TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: March 11, 2010

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
March 11, 2010
12:00 p.m. CT

Operator: Ladies and gentlemen this is the conference operator. Today's conference is scheduled to begin momentarily. Until that time your lines will again be placed on music hold. Thank you for your patience.

Good afternoon, my name is (Mason) and I'll be your conference operator today. At this time I would like to welcome everyone to the MMSEA111 call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during that time simply press star then the number one on your telephone keypad. If you would like to withdraw that question press the pound key. Thank you.

Mr. John Albert, you may begin your call.

John Albert: Thank you. Hi. Good morning or good afternoon, depending on where you're calling from. Just again to remind everyone that this is – today for the record is Thursday March 11th, 2010. This teleconference is a non-group health plan conference regarding the technical implementation of a Section 111 of the MMSEA. As we've done in the past, Pat Ambrose who's here will go over a lot of new technical information that relates mainly to the recently-posted new NGHP user guide, as well as some of the alerts and other issues. We will follow with a question and answer session.

Again, this call is geared more toward technical implementation. Next Tuesday the 16th there will be an NGHP policy call. We would ask folks to please hold those questions for that call next week so that we can get the technical information to the more IT audience we expect on this call out to them and assist them.

So with that I'll just quickly turn it over to (Pat) and we'll move on.

(Pat): OK first I'd like to bring to your attention new postings to the CMS section 111 website, which hopefully you all know is www.cms.hhs.gov/mandatoryINSREP. On the liability worker's comp no-fault, or NGHP page version 3.0 of the NGHP user guide dated 02/22/2010 has been posted. We've also recently posted an updated (X12-270,271) companion guide that includes the (RREDCN) field. This document is version 4.0 of the X12-270,271 companion guide and is date February 2010.

We've also updated the NGHP call schedule and as John mentioned please note the call on March 16 is for policy topics.

On the MMSEA 111 alert page of the website we have posted three alerts recently. Those include who must report, giving you information about the definition of a non-GHP or NGHP RRE. That's dated February 24th. There's a document on NGHP RRE compliance also dated February 24th. And there's a third alert, entitled Required Reporting which provides some information on pending policy issues and instructions related to that date 02/24, or February 24th, 2010.

Note that these alerts supersede any related info in version three of the user guide, particularly the “Who Must Report" alert, completely replaces section 7.1 of the user guide. Obviously we will be updating the user guide to incorporate this alert information at a later date. Note that the e-mail notification for the website does not appear to be functional yet; CMS is working on this. And in the meantime please check the "What's New" page frequently for new postings.

Bill Deckhart: We did have (word) today – hi, everybody this is Bill Deckhart and thanks for letting me interrupt. We did have word today that it is, we believe now, functional again and alerts should be going out on postings as of a couple of weeks ago. If it was a posting prior to that, though, you probably won't get an alert on it. But the main point here is that we do believe the alert system is functioning again and we've been told that it is and that those of you who were not getting alerts do not to worry that you were removed from the mailing list; it's simply that that was not functioning.

(Pat): OK during this call we will try to cover most of the technical issues raised since the last call and sent to the CMS section 111 e-mail address. However if you have technical questions, not policy questions but technical questions about testing, errors received on test files, problems with file transfer and the like – those must be directed to your EDI representative. Specific technical questions like these cannot normally be addressed on this call, nor will you receive an answer back from the CMS section 111 e-mail address. If for some reason you're not satisfied with the handling of your issue, after you report it to your EDI representative then please follow the escalation process that's described in section 18 of the user guide.

Please review the new reporting dates that are documented in version 3 of the user guide. Note that RREs are encouraged to begin production reporting as soon as possible and do not have to wait until first quarter 2011 to do so. Also note that when you report your first production claim file retroactive reporting is required, and this will be taken into account as far as timely claim submission, the compliance flags and so on. There were some questions submitted regarding that.

RREs will retain the same file submission period for the claim input file. So for example if you're in group four and you were supposed to report your first file April 22nd through the 28th of 2010, meaning the 22nd through the 28th days of the first month of a quarter then your first claim input file is required now, January 22nd through the 28th 2011. So again, your file submission timeframe remains the same and that will apply to when first production files are submitted, whether they're submitted first quarter 2011 or prior to that. Please remember to submit your claim input files as close to the first day of your file submission timeframe as possible. Again, refer to the user guide regarding file submission timeframe.

I have an announcement about the direct data entry; actually it's not different from the information that we've provided previously on this topic. CMS is working on a schedule for implementing a direct entry option on the section 111 COB secure website in lieu of file submission for RREs that will have very few claims to report per year for section 111 mandatory reporting. The definition of these small or low-volume RREs is not yet final, and a definite

implementation date for the direct data entry option on the COB secure website has not yet been established. However, this is a very high priority for CMS and we understand the urgency and will issue this information as soon as possible.

All changes to requirements listed in version three of the user guide have been implemented in the system for tests and production claim input files except for those specifically documented as being effective April 5th, 2010. Since production claim input files are not required until the first quarter 2011 (our) RREs have adequate lead time to implement and test these changes. We are committed to providing at least six months lead time for any other changes required to production reporting.

The only significant changes planned at this time are for fields 58 through 62, related to the product liability and mass tort reporting. And as you know there are certain policy issues outstanding pertaining to what claims must be reported under certain circumstances, however that won't affect the actual file layout.

There are a couple of typos, typographical errors in version three of the user guide. The first refers to address lines two through four of the new foreign RRE address fields. These are fields 13 through 15 on the (TIN) reference file. They erroneously refer to foreign employer in the field description; they should have referred only to a foreign or RRE not based in the United States. The second type is in the third bullet of section 13.3 related to the frequency of the query submission. We have not changed the frequency allowed for query input files; that is, they are allowed on a monthly basis. So where this bullet says that, "If more than one file is submitted in a calendar quarter," it was supposed to say, "Submitted in a calendar month."

We will soon release a new CBT computer-based training module that will be released to provide RREs helpful information related to claim input file testing. This is based on experience with testing thus far on section 111 mandatory reporting. This information was covered on previous town hall calls; RREs and agents are encouraged to enroll in the CBT courses, and then

you will be notified when new or updated courses are available, including this lessons learned, so to speak, CBT.

On a previous call I talked about address formatting standards. In the updated user guide and on those previous calls we have requested that RREs adhere to certain standards for formatting addresses. We stated that only the street number and street name should go in address line one and any other information related to the address such as suite number, attention to, mail routing and so on should go in address line two.

This is not exactly accurate; the real requirement or request is that you put the street number and street name in one address line field and the other information in the other address line. So street number and street name can go in line one or address line two, as long as they are segregated from other information such as suite number, attention to, PO boxes, apartment numbers and so on. This isn't actually a requirement; at this point in time you'll see that the definitions of these address fields have not been changed, but this is a request such that we can use that address in the most effective manner.

I'm now going to launch into some information that I'm making available, based on answers to questions that have been submitted to CMS and other sources where we believe we need to add further clarification. The first major topic is the ICD9 codes. As you can see in version 3 of the user guide requirements for ICD9 have been modified. Please note that RREs may use diagnosis codes submitted on medical claim records they receive from the injured party related to the claim and/or derive ICD9 diagnosis codes from claim information the RRE has on file. Again, these codes may be derived by the RRE and do not have to be diagnosis specifically made by a provider or supplier of medical services, such as a physician or hospital.

They are used by Medicare to identify claims Medicare may receive related to the incident, for Medicare claims payment and recovery purposes. An exact match to ICD9 diagnosis code is not required during this identification but RREs are encouraged to apply as many specific related codes in the ICD9 diagnosis code one through nineteen fields as possible to ensure Medicare identifies the applicable medical claims it receives.

In particular, if there are multiple injuries or illnesses claimed then the RRE should be submitting multiple ICD9 codes that describe each. You may submit gaps in ICD9 diagnosis code fields one through nineteen, in order words submit a valid code in ICD9 diagnosis code one (spaces) and ICD9 diagnosis code two and submit another valid code in the third field, for instance, someone actually pulls that question. I assume that's because they're posting codes and then checking for their validity and may space one out before they submit the record on their claim input file.

ICD9s in field 15 and the ICD9 diagnosis code starting in field 19 are required on files submitted on or after January 1st 2011, regardless of the actual (ORM TPOC) date of incident or any other date on the claim. So the requirement is related to when the file is submitted and processed. That means that the retroactively reported claims much have valid ICD9 codes on them per the requirements in the user guide if you're submitting them in the first quarter of 2011.

Field 57, the description of illness or injury can only be used on tests and production files submitted prior to January 1st, 2011. That might actually be an incentive for some RREs to start reporting production files sooner, since they may make that initial report of those claims without the ICD9 code requirement prior to January 2011. Obviously you should put a full description in field 57 in lieu of those ICD9 codes.

I'm now going to go into some information related to queries and the query input file. Another topic that was added to section 13 of the user guide relates to the frequency of query file submission. Query files may be submitted within 30 days of each other as long as the month is different, however if there is a query file in process and another query file comes in, the second query file will be suspended, even though the receipt date – the month on the receipt dates of those files is different.

