TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: December 8, 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
December 8, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all lines will be on listen-only mode until the question-and-answer session of today's conference call. The call is also being recorded. If you have any objections, you may disconnect at this time. I will now turn the meeting over to John Albert.

John Albert: Hi. Good afternoon, everyone. My name is John Albert. I'm with the Centers for Medicare and Medicaid Services and for the record, today is Tuesday, December 8.

This is one of the continuing town hall conference calls we've been holding with the public to roll-out the implementation of the Section 111 MSP reporting requirements.

Today's call is specifically geared towards non-group health plan meaning worker's comp liability no-fault insurers and this call is also geared towards to answer your more technical questions regarding implementation.

We'd ask that you please hold the policy questions until next week's call on Tuesday, December 15 at the same time. We'll be hosting a policy-oriented call. We're a little short on some participants on this end so we hope to be able to answer as many of your questions as possible.

But I also want to remind everyone on the call as we do every time that sometimes we misspeak or, you know, regarding answers and that the official

answers to all guidance concerning Section 111 is on the mandatory insured reporting Website which you should all be familiar with.

That and specifically I want to point you to the user guide and any more recent alerts that have been posted. We're going to start as we do on most of these calls with a presentation by Pat Ambrose regarding some of our technical issues that have come up since the last call and then we will open up the floors to questions and answers.

We ask that you please limit to your questions to one primary and one follow-up and then allow other people to get on the line to get their questions answered and with that, I'll turn it over to Pat.

Pat Ambrose: Okay, thanks, John. As - first some preliminary announcements - as we've announced previously, there are new and updated computer-based training modules available for NGHP RREs and agents.

The updated curriculum was recently posted to the CBT page of the CMS mandatory reporting Website. If you're enrolled in the CBTs, you should have received an e-mail concerning this.

To enroll in these courses, go to the mandatory insurer reporting Website page and click on MMSEA 111 computer-based training tab and follow the instructions there.

We have posted downloadable files that contain (tuft) beneficiary data, the insufficient ICD-9 codes found in Appendix H of the User Guide, and the error codes also found in the User Guide for the claim response files.

These files have been posted on the Section 111 COB secure Website which is found at www.section111.cms.hhs.gov. Again, that's on the Section 111 COB secure Website instead of the CMS mandatory insurer reporting page. When you go to the COB secure Website, you do not have to login.

You just need to accept that login warning and the login page will display. On the menu options across the top of the page, you'll see a menu option for reference materials and if you click on that, you will see links to these downloadable files and information concerning them.

We will be unable to publish the non-GHP User Guide before the end of this year 2010 as previously announced. Instead, the outstanding policy changes and corresponding requirements for reporting will be published in alerts as they become available on the CMS mandatory insurance reporting Website.

The new User Guide will be posted as early in 2010 as possible and I will provide some additional information about changes that may affect you from a technical perspective.

Note that there is no change to the non-GHP schedule for testing and production reporting. Testing commences January 1, 2010 and the first production files are due in 2nd Quarter 2010, April through May 2010 during your assigned file submission timeframe for your particular RRE ID.

RREs are to incorporate - no, I'm sorry. However, some of the changes that you know are still pending will be effective at later dates to allow RREs time to incorporate the changes into their system.

Also please note that the test system will always be available even after your RRE ID goes to a production status and you start submitting production files

so you may test changes to your system by submitting test files even after you have begun submitting production files.

Here are some things that will be updated in the User Guide and posted as alerts that might impact you from a technical perspective. We are making changes related to registrations and the TIN reference files to accommodate foreign RREs that do not have an IRS-assigned Tech Identification Number or TIN or a U.S. address.

The plan is to allow the foreign RRE to use what we refer to as a pseudo-TIN or a fake TIN number and we are adding new optional fields to accommodate a non-U.S. address or an international address.

On the TIN reference file, these will be free-from text fields added to the record in an area that's currently defined as filler and there will be no specific requirements because there are so many differences in the way that international addresses might be formatted but just some basic requirements for at least supplying that information.

And again, the registration process will change to accept this fake TIN number and some other things to registration to allow the foreign RRE to get through that process.

These changes will not be effective until April 2010, and again more specific information will be published on exactly what needs to be done. But again, foreign RREs without a TIN and/or U.S. address who are unable to register at this time due to the limitations of the registration application online will be able to do so starting in April 2010 and obviously will have somewhat of an extension in terms of reporting.

The changes that I referred to also regarding the TIN reference file to allow this foreign address for the RRE to be submitted will also not be available until April 2010. The testing of file submissions by foreign RREs in this circumstance will commence April 2010.

A change is being made as has been previously announced to accept the last three versions of the valid ICD-9 codes published on the CMS Website rather than just the latest one as we've previously stated. I have some more information later on in the presentation about that to help you locate those files.

As you all know, the field descriptions and requirements related to the product liability indicator, product generic and brand name, product manufacturer and alleged harm will be updated. These are Fields 58 through 62. The requirements have not been completely finalized yet.

The field names will likely change, and their descriptions, but the field and record lengths will not change for this. And obviously the testing related to these fields cannot begin in January on January 1 and more information will be supplied related to when testing for those particular fields can begin and when reporting will be required for the related claim that you might need to use those fields for.

A further explanation of what RREs are to do related to ceasing business or transitioning reporting will be added to the User Guide. An important thing to note there is that if a new RRE is taking over reporting, there are several different possibilities.

But if a - what I'd really want to say - is that a claim record previously reported and accepted by the COBC for Section 111 under one RRE ID may

be subsequently updated by a different RRE ID as long as there's matching fields, as long as the key fields match. Again, more information in the User Guide will be forthcoming on that.

We are adding two RRE-defined Document Control Numbers or DCNs to the query file, to the query process, the X-12, 270, 271 and the corresponding flat files for the HIPAA eligibility wrapper or the HEW - H-E-W - HEW software.

A new companion use of these fields will be optional. These DCNs are being added to the query file to allow better matching of input records to output records. This change will actually be effective with files processed after January 10, 2010 so we need to post this information in the form of an alert to see if beyond - and look out for that.

A new companion document for the X-12, 270, 271 mapping will be posted to the Website with the information on how to define these fields in your translator software if you're using your own X-12 translator and also the HEW software will be modified to use these DCNs as well.

The new HEW software will be available in January and the Windows PC server version can be downloaded from the COB secure Website starting in I believe it's January 6 and the mainframe software can be obtained from your EDI rep at that point in time.

In addition, we are working to make the Windows version of the HEW software more automated so that it can be invoked from a command line process. We'll also explain this in that alert and the information on how to invoke the software in a more automated fashion using this command line process.

That information will be added to the documentation that accompanies the HEW software download. That change to invoke the HEW from a command line process will be also available in that new release of the HEW software in January.

Note that there is a version of the HEW software already available that has been updated to handle the situation where the X-12 271 file is downloaded in a Unix text format rather than in an MS DOS text format. The new version of the HEW will accept and process Unix text files as input as well as MS DOS text files as input.

That was an issue that's come up on previous calls and we are updating the software to make that process run a little bit more smoothly rather than you having to change the type of the file to an MS DOS text format prior to running the HEW software.

I've been notified that corrections are needed for error codes related to the representative claimant and claimant representative phone extension fields. These fields are five place and will remain so but the error codes indicate that a four-digit number is to be provided.

These fields are alphanumeric and should be supplied as such so they should be left-justified with an extension of up to five digits and any remaining bytes filled with spaces. Also note that the office code site ID field must actually be a nine-digit number or if it's not used, submitted as spaces. Alphanumeric office codes will not be accepted.

This will also be corrected in the updated User Guide but as you're developing your systems and creating office code site IDs, please note that they must be nine-digit numbers. Again, this is an optional field but if you're

using it, please make sure that you format them as a nine-digit number. I apologize for that discrepancy in the previous User Guide.

There are also changes pending as you know for various policy issues related to what entity is RRE in certain situations and whether information for certain claims and insurance products must be reported which will impact what you include on your file submission.

Again, these policy changes or notifications will be issued in alerts and posted to the Website as soon as they are available and then included in the updated User Guide.

Now some more for - we've had several questions about ICD-9 codes so I'd like to try to provide some additional information. As stated previously for ICD-9 codes, the last three versions posted to the CMS Website will be used to validate ICD-9 codes submitted in the alleged cause field 15 and any of the diagnosis code fields starting in field 19 of the claim input file detail record.

CMS posts new versions of valid ICD-9 codes by October 1 of each year and the COBC will implement the new version the following January 1 of each year to allow RREs time to incorporate the changes in their system and again starting with each January, we will accept the last three versions.

So when testing starts January 1, 2010, the first production files and when the first production files are due in 2nd Quarter 2010, we will be using the following from Versions 27, 26 and 25.

