TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b)(7)

DATE OF CALL: June 4, 2009

SUGGESTED AUDIENCE: Group Health Plan Responsible Reporting Entities – Technical and Policy Questions and Answers Session.

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FTS-HHS-HCFA

Moderator: John Albert
June 4, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. We'd like to inform parties your lines are in a listen-only mode until today's question-and-answer session. At that time please press star 1 on your touchtone phone to ask a question.

Also today's conference is being recorded. If you have any objections, you may disconnect at this time. I'll now turn today's call over to Bill Decker. Thank you. You may begin.

Bill Decker: Hi. Good afternoon, everybody, or good morning depending upon your time zone. My name is Bill Decker and I'm with CMS. We're here in Baltimore, Maryland. With me today on this call are Pat Ambrose, who is going to be speaking with you in a little while, and Barbara Wright and (Bill Spania). We also have a couple of other staff members here who are keeping track of us.

Today's call is a GHP call. It is both technical and policy-oriented. In other words you can ask any kind of question about the group health plan reporting for Section 111 that you wish after we have made our own presentations here.

And we just want you to try to - we're going to try to enforce the limits of one main question and one follow up for everybody who is asking me a question so that we can try to get as many questions asked and answered hopefully during this session today.

I'm going to lead with a couple of things that I want to preface anyway before we get going here. We get from - we get a lot of questions both in GHP and

(NGHP), but a lot of questions generally about the general issue of Social Security Numbers.

And I want to try to (maybe) you once again make clear for you all that first of all we're talking about Section 111 reporting. And that reporting involves Medicare beneficiaries. We don't want to have you leave that. You need to tell us about anybody who is not a Medicare beneficiary at the end of the day.

We in fact always insist that what you should be sending us is information about people that includes their Medicare ID number, their Medicare HICN and the Medicare health insurance claim number. That's our primary identifier for the folks who will be reporting to us.

If you don't have a primary identifier that is the HICN you can, and we tell you you can, send us a Social Security Number for an individual with some other identifying information and we can look up that individual on our database.

We will tell you in a response whether that individual is a Medicare beneficiary or not. And you will continue to report information about the people who we identify for you, our beneficiaries.

It's important for ROEs to understand that they have to keep track of everybody that they are providing insurance coverage for over time because people will become Medicare beneficiaries in the future who are not Medicare beneficiaries now.

They become Medicare beneficiaries for a variety of reasons. But the principle reason, the main reason is because they age into the program. They turn age 65 and become a Medicare beneficiary generally speaking at that age.

They can become Medicare beneficiaries earlier if they are disabled or if they have end stage renal disease. All of you probably know that. What's the relationship between all of that and the SSN?

The SSN is the basis for the Medicare ID number and generally speaking. And in fact we get the Medicare HICNs from the Social Security Administration. They are the ones who actually issue - (divide) the HICNs and send them over to us.

If you're going to send us an SSN, that's fine as long as you send it with the other identifying information. We'll tell you if that individual is a Medicare beneficiary or not. You don't have to be terribly concerned about individuals who do not have Social Security Numbers because in general those people will not be Medicare beneficiaries.

The first rank is tell us about Medicare beneficiaries. The second rank is if they don't have an SSN they aren't going to be a Medicare beneficiary, at least not right now. And as a consequence you don't have to worry about telling them about it, telling us about them rather.

So if you're concerned about the various issues that come up that we've heard about, people, should I send you information from someone's Green Card? Well, no, not if it's not a Social Security Number.

Should I send - we have people who are the dependents of folks from other countries. And do we need to get Social Security Numbers for these folks to report to you? And the answer is no, you don't. That's not your job.

And in fact these folks who are dependents of folks from foreign countries are not probably going to be Medicare beneficiaries. Remember that we're talking about Medicare beneficiaries and Medicare beneficiaries only and that you can use SSNs to find out if people are Medicare beneficiaries.

But as (for you), but it's not necessary for you to be terribly concerned about people who do not have Social Security Numbers for one reason or another, not at least at this point. Maybe they may become Medicare beneficiaries in the future because they may get SSNs for some reason in the future and thus become eligible for Medicare sometime in the future.

But really I - we've had this question over and over and over again. If someone doesn't have an SSN what do I do? Basically don't worry about reporting that person.

As to the general question of searching for SSNs some of you may have noticed that we have posted on our Web site a couple of documents that will help RREs and beneficiaries and the - to get to the question of how do I find an SSN.

Both of these documents are on the What's New page at this point. We wanted to get them up on site before this call in particular. And we will be moving these documents to the GHP page shortly we hope.

But the documents are an alert dated May 26 that says, "Compliance guidance regarding obtaining individual HICNs and/or SSNs or group health plan reporting under 42 U.S. Code 1395 YB7," which, of course, is part of the MSP regulations.

The second document is a suggested language that folks can use to collect - to give to potential beneficiaries and beneficiaries and others who you may be trying to collect Social Security cards from - Social Security Numbers from or HICNs from, preferably health insurance claim numbers.

And this simple language can be used by anyone for them to give to beneficiaries or people who may be beneficiaries so that they can either tell you they are a beneficiary or tell you they are not. At this point you should just know those documents are there and feel free to use them as you wish.

The alert document is from us. And it says in that alert document that the suggested language on the questionnaire is suggested language. You can in fact alter that language for your - to your own devices if you wish.

We just wanted to let you know that it was there and that it will soon be moved to the GHP page. That's I think as much as I'm going to cover in my introductory remarks at this point. I'm sure that we'll get lots of questions on all these things. But in the meantime I'm going to turn this over to Pat Ambrose.

Pat Ambrose: Okay. Thanks, Bill. I have some general announcements or information to share with you. And then I plan to go through questions that have been submitted to the Section 111 resource mailbox and provide answers to some of those. And then we'll open it up for your questions and answers on the call.

Registration for RRE IDs will remain open indefinitely. In the event that your reporting structure changes and you need a new RRE ID at a later point in time, you discontinue the use of an RRE ID that you no longer need to report under. Or if you have registered for an RRE ID and then realized subsequently

that you do not need it for reporting, please contact the assigned EDI representative and they will be able to discontinue that RRE ID for you.

During the new registration and account setup process on the COB secure Web site, if you discover that you have provided incorrect information for your authorized representative or your account manager please contact the assigned EDI representative for that applicable, or RRE ID to have that information corrected.

Also note that RREs will be able to change their file transmission method later if needed. To make that change you'll need to contact your EDI representative as well. Your account manager for the RRE ID may change some of the information subsequent to the account setup. And you'll see those actions under each RRE ID line on your RRE listing page after log in.

Your RRE ID status will change to production as soon as your MSP input file testing requirements have been passed. You can send production-query-only files on a monthly basis any time during a calendar month as soon as that is completed.

So you may send production-query-only files prior to July 1 and prior to your initial MSP input file submission timeframe. The new GHP User Guide Version 2.3 dated May 22, 2009 has been posted to the GHP page of the Web site.

That Web site again is www.cms.hhs.gov/mandatoryinsrep. On the left-hand side you see links to the various sub pages for Section 111 reporting. See Section 1 of the Version 2.3 GHP User Guide for the list of changes.

One change in particular I'd like to note since there was some questions related to employer size is that we have added an additional link where you can find information about employer size and how it relates to MSP and your Section 111 reporting.

That link can be found in Section 7.2.7 of the user guide. And the link itself is cms.hhs.gov/manuals/downloads/msp105c02.pdf. That's actually an CMS MSP manual for claims contractors and other Medicare contractors that provide services for (PMS). But it has helpful information explaining the employer size calculations for MSP.

Other recent postings to the Section 111 Web site include an alert to employers dated May 6, 2009 on the overview page of the Web site. There is also a notice and agenda for the remaining teleconferences in 2009 dated May 27, 2009 on the GHP page.

We have also posted the X12 271 Companion Guide dated May 26, 2009 for use by those who are using their own X12 translator instead of our HIPAA eligibility rapper software or the HEW, also referred to as the HEW software.

This companion guide then may be used for your translator to format your 270 and 271 transactions for the query-only file. That companion guide can be found on the GHP page.

And as Bill mentioned on the What's New page the May 26, 2009 alert regarding compliance for obtaining individual HIC numbers and/or Social Security Numbers for GHP reporting and the HIC number SSN collection model language. Again those two are on the What's New page right now and shortly we'll be moving those to the GHP page.

The HEW software is available in a mainframe version and a Windows PC server version. That HEW software is currently available through your EDI representative or by calling the COBC EDI Department. The phone number for that is 646-458-6740.

With our July release we'll be posting the Windows PC server version on the COB, the Section 111 COB secure Web site for downloads. I want to remind everyone to sign up for the computer-based training module.

