TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: February 9, 2011

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
February 9, 2011
1:00 p.m. ET

Operator: Good afternoon. My name is (Sarah), and I will be your conference operator today. At this time, I would like to welcome everyone to the MMSEA 111 NGHP Conference Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw you question, press the pound key.

I would now like to turn the call over to Mr. John Albert.

Mr. Albert, you may begin your conference.

John Albert: All right, thank you, operator. For the record, today is Wednesday, February 9, 2011, and again, this an NGHP technical call.

I also have to put out the disclaimer that while we try to reflect what is on the written materials, we sometimes misspeak at these calls and that, where there is a conflict between what we say on these calls and the official views or guides and other materials on the Section 111 Web site, that that written material also takes precedence over what we say on these calls.

A couple of quick things. We recognize that there are a couple of transcripts that are outstanding. We've recently received those. There was supposedly an issue with the contractor that does that. But those should be posted fairly quickly now that we have them in hand.

Also, again, I will stress that we're absent one of our key policy players here, so this truly is a technical call, and once we get through the usual presentations that we make, again, we would like you to keep your questions

to be more of a technical nature. We have upcoming calls that are published on the Section 11 Web site announcing future telephone calls, including the next policy call, which is February 23, and there are calls scheduled now out through June 29, either technical or policy or both.

One of the first announcements I wanted to make was that we recently decided within CMS to delay opening up the direct data entry option for a considerable time. Right now, our target date is actually sometime around July. We are pilot testing with multiple users right now, and in the interest of ensuring that the product was as good as possible, we decided to delay opening that up to everyone. That will not absolve anyone of their responsibilities under Section 111 to report data back to October 2010.

And just very quickly, we recognize that there are a lot of people anxious to get started on this, but again, we're not going to be able to open this up at this time until probably July and the slight possibility we could go a little earlier. But we will provide direct communication to anyone who has signed up for direct data entry regarding status of the direct data entry option.

Also, again, I just want to stress that you know the requirements for getting the data submitted are still the same. We also recognize that one of the first questions people ask is what does that mean in terms of compliance, and we are looking at all of that, including the types of compliance codes or flags that we would be providing to submitters. And again, rest assured that a delay on our part does not constitute somebody getting dinged for (CMP). Just want to put that out there and put everyone's mind at ease on that.

So again, stay tuned to the Web site. Again, for those that are registered, we anticipate directly communicating with you, announcing you know the pending dates, et cetera, and in the meantime, we'll continue with our pilot testing; in fact, expanding that pilot test to, again, make this as good a product as possible.

And with that, I will turn it over to – do you have (anything)?

Male: No.

John Albert: OK, to (Pat Ambrosin), who has a laundry list of things to go through, as she usually does. So – and then we will open this up to the general Q&A session afterward. But again, please refrain from more policy-oriented questions because we do not have the right staff and resources here at this call today to answer those questions. We keep those till February 27.

(Pat)?

(Patty Ambrosin): OK. Thanks, John. This is (Patty Ambrosin). As on previous calls, I do have some announcements to make. Then I'll address some of the questions that have been submitted to the CMS mandatory insurer reporting e-mail address and try to stick to questions that have not been answered previously.

First off, recent postings on the mandatory insurer reporting Web site, which is www.cms.gov/mandatoryinsret. We have posted the updated schedule for upcoming town hall calls for Section 111 through June 2011. Those schedules can be found on the GHP and NGHP pages. The transcripts for past calls, as John said, are pending.

Some other pending alerts that are not yet posted or updates not yet posted but are in the works include a posting or an alert regarding workers compensation and no-fault, nonmedical, otherwise known as indemnity one-time lump-sum payment and instructions on reporting those for Section 111. We have addressed this on previous calls, but written instructions has not yet been published. There's also an alert pending for foreign RREs and what entities are required to report versus not.

There's additional guidance concerning liability claims involving exposure and the mass tort issue. That is still pending. We have already published an alert regarding address validation. We intend to update that alert with more information about validating (tin) tax identification numbers as well as addresses associated to those tax identification numbers or (tins) and the new pin reference response file. These changes to add the new (tin) reference response file have been pushed to the October 2011 release, and the alert for this information, including the layout for the (tin) reference response file will be published by April 1, 2011. So that will give you six months' advance

notice to prepare for that new response file and corresponding changes to (tin) validation and address validation that you'll need to accommodate in your system.

We're currently updating the direct data entry, or DDE, alert, as John indicated, to indicate that we're pushing the live date for all REs selecting the DDE option to the July timeframe. We also are going to post an alert on a new online query function on the (COB) secure Web site known as the Beneficiary Lookup Action. That alert is pending, and I have more information on that functionality later in the presentation.

We also have plans to add a downloadable file of valid ICD-9 codes. We're adding this to the Section 111 (COB) secure Web site log in page found at www.section111.cms.hhs.gov. It will be under the reference materials option that's the same location as the error code list and the list of test beneficiary data that's available for you there now. I don't have the date for when we're posting this list of valid ICD-9 codes, but note that it was created by taking the list of ICD-9 codes from the CMS Web site, as indicated in the user guide, starting with version 25, including 26, 27 and 28, dropping the duplicates, dropping the V as in Victor code, those codes that begin with V, since they're not valid for Section 111 reporting, and also dropping the excluded codes from Appendix H of the user guide.

Note that there are further edits in the system beyond just matching this file for the alleged cause field 15. As you know, that must be an ICD-9 code that begins with the letter E, as in Edward. And further codes related to the ICD-9 diagnosis code field one through 19, as you know, they cannot be E codes and so on. So again, those requirements are in the user guide. But I just wanted to let you know that we have created this so-called wait list, or list of valid codes that might assist you in your system. You're not required to use this list. You can create your own, but that's forthcoming.

I wanted to review quickly the required reporting dates and timelines. These are required timeframes. Earlier reporting is acceptable and encouraged. Please note that you must apply the interim reporting thresholds as applicable. So in first quarter 2011, all claims with ORMs, that's including liability,

workers compensation and no-fault claims for which the RRE has assumed ongoing responsibility for medicals or ORMs on or after January 1, 2010 must be reported. Now, that applies to those who are submitting via a file submission. As John mentioned, direct data entry, RREs have until July of 2011 to start reporting those claims. However, the date retroactive reporting of ORM still remains January 1, 2010 for all RREs.

Claims with workers compensation and no-fault TPOC, T-P-O-C, or the total payment obligation to the claimant with TPOC dates are October 1, 2010 and subsequent are due in your first quarter 2011 reporting, and again, with that delay for the direct data entry submitters. Claims with only liability TPOCs and with TPOC dates are October 1, 2011 and subsequent are due to be reported in first quarter of 2012. So if you have any questions on those reporting timeframes, please contact your EDI representative. They could supply you with that information. There's, of course, an alert out on the Web site with that information as well.

The update to the NGHP user guide is in process. We hope to publish it in early March. All the major changes are published in the form of alerts. Some items that will be updated that are not already published but have been discussed on previous town hall calls include the changes that were already implemented to accept ORM termination dates less than 30 days greater than the date of incidence. A modification to the CJ06 edit was already made for this, and note that the requirement concerning ORM termination dates not being reported more than six months in the future will still remain in tact or still remain the same.

Changes being made to the representative claimant and representative claimant address city field to not allow numerics in those fields has already been implemented in the system. This change was made in our January release or sooner, and again, that will be published in the user guide. But obviously, you should not be submitting a city name that has a number in it.

Retaining – the retention of all ICD-9s for version 25 going forward. So we currently accept ICD-9s from version 25 through 28. We've announced that on previous calls. The user guide will also contain information on the

beneficiary lookup action that I referred to and have more information on later. It'll have some more information on direct data entry.

And some other miscellaneous updates to various field descriptions and the like, just to add clarity but not change any requirements. Note that the description of illness injury field 57 is discontinued as of this point in time. You should move spaces to that field. We will not be making use of field 57 any longer.

Note that we've rolled out computer-based training modules, or CDTs for ICD-9 reporting, direct data entry and version 3.1 of the user guide. You can sign up for those CDTs on the mandatory INFRET Web site that I gave earlier. Again, if you're not familiar with how to sign up for the CDTs, you can contact your EDI representative.

As announced previously, we are adding a beneficiary lookup feature to the section 111 (COB) secure Web site. That URL is www.section111.cms.hhs.gov. I'm working on the user guide updates, and I believe the plan will be – actually, we are publishing alerts on this, I'm sorry. My script here was somewhat outdated. We will publish scripts with more information.

But it's pretty intuitive. When it becomes available on March 1, 2011, you will log into the site with your normal (COB) secure Web site log-in ID, and the beneficiary lookup will be an action available in the dropdown action list on the RRE listing page. You will manually enter the (tic) number HICN or the Social Security number of the injured party, their name, birth date and gender, and it will then tell you whether this person is matched to a Medicare beneficiary or not. It will be limited to 100 queries per RRE ID per month. If you use it, you can still submit a query file.