There is a link in the current User Guide that will take you to the page on the CMS Website where the files of valid ICD-9 codes may be downloaded. This link is in Section 11.2.5 of the current User Guide.

I'll try to again get this information posted in the form of an alert as soon as possible but in the meantime, let's go through this download process. Open your browser and go to that link in the User Guide which is www.cms.hhs.gov/icd9providerdiagnosticcode/06_codes.afp.

Again, if you didn't get that link copied down, it's in the User Guide. When this page displays, you will see a series of zipped files under downloads on that page and they're each labeled with a version. There's actually two download files for Version 27.

Use the second download Version 27 abbreviated code titles effective October 1, 2009 and updated 7/29/2009 and next you would want to download Version 26 effective October 1, 2008 and lastly Version 25 effective October 1, 2007.

After you download the zip files, open them up. You will see the following text files inside that are the actual text files of valid ICD-9 codes that you may use. These files have descriptions for each individual code.

They are basically formatted with five bytes of a diagnosis and ICD-9 diagnosis code. Note that that is without the decimal, followed then by a space and then followed then by a short description of the diagnosis code.

Again you'd want to use the files with the diagnoses or the DX codes and these text files after that are present inside the zip files are CMS 27_DEFC_short_DX.text or dot TXG, excuse me. That's Version 27.

The Version 26 text file is V26 I-9 diagnosis.txt and Version 25 is I-9 diagnoses V25.text. Also note related to diagnosis codes that CMS will be transitioning to ICD-10 codes by October 2013.

I fully expect that we will accept ICD-9 codes up until that point and most likely will have a transition period where both ICD-9 and ICD-10 codes will be accepted but again the transition will not occur until at the earliest October 2013.

Also another important announcement and hopefully good news for most of you using the secure file transfer file transmission process. A fix has been applied to the Section 111 SFTP server software last weekend.

This fix was intended to resolve the issue where users associated with multiple RREs timed-out when attempting to build a directory listing and in general resolve the performance issues that many of you experienced when accessing the SFTP server and getting timed-out as a result.

So we expect that this has resolved the majority of the issues with the SFTP file transmission method; however, you still may experience issues related to authentication errors that must be addressed by your EDI representative.

Please try connecting to the - if you've been experiencing problems, response-time problems - please try reconnecting to the FTP server again to make sure that your issues have been cleared up and if not, let your EDI representative know if you're still experiencing a problem after attempting a connection again.

Again that fix went in over the weekend so if you haven't tried SFTP or a connection to that SFTP server this week, please do so and you might experience a much-improved in performance.

Also an announcement related to the query process. Note that when you submit a value of zero for unknown in the sex or gender field of the query record, the COBC will change this to a value of 1 for male prior to matching.

Your response file record will then contain the change value of 1 regardless of whether you get a match or not, regardless of whether the disposition code returned is an 01 or a 51 on the query response file.

As previously stated on these calls, you do not have to supply subsidiary information during the new registration stuff on the COBC secure Website. If you have trouble entering this information, you may simply skip that page.

In addition, you do not need to provide it subsequently to your EDI representative at this time so essentially the subsidiary information is optional and there is no need to send it to your EDI representative if you are unable to enter it during registration.

Please remember to notify your reporting agent that you have registered and entered their TIN as your agent during the account set-up step on the COB secure Website. You must also invite individuals from your agent company as account designees as applicable.

You must complete whatever contract or paperwork with your agent outside of the COB secure Website. The Section 111 COB secure Website does not notify your agent for you just because you provided their TIN at registration.

You really must meet with your agent prior to COB secure Website registration so that you can complete the RRE profile information correctly, particularly for the agent information supplied and for the file transmission method that you select if that agent is actually transmitting files for you.

I think I've announced previously that there is an issue in the current posted X-12 270, 271 companion document. It includes or it indicates that the DMG segment is situational.

That is not correct and that will be corrected and removed from the X-12 270, 271 companion document. There's a number of changes pending again for those DCN fields that we're adding and this change will also take place.

The statement in the companion document that I'm referring to is something to the effect that the 2100C-DMG's subscriber demographic information segment is situational and goes on from there. Again, that statement is not correct.

Now I'm going to go to some of the questions that were submitted to the CMS resource mailbox for Section 111 and provide answers to the ones that I'm able to of a technical nature. A very basic question was submitted related to how files are formatted and how the HTTPS file upload method works.

If at this point you are just getting started with Section 111 reporting and confused about the process, please make sure that you've thoroughly read the User Guide posted to the NGHP page of the CMS mandatory insurer reporting Website and contact your EDI representative, either your assigned EDI representative that has been assigned after registration or you may call the main COBC EDI department number at 646-458-6740.

Another question was asked about the ORM termination date and the requirement that it must be more than 30 days greater than the CMS date of incident. This is true.

That again is due to an internal system where we're posting this information within Medicare systems. You may default the ORM termination date with date 31 days after the date of incident if it is actually less than 30 days from the date of incident.

It should say no-fault claim that you're reporting, then put the actual date that the no-fault limits were reached in field 82 which is the exhaust date for dollar limit for no-fault insurance. There's no 30-day requirement related to field 82. That only relates to the ORM termination date.

It was pointed out that it's difficult to catch the actual URLs or Website addresses that I provide during these calls, particularly those related to the ICD-9 codes and as I said before, this link to where you can find the files of valid ICD-9 codes is in the current User Guide in Section 11.2.5. I think once you go to that page, it should be fairly self-explanatory.

A question has surfaced regarding a sole proprietor using the owner's SSN as the Tap Identification Number or TIN in lieu of obtaining a federal tax ID or a separate TIN. In the MFP input and TIN reference files, no, I'm sorry. This was a GHP question, but it actually could apply I think to non-GHP as well.

If the RRE is a full proprietor, you may submit an SSN in the TIN. It most likely will kick out - not really kick out - it will be accepted but result in a compliance flag.

However, whenever you receive a compliance flag for an invalid TIN, RRE TIN that you've submitted on your claim input file, please contact your EDI representative who will ask you to provide appropriate documentation and then be able to update our internal systems if we were unable to validate that TIN.

So per Section 12.4 in the User Guide, if you believe that the TIN is indeed valid, then please contact your EDI representative for resolution. Once that's been resolved, the next time you submit that TIN, the flag will not be posted.

A question was asked about whether a claim is reportable even if liability has not yet been established. There is no admission or acceptance of liability waiver of any rate of defense, etc. This is a policy question but I think it is answered in Sections 3.11.10.2 and the actual language of the Section 111 legislation.

If you do a search on the User Guide on the word admission, you will come up with the language that states that it is reportable regardless of whether or not there is a determination or admission of liability.

If medical payments are being made due to state law or otherwise, an ORN must be reported if settlement is reached, then the TPOC is reportable, again regardless of whether or not there is a determination or admission of liability. Updates or deletes can always be submitted at a later date if a TPOC or ORN is retracted.

Another question that's somewhat policy-related states that we had a worker's comp case and we denied medical benefits and indemnity prior to 7/1/2009. The case was settled after 7/1/2009 with a TPOC payment by us for $4500.

It goes on to say that several other carriers were involved and the total payment was $25,000. We never accepted ORNs, never paid any medicals, and the TPOC we paid is below the threshold of $5000.

Can we assume that this case is not reportable? Regarding the ORN, if the ORN was not established and not in place 7/1/2009 and subsequent then that is not reportable. In addition, TPOCs with TPOC dates prior to 1/1/2010 do not have to be reported.

Regarding the threshold, it really depends on the nature of the settlement and whether it was a settlement related to a joint and several situation or not and again, we've covered that previously on previous calls.

Another question was submitted asking can a self-insured employer register initially as an RRE with no agent and then subsequently amend its registration to include an agent and yes, you must though contact your EDI representative to add the agent information to your RRE profile.

However, after registration, your account manager may add people from the agent company as account designees at any time on the COB secure Website. I am making changes later to the User Guide that will more clearly explain what you can update regarding your RRE profile but I will announce now that after registration is completed on the Section 111 COB secure Website, your account manager may update certain information related to the RRE profile after logging on to the COB secure Website.

Account managers may use the RRE information action off the RRE listing page to update the RRE name, address and telephone information. Changes to other information such as reporting agent, file transmission method or the Tax Identification Number or TIN associated with the RRE ID must be requested through your EDI representative.

You must also contact your EDI representative to change your authorized representative or account manager to a different individual. Note that all users

of the COB secure Website may update their own personal information associated with their login ID such as e-mail addresses, phone numbers and the like after logging on to the site.

A question was asked about whether we plan to add more disposition codes and/or compliance flag values to the tables in Appendix E. There are six disposition code values currently published as 01, 02, 03, FT, 50 and 51 and only one disposition code is on the claim response file record.