The responsible reporting entity's account manager will get a threshold e-mail with a somewhat confusing message. It states, "Multiple files submitted within submission period," even though there is no actual submission period

for queries. However, when the first file completes, the EDI representative can release the second file and let it process. This was updated, again, in the user guide. So in other words, we can't have two query files processing at the same time, even if the receipt date months are different.

Now that said, there really shouldn't be a need to send query files only two weeks apart, however I understand that there might be situations under which an RRE may do this as they go through the testing process and prepare for production reporting. We are seeing, however, RREs submitting identical query files repeatedly, essentially the same set of individuals every month. Again, I can see if you are end-to-end testing that you might do this now, but on a regular basis there should be no need to query the same individual every month.

The COBC usually gets Medicare entitlement information 90 days in advance; you only need to query an individual once per quarter. Please review the information in the note at the end of section 13.1. Queries for an individual – I mean rather, queries for an injured party should be submitted after ORM is assumed or after a TPOC date. You do not need to report for section 111 until after settlement judgment aware or other payment is established or ORM is assumed.

You may use means other than section 111 queries to determine whether an injured party is a Medicare beneficiary, however make sure you adhere to the data use agreement of those other CMS Medicare query applications you may be using due to other Medicare-related data exchange. Make sure that the data use agreement allows for this use. The section 111 query is optional but those other query applications may have rules that preclude their use for this purpose.

So a question was actually submitted asking – I believe there was a hospital RRE who has access to Medicare information via a separate application. I can't tell you whether you can use that other query application for section 111 purposes; you have to review the data use agreement for that.

(Bill Deckhart): But it's highly unlikely.

(Pat): OK. Now I'm going to talk about some issues that have come up related to the Medicare health insurance claim number HICN, which I often pronounce "Hicken", and also Social Security number issues. If the Social Security Administration is assigning these HIC number, the SSA portion of that is a nine-digit number, usually the SSN of the beneficiary or spouse with at least one letter suffix, maybe more than one letter of suffix at the end following that nine-digit number. This is called the beneficiary ID code, or BIC, or "Bick" in the tenth position. If they're in the 11th position it could be a letter or number.

So in other words normally HIC numbers are nine-digit numbers followed by either a one character suffix or possible a two or three character suffix. There are certain ranges in use for Social Security numbers; Social Security numbers do not begin with the number nine at this point. Most likely if you receive a so-called Social Security number beginning with the number nine this is probably a tax identification number assigned to an individual who is not a U.S. citizen and therefore does not have a Social Security number and would then not be a Medicare beneficiary.

Now the railroad board also assigns some Medicare health insurance claim numbers, or Medicare HICNs. These take on a different format. Generally they are a six- or nine-digit number, with up to a three-character prefix. So a prefix in front of that six- or nine-digit number, for example the letter A followed by six digits, the letters M-A followed by nine digits and so on. Railroad board-assigned HIC numbers are accepted for section 111 reporting – in other words we do accept them, and the matching algorithm is the same.

We have some questions about specific HIC numbers beginning with the characters H-0. This actually caused a problem with the HEW, H-E-W, HIPAA Eligibility Wrapper software. When this HIC number beginning with H0 is submitted on a HEW query record the HEW software thought that the detail record was another header record and it generated an error. At one time some railroad board beneficiaries had HIC numbers that began with H0, however this numbering scheme is no longer used. There is no current living beneficiary with a HIC number starting with H0, and we assume that this range will never be used again going forward.

So if you have HIC number starting with H0, it is either inaccurate or it belongs to someone that is no longer alive. An associated claim record would not be reportable, given the reporting dates. If you must query a person for whom you have a HIC number starting with H0 and you're using the HEW software, then perform that query using only the Social Security number because we're pretty confident that that HIC number is not valid.

Not everyone over 65 is a Medicare beneficiary, and you also do not have to be 65 or older to be a Medicare beneficiary. Even a child under age 18 could be a Medicare beneficiary under certain circumstances. So you'll note in the user guide there is no age threshold applied to NGHP section 111 reporting.

A question was asked about what to do if a claim was reported and accepted, and then later the RRE discovered that the Social Security number, or the HIC number, were used fraudulently, and it was not the Medicare beneficiary that was injured and paid. In this circumstance the RRE should submit a delete record on the next quarterly file to remove this false report, then please contact your EDI representative to discuss whether any further action is needed.

I'm going to provide some technical information related to Workers' Compensation Medicare set asides as it relates to section 111 reporting. Even though you may be working with the Medicare Workers' Comp Recovery Contractor, the WCRC on the Medicare Set Aside, or the MSA, you must still report the claim, if applicable, under section 111. You would report Ongoing Responsibility for Medicals, or ORM, under section 111 as soon as it is assumed.

Once a settlement is reached an update record with the ORM termination date and the TPOC, T-P-O-C, or Total Payment Obligation to Claimant amount end date, reflecting the settlement, would be submitted. The TPOC date is determined using the same rules as all TPOCs – see the field description in the user guide. I think it's likely that the TPOC date would equal your ORM termination date under these circumstances, but it really depends on the nature of the settlement.

If the injured party is not a Medicare beneficiary at the time of settlement, where an MSA or Medicare Set Aside is involved, again, if the injured party is not a Medicare beneficiary at the time of settlement or during the period the RRE had ongoing responsibility for medical, then the claim does not have to be reported under section 111. No further monitoring is necessary unless a subsequent TPOC or ORM is established at a later date.

Now some questions about registration have come up. Please note that a parent company may register and report on behalf of its subsidiaries. You do not need to obtain an RRE ID for each subsidiary. Note that the rules regarding this are in "Who Must Report?" in the February 24th alert, "Who Must Report?" A sibling company cannot report for another sibling and so on.

Also when reporting the claim input file in cases where you have registered as the parent on behalf of its subsidiary companies you may use the parent TIN, or each applicable individual subsidiary TIN as you see fit, as long as you adhere to the reporting hierarchy described in the alert. The parent can take responsibility for all its subsidiaries, but one subsidiary cannot take responsibility for a sibling.

(Barbara Wright): The issue that Pat's talking about right now is potentially less an issue for all of you since the RRE alert. Before a lot of the concern about whether or not to have the parent register dealt with the fact that there would be potentially two responsible reporting entities in some situations. If they had a captive insurer the captive insurer might be responsible for reporting part of it, but the other subsidiary might be responsible for reporting with respect to the deductible. The rules that we set forth in the February 24th alert means that there are fewer situations where both the insured and the insurer will be reporting on the same claim.

So the rules – you're still allowed to use them, if you want, to have your reporting higher in the corporate structure, but it may be less of a problematic issue. You may in many instances, if a captive insurer was your issue, if you have a license and regulated insurance company as a captive insurer, they may be doing your entire reporting.

(Bill Deckhart): For the record, that was (Barbara Wright) who was speaking just then.

(Pat): OK another topic related to registration and somewhat similar as far as setting up your RRE IDs. You may report all lines of business in one file, under one RRE ID, or in separate files under different RRE IDs. If you register by line of business and use multiple RRE IDs, the same person can be the authorized representative for each of the RRE ID. Please see on the section 111 COB secure website, please see the "How To Get Started" document and of course the user guide, which covers more of this information.

Now I have some information regarding Ongoing Responsibility for Medicals, or ORM, questions related to ORM. Under the new rules for retroactive reporting of ORMs, you only need to report on ORM related to claims the RRE considers open as of 01/01/2010. If the RRE moved the claim off its active claims file before then it does not need to be reported.

One retroactive date for ORM is used now, and that is January 1st, 2010. So you can disregard what was previously documented in the user guide and in older versions of the user guide regarding exceptions and et cetera in section 11.9. For about the July 1, 2009 and the January 1st, 2009 dates. Now that said, you may report older ORMs, but you are not required to.

RREs are not to submit an expected, anticipated or contingent ORM termination date. The ORM termination date should only be submitted when the termination of ORM is certain. Future dated ORM termination dates can be dated no more than six months after the file submission date, in other words, the ORM termination date cannot be more than six months in advance, or six months greater than the file submission date. Please see section 11.8 of the user guide.

(Barbara Wright): One additional comment about Pat's prior comment about not reporting earlier ORM, that you could but you were not required to. Please distinguish between a situation where ORM was closed prior to the required date and one where it was not closed. If you have a situation where it remains open as of the required date you may not choose to report ORM starting concurrent with

that if you assumed responsibility earlier; you have to report the correct start date for the ORM if it's reportable.

(Pat): Right, and that so-called start date is the date of incident; there's no actual first start date of ORM, or date of when the RRE first assumed ORM. And that actually goes to my next point here. Again, there is no date when the RRE first assumed ORM submitted on the claim record; obviously the date that the RRE assumed ongoing responsibility for medicals could be sometime after the date of incident; you can't control when the claim actually gets reported to the RRE. However, you are to report ORM as soon as it is assumed and not wait to receive an actual medical bill from a physician, hospital, or other provider or supplier.

There are no late reporting penalties for reporting the assumption of ORM. Reporting of ORM assumption is, though, covered by the same 45-day grace period described in the user guide. Since no ORM assumption date is reported, the RRE needs to keep track of when they assumed ORM after the claim is received, so that this could be produced in the event of an audit by CMS.