You can do this by going to the mandatory INS REP page, the Section 111 Web page. And on the left-hand side of the page click on the link for MMSEA 111 Computer Based Training and follow the instructions. The curriculum for the GHP computer-based training modules is posted on that page as well.

Once you have signed up for the CBTs you will receive an email invitation shortly after that state. And also note that there is no charge for this computer-based training.

We do make updates and additions to the courses in the curriculums. And once updates or additions have been made once you've signed up for the CBTs you will automatically be notified of any changes or additional courses.

The new CBT courses that are in process and will be posted within a couple of weeks include those for the Section 111 COB secure Web site. In the meantime, if you have questions or issues using the Section 111 COB secure Web site, there is a user guide available for that that can be found under the Reference Menu option after you've logged in to the site.

There’s also information of course on the home page of the COB - the Section 111 COB secure Web site. That Web site is section111.cms.hhs.gov. And

under the How To menu option you can find various how-to documents that will help you through the registration process and getting your initial log in ID.

I want to go through an issue that has come up regarding agent information that was or is being supplied during account setup on the COB secure Web site. The agent information that is supplied during account setup is keyed by the COBC by the agent TIN or tax identification number.

When you're entering your agent TIN during account setup please do not include dashes. Just include the nine-digit TIN with applicable reading zero. And again please don't include dashes or hyphens in that field.

If another RRE for account manager for an RRE ID has already entered information for that agent TIN then you will - once you supply that agent TIN the information will be pre-populated for you.

In some cases some mistakes have been made by account managers entering information for their agents. And you may note that the information that displays by the system does not exactly match the information you may have been given by your agent.

If this occurs please contact your agent and have them contact the EDI department to get it corrected. (The) EDI representative only needs to update the information once for that agent TIN and then it will be associated to all RRE IDs that have performed account setup using that agent TIN.

Agent information displays on your profile report, but technically it is informational only. You may still sign and return your profile report even if corrections are needed. However, if you would like a refreshed or revised

copy of your profile report after the agent information has been updated, your EDI representative can regenerate your profile report on request.

Now I'll go in to some of the questions that have been submitted to the Section 111 mailbox. The first question relates to if the query file method is utilized for MSP reporting. Does the GHP or the RRE only send those records that have been identified in the query response file with the disposition code of 01?

Your - you must query at least those individuals fitting the definition of an active-covered individual although you may query other individuals such as retirees who may be inactive-covered individuals.

However just speaking strictly about the MSP input file preparation you must query at least those individuals fitting the definition of inactive-covered individuals. See the user guide for the definition of an active-covered individual. Then submit only those for whom you receive a 01 disposition code back.

Also note the disposition code that you get back is dependent on the information that you send us. A 51 disposition code indicates that we have not matched your information to a Medicare beneficiary. And it’s only as good or accurate as the data that you have submitted.

For further information about using the finder file method or the query-only file prior to creating and submitting your MSP input file I suggest that you sign up and take the computer-based training. And there is one course in particular entitled MSP Input File Reporting Methods that explains this topic in depth.

Along the same lines a question was submitted about whether an RRE could submit full files for their quarterly updates. And the answer to that is no, that your quarterly update must only contain new information in the form of add updates and deletes.

One reason in particular for this is that by sending the full file replacement each month you will not be able to have the COBC recognize what records to remove if they were sent erroneously or what records to change the key field information if that is necessary.

So please follow the instructions in the user guide and send only updated information on your quarterly update files in the form of add updates and deletes. We've added an event table to the user guide that helps you to find the triggers for what to include on your quarterly update files.

Another question was asked about what response or what disposition code is returned on a response record for a delete record. An 01 disposition code will be returned if that delete record was accepted. To be accepted it has to match the key fields of the original record and has to delete the successfully processed by the COBC.

Another question which is a little bit complicated, but I'll try to answer it and perhaps we might need follow up later on in the call. The questioner was asking if we send multiple contiguous (series) of coverage how does that effective the return MSP effective date.

And so for example they are suggesting that they might send an add record for a coverage starting January 1, 2009 and ending March 31, 2009 with an employee coverage election of one. And then send an add record for an

effective date, a GHP coverage effective date of 4-1-2009 and ending 5-31-2009 with an employee coverage election of a two.

The response file does provide the MSP effective date back. And the MSP effective date is calculated by the COBC using obviously the coverage dates, the Medicare coverage dates on file and also the GHP coverage effective dates that you submit.

So assuming in this case the individual reported was a Medicare beneficiary for this entire timeframe January through May of 2009 then you will receive and MSP effective date on the first record of 1-1-2009. And on the second record the MSP effective date would be 4-1-2009.

Another question was submitted that on Page 49 of the current user guide it says MSP occurrences cannot be posted for periods of less than 30 days. If GHP coverage changes in less than 30 days, but coverage continues you must send one update record to update the existing MSP occurrence with the most current information.

This 30-day limitation is beyond our control. There are other systems that the COB (sees) and needs to maintain the MSP occurrence design mainly on the common working file (CWS). And this is a (CWS) requirement that an MSP occurrence be at least 30 days.

In a particular example that was provided it was asked that if a record was submitted from January through March where the employee had single coverage only. And then from April to April 1 to April 10 the employee covered him or herself and their spouse. And then on April 11 the employee adds their child.

They asked if they should send then a record, maintain the record from 1-1-2009 through March 31, 2009 with the employee coverage election of one for the single coverage only and then send a record, an open-ended record with an effective date of April 1, 2009 with an employee coverage election of two for family. And that is the correct way to submit that information.

So there's a period of time there of 10 days where the employee only covered him or herself and their spouse. However, since we can't store an MSP occurrence of less than 30 days there's no choice but to reflect that coverage starting in April. And I don't think that this will have a material effect on any claims (unintelligible) recovery issues.

Another question was submitted about whether the COBC provide a master list of previously submitted data for an RRE ID. And we are unable at this time to supply such a list. You need to design your system so that you're keeping track of what you have submitted to the COBC and what the results of that submission were, whether an 01 disposition code was returned back, et cetera.

Along those same lines a request was made for a high-level flow chart or a decision tree guide to determine what will be in the MSP and non-MSP file. We don't have something like that available at this time.

However, the basic distinction is to determine if a covered individual is an active-covered individual first and then send them on the MSP file or query them if you're using the finder file and subsequently submit them on the MSP file if they're a Medicare beneficiary.

After that determine what covered individuals are not active-covered individuals. And if they were covered by Medicare, Medicare would be primary.

Those, in other words, those covered by a retirement plan, and those are the individuals that are reported on the non-MSP file. And make a note that the non-MSP file only includes coverage information for prescription drug coverage that is supplemental to Medicare.

Another question relates to Section 6.1, Page 15 about the number of files (where) the GHP reporting process. In that section it states six different record layouts. But then when we go on to describe the basic reporting options versus the expanded reporting options we show five layouts and then seven layouts.

This is, I agree a bit confusing. In the six we were counting this in reference file as part of the MSP file. So, essentially, you know, that's where we came up with the six. What I would encourage you to do is just pay attention to the files that are specifically listed for the basic reporting option in Section 6.2, or 6.2.1 and 6.2.2 for expanded reporting.

Another question came in pertaining to people that have coverage through two different employers. Both employers offer coverage through the same carrier. But this person has eligibility in two different groups and may have the same coverage with the same beginning and ending dates.

In this situation should the RRE send two records for each group? Basically if the keys match in this circumstance the second record would, if you send two records, the second would in essence overlay the first record if everything else matches.

And, yes, as someone is pointing out here that make special note that there is a relationship code that's part of the key. So often times that theoretically should be different. So, however, if the keys are different, then sending both records will result into MSP occurrence being created.

Another question was submitted about are we required to report all ESRD numbers on a group plan regardless of whether they are in their initial 30-month coordination period or do we only report them during the 30-month of eligibility where Medicare pays secondary.

CMS asks that you report members that have ESRD regardless of your knowledge of the coordination period. The system has edits and logic in place to handle that information instead of MSP occurrences accordingly.

Another question was submitted asking, if a file is sent and accepted with a transaction type of zero if we send an update, an update file with the same record and transaction type, will it result in an (SP) error? In this case - and the zero being an add record - the system will treat the second record, the second add record, as an update.

But, as I said before, you are required to only send new information in the form of adds, updates and deletes, not full file replacements each quarter and, again, a full file replacement would not successfully delete any records that were sent and added erroneously.

We also don't want to collect more information than we need and take in repeated information quarter to quarter from you. It really is a waste of processing time and transmission time on both ends, both for the RRE in the field you'd fit in.

A question was submitted about one of the - I'm well - someone was taking one of the computer-based training and a particular slide stated to successfully delete a previously added record.