There are three compliance flag values of 01, 02 and 03 but there are 10 compliance flag fields on the response file record. There's currently no plans to add any more values to either of these so for the time being, the highest number of compliance flags that you could get on a response record would be three and compliance flag Fields 7 through 10 will be returned with blanks at this point in time.

At some later date, additional compliance flags might be added. I don't anticipate any changes or additions to disposition codes and you will always receive one unique disposition code per response file record.

A question was asked about submitting multiple records for the same injured party or Medicare beneficiary for different claims that have the same date of incident, insurance type and so on. You are to report these on separate records if they reflect separate claims.

They will not be considered duplicates. The claim numbers should be different with these claim reports as would the description of illness or injury or the diagnosis codes you're submitting and possibly other information.

This topic is covered in the User Guide. See Section 11.10.2 where it states records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc.

Consequently it is possible that an RRE will submit more than one record for a particular individual in a particular quarter's submission window. We may maintain only one record of ongoing responsibilities for medicals or ORMs but the TPOCs are handled separately from regarding the separate claim report and separate incident on the back end.

Another question was submitted stating that we have a general liability policy with a med-pay limit of $5000. If I pay the $5000 in a lump sum, this has to be reported as a TPOC and then the settlement would be an additional TPOC payment.

I don't really have enough information to answer this completely. We need to know if the med-pay is reflected both paying individual medical services that happen to exceed the policy limit resulting in one payment and is the med-pay under this policy defined as no-fault?

If that's the case and it's not really a lump sum settlement, then the med-pay is reported as ORM with an insurance type of no-fault and not as a TPOC. Subsequent settlements that might be related to that claim under liability are reported with the insurance type of liability and the corresponding TPOC amount and TPOC date. Those may be submitted as update records.

Remember that if you submitted the record initially with ORM and the ORM indicator equal to Y that the update when you're submitting the TPOC amount should also have the ORM indicator equal to Y with that corresponding or that applicable TPOC amount and TPOC date.

A question was submitted regarding the ICD-9 codes that are submitted in Fields 15 and the diagnosis codes starting in field 19. You must use an E code, E as in Edward code in field 15. That's an ICD-9 code that begins with the letter E.

A V code, V as in Victor, can be submitted in one of the diagnosis fields but at least one diagnosis must be submitted that is numeric, not an E code and not a V code and not on the list of insufficient ICD-9s.

Another question was submitted related to test data. In the User Guide it says something that your test data should be real data. What we're really getting at there is encouraging you to create test file submissions that reflects as closely as possible realistic situations but test data does not have to be real. It does not have to represent real claims in your system.

That was really just a suggestion to recommend that you pull claim information from your production system and modify in order for Section 111 claims input files to testing. Your test data must be created in such a way that you pass the edits documented in the file layout and the error codes in the User Guide.

We recommend that you use this test beneficiary data that I mentioned earlier on this call that's available on the COB secure Website for some of the injured parties that you're submitting so that you're sure to match to a Medicare beneficiary.

Another technique might be to select injured parties who are over age 55 that are more likely to be entitled for Medicare. A question came up about the time in which query files will be returned.

According to the User Guide, production query files are to be returned within - by the COBC - the response files should be created within 14 days, that's two weeks, 14 days. On the other hand, the claim input files and the corresponding response claim response file is to be posted for your use or returned to you within 45 days.

In both of those cases, the response files will be created as soon as possible by the COBCs so they may be created sooner than those dates but again, the commitment that we're making is to return query response files within 14 days and claim response files within 45 days.

That should give you enough time to process the claim response file then prior to your next quarterly claim input file submission. A question was asked regarding reporting of ORM termination dates and in a state where the state law covering auto insurance both that benefits our payable for two years from the date of loss with a maximum benefit amount associated.

In this case, I think it was the state of Massachusetts and a maximum benefit of $8000 and the question was regarding when to report the ORM termination date. The claim might be administratively closed prior to that two-year limit, but technically it's still open for ongoing responsibility for medicals if something does come up.

My recommendation is that you may initially submit the record with a future dated ORM termination date that reflects the date two years from the date of incident, and then update it on an update record with an earlier date if ORM terminates earlier when the maximum benefit or the policy limits are reached or whatever circumstance actually ends ongoing responsibility for medicals sooner than that two-year limit.

We don't accept future dates in the date of incident or TPOC dates, but we do accept future dates in the ORM termination date.

You need to be careful though that you have a situation where the ORM is definitively going to end at the end of two years if you have a state that has sort of what I'll call a cycle situation where it will end at the end of two years if there hasn't been any related treatment for two years or at the end of three years if there hasn't been any related treatment.

That's a contingent termination and you can't input that ahead of time because you don't know whether or not that condition will be met. Okay. Another question was submitted regarding what happens to Section 111 data after it's been reported and accepted by the COBC.

What if the claim has already - some work is already taking place with the CMS MSP recovery contractor related to the claim and what is that interaction that happens there?

All information reported under Section 111 is provided to the CMS MSP recovery contractor also known as the MSPRC for consideration for recovery purposes.

If the MSPRC has not started a recovery then one may be triggered by Section 111 reporting. If recovery has begun, the Section 111 information will be treated as additional information and taken into account.

It is possible I suppose that additional demands may be triggered based on new information but regardless of whether you've already been working with the MSPRC related to that claim and Medicare's interests related to that

claim, the claim information is still reportable under Section 111 and must be reported under Section 111.

In general, when the information reaches the MSPRC, they're setting-up within their systems a matching process so they can determine whether or not they've already established an electronic record related to the underlying claim. And they're checking that and doing matching criteria to determine whether they have to start a new action, looking at whether or not the information they get is basically the same.

So for instance, if an attorney who's representing a beneficiary has self-identified the case to the COBC and subsequently reported the settlement judgment or award, if that information is consistent with what is submitted by the RRE then no, they won't be doing another demand of anything.

If it's inconsistent, in most instances they'll be obtaining clarification from the beneficiary/the beneficiary's representative but we do have processes that we're putting in place to do significant matching.

Okay, on a different topic, someone pointed out that in the list of error codes in I believe it's Appendix E, we have listed an error code as C-131, C-1-3-1, sufficient ICD-9 diagnosis code required.

That actually should have been CI-131, I believe, and this is a mistake and will have to be corrected in updated versions of the User Guide and that downloadable error code table.

I apologize for that error, that oversight. Another question was submitted related to the alternative to submitting an MT file when an RRE has nothing to report for a particular quarter.

There is a function being added to the Section 111 COB secure Website which will be available by April 2010 for an RRE, a user associated to the RRE to logon to the COB secure Website and perform this action that will indicate that there is nothing to report for that quarter, for that RRE ID, and that will save you from having to submit an MT file.

The MT file will also be accepted. Actually, this action on the COB secure Website has the effect of MT file submission for you and by MT file submission - this is covered in the User Guide - we mean a claim input file with a header record, no detail records, and a trailer record with a zero detail record count on it.

We have received requests to grant the lead authority to users of the SFTP mailboxes or archive response files or change the date that response files will be deleted. Currently the COBC is - to delete response files after they've been in the mailbox for 180 days.

A change to this process is under consideration by CMS and the COBC. We have not yet made a determination as to what will be done in that circumstance.

A question was submitted again related to on a particular claim. The RRE is already in the process of making arrangements to reimburse Medicare for portions that they have paid toward a patient's medical bills and they are asking whether they need to report this claim under Section 111.

And yes, as long as the claim meets all the other requirements for Section 111, it still must be reported. Section 111 doesn't change your other reporting responsibilities related to MSP and the fact that CMS has been notified of this

claim by the beneficiary's attorney or the RRE does not change the fact that it would be still reportable under Section 111.

I think I mentioned earlier related to ICD-9 codes, the decimals in ICD-9 codes must be removed before you submit them. Please see Section 11.2.5. That's it for the information that I wanted to cover and operator, I believe we are ready to open it up for a live question-and-answer session.

I'd like to remind folks that please limit yourselves to one question and one follow-up question so that everyone has an opportunity to dial-in and get their questions addressed.

John Albert: And operator, if you could have folks identify who they are and who they are with, what company they represent.

Coordinator: And thank you, and you're ready for the question-and-answer session at this time?

John Albert: Yes.

Coordinator: At this time, if you would like to ask a question, please press star 1 on your touch-tone phone. Please unmute your line and record your name clearly as prompted. To withdraw the question, star 2, and one moment please for the first question. (Dave Mullins), your line is open. Please state your organization.

(Dave Mullins): The (Compensation Insurance Fund).

Pat Ambrose: Please go ahead.

