and they remember. Anyhow, for starters, I'd like to remind everyone of the recent changes to the 10 reference file layout regarding recovery agent information. That took effect as of July 13th. These changes were first noted via an alert published on November 10, 2014. Layout changes were provided via that alert and have also been included in subsequent updated versions of the NGHP User Guide.

Prior to the implementation of this change, RREs were provided to work around which could be utilized in situations where they wished to have recovery correspondence forwarded to a third party for handling. That workaround allowed the RRE to provide the third party's address and the standards TIN, office code mailing address field 6 through 11 and when utilizing the workaround a C/O or an ATTN would be provided in the TIN, office code mailing address line 2 or field 7 followed by the third party's name.

So, please note, with the aforementioned changes to the TIN reference file layout. This workaround has been discontinued and should no longer be utilized. New changes to the layout involved the addition of specific recovery agent name and address fields which are field 16 through 22. These new recovery agent fields replaced the former workarounds. If an RRE wishes that a third party be forwarded copies of the recovery correspondences then they

must now provide that third party's information via field 16 through 22 on their TIN reference file.

The actual RRE's address must now be provided via field 6 through 11. In situations where recovery agent info was provided, all recovery correspondence will be sent to the RRE address supplied in field 6 through 11 and a copy of that correspondence will also be sent to the recovery agent noted in field 16 through 22.

OK, next as you should hopefully all be aware, and as John had referenced, the transition from ICD-9 to ICD-10 will be taking place in just over two months from now. As of October 1st, we'll be – we've – excuse me, we will begin accepting ICD-10 codes on all production claim input files, and for all claims with dates of incident 10/01/2015 or later, ICD-10 codes will be required. Claims with dates of incident 10/01/2015 or later submitted with ICD-9 codes will be rejected. The claim with dates of incident 09/30/2015 and prior, we will accept either ICD-9 or ICD-10 codes. However, please note that we cannot accept a mixture of both ICD-9 and ICD-10 codes within the same claim record. Each claim record must be submitted with either ICD-9 or ICD-10 codes but not both at the same time.

The ICD indicator field 17 must also appropriately reflect the proper ICD version being submitted within the claim records. The value of space or 9 may be used to indicate ICD-9 and a value of zero may be used to indicate ICD-10. If the ICD indicator does not appropriately match the type of ICD codes being submitted, the claim record will be rejected. Please note that RREs will not be required to convert previously submitted and accepted ICD-9 codes to ICD-10 when submitting future updates for claim records with dates of incident prior to 10/01/2015. However, an RRE is free to submit ICD-10 code on such an update if they wish as long as all code submitted for that claim record are converted to the ICD-10.

Also, although ICD-10 codes will not be accepted on production files until 10/01/2015, we have been accepting ICD-10 codes on test files since October of 2013. Still, very few RREs who take advantage of the opportunity to submit ICD-10 codes via test files to date. While testing for the ICD-10

transition is not required, it is highly recommended that RRE submit test files containing ICD-10 codes in order to ensure that they are adequately prepared for the 10/01/2015 transition. Test file submissions will not interfere with any current production file processing and may be processed simultaneously with your current production files.

OK. One further reminder, and John, touched on this briefly as well. This one is regarding the June 18, 2015 alert regarding the change to the matching criteria for submissions utilizing partial SSNs. As of the aforementioned date, when a partial SSN is submitted and a match is found on the last five digits of that SSN, we now require a four for four match on all remaining criteria which include the first initial, first six characters of the last name, date of birth and gender. This change was implemented in order to improve the accuracy and quality of matches via the partial SSN submission process.

This change to the matching criteria for partial SSN submission applies to both the claim and query file processes. Since this change was implemented, we've received a number of questions regarding the duplicate disposition code or DP which was implemented along with the partial SSN reporting process back in January and reporters have been inquiring as to how this change in the matching process would impact the DP disposition code and whether that new duplicate disposition code would still apply. And so to clarify, the logic which we generate the aforementioned duplicate disposition code has not been removed. They could technically still be possible to receive that DP disposition code but such a scenario should be exceedingly rare given the more stringent matching requirements down the place.