The COBC must be able to match the key fields at the MSP occurrence and, in particular, this question was asking, do I have to send the actual MSP effective date that was returned on the original response record in order to successfully delete and, no, you do not have to do that.

You may always send on, as updates and deletes, your original GHP effective date and the system will match it to the appropriate MSP record with the applicable MSP effective date.

Another question relates to how much - on one of the previous calls, one of the callers mentioned that they only maintained three years of eligibility in their system. And, also, how this is further complicated about or could be complicated about or regarding someone who changes their coverage on a frequent basis and how much history of the coverage changes is actually kept track of on or in the (ES) system?

As the person continues to change plans, the person’s effective date of coverage will continuously change to the effective dates that they entered the earliest plan we have on record.

Basically, if the effective date is different, there is a chance. If you send a different effective date, there is a chance that a new MSP occurrence will be built instead of updating the previous record that you sent.

So my advice in this circumstance is that you maintain a record in your system of the original GHP effective date. In other words, maintain a record of what

you have submitted for Section 1.11 reporting in order to update records going forward on an accurate basis.

Another question was asked, if an RRE does not have a Social Security Number or a (PIC) Number available for a covered individual, what to do and what will happen if they send that record without either? If you send a record to us without an SSN or a (PIC) Number, that record will be rejected with an (SP) error.

We have no way of matching it to a Medicare beneficiary in that case and that (SP) error does get included in your - in that threshold error for 20% or more of the records being submitted in error if you happen to have a lot of those.

A question was submitted regarding the user guide in Section 7.1.2. The questioner understands that, if a retiree is only considered an active covered individual, if the retiree has ESRD, what if the retiree is on Medicare Disability or what if the retiree's spouse is either has ESRD or is disabled?

Basically, you must have coverage due to current employment for Medicare to be secondary when entitlement is due to disability. The same is true for the spouse. Being a Medicare beneficiary, their coverage, GHP coverage, must be due to current employment.

However, that's not the case. Current employment doesn't affect MSP related to ESRD and, if you read the definition for an active covered individual, you'll see that any individual with ESRD is considered an active covered individual regardless of their current or the subscriber's current employment status.

Another question was submitted asking, we are a (CPA), but have several HMO plans where the claim's administration is handled by the HMO. We are

wondering what would happen if we submitted a person on our MSP input file that was also being submitted by the HMO?

Assuming that there are two RRE IDs in this case, essentially, one record will overlay the other if the key fields match. So please use the user guide in relation to the key fields in that circumstance and, again, you should really only be recording records that are associated with that particular RRE on your MSP input file.

If we have a person with ESRD, will we be submitting them? I've answered this question. Report your ESRD regardless of the coordination period.

A question was asked, would an account that is already a health insurance pair that has registered for GHP Section 1.11 reporting be able to use the same RRE ID for their non-GHP or the liability insurance, no fault insurance, Workers' Compensation, part of the Section 1.11 program, and the answer is no.

The files are completely different, unique, different RRE IDs. If you happen to be a GHP reporter and/or a non-GHP reporter for Section 1.11, you cannot combine your reporting or combine your files in any way.

Another question was submitted that we have a few spouses on the plan that do not have Social Security Numbers. What should the (TTA) provide to CMS? The Green Card Number and, just to reinforce what Bill said earlier, if a covered individual does not have an SSN, that would imply that they could not have Medicare and you should not report them.

There is a rather long question submitted related to reporting of termination dates and the late submission check and the 45-day grace period that we provide for reporting on your quarterly update files for your MSP input file.

And without going into great detail about this, if you are unsure of the termination date when your quarterly reporting submission time frame rolls around, that if that termination date has not been confirmed, you do not need to report the termination date. I'm talking strictly termination dates here, not the effective dates.

The late submission check does not apply to the reporting of termination dates. It only applies to the reporting of effective dates. However, of course, it’s in your best interest to report that termination date as soon as it has been confirmed on your next quarterly update file.

Someone asked a question, there was some confusion between the (SP) 36 error that might be returned back versus the (SP) 30 error and what fields those errors relate to?

For the beneficiary’s Social Security Number, field nine, if you send an invalid code, it would be returned as an (SP) 30. SP 30 relates to field nine, the beneficiary’s Social Security Number. (SP) 36, on the other hand, relates to the policyholder or subscriber SSN.

So, if that SSN for the policyholder or subscriber is invalid, then, in that case, you would receive an (SP) 36. Please see Section 1 of Version 2.3 of the GHP User Guide. We have updated, tried to update, some of the error code descriptions to add some clarity and (SP) 30 was one of them that we did update.

Another question was asked as to whether on the query only response file whether we return updated information from the COBC Medicare (TAPE SKIPS)....match your information to a Medicare beneficiary, do we return what we have on file for the (PIC) Number?

The surname, the first six bytes of the last name, the first initial, date of birth and gender, and, yes, those fields will be returned with updated information if we have it on file.

So when you get a query response, just like with the MSP response file, when we match your information to a Medicare beneficiary, we will send back updated information. If it might be different from what you have on file, I will make an update to the User Guide to reflect that. It was an oversight on our part.

Another question was asked about when prescription drug reporting needs to be submitted and is it mandatory at this point? Please note that Section 1.11 does not require the reporting of prescription drug coverage information.

However, we ask that you do report it under the expanded reporting option, so see the user guide for that information. Section 1.11 only requires reporting of hospital and medical coverage's at this time. A question was asked about reporting the employer's TIN in the case of a multi-employer or multiple employer group health plan?

We do ask that unless the GHP is or uses an hour's bank arrangement that in the employer's PIN field on your MSP input file that you do provide the individual employer (CAST) identification number and not the plan sponsor's (CAST) identification number.

Our requirements or instructions state that, in the case of a multiple employer plan that uses an hour's bank arrangement, you may supply the plan sponsor's PIN and the employer can. But, in all other cases, you should be supplying the specific employer (CAST) identification number for that individual coverage record.

Another question was asked regarding the amount of time that it may take for the COBC to return a response file for the MSP file? The User Guide states that you will receive MSP response files within 45 days and that is the hard and fast rule. Now, on average, the COBC turns around a response file much sooner than that, but you will always receive a response file within 45 days.

Last or the next to the last question, someone asked that they understand we do not want retirees already on Medicare reported on the MSP input file, but do you want retirees not on Medicare?

Again, no, the definition of active covered individual. And, in most cases, except for ESRD, your coverage must be due to the current employment status of the subscriber in order for Medicare to be secondary and so, if an individual is not a Medicare beneficiary and they are in a retirement plan, unless they have ESRD, they should not be reported on the MSP input.

Secondly, this questioner asked that or stated that they are sending files to Medicare for the Part D RDS, Retiree Drug Subsidy. And, if they sign up for the expanded reporting option under Section 1.11, how does this effect their submission of their RDS retiree files? Essentially, there is no effect.

If you're already set up to send your retiree files directly to the RDS Center, I suggest that you continue to do so and, then, you would only be submitting "N" and "D" record on your non-MSP files.

For Section 1.11 reporting, there is the opportunity to do RDS retiree file reporting by making use of (unintelligible) records on the non-MSP files. But, that’s probably a more complicated process for you to go through if you've already set up a reporting mechanism to go directly to the RDS Center.

One last question, what employer size should be reported for records reflecting an individual with ESRD who is in a retirement group? You should be reporting the actual employer size, but note that the employee’s status that you are submitting would be a two for a non-active individual and that COBC has processing and edits in place to handle that information and post them as key occurrences accordingly.

So that’s it for the Q&As that I had and was able to answer. At this time, I guess we'll open it up to the questions from our callers.

Bill Decker: Yes, Operator, this is Bill Decker. Can you just, and everybody on the call, can you just give us 30 seconds. We’re going to go offline just for a tad here. We'll be right back to you. Hang on.

Coordinator: Thank you.

Bill Decker: Okay, hi, Operator. We’re back and we’re - we'll take questions now. Thanks.

Coordinator: Okay, thank you. For questions on the phone, please press star 1. Please unmute your line and record your name to be introduced. Again, for questions, press star 1. If you'd like to withdraw the request, you may press star 2.

As a reminder, please limit yourself to one main question and one follow-up question. Thank you, one moment, for your first question. Thank you. Our

first question is from (Barbara Collisten), your line is open and state your company name, please.

(Barbara Collisten): I'm with (Sun Guard) and my question is, when we send you (A/Ds) - if we send you a record and you accept it and you return an MSP effective date and maybe a term date and Medicare Part A/D, coverage information, and then, we send you a delete, do you return exactly the same information that you returned the first time?

In other words, the same MSP effective date, the term date if there was one, and the Medicare effective and term dates or do you maybe not send back the Medicare effective and term dates because they're still valid? How does that work?

Woman: I am not entirely sure and need to follow up on that question to get you an answer. I'm sorry.