Now, note that it's not available for RREs that select the DDE option; however, there is functionality in the DDE to match your injured party information to a Medicare beneficiary. So DDE has the same functionality available and should provide direct data entry users with the same, in essence, query functionality that this beneficiary lookup does. Now, again, the current

implementation date for the beneficiary lookup is March 1, 2011. These screens are actually there now, but they're not operational. The allowed transaction count is set to zero for all RRE IDs. So you might see this action on your RRE listing page, but you – it's not functional. You won't be able to use it, and that transaction count will be set to 100 starting on March 1, 2011 and then reset to 100 at the beginning of each month.

Let's see. Also, if you have selected direct data entry, you will also see the related actions for that out on the (COB) secure Web site, but again, the transaction count is set to zero, so it's virtually not functional or operational for you except for the pilot RRE that John referred to earlier. And when (DDE) becomes available, that transaction count will be set to the appropriate 500 transaction count, and off you go.

As some of you know, we have formed a data validation team that is currently reviewing Section 111 file submission. On occasion, this team may reach out to RREs to ask questions about their findings. I'm going to cover a few things this team has come across that might be of benefit to all RREs now that reporting has be – commenced this quarter.

First topic is liability reference that are reported with ORMs. This is a perfectly valid situation, but we did do some research on claims that have been submitted, liability claims that have been submitted thus far with ORM, and that is the plan insurance type reported as liability. So originally, we thought – we thought that we would see less of these reports where liability – where ORM was accepted on a liability claim, but we have learned from the industry that that was an incorrect assumption. Liability cases may involve the RRE accepting ORMs.

We do want to advise you, however, that when we questioned several RREs about their submission of liability records with ORMs, a number of RREs told us that they reported accepting ORM in error and had mistakenly identified the plan insurance type of liability, and they really meant to submit the claim, perhaps, as workers compensation instead. The message we want to share is that if you are submitting records where ORM is assumed and the plan type submitted is liability, you may just want to double-check the accuracy of that

report and check those records to make sure that that combination is correct. I'm not saying that it isn't. I just want to make sure that you know you're all clear on reporting ORMs on liability claims. If you do assume ORM, you are to report it, and the same ORM reporting – retroactive reporting back to 1/1/2010 applies.

Now, also, as part of CMS oversight of Section 111 reporting on a weekly basis, our data validation team reviews system reports that capture data from submitted claims input files. One such report that is reviewed contains detailed data on the number and type of error codes returned on response files. So we thought it would be useful to highlight for you some of the most common errors and what our research has shown to be the cause of these errors.

To date, for the first quarter of 2011, the error that occurs most frequently is CI05, which corresponds to the ICD-9 diagnosis code number one, which is field 19. Errors are being made because RREs are failing to submit a valid ICD-9 diagnosis code. Some RREs simply leave off all of the – or are leaving all the diagnosis code fields blank.

As you should be aware, starting with files received after – or on or after January 8, 2011, RREs are no longer permitted to use field 57 to submit a narrated description of the illness or injury; instead, RREs must submit a valid E code in field 15, the alleged cause of injury, incident or illness and at least one valid ICD-9 code starting in field 19, the ICD-9 diagnosis code field number one.

According to the user guide, ICD-9 diagnosis codes are to be left-justified. They may be three, four or five positions in length; however, they, remember, must match exactly on the first five positions of the list of valid ICD-9s provided on the CMS Web site. So if the code is a four-position code in those lists, it must be submitted as four positions. We won't accept only three. We have found that when the ICD-9 code is only three or four positions, and there are valid ICD-9 codes that are only three positions. Some are three, some are four, some are five.

Some RREs are adding one or two trailing zeros; thus, creating an invalid ICD-9 code. If the ICD-9 code is less than five positions in length, the extra position or positions in the field are to be left blank or filled with spaces. In other situations, some RREs are not left-justifying when entering a three or four position ICD-9 code, and instead RREs are adding leading zeros. This also creates an invalid ICD-9 code in those cases.

Another common error seen is CI03, which corresponds to field 15, the alleged cause of injury, incident or illness. Again, as of January 8, all records submitted must contain an ICD-9 code that contains with the letter E in the alleged cause of injury field 15, the code selected to not be one found on the excluded ICD-9 diagnosis code list found in Appendix H of the user guide.

Our research of this error indicates RREs are neglecting to populate this field, some RREs, rather, and RREs are receiving errors related to diagnosis coding – or actually, what I need to say is that RREs that are receiving errors related to diagnosis coding that I've described should review Section 11.2.5 of the user guide. And as I've mentioned previously, we've also created several computer-based training courses to provide further insight into ICD-9 coding. If you are receiving errors, we highly recommend that you view those courses for further information.

Another common error code that we're seeing is CI04, the state of venue. This error is most often the result of the RRE leaving the state of venue field blank. All records must include the postal abbreviation that corresponds to the state. Who state law controls revolution of the claim. Please see the error – I mean the field description in the file layout for state of venue for the valid values. Refer – and that's field 17. That provides a full description.

The final error code I want to bring to your attention is CI01, the CMS date of incident. This error is most often the result of the RRE simply not providing the date of incidence. The CMS date of incidence field is required. The industry date of incident field is option, but the CMS date of incident field is required, and your record will be rejected with CI01 if you do not provide that information.

We have come across some issues where RREs have received errors back on files that are not documented in the user guide. In general, these errors should not have been returned to you and reflect potential changes that need to be made to the CMS (COB) system for Section 111 to handle unexpected circumstances.

If you receive an error that is not documented in the user guide, please report this as soon as possible to your EDI representative with the details of the file and records involved. Your EDI representative will then pass that on for further investigation. You, as the RRE are to resubmit the record on your next file submission with current information for that claim, and you EDI representative will advise you if there is a correction that you could make on your end to clear that up in the meantime. But generally speaking, all of these errors that have been sent back that are not documented are ones that we need to tweak the system for related to how we post our Medicare secondary payer information (MST) information to other systems.

Now, I want to cover some information about (tin) validation and (tin) address validation. Now is the time to clean up issues related to (tin) that cannot be validated by the system and to (tin) address fields found to be in error. Please examine the compliance flags returned carefully. As documented in the user guide, RREs are to correct the problems that are identified by compliance flags and resubmit records accordingly. Even though the record wasn't rejected with an error, you're still obligated to make a correction for that compliance flag and resubmit records accordingly.

If you get a compliance flag related to (tin) validation, and the (tin) is actually valid, contact your EDI representative, providing evidence that that (tin) is actually valid. Your EDI representative will then update the system to add that to our list of valid (tins), and the next time you submit it you will not get this compliance flag back.

Refer to the field descriptions for the address field to correct the address fields that are returned or those for which you receive compliance flags. Note that CMS intends to eventually convert these compliance flags, the address compliance flags and the (tin) compliance flags back to errors and start

rejecting records for these rather than just returning a compliance flag. So the purpose of returning compliance flags now is to allow you – allow you time to make the correction before we start actually rejecting records.

As I mentioned before, the new (tin) response file that was mentioned in the address validation alert that dated October – I mean November 18, 2010, this response (tin) referenced response file will not be implemented until October 2011. An alert with the file layout and requirements will be posted by April 1, 2011. As always, please submit your specific technical questions to your EDI representatives first. These questions related to your file submission, errors and compliance flags can't be addressed effectively if they're only sent to the CMS resource mailbox or elsewhere. You'll get a much faster response to your specific technical issues if you contact your EDI representatives and follow the escalation procedures in Section 18.2 of the user guide as necessary.

So with that said, I'm going to try to cover some of the questions, technical questions that have been submitted since the last town hall call. I'm trying to stick to technical questions and specific reporting questions that have not been answered in my prior presentations, today or on previous town hall calls. If your question is not addressed, please contact your EDI representative or review the transcripts from the prior calls when those get posted.

The first question that I have on my list deals with the delete threshold error. Concern has been expressed over the five percent delete threshold and that it will frequently be triggered, especially on small files. So note that this threshold check is just a safety net and not an actual error. We are keeping it set to five percent for this initial recording period and will adjust it based on experience later to reduce any unnecessary suspension of files.

But in the meantime, if you receive a notification of a delete threshold and your file is put on hold, contact your EDI representative and explain the reason for the delete. We want to make sure that RREs are utilizing this delete transaction correctly. Based on our past experience with electronic exchanges of MSP information, we've found that it's frequently misused and misunderstood. Of course, we have instructions in the user guide about the

delete functionality, our delete transaction and requirements in the event table as to when it should be submitted.

If it's a small file, it is true that a relatively low number of deletes might suspend the file, but your rep will just release it after you contact them and you both agree on that being the cause behind it. So if a reasonable explanation is provided, your EDI rep will release it, and as I said, will adjust the delete threshold based on experience. But we just don't have anything better to go on than that right now.