And finally, I just wanted to comment on the type of issues being submitted to team as a resource mailbox as John had also referenced and as the pl110-173sec11-comments@cms.hhs.gov e-mail that we're referring to and it's included in all the town hall teleconferences notices posted to the CMS Web site. I'm sure most of you are familiar. Anyway, more and more we've been finding that the types of questions and many of the topics referenced in e-mails to the resourcing mailbox really thinks it would be more appropriately directed elsewhere.

First off, is resource mailbox is not an appropriate place to submit recovery related questions. This resource mailbox is intended for issues relating to the Section 111 data collection process only. If you recovery related questions and the best first course of action is to contact the BCRC call center at 855-798-2627 and doing so will allow you to speak with a recovery specialist to the BCRC or to be routed to a specialist at the commercial repayment center a appropriate.

In addition to a significant volume of recovery related questions, we've also seeing an uptake in the volume of basic technical questions being submitted to the technical resource mailbox, and please note, if you have technical questions about the reporting process, you should really be reaching out to the BCRC directly. The first point of contact should always be your assigned EDI representative. Every RRE that is registered as an assigned EDI rep and their contact information should be present on your Section 111 profile report, however, if you're uncertain who your assigned EDI representative is, you may either contact our general EDI phone number at 646-458-6740, and you'll be appropriately directed or you may utilize there is direct contact information provided via the escalation process outlined with Chapter 1 of the NGHP User Guide. And that can be found within Chapter 8 within the Chapter 1 NGHP User Guide document.

It contains information regarding the entire contact protocol including the escalation process. I'm actually the first point of contact within that escalation process personally and you'll find my direct confirmation there – excuse me, information there. You can always reach out to me and I can provide you with current contact information for your assigned EDI rep, or if you already have your EDI reps contact information, but you still have difficulty obtaining the answers you require then please don't hesitate to utilize that escalation process. That's what it's there for.

One common (thread) that we have seen via the resource mailbox quite a bit in recent times concerned situations where RREs are either looking to update their information or perhaps may be involved in a situation where business and subsequently reporting requirements are transitioning elsewhere. The most appropriate course of action in such circumstances may vary depending

on the exact scenario but if you reach out to us directly to BCRC, we can most definitely provide you with appropriate guidance once we've got the details of your situation. And again, please reach out to the – your EDI rep directly or utilize the escalation protocol if need be.

And that's all I have. So, I turn it back to you, John.

John Albert: OK. Thanks, Jeremy. Barbara Wright is with us as well and she wanted to provide some information related, again, to some of the – some of the more policy related questions that came in through the CMS resource mailbox.

Barbara Wright: Good afternoon. I just have a couple of quick reminders. As you may remember, if you have responsibility for Ongoing Responsibility for Medicals and the individual is not a beneficiary yet, you need to monitor that individual and report when they become a beneficiary, and one of the things the reference guide spoke about was having – if you use the model language for your documentation if they weren't a beneficiary having that resigned and dated approximately every 12 months. We've been asked more than ones whether such resigning and dating is required after the reporting entity close his coverage.

What we wanted to distinguish, again, is the concept of closing coverage and no longer having responsibility for ORM. If legally, you no longer have responsibility for ORM, then there is nothing else to monitor. However, if you're closing your record for administrative convenience or other purposes closing your coverage does not by itself relieve you of the responsibility for monitoring. The second thing is we've received more than one inquiry asking about if you've received a letter from our contractor stating that there is no Medicare (lien) or no recovery claim related to the settlement that you're dealing with. Does this affect reporting for another was reportable settlement? The answer is no. You still have the reporting obligation.

And last but not the least, there were several questions that at last implied that the entity sending in the questions (believe) that for workers' comp at least maximum medical improvement cut off any reporting responsibility. That's not correct from our perspective. Again, the issue is whether or not you

legally still have the responsibility for any Ongoing Responsibility for Medicals. If under state law, maximum medical improvement terminates your obligation and you have appropriate documentation of that maximum medical improvement fine. But as a general concept, maximum medical improvement just by itself does not cut off – cuff off any responsibility from CMS' perspective.

John?

John Albert: OK. I think that's it for here at CMS and the BCRC. So, operator, we can open it up to questions.

Operator: Certainly. At this time, if you would like to ask a question, please press star followed by the number one on your telephone keypad. We ask that you please limit yourself to one question and one follow up in the interest of time. If time permits, you will be able to re-queue for further questions.