A question was submitted regarding reporting the ORM termination date in cases where an employer or Workers' Compensation carrier is required to pay for medical care for an injured worker pending the outcome of the compensability investigation. At the conclusion of the investigation some claims are determined not to be compensable and are denied. Some medical payments may have been already issued and the claim may have been reported with ORM.

It is assumed that once the claim is denied and that denial has become final, that the ORM will terminate at that time and the ORM termination date will be reported to CMS. So that's the gist of the scenario or question.

So the ORM termination date reported to be the actual date that the RRE's responsibility ended, the date after which no bills would be payable by the RRE for that related injury. The ORM termination date should be reported in the next quarterly claim file as an update. In some cases, do to hearing or

appeals, this may result in the RRE reporting the ORM termination date late and receiving a compliance flag.

There is no automatic fine imposed when the compliance flags are posted. They are meant as warnings, and in this case I don't see how the RRE would have any other choice. Certainly you want to report the ORM termination date as soon as possible. If, under these circumstances, you receive a compliance flag, that essentially can be disregarded.

Another question was submitted relating to or regarding ORM termination in the event of the injured party's death. This would be a reasonable date to set the termination date to, however remember that an ORM term date must be 30 days greater than the date of incident for reasons that are beyond our control – other Medicare systems with which we interface. So please follow the instructions in the user guide about this and set that ORM termination date to at least 30 days or 31 days subsequent to the date of incident.

Also, in the event of additional TPOC in a circumstance like this, where the injured party is deceased, there is no check in the system on the TPOC date against the ORM termination date or against the injured party's date of death. And in fact, it would be expected that the TPOC date could be after those dates, and most likely would be.

A question was submitted regarding the reporting requirements for Workers' Compensation claim open for Ongoing Responsibility for Medicals but has had no activity or related payment for a long time, and that has no bearing on whether the claim is reportable or not; if the claim is still open as of January 1st, 2010, with ORM that is reportable, please see section 11.8 and 11.9 of the user guide.

In states that require lifetime medicals for no-fault or for Workers' Compensation, if the claim does not reach the no-fault policy limit, for example you may never end up report an ORM termination date, which is an acceptable circumstance. It doesn't matter if you leave the record open as far as your reporting for section 111 – see section 11.8 and other places in the

user guide on terminating ORM. You obviously must follow the applicable state law governing that claim.

OK I'm going to move on to some questions that were submitted related to Total Payment Obligation to Claimant, or the TPOC. The TPOC date, T-P-O-C, the TPOC date is the date the payment obligation was established. It may be but not always is the check date or payment date, it is the date the obligation is signed, if there's a written agreement, unless court approval is required. If court approval is required it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement it is the date the payment, or the first payment if there will be multiple payments is issued.

General speaking at this point you do not need to use the funding delayed date at all. Plug it with zeroes. The delayed date field, this funding delayed date field was only intended to apply to certain product liability and mass tort or class action claims where the settlement may delay the funding of payments on claims. And again, more guidance on this is pending that may end up not making use of this field either.

TPOCs are reportable, regardless of whether there is an admission of liability on the part of the insured or the RRE. This is in section 11.10.2.

Now some information about disposition code 50. If you receive a 50 disposition code, the COBC will actually complete processing the original record. You are instructed to submit the record again so that you get an actual valid disposition code back for you processing, or for that record submission. When you resubmit that record it will be processed again, and essentially treated as an update. If it was a delete, you may get an error saying there is nothing left to delete, so that can be disregarded and you can assume the delete was completed.

So what the question had to do with was, "I submitted an add record, I got a disposition code 50, should I submit it as an add record again?" Yes, and you will not get an error for that, and it will essentially be treated by the COBC as an update. And again, if you submitted a delete record and received a 50 back

for some reason, the delete processing will continue, and if we successfully deleted that record, when you resubmit it the next quarter they'll actually get back an (SP) disposition code with an error indicating that the record could not be identified for deletion. So all that said, please remember that you're not going to get this disposition code 50 on a very frequent basis, but I do understand you have to code for it.

Some questions were submitted regarding disposition code 03. This is a disposition code returned on the claim response file. Disposition 03 is returned when the injured party on a submitted claim is matched to a Medicare beneficiary, but the dates on the claim record do not overlap Medicare coverage. So there is no MFP, and the Worker Comp, no fault or liability claim has no impact on Medicare claims payment as of yet. This could occur in situations where Medicare coverage ended before the date of incident, or Medicare coverage started after the ORM termination date or after the TPOC date submitted.

If the claim was only reporting TPOC, you do not need to monitor further unless the claim is reopened for another TPOC payment or for ORM. If the claim report was for ORM and ORM continues you must continue to submit the claim record until ORM is terminated. This is because the ORM could become entitled to Medicare in the future. You won't be able to identify this, though, from a query. So under those circumstances you have no choice but to continue to submit that claim.

Again, individuals may become entitled to Medicare due to ESRD, End Stage Renal Disease and disability, and in those cases at certain times under certain conditions the Medicare entitlement may come to an end and then it may resume again for those same reasons, or for when the individual ages into the program. Once an individual has reached age 65, generally speaking, they remain entitled to Medicare indefinitely.

So that's trying to help you a little bit understand better what the disposition code 03 means. Not only are they a Medicare beneficiary, but the dates reported on your claim do not overlap Medicare coverage. Did you have something to add, (Barbara)?

(Barbara Wright): We need to go on mute just a second, please.

(Pat): OK, please stand by.

OK we're back. I'm sorry, I just needed to clarify – or we needed to clarify something internally. And when I'm referring to the Medicare coverage, that is coverage under Medicare fee for service for parts A and B as well as coverage under Medicare Advantage, which sometimes is referred to as part C.

OK, other miscellaneous information in answer to questions that have been submitted or problems that have come up. Dollar amounts are reported using numeric digits; obviously we're the last two digits (reflect cents) or the digits after the decimal. So for example take a dollar amount like the TPOC amount which is 11 numeric digits long. A TPOC amount of $6,000.00, six with three zeroes, must be reported as zero-zero-zero-zero-zero that's five zeroes, a six followed by zero-zero-zero-zero-zero, followed by five more zeroes. In other words, with five leading zeroes, the number six, and three zeroes for the thousands places, followed by two zeroes for the positions after the decimal. So please see the field descriptions; they actually do provide examples of exactly that.

When submitting a non-zero TPOC amount you must submit a non-zero TPOC date and vice versa. If you submit a TPOC amount with no corresponding date you'll get – or vice versa – a TPOC date with no corresponding TPOC amount, you're going to get the CJ03 or CJ04.

Another question came in related to the HIPAA Eligibility Wrapper software, or the HEW software, version 2.0.0. Our RREs are not required to upgrade to this new version of the HEW software at this time. But you will be at some point, so please plan for that in the coming year. You may use version 2.0.0 without making use of the new RRE DSN fields – those are optional.

Also, here's a question that came up related to an injured party is under 18. So payment is actually issued to a parent or guardian, the injured party is a child under 18 that is a Medicare beneficiary if the claim is reportable. The parent

or guardian should be listed as the injured party's representative using the value of "G" for Guardian; if there is also an attorney representative, CMS would rather have the attorney information reported as the injured party representative. And then you would just not provide the parent guardian information.

Claimant one through four fields are only used in the event of the injured party or Medicare beneficiary's death. The spouse of the deceased injured party is frequently claimant one. When reporting this, the injured party remains the same throughout this process, and again the injured party is the Medicare beneficiary. The spouse is not considered a representative but rather claimant one in those cases but they're filing a claim on behalf of a deceased beneficiary. Changes to the representative do not trigger an update but you can send it if you choose to do so.

There's a question about phone number requirements. Phone numbers are required if the entity in question, the entity that you're providing address and phone information for has a U.S. address. If you submit FC, the letters F-C in the state code for representative, claimant, or claimant representative, then plug the phone number with all zeroes, since we're assuming they would have an international phone number, which we don't accommodate.

If you receive an SP disposition code, and before you can resend the corrected record in your next quarterly file submission you realize that the record never should have been reported in the first place – you do not need to send a delete for it. Deletes are only required for records that were returned with an 01 or 02 disposition code. Please see the event table in the user guide for this. We do not track records that were rejected with an SP disposition code, so we're not sitting there expecting a delete for a record that was never originally accepted, and in fact if it was never accepted the delete would fail.

A question was asked about what fields are required for reporting no-fault claims. The answer is that all fields in the file layout are required unless the field specifies that it is specifically for Workers' Comp or liability only. If there is an injured party representative such as an attorney related to a no-fault claim then report this info; if not, leave this section blank.

CMS will not notify RREs of the date of death of a beneficiary. There is no threshold for reporting a no-fault claim, or no-fault claims which include Med-Pay and PIP. So if you review the section in the user guide on the interim reporting thresholds you'll see that there are no thresholds that apply to no-fault claims; all are reportable if the injured party is a Medicare beneficiary and they should be reported with insurance type D. And in most cases most likely you're reporting Ongoing Responsibility for Medicals and you would put a Y in the ORM indicator.

Delete transactions do not have to include the auxiliary record in the event that one was sent previously. So if you sent a claim record with a detail and an auxiliary record and you received a disposition code 01 or 02 and the record was accepted and then decide that you need to delete that record, you do not have to include the auxiliary record on that delete transaction.