A question came up about CMS's policy on migrating to the 5010 standard for the (Anci X12) 270 and 271 transaction sets. We do eventually have to convert to the 5010 standard for Section 111, and we will be providing you instructions on that. Rest assured that this is not going to happen really even in the next six months. We hope to have information to you prior to that, but there'll be more than adequate time to make the adjustments and test your files. There's really nothing that we plan to change related to the 5010 as far as how we use the fields on the 272, 71 transaction set. So this should be pretty minor implementation for all of you concerned. And again, more information is pending on that.

Let's see. The next question is a little bit more complicated. It came from a small homeowner's insurance carrier. Certain claims involve the payment of premise's medical payments coverage to others. The carrier of the usual practice is to tender medical payments as a lump sum as an offer of settlement under the medical payment's coverage. They are saying that they are not assuming ongoing responsible for payment of medical expenses, and the lump sum payment is a one-time payment to the claimant, not medical provider. They're asking in this circumstance if it falls within the definition of a TPOC as opposed to ORM.

My best answer, and we have others here that might want to chime in, and as John said, you know you really need to refer to the published information in the alerts in the user guide. But my best answer is that if the RRE's obligation is not to reimburse medical claims as they are submitted on an ongoing basis, but rather the obligation is a one-time lump sum settlement offer, that seems

to meet the definition of a TPOC, and they should report this with the appropriate insurance type, I believe, of liability as a liability TPOC. Again, meeting the requirements for the threshold and the retroactive reporting, and liability TPOCs typically don't have to be reported unless they have a TPOC date of October 1, 2011 and subsequent.

The next question came from an insurer related to auto insurance. They write in an endorsement related to a seatbelt death benefit, which is an endorsement on the auto policy honored in a death case as a result of injuries sustained in a motor vehicle accent as long as the safety restraint device is used. Basically, if an insured dies in an auto accident and was wearing the seatbelt, they would pay this benefit to the estate similar to our life policy, but it's attached to an auto policy. It's not related to any medical bills, but is a lump sum payment to the estate. They're asking if this is reportable, and if it's reportable as TPOC or ORM.

They go on to say that if it's you know asking questions about how they should report the – if they're also reporting no-fault coverage and the no-fault limits. Again, my best answer for this is that CMS gave some direction on reporting similar awards related to workers compensation on a previous teleconference, and an alert was drafted, but it has not yet been published that covers workers compensation and no-fault TPOCs similar to the – it does have language about the payment being mandated by law rather than being optional, as is this endorsement. The language also has a caveat on whether ORM remains open or is terminated.

So my recommendation, until that alert is published, is that I would report one no-fault claim report with the ORM indicator equal to why the appropriate, and in this case, it was $5,000 in the no-fault policy limit sealed 81. The date of death or the date, the $5,000 no-fault limit was reached. Whichever is earlier should be in the ORM termination date and the date that limit was reached if it was to be in the field 52 for the – I mean 82 for the no-fault – when the no-fault limit was reached, all of that on the same no-fault record, and also put the $10,000 award in this care, or whatever the award was for that seatbelt death benefit on the same claim as a TPOC with the TPOC date associated to that.

I would not include the award for the seatbelt benefit in the no-fault limits. I agree that this should be reported as no-fault, and I don't think that CMS wants the $10,000 or the one-time death – seatbelt death benefit included in the no-fault limit, but would rather want it reported as a no-fault TPOC. Again, that is my best advice at this point in time, and we'll take that into consideration for that upcoming alert.

Another question about how to report a particular claim. This is a liability claim with a settlement of $15,000 for some medical bills and general damages, pain and suffering, plus an agreement to provide coverage for up to an additional $10,000 for necessary incurred medical expenses for up to six months following the settlement date.

So the question was you know how to report this circumstance. I believe that you had a settlement or TPOC amount of 15,000. So you should report this as a TPOC of the 15,000, and ORM for six months. The extra $10,000 that is for the additional incurred expenses is not part of the TPOC but rather considered ORM, and you should make one liability claim report or whatever the appropriate insurance type is, with ORM equals Y and the $15,000 TPOC and the ORM termination date would be six months after the settlement date. Remember, the reporting requirements about reporting future ORM termination date stuff.

John Albert: Would they be able to report that all at once, or do they have to go back and update it?

(Patty Ambrosin): Yes. Yes, you can report it all at once as long as that ORM termination date isn't more than six months into the future.

John Albert: (Inaudible).

(Patty Ambrosin): There is a question about periodic indemnity payments for workers compensation and death benefits. This is another one that I need CMS verification on as to whether these ongoing periodic payments after the death of the injured party or beneficiary after their date of death. My understanding is that the once ORM ends on that date of death for that deceased/injured

party, your reporting obligation for this claim is done. So report the ORM termination date and that these ongoing periodic payments for lost income or death benefits paid to survivors is not reportable. And so I look to you for …

(Bill Zaboyna): Generally, I'd say that's the case; however, you've got to be careful that some of these – that the payments were not for medical expenses incurred prior to death.

(Patty Ambrosin): Right. So that would be your key that the ongoing periodic payments after the death of the beneficiary and after ORM ends are not in any way covering medical expenses for that injured party.

John Albert: And for the record, the gentlemen who just spoke was (Bill Zaboyna).

(Patty Ambrosin): OK, thanks, (Bill). The next question related to something that we talked about on the last town hall call where someone had asked a question about a workers compensation claim. Where two injuries are alleged, the workers comp carrier assumed ORM for one injury but did not agree or you know the second injury was not work related. However, the workers comp carrier did settle for the second injury even though it was not work related just to you know close out the claim and get it off the books.

And we gave advice as to reporting the situation so that we don't mess up the Medicare claims payment for this beneficiary going forward and only track and consider the workers comp claim related to the injury that was accepted for ORM. So we instructed them to report one record with ORM for the injury that they accepted ORM on and one record with no ORM. The ORM indicator equals end with the TPOC amount for what they settled that second injury for, assuming that TPOC amount meets the appropriate reporting criteria.

The question that was submitted was, "You know, hey, this is a new requirement. It's not in the user guide. We have to report in March our first file, and we can't get ready in time." And that's OK. We're not expecting you – I will add this scenario to the user guide. We're not expecting you to have this change in instructions implemented in your system. We were providing advice as to how you, you know should appropriately report the circumstance.

I didn't know that it would be that common. But regardless, implement the change as soon as you are able and you know report accordingly.

So again, the intent for that advice was not that you react immediately, but you know get that system change scheduled as might be necessary in your system going forward. So I hope that provides you with some – for the clarity on that.

Let's see. Some – as I mentioned, we do have an alert pending related to lump sum indemnity payments, and I'm not – I'm not going to cover anymore than that. But just let you know that an alert is pending on that with further instruction.

Next, some questions about direct data entry and how to go about using direct data entry, and this RRE in particular was stating well – well, you know I don't have a query component with direct data entry. So you know how might I work this situation in my – in my processes? And in essence, you do have a query capability with direct data entry because the very first data entry screen is for you to enter information about the injured party, and the system will come back and tell you whether that person was a matched Medicare beneficiary or not. If not, you can't proceed at that time with additional claims information.

But if they are matched to your Medicare beneficiary, you can proceed with adding additional claim information. And you can save that claim out there and not submit it for up to 30 days. If you come back within 30 days and complete the claim information and submit it, that still only counts as one transaction. So you're not going to get counted twice.

So if you enter the injured party's information, it is matched to a Medicare beneficiary and you save the claim, it'll stay out there pending for 30 days and allow you to then come back, update it and actually submit it and not have another transaction counted against you, and that might be a perfectly acceptable situation.

I mean the system is designed with the section 111 reporting requirements in mind in that reporting is not required until ORM is assumed or a TPOC

amount has been established you know after settlement judgment of order of a payment. So you know that's essentially we're assuming that you're waiting until you have assumed ORM or established a TPOC before you start entering the claim into the system. So – but you do have that 30 days.

(Bill Zaboyna): If they don't complete (claims), (does) the account against their limit?

(Patty Ambrosin): Yes. Yes. The next question was, can we resubmit the same identification for an injured party, and would the – being charged with two submissions? And that is basically the case. If you do not save the claim – like, for example, let's say you've entered injured party information and it's not matched for Medicare beneficiaries, but ORM continues, then you need to come back and check the Medicare status, and you're using direct data entry to check their status when you reenter their information, that will count as another transaction.

So 500 transactions should be plenty, though, for these small reporters, even in that circumstance. You know remember, this is not designed for somebody who's got you know 500 claims to report per year. You do get up to 500 transactions, but you know it's really intended for someone with a small amount of data to report.

Also note that you can report under direct data entry for one RREIV and report as a file submitter under another RREIV. So we have one large RRE who is actually doing that, submitting the bulk of their data via the file submission, but they have one line of business that is not fully automated, and they ensure that the setup is separate RRE ID and report back using direct data entry.