(Barbara Collisten): Okay.

Woman: There's a, you know, we'll return the (O-1 Disposition Code) on the delete. As to whether the system fills out the rest of the information related to the MSP occurrence that is deleted, I'm not entirely sure.

(Barbara Collisten): Okay.

Bill Decker: You're actually asking if we fill out the - in the response file, if we return to you the data that was actually send in?

(Barbara Collisten): Yes, because we've already posted it in our system and, then, we want to pull it back out.

Bill Decker: Right.

(Barbara Collisten): And so, we need to know if you're sending it back?

(Barbara Collisten): We need to figure it out somehow.

Bill Decker: Are you - is your organization going to be an agent or are you just a...

(Barbara Collisten): (Unintelligible) vendor. We're providing this coverage, this product, to our clients.

Bill Decker: Okay, thanks. That helps us a lot.

(Barbara Collisten): Okay.

Coordinator: Thank you. The next question, (Mary Ann Bowers), your line is open and state your company?

(Mary Ann Bowers): Hello, I'm from (Pilgrim Healthcare) and thank you for taking this question. What happens if there are more than four (SP) errors associated with a record? Would you provide two records on the response file?

One with four errors and a second record with additional errors or would you provide one record with four errors, have us fix it and then resubmit and then provide any additional errors on the next response file?

Pat Ambrose: Actually, we would only provide one response file back, but I'm quickly trying to check the file layout. I thought that there were more error codes on

there, but I might be mixing up my non-GHPs and GHP, which I have a tendency to do unfortunately.

But the answer is we'll fill out on your response record, as many errors as will fit, and, if there are more errors, then what will fit, we will not supply you with second records with the additional errors unfortunately.

But, truly, after testing, this happened -- this would happen very rarely and so, but, in the case that it does you may correct the errors that you know about, resubmit the record and find that additional errors are returned back on your response file record. Okay?

(Mary Ann Bowers) Very good. Thank you very much.

Coordinator: All right, thank you. Next, (Elizabeth Wilson). Your line is open and state your organization.

(Elizabeth Wilson): Health Plans Incorporated. We wanted to know if we use something like the form that you posted to solicit Social Security Numbers for member and we received no response at all, not a signed form, nothing saying that they, you know, are refusing to provide the Social Security Number, anything at all.

Is it sufficient to have a record of having attempted to get that Social Security Number to show our good faith efforts in the event that this, you know, an individual turns out to be a covered individual further down the road?

Bill Decker: That’s a good question. We’re going to take 15 seconds to come up with an answer for you. Hang on a second here.

(Elizabeth Wilson): Thank you.

Bill Decker: Okay, fine. The answer that we have now - this is a new posting and we appreciate the fact that people are going to have questions like this because it helps us refine this process. Our advice to you - our instructions to you, in fact, are to keep a record of the fact that you tried to obtain the information using this documentation.

Keep that record as documentation in case you need to show us that you actually went through the process. As to anything beyond that, we don't have an actual answer for you yet. We don't know if that will be sufficient for - we don't know if that will be the end of the process that we may get into place or what will happen.

But the fact - down the road - the fact that you have attempted to obtain the information using the documentation that we provided - you just need to keep that on hand in case it ever comes to the point where we ask you if you tried.

(Elizabeth Wilson): Okay, great. Thank you very much.

Bill Decker: Sure.

Coordinator: Thank you. Next, (Tony McMurray). Your line is open and state you organization.

(Tony McMurray): (Steven Healthcare).

Coordinator: And your question.

(Tony McMurray): We had a question about the query file. If we send a query file with everybody on it to get the information who is on Medicare and get that back,

then we would be sending back to you only those that have Medicare. If we do not send a query file, what should we send?

Woman: You would use the definition of active-covered individuals that's in the user guide and send all of those people that fit that definition using the age threshold and the fact that you know them to have end stage renal disease or possibly the fact that you already know they are a Medicare beneficiary and you have their (PIC) number.

So you can send all of your active-covered individuals and then the COBC will go through those records and first check for whether they are Medicare beneficiaries and then determine is MSP is applicable.

So you do - you know, and what I would recommend is that you sign up for the computer-based training and take that specific course on choosing, you know, this method. It's called the MSP Input File Reporting method and I think it was recently updated to pretty thoroughly explain exactly what you're asking.

(Tony McMurray): Okay, one of the main questions was whether or not we are required to send the query file.

Woman: You are not. The query file is optional.

(Tony McMurray): Okay, because, again, one call we were actually - it was actually explained, you know, we need to (unintelligible) the HICN numbers and I guess then somewhere along the way it's kind of changed on us. All right.

Woman: Yes, and, again, I think the truly - one of the best sources of information that we've got out there is that computer-based training module about saying you

may use this finder file method with the query. Alternatively, you may use the definition of active-covered individuals and report that way and be fully compliant with Section 111 reporting.

(Tony McMurray): Okay, so using (unintelligible) in all of our files because at this point we don't know who has Medicare or not unless they have told us.

Woman: Yes, but please use that age threshold as well.

(Tony McMurray): Okay.

Woman: You know, again, take a look at, you know, so you don't have to send, you know, a six-year-old that doesn't have ESRD and you don't know otherwise to be covered by Medicare since they're under the age threshold.

(Tony McMurray): Okay.

Woman: Okay, great.

(Tony McMurray): Thank you.

Coordinator: Thank you. Next, (Jim Spofford). Your line is open and state your organization.

(Jim Spofford): United Health. But I'll withdraw the question at this time.

Coordinator: Okay.

Woman: Operator, we need to mute ourselves for another follow-up discussion here internally.

Coordinator: Thank you.

Bill Decker: Yes, hi. We want to go back to that last question just a little bit and make perfectly clear, we hope, two things. One is that just because we told you that someone's not a Medicare beneficiary, if you suspect that they are, you should go back and check to see if they are or not.

You could get someone who is 66 years old and actively working and that would seem to indicate that that person is a beneficiary. If we told you for some reason that we did not have a record of that person as a beneficiary, it doesn't meant they're not a beneficiary. You could have submitted information that was impossible for us to check. That's the first thing.

If you have a reasonable expectation that someone that you should be reporting is a beneficiary, you should try to report that person to us whether we - and if we tell you that we don't have a record of that individual, you should go back and check with the individual.

Second thing is that everyone needs to remember as we go forward that the fact that if someone is not a beneficiary today does not mean that person who is continuing to work. Is or not going to be a beneficiary six months from now or a year from now or two years from now.

And as long as you're reporting to us you're going to have to keep that in mind also. The beneficiary population is not static it is ever changing. And you have to keep the in mind as you go forward with the reporting to us.

Woman: To add one little thing to what (Bill) said, couple of his phrases. We are not saying someone is not a beneficiary. When we do the match we're saying we

can't identify them as a beneficiary based on the information you've submitted. Just want to make that really clear. Next question please?

Coordinator: Okay thank you. (Amy Miller) your line is open and state your organization.

(Amy Miller): WPS Health Insurance. We need direction on how to notify CMS that a person who previously had an SCE approved is no longer eligible for SCE. For example if they were part of an employer that only had 15 employees. And the group size has now grown to over 20 how do we tell CMS is it just a quarterly file? Or do we need to fax something? Or is it some additional paperwork?

Man: You should have received information from COBC in your approval documents for that individual (unintelligible) responsibilities to report back to COBC when certain names have changed.

(Amy Miller): Okay we'll check that documentation thank you.

Coordinator: Okay thank you next (Andrea Slatey) your line is open and state your organization.

Man: ATR EIU Welfare Pension Fund. This isn’t (Andrea) by the way. Two questions the first one is regarding threshold errors. We’re in the midst of testing right now and the second file that I sent had 13 deletes a series of updates and some adds. And we ran into a threshold error.

We are a multi employer fund and I'm wondering what will the COBC do in the future if we do happen to run into these threshold situations. Because our employers can go, our employees rather can go in and out of coverage frequently which might cause the effective date to change?

Woman: What happens when you hit the, you know, first I'd caution you to make proper use of the deletes. And, you know, sending in a termination date and if there's a change that would actually be an update the sender termination date. And then an add record to with the subsequent effective date to reflect some change in coverage.

But that being said presuming that you're sending in a delete for something that was either erroneously sent before or you need to change a (TC) filed that was erroneously sent before.

If you hit a threshold error the file is suspended. You will get an email your account manager will get an email. Your EDI rep is also notified and you or the, you should contact your EDI representative to discuss the issue. They have a means of looking at the file and talking over what's happened in that scenario.

And if the file was submitted correctly and it just, you know, because of a freak turn of circumstance or something to get that threshold error. They may release the file for regular processing.

The threshold errors are there just as a safety check to make sure that you're not submitting something that there is an erroneous submitting going on.