(Dave Mullins): Hi. Our question is mainly related to if there is any correlation between the responses that we receive from death and production systems. In other words, if we send a clarifying to your death system and then later we send it by to a production system, is there any sequence that we should be worried about that, you know, will you be first processing the death clear response and then sending us the production query response or these are completely independent systems?

Pat Ambrose: They should be completely independent.

(Dave Mullins): Okay, so in other words, there is no dependency with each of those?

Pat Ambrose: That's correct.

(Dave Mullins): Okay. Can I ask you (Andrew) a formatting-related question?

Pat Ambrose: Yes.

(Dave Mullins): You're using our own translation software and we try to comply with our put - that HEW - creates. We have learned that there's a wrapping around up to 80 bytes, 80 connectors. Is there any documentation available for that?

Pat Ambrose: It is in the companion guide, it does indicate that the X-12 271 is returned. It's actually the 270 has to be submitted and the 271 is returned in files that are in 80-byte record. The last record would be just whatever the remaining bytes are.

Obviously those are - each of those records has a carriage control return character at the end of each. It really is, you know, so those files are not one long continuous string of data but instead are broken-up into 80-byte chunks

and the documentation for that as far as I know is in the companion guide related to the X-12 270, 271.

(Dave Mullins): Yeah, we found some information, but not everything was completely explained like it should be, only your next format just might be (unintelligible). And there's some spaces padded on the last line, if the information is not up to 80 characters to we are hoping if we in the next alert would contain a little more accurate information on that.

Pat Ambrose: Yes. Would you mind sending that to the CMS - actually, it'd probably be best if you provided that information to your EDI representative, but you may also send it to the CMS resource mailbox and we'll take care of it.

(Dave Mullins): Okay, yes. All right. So, thanks.

John Albert: You can provide your RRE ID as well on the e-mail to the resource mailbox if you don't mind just so we can track you down, and whatever other contact information.

(Dave Mullins): Absolutely. Thank you.

Coordinator: Thank you. Our next question is from (Nel Peece). Your line's open. Please state your organization.

(Nel Peece): (Foster Funds). On situations where you have a legal issue, in California we have a law that says we have to pay up to $10,000 towards medical if we are investigating a claim and we issue a delay notice, we have 90 days to either accept or deny even though the medical bill may exceed the $10,000 if we deny the claim.

We're only responsible for that first $10,000. In many cases, the denial will be unchallenged and at some point we can close our file. Usually we close it within six months.

However, there is the possibility for a year that the claimant can challenge that denial and litigate the issue at which time obviously we litigate it and eventually there comes either a verdict, an award by a judge or we have the denial upheld and at that point I'm assuming we could issue a TPOC.

But is there some period that we have to wait for because I'm guessing we're going to issue a report showing that it was an ORM if it's in the first 90 days and we don't have an investigation completed.

Can we - if we issue a denial at which point our $10,000 limit stops all further payments, can we issue a TPOC there or do we have to wait until the statute runs which is a year I believe?

Pat Ambrose: I'm somewhat confused about is ORM terminating or have you reached a settlement? If you've reported ORM and you technically still have responsibility for medicals, it should remain open until you don't.

A TPOC can't be reported until that settlement has actually been reached and the TPOC amount determined I think.

John Albert: You meet the definition of the TPOC reporting date. If we heard you correctly, it sounded like you have a responsibility to pay up to $10,000 but if you deny once you reach that $10,000, you have no further responsibility unless liability is proven or there's a judgment or award, etc.

If your ORM has terminated based on state law, you should report that termination date and if you are later - if it's later litigated and that results in further ORMs then make the update necessary for that. If the litigation results in a TPOC, then make the necessary update for that.

Pat Ambrose: And you may send an update transaction on a record that reflects ORM equal Y and then ORM termination date and you've already submitted that and it's been accepted. You can submit a subsequent update on that record with that same information and a new TPOC amount.

(Nel Peece): Okay, well that's great, so basically if we think it's closed and everything and he pops up later with an attorney and saying we're challenging this, then I just issue an update with a new ORM.

Pat Ambrose: Yeah. As long as that reflects the same insurance coverage type, you know, and all that, yes.

John Albert: The example you gave as you were closing that based on a state law provision, you weren't closing it just because you thought they weren't submitting new claims, I mean, so you need to be careful to distinguish that.

We've said when you are submitting ORM termination, it either has to be because you've met some state law requirement, it's been exhausted, something like that. It can't simply be fully because there's no claims and you don't think they're going to assume it anymore if you have continuing responsibility.

(Nel Peece): Yeah, well the denial if it's unchallenged, there's a one-year statute I believe at which point they can no longer challenge. Theoretically, I guess a court could overturn that.

Pat Ambrose: Yeah, we're not saying you have to wait to see whether or not it's appealed or anything. What we're saying is if someone's in a state where you're required to pay, let's say they didn't have the special criteria that you talked about. It was open-ended. It simply said you're required to pay up to $10,000 unless they have the type of notice we talked about where the treating physician says there's no further related treatment, then they need to leave that open until that limit is reached.

You gave as an example where there's a specific state law limit and that limit was reached.

(Nel Peece): Right. Okay. Thank you.

Coordinator: Thank you. Our next question is from (Crystal Brodsky). Your line is open. State your organization.

(Crystal Brodsky): Hi, this is (Crystal Brodsky) from PMSI. The question I have is if a claim is settled but only the pharmaceutical benefits are left open, should there be an ORM termination date or should we wait until the pharmacy portion has also closed?

Pat Ambrose: I guess one of the - if you haven't submitted that to the resource mailbox, please do so. I think one of the things that we need to look at that. If it's someone where they have an established record, or if you're talking worker's compensation and they've included pharmaceuticals in that WCMSA, then I think we would probably have to have the record left open.

So if you have submitted that in writing, we'll look at it. If you haven't, if you would submit it to the mailbox.

(Crystal Brodsky): Okay. Thank you.

Coordinator: Thank you. Our next question is from (Savi Kapan). Your line's open. Please state your organization.

(Savi Kapan): Hi, this is (Savi) from the Hartford. I have a question regarding the HEW software. During the initial conversation, I understand that there will be a new version of HEW software that will be given, too. I was wondering whether this HEW application will be available to work on only the new format of (mon-25) or the existing format, too.

And another question is, is there any - you are on the CMS server, or any location where we can learn more about HEW software?

Pat Ambrose: I need you to repeat your first question about the HEW software and what was available in this new version versus the old version.

(Savi Kapan): Yeah, the new changes that will be happening to the HEW software, when that support, that existing layout of the monthly file, or the new layout that is coming up?

Pat Ambrose: The layouts for the flat files that are input and output into and from the HEW software are different on the new version. So you have - if you - you may continue to use the old version using the file formats that are currently defined in the appendices of the User Guide or when the new version becomes available, you may use that and it has a different file format.

Basically the files are longer and include the DCN so in order to use the new features related to the DCNs, you need to use the new file formats in the new

version as well as to use a new feature to invoke it from a command line, you'll have to be using that updated version.

The current version is Version 1.2.0 for the Windows PC and the updated version will be 2.0.0.

(Savi Kapan): Thank you so much for the explanation. I think that has given me enough information, and can I know, till what time or what is the expected time this new software comes into picture? Is it from Jan 1, 2010 onwards or is it later in the year?

Pat Ambrose: It's going in our January release which actually is not effective right on January 1 but I believe it's the 5th or 6th and I am tasked with creating an alert to post to the Website as soon as possible to let you know exactly.

But my understanding is that the software will be available for download from the COB secure Website around January 6.

(Savi Kapan): Thank you so much and before I close my question on the HEW software again, do we have any existing documentation or the read-me files that we can go through because we are still excited about the new software and would like to know more about it in advance?

Pat Ambrose: I don't have anything available at this point in time for the new version, no, I'm sorry, but very soon, we'll get it out there for you.

(Savi Kapan): Thank you so much.

Coordinator: Thank you. Our next question is from (Mike Gardner). Your line is open. Please state your organization.

(Mike Gardner): Yes, this is (Mike Gardner) with (Corvelle). I had a question about the update rules versus new. I understand when to submit new as far as the key fields there and I understand what to submit as an update regarding the key fields there.

My question revolves around all of the other fields and I understand if there's a change to those fields, we're not required to submit an update but what if there's a compliance flag that indicates information is missing that is required.

Do you want an update at that time or do you want us not to submit an update or how would you like that to work?

Pat Ambrose: Yes. When you get a compliance flag and I think this is in the User Guide, it should indicate that if it's the type of compliance flag for which you could make a change to correct the information, that you should do so on an update record in your next quarterly file submission.

(Mike Gardner): Okay.

Pat Ambrose: So you know, there's a late submission flag which is obviously you can't change that but there's a flag related to the TIN validation. And if you discover that you submitted an invalid TIN but the record was accepted; however, you got a compliance flag related to that, you should send an update on your next quarterly file submission for that record with the corrected TIN.