So the next question is asking about we are currently required to start reporting during the first quarter of 2012, so I assume that they are a liability only insurer and have only liability and TPOCs report. And they're asking, so if I'm using direct data entry, does that change either the date on which I must first start reporting or change the TPOCs that I must report?

And as we mentioned, that you will be required to start reporting via direct data entry in July or when CMS opens up direct data entry for all direct data entry RREs. But most importantly, the criteria for the actual claims that are

reportable is no different under direct data entry versus file submission. So you still have the same retroactive reporting requirements and also the same liability TPOC date reporting requirements as anyone else. So the timing of when you can actually submit that information might be different, but the actual set of claims that are reportable is the same.

Let's see. The next question had to do with, again, a – I'm going to skip that one. I'm sorry. I apologize, since without (Barbara) here I'm a little bit hesitant to cover some of these. The next question had to do with ICD-9 codes and that we recently advised that we are not going to pull any codes from the list of valid ICD-9s, but we will just add new ones as they come along. And so this RRE is asking – so let's – I've already recorded a claim, and then you issue you know an updated list of valid ICD-9s, and am I supposed to go back to the claims that I've already reported and check to see if any of the new ICD-9s apply to that claim and update my claim, and no, you're not expected to do that. Once you have reported your claim with a valid set of ICD-9s, you're not expected to go back and revisit it based on any new ICD-9s that we might add to the system subsequently.

The next question had to do with what happens when a Medicare beneficiary passes away, and we will still match their information when you submit it as an injured party, and in the – in the query process or in direct data entry. So deceased beneficiaries remain on our file of Medicare beneficiary information, and if you submit information for an injured party that is deceased, and it should match to that deceased beneficiary and return a positive match.

Now if you are finding any discrepancies, as we've said before, with the query process, where you've submitted information, you believe it to be accurate, and you're not getting back the query response that you expect, then report that in a secure fashion to your EDI representative for research. I don't know. You know there might be cases where there are discrepancies, and we'd like to get those cleared up, if we can.

(Bill Decker): Yes, hi. This is (Bill Decker). There could be – the most common problems with doing the query file without using a (Hickin). Without a (Hickin), you're probably have a Medicare beneficiary is using a woman's married name rather

than her Social Security name or using the wrong age. If you've got – you really need to (double) check those when you're doing queries on SSN. So it's one of the two major problem areas that we've looked at.

(Patty Ambrosin): OK, great. Thanks, (Bill). The next question had to do with supposing I am using direct data entry and then I decide to opt out of it and start submitting via file submission what period would be assigned to me for file submission going forward. So I was DDE, and now I'm changing to a file submission method. (Are) used to convert from DDE to file submission will be assigned a submission period, otherwise known as a quarterly reporting timeframe. The newly assigned submission period will be the same period as when the RRE was converted.

So when you are flipped from DDE to a file submission method, that would be the file submission period for which your RRE ID will be assigned. So for example, an RRE converting to a file submission on January 10 will be assigned that submission period (which is) submission period two. See the user guide for the numbers that we associate with those submission periods.

Now, if you are concerned about getting your file submitted timely with – given that assignment, as always, contact your EDI representative and discuss a plan for transition and talk about you know your concern. But generally speaking, you should have entered all the claims that are reportable up to that date, and so when the switch is made, most likely your next file submission would be the next quarter. But do talk to your EDI representative if you – if you have any questions about that.

Let's see. There – the next question, I think, has been answered on previous calls about a professional liability policy involving a settlement that involves property damage as alleged mental anguish, but there was no medical treatment for the alleged mental anguish, and they're asking how they go about reporting the TPOC amount. Maybe the settlement might have specified $10,000 property damage in the – in the settlement. But as we've stated on previous calls, you are to report the entire settlement amount or the entire TPOC amount. Medicare is not bound by the allocations of damages in the settlement when it comes to recovery.

Male: The key – the key is where medical is claimed and/or released through – with a general release to the professional liability claim, and that general release included release from any associated medical, then it needed to be still reported. Now, if you had a very narrow release, where medicals were neither claimed and – nor released; in other words, only claimed was property damage, the only thing released was property damage, they could come back after the liability insurer for any associated medical. Then I don't think you need to report it. But the key is, where medical is claimed and/or released.

(Patty Ambrosin): OK, the next question; clarification for the CD07 and CD08. These are related to the name of the injured party. CD07 you will get if you submit invalid characters in that name as described in the error description and in the field description, particularly – and the same with CD08. So you know these fields are required. They must contain either letters or spaces. The first position must be an alphabetic character for the first name and so on.

The real concern here was, instead of (Robert), RRE submitted (Bob) for the first name on the query, and we might have returned (Robert) in the first name on the query response. And when they go to submit the claim, they want to know if they put (Bob) in, is that going to be – are you going to get the CD07 or 8, and you will not. If you match on the query, with (Bob), you will match on the query and on the claim submission with (Bob), and those errors are really related to just the formatting of those fields, not related to whether they match what we sent back on the query response.

The next question had to do with they are – an RRE is currently testing. The testing requirements state that they have to submit at least 25 claims for testing, and they don't have 25 production claims to test with. What you need to do is dummy up the data and take the production claims that you have, put in – change some of the dates, and also you can make use of the test beneficiary data that's on this Section 111 (COB) secure Web site. So we are expecting you to actually dummy up the data in order to get a file of at least 25 claims and contact your EDI representative for help with questions like that.

The next question says for workers compensation claims, reporting is required if the RRE had ongoing responsibility for medical as of January 1, 2010. If the injured worker died prior to January 1, 2010, therefore, there was no ORM as of January 1, 2010, but they're paying death benefits to the dependents. So we need to report those claims.

And my answer would be no, as long as those you know ongoing payments do not reflect medical for the deceased beneficiary. You do not have ORM, and that claim is not reportable.

The next question is asking about when, in what cases claimant one data is required. Claimant one data is not required just because the beneficiary is deceased. So please go to the section in the file layout just above claimant one data and read that description where it states that it's only required if the claimant on the current claim is not the injured party or Medicare beneficiary and that the injury party or Medicare beneficiary is deceased. The claimant may be the beneficiary of the estate or other claimant in the case of wrongful death or survivor actions. So again, if not supplying claimant one information, you can just default all of those fields 104 through 118 to spaces.

The next question is asking about for workers compensation. They have a scenario where there is no ORM. The claim was – there was a TPOC amount over the threshold, and the claim was reported. And the TPOC date was 10/15/2010. So the TPOC is after the 01/01/2010 retroactive reporting date for workers compensation, and it's over the TPOC threshold for workers compensation, and the record was accepted with an O2 disposition code.

OK, now the RRE has determined that the TPOC date was not 10/15/2010, but it's actually August 15, 2010 and prior to the required TPOC reporting date for workers compensation. And they want to know do they send a delete transaction or an update transaction, and really it is up the RRE as far as Section 111 reporting requirements go, since the TPOC is now not required to be reported because the TPOC date is actually prior to that October 1. You can either submit a transaction to update it with the proper date. We do accept TPOC dates with earlier dates. Or you could submit a transaction to delete it. It's really your choice.

The next question had to do with the funding delayed beyond TPOC's start date, field 102. I'm not going to get into all the particulars of this other than to note that more information on field 102, the funding delayed beyond TPOC's start date, and the other TPOC two through five corresponding funding delayed field. We will provide requirements for this field at a later date. Right now, the requirements are that it's an option field. You may provide a valid date if you so choose.

So follow the instructions in the user guide for now, and we'll provide additional instructions, I assume, when we provide information about the product liability fields in fields 58 through 62. So in essence, we're not asking you to worry about now.

There is information in an alert out on the Web site that tells you when you are required to report. So if the settlement takes place today but you do not know who is being paid and how much, the claim is not reportable until the RRE knows what injured parties are being paid and how much. So that information is in an alert already on the Web site. Again, we'll probably make use of this funding delayed fund in the – in the future.

And you know given those circumstances, you might end up reporting a claim that looks like it's reported late to us. We might return a compliance flag, but it's not – that's not something that you need to worry about as long as you're following those requirements that have been published.

The next question was about the (DCN), and last question was about the (DCN) and can the RRE submit from file to file the same (DCN) on the claim report for one particular claim? And yes, the (DCNs) are mainly for us to identify records within one file submission. So the (DCN) is supposed to be different for each of the claim report records in a particular file submission, but if you want to assign a particular (DCN) to a claim report and submit that same (DCN) in subsequent files when you update it or delete it, it's perfectly fine and acceptable practice.

So with that, John, that concludes (inaudible) session.

John Albert: OK, this is – thanks, (Pat). This is John again. I just wanted to just update something I said at the beginning, just for the record, and that was I talked about the delay in the direct data entry, and I did mention some of the ongoing dates that are already out there in terms of how far back people have to report. I just want to clarify that, again, the delay in the direct data entry option being available does not affect any of the timeframes regarding dates of claims that should be submitted you know whether it's ORM back to 01/01/2010 or workers comp no fault TPOCs of 10/01/2010, et cetera, that's all separate from (BDD), and none of those dates change as a result of the delay in DDE.