Your first question comes from the line of Keith Bateman with PCI. Your line is open.

Keith Bateman: Hi. This is (Keith). I've had several inquiries about whether audits are being conducted in Section 111 Reporting Compliance (needed) by one of your contractors or the OIG. Any comment on that, please?

John Albert: On that – we're – (where of us) and that what we do internally. No external (longitude) as far as we know. I have to say that that couldn't happen in the future, but...

Keith Bateman: John, by internal what do you mean? Your contractor is...

John Albert: Yes. Yes, we do – we do internal Q&A and all that through our integration contractor as well as the individual contractors at which CMS staff here as, you know.

Keith Bateman: OK. So, those are a non-contact with the RRE. You just – you're doing it internally (putting) whether they're reporting directly, is that what you're saying?

John Albert: Yes, yes. You know, we've had – as I mentioned before, we've had issues that have come up. For example, folks that fell off the radar and it's not limited just to NGHP reporters but we had one large national reporter that suddenly we couldn't get a hold off and, you know, that was a big problem, so.

Keith Bateman: OK. OK. I have one other quick question.

John Albert: OK.

Keith Bateman: The ICD-10, Medicare for providers has provided a grace period and said, as long as they report the right family which their latest Q&A (says) it's the first three digits of the ICD-10 that they will be paid. Is there going to be a similar grace period for RREs?

John Albert: What's that grace period is?

Female: It's (gross).

Barbara Wright: I just...

Female: You know, what I do know.

John Albert: Yes.

Barbara Wright: I don't think we were familiar with that particular grace period but keep in mind if I'm understanding you correctly, you're saying the grace period lets the entity report with less specificity, and if you're reporting a code connected to ORM, the less specificity you give us the more claims we're going to include under that code, so...

Keith Bateman: Right, right. But CMS...

Barbara Wright: ... got (interest).

Keith Bateman: ... right CMS is saying, if a provider at least gets the family of codes correct, they won't deny payment during the grace period. Could you take a look at that because that's going to affect what we received from providers?

Female: Yes.

John Albert: Yes, we can – we can take a look at that but I mean, you know, either way, I mean, it's still going to be ICD-10 code. So that...

Keith Bateman: Right, right.

John Albert: ...but (Keith)...

Keith Bateman: But I'm saying there – they came out with their latest clarifying release July 27th.

Barbara Wright: So, OK.

Keith Bateman: Those from CMS Media Relations.

John Albert: Yes. Under CMS.gov, under Medicare, under the section called Coding which is right next to Coordination of Benefits, there is all the official guidance there regarding.

Barbara Wright: And that alert was supposed to be (yesterday) as we're saying.

John Albert: Yes. Yes, yes. OK. So, yes, we're not familiar with that alert.

But the main thing is (we have such) – if that's the case, you know, further change or just like, you know, we – CMS has delayed multiple times and everyone aware of, the rollout of the – upgrade to ICD-10. Again, you know, the official CMS Guidance is the official CMS Guidance and that's where it should go.

I mean, you know, our guidance reflects the CMS Guidance in terms of we expect people to submit ICD-10 codes if there are some slight variations of that that come out the last minute then we will abide by that accordingly. Just that as Barbara said keep in mind that regardless, there are potential risks if we're – at least it could be potentially more troublesome for everyone involved in coordination and recovery if we have less specific (code).

Operator: Your next question comes from the line of Patricia Nuckols with Paramount Healthcare. Your line is open.

Patricia Nuckols: Yes. Good afternoon. I have question I think that's probably directed to the BCRC and I'm hoping you guys can help me. We have a lot of members that were getting records showing that they have another primary payer and the members are calling in and asking us to help them that the information is incorrect or it's outdated. We have been directing them to call the 1-800 Medicare number.

And what we have been finding is actually like old auto accidents that have been closed out or the person never was in an auto accident or an old workers comp claim that's no longer active. What's the best way for the members to – I've had to do like three-way conference calls with the BCRC to get them resolved. But what's the – how can we direct our members to help them be able to solve these questions or solve these issues?

John Albert: I think just for curiosity there, are these related to Medicare Part C plans potentially?