(Mike Gardner): And the TIN is specifically noted in what should be sent as an update, but I'm thinking like for example if I've got an attorney involved on the claimant side and I don't input the attorney's phone number.

Pat Ambrose: Well, that's slightly different. If it's a field that's required, then you will actually get the record rejected with an SP disposition code and an error code. Now error codes have to be addressed and corrected and that record again resubmitted in your next quarterly file submission.

(Mike Gardner): Okay, so the attorney field is regardless of the C code also would have an SP code, then? So like if I've got - if I could use one here - like CR 08 is represented as city. It's required if representative indicator is not equal to space?

Pat Ambrose: Yeah, now, what you get is that error code in conjunction with the SP. The SP is a disposition code and it will be in the disposition code field and the corresponding - and so that tells you uh oh, this claim report was rejected for errors.

Now what are those errors? Go to the error field, error code fields and see which ones are posted there and address those.

(Mike Gardner): I see. Okay, thank you.

John Albert: I mean, anything that receives an SP disposition, it's as if you never sent it to us to begin with because we didn't accept it, so you have to fix those in order to get that record to post to CMS.

(Mike Gardner): And an SP disposition is fired if any of the required fields are not filled in?

Pat Ambrose: That's right.

(Mike Gardner): Okay. Thank you.

John Albert: Operator, are there any more questions?

Coordinator: (John Walker), your line's open. Please state your organization.

(John Walker): Good afternoon. This is (John Walker) with (One Beacon Insurance). How are you today?

Pat Ambrose: Good. How are you?

(John Walker): I'm doing fine, thanks. Two quick question, hopefully. Our understanding right now is that when on the return file, we don't find - we don't have a date when the person became eligible for Medicare benefits and in our minds that creates kind of a black hole and I'll give you a quick scenario here.

If our monthly query is on the first of the month, the claimant becomes eligible on the 10th of the month, we settle on the 20th of the month, we don't know until the next file that we query what's happening with that. And even at that, if there's no date associated to it, we're not sure if that person's reportable or not. How should that be handled?

Pat Ambrose: Could you hang on just a second?

(John Walker): Sure.

Pat Ambrose: Well, you really need to query after you've established ORM or established a TPOC date to know what the status of that injured party is as of your reporting requirement.

(John Walker): Right, I mean, I could see waiting a month for the next query or something like that but is that all I would have to do is go out that one extra time or are there any - okay.

Pat Ambrose: Yes, yes.

(John Walker): Are there any plans to provide that date as to when they became eligible.

Pat Ambrose: First of all, when you go out one extra time, that's true with the TPOCs but if you have ORMs, you are going to have to do - set-up some regular querying in case they become entitled at a later date as long as that ORM continues.

(John Walker): I understand that.

Pat Ambrose: What we were talking about offline, if it eases your mind any at all, is at least when someone becomes entitled on the basis of age, entitlement is always as of the first of the month.

We think but are not sure the entitlement is always as of the first of the month regardless of when you become entitled. We can check on that but - so it's not that people tend to become entitled at different days of the month.

(John Walker): Okay. All right.

Pat Ambrose: Also realize that particularly for those entitled due to age, we have that information on our files about when they will become in the future entitled to Medicare in months in advance.

Now that might result in when you do submit the claim record that 03 disposition code which indicates yes, this injured party is a match to a

Medicare beneficiary; however, the information that you've submitted does not overlap their Medicare coverage and in the User Guide, it does discuss what to do in those circumstances.

But if you have no - you know, ORM has ended - then you don't need to continue to requery and if you have no subsequent TPOCs, you don't need to continue to worry about that.

(John Walker): Okay, so it's understood on your end that I mean you could get submissions that are extra.

Pat Ambrose: Yeah.

(John Walker): Okay.

John Albert: That's why we also have like I said the - for the - in terms of the timeliness factor, I mean, something that happened that close to a reporting period, you basically would have until the next reporting period to submit it.

Pat Ambrose: Remember, there's the extra 45 days till then if you - settlement or whatever takes place within 45 days of your reporting submission window, then you are allowed to delay until the next time, so you would always have the opportunity to query.

(John Walker): Okay. One other quick question here. I know earlier you mentioned about claimants with multiple coverages on different claims and everything but we've got situations where we'll have a claimant that has multiple coverages for the same claim.

In that particular case, if one of the coverages is accepted and the other is rejected, I don't see a way in the return file that you're breaking out and speaking to the individual coverages.

It's more at the claimant level. How would you handle a situation like that and to give you a better example, maybe I had a PIP and a PIP access on the same line - on the same coverage, excuse me?

Pat Ambrose: Well, I think the User Guide states that that - I'm not entire sure - but I believe those are both no-fault and there's an example related to med pay and PIP and that the limits need to be combined and that needs to be put into one report, you know, by the insurance type of no-fault.

John Albert: So that you would simply leave the ORM open until both limits had been exhausted.

(John Walker): Okay, and how about a situation where I had one ORM coverage and a TPOC coverage? In that scenario, I'm going to get back, you know, if one is accepted and the other is rejected, I didn't know there's a timing issue here but...

Pat Ambrose: What do you mean, one is accepted and one is rejected? Is that by the insurer?

(John Walker): By you. In other words, I submit the file and you know, in a normal situation the ORM is going to go before the TPOC. And the ORM coverage goes through fine, but when I submit the TPOC, you're going to reject it but from a systems standpoint, I mean, it's going to come back and it's going to look like both rejected.

I don't know of a way that you're breaking it out and rejecting or accepting at the coverage level.

Pat Ambrose: So let's assume that it's the same insurance type so you know, you've submitted ORM under a particular insurance type, worker's comp for example, and then that's been accepted and then you submit an update record.

Again you're submitting the ORM still equal to Y and you submit a TPOC amount on this update record and if that update record is rejected, you need to correct it and resubmit it. We still have the ORM on record.

It's not like we have - once we have accepted the records with an 01 or an 02 disposition code, we're keeping it unless you send a delete. But if you send a subsequent update to a record that was previously accepted with an 01 or an 02 and that update was rejected, it's just the update that was rejected, not the entire thing.

(John Walker): But that would be for the same type, an ORM, but what about an ORM and a TPOC, two different coverage lines?

Pat Ambrose: That - if you're talking to different coverage lines like ORM for no-fault and TPOC for liability insurance, yeah, those are two separate records. Yeah, those are two separate reports because the reports are made by (unintelligible).

(John Walker): And that's the point I'm trying to make here is if you reject that, you're rejecting it at the claimant level, right, not the coverage level?

Pat Ambrose: No, no, no, at that claim report level, at that coverage level.

(John Walker): Okay.

Pat Ambrose: Yeah, at that record level. So we've accepted the no-fault ORM and if you send - you would send actually an add record for the liability and the associated TPOC amount. And if that gets rejected, it has no impact on the no-fault record that was already accepted and again, you need to continue to work on correcting that liability report but it is considered a separate report to us.

John Albert: In that same example, if you had ORM for no-fault and it's by coincidence or otherwise terminated at exactly the same time that the TPOC date existed, you would be sending a termination record for the ORM coverage on no-fault and a separate add record for the liability TPOC.

You could not - you can't change something for two lines of coverage within the same record.

(John Walker): Okay.

Pat Ambrose: Yeah, what's important is that you realize you're reporting these records by insurance type, worker's comp, no-fault and liability, so your no-fault and liability reports even though you consider it one claim are reported on separate record.

John Albert: And the same goes for policy numbers. If you have the same beneficiary who is being paid through more than one policy, say their own policy and the other driver's policy or something and there's no-fault for each of those and there's a TPOC for each of those, then you're actually going to have a total of four records for that person.

(John Walker): Okay, all right. Thank you. That's been very helpful. Appreciate it.

Pat Ambrose: Welcome.

Coordinator: Thank you. Our next question is from (Liz Gayle). Your line's open. Please state your organization.

(Liz Gayle): North Carolina Farm Bureau. I had another question on the ORM termination date. You stated earlier that we are not to submit future dates if it is a conditional type payment but you do allow future dates.

Pat Ambrose: The system allows it, but if you - if it is not terminated under our criteria for termination, if that's not a certainty, you can't - you should not be submitting a future date, because it would be incorrect. And it opens us up to paying inappropriately if it doesn't terminate on that date and then your next submission window isn't like for three months or something.

The point is to have an open record until it's actually - until it is legitimately terminated.

(Liz Gayle): So even if we submitted an update if that future date changes?

Pat Ambrose: You can - I mean technically, not speaking policy, but technically you can submit an update to an ORM termination date, but the point is the instructions are that you should not be submitted a term date.