With that, operator, I'd like to open it up to questions, and again, as you probably already heard us say a couple of times, we're missing some key folks here in terms of policies. So please keep your questions to more technical in nature. We also do have on the line and available to speak also someone from our EDI department as well, (Bill Ford).

So anyway, operator, you can open it up to questions. And we ask that you please limit your questions to one and one follow-up to allow other people to get a chance to get on the line.

Operator?

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star, then the number one on your telephone keypad. And your first question comes from the line of (Andy Carntodiako) from (Public). Your line is open.

(Jason): Thank you. Actually, this is (Jason) at (Publics). I have a question about the turnaround for the alerts that are supposed to follow changes. Late last year, in the fourth quarter, there were several climate changes, and there are still no alerts covering that information.

(Patty Ambrosin): Could you be more – do you have a particular question about a requirement that we can answer?

(Jason): Well, we're in the process of turning over personnel from development to support, and some of these requirements that aren't documented anywhere, I

just wondered when we could expect that type of information to be available to subsequent personnel?

(Patty Ambrosin): OK, the updated user guide will contain that information, and it will be published mid March. The – also, in addition to starting with the version 3.1 of the user guide, all of the applicable alerts out on the NGHP alerts page and the (MMFDA 111) alerts page apply, and then unfortunately, then some of the other information is contained in transcripts that we mentioned earlier, and we are in the process of getting the transcripts for the previous calls posted as soon as possible. So …

Male: And additional alerts are going to be published as soon as possible.

(Patty Ambrosin): Yes, I mean we do have alerts pending that I covered earlier. So I do apologize for the inconvenience, and we're working hard to get that information out there. But if you have a question or you know if subsequent personnel have questions, what I recommend is that they contact their EDI representative and you know and ask those questions and get them answered in the meantime.

Male: And there may be cases where some new material never shows up in an alert because it's actually only in the next version of the user guide. So …

(Patty Ambrosin): Yes, and also note that the user guide will have in the first section, as always, the list of all the changes that are being made so you can readily see that. OK?

(Jason): OK, and then if I could ask my totally unrelated follow-up question.

(Patty Ambrosin): OK.

(Jason): We – when we got one of our response files back for the claim file, we received a error code that was associated with the (tin) mailing address – or mailing name. And we couldn't figure out anything was wrong with it, and it was the same one that we had submitted during our test cycle, and it was accepted at that time. And so we also had an issue with our office code because it wasn't padded with zeros. And so when we corrected that, it

actually alleviated the error that was associated with the mailing name. So it seemed like it was almost like a phantom error. The edits seemed to be impacting one another. Have you heard anything about that?

(Patty Ambrosin): Yes. I mean I know why that's happening. I really don't want to bore everybody with the gory details, but it – that's one of the reasons why we are working toward giving you an actual (tin) reference response file, to give you specific information. Going forward, we should be sending back the appropriate compliance flag for the errors, but essentially what happened was – again, it's just too complicated to explain, but I know why you got it. I'm glad that you have it corrected, and we are you know really on a mission to provide exact and particular information about these errors on a go-forward basis.

(Jason): OK. Thanks a lot.

John Albert: Thanks for reporting it too, again, to anyone who – as (Pat) mentioned in her presentation earlier, I mean there are these occasional errors that we're not always sure why they are, but the more that people report them, we hopefully can resolve as many of those issues as possible.

(Steve Corey): Well, I would say it's important that the office code that you submit on your records matches the office code that you submitted on your (tin) – on your (tin) reference file. If the two are not matching, even compliance errors and errors coming back from the initial submission will still (tear).

(Jason): Right. Well, the error code associated with the office code itself made sense to us. But there – the other error did not. It …

(Patty Ambrosin): Yes …

(Jason): … in itself was fine.

(Patty Ambrosin): Yes, understood, understood. And it you know it does have to do with you know one impacting the other, and it really shouldn't – and like I said, we're working to you know correct that, and in particular, give you back a (tin)

reference response file in the future that will be very specific about what the issues are.

John Albert: And for the record, that other person was (Steve Corey).

Operator: Your next question comes from the line of (Janet Traffler) from Conoco-Phillips. Your line is open.

(Janet Traffler): Thank you, and Happy New Year, everybody. I just – I had a question that goes right along with the last discussion regarding the (tin) referenced file address validation, and this is just for clarification on my part. If we receive a compliance code on our record on a response file of four through nine, one of those compliance codes, the response record – or the claim record itself may be accepted assuming there are no other records. My point of confusion is, it says in the alert that we have to resubmit the records. Is it resubmitting the claim records, or just resubmitting the (tin) reference file?

(Patty Ambrosin): We really want you to resubmit at the record level because of our current processing, and in order for us to update all the systems downstream. So if you receive a compliance flag on a claim record that is related to an actual error on your (tin) reference file record, you need to fix both and resend both in your next quarterly file submission.

(Janet Traffler): OK, thank you.

(Patty Ambrosin): You're welcome.

Operator: Your next question comes from the line of David Piatt from Piatt Consulting. Your line is open.

David Piatt: Hi, (Pat). It's David. I have another (tin) reference file question too. One, a company has gone through a name change, and so I have them contact you guys up and tell them that they were going to change their name. But when you're – when you're doing these validations, are you down to each data element in the (tin) reference file like it's a zip plus four changes? Is that going to throw a compliance error right now?

(Patty Ambrosin): Only if you submit an update with an invalid value.

David Piatt: So (what's the) difference in the one I submitted before?

(Patty Ambrosin): No, I – we would take that as an update and apply it as long as it's valid information in that field, and we would encourage you to do that.

David Piatt: OK, but at some point it's going to look like a different company reporting under that (tin). So is the criteria just the company name?

(Patty Ambrosin): Yes, I mean that's OK if the name is changed. You know we're storing it by the tax identification number, and I don't – I don't really see a problem with that. You know we'll …

David Piatt: If I could – but I guess, I mean you're trying to match a name to a (tin), right?

(Patty Ambrosin): Oh, actually, we don't at that level. What we want on the (tin) reference file is a valid mailing name and address for which you would want the RRE to be contacted for questions, issues, and in particular any demand notices, recovery demand. So it does not – we're not going to the IRS file and saying does this (tin) name match what the IRS has on file? If that's – is that your question?

David Piatt: Yes, that's what I was really trying to drill down to. OK.

(Patty Ambrosin): We do – we do that kind of validation when an RRE registers, and of course you know there can be discrepancies, and we have to work those out during registration. But when it comes to the actual (tin) file, we're just checking the (tin) to make sure it's a valid (tin), and whatever name and address you give us with that (tin) is what we're then going to use and pass on to downstream systems.

Male: Yes, that address is the key.

John Albert: Appropriately formatted addresses.

Male: Yes.

(Patty Ambrosin): OK?

David Piatt: OK. Thanks, John. Thanks.

Operator: Your next question comes from the line of (Marcia Nedro) from (Frederick CMS). Your line is open.

(Marcia Nedro): Good afternoon. I have two questions, and forgive me if they were answered previously. I just want to confirm what I believe is correct, that the data that we're sending now for workers compensation and no-fault med (payback) claims, that data is being transferred over to the (MSPRC) so we no longer have to also report it to them as well. It's considered reportable. Is that correct?

John Albert: Well, I mean the requirements under Section 111 are independent of any other reporting obligations …

(Marcia Nedro): Yes.

John Albert: … have. So I guess that's – I don't …

(Marcia Nedro): … that'd be that policy think question?

John Albert: Yes, I mean I don't really …

(Marcia Nedro): I guess I just wondered if they're starting to talk to each other yet.

John Albert: Yes, but I mean the data that we're collecting is going to (MSPRC).

(Marcia Nedro): It is? OK.

John Albert: Because that doesn't – yes.

(Marcia Nedro): Well, we were told my somebody in CMS that we didn't have to report. I just want to make sure that it was – that because you are now communicating that you didn't have to report. But I just want to confirm that. That included also no fault.

John Albert: It depends on who you're representing. If you're – if you're representing the claimant, the Medicare beneficiary, and a director has been established by

initial contact with our coordination of benefits contractor, that record is right now open and will stay open until such time as they are ultimately contacted …

(Marcia Nedro): Correct.

John Albert: … (MSBRC) that it has been closed. Now, if you sent something in addition, if you're representing the insurer, then the insurer has the separate and independent obligation to report separately under Section 111. The Section 111 data is transferred to the (MSBRC), and what you don't want to have, I would think, is a situation where, by one stream the case is open and the other stream the case is closed, because that's just going to make it more complicated to resolve any Medicare recovery claim.