Man: Okay.

Woman: Yes so and if you sent it incorrectly your EDI rep will delete the file and ask you , give you instructions on when to send a corrected file. It kind of depends on how quickly you can make that change. And when your next file submission timeframe is coming up and that sort of thing.

Usually they ask you to send a corrected file as soon as possible and that will get suspended for, you know, submitting a file outside your submission timeframe. But they will be on the alert for it and they'll release that for processing. So we've got you covered there.

Man: Okay I understand and then the second question is I want to verify something that you said earlier regarding ESRD members. We have just a handful of ESRD members about 40 or so. And did you say that we need to send them even though they may not be currently covered?

Woman: There they need to have GHP coverage for you to report them.

Man: Okay that's good.

Woman: What is was was current employment status you send your members that have ESRD regardless of why they are covered by the GHP. In other words regardless of the subscriber's current employment status.

Man: Okay so the ESRD members have to have current coverage in order to be included. So if someone was ESRD but last covered in like November 2008 we wouldn't have to send them?

Woman: That is correct.

Man: Okay that's it thank you.

Woman: You're welcome.

Coordinator: Thank you. Your next is (Jamie Hirschman) your line is open and state your organization.

(Jamie Hirschman): Yes I'm with Western Health Advantage and we tend to submit our retirees only on the non-(MSP) (unintelligible) files. And most of our retirees but not all of them have drug coverage. So we're going to be using action type D for drug reporting records for those members.

I wonder what action type we use for retirees that don't have drug coverage? There's an end designation there for non-reporting records and that's use for query only. And there's no drug information reported for those guys those retirees.

Woman: Right we are not interested in those individuals medical or hospital coverage because in that case Medicare would be primary. On the non-(MSP) files we only want you reporting coverage related to supplemental prescription drug coverage.

So you wouldn't report anything but that for those individuals on those D records as you stated.

(Jamie Hirschman): So we wouldn't submit those without drug coverage at all?

Woman: Correct.

(Jamie Hirschman): Okay great thank you.

Woman: You're welcome.

Man: I do want to say for everybody else that's out there. That if you're sending in a non-(MSP) input file and sending in drug records. You can actually also include end records on that file if you want to query on other people. But you're not actually reporting anything to us about it, you're just asking us if they're Medicare beneficiaries or not.

You can mix D and N files on the same record. But we what you need to be sending is that D file.

Woman: Next question?

Coordinator: Thank you. (Amanda Antoneli) your line is open and state your organization.

(Amanda Antoneli): (Unintelligible) Health Plan. We have a couple of questions regarding the query file. We'd like to submit the query file using NEHEN Services. Is there an implementation guide as to how to set this up?

Woman: I'm not familiar with what you're referring to but your choices are either to submit using. All the query only files have to be submitted in an (S12-270) format and the response file is returned in the next (S12-271). So you need an (NCS) 12 translator to create those files or you may get a copy of the (Q) software from the COBC the HIPAA Eligibility (Wrapper) software, ATW, by contacting an EDI representative.

And the (Q) software is used to take those flat file layouts that are in the user guide, feed them into the (Q) software it will create or translate that into the (S12-270). And then when you get the (S12-271) back from the COBC, feed that response file into the (Q) software and it will create the flat file that's described in the user guide for your use.

(Amanda Antoneli): Okay.

(Joan): Hi this is (Joan) (unintelligible) at (Polk) Health Plan and this person who works with NEHEN it's the New England Health Electronics Network. And it's currently used by 40 or 50 providers in the New England area at hospitals and doctors' offices to send queries to CMS. And it's - they have the ability to send batch files.

Now we're a member of this consortium as a payer, so we have been told that it's possible to send batches through that.

Woman: Not actually to a Section 111 reporting that is an entirely different query process. That goes to the CMS data center for Section 111 we're using the CMS sanction data center as the coordination of benefits contractor.

And I also encourage you to review the data use agreement that's on the profile report and in the section of the user guide. But for your queries for Section 111 and our use of the 270 and 271 is slightly different from what that organization is using for other Medicare purposes.

So for Section 111 you really need to use the process that we have outlined in the user guide. And not send your queries for individuals through that other option since it's, you know, kind of mixing apples and oranges and, you know, not really a proper use necessarily of, you know, exchange of data.

(Amanda Antoneli): Can I ask a question about files on transmission methods then? In the user guide you mention ATT and Global Network. We have a town ID with (IVAN).

Woman: Yes.

(Amanda Antoneli): With you guys. Can we use that account?

Woman: Yes.

(Amanda Antoneli): Okay.

Woman: You'll have different destination data set names. In other words when you transmit a file to the COBC first off you'll be transmitting your files to the COBC's (AG&S) account not the CMS data center's (AG&S) account. And different file names than in the COBC data center.

And likewise the COBC will transmit that to you but you will set up separate data sets names on your system for the Section 111 files. But the same account you should be able to use the same account but you will be transmitting to the COBC a different (AG&S) account.

So when you select that method on your profile report you'll receive back the connectivity information you need or the (AG&S) account information that you need for the COBC.

(Amanda Antoneli): Okay thank you. I have some questions regarding the (unintelligible) from questions regarding the basis application.

Woman: Yes.

(Amanda Antoneli): Is there a maximum number of accounts that can be set up for health plans provider?

Woman: I'm a little bit confused about the request the way that (Basis) works is that first you register as an RRE and get your RRE ID and then you make the request to get a (Basis) account or log in from your EDI representative.

I'm not sure of how many users how many log in IDs they give you, might give you for that. I'd have to go back and check and then there's a limited number of queries that you may make through (Basis) per month for each RRE ID.

(Amanda Antoneli): Up to 200 I believe?

Woman: Yes yes that sounds right.

(Amanda Antoneli): Okay how long does it take to set up an account and also how long will it take if we would like an access revoked for a specific user?

Woman: I'm sure it's just a matter of days.

(Amanda Antoneli): Okay.

Woman: But again contact your EDI representative and they can give you more specifics on that. I'm afraid I don't have it all here.

(Amanda Antoneli): Okay was that the number that you had provided the 646 number?

Woman: That's the general EDI department number after you've registered and gone through new registration. An EDI representative and their contact information and email and direct line will be provided on the COBC secure Web site. You'll see it displayed on that summary page as well as on your profile report.

(Amanda Antoneli): Okay and do we also contact the EDI department for the implementation guide regarding the (Q) application?

Woman: Yes when you right now the (Q) software is only available through an EDI representative. We are planning to post that as downloads on the COBC secure Web site with the July release.

And along with the software they'll give you all the information that you need to get the (Q) set up and running.

(Amanda Antoneli): Okay.

Woman: Now note that if you're not using the (Q) software and you're using your own (S12) translator the companion guide that tells you how to translate to the to our version of the (S12-270 and 271) that is posted on the Section 111 mandatory (in depth) Web page.

(Amanda Antoneli): We have that. If we choose to go with the (Q) application is there a support, once we go live during production if there are any issue with the application. Does the CMS provide any support?

Woman: Yes absolutely the software is free and it's maintained by the COBC and again you would contact your EDI representative if you have some kind of issue.

I'm going to have to ask that we take another call, you may certainly call back in if you have additional questions. But we'd like to give other folks on the line a chance.

(Amanda Antoneli): Okay thank you.

Coordinator: Thank you. Next we have (Tammy Myer) your line is open please state your organization.

(Tammy Myer): Community Health Insurance. The question that we have is if we are sending you a spouse who is non-(unintelligible) Medicare beneficiary. We are required to send the (unintelligible) of the policy holder. Based on previous discussions we are only required to obtain the (unintelligible) of an individual if they were known to be a Medicare beneficiary.

So in this case the subscriber may have fees that we are required to report (unintelligible) so I guess now because we are reporting the (unintelligible) we have to get the (unintelligible) subscriber correct?

Woman: I believe that you have identified what may be an issue we'll have to take that offline. I need to check with the systems people to see what the edit is exactly on that policy holder or subscriber (unintelligible) (field).

But, you know, what you've stated does appear to be an inaccurate statement. So we'll have to take that offline and get back to the group on that at a later date.

Man: However we would ask that you request the (unintelligible) and it only really becomes an issue if the subscriber won't provide their (unintelligible).

(Tammy Myer): Correct, so we were just always going down the road of just getting it on the person that we needed to supply it on. And now we’re backtracking to find the subscriber and (unintelligible) as well. Kind of where the catch is coming in.

Then also a follow up on your ESRD response. So basically if a member is has ESRD and they're outside that 30 month window. And they have Medicare on our system as prime we have to send that person to you right?

Woman: Well we ask that you do yes. Yes.