If reporting transitions from one TPA or agent to another, and the new agent cannot get accurate data from the former TPA or agent, the new TPA or agent may submit adds for records that might have previously been reported and accepted. Again, these ads will not be rejected and will essentially be treated as updates if the key fields match. Please see the section added to the last version of the user guide on ceasing and transitioning business – that should provide some help there.

Lastly, for section 111 reporting is required only if the injured party is a Medicare beneficiary, which could be before the individual reaches age 65. However, for section 111 you do not report this claim before the individual is entitled to Medicare. I think that was actually submitted in relation to a Workers' Comp MSA, Medicare Set Aside.

With that, John?

John Albert: Yes, this John. I wanted to add a couple of things. First of all want to make sure everyone was aware that they're out on the website, I think, indicates still a whole date of March 31st for a call. There will be no call on March 31st.

Also I wanted to mention, which I forgot to at the beginning of this call – well first of all, all of the previous calls are now out on the (Matro) Insure Reporting website. I know we've had some problem s in the past getting all those up there. But they are there but the other thing too is the qualifiers that on occasion we may contradict stuff that is in the official communication to the public, which is comprised mainly of the user guide, as well as any alerts that eventually get folded into that user guide. So if there is an instance where we contradict something in the guide, the guide always rules.

The other thing too is regarding …

(Barbara Wright): The guide or the subsequent alert.

John Deckhart: Yes, or subsequent alert. Another thing too is that while we did delay implementation of the reporting requirements until January of 2011, I'll reiterate that we strongly encourage folks who are ready to begin submitting production files on or after April 1st of this year, I would always advise if you're ready to go ahead and do so because there's no better full test of the process than actual exchange or production data.

So the last thing also is that I wanted to remind people regarding the data use agreements that they signed with CMS as part of the section 111 reporting regarding who can see that data, have that data, have access to that data and how it can and cannot be used. We just want to make sure everyone is aware that the data use agreements that the RRE signs with CMS is between us and the RRE and no one else, and that there are very strict prohibitions regarding how that data can be used and how it shouldn't be used. (Barbara), did you have anything to add before we go to Q&A?

(Barbara Wright): One quick thing, if it wasn't mentioned earlier: we have been having some continuing problems with the automatic notice function on the web page. And so we would continue to advise you to potentially check the site at least once a week. We do continue to put something on the "What's New?" page any time we add something to the website, even if that document is posted or linked on another tab.

So if you're not seeing any alerts do not re-sign up for an alert; you don't need to do that. That function is not within our area's span of control and they've been having a little bit of problem with that system-wide. So just please check the website on a routine basis.

John Deckhart: And with that I guess, operator, we can turn it over to questions. We ask that people limit their questions to one and one follow-up and then allow other people in the queue to get their turn. You can always, of course, jump back into the queue after you've completed yours if you have more questions. But with that, operator, we'll take some questions.

Operator: All right at this time I would like to remind everyone in order to ask a question press star and the number one on your keypad. We'll pause for a moment to accumulate the Q&A roster.

Your first question comes from (Wendy Raider) from (East State) Compensation Insurance Fund. Your line is now open.

(Wendy Raider): Hi this is (Wendy Raider) and I'm asking a question regarding multiple TPOCS. And in the new user guide on page 55 it says that the sixth or subsequent TPOC is added to the fifth, but it doesn't say what to do with the TPOC date and I would like to know do we use the new TPOC date or keep the fifth TPOC date?

(Pat): I'm sorry about that. You would update – replace the TPOC date number five with the updated date.

(Wendy Raider): OK. And then the follow-up question – this is also on multiple TPOCS, on page 53 it uses the phrase that a new TPOC is more than one distinct TPOC. And does the word distinct mean distinct and negotiated agreement, or that the money is completely distinct and not included in any previous report?

(Pat): I believe that it has to do with the distinct negotiated report. What we're trying to cover there is very often you'll have a settlement amount but it is paid in an installment and we ask that you report just once the total settlement amount and not report each installment payment separately as a separate TPOC.

(Wendy Raider): OK so in California we pay PD advances as soon as we know that there's any PD, and that could be before maximum medical improvement, so we don't actually know the amount, and the amount hasn't been determined. But we are making payments, so we want to know whether or not these advances would be considered TPOCS.

(Pat): Could you define PD for me?

(Wendy Raider): Permanent Disability. That would be after the amount that's going to be due because of the permanent consequences of the injury. In other words it's not temporary disability, which is during the time when the person is still improving.

(Barbara Wright): Is this Workers' Compensation, first?

(Wendy Raider): Yes it is.

(Barbara Wright): So you're talking periodic indemnity for losses other than medical, et cetera?

(Wendy Raider): Right.

(Barbara Wright): We've still got language in the clearance process for periodic indemnity and we hope that will resolve your issue because we're trying to make sure that in most instances it should be fairly rare to have multiple TPOCS to report, period.

(Wendy Raider): OK well we're anxiously awaiting that language and we'd really like to get it soon.

(Barbara Wright): OK.

(Wendy Raider): Thank you.

Operator: Your next question comes from (Susan Kornbluth) from New York State Insurance. Your line is now open.

(Susan Kornbluth): Hi I have a question. The summary of the changes in the new user guide don't mention anything but I was just wondering did the file layout change? Because we have everything set with the parameters and the field sizes and stuff.

(Pat): No. There are some changes to some of the individual field descriptions and requirements but there's no change to fields that are present, the length of those fields or the record layout. I'm talking about the claim input file and (response).

(Susan Kornbluth): Right, right right.

(Pat): Yes the query file you'll see – well the X1271, obviously, hasn't changed, other than what is documented in the companion guide. The H-E-W software, the HEW software version 2.0.0 has some changed record layouts. But as far as the claim input file, no, there are no structural changes.

(Susan Kornbluth): OK thank you. And the other question I had is if we submit ICD codes for a claim, if those codes reported and subsequently become invalid, do we need to do anything?

(Pat): Yes – well first check the event table; I believe that it does list the ICD9s as triggering an update. And I would highly recommend, no matter, sending an update to either remove ICD9 codes that it turns out do not apply to the injury reflected by the claim, or to add additional ones, to be more specific.

(Susan Kornbluth): Right, but if they become invalid we would have to?

(Pat): Oh, oh, oh, you mean invalid …

(Susan Kornbluth): Subsequently.

(Pat): No. I mean you would not need to make an update based on that. However, when you do submit an update subsequently it will be affected by the changes there. I really don't anticipate adding a lot to that exclusion list in appendix H going forward, and I can't speak to how many changes take place on the list of valid or acceptable codes on the CMS website.

(John Albert): I think the focus now is primarily moving toward (ICD10).

(Pat): But I understand your concern about – you know, I previously reported this claim and now, for some reason, I'm sending an update. I'm not changing my ICD9 but that ICD9 is no longer considered valid. You know, let me take that back and consider it, but right now if that code has fallen off the list of valids it would trigger an error.

(Susan Kornbluth): Or if it's something like let's say we only submitted one code, or even let's say we submitted two or three codes and one or more subsequently become valid and we're not doing any updates.

(Pat): Yes if you're not sending another update record we're not, you know, you're not required to do anything to take any action. But if you have to update for some other reason.

(Susan Kornbluth): OK. All right, thank you.

Operator: Your next question comes from line of (Frank Saarland) from New York State Insurance. Your line is now open.

(Frank Saarland): Yes, one question regarding the – actually let's see – well you just answered the question about the invalid – actually I don't have any questions because they've all been answered.

Female: I'm so glad to hear that. Thank you.

(Frank Saarland): Thank you.

Operator: Your next question comes from line of (Paul Schaefer) from VCM. Your line is now open.

(Paul Schaefer): Hi. Quick question. I know you've addressed the issue about captives, but we managed foreign captives that are elected 953D election with this election to captive (is taxed) as a U.S. company. My question is this, with this election they have to designate a representative with a U.S. address. The captive's tax ID number but didn't reference that representative's address. In our case it's typically us since we manage the captive. Can we use the address when we

register or should we just wait for the foreign address, knowing that the tax ID number references that address?

(Pat): You have a TIN?

(Paul Schaefer): Yes because we filed as a 953 so we're taxed as though you're a U.S. company, even though you're a foreign company.

(Pat): And – I'm sorry, do you want to weigh in?

Bill Deckhart: Are you the TPIA or are you the captive insurer?

(Paul Schaefer): We are the captive manager.

Bill Deckhart: Yes, but you're not the captive insurer, you're basically a third party administrator, or a third party manager of the captive funds?

(Paul Schaefer): Correct. The captive's registered address is foreign, but when you file the 953 to receive a tax ID number you have to appoint a representative who has a U.S. address.

Bill Deckhart: Yes, I mean my concern was – you were saying you were the one that was going to register; I'm not sure that you would be the entity that would register.

(Paul Schaefer): And you're exactly right. We wouldn't be the ones that would register; it would be the captive owner.

Bill Deckhart: OK.

(Pat): OK.

Bill Deckhart: Then the question is which address?

(Pat): I'm not sure I can directly answer the question but when the foreign RRE registration process is available as of April 5th, 2010 you will be able to enter a valid tax ID number, along with an international address, or an indication that you have an international address. Or you could, conversely, enter the

fake or pseudo TIN with a U.S. address. I mean there's no requirement that you must use a fake TIN and indicate an international address.