Patricia Nuckols: I think a few of them might have been Part Ds actually, but mostly so for drug-related issues. They're trying to get their drugs filled, and you know, they're showing up at the pharmacy and the pharmacy says that they have another carrier on file and they don't know who that carrier is, and you know, then they're calling in to our health plan and just think of it we put something on their, you know, stopping their benefits, but it's really something that's coming I think from the marked COB file or from – or from the NSB file.

John Albert: Well, I mean I – that's – it's kind of like – we take in obviously prescription drug coverage data and send it to the system that then sends it to the Part C and D plans. They're supposed to be using the information that's on the file that, you know, the – we are the source of the information through data collection of BCRC. We do know there have been issues. I mean there's a lot of Part D plans. There have been issues with Part D plans relying on internal systems and things like that, but that's not really anything that we can address.

Patricia Nuckols: OK.

John Albert: I don't know if Jeremy or Jim or whoever, if you have anything to add, because we've seen – I have personally seen and been involved in some of these disputes. You know, I know there's been a lot of clean up of old Part C and D information as well because a long time ago decapitated rates weren't based on whether there was MSP or not and there is now.

Patricia Nuckols: Right.

John Albert: So – but these are – these are auto – you're talking about auto (no fault). But again there's been some clean ups on that as well.

Barbara Wright: Right. The other thing is that you're talking about NGHP and not GHP. When there's a note with MSP record, that doesn't automatically stop payment and we issued – it was a med learn article, what, a year or a year and a half ago.

John Albert: Yes. (Especially done) on several times. Yes.

Barbara Wright: Yes. To make it clear to providers and suppliers of all type that when there is an open record while they need to follow the prompt pay rules and everything, that an open record doesn't automatically mean that there is coverage that's saying primary to Medicare. So generally there shouldn't be denial based just on that.

Patricia Nuckols: OK. So I can...

John Albert: Yes. And in terms of claims – like claims payment issues per se, I mean you probably should go to (One Hand) or Medicare for that. If it's a question of information that's incorrect on the file, I mean, BCRC can correct that information.

Patricia Nuckols: Yes.

John Albert: They can tell you like what the source to that data is and all that kind of stuff. I mean if you, guys, Jeremy or whoever want to chime in.

Jeremy Farquhar: Yes. I mean...

Patricia Nuckols: Yes. So we – I'm sorry – I initially sent the members that I've been working with to the 1-800 Medicare and I guess from what they've said they've been told that the plan has put a hold on – or something on their record that flagged their record. And I tried to explain as a plan we didn't really put anything, you know, on hold.

The hit had come from somewhere and I ended up, like I said, doing a three-way conference call with about at least six members that I'm aware of to the BCRC because they wouldn't speak to me about what was, you know, holding up the record or what was on the record unless they had the members authorization. So I got the member on the line.

And most of it was like dated stuff from like 2012 and 2013, the ones that I've dealt with. But ones the member said they no longer had that coverage or they never had that coverage then we were told that they would be updating the Medicare record and within like 48 hours it would show them as having Medicare primary again.

(Jim Brady): Right. So I think – I mean if I can interrupt – this is (Jim Brady) of BCRC. I mean I think the best direction for you to give the beneficiary is if it is one of those situations that you just call BCRC call center. I can give you that number.

Patricia Nuckols: OK.

(Jim Brady): It's 1-855-798-2627. In that way, you don't have to go, of course, through the 1-800 folks to get to us. And assuming we have all the right information, we should be able to take care of that update while we have the person on the phone. Just to clarify though, you're talking about situations where there is another primary payer to traditional Medicare not situations where it's an MAPD plan or something like that, right?

Patricia Nuckols: But we're an MAPD plan. So something is triggering, you know, like I said mostly – I think most of these have been drugs. And then they brought up a question like as a plan is there a way for us to find out which one of our

members might have like a list of these that we could research and work on and try to help the members resolve, is there a way to get anything?

(Jim Brady): So how about we do this? So (Bill Ford's) name is in the user guide.

Patricia Nuckols: Right.

(Jim Brady): (You see his) number, give him a call. He's sitting right next to me and he's volunteering to take your issue and your examples, and you know, we'll work him down. He's got contacts on the Part D side as well. So we can try to source it out and get to the bottom of it. It sounds like something that will require a little more research than we want to go through right here on this call.

Patricia Nuckols: OK.

(Jim Brady): Bill is at your disposal to assist.

Patricia Nuckols: OK. That will work great. Thank you.