(Marcia Nedro): OK, I think I understand that. Thank you. One real quick question on that claim. If we have – and we have a lot of workers compensations claims that this happens to. You have a hearing loss or whatever, and the person dies. It's not related. We really don't – that's just – we just close out ORM. We don't have to put in a claimant name or anything along those lines. I think – I just want to confirm that as long as it's not related to the incident and we're not paying any additional medicals, we just close out our ORM. You don't really need to know anything about the beneficiaries or anything like that.

(Patty Ambrosin): No. Additional claimants, not in that case.

(Marcia Nedro): Right. OK, thank you.

Operator: Your next question comes from the line (Pushba Pamadene Mukali) from (State Funds). Your line is open.

(Pushba Pamadene Mukali): I didn't have any question if I pressed the (X).

(Patty Ambrosin): Oh, thank you.

(Pushba Pamadene Mukali): Sorry.

Operator: Your next question comes from the line of (Keith Bateman) from PCI. Your line is open.

(Keith Bateman): Hi. I have two questions. The first one is have you made any determination of to why (Hicka) numbers were obtained through the query system were getting rejected in the edits on the claim input file?

(Patty Ambrosin): But which (Hicka) numbers were those? I'm sorry.

(Keith Bateman): They were ones that were obtained through the query …

(Steve Corey): … check it upon submission.

(Patty Ambrosin): I don't have an update on that issue. In fact, I'm not even – were – those were reported appropriately to the EDI representatives involved?

(Keith Bateman): Yes.

(Patty Ambrosin): OK, I don't …

(Keith Bateman): And you guys have worked on it, and you had an e-mail on it too and responded in the past.

(Patty Ambrosin): OK, I guess I'm not quite sure.

John Albert: (Bill Ford) on the line. Is there anything you can add to that, because that …

(Bill Ford): Well, I would need to look at it. If I can have the RRE ID, I can go take a look at it. I'm just wondering if it's possible that the reporting dates were prior to the Medicare entitlement date.

(Keith Bateman): That's what you were checking, I think, one of the things you were looking into.

(Bill Ford): OK, and can have your – I could follow-up with a rep if I had your RRE ID.

(Keith Bateman): No, I don't remember whether you're the one or somebody else was already following up with the member – one of our member companies.

(Bill Ford): OK.

(Keith Bateman): OK, second question, is this problem – forgive me if it's covered in the user guide, but I got this from a member and haven't had a chance to go back and look. On names with a period in it, like St. John, does the user guide tell you how to report those names?

(Patty Ambrosin): You know I don't think we accept that as a valid character in the field. I need to look that up, and I would try, in essence, the RRE might have to try several things. What we really want is the name as it appears on their Medicare card, and then you know if I were programming it, I would try it as S-T space John for the last name, and you know see if we get a match, and if not, try smunching it together, technical term.

(Keith Bateman): S-T-J.

(Patty Ambrosin): Yes.

John Albert: We can look it up in the meantime before the call is over. I think I can get you an answer.

(Keith Bateman): I don't know – what I said, I don't even know if it's covered.

(Patty Ambrosin): Well, the user guide probably is telling them that they cannot submit a character like that.

Female: (Inaudible) apostrophes and spaces (inaudible) it doesn't say period.

(Patty Ambrosin): Right. So – right. So I would submit it as – try submitting it as S-T space, or – and then try some – if you don't get a match, try eliminating the space. But it really is going to matter how it's printed on their Medicare card, is my best understanding of that situation.

(Keith Bateman): OK.

(Patty Ambrosin): And again, that kind of scenario could – you could work with your EDI representative on it as well.

(Keith Bateman): It appears the period's …

(Patty Ambrosin): Pardon me?

(Keith Bateman): It appears the period is acceptable, so.

(Patty Ambrosin): Oh, in the last name a period is acceptable.

(Karen Hein): Let's see – oh, I'm sorry. No.

(Patty Ambrosin): No, it's not.

(Keith Bateman): It's a letter, hyphen, apostrophe or space.

John Albert: So again, letter, hyphen, apostrophe or space as well as alpha characters. That's all that's accepted in those fields.

(Keith Bateman): (Inaudible) is not acceptable. (Inaudible).

John Albert: Yes.

(Patty Ambrosin): OK, next question, operator, please.

Operator: Your next question comes from the line of Peter Foley from American Insurance A. Your line is open.

Peter Foley: OK. Just a comment on your answer on the medical payments question regarding the homeowner insurer that settles with the claimant with – for the medical payment portion of the file.

(Patty Ambrosin): Yes.

Peter Foley: I'd like disagree with you as to whether that is a TPOC versus ongoing responsibility for medical.

(Patty Ambrosin): OK.

Peter Foley: OK, just to consider that, to take a step back and look at that again. You have to look at the awarding of the medical payment coverage. And follow-up to (Keith)'s point, just a comment that we were told that if a Medicare beneficiary is going to become a beneficiary within six months, you will get a

positive query. But when you try to submit the record, if they haven't become a beneficiary, it will be rejected. And lastly, I'm obligated to ask a question; have you set a date for the mass tort call?

(Patty Ambrosin): No date has been set for the mass tort calls. The query versus for future entitlement, the way the system has been changed is that if you query and the Medicare beneficiary is not entitled yet, their entitlement date starts in the future, the query is to return a 51 not matched until that date of entitlement has been reached. However, if you submit the claim, even though the query might not – maybe you didn't query, but if you submit a claim for the circumstances that the entitlement date is in the future, the system should be returning a 03 disposition code. And then you know follow the instructions for the 03 disposition code, which means resubmit it if ORM continues, et cetera.

Peter Foley: OK, thank you.

(Patty Ambrosin): And you know to Mr. Foley's point about the med pay, you really need to read the definitions that are in the user guide of ongoing responsibility for medicals and TPOCs. I kind of base my answer on the way that the question was phrased about lump sum settlement and so on, but just because you happen to pay all of your medical claims out in one lump sum because perhaps they were you know – you've reached that limit quickly in a day or two or something like that, that does not constitute a lump sum settlement, necessarily. So there is distinction in the user guide for ORM versus lump sum, and you know I'd refer you to that, and we'll try to address those questions again in the future.

Operator: Your next question comes from the line of Debora Daniels from Alfa Insurance. Your line is open.

Debora Daniels: Hi, Ms. (Pat). I have two questions, please. I understood – I thought I understood how the guy asked about the homeowner medical. But my question is, we have a homeowners policy. So was at that person's house, and that person had fallen and gotten hurt. So we paid them under their medical coverage. In our definition under the homeowner policy, medical and liability all fall in the section two liability. But the medical we were paid at regards

who's at fault. And I was thinking of that as been no fault. Am I interpreting that correctly, or?

(Patty Ambrosin): I have to defer to (Bill Zaboyna) on this.

(Bill Zaboyna): Look at this – I don't have a copy of our regulations with me, but look at the definition in our regulations as to what constitutes no fault insurance, because it …

Debora Daniels: And it says in there that no fault insurance means insurance that pays for medical expenses for injuries sustained on the property (apprentice) of the insurer or in the use, occupancy or operation of all available dollars of who have been thought at fault. Then it goes on to say but it includes – this includes insurance, but it's not limited to automobile, homeowners and commercial plans. It is sometimes call medical payments coverage.

(Bill Zaboyna): Right. Well, I would then consider it – if it satisfies that definition, I would consider it no fault insurance.

Debora Daniels: That's what I was – that's what I was interpreting it as, and when that other guy asked that question about the lump sum offer, I was thinking he might have paid it in the liability portion. So I got kind of confused. OK.

My second question is, please, for the testing. We are still in a testing phase. We submit our initial file with the 25 claims. When you do the second testing step. When you do the five update and five delete, do you just make changes to your first initial file test file or do you create a whole new file to submit?

(Patty Ambrosin): You may you know you're making updates for the claims that you already submitted and were accepted, and then I believe it also asks you to submit some additional adds additional new claims too.

Debora Daniels: Right.

(Patty Ambrosin): So what exactly is your question?

Debora Daniels: Do I – do we do – OK, we submitted the initial 25 clients. Well, we did a five update and five delete, do we do that from the 25, or do we just do the whole different set of …

(Patty Ambrosin): Yes. Those are to be – so you submit one file, get some claims accepted, and then in the next file delete some of those claims from the first submission and update some of those claims from the first submission.

Debora Daniels: OK, great. That's what I needed. That's what I thought we were supposed to do. I just wanted to clarify. That's it. Thank you very much.

(Patty Ambrosin): OK, and I will follow-up and make sure, again, on that homeowners med pay, obviously my answer was not good. So for the record, I apologize for that, and we will follow-up on that and get a better answer going forward.

Debora Daniels: And no problem. It could be that I misunderstood, and I just wanted to clarify it to make sure that I'm doing it correctly on our end.

(Patty Ambrosin): Yes, and I'm probably the one who misunderstood, I'm afraid. OK, thank you.

Debora Daniels: Thank you.