(Paul Schaefer): Right.

(Pat): I don't know if that's helpful or not. But I can't tell you what address you must associate. Now when we do check the TINs from registration I can tell you this much, that we do go against files that look at the TIN and the name and address that are on IRS records for that IRS assigned TIN. And in some cases they don't match and that requires then follow-up by the EDI representative to sort out the situation.

(Paul Schaefer): See that was our concern. We didn't want to file, you know, register under the U.S. address because it's a representative; it's not the actual registered address of the foreign entity. So you pretty much answered my question that we wait until the foreign address is available. We could put our tax ID number in at that point.

(Pat): Yes, and online you put FC and the state code and then follow-up with your RRE, I mean your EDI representative to supply the international address.

(Paul Schaefer): Exactly. And then I assume it wouldn't matter about the phone number because we'd probably just put the phone number for us, or have the owner put it for us if there's specific questions on the captive itself?

(Pat): Well the phone number for the authorized rep should be the phone number for that individual and you can supply that to the EDI representative as well. You can provide other contact information, you'll be providing account manager information and account designee information. So you'll be able to provide that to your EDI representative.

(Paul Schaefer): Excellent. Thank you so much.

(Pat): You're welcome.

Operator: Your next question comes from line of (Ramilia Lach) from Littleton. Your line is now open.

(Ramilia Lach): Hi, and I started the conference late, so I apologize if this question has already been asked or if this information has been provided. But I'm still trying to figure out what's the process for registering foreign entities? Are we any closer to having that information provided?

(Pat): Yes, that information is documented in version three of the user guide that's out on the website now.

(Ramilia Lach): Oh it is in there?

(Pat): Yes.

(Ramilia Lach): OK, well I'll take a look at that and …

(Pat): Yes all the changes that have been made to the user guide are listed in section 1, and I don't have the exact place for where that foreign RRE registration process is but it's the registration section.

(Ramilia Lach): OK I'll take a look at it. Thank you.

Operator: Your next question comes from the line of (Lisa Reilly) from BCMI. Your line is now open.

(Lisa Reilly): Hi, I'm going to let (Tom Dostel) ask a question; we're both on the call.

(Tom Dostel): Yes, we are a third party administrator and we do reporting for between 50 and 100 RREs. And as such as have developed software to assist us in doing that. And we're using the SFPP file transition method and we've been testing now, I guess, for a month or so. And we hit a problem the other way which kind of threw us a little bit. And that we have an automated process that does our data transmission. And the other day all of our processing, all of our communications stopped working with you folks and we thought that perhaps the server was down on your end or something. And then the same thing happened the following night and as it turned out what happened was that our password expired and we did not know that because I guess what happens is you have to lock in to your website. And then at that point, then it tells you

that your password's expired, which we don't log in every day, make it a point to find out that our password expired.

So I guess what we would like to do is we like you to, number one, either publish a schedule or you password expiration dates, or number two, communicate that via e-mail. But the problem with number two is that we are designated by the people we do the reporting for as a (comp) designee, who do not get the e-mails.

So therefore we would like you to include the designees on the e-mail list of the people that get the e-mails as far as the HICN query and claim receipt e-mails. So that is my request – some better method of handling this password expiration and B, to include the account designees on your e-mails. Thank you.

(Pat): OK, let me point out that in the user guide under the file transmission method section for secure file transfer. We do describe that you're using the login ID and password from the section 111 COB secure website and that must maintain that password by logging into the website. I recommend that you make a habit of once a month go into the website and using the change password function. Log in and then use the change password function. I realize that it's a manual step but we are required under current CMS file transfer and security protocols, that that's the way it's done.

So I do understand your concern there; we are not going to notify you in the future of password expiration but it's really up to you on a once a month basis – it's really every 60 days that your password expires and this is documented in the user guide so just go out there once a month and do it.

Secondly, as far as notifications, we have logged out requests from other RREs about the e-mails. Right now there's not a change in the pipeline but we do recognize that we need to add some flexibility. But right now your account manager needs to forward any pertinent e-mails your direction. We are working, as I said, on a better methodology for notifying account designees, agents and others besides the account manager of important things related to file processing.

(Lisa Reilly): OK.

(Tom Dostel: OK, thank you.

(Pat): You're welcome.

Operator: Your next question comes from the line of (Dave Mullens) from State Fund Insurance. Your line is now open.

(Dave Mullens): Hi. So the question is can we send text files using a new (or send two) of the TW software and at the same time send production files using (Whirlwind Shenoff at TW) software, which is 1.2.

(Pat): Yes. Yes you may do so.

(Dave Mullens): OK.

(Pat): Because in the end what you're actually transmitting from the output, from the HEW software is the X12270, and then receiving back in the 271. So long as you're using one version in production and the other version in (Tuft's) you should have no problem with the translations back and forth. That should be perfectly acceptable.

(Dave Mullens): Also the additional columns should be there with the new version, this (here) 1 and 2.

(Pat): I'm sorry, repeat the question?

(Dave Mullens): So (at that then external) just format it will be new additional columns and the byte size is different, right?

(Pat): Yes. With the – you know, with the version 2.0.0 you can make use of that RREDCN field and the input and and output files into the HEW and out of the HEW are different record lengths. But again, if you're using the old version in production and the new version in Tuft and you run each version of the HEW software accordingly for those tests versus production files I don't see a problem.

(Dave Mullens): OK thank you.

Operator: Your next question comes from the line of (Jean Therio) from The Doctors Company. Your line is now open.

(Jean Therio): Oh yes, hi. I have a couple questions. First it's regarding disposition code 03. We're now – so we can't really test disposition code 03 since we can't get the MSP effective date from the query, correct?

(Pat): Yes. What I'm thinking about is the test beneficiary information. That's probably the case. But I might be able to follow-up in the test beneficiaries and we might actually be able – because those test beneficiaries do have start and end dates. I might be able to provide those to you in an updated version of the files that are posted out that and you could utilize those.

(Jean Therio): Right, that way we just test all the different codes, appropriately.

My second question is on the ICD9 codes – I'm new to this project as well. Looking at the website there are two sections of codes out there for version 27. One starts with CMS 27 underscore and the other one is 327 (long). Is that – should be just use one or the other or …

(Pat): No, the specific text files that you're to use are listed in the user guide. And even the specific name of the zipped file is listed in the user guide, and it's actually the second version 27 link. So take that zip file, download it, unzip it and you'll see the text file in there that matches exactly the name that's in the user guide.

(Jean Therio): Oh OK. Because it has different modified dates on these four files out there?

(Pat): Correct.

(Jean Therio): One is January 2010; the other one is November. So you're saying I have to go back to the user guide and look at which file and the one that – in November is the one that we have to use?

(Pat): Yes you want to use the files that are listed exactly in the user guide.

(Jean Therio): OK, thank you very much. That's all I have.

Operator: Your next questions comes from the line of (Ellen Eitzel) from Chubb. You're line is now open.

(Ellen Eitzel): Hi, I just have another question on the disposition code 03. So are you saying that if we get an 03 back, that we should continually resubmit that record every quarter until we get an 01 or an 02?

(Pat): It depends on the circumstances. If all you reported were TPOC amounts and you get an 03 back you do not have to do any further processing on that claim. In other words, it's not reportable for section 111 unless you have a subsequent TPOC that might be reportable later.

(Ellen Eitzel): And then that goes as an update?

(Pat): No, it would go as an add because an 03 – well, an 03 is basically saying your record is perfectly fine; there are no errors. And the person is or was a Medicare beneficially, but your claim information doesn't overlap Medicare. So we're not rejecting it we're just saying we didn't need this report.

(Ellen Eitzel): OK then …

(Pat): So if you have another TPOC to report after getting an 03 on a claim that's just TPOC related, then you would send it as an add because it was not accepted previously.

(Ellen Eitzel): OK but even though – see what's confusing is the description of the disposition code in the user guide said, "Record we accepted by the COBC."

(Pat): Yes, I hear you.

(Ellen Eitzel): And that implied to me that it was added to your database.

(Pat): Yes, yes, my mistake. I'll see if I can't update that. And then now – to continue though, making sure everyone understands, if you have Ongoing Responsibility for Medicals on that claim that remains open, right now you have to continue to monitor whether that person becomes Medicare

beneficiary at some point in the future. Now unfortunately the query is just going to give you an 01; continue to give you an 01; it won't give you any additional information since you don't know—you're not given the Medicare start and end dates on the query.

So basically if I were setting it up I think the only choice is to continue to submit the claim record and know that a claim open for ORM that gets an 03, well, just plot it back on the quarterly file submission next quarter. And until you ORM terminates you'll have to continue to monitor that person's status in that fashion.

(Ellen Eitzel): OK, so see what's confusing too is you just said they weren't a beneficiary but yet you're saying that they were identified as a beneficiary …

(Pat): I'm sorry, I misspoke. I meant if their entitlement starts again. It really depends on the circumstances. Basically would could happen is that an individual is entitled to Medicare for ESRD or disability and then that comes to an end. And then you report a claim with ORM with a date of incident that is subsequent to the end date for their Medicare coverage. You'll get back an 03, basically saying that it doesn't overlap their Medicare coverage, they're not entitled to Medicare benefits during the time that you have ORM right now.