You have a certain term date so if you have one that's based on what I called that like a cycle type payment. I know that's not a technical term, but if you have something like that, no, you should not automatically be submitting a term date three years ahead of time in the hope that you won't have any claims in between.

(Liz Gayle): Okay, thank you.

Coordinator: Thank you. Our next question is from (Claire Bellow). Your line's open. State your organization.

(Claire Bellow): Good afternoon. (Claire Bellow), I'm with Vertical Claims Management. I just wanted to clarify one of the earlier questions with regard to the submission files where you have a required field that's empty and there's an error and it's rejected.

Am I clear that that means that the file is not recorded as having been reported at all?

Pat Ambrose: That's correct.

((Crosstalk))

Pat Ambrose: Not the file, but that particular record on the file, yes, that is correct. We don't - you know, it is pretty much as though it was not ever reported to us or ever submitted.

And again, you need to submit it on your next file, the corrected record on your next quarterly file and it's possible that it might then be considered late but it'll still be accepted and processed, and you'll get a notification of its lateness in the form of a compliance flag. And there's no automatic calculation of a finer penalty or something of that nature but it is a warning to you that it was received later than it should have been.

(Claire Bellow): Okay. Has there been any thought given to reducing the number of the required fields in the submissions? And when I say that, I'm talking about

things like zip codes and phone numbers for counsel, things that we just may not have.

Pat Ambrose: Not currently at this time. I don't think there's anything pending there. I think on one of the calls, we might have - not at this time. So if you, you know, I mean, we do realize that if you can't submit all the required fields for a representative, that you might not be able to provide that representative information that will - it's...

(Claire Bellow): But then I can't report it under Section 111, either.

Pat Ambrose: Well, you could report it without the representative and basically as though there is no representative which is not obviously compliant.

(Claire Bellow): Right.

Pat Ambrose: So you have to work toward obtaining that information.

(Claire Bellow): You know, I hear you and believe me, we are all I think working very hard towards getting to that compliance point, but I have to say that there are a lot of fields that are required in the quarterly submission that if a claim has not gone to litigation, we may never have.

You know, these are cases that may come in - and I'm speaking from a liability standpoint, I don't do worker's compensation - and so some of these cases, they come in, they're settled fairly quickly.

They might be a general liability case, a slip-and-fall, you know, it's a pretty fast turnaround, and so the number of required fields I think are difficult in

some of these cases for us to ever know which creates some compliance issues.

Pat Ambrose: Well, we thank you for your comment and it is duly noted. I don't know what else we can tell you at this point in time. You could also submit that to the resource mailbox as well if you haven't already done so.

(Claire Bellow): All right. Thank you.

Coordinator: Thank you. Our next question is from (Joanne Mosspenn). Your line's open. State your organization.

(Joanne Mosspenn): Hi, this is (Joanne). I'm representing (Transtar). I just have a couple of real quick questions. I kind of came in on the middle of the meeting and I did hear that there is supposed to be a new user's reference guide. Do you have a timeframe for that?

Pat Ambrose: Actually, what I said was our original timeframe for publishing one before the end of the year is not going to happen. I hope that we can get the User Guide updated by the end of January or but it might spill over into February but you know, we are committed to getting that User Guide updated and published as early in 2010 as possible.

Any changes that we have been talking about, we're trying to get published in the form of alerts so the alert could be used in conjunction with starting with the current version of the User Guide Version 2.0 and then the alerts that have been posted subsequent to that and will be posted subsequent to that.

We have consistently said that you should always look at the most recently posted version of the User Guide plus any alerts that were issued subsequent to that.

(Joanne Mosspenn): Okay, and I just want to confirm, the HEW software with the changes including the command line submission is supposed to be January the 6th, around that timeframe?

Pat Ambrose: Yeah.

(Joanne Mosspenn): And that will include the documentation?

Pat Ambrose: Yeah.

(Joanne Mosspenn): Okay. That's it. Thank you.

Coordinator: Thank you. Our next question is from (Jay Cuminar Leksman). Your line's open. Please state your agency.

(Jay Cuminar Leksman): Hi, this is (Jay Cuminar Leksman) and I have a question here. We downloaded the HEW software from the CMS Website and it had a full 21 sample site which is called (unintelligible). We just want to know, is it a valid file which we can use it for testing?

Pat Ambrose: Well, it's a sample file. I don't know. It is not something that you could submit as an actual test file. Well, I mean, I suppose you could but you probably won't match any Medicare beneficiary data.

You need to replace if you want to get a positive hit replace the individual's information with either individual from your system in production or use our test beneficiary data that can also be found now on the COB secure Website.

But I really - I'm not that familiar with it but I would - that sample file there is there for - to aid you in creating the files that you need to feed into the HEW or the HEW software but it is not intended that you use that actual file for testing Section 111.

(Jay Cuminar Leksman): I just want to make sure the file format is an enabled one which we can use as...

Pat Ambrose: As far as I know, yes. Now, what you're looking at now would be Version 1.2.0 and again, Version 2.0.0 will be available in January, and it will have a different file layout.

(Jay Cuminar Leksman): Okay, yeah. Thank you. That's all I have.

Coordinator: Thank you. Our next question is from (Lynn Hosey). Your line's open. State your organization.

(Lynn Hosey): Hi, I'm (Lynn Hosey) with (Franciscan Missionaries of Our Lady of Health System). I have a question regarding Medicare liens. Is there a field to report that or do we just not need to acknowledge that at all?

Pat Ambrose: There is no such field and as far as Section 111, it is not something that is reported on a Section 111 claim record.

(Lynn Hosey): Okay, great, and I have a second question regarding that.

Pat Ambrose: Well, we actually have a follow-up on the question - on your first question. When you say Medicare lien, you're talking about - you know that Medicare has a recovery claim or you know that Medicare has already issued a demand or were you talking about something else?

(Lynn Hosey): I know they've already issued - well, no, we have it from the attorney that there is a lien on the claim.

Pat Ambrose: So there is nothing on the Section 111 reporting.

(Lynn Hosey): Okay.

Pat Ambrose: But you still have to report the claim, but yeah, yeah. Okay. And if you're talking to an attorney or anything, if any attorney ever asks you, I've contacted the coordination benefits contractor or I've contacted the Medicare secondary repayer or recovery contractor, since you're reporting, do I need to tell them about the settlement?

The answer in that case is that you're reporting requirements are separate from their obligations. The fact that you're reporting doesn't change any obligations they have with respect to reporting and with respect for the need for their client to repay us.

(Lynn Hosey): Oh, that's good to know.

Pat Ambrose: I mean, you're not substituting for any obligations they have. This is your responsibility just as if you go through an individual contact with the COBC for whatever reason, that doesn't eliminate your responsibility to do your 111 reporting.

(Lynn Hosey): Right.

Pat Ambrose: Okay?

(Lynn Hosey): Great.

Pat Ambrose: Did you have a follow-up?

(Lynn Hosey): Well, it's not really a follow-up but we're trying to get everything off the ground and we're kind of starting late. As far as HEW software, with the new version coming in in January, should we install ours now or wait until January?

Pat Ambrose: I personally - I mean, I can't say - but I personally would probably work with version - with the current version to get things rolling and then modify your processes to use the new version when that becomes available.

(Lynn Hosey): Yeah, I like that idea. I have to get IS on board with it. Okay. I appreciate it. You got my questions answered. Thank you.

Pat Ambrose: You're welcome.

Coordinator: Thank you. Our next question is from (Yvonne Webb). Your line's open. State your organization.

(Yvonne Webb): Hi. This is (Yvonne Webb). I'm at CNA and I had a quick question. We have submitted a couple of query files and got a response back and there were a few errors on the response file. It's not in the format that we were expecting from the User Guide and I was wondering if you'd made any headway on that or - as I had heard some things like that on the last call.

Pat Ambrose: You know, all the issues as far as I know right now that were reported regarding query response files have been, you know, turned out not to really be issues. I did announce earlier in this call that if you submit a zero in the gender or the sex code, we will return a 1 because we can't do anything with an unknown and the system current just assumes we'll change that value to a 1 and return it.

(Yvonne Webb): We've actually got characters back in the gender.

Pat Ambrose: Yeah, you'll get an actual 1 back in the gender, whether we match the person or not. And then beyond that there were not, you know, the kind of mismatching or people saying that we were not matching according to how it's stated in the User Guide and it more had to do with matching up input records to response records.

They apparently not returned in the same order always and of course you know, the matching can get a little bit tricky if you have more than one record on there for one individual - for the same say Social Security number - but maybe other different corresponding information.

What I have to recommend is that you take your specific example and provide it in a secure fashion to your EDI representative for investigation if you have an example of something still in error.