Operator: Your next question comes from the line of (Kathy Kacer) from Lumberman Underwriting Alliance. Your line is open.

(Kathy Kacer): Thank you. Good afternoon. I was the one – our company was the one that sent in the question about the body parts, and I just wanted to make sure that we're totally understanding this. If we have one claim where the injured worker came in and said that they have a wrist injury and now they have pain in their figures, but you're not – you're denying the pain in the fingers, do you now want, if there's a TPOC saying that you've denied ORM for the fingers?

(Patty Ambrosin): Did you – did you settle for the finger injury with a TPOC amount? In most cases, settlements are cumulative, and you know prior to that announcement in the December call, you never had to report a denied or body part where ORM was not accepted.

(Bill Zaboyna): If you do not – OK, we have to make a distinction here. If it was the fingers that were in dispute and you never made any payment associated with the fingers, then there's nothing to report. However, if you've assumed ongoing responsibility for the wrist, then that's reported as ORM. If as part of your settlement you're getting a release of some sort for the – for the fingers as well, then that part of it associated with the fingers is a TPOC.

(Patty Ambrosin): Now it has to meet the threshold for reporting, but yes.

(Kathy Kacer): So only if the release attributed any dollars to the denied body part would you have to report in this …

(Bill Zaboyna): It does not have to specifically mention specific dollars. Remember, the threshold is if the injuries were claimed and/or released. So if the release has the effect of also releasing any further claim with respect to the fingers, then it needs to be reported as the TPOC.

(Patty Ambrosin): And that's referring to TPOC. If you look at the user guide, it tells you, you know the ICD-9s that you have to report for ORM and those that you need to report for TPOC. For ORM, it's essentially what you have assumed ORM for. For TPOC – for TPOC, it's what you have – what's been claimed and/or relieved. So just because you don't think you know it is – they claimed it and it was you know released, OK? Does that help clear it up? And this is particularly that example about you know the multiple body parts and you're accepting one for ORM and settling the other, you know that was a specific circumstance where just to, in a sense, get it off the books the second injury there was a settlement for the second injury to sort of get it off your books and make it go away. But ...

Male: (Inaudible).

(Patty Ambrosin): … yes. But if you never you know assumed ORM or never settled for the fingers, then that's not reportable.

(Kathy Kacer): OK. And just one additional question on a separate topic, but we're just trying to finish our programming, the ORM termination date will reduce it to less than 30 days, but can it be the same as the date of incident?

(Patty Ambrosin): Well, that's an interesting question. It's not published that way in the user guide. It turns out that downstream systems that we have to interface with won't accept it, and not the (MSPRC), actually, another common working file system that deals with Medicare claims payments. So I would like to withhold advice on that for right now, because we might be able to handle that on our end rather than changing a requirement for you.

So right now the requirements are you know at least equal to or greater than the date of incident, the ORM term date. And I need to circle back around on that. It's something that came up – you know before, we wouldn't allow the ORM termination date to be within 30 days, so we didn't run into this issue, and then subsequently we get. So that's the more honest answer than I probably should have given you.

(Kathy Kacer): Thank you.

(Patty Ambrosin): OK.

Operator: Your next question comes from the line of Todd Simpson from Central Insurance. Your line is open.

Todd Simpson: Hi. Thank you and good afternoon. Our company in their production file received a number of SP errors. And essentially what happened was we use an agent, and the agent picked up a number of plans which we didn't think would be reported. So they're old like TPOC liability claims. And so my question is, I understand that according to the user guide we're supposed to resubmit those, but they're claims that we didn't want reported in the first place. So is – are you guys matching up you know you've got key errors to make sure that we report them back in, or are we OK just cleaning those up and not sending them back in?

(Patty Ambrosin): You are OK not to send them. Yes, we're not keeping track of records that we returned with an error and waiting for you to correct it and send it back specifically. I mean we have records, but we're not – so if they're not reportable claims, just do not – you know remove them from your file and do not report them going forward.

Todd Simpson: OK, fantastic. And then just as a quick follow-up, we received just a few SP 32 errors. Is that one of those errors that you talked about not being published and we should let our EDI rep know about it?

(Patty Ambrosin): Yes, that is, in fact, exactly the circumstance that the last caller brought up, that we are working toward correcting and will have that corrected very soon.

Todd Simpson: Oh, OK.

(Patty Ambrosin): So yes, there's – I mean do report it, please, to your EDI representative in the meantime so that we have you know as many examples as we need and you know resubmit the claim next time.

Todd Simpson: OK. Well, thank you very much for your help.

John Albert: Operator, this is John. I just wanted to pass on some information to the callers, to the reference to you know wanting information regarding ICD-10. There is a CMS.gov Web site that has information and updates regarding ICD-10s and the latest you know developments in terms of implementation, et cetera, that might be beneficial. And again, it's CMS.gov/icd10. That's pretty short and brief, but that's a resource out there for anyone to go and look at in terms of latest thoughts on the ICD-10 process at the CMS level.

So we can take the next question.

Male: Is that dot gov forward slash?

John Albert: Yes.

Operator: Your next question comes from the line of (Vax Nadale) from New York City Law Department. Your line is open.

(Vax Nadale): Hello, everyone. Thank you for your help. I have a follow-up question about the field 57 being discontinued. When you were discussing the data validation team's finding, someone piped in, and I thought I heard somebody say that that change went into effect after January 8 of this year, and I'd just like to get confirmation because we're trying to finish up our testing, and we

thought we were done. My EDI rep knows about this, but our last claims test was sent on January 19, and it doesn't seem – just doesn't seem to have kicked in yet for that file. So could I get some confirmation on field 57?

(Patty Ambrosin): What do you mean it hasn't kicked in?

(Vax Nadale): I had many, many records go through with field 57 still having data.

(Patty Ambrosin): But did you have valid ICD-9s in field 15 and 19?

(Vax Nadale): I did.

(Patty Ambrosin): That's why. We're basically just ignoring it. On previous calls, I said – and in this one, I said to move spaces to it. We don't want you to continue to use it assuming that somebody's looking at it, because we aren't. But the system is you know basically just ignoring it.

(Vax Nadale): Will there come a time that …

(Patty Ambrosin): No.

(Vax Nadale): So I don't need to worry.

(Patty Ambrosin): No.

(Vax Nadale): OK, then my follow-up question then becomes the new special default ICD-9 code, the no injury one that was supposed to come into effect on January 10. Did that actually go into effect on January 10, because again, the same January 19 file I have a – I have a CI – I just forgot the number error, 25, sorry, regarding those fields.

(Patty Ambrosin): Well, there's other criteria that goes along with the (NoINJ), or NO INJ, and so you know, yes, it went into effect, and as of – it should have been as of January 8, in fact. And you know the claims being edited for it can only be used with liability claims and you know yada, yada. I don't know all of it off of the top of my head, but …

(Vax Nadale): Unfortunately, I do.

(Patty Ambrosin): Yes. God bless you. So at any rate, you know if you find a discrepancy please report back to your EDI rep because that you know criteria for the use of (No INJ) should be in the system now, and if you're getting a test file back saying you shouldn't use that field or use that value or you know you did and it should have given you an error back, you know whatever the discrepancy is, please contact your EDI rep and give us an example.

Todd Simpson: OK, thank you.

Operator: Your next question comes from the line of (Crystal Roski) from (PMSI). Your line is open.

Male: Hey, thanks for taking our questions. If it's OK, we actually have four questions, sorry. But I think they're all somewhat related to – they're all related to file processing. The first one, I don't know, maybe we have to take this offline or walk through, but we've had some questions about when we get duplicate file submissions and would like to know what happens when a file is actually (SFTP). Is that moved to another location for processing? Is it logged, and are there specific versions for files that we send, because when we would send the replacement file for that when we get permission to do so, it will have the same name. So we wanted to know what happens to those files after they're submitted to (SFTP).

Male: So it's (surrogate) overlay.

(Patty Ambrosin): Yes, I mean if it's still in your folder on the (SFTP) server, I'm being told it'll et overlaid. So but …

Male: And those files will be transmitted to the mainframe portion, I mean from the looking at the secure FTP folder, you will only see the last file that was submitted.

(Steve Corey): So you maintain multiple versions of that file?

Male: If the file was submitted, it'll be picked up and transferred to the mainframe. If you come back in like five minutes and submit that same file name again,

the second file will also be picked up and transmitted to the mainframe. So potentially you will have those files on the mainframe.

(Patty Ambrosin): And only the most recent version in your Inbox, so to speak.

Male: OK, and then that's what generates the threshold warning. You know that even though we name the same file – I'm sorry, even though we name the file the same and we send it to you twice, you actually have multiple versions of that file so you know that it was submitted twice.

(Patty Ambrosin): Yes, we're changing the name as we transfer it out of your (SFTP) folder into the system for processing. We're changing the name and giving it a – yes. They'll have unique names. So we do have them as two unique files, just not in your (SFTP) folder.