However, that person may become entitled to Medicare and get Medicare benefits subsequent, due to ESRD, disability or their age. And then we would want – if you still have ORM we want that reported and we want to be able to add that to our database at that time.

(Ellen Eitzel): OK. So if we get the 03 back and we only have TPOC …

(Pat): Yes, you're done.

(Ellen Eitzel): We're done unless we have new TPOC information?

(Pat): Correct.

(Ellen Eitzel): And if we had new TPOC it would go as an add?

(Pat): Yes.

(Ellen Eitzel): OK. But if we have ORM then we should keep resubmitting – if we get an 03 we should submit it to next quarter until we get an 01 or an 02?

(Pat): Unless ORM terminates. And then you are done; you don't have to continue reporting.

(Ellen Eitzel): OK so if we submit ORM and a termination date and we get in 03 …

(Pat): Then you're done.

(Ellen Eitzel): Then we're done. OK, ORM date. OK I think that's good – the user guide wasn't very clear.

(Pat): Yes I've made a note of that and I'll see what I can do to revise it.

(Ellen Eitzel): One other quick question I had submitted via the mailbox; I didn't hear the answer. There's threshold that checked for the delete record count, or the percentage of delete records that are submitted.

(Pat): Yes?

(Ellen Eitzel): What's the point of that?

(Pat): It actually is an attempt to make sure that RREs invoke a proper use of the delete function. On the GHP side we have a lot more experience with collecting data, and very often what people would make the mistake of is sending a delete transaction when someone – when their GHP coverage ends. So we assumed that a similar misunderstanding could happen on the non-GHP reporting side where you've reported ORM and then rather than submitting an update with the ORM indicator equal Y and the ORM termination dates, that some folks would mistakenly think that they're supposed to end a delete and delete the record and we do not want that happen.

(Ellen Eitzel): I'm just asking that – so if we have, after our initial submissions and I'm assuming our volume will go down over time, that is we just have a couple of deletes and it's a small file we're going to exceed that threshold every time, then?

(Pat): Yes, it could trigger it. And obviously we'll adjust it as we go. The EDI representative is able to release those files, and as we get more experience, if we find that the threshold does not apply and it's not working well for us, we'll change it. It won't affect your reporting, though.

John Albert: Yes, those kind of thresholds have nothing to do with things like compliance; it's just basically it's a check for both us and the submitters to look at the data and see if there are things that would potentially lead to a question of is someone using the transaction correctly. Because again, delete should only be used to remove mistakenly-posted records and that is it.

And we have had experience in the past, as Pat said, with any type of ongoing coverage, where people entering a delete instead of an update, to (term) the record. And that's all that is is to, if we see something it would trigger us to stop what we're doing and say, "Hey, look, is this being done right?" because if people continue to send deletes inappropriately for what are essentially updates to terminate records, that is not following the procedures. And the point is to alert you and us that there's a potential issue here, that's all. That's all that's for.

Bill Deckhart: It's a keyway tool.

John Albert: Yep, it's just a QA tool.

(Ellen Eitzel): OK, good enough, thank you very much.

Operator: Your next question comes from the line of (Donna Bouchard) from the Farm Bureau Insurance. Your line is now open.

(Donna Bouchard): Hi, (Pat). I have a question regarding the frequency of the query. You were talking earlier that we should only submit on a quarterly basis?

(Pat): Well that would make sense to me.

(Donna Bouchard): Let me tell you know I've got it (speced) out here is that every month we're going to go grab up everybody that we have not gotten a verified HICN, we had ORM assumed, not terminated, or terminated within that quarter, or

TPOC that we needed query on, which, in the State of Michigan, because we're unlimited, it's just going to keep growing. And I just want to make sure you're not going to have a problem and start rejecting those.

(Pat): No, they'll be no rejection. Again, you most likely don't need to subject the fame people each month. And then I do understand the issue with the query files eventually growing, particularly for those states that have lifetime medicals for either no-fault.

(Donna Bouchard): And we want to know right away if someone's a Medicare beneficiary, when they are, so that we're going the right stuff too.

(Pat): Understood.

(Donna Bouchard): OK. Disposition code 50 – I've got to go back to that one. I believe you said we get a 50 because it's still being processed and we had sent an add. The next quarter we have to send the add again?

(Pat): Well what we want is for you to get a real disposition code, so to speak. We want you to know what we ended up doing with that record, and the 50 doesn't tell you anything but "We're dealing with it.

(Donna Bouchard): What if I sent an update?

(Pat): It actually would be OK.

(Donna Bouchard): It would be OK? All right, great. I'm going to try and do an add, but if we've done something else in the meantime that queued up an update, it would hard for us to go back to an add.

(Pat): Understood. It'll end up being treated, essentially the same way.

(Donna Bouchard): OK one more quick question. When I do a delete is it OK is the auxiliary record is there?

(Pat): Yes.

(Donna Bouchard): OK, thank you.

Operator: Your next question comes from Alan Reich from Paul Reich Myers. Your line is now open.

Alan Reich: Thank you. I have a question for the plaintiff's attorneys. Will we be able to query the database to determine if a plaintiff is receiving Medicare?

(Pat): No. The query process is only for responsible reporting entities for section 111.

Alan Reich: Is there a plan to make that accessible to us? It certainly would be easier for us to be able to comply and quickly determine if there are clients who are not – this is not applicable to, and the ones that are.

John Albert: Well one of the things you need to think about there, if you haven't already done it, if you're a plaintiff's attorney is re-evaluate or assess your intake procedure in terms of what you're asking for. You know, there's no reason you can't make, as part of that intake procedure, asking them questions about Medicare and asking for a question. Any health care (cards) simply because you would presumably want that to have complete access to their medical records as well. And we would point out that it's also – wouldn't – as we've told the RREs, it's not sufficient to query just when you get a pending claim because someone could become a Medicare beneficiary during the time the claim is pending.

So we've alerted, warned, or whatever pairs you want to use. All the RREs that if they essentially get a negative reply while the claim is pending they should check one last time after the TPOC date to make sure that they have become a beneficiary.

Alan Reich: Well that all makes sense to me. But number one I may not get 100 percent accurate information from my client because number one, there may be a estates involved, deaths, et cetera, but number two, as their circumstances change over the years and some of these cases take many years to come to fruition. It would certainly help us to be able to access this database and to do the queries as frequently as would be prudent, rather than having to make phone calls to COB where you're limited to five phone calls – five clients per

phone call. In other words why would plaintiffs' attorneys not be given access to this database that RREs are given?

John Albert: Because RREs have access to the database in connection with their statutory obligations under section 111 reporting. We have no authority to simply give anyone you might have a relationship with CMS – unfettered database, to find out who is or is not a Medicare beneficiary; we simply don't have that authority.

(Pat): I'm sorry but we need to move on to allow technical questions to be submitted. You could submit this to the section 111 resource mailbox. But I think you've got your answer.

Alan Reich: All right, well thank you.

Operator: Your next question comes from the line of (Rich Eijager) from (Vibrance). Your line is now open.

(Rich Eijager): Hi, my question regards the four claimant records in the detail and auxiliary claim files.

(Pat): Yes.

(Rich Eijager): So I have a scenario. Let's assume I add, or do an add with three claimants. And then at some point down the line I determine that claimant one wasn't applicable and I'm going to remove them. So I guess which of these two is correct – I submit an update record with a blank claimant one and no change to two and three, or I submit an update record where claimant two has moved up to claimant one, claimant three has moved to up claimant two and then claimant three becomes blank.

(Pat): It is probably your choice. I don't know of anything in the system that requires you to keep those claimants as positional. I'll have to follow-up on that but I would say right now it's your choice.

Also what I wanted to do is point you to the event table in terms of when, you know, what information actually triggers an update, and I honestly – I'm sorry that I – I'll get there eventually – to see if the claimant – yes.

John Albert: But keep in mind you're only using that claimant field is the injured party who's a beneficiary is deceased.

(Rich Eijager): Yes, assume that I'm using the fields correctly, I guess.

Bill Deckhart: Yes. I think an update, it's just going to overlay anyway.

(Pat): Yes. Yes. I think what would be most practical is to move it up but I think the system will process perfectly well if you just space out a particular one and submit the others. But I really need to double-check that and I'll have to follow-up on a subsequent call.

(Rich Eijager): And it sounds like this is kind of the same for the ICD9 codes you mentioned, blanking one out.

(Pat): Yes, those are fields that I did specifically go back and check to make sure that you could space out one and leave a code in field number one, leave two blank and put a code in number three. I did specifically ask whether that was valid and was given a positive answer. But I have not asked about the claimants. So I'm sorry, I just don't know.

John Albert: (But that's a good question) and we'll get back on that one.

(Rich Eijager): Thank you.

Operator: Your next question comes from the line of (John Wahl) from CP Rail. Your line is now open.

(John Wahl): Thank you. It's nice to have additional time to work on this; I'm sure everybody appreciates that. I'm just wondering if the time has been pushed off to 2011 because there are some problems with claim input files and responses. I'm getting some things that I'm working on with my EDI representative that don't seem to make any sense; they don't seem to be errors to me.