(Tammy Myer): Okay. And if I could ask a quick question on (SP) ES error code. It indicates (unintelligible) that the employers size submitted was correct. And continue to resend the record since the employer size may not change and may continue to receive an (SP) disposition code for these. What are we expected to do with those?

Woman: Well I probably need to make an adjustment to that language. We've said I other places in the guide that if the employer size is less 20 and not involved in a (more) high end employer multiple employer plan. All those, you know, particulars have been addressed then you actually don't have to send the record at all.

So but if you do you may get that (SP) (unintelligible). So, you know, you kind of have a choice, you can consent it knowing essentially that, you know, you will get that error back.

You know, it depends on the entitle, the reason for entitlement for that individual as well of course. Or you may choose to stop sending that record until the employer size changes. So I'll make a note of adding some further clarity around that.

(Tammy Myer): And basically what I'm getting at is if we said the group size was 20 and you send it back because you think it's 15 or whatever.

Woman: No we have no way of knowing the employer size we're relying on your information for that. So we will not, you know, be changing that, we're taking your word for the employer size on the submitted records.

(Tammy Myer): Okay. I guess that will do it, thank you.

Coordinator: Thank you. Your next question (Tina) (unintelligible) your line is open and state your organization.

(Candy Opel): Actually it's (Candy Opel) and I'm with Trust Mark. And we've already gone through the registration process and received a July 1 date. We've had some IT resource in the issues and we contacted our rep on May 8th explaining our situation. And she said that she's going to send it on to other folks to see what we could do.

Because we are not confident at all that we will make this testing timeframe that you have out there. Nor so we think that we'll be able to ready for our first production (file 171). So we're trying to ask for an extension and we haven't heard back from here I've been leaving messages and I haven't, you know, I followed up with my email.

Woman: And your company is High Mark did you say?

(Candy Opel): Trust Mark.

Woman: Trust Mark I'm sorry. I'll follow up for you on that but I also refer you to there's a compliance document out there on the GHP page that talks about, you know, what to do in this circumstance. Essentially to cover yourself and you have done that, this, what we want to try to maintain the assigned file submission time frames.

But, you know, there are situations everyone understands that there are situations where your initial file on maybe you might miss that date. And basically if you're working diligently and staying in touch with your representative you have nothing to worry about.

But I will follow up and make sure that this has been logged in the appropriate place in the system. And that you get the appropriate follow up.

(Candy Opel): All right thank you.

Coordinator: Thank you. Next (Kim Baldini) your line is open and state your organization.

(Kim Baldini): American Community Insurance. How do we handle a situation where we have an employer who is telling us they do not have an TIN. That they filed a schedule C and they don't have a number?

Woman: Could you hang on a second?

(Kim Baldini): Sure.

Woman: On, you know, we have to advise you that whatever they use for filing those taxes is what needs to be submitted. And if that happens to be that this is (under) a social security number that that would constitute the employer tax identification number or TIN.

(Kim Baldini): Okay thank you.

Woman: Do you have another question or operator we need the next person one of the two?

Coordinator: Okay thank you next in queue we have (Pattie Lockgreen) your line is open and state your organization?

(Pattie Lockgreen): (Unintelligible) Financial Group. And my question is similar to the one before with not meeting the submission dates. If we meet our first submission date but then on a future one for some reason we have system errors and we miss our weeks timing. Is there a penalty or is there something we should do if we know we're not going to meet that date?

Woman: Yes we ask that you notify your EDI representative immediately when you know that there is a problem. And they are to make a note of that in the system that we have a record of it.

And there's no automatic penalties calculated by the system at this time however you will receive first an email to your authorized representative and account manager. Seven days after your final submission time frame if we haven't received the file.

And then if we as time goes on I think it's within 30 days we'll actually start sending letters via the U.S. Postal Service. But if you have informed your EDI representative you will have covered yourself in that circumstance.

(Pattie Lockgreen): Okay great. And I have a follow up we had, you had mentioned before on your subsequent files only send adds updates with deletes. And that includes anyone we haven't received an 01 disposition on though correct?

Woman: Oh yes absolutely.

(Pattie Lockgreen): Okay great thank you. That's it.

Coordinator: Okay thank you and next (Jason Logan) your line is open and state your organization.

(Jason Logan): Amalgamated Life Insurance. I have three quick questions. We are trying to submit our first test file via HTTP and the system is not accepting the file and the RR my RRE does not know what's going on.

She's telling me that they don't know what the situation is and when it's going to be fixed. How do I get a time extension or something like that? I have two organizations I'm doing this for.

Woman: Okay first make sure that whomever is trying to upload the file.

(Jason Logan): I'm doing that.

Woman: Okay so if you're uploading the file via and you're on the Section 111 COBC secure Web site. And the upload file action is not successful.

(Jason Logan): Oh I get a successful message. And she doesn't ever, she never receives the file. It disappears between...

Woman: Well when you, are you referring to she as your EDI representative?

(Jason Logan): Yes, yes.

Woman: Well the file goes into the system, you're not receiving a response file back?

(Jason Logan): No.

Woman: A response file is not being posted. Okay well make sure your EDI representative has reported this issue internally and I'm sure they're working on it. And again also make sure your EDI representative has, you know, that you've indicated that obviously this is holding up your ability to successfully test and meet your live dates.

And, you know, just keep diligently working on it and you have covered yourself in that circumstance.

Man: He's the agent.

Woman: Right you're an account designee?

(Jason Logan): Yes.

Woman: And the RRE for that again was?

(Jason Logan): I have two of them.

Woman: Well just give me the company name.

(Jason Logan): United (unintelligible) National Health Fund. And (Allicare).

Woman: Okay well I'm make sure that we're following up on that.

(Jason Logan): Okay my next question is we have members in California. They do not want to provide date of birth. How do we handle that?

Woman: Well hopefully you can get a match on the other three fields. We need to when we're matching an individual we need to match either the social security

number or HIC number. And then the first initial the first six digits of the last name, gender and date of birth.

And if they won't give you the date of birth out of after we've matched the SS and HIC number. Then three out of four of the remaining fields have to match so technically if everything else matches you wouldn't need the date of birth. But you do need the gender and first initial and first six (sights) of the last name to be completely accurate and match.

(Jason Logan): So should we put in a dummy date of birth?

Woman: I'd have to refer you to the user guide to use the default for that field. But, you know, that was, it would not be in your best interest to, you know, to just make up a date.

(Jason Logan): Okay.

Woman: You said that you're the agent on this or account designee. But you're saying that the TPA/insurer has no record of date of birth?

(Jason Logan): No they do not want to provide the date of birth, the members. They keep telling us that the employers of these people say we don't have to submit date of birth according to state law.

Man: Got that?

Woman: But you're saying that it's the actual RRE is unable to get this information. It's not the RRE that's chosen not to provide it?

(Jason Logan): Correct.

Woman: The insurer/TPA does not have this information only the employer has it?

(Jason Logan): Correct.

Woman: Okay.

(Jason Logan): Okay thank you.

Woman: Next question.

Coordinator: Thank you. Next (Patricia Newton) your line is open and state your organization.

(Patricia Newton): Hi I'm from (unintelligible) Health Plan. I was just wondering do we know what the anticipation time is for sending the response file back to the plan this time around. When we send a test file to you?

Woman: I believe the turnaround time for a response file on a (sub) file is within a week. Please take a look at the user guide it should be listed in there.

(Patricia Newton): Okay because we sent one on May 23rd and I know we're still waiting so it's been a little bit over a week. So we were just wondering this time around I know last time around the beginning of the year it was taking any time in between two and three weeks. So we didn't know if it was a week or less this time around?

Woman: Yes I mean with the new testing process the files are picked up automatically on a nightly basis. And there should be, again I have to I don't have it right in front of me to quote what the turnaround time is supposed to be on a test file.

If you're concerned there's nothing stopping you from contacting your EDI representative to check on things for you. And, you know, also report it if there's essentially a system issue on our end but I know of no such issue at this time.

(Patricia Newton): Okay all right. And then my next question is with regards to the revised user guide. The question has come up I think it was in Section 7.2.2 in regards to TIN indicator apps.

Do you have a more of a breakdown definition of what you consider for the federal I think it was for the federal government for the indicator apps?

Woman: Yes access and frank or SS and federal is the indicator for when the employer is a federal entity. And so I'm not really sure what your question is if you could be more specific?

(Patricia Newton): Well I think is it just when the employer is a federal office?

Woman: Yes a federal agency, the federal government entities for instance one that's unusual or people don't necessarily think about it. Is the presidential libraries are run through a group and they're all federal entities.

In most, you may need to ask them are they in fact a federal government agency.

(Patricia Newton): Okay I think that that was the question to, you know, we had some federal offices and there was the entity within those offices that were all governmental agencies. And I think some were and some were not and I think

that's where the question was raised. So some of the staff there wanted a further breakdown, so okay thank you.