(Jim Brady): All right.

Operator: Your next question comes from the line of Melissa Harkins with Indiana University Health. Your line is open.

Melissa Harkins: Yes. My first question has to do with not having to report claims, ongoing, (responsibility) the medical and work comp that's less than 750 medicals only. Just curious if there's any thought to increasing that.

Barbara Wright: We haven't – we aren't considering changing at this time and I would have to look at the user guide but I don't think you'd quote it quite all the requirements. So I would – I think, for instance, it requires any payments being made directly to the provider supplier.

Melissa Harkins: Correct. And then my second question is kind of a followup to the previous caller. I just wanted you to be aware that we've had instances where work comp – we have an open work comp claim and our employees then seek medical treatment and has been refused because he has an open work comp

claim and they would call 1-800 Medicare and Medicare has gotten the hold of some of our, you know, frontline work comp workers.

And then in the conversation, they've discussed whether the claim was still open or not and some of those frontline work comp folks don't understand the fact that although we've administratively closed it on our end that it doesn't mean that it's – you know, it doesn't mean it's close on your end.

And so, they have been – they have discussed with somebody – I don't know who it is – but they told them that it's – the file has been closed. And so then they'll go ahead and close out the ongoing responsibility for medical and then – and that's not correct. I just don't know where that education (needs) to be...

Barbara Wright: As I just heard you say, it sounds like it's internal education that your – the workers comp people are getting it wrong.

Melissa Harkins: Well – and I told them that and I told them that the – you know, that it still needs to remain open. But they said, "Well, Medicare said they'll go ahead and close it anyway." So that's concerning to me.

Barbara Wright: Yes. Well, I mean it's giving us false information. So any work comp entities that has that problem internally, (well), it's staff needs to figure out a way to correct it.

Melissa Harkins: And we have. We've gone back through and we've made sure that they remained open. I just want to know also I guess that where we can also – I know this letter has been sent out and you said that she thought that letter makes it clear to providers that, you know, generally an open record doesn't mean, you know, that they can go ahead and deny claims – that they're still denying claims. So I don't know if there's some way to get that letter back out, you know, of more recent than, you know, a year or two years ago.

John Albert: Well, certainly – I mean if you do need somebody from CMS, you know, to talk to whoever it is to make sure this is framed out and they understand, we're more than happy to assist on that front. But yes, definitely, I mean this

is – this has been an ongoing issue of confusion since the very beginning. So – but no, I appreciate your suggestion.

And you know, it's just like we've sent out repeated provider education bulletins that are essentially repeats of earlier ones reminding them about, you know, proper or improper denials of claims based on, say, for example, diagnosis codes and things like that. We certainly can look at providing that again. So thank you for that.

Melissa Harkins: Thank you. That's it. Thank you.

Barbara Wright: The other thing is – and I don't know if Jim or Jeremy would have a site handy – but within the user guide, it makes it clear that a record should not be reported closed when the issue is administrative convenience or administrative – done administratively for the workers comp or no fault entity (as better) as it's only when you no longer have legal responsibility.

And it might be worthwhile for any entity to re-circulate that information to their staff to make sure they understand the distinctions because sending out what John was talking about where it just talks about the provider or supplier not refusing services that's not going to help – necessarily help with the problem you described. You need to make sure that the staff that's doing these type of calls right now sees what's in the reference guide and recognizes the difference between administrative closure and legal responsibility.

John Albert: And under the policy chapter, which I'm sure that's where that is, I'll just do a word search under like administrative or something like that and you should be able to find it. I just don't know where it is right on top of my head, but it is there.

(Suzanne Mathis): Before we move on (inaudible).

John Albert: Yes, sure.

(Suzanne Mathis): Hi, folks. Before we move on I wanted to clarify one thing. This is (Suzanne Mathis). Keith Bateman had a question earlier regarding the ICD-10 transition and how it affects the MSP piece of that. I just wanted to clarify

that the July 27th posting that CMS put out is an update to some FAQs that had originally published on July 6th.

The FAQs contained in that most recent publication do specify that there is no delay in ICD-10 code usage. The FAQs specifically state that Medicare claims with the date of service on or after October 1, 2015 will be rejected if they do not contain a valid ICD-10 code. I believe that the confusion derived from one of the subsequent FAQs and it's related to claims denials based on the specificity of the ICD-10 code.