John Albert: I mean CMS made that decision based on a lot of things but the primary reason was to allow the public more time to basically get their files together. Because as I've said many a time, we are much more interested in complete accurate files than quick and dirty, so to speak. So that's just a decision that was internal to CMS based on what we've been seeing so far and that's all we can say about that.

(John Wahl): It doesn't have anything to do with software on your end?

(Pat): No, not to the best of my knowledge, no. I think I – we did have some issues but on previous calls I announced changes or corrections that were being made. Not to say that subsequent problems might come up but at this point we do have lots of RREs who have attained a production status. Not that they're necessarily reporting production files but they have passed the testing process, so it is possible.

John Albert: Several thousand.

(John Wahl): OK, thank you.

(Pat): Operator, I think we're going to the next.

Operator: Your next question come from the line of (Debbie Pank) from (Utica) National. Your line is now open.

(Angela Miller): Hi, this is actually (Angela Miller) from Utica National. We have a question. We've contacted our EDI rep for the HEW software, the version 2 for the main frame and we've sent two query files now but we're having a problem after we do the X271 conversion. We seem to be missing records on the first production query file that was sent in January. And our records match what COBC received. And then when we do the conversion we're missing on the first January file we missed about 13,000 plus records after we'd done the conversion.

So COBC sent us – they retransmitted the file and the same thing happened. But the EDI rep suggested that we send another query file for February. So

we did send one and again the records matched – we were off by one record this time. But after the X271 conversion we're about record 12,944, we're getting CMS in the HICN field and our RRE ID number in there.

And the first time we contacted the EDI rep was February 11th and then the office was close (the) developers received the request but the office was closed due to the weather. So we still haven't heard any response and we don't know – I mean we had the version for the HEW software for the first version and everything was working, but now since we've done the DCN we don't know if this is a problem for main frame users – and the EDI rep didn't know, but it's a month today, so we're wondering …

(Pat): OK. Can I have your RRE ID and I'll make sure that we follow up on this?

(Angela Miller): OK. It's 21190.

(Pat): OK and (if anyone else) is using that mainframe software and experiencing trouble please report it to your EDI representative and I'm certainly going to take this as an action to follow-up on and see what the story is.

(Angela Miller): OK thank you.

(Barbara Wright): Also don't forget that the user guide does specify an escalation process.

(Angela Miller): OK, well we weren't sure because we did get a response from her, but you know, she said the ticket was still open but we don't know when they'll respond. Thank you.

Operator: Your next question comes from the line of (Christie Stoeffer) from Broadspire. Your line is now open. (Christie Stoeffer) from Broadspire your line is now open.

(Christie Stoeffer): I'm sorry I didn't have a question.

Operator: Your next question comes from the line of (Doreen Thompson) from Broadspire. Your line is now open.

(Doreen Thompson): I'm sorry I don't have a question.

Operator: Your next question comes from the line on John Arment from MPCGA. Your line is now open.

John Arment: I got a question, when there's a discrepancy between the file layouts and the error codes, which one supersedes? For example in the new users guide on page 141 under the field number 80, the plant contact phone extension, the data type is alphanumeric but the error code on page 223 CP10 indicates the field must be numeric.

(Pat): I would go to the error code but I will follow-up on that one. What was the error code again?

John Arment: P10. And it deals with all the phone extensions so there's like four or five of them.

(Pat): OK. I tried to get those in synch; perhaps I missed that. I'm sorry. So – but I would go by the error code description.

John Arment: The question I had is on the new query file we're using the RREDCN field one and two with embedded spaces. But when we get the return file our embedded spaces are removed. Is that how it's supposed to be?

(Pat): Not to my knowledge; I'm follow up on that also.

John Arment: Thank you.

Operator: Your next question comes from the line of (Meg Felice) from Travelers. Your line is now open.

(Meg Felice): Hi. I'm not sure if this question would be considered a technical or policy but I'm going to give it a try. And this concerns something that was mentioned in the last call on 02/25 and is also stated in the 02/24 alert, "Who Must Report?" I know (Barbara Wright) explained in the last call that there'd a change in the "Who is an RRE?" in the case of payments made on a deductible policy and that's stated on page four in the alert that the insurer would be the RRE for all those payments unless it's fronting policy. But a caller pointed out there was conflicting language on page 12 of that same alert under the special

considerations paragraph that states that self-insured companies are still responsible for the report. And I was just wondering when there would be a revised alert published, because you've told us not to take the advice of – sorry.

(Barbara Wright): When you say page 12 is that part of the attachment, that definitions and reporting responsibilities?

(Meg Felice): Let's see – it's part of – I guess appendix G. It's a paragraph that starts …

(Barbara Wright): We've said we do need to correct that, that that was an oversight, that the clear intent is what is in the language of the alert itself that when the self-insurance at issue is a deductible under a policy, that the insurer is the one that's responsible for reporting.

(Meg Felice): That's the guidance that we figure we'll be following, but because you've stated that we should wait until something is definitely stated in writing before we do anything I was wondering if there's be a revised alert published.

(Barbara Wright): Yes, that's on the list too.

(Meg Felice): Any idea as to just an ETA?

(Barbara Wright): We're trying to figure out if there's any other changes. I haven't seen a report from anybody else catching any error there. So if that's the only one, presumably we should be able to get it out within a week.

(Meg Felice): OK very good. Thank you so much.

Operator: Your next questions comes from the line of Cathy McLaughlin from Workmed Benefits. Your line is now open.

Cathy McLaughlin: Earlier in the call you mentioned that when a denial becomes final, referencing ORM – can you define final?

(Pat): No. I was actually reading off a question that someone else submitted, so I – you know, I'm only deferring to the RRE and their determination of that. I don't know if Barbara can state any more, but no, I can't.

Cathy McLaughlin: Would I be correct in understanding, do you think, that it would have to be statutorily determined?

(Pat): Yes.

Cathy McLaughlin: OK.

(Pat): Yes, and that's why I can't answer it.

Cathy McLaughlin: Yes. OK well I just wanted to make sure that I wasn't over thinking it. Thank you.

(Pat): You're welcome.

Operator: Your next question comes from the line of (Celia Winchell) from Crawford. Your line is now open.

(Celia Winchell): Yes, thank you. I have a couple of questions. The first one goes back to the use agreement. We have several RREs who had registered and we had begun to query (for), which likely now with the new language would need to revert to or go to the carrier to be the RRE. When we contacted the EDI reps they said that it was fine to continue to query under that RRE ID but with the use agreement we wanted to make sure that that was indeed the case, or do we need to stop querying under that until they can cancel and then start to submit them under the carrier's RRE ID?

(Pat): Quiet honestly, I believe that you should stop querying under the RRE ID that is no longer going to be used going forward and convert as quickly as possible to querying by the carrier. I mean the authorized rep for the entity that was an RRE and now is not did sign the data use agreement, so you're not in particular violation as far as I can tell. But really what should happen is that RRE ID that is no long going to be used should be reported and put into a status such that – by the EDI rep such that it won't be used going forward. In some cases they're put into what we refer to as a delete status. In other cases we put them into what we refer to as a deactivated status. But nonetheless that

needs to be reported to the EDI rep so that they can change the status of that RRE ID.

John Albert: (So they're a designated agent)?

(Pat): So basically what I'm telling you is that those queries now, if that entity is no longer an RRE then their RRE ID should no longer be used going forward and you should make that adjustment.

(Barbara Wright): I mean are you a designated agent for both RREs?

(Celia Winchell): Yes.

(Barbara Wright): OK, well, let's say you've got RRE ID number one and number two and you were currently querying under one but it's now going to be reported under two, yes you need to do your querying under two, because as we've said, part of the data use agreement is you shouldn't be mixing information from RREs. So if number one is no longer an RRE you should be doing the querying under the appropriate RRE.

(Celia Winchell): OK and so the next one is in those instances where the testing has already been completed or is well in progress on certain RRE IDs and they're in a production status, since what I heard is you'll be using version 3.0 and any changes from that; will there be any retesting that needs to occur?

(Pat): No. It would be highly advisable for you to retest your system for anything that has changed but we're not requiring additional testing for RRE IDs that have been converted into a production status. Most of the changes were actually implemented in the system prior to now, proper to publication of the user guide and are not material, in our opinion, to require that you retest. But again, I'd recommend that RREs and their agents retest for anything that they're changing, of course.

And you may continue to send test files if the RRE ID is in a production status; that's perfectly acceptable and always will be.

(Celia Winchell): Okay, but if I understood as well in the beginning, if you do select the options, to report early – it's not as though you would get a grace period or anything like that on a potential for fines – all of those thresholds and things would apply at the point that you report, correct?

(Pat): Well there are no fines being imposed, and so I'm not quite sure what you mean there. You might get a compliance flag for something that's reported late, however …

John Albert: Yes, I mean technically again the requirements don't really kick in for production files until January, and if anyone reports early – I mean if that doesn't demonstrate goodwill I don't know what – you know.

(Pat): And you should not receive compliance flags for late submissions on these files – earlier production files, and you also should receive them on the retroactive reporting that takes place in the first quarter, and if you do you'd want to report that to the EDI rep and then we might have something that we need to adjust in the system for that. But again, the compliance flags are simply a warning; they do not indicate that CMS has triggered some kind of penalty or fine imposition.