Coordinator: Thank you next (Vicky Troni) your line is open and state your organization.

(Vicky Troni): Capital Blue Cross. We currently have some vendors that pay...

Woman: I'm sorry can you speak up we're having trouble hearing you.

(Vicky Troni): Can you hear me now?

Woman: Yes a little better.

(Vicky Troni): Okay this is Capital Blue Cross. We currently have vendors that pay a chiropractor. Which is a very very small subset of our membership. And they were contacting us today requesting the MSC information that we have on our files for those members. Saying that they also need to report these members.

We are already reporting them do they also need to (unintelligible)?

Woman: Is this a separate policy is it a carve out of an existing policy or what's the arrangement between the chiropractic services and the rest of the service?

(Vicky Troni): Basically they normally price our claims for us. And do some of the pre-auth information as well. But there is a very very, there's one group actually that they actually pay the claims for us on our behalf and we reimburse them.

But we are also have the rest of the medical coverage that we send the MSC information to you. So (there)'s (unintelligible) that same member.

Woman: Could you send a note into our resource mailbox just describe the very detailed specificity and give us contact information in that?

(Vicky Troni): Absolutely okay.

Man: I'll have to research it thank you.

(Vicky Troni): Thank you.

Coordinator: Thank you. Next question (Kim McCurrin) your line is open and state your organization.

(Kim McCurrin): Blue Care Network Of Michigan. I hope I didn't miss this being asked in a different way. My understanding is from a delete add update perspective when it comes to the HIC and the SSN or the four matching fields the first initial the last name the date of birth and gender.

If that is the only thing that is changed on a record we do not send a delete add or update for it. It would only be sent in the subsequent submission if another field on the field creates a change.

Woman: Actually what I need you to do is take a look at the events table in the user guide. And it in Version 2.3 and the HIC number is actually one of the key fields. So essentially if you sent the wrong person and, you know, with not the HIC number, you know, or SSN for the right person.

That is a key field and you would need to delete add and change it to the correct person. But the other matching criteria that we use are not key fields but rather just matching criteria.

So for example someone's last name changes that does not trigger a delete add it does not trigger an update. But the next time you send a record for that individual you would send some of the current information you have for their last name. And hopefully by that time they have changed their name also with social security and therefore we would have that name change and be able to match it.

So the name and date of birth and gender are not key fields and would not trigger any action on your part. You would just send that information on any subsequent records that you might have to make in updates.

But the HIC number is one of our key fields but, you know, in theory we shouldn't know about a HIC number change. You know, unless we gave it to you and, you know, that won't trigger something it really is a matter of you sent the wrong person to us.

(Kim McCurrin): Okay because I guess this is from an EDI rep that's who told me not to send one for the HIC or the SSN. And I was confused because I'd seen it in the user guide use delete add.

Woman: Okay well yes I just have to refer you to the user guide and the event table that's newly been added. And I think it's clear there.

(Kim McCurrin): Okay and can I ask for employers side do we send an update only if it's changed and has been different in our system for greater than 20 weeks?

Man: That's not in your system for 20 weeks it's when did the, did the employer have at least 20 employees in the current or pre-prior calendar year. You need once the employer has had 20 employees in the current calendar year. You

need to make sure you change the record and show that it's also less than 20 or more.

(Kim McCurrin): On the current calendar year.

Man: If they had 20 in the prior calendar year I think you would have known it.

(Kim McCurrin): Right.

Man: Now if they're starting the year, if they had 15 in the prior year and then in January went up to 20. January 1st then 20 weeks later you would need to change the report to show 20 or more employees. Because that would trigger Medicare becoming secondary from that date onwards.

(Kim McCurrin): Okay thank you.

Woman: (Ashley) before you go to the next question a couple of follow ups. You'll see in the user guide that test files should be returned to you within one week or five business days. And if that's not the case again contact your EDI representative and for the last caller there's another reference that might help explain employer size calculation.

In the updated user guide you'll see it in Section 7.2.7 there's a new link that's been added. You also see that link listed in the changes in Section 1. Okay next question please.

Coordinator: Thank you. (Darryl McCall) your line is open and state your organization.

(Darryl McCall): Priority Health. My question is with regard to the query file. We've got an early submission date and my understanding is that you use the query file and

then the criteria, the age criteria and so on and so forth. To actually determine who to submit.

With the query file it takes 14 days to get a response file back on that. Or up to 14 days. Since we have an early submission there may be individuals who actually have Medicare secondary that we're unaware of. Because they fall outside of the active covered individual criteria.

Is that an issue, I mean we have to obviously identify those people going forward. But does that present a problem if we miss an individual because they fell outside of the active covered individual criteria?

Woman: But you know them to be Medicare beneficiaries?

(Darryl McCall): No we do not know them to be beneficiaries.

Woman: Oh well, you know, if you didn't identify them on your initial query. Now there's two things, one, there's two options for reporting. One is to strictly go by the definition of active covered individuals and not use the query at all. And just anyone who falls into that definition as defined in the user guide submit everyone who falls into that definition on our MSC input file.

(Darryl McCall): Right.

Woman: And then of course the other option is using the finder file method and submitting only those that were found or matched to Medicare beneficiaries through the query process.

And if you miss someone and you submit them on your next quarterly file they will be marked as late submissions because you will have that late submission compliance flag on the response file.

There's no automatic calculation of a fine or a penalty and, you know, we'd encourage you to, you know, do the best you can for your initial file. And, you know, and then get caught up I guess, you know, as soon as possible in your subsequent quarterly reporting.

So you're basically identifying this as a onetime problem for yourself because of your initial submission date?

(Darryl McCall): Correct.

Woman: So just keep your EDI rep updated that this is a particular problem for you with this first file.

(Darryl McCall): Okay and we've already done that so it sounds like we're covered already.

Woman: Yes.

(Darryl McCall): Thank you very much.

Coordinator: Thank you. Next (Lee Marcus) your line is open and state your organization.

(Lee Marcus): Hi (unintelligible) Administrative Services. And I have two questions one is if a given month is not closed and that we don't have the data yet to send for the final monthly recorder. Should we send a partial file without that particular groups data or send two of the three months for that group?

Woman: Yes I would send as much information as you have when your file position time times rolls around. And then again catch up on your next quarterly submission.

(Lee Marcus): Okay.

Man: Keep your EDI rep informed.

(Lee Marcus): Yes I had asked her if we could extend our due date like by another week or two and that way we'd be sure to be closed. But she said that that couldn't be changed.

Woman: Yes we don't want to change your file submission time frames. You know, we realize it's going to take a while for everyone to get their processes established and be reporting on a timely basis.

We'd like to, you know, because we're trying to spread out our processing. But if you keep your rep informed of your progress and the fact that, you know, you might have some additional, you know, a higher number of late reports in your say your second quarterly files. Because of in a sense catching up.

(Lee Marcus): But this could be on any quarter because we're getting information from unions we're a third party administrator.

Woman: Okay now the other and again we ask that you submit during your, what you have available in your system during your file submission time frame. And not hold your file for, you know, getting that information a couple of weeks later or something like that.

(Lee Marcus): Okay but would we send the missing data in the following quarter?

Woman: Yes you would. Yes you would now also take a look at the guide where it talks about the 45 day grace period. Any effective date that's within 45 especially when we get your quarterly input file. We're looking at the effective date on the submitted records to add records to new records. And saying are they older than 100 or are they more than 135 days old.

And if so that's what we're triggering the late submission indicator for the record for. So if, you know, if it's within a, if the effective date of that coverage is within 45 days on your file submission time frame. You are you have a grace period to then report it on the next quarterly file anyway.

And again this is in the user guide and it's also explained in the CDT pretty well with some pictures that might be a little easier to follow than my babbling on.

In other words we're not judging you on a calendar quarter, your quarter for our purposes runs from your file submission date in one quarter. Until your file submission date in the next quarter.

And we realize because sometimes you'll have an effective date the day before you file submission. That person will fall within that grace period and can be reported in the subsequent quarter. So if you were looking at it as an ongoing issue the grace period should cover you.

(Lee Marcus): Okay. And similar but a little different question is suppose a person does not have coverage for any month in the given quarter. So we do not report them and that's maybe because he didn't pay his premiums.

But maybe the day after I send you the file he retro pays for the first month of the previous quarter?

Woman: Well we do ask you to report that on your next quarterly input file. Retro-active, you know, the effective date for the coverage and it may get marked again with the late submission flag depending on the timing. But we still want the data and if you have a record of the fact that, you know, this took place and they paid late. And their coverage was retro-active then, you know, you have covered yourself and, you know, don't need to worry about that.

(Lee Marcus): Okay even if he didn't pay for the current quarter that I'm reporting?