So if you were to look at those FAQs and look specifically at question number seven you'll find that it reads that Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical review based solely on the specificity of the ICD-10 diagnoses codes as long as the physician/practitioner use a valid code from the right family of codes.

That's a really, really, really specific (new ones) that shouldn't affect what we do on the MSP side of the house. We wouldn't expect that any of the claims processing folks on the phone right now would potentially run into issues related to that. Obviously, if you do, let us know. But at this time, we're remaining steadfast in what we've stated before, which is that ICD-10 codes will be required by all physicians, providers and other suppliers for date of service on or after 10/01.

John Albert: And for the record, that was (Suzanne Mathis). Is that found in the coding – so I think we've mentioned that under the Medicare.gov, under the Medicare tab, there's a section called coding and that's where, again, all the ICD-9 to 10 transition information is including.

(Suzanne Mathis): ICD-10 under latest news.

John Albert: Under latest news. OK.

(Suzanne Mathis): So hopefully that addresses any of those concerns or any of that confusion. So just – if you do review those types of FAQs, they're really, really

comprehensive and they're very, very specific and very (new ones). So we certainly encourage you to take a look at them.

John Albert: There's a lot of information on that section. Can we take the next question?

Operator: Certainly. Your next question comes from the line of Teresa Lynn with Corvel. Your line is open.

Teresa Lynn: Thank you for taking my call. This is in regard to all of the other previous questions regarding claimant who are being told by providers that they have an open – primarily open work comp claim. And we are in the process of keeping our adjustors educated on the fact that they cannot arbitrarily close the ORM. But the problem really becomes an issue because the claimants are insisting that they're not treating for their work comp claim. They're treating for other treatment unrelated to the work comp claim and they don't know where to go.

I submitted this question. This has been an ongoing issue for some time. I've received five of them this week alone. What do we tell these claims when we have to leave the ORM open?

Barbara Wright: Are you saying that they aren't getting treatment or that they are having their claims denied by Medicare?

Teresa Lynn: Well – and Barb, I've actually heard you speak live and we've – you've actually pitched on it. Unfortunately, for many of these claimants, they are very unclear as to what they're being told. And my concern is if they're going to a provider who had treated them for their work comp claim that they inadvertently leave a diagnostic code on the billing to Medicare and Medicare denies it because it's part of the ORM.

I don't know, Barb. I don't know. I'm looking for anything I can tell these claimants where to go, what to do, what questions to ask. If it's a provider issue, the letter that you have that you referred to earlier, is there anyway that we could get a copy of that letter so that we can submit it back to the provider?

Barbara Wright: Well, John is going to be looking into which ones we issued in the past and whether or not...

Teresa Lynn: OK.

Barbara Wright: ... it's re-issued. So we should be able to make it available to you.

(Jim Brady): Yes, yes.

Teresa Lynn: OK.

(Jim Brady): So I mean really it seems like – and I know it's not a simple in real life as it is in theory. But I mean the beneficiary should be able to go. If it's the provider that's denying the treatment, beneficiary should be able to go to that provider and say the issue is not related to my work comp case and the provider should be in an excellent position to agree with that. So they should not be denying unrelated treatments that's, you know – that's a horrible thing and it's a big deal that the beneficiary should not put up with.

Teresa Lynn: (Is that a play)?

(Jim Brady): If it's -- the MAC contractor is denying the service after the fact, then there's the appeals process, and you know, the provider should be going through that appeals process and taking care of that. It shouldn't be something that the beneficiary should ever have to get involved with. So I think in either case – you know, theoretically speaking in either case, the system has a mechanism of dealing with those scenarios.

Teresa Lynn: OK. And – thank you very much. And I – the number that you referred to, 855-798-2627, would that be a number to give the claimant to call in the event that there is a big issue?

(Jim Brady): I mean certainly that could help, you know, if there's a question of whether the record is even out there. But in the case as you're describing, it sounds like, there's no contest that the record is out there. It's really just a question of what – what's happening with it out in the street. So I think the amount of

assistance we could pull out, the beneficiary in those cases would be limited. But you know, certainly, there's no reason the beneficiary can't call.

Teresa Lynn: OK.