John Albert: Which is why I stated earlier that anyone who reports in production files prior to January 2011 is going to be better prepared for when 2011 gets here. So we strongly encourage it because again, as probably a lot of people on the call have see, you can test and test and test but there may be still be issues that come up in your early production that have to be addressed. So this just basically gives everybody earlier notice of any potential issues, and that's both for CMS as well as for the RREs. So we strongly encourage, again, people that we feel are ready to submit some production files prior to 2011.

(Barbara Wright): What we said repeatedly is we want to work with you. What you may have been referring to as far as that – we're not letting up on fines or penalties or anything, is I think we made it clear that simply because you're submitting early doesn't give you a free pass to submit bad data, that's all. We want to work with you to get correct data, to get it up to date, but something should not be simply routinely submitting bad data.

John Albert: Yes, but again, it gives them more time to – it actually gives you more time to correct it because again, the reporting requirement isn't now until January 2011.

(Celia Winchell): OK, thank you.

Operator: Your next question comes from the line of (Ken Lucas) from (Effective Link Solutions). Your line is now open.

(Ken Lucas): Hello, thank you. Actually my questions have been answered – web-based solution. And just to reiterate, or just to make sure I heard right, you are potentially considering adding the designated agents to the e-mail distribution?

(Pat): Yes, in some fashion. We're looking at another means of notification, perhaps. I really as an account designee you can always log on to the COB secure website and check the status. I realize that doesn't necessarily help if you have thousands of ERR IDs to check on. In the meantime the best answer I can give you is to request that your account manager forward the e-mails, but we are looking at either expanding or making the e-mail notification process more flexible, or implementing some other type of notification process. But I'm not prepared to tell you what that is yet.

(Ken Lucas): Sure. Well I'll go ahead and developing something then. I just wasn't going to develop it if it wasn't needed but I'll just go ahead and develop that thing. So thank you very much.

(Pat): You're welcome.

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

Keith Bateman: Hi, thanks. I have three technical comments and then a heads up for you, of a policy nature. One, people are telling me they're still have problems accessing the COBC server.

(Pat): The (FS TP) server for file transfer?

Keith Bateman: Yep.

(Pat): The only known problems now are some log in IDs do have the proper permissions associated with their RRE IDs. That should be reported to EDI reps and they're working through those and correcting the permissions. But as far as availability of the server, since the last round of sixes when in last month it's been very stable, to the best of my knowledge.

Keith Bateman: Well I don't have the details, (Pat), but I've heard from at least two companies. They're still have problems, even if they're trying in the middle of the night.

(Pat): Right. And they should report that and escalate it accordingly if they don't feel like that issue is being handled appropriately. If you have the RRE IDs I could take them now.

Keith Bateman: I don't have them, (Pat). I'm not technical so my questions aren't entirely technical, but I'm working with what I've got. Another one is where they have not made a query because they already knew a social security number or pick a number. They're getting some of those files rejected because they didn't do a query.

(Pat): Well that is not the reason for the rejection. It could be that we're not matching their data to a Medicare beneficiary. The matching process both for queries and for claims involves getting an exact match on either the HIC number or the SSN and then three out of four of the remaining fields, which are the first initial, first six bytes of the last name, the gender and the date of birth. And so it could be that they might have the HIC number, for example, know that this is a Medicare beneficiary, but the other information such as name and date of birth don't match our database. And so unfortunately we can't match that and validate that that's a Medicare beneficiary and we'll return a 51 disposition code.

Keith Bateman: And the other one is on submission of the TIN reference number – they have submitted it, there's no change but when they submit files they're told where's your TIN reference number? So they'd already submitted it.

(Pat): Yes, I'd have to see more specifics on that, Keith.

Keith Bateman: OK. And a heads up for you. This follows up with sort of the plaintiff's attorney question. We're getting this – hearing from states through their Medicaid program and in one case a second injury fund where they're thinking and requiring that we supply copies of the records that we submit to you. And as a understand it, that would be inconsistent with the agreement.

Bill Deckhart: What do you mean copies of the records they submit to us?

Keith Bateman: Claim input file.

(Barbara Wright): You're saying that the Medicaid state agency is going to try to require everyone to submit a second copy of the CMS …

Keith Bateman: Right, they're talking about it. They haven't done it but they're talking about doing that.

(Barbara Wright): I think it's inconsistent with statute right now. We'd certainly want to know if there's any effort to do that so we could check into it.

Keith Bateman: I first heard about it with Medicaid and now I've heard about it with a second injury fund.

(Barbara Wright): Well …

Keith Bateman: I'm just alerting you.

Bill Deckhart: Yes, thanks.

Keith Bateman: OK, that's it.

(Pat): Thank you.

Operator: Your next question comes from the line of (Joanne Mosphan) from (Transtar), Inc. Your line is now open.

(Joanne Mosphan): I'm sorry, my question has already been answered.

Operator: Your next question comes from the line of (Donna Bouchard) from Farm Bureau Insurance. Your line is now open.

(Donna Bouchard): Yes I got back in, (Pat). All right, TPOCs and the user's guide say they should be positional – you answered a question earlier about the claimants not having to be positional.

(Pat): Yes, I don't know that for sure.

(Donna Bouchard): Well I went back on page 55 and it says the TPOCs should be positional; this is so difficult to code. Do we have to maintain the position?

(Pat): Well right now the only answer I would have is what's in the user guide but I can take it as an issue and go back and back.

(Donna Bouchard): Yes because I guess I was reading this before that they had to maintain their position and now I'm reading that you just should.

(Pat): Oh, well it really was – the TPOCs – now we're not talking claimants but the TPOCs – it was intended that they remain and you must.

(Donna Bouchard): OK. This was in the paragraph that was updated in order to add the sixth and subsequent TPOCs, so maybe it did change.

(Pat): Yes, well it didn't change – I mean that is my error. I did not intend to change that. All I'm telling you in the paragraph or that update is a resolution to, "What if I have more than five TPOCs?"

(Donna Bouchard): OK, so still maintain positional. Bummer. And then just to clarify one other thing, I believe the user guide is telling me that when I go into a test status I can do test and production query.

(Pat): Yes.

(Donna Bouchard): That would be great; thank you so much.

(Pat): Yes query – not (test) but query.

(Donna Bouchard): Right, right. Thanks.

Operator: Your next question comes from the line of (Susan Kornbluth) from New York State Insurance. Your line is now open.

(Susan Kornbluth): I have another question. Everybody talks about foreign addresses for RREs but how would we report a foreign address for a beneficiary?

(Pat): Well you don't report the address for the injured party beneficiary. We already have that information on file so we don't need to report those fields for the injured party.

(Susan Kornbluth): OK. All right, thanks.

(Pat): One more question?

John Albert: Yes.

Operator: Your last question comes from the line of (Jean Therio) from The Doctors Company. Your line is now open.

(Jean Therio): Yes hi. Couple questions here. On the TPOC threshold amount with no ORM – I trust that if it's less than the threshold specified it will be rejected?

(Pat): (That's correct).

(Jean Therio): Right, but it'll just be rejected with an SB code so we can just submit it again, if it's less than $5,000.00 for 2010 and things like that?

(Pat): Well in that case if it's rejected with an (ST) and it's – if it's under the threshold you wouldn't bother to resubmit it again. We're basically telling you that we don't want that record, unless you've submitted an incorrect TPOC amount.

(Jean Therio): OK because right now we don't have any logic to handle any threshold amounts at all but –

(Pat): Yeah, you're going to get potentially a lot of errors back, related to not meeting the threshold amount, then.

(Jean Therio): OK so I'll make sure that to be included. And then one last question is there any additional information on how to invoke the HEW software with the command line, with the new one?

(Pat): Yes. Actually if you were to type in H-E-W dot E-X-E dash question mark I think that it would provide you with that information.

(Jean Therio): OK.

(Pat): But the command, I think I have that I could actually give you, if you could hold one second. Good thing this is the last question.

(Jean Therio): Thank you. I was hoping too because we're trying to automate this part of the thing, now that it's come with the new command line.

(Pat): Yes, and that will be updated on the section 111 COB secure website to add that information about how to invoke it, but I don't know that that's there yet, so let me see. I'm still paging through. OK, here we go. The command to executive the HEW software without the gooey presentation is H-E-W dot E-X-E space dash or hyphen capital O , capital N. The dash O indicates this is the outbound conversion to the 270 format, so that you're creating the file, the input file to submit. The N indicates non-gooey. Now when you get your response file back, you can execute the HEW software by H-E-W dot E-X-E space dash I-N. The I indicates inbound and the N, obviously, the non-gooey presentation.

And that's really all you have to do. It uses the same INI file so you need the INI file setup and, you know, pointing to the correct files.

(Jean Therio): OK. Thank you very much.

(Pat): OK, you're welcome.

John Albert: Operator? With that I'd like to thank everyone for the participation this call. We have to wrap it up as we all have some other meetings to get to. Operator,

if you could let us know also how many were still on queue as well as how many participants we had.

Operator: All right. There were 382 total participants in this call and two people had queued up after you said that that was the last question.

John Albert: OK, thank you very much.

Operator: You're welcome. And this completes today's conference call. You may now disconnect.

Dick Deckhart: Thank you, operator.

Operator: You're welcome.

Dick Deckhart: Bye.

Operator: Bye now.

END