Woman: Yes and so we still want to know about it and if you have to submit the records with, you know, an expected termination date because technically his coverage does not.

It's not open ended because he hasn't paid for the second quarter then, you know, then you would be, you know, reporting it with an effective termination date. And then possibly updating the records whenever he does make that payment in another subsequent quarterly file.

(Lee Marcus): Okay and my last real quick question is. When you say the birth date is you know age is 55 or older. As of when?

Woman: As of your file submission time frame.

(Lee Marcus): As of the quarter okay.

Woman: Yes yes as your file submission window again we're not looking at particular calendar quarter for you. We're looking at the quarter based on your submission window.

(Lee Marcus): Okay so if a person turned 55 the day I send the file then I would consider him...

Woman: Yes you might want to use, you know, kind of a plus or minus range if. You know, if you submit the ones that is under 45 technically you have to submit that record with the HIC number and it is 45. I know right now the threshold is at 55 and is lowered to 45 later. The system is only requiring HIC numbers that are less than 45 but, you know, it's not going to be a big deal.

We'll just reject that record with an ST99 saying, you know, we're not taking information for people less than 45 without those HIC numbers. But right now for the 55 you shouldn't even run into that. So you might want to use, you know, sort of a plus or minus, you know, birth date range.

(Lee Marcus): Okay well thanks very much.

Woman: Okay thank you. Next question.

Coordinator: Thank you. Next (Paul Smith) your line is open and state your organization.

(Paul Smith): Group Health Cooperative. And it was mentioned on the last call and we kind of toyed around this question in this call. But I wanted to get some additional clarity.

It was mentioned that we're expected to keep track of and report the date when the total number of employees for a group becomes 20 or more members for at least 20 weeks.

And that was not a requirement that we were aware of prior to the last call. And I guess my question is, you mentioned that there's a new link in the new version of the GHP guide.

And we just looked at that link and what we want to confirm is do we have to immediately when we become aware of that change. Start reporting that group after they hit the 20 week threshold. Or can we do it as the guidance actually talks about that we are supposed to report employer group size once a year?

Woman: Well if you're not reporting accurately because you chose to delay then your likelihood of overpayment demands once you report escalates automatically. Because if we're paying incorrectly there will end up being recovery claims.

The advantage of reporting timely is that we do a pre-paid denial. So that we don't inappropriately pay claims. The other thing in what in the way you've been phrasing things you keep talking about the group size. When you're talking about the number you're talking about the number of employees you're not talking about the number of covered lives.

(Paul Smith): Right correct. Correct so the real issue is that even though the guidance says we're supposed to report the total of number of employees once per year. The reality is that we need to be aware of changing number of employees throughout the year. And then change our quarterly submissions based on that changing size is that correct?

Woman: That's the recommendation yes.

(Paul Smith): Okay thank you.

Coordinator: Thank you. (Linda Hancock) your line is open and state your organization.

(Linda Hancock): My organization is UFCW Trust Fund we're an (unintelligible) labor trust. And my question is that through our trust that is a very small trust. Only has 270 members in it, it's currently active but our board has recently made a decision to dissolve that trust.

And my question is do we still need to submit the test files for that particular trust? Because they will be dissolved by September.

Woman: Yes I guess CMS believes that if they had coverage as of January 1st 2009 that reporting would be required for that information.

Man: Yes the law took effect on January 1st and so any covers that were in effect as of January 1st and going forward should be reported. I'm sure that there are going to be other firms and other situations where the same thing happens.

That people who have been covered or have been supplied with coverage are going to lost it for one reason or another between now and the end of September. Or now and the end of this year and now and the end of any time.

But if there was coverage provided to them starting January 1st we have we here in CMS and in the Medicare program have been tracking that coverage and are hopefully paying correctly when we should. And what we are asking the folks out there to do is to tell us when their paying and hopefully they're paying correctly. That would be you all out there.

We're still going to have to have that information coming in to be sure that we can coordinate benefits with you up until such time as it's no longer necessary. As in this case dissolving the trust.

(Linda Hancock): Okay thank you.

Woman: Be sure to include the appropriate termination date on that report as well.

(Linda Hancock): Okay.

Woman: Next question?

Coordinator: Thank you. Next (Stephanie Stamy) your line is open and state your organization.

(Stephanie Stamy): High Mark. Just had a question we had asked these four about the valid patient relationship codes. Where we have the situations where at the time we've been determining (primacy) for say a mother-in-law or some other type of sponsors attendant.

They were covered due through the ESRD during that coordination period while we're primary they become aged. When we're sending those members, they are being returned with an age entitlement reason and then they get an edit error.

Because we can't send anybody other than a spouse or the member. Do you know if anybody is looking into that yet?

Man: Have you submitted that in writing?

Woman: Yes.

(Stephanie Stamy): We had brought it up at another meeting and someone said that that was being looked at, that they were aware of it. If you need it I mean I can send it in writing again.

Woman: Yes I think I saw it in the review of questions. But if you submit it again that would be great to the Section 111 resource mailbox.

(Stephanie Stamy): Okay.

Man: I'll second that I think I saw it too and it is a complicated issue for us. We still are looking at it but your next submission in the mailbox we (unintelligible) to stay on it.

(Stephanie Stamy): Okay I'll be gentle.

Coordinator: Okay thank you. Next question (Amy Brill) your line is open and state your organization.

(Amy Brill): (Unintelligible) Nation. Who is the RRE for self insured plans if they have a CPA that handles and pays the claims?

Woman: The CPA.

(Amy Brill): Okay I just wanted to be sure. Thank you.

Coordinator: Okay thank you. Next (Laric Anderson) your line is open and state your organization.

(Laric Anderson): Health Partners. I guess I'd like a little bit of clarification on the late submission of files. If when we send our first file we put in the earliest effective, I mean the effective date the earliest effective date for the coverage as it crosses one one.

On subsequent quarters do we continue to send the earliest or do we only send in if they weren't accepted at the CMS. Or do we just use the effective date of our coverage for the current quarter?

Woman: No it should be the effective date of the coverage, the original effective date as long as the coverage has remained the same.

(Laric Anderson): Okay and so then how would you know that it's not, that it's on time versus being late?

Woman: Well it's by the use of your add and update records. So if you're sending, I mean once you've sent it to us if it has an open ended termination date ongoing coverage. You don't need to send it again unless something changes or the coverage terminates then you would send an update with the termination date. And you do that with an update record. The late submission check doesn't apply to updates only to newly added records.

(Laric Anderson): So if we sent it the first time and it wasn't accepted at CMS with the earliest effective date. We don't have to send it again?

Man: Yes.

Woman: Well why wasn't it accepted I mean if there was an error you have to send it again. But if it wasn't accepted because that person isn't a Medicare beneficiary.

(Laric Anderson): Right.

Woman: There is instruction in there if the coverage continues and the individual is still an active covered individual. You either need to continue to monitor their Medicare status through the query or continue to send them. And this is described in the user guide, you know, in the section on how to handle your disposition code.

(Laric Anderson): Right well I understood that I figured we would just keep sending it. I guess I didn't understand why that wouldn't be considered a late submission if we continued to send it the same way.

Woman: Well the logic is also looking at the, you know, the fact that the, looking at the Medicare entitlement dates. So, you know, if the person wasn't entitled to Medicare you're not, you know, late submission checks should not be set. Or flags should not be set if they have just become entitled to Medicare.

So that's taken into account...

(Laric Anderson): Okay so the late termination is just to say it would have been eligible for Medicare?

Woman: Yes.

(Laric Anderson): Okay thank you.

Woman: Yes.

Man: Operator, operator?

Coordinator: Yes sir?

(Bill): Yes this is (Bill) we're going to be able to take one more question and then we're going to have to end this call. We're at our time limit here but we will take one final question if there is one in the queue.

Coordinator: Yes thank you. We have (Liz Corton) your line is open and state your organization.

(Liz Corton): Hi I'm from American Specialty Health which is the chiropractic (carve) out company that Capital Blue Cross referred to earlier. We have several large health plan clients where we do chiropractic business for them and we pay the claims.

So if you could add me onto your response back to Capital Blue Cross that would really be helpful for us. Because we see the (unintelligible) too and I talk to my EDI reps but he didn't - I don't know if you didn't understand the carve out or that we would be reporting the same information as these large health plans. But I didn't get the answer I was hoping for, so if you could include me on that that would be great.

Man: That will be fine, can you send please send us your contact information to the resource mailbox?

(Liz Corton): Sure thing.

Man: Thank you very much.

(Liz Corton): Thank you.

Man: Okay operator I'm sorry but we'll have to end this call now. And when the call is - when we're offline operator can you give us the statistics on it please?

Coordinator: Yes thank you. Okay thank you for participating in today's conference, have a great day you may disconnect.

END