(Yvonne Webb): Okay. So we sent the question to him yesterday. I just thought I would hope against hope.

Pat Ambrose: Yeah, okay. I'm sorry I can't update you.

(Yvonne Webb): Okay. Thank you.

Coordinator: Thank you. Our next question is from (Lori Palustri). Your line's open. State your organization.

(Lori Palustri): Yes, I'm with (Safe Corporation). I'm asking specifically about Fields 58 through 62 and I know we're expecting an alert shortly on that, but on Fields 59 to 62, has there been any decision on when those fields are going to be effective? Is it going to be January 1 of 2011 or is it going to be 2010?

Pat Ambrose: Well, I, you know, I'm going to have to state that we don't have the requirements finalized, therefore our system is not updated to process those fields. The exact date as to when those fields will be incorporated is still pending I believe here at CMS but you will not be able to accurate test with those fields starting January 1, 2010.

(Lori Palustri): Okay. We're just wondering if we need to start collecting this information now in order to get the information submitted when we report in April.

Pat Ambrose: I'm not sure what you would collect without having the requirements clearly defined.

(Lori Palustri): Yeah, I guess that's what we're unsure - and we're running out of time. And so we're just not sure if we should be planning to have another project start that pulls this data in quickly, or if we've got a little leeway there and it's 2011 and we've got more time to fit that in. So I guess we'll wait for any alerts that come out on that and just see what happens.

John Albert: And regardless of what happens in terms of final requirements, we of course will give people plenty of time to supplement them as well. We will not come out and spring something at the last minute and say, it's too far over.

Pat Ambrose: Well, and you know, again the requirements are not finalized so we don't have the code in our system to handle it, either.

(Lori Palustri): Any expectation as to when they'll be finalized?

Pat Ambrose: As soon as possible.

(Lori Palustri): Okay.

Pat Ambrose: I, you know, within - we can't give a date. There are pending issues but believe me, people are working very hard to get that completed.

(Lori Palustri): Okay. Thank you.

Coordinator: Thank you. Our next question is from (Jeff Carroll). Your line's open. State your organization.

(Jeff Carroll): (Deacon Insurance).

Pat Ambrose: Please go ahead.

(Jeff Carroll): (Deacon Insurance).

Pat Ambrose: Yes, we can hear you.

(Jeff Carroll): Okay. I had just a couple of points just on the query and also the gentleman that called earlier about the 80-character situation. I maybe had something to help him out with that.

The first thing was the - I'll say that first real quick. What I found out is if I download the file - this sounds kind of silly - if I just download the file and open it up, save it as a WordPad and open it, WordPad gets rid of all the carriage control characters. And then I can run that through the HEW inbound and it works fine, so I don't know what that - if I don't do it that way, I've got to go in and manually get rid of all of those which is definitely not very good for a lot of records.

Pat Ambrose: Yeah, and I'm quite sure that that issue has been addressed because I think we're talking about the fact that it doesn't like those Unix characters - is that...

(Jeff Carroll): Yeah, I think so.

Pat Ambrose: Yeah, and that has been and will be in that new version of the HEW software to address that so that you won't have to do that any longer. I have a feeling that there is - you might be able to obtain that fix from your EDI rep right now but I'm afraid I'm not up to speed on exactly how it was released or is being released but I can say for sure that a fix for that will be available in the 2.0.0 version in January.

(Jeff Carroll): Okay. Another couple of points. I'm not having a problem with the version I have now. I'm able to cross-reference back to my records. When we - when that new version comes out, will we be forced to use that? Does that change the file that's coming back from you to where we'll have to go to that new layout?

Pat Ambrose: No. You can continue to use the old version or the new version.

(Jeff Carroll): Okay.

Pat Ambrose: Yeah, we're going to - for the time being as of January and I'm glad you asked that question - we will - you will be able to continue to use the current version of the HEW software and don't have to use the upgraded version with the DCN.

I would recommend that you plan to upgrade to the Version 2 at some point but you don't have to do it right away.

John Albert: But if at some point it becomes mandatory, you will receive sufficient notice.

Pat Ambrose: Oh, absolutely.

(Jeff Carroll): Okay. Another kind of observation. I know at least who I'm dealing with on this. It seems like the turnaround time is really slow. I mean, I turned in a production query over three weeks ago and have not received it back and I sent it e-mail and I just got a comment that oh well, we received it but it didn't go through our server.

But I'm just wondering, I'm running into that. I've only been able to send one successful file since July. You know, I'm kind of concerned about if we send one every month, it takes almost a month or better to get it back, we're really just going to be behind the game.

Pat Ambrose: Yeah, well obviously we're working towards correcting the response time and processing issues that we've had. I announced earlier on the call, I think some of that might have had to do with the SFTP problems we were experiencing.

I can't say for sure but we're not going to rest until it's working smoothly and we're returning those query response files within the 14-day requirement.

(Jeff Carroll): Okay, well thank you very much.

Pat Ambrose: Thanks.

Coordinator: Thank you. Our next question is from (Charlotte Griffin). Your line's open. State your organization. (Charlotte Griffin), your line's open. I'll go ahead and move to the next question. (Brad Ellis), your line's open. State your organization.

(Brad Ellis): Yes, this is (Brad Ellis). I'm with the (Community Web Center Exchange, RRG). We have 37 insurers. They're each RREs and I'm the account manager of each and as we sign them up, they've obviously all got different reporting dates. Is there any way we can get a common reporting date?

Pat Ambrose: I'm sorry. At this point in time, we're not accommodating requests to change files to submission dates. You could also forward this request to your EDI representative but we're not - you're going to have to set things up to plan to submit on those different assigned file submission timeframes.

(Brad Ellis): Okay, thank you.

Coordinator: Thank you. Next question is (Aaron Larson). Your line's open. State your organization.

(Aaron Larson): Hi. I'm with (Deseret Mutual). We're joining this a little bit late to the game so my questions may be a little more simplistic than have been asked already on this call.

I just want to clarify and I believe I know the answer to this but as far as when our first file submission for ORM or TPOC goes through, there's no minimum age requirement of those that we are not sure are or are not Medicare beneficiaries; is that correct?

Pat Ambrose: That's right. There's no age requirement for the non-GHP reporting.

((Crosstalk))

(Aaron Larson): And I ask that because we are involved in a GHP version as well and I know there's age requirements there so we're just trying to accommodate to the non-GHP.

John Albert: Or the GHP, remember though that you are responsible for submitting records for Medicare beneficiaries under 45 or 55 so you do need to know who they are. For NGHP, you should not simply be submitting a file of all claims where you've got a settlement, judgment, award or other payment.

You should only be submitting records for individuals you have determined are Medicare beneficiaries. It's conceptually a little bit different. You're encouraged in the GHP mold to go ahead and submit a wide array because it works differently.

(Aaron Larson): Okay.

Pat Ambrose: So in other words, we recommend that you either have some process to determine an interparty if Medicare status within your own claim settlement process and/or use the query function and query on a particular individual first, yeah, and then create - if you find that they are matched to a Medicare beneficiary, then create the claim.

(Aaron Larson): Okay, and that's kind of what we assumed we would have to do, at least for non-GHP. Our GHP, we're much more certain on that level, so okay, and then as far as - I know TPOC submissions, you do submit a dollar amount.

For ORM though, you would never really submit a dollar amount, is that right? You just submit the individual that you know all the - okay.

Pat Ambrose: That's right. That's right. If it's worker's compensation, that's completely right. If it's no-fault, remember that you do submit the exhaust limit at a certain point. Field 80 something is 80 - somewhere around there, there's a limit on the policy, yeah.

So where you've got ongoing responsibility for medicals, even if it would be that rare circumstance where it exists in a liability situation, you do not submit information on the individual payments you make.

(Aaron Larson): And that's essentially what I'm asking. The individual payments we're not submitting on, we did realize that we have to submit the maximum claim payout, claim payout per ORM, that is.

And then I was just wondering, a follow-up on the future end dates for ORM. If we have a defined period of time that a person is eligible in the ORM category, can we list that as a future date or do we have to list it differently if

it comes in the future that we know they're going to terminate in the future, we just have to list it differently rather than a defined date?

I gather that it's not appropriate to list a future date.

Pat Ambrose: No, no, that's not - let me say from a technical perspective. If you don't have an ORM termination date established, you submit zeroes in it, but if you have a definite ORM termination date according to state law and all applicable regulations, etc., then you may submit a future date in the ORM termination date.

The caveat we gave is when you have a contingent termination (unintelligible) contingent on subsequent events like no further relating claims for X period of time or anything, then you should not be submitting a future date because you don't know that it's a firm termination date.

(Aaron Larson): Okay, great. That answers it. Thank you.