Male: OK, so you may have to have their – so that's how you maintain the version of the files. So if we were – when we submit a correction file, like let's say that we had a file that was just had a severe error, it couldn't be processed, it had a carriage return in it, or we were, in some cases, we had an issue with just the (tin) records of a claim – I'm sorry, the (tin) records, but no the claim records, and we resubmit the file. Do you recommend that we resubmit the file in its entirety, meaning the (tin) records and the claim records, or should we send just the spot or the sections that we're around in?

(Patty Ambrosin): Yes, you'd want to have those claims records processed against the correct (tin) – matching (tin) records. So yes, I would make a practice of doing that. And again, it depends on the circumstances and so on. Your EDI representative would advise you on that, but we do want to reprocess the claim records with the proper (tin) information. So I would say, as a general rule, if you're resubmitting (tin) records, you should resubmit any of the corresponding claim records.

Male: OK, very good. And is there any way when we – when we submit a file to you after we've worked with the EDI rep to turn off the threshold warning?

(Patty Ambrosin): No, not …

Male: OK, so …

(Patty Ambrosin): Yes, I mean it's just – it's going to happen, but if you're in touch with your rep, they're – you know they're going to see it and deal with it right away without a whole lot of you know delay.

Male: Right, and they'll – and then we just – but if we've communicated to them and they've approved it for us to send a corrected file, they'll go ahead and release it. We don't need to call them.

(Patty Ambrosin): I would – I would still call, personally. You know with every threshold notification, you know I would – I would just do that out of habit or you know just make a policy that that's what you do.

Male: OK, and just two more questions. I'm sorry, some of those answers spawned a different question. I apologize. And then the next one is we will – since we're connected to (SFTP), we'll find files in our folder that are responsive to files we didn't submit, and then we automatically download and find those aren't related to either a 270 or an (MIR) that we submitted.

(Patty Ambrosin): OK, that needs to be reported immediately if, indeed, you know that's the case. But you know you being an agent, it might be that you know the RRE, who registers and the name who has the agent and then invites you as an account designee, let's suppose you're not the account manager but you're an account designee, you know there might be an RRE out there who's inviting you to their account that you're not aware of. So before we jump the gun and say we've put files out under the wrong RRE ID, I just want to point out that we've run into circumstances where agents have essentially been given access to RRE IDs that they didn't know they had access to. So double-check that.

You know you can log on with your ID and see what RRE IDs are associated with and you can work with a rep. But in that circumstance, we most certainly want that reported immediately so it can be investigated. But I don't want to get everybody all excited that we're you know transmitting files back to the wrong RRE ID. I have a feeling it might have something to do with setup on your end, but we'll see.

Male: OK, and then related to that, the issues we're having connecting to the (SFTP) site, we have, I believe it's an issue connecting when we are trying to access too many folders using one of our account rep's user ID and password. So we have multiple account managers here. So I think we have – we'll have (inaudible) three, but we're still experiencing – you know and we're logging the errors as connection failures when trying to connect to the (SFTP) site, and then connection failures or maintaining a connection as we're trying to download files, they'll – our (SFTP) automated processes actually have to reconnect and then download the files, and they're running you know every 15 minutes. Is there – is there going to be a solution for us or for those folks who connect and have a large number of RREs that they represent, where they can connect using, let's say, you know one account?

(Patty Ambrosin): Well, first off, I thought we had cleared up most of those issues. But I – you know we're going to have to take this off line and follow-up with you to find out what needs to be done there. But you know we will work with you to resolve this so that you can connect in a – you know reliable fashion if you're not right now. Whether you – I tend to think that whether – that you might still need to use multiple log-in IDs and not you know use one single log-in ID for all of your RRE IDs if you have you know 500 of them or more or something. So we'll – we're just going to have to follow-up off line.

Male: OK, we'll schedule something with you. And I didn't mean to throw that out. I didn't know if it was a public concern or if it's something that's specific to us, and we're open to maybe you know looking at a different mechanism. Somebody informed us that really the preferred mechanism is (Gentran).

(Patty Ambrosin): Well, that's what – we used a (Gentran) product on our side. It shouldn't make a difference what you use.

Male: OK, I didn't know if you guys were using a value-added network, and that's how we're trading files to do your (Gentran) product or not, but …

(Patty Ambrosin): All right, well, now you're way beyond my …

Male: OK, I'm sorry. All right.

(Patty Ambrosin): OK.

Male: So we'll set – can we just set something – have (Brenda) or (Crystal) set something up with you separately on this?

(Patty Ambrosin): Yes.

Male: Will do. All right. Thank you very much. That's it. Thank you for taking our questions.

(Patty Ambrosin): Sure.

Operator: Your next question comes from the line of (Shawn Downy) from (Jonnie Stern) Company. Your line is open.

(Shawn Downy): Yes, we had sent in a question regarding how long after a claim settles we have to query to confirm if that's a Medicare recipient. We settled a case, say, on October 10, and our October 1 came back as a 51 not found. We got a response from (COBC), and they said it would be a good idea to query one more time afterwards. Our system isn't programmed to do this, but my question is simply will something of this nature be clarified in the user guide?

(Patty Ambrosin): Well, you know it's actually there.

(Shawn Downy): Oh, it is?

(Patty Ambrosin): You know maybe I can do a better job of making it more clear, but the – you know you're required to report for Section 111 after settlement, judgment, award or other payment. So you really have to query and know the Medicare status of that injured party after – on or after settlement, judgment, award or other payment. So you've established ORM or you've made a TPOC. If you have a 51 on your query, you need to continue to monitor that individual status until ORM ends or after you know – one time after the TPOC. You know personally, I wouldn't bother to query, and I know that maybe I shouldn't say it that way, but you, you know you might not want to query until you have established ORM or the TPOC amount.

But I understand people wanting to know this information earlier than that, and that's fine. But if you get a 51, you have to – you have to monitor that person's Medicare status or confirm their Medicare status on or after the TPOC date or on or after ORM assumption, and you know if ORM – if ORM ends and you have confirmed you know at that point that you know one last time that they are not a Medicare beneficiary, you don't have to report.

(Shawn Downy): OK. Yes, and that was the case. We were – we had ORM, and then you know we had a termination settlement and a TPOC, and they were not – you know it was not found at the time of that settlement. So is it – is it clearly – do – you probably can't tell me exactly where this is spelled out in the user guide. We appreciate that we're hearing query one more time, but you know nothing that we hear on the calls or even in written communication is considered to be you know until it's written, and we didn't find clear language that clearly spelled it out the way that we had asked the question.

(Patty Ambrosin): OK, well, I'll make a note of that. I think it would be in the section on response – on the response file in the – under each disposition curve. But I will – in fact, under – if you look in that section and look under disposition code 51, and O3, I believe you will see something like that, but I'm making a note of it right now, and we'll you know see what I can do to clarify it.

(Shawn Downy): OK. Well, thank you very much.

Operator: And your next question comes from the line of (Loretta Palmenville) from (Time Warner) Insurance. Your line is open.

(Loretta Palmenville): Thank you. Good afternoon. I was hoping that as you go back and reviewed the med pay issue that was discussed previously this afternoon with regard to homeowners' policies, if it could be also considered in terms of a commercial general liability policy. We are writing only liability policies in Michigan right now, and Michigan law is quite clear that even though the policy says that it is without regard to fault, that it is to be paid only at the direction of the insured. So it's not really a true med pay as I think it might be considered elsewhere. So if you could please take that into consideration also?

(Patty Ambrosin): Yes, could you please send out to the mailbox, do you have the e-mail address for the Section 111 mailbox?

(Loretta Palmenville): If you could give it to me, please.

(Patty Ambrosin): Well, what I can do is tell you to go to the new page on the Web site. So go to – you know the mandatory insurer reporting Web site?

(Loretta Palmenville): I do.

(Patty Ambrosin): And on the left-hand side, there's a series – like a menu, a left-hand menu, and there's what's new, and then if you go to the top of that What's New page, the e-mail address is there. It's very long, so even if I …

(Loretta Palmenville): OK, we'll do. I appreciate the help. Thank you.

(Patty Ambrosin): Yes, thank you.

John Albert: Operator, it's now 3 o'clock Eastern Time, and we have to wrap this call up. I'd like to thank everyone for their participation. We hope that we answered most of your questions today. Keep in mind, again, out on the Web site are the schedules for the future calls. The next call, the 23rd, is a policy call. We'll probably get into more of these med pay issues.

(Patty Ambrosin): Yes, we definitely will.

John Albert: The next call after that is March 9, which is a policy and technical call. But in the meantime, please keep working with your EDI reps and submitting your questions to the resource mailbox, and you can hereby pass along presentation every time that we definitely try to answer all of those, or as many of them as we can on the next call, go through the materials.

Other than that, I'd say thank you, and operator, if you could stay on the line after disconnecting everyone, we'd like to know about participations and how many were still in the queue.

Thank you.

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

END