John Albert: Yes. I mean we don't – I mean we're not really involved in claims processing. It's just the accuracy of the information on the record. And assuming there's no issue with the accuracy of information, it does become – I think Jim said it, it's a provider, you know, Medicare contractor issue in terms of, you know...

Teresa Lynn: So you think it sounds more like a provider, the physician also and the medical office is denying it saying they have an open claim?

John Albert: I mean yes. I mean that's why they have the (meddler) and articles that we before is that, you know, we know that there's a constant battle with – it's just like anytime new people come in, they've got to learn the ropes and they just see MSP and stop at that, not realizing that, "Oh, there's specific codes related to that," and you know, stuff that – and that's why we've even gone so far as to not allow certain codes on Section 111 reporting because some of them are just so routinely misused that the odds are that it's better just to not allow those to come in.

Teresa Lynn: OK. I appreciate it. Thank you.

Operator: Your next question comes from the line of Catherine Goldhaber with Segal McCambridge. Your line is open.

Catherine Goldhaber: Hello. Thank you. I have a question regarding exposure cases. With an exposure case, the DOI is to find us the data of first exposure. But for most cases, concerning asbestos, there will not be a DOI on or after October 1, 2015. At some point, will CMS determine that the reporting code needs to line up with the treatment codes such that the date of diagnosis will become the determining factor as to whether or not to use ICD-10 versus ICD-9?

Barbara Wright: At this point, we're not considering the change that you suggested.

Catherine Goldhaber: That was my only question. Thank you.

John Albert: OK. Thank you.

Operator: Your next question comes from the line of Jacqui Miraglia with Blue Vault.  
Your line is open.

Jacqui Miraglia: Hi. Good afternoon. My question actually was answered about that frequent FAQ regarding the delay and the ICD-10, but I totally get that there absolutely is not a delay. But while I have an audience, I wanted to ask just a very broad question. Is there any way – because I've search for this a lot, is there any way I can get an exact number as far as the recovery yield for CMS for Section 111 reporting like on an annual basis how much is recouped through that process? And I know this is sort of a random question, but I figured I take advantage of the time.

John Albert: I mean we do reports to Congress that I assume were publicly available. I don't think they break it down by Section 111 per se but Section 111 is certainly the largest source of MSP data right now and that's been for a while.

Jacqui Miraglia: So we just be under general CMS recovery for MSP?

John Albert: Yes. CMS, they do like an annual CFO report and all that. I assume those are published and available.

Jacqui Miraglia: OK. All right. I'll do...

Barbara Wright: I mean NGHP reporting at best is typically broken down by liability versus workers comp...

John Albert: Yes.

Barbara Wright: ... versus no fault, not the source of the MSP information that resolved within the recovery.

Jacqui Miraglia: Got it. All right. Well, that's helpful after searching that way, but I appreciate your time and thanks for asking – I mean answering the question.

John Albert: Sure.

Operator: Your next question comes from the line of Gino Moreno with MS (inaudible) Claims. Your line is open.

Gino Moreno: Hi. Yes. I would like to know whether (an RE) still has the duty to report its ORM as it pertains to Medicare – its Medicare beneficiaries who received their Medicare benefits from a Medicare advantage plan?

John Albert: No. No. I mean the Medicare Advantage Plan is Medicare.

Male: Yes. It has no impact is what I think you're trying to say and they're still required to report ORM.

Gino Moreno: OK. So if they – if they failed to report, it would still – it's still be in violation of Section 111?

Male: Absolutely. Whether they have traditional Medicare or Medicare Advantage Plan, non-group health plan reporting is required and so is group health plan reporting for that matter, but you would have to report that ORM coverage. We still coordinate benefits with that Medicare Advantage coverage.

Gino Moreno: So how – so how would Medicare Advantage have information to this (one) – to them reporting?

Jeremy Farquhar: The Medicare Advantage Plan will see files with the data that's collected. So they know who's got other insurance.

Gino Moreno: Perfect. OK. Thank you very much.

John Albert: Sorry. I garbled that my response. Thank you, Jeremy.

Operator: Your next question comes from the line of Pamela Norris with City of Charlotte. Your line is open.

Pamela Norris: Hi. My question goes back again to the issues with the coding and also the Medicare beneficiaries not being seen by doctors. We have that problem here too. They have an open workers comp claim because the ORM has not

termed and they go to their doctor to get treatment for other than their workers comp claim and they are turned away saying, “No, we can’t see you because you have an open work comp claim.”