Coordinator: Thank you. Our next question is from (Karen Lowry). Your line's open. Karen Lowery), your line's open. I'll move to the next question. (Trevor Meyer), your line's open. State your organization.

(Trevor Meyer): (Hamblin and Bertonson Liability Management). I have a question on field 81 which was just mentioned a minute ago, the no-fault limit. What's the dollar amount?

John Albert: If - we're submitting on behalf of an insured that has a certain FIR limit and then the vendor has a policy that is carried by an insurer which has its own limit, in that field, are you looking for the FIR limit, the limit of who we're reporting for, or are you looking for the policy limit?

Pat Ambrose: We're looking for the limit for what you're responsible for reporting, so if there's a limit - if it's a situation where you're responsible for reporting both for any deductible or co-insurance as well as any amount above that, and you need to report the total, if there's two separate RREs involved, they need to report the separate amounts. Is that enough to answer what you're asking or are we missing something?

(Trevor Meyer): Yes. Yes. I believe that's enough. That answers the question. Thank you.

Coordinator: Thank you. Our next question is from (Camilla Clarity). Your line's open. State your organization.

(Camilla Clarity): (Keenan and Associates). It's required that we're supposed to submit the first and last name of the claimant. How are you handling the unique situation where if the claimant only has a single name, such as like Madonna?

Pat Ambrose: And are we talking about an injured party or...

(Camilla Clarity): Correct. We actually have a claimant like this where they just have a single name and it's also the single name is listed - is indicated on their Social Security card as well, too.

Pat Ambrose: If it's on their Social Security card that way, then it would be in our system that way and I'd have to...

(Camilla Clarity): So as far as - I guess as well again, how we (curve) set it up in our system, because our system is required to have a first and last name, we kind of put like Miss in the first name field and then the single name in the last name

field. So I just wanted to try to make sure that if we submit it that way, will you recognize that this is a single name claimant here?

John Albert: That would impact whether or not we would reject or give you notice that that was insufficient information to determine whether or not the person is the beneficiary because if there was only one name in our record and you added a separate first name or first initial, then that would be one strike.

Pat Ambrose: You have to match on exactly either the HIC number and the SSN or the SSN first and then three out of four of the other remaining fields so...

(Camilla Clarity): So the Social Security number technically then could be where the match would be so even if the name is off, you would...

Pat Ambrose: Well, let me finish that for a second. The three out of four fields that you have to match on do not include the HIC number or SSN so first, depending on whether you submit the HIC number or the SSN, we match on that.

Then there are four remaining fields, so the date of birth, the gender, the first initial and the first six bites of the last name, so there are four fields there. As long as you match on three out of the four, we're good to go.

(Camilla Clarity): Okay, so the date of birth - if the date of birth is correct, the HIC number or Social Security number is correct, and the gender is correct, then that would be sufficient.

Because again, that's what we're trying to do is to keep it - us from getting our record rejected because of the fact that the name is not matching.

Pat Ambrose: One of the names have to - either the first initial or the first six bites of the last name have to match as well too.

(Camilla Clarity): Okay, well how would you put in a single name in your system?

((Crosstalk))

Pat Ambrose: I can't say exactly whether we have a record on file of somebody with a single name, but if they are a Medicare beneficiary, then that name shows up - however they're on our file - shows up in their Medicare card or their Social Security card. It would be the same and if it's possible that they have only one name on it, then - but it needs to go in the first or last name as it's formatted on that card.

John Albert: What I would do is I would do two queries on that individual and use that one name in the first query record as the first name, the first initial or the first name, on the second query record use that name as the last name. And if that is the only name on SSN - especially with that SSN - that should match, assuming you have the date of birth and the gender correct.

(Camilla Clarity): Okay, now, the fields are - it's indicated that the fields for our first and last name, they're required fields, so to do it even the way you have said it, if we put it in the first name and there's nothing in the last name, you know, it's like...

((Crosstalk))

Pat Ambrose: You'll have to in that circumstance default one or the other field to something, like you said Miss, Miss Madonna. I don't know.

(Camilla Clarity): I know, yeah, well that's how we actually have it in our system now.

Pat Ambrose: Yeah, well, I guess...

(Camilla Clarity): And it's rejected it. Unfortunately, we have to do other state EDI reporting and it's rejecting, so it's just like kind of killing us right now.

John Albert: Just remember when you're talking about matching three out of the four, the SSN or HICN is in addition to that. It's not one of the three to four when you repeated it back to us, you included it as one of the three.

The other thing is you started your question by referring to the claimant and in the record layout, the beneficiary information goes in the injured party fields. The term claimant is used only in situations where the beneficiary is deceased and there is someone else pursuing the (unintelligible).

(Camilla Clarity): Yeah, that's just a matter, you know, a difference of terminology, but I understand what you're saying, though.

Pat Ambrose: Yeah. We just want everybody to be alerted to that so that we're not changing how we're using terms.

(Camilla Clarity): Right, okay. Okay, I guess we submit the record and we'll see - you know, try to figure out how it is in your system.

Pat Ambrose: Again, as John indicated, you could kind of play with this situation on your query file.

John Albert: Pat, would you know what would happen if they submitted that name as both the first and the last name? Would we give them the correct name back if it matches?

Pat Ambrose: Yeah.

John Albert: Okay, so if you submit that single name as both the first name and the last name, if a total of the three criteria match, you'll get back what we have.

(Camilla Clarity): Okay. Okay, well that's what we'll try and do then. Okay. Thank you so very much for your time.

Pat Ambrose: Operator, could you tell us how many questions we have in queue?

Coordinator: We probably got about 10.

Pat Ambrose: Well, we'll try and do a couple more but we're coming up on 3:00 so...

Coordinator: Okay. Our next question is from (Mark Stanfield). Your line's open. State your organization.

(Mark Stanfield): HSLI. My question concerns the use of agents and the transfer of an RRE from one agent to another. Is there a method outside of the RRE data that's supplied to the new agent for that new agent to determine the status of reporting on their claim?

Pat Ambrose: No, I'm afraid that's an update that I'm making to the User Guide but there is - the COBC is not able to provide you a file say of records previously submitted by an RRE ID or under an RRE ID so the transition from one agent to the next is the responsibility of the RRE and its agent.

(Mark Stanfield): Well on the follow-up on that, what will happen in the case of let's say the new agent erroneously submits duplicate records because the date that was supplied to that agent was incomplete or not accurate?

Pat Ambrose: I don't think there'll be any harm done, you know, it's the so-called duplicate information will as long as it passes the edits will be accepted. It might if it is reported if we consider it reported a late submission, compliance flag on it but again as stated previously, that doesn't automatically trigger any particular action and you would certainly have a reason for that.

And there should not be - essentially if you reported an add record again, it'll get treated - it will still get processed and accepted and essentially be treated as an update.

(Mark Stanfield): Okay. Thank you.

Coordinator: Thank you. Next question is from (Cecilia Windchannel). Your line's open. State your organization.

(Cecilia Windchannel): Yes, thank you, I'm with (Crawford). We wanted to confirm our understanding on whether to include or not include indemnity payments as a TPOC. Our understanding was that if your internal systems and processes are such that those would not contain anything that wouldn't be statutory wage replacement, that we would not include those.

John Albert: There is revised language in process for the alert that's out there about indemnity payments and we hope to have that out as well very shortly, so I think we'll have to wait until we put that out.

(Cecilia Windchannel): Okay, and then as another item, so you have any intentions on your ORM termination where it has to be greater than 31 days or greater on maybe modifying your systems in the future to allow for the - less than that?

Pat Ambrose: It's not a - the requirement for that is not a system that's controlled by this particular group here and by the COBC but you know, we'll take that under advisement.

John Albert: It's something we're considering but this affects pretty much every system CMS uses so, it's not something that we necessarily have control over so we have to work within it for now but it is something that's under consideration.

(Cecilia Windchannel): Okay. I think from, you know, we had a concern that we didn't want to claim it to more or less get hung out there where maybe we show it actually terminated on the 15th but we had to submit it as the 31st, so we're not willing to pay but it may look like you're not willing to pay either?

John Albert: Yeah, we're very well of that issue.

(Cecilia Windchannel): Okay. Okay.

John Albert: So operator, it's now 3:00 and we need to wrap it up, so - we have other meeting commitments, etc. I'd like to thank everyone who attended today's call. Also again keep your eyes on the mandatory insurer reporting Webpage for announcements concerning future calls.

There is actually an NGHP policy-related call scheduled for next Tuesday, December 15, and we also have calls scheduled into next year as well. With that, I'd like to thank everyone for their participation and we will talk to you soon. Thank you.

Pat Ambrose: And operator, could you get back to us with the number of people on the line, etc?

Coordinator: Yes, I can. At this time, all lines may disconnect and have a great day.

END