So that is a real big issue I think that’s continued and it has been around for a long time and I don’t know but I really think it’s something that, you know, we don’t have any – we don’t have anything that we can do to fix that but certainly, you guys do and that would be a hope that someone can work on that.

John Albert: We will.

Pamela Norris: That was – well, I guess it was comment.

John Albert: So thank you. I mean we’ve heard a lot of this. And you know, they tend to – this issue tends to come kind of like in waves to us. So we will definitely take this – take this away from today’s teleconference to deal with the issue.

Pamela Norris: OK. And my question that I – that I originally wanted to ask is having to do with the correct ICD-9 or 10 codes. In the past, I’ve seen where we’ve put in our system that’s then transmitted to Medicare the correct ICD-9 code for our injured body part. And yet, when we get conditional payments or conditional payment amount sent to us, there’s all kinds of other diagnosis codes on there that really have nothing to do with us or the claim and yet we have to spend our resources trying to figure out what they are only to have to go to the dispute process of paying these claims.

So is there anything that’s going to be changing because – I guess what I’m saying is my understanding was that as we put the correct codes in there that you guys received why are we getting all this other stuff that’s not related to our workers comp injury?

Barbara Wright; I mean there’s a – there’s at least two possibilities. And first off is whether or not the correspondence you’re getting is the CPO that’s related just to ORM because if there is a settlement judgment award or other payments, CMS still has the right to recover for anything that’s claimed released or released in effect. I mean that’s one possibility of why.

The other reason, sometimes when we get questions on this it's because the build service has several codes attached to it and the one that's related to the injury are – you know, that everyone agrees as related to the injury is there but other codes there as well simply because there's multiple codes on a service doesn't mean that it's – that it's not related. If in fact, you know, the code that everyone agrees belongs there is there. So you know, that's at least two instances where there would be codes that we would have rights with respect to that might appear at first glance to not (fit the mold).

Pamela Norris: Well, I know that – I have taken – and this may or may not be correct but I have taken the position that if I get the provider bill and it has something that's unrelated to his injury, that bill goes back to the provider and ask them – and I have to ask them to change it because we're supposed to put those in there but it's not related. And so, it's going to cause huge headaches down the road. I've received conditional payment letters with upwards of 20 pages of charges that are totally, you know – they're for like the primary care doc going in for their diabetes check, their blood pressure check, and all those types of things.

I mean is – are the new – how do we get the doctors I guess to leave those off of there?

Barbara Wright: I don't think you're going to be able to control the doctors billing according to what they consider appropriate medical practice. I know that we here are looking – always looking for ways that the contractor can filter cases better. So I don't know – I honestly don't believe that providers, physicians and other suppliers are going to change their billing practice when their billing is medically appropriate.

What you're describing sounds more to me an issue of whether or not we potentially should have included the claim in our conditional payment letter.

Pamela Norris: Yes. But you see, there again we have to do the investigation and it's taking a lot of time and resources for us and I feel like there should be some ways to get rid some of those, like the – I can't remember what it is now – but the

diagnosis code 4012 I think is for blood pressure. If they have a broken ankle, I would think those would automatically not even show up.

Barbara Wright: I apologize for cutting you off but we are both past our time limit.

Pamela Norris: It's OK.

Barbara Wright: And your question really is a recovery claim question. It really is out of the scope of this call at best. But I can say right now is we're always looking for ways that we can improve the filtering, but it's not – it's not completely automated effort. It's not completely a manual effort.

Pamela Norris: OK. Thank you.

John Albert: All right. Operator, as Barbara said, we're past the time. If you could sign everybody off, I wanted to thank everyone for their participation. Again, as I mentioned before, on the COB, on our What's New tab, will be information about the upcoming webinars to roll out the ORM recovery process with the commercial repayment center.

Again, also, I didn't mention it, in case people didn't know, there is actually a way you can sign up to get alerts via Gmail that – not Gmail – through .gov delivery letting you know about new publications that are put out on our CMS web pages. So please take advantage of it as well so that you'll not just keep looking at the site every once in a while.

With that, thank you, and good day. And if operator, you could keep us in the post conference. Thanks.

Operator: This concludes today's conference call. You may now disconnect.

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