TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b) (8)

DATE OF CALL: May 4, 2011

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

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS' DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
May 4, 2011
1:00 p.m. ET

Operator: Good afternoon. My name is (Denise) and I'll be your conference operator today. At this time, I would like to welcome everyone to 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'd like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you'd like to withdraw your question, press the pound key. Thank you.

Mr. John Albert, you may begin your conference.

John Albert: Thank you operator and good afternoon from CMS. My name is John Albert and for the record, today is Wednesday, May 4. This is non-group health plan technical call. This, again, is geared towards the more technical questions that folks have when terms of – in terms of implementing the section 11 NGHP reporting requirements.

We have a couple of folks here who support the technical process, the technical side of the operation and we are without many of the key policy folks, so again, this is a technical related Q&A session as well as presentation. We ask that if you have policy questions to please hold them until the next call, which is May 18, which is a policy call or June 29, which is the policy and technical call. In the meantime you can, of course, continue to submit your questions through the resource mailbox as well as through your EDI rep as well.

Again, as we do on all these calls, we mention a disclaimer and that there are times where we may say things that contradict the written guidance, that is at the section 11 Web site. Again, where we contradict that information, the

information on the web pages take precedence over anything we say on these calls.

Often times through these calls we may you know develop addition material to post out there on the Web site, but again, until those materials actually show up at the Web site, there's no official pronouncements from us you know that would override anything that's on the web pages, so please keep that in mind.

We have a presentation by (Pat Ambrose), then we're going to open up to the usual Q&A session. We ask that folks please limit their questions to one and one follow-up and get back in the queue. That shouldn't be a problem. We don't have quite as many people as we've sometimes had on these calls, but again, please limit your questions to technical in nature, because that's the kind of people we have here today to answer those questions.

With that, I'll turn it over to Pat.

Pat Ambrose: OK, thanks John.

John Albert: Technical difficulties, sorry about that.

Pat Ambrose: Are we good?

John Albert: Operator, can you hear us OK still?

Operator: Yes, I can.

John Albert: OK.

Pat Ambrose: OK, not sure what that was all about. Anyway, through some recent postings on the CMS mandatory insurer reporting Web site, which all of you should know by now is www.cms.gov/mandatoryinsrep. On the MMSEA 111 alert page, we posted an alert about the upgrade schedule for the query file and HEW Software. We are moving the X12 270, 271 to version 5010A1. That alert is dated April 5. The conversion will be done, starting in October and completed by January 2012.

There also is an alert that was posted since our last call. On the NGHP alert page, this is related to the 10-reference response file and address validation and that's dated April 1, 2011. I'd like to mention that there's a typographical error in that alert, in the file layout for the 10 response files.

In the header record filed three, the value that should be submitted in field three should be NGHTNRP, instead it has NGHTNRFP and that's too long to fit into that field. You'll see the correct value is in the corresponding field on the trailer record, so please make a note of that as your preparing your software just to deal with the 10-response file. Field three on the header record will be populated with NGHTNRP.

The user guide version 3.2 is in draft form and is currently under internal review after CLBC and CMS. We hope to them finalize those changes and get it posted no later than June 1. We are certainly working towards getting that posted as soon as possible.

As we said before, there won't be really any surprises in that version 3.2 of the user guide, since most important information has either been provided on these calls and on alerts that have been posted to the Web site. But I'll go through a few notes that I made here, to give you a heads up about what's coming in that version 3.2 of the user guide.

First of all the user guide was updated to note the extension for reporting liability TPOC date of 10.01.2011 and subsequent and also was updated to note the extension for the interim reporting threshold. The changes were made throughout the guide related to that.

I also made some changes to add clarification to the data type for various fields and such as 92. Parentheses are only accepted in certain alphanumeric fields. Parentheses are only accepted in the policy number, field 74, the claim number field 75 and the plan contact department name field 76.

So what we're doing is changing the definition for alphanumeric to remove parenthesis as a valid special character and adding a new data type for those three fields called alphanumeric plus PROHand, not very creative, but it gets the point across. So just to clean up that discrepancy and of course the

changes were made in appendix A for those field types, to change them to alphanumeric plus PROHand.

Let's see, exception 1125, the ICD-9 section was updated. We removed the description, the (onus) injury field 57, that's been changed to reserve for future use and must be sold with spaces. As it has been asked and answered before, if you put something else in there, it's not going to be returned as an error, but it certainly will not be used.

And then we added information about the KNOW IMJ default code for limited liability situations, updated the information about what files off the CMS Web site we use for valid ICD-9 codes. Those include versions 25 through 28 and notations about not dropping codes in the future and so on, so all the information that has been provided previously.

Some information related to Direct Data Entry or DDE was updated and added throughout the user guide, so that the user guide makes a little bit more sense for DDE users. Remember that all requirements in the user guide apply to Direct Data Entry, with the exception of actual mechanics of creating and submitting a file. So the field descriptions in the file layouts apply.

Of course you are not submitting a file, but you will be entering those data elements manually. Requirements concerning who must report and what must be reported. The requirements in the event table and so on, all apply to Direct Data Entry or DDE submitters as well as file submitters.

We added a do's and don'ts section, just some helpful hints on submitting claim input files based on what we've seen so far. We also added the information about 10-validation and address validation and the 10-reference response file that's in that alert that I mentioned earlier. A couple of events were added to the event table to provide additional examples.

We also noted that, remember that ORM, the ORM termination date maybe less than 30 days from the data of incident now. In other words the ORM termination date doesn't have to be greater than 30 days from the data of the incident, as was a requirement before. That was actually changed quite some time ago, but it's just now being added to the user guide.

We beefed up the explanation of disposition code 50, to provide more information on what to do in those scenarios and that's based on some questions that we have received about that and to that point, keep sending you questions and comments to the CMS resource mailbox. You can find that on the web, what's new page of the mandatory IMS REP Web site page on the CMS Web site. We do you know obviously, look at those questions coming in and try to react accordingly and I've gotten some good information about updates that should be made to the user guide based on input that people have supplied there, so.

Also we noted that the information about the upgrade of the X12 270, 271 to the 510 version and the upgrade of the HIPAA eligibility wrapper of the HEW, often known as the HEW Software.

I did go through the field descriptions and error descriptions, updating them and trying to bring them in line with each other. These don't reflect requirement changes, but just trying to be consistent between the field descriptions and the error descriptions and show all the requirements for particular fields in the file layout, rather than forcing REs to rely on reading both the field description and the error code. It's a challenging task, so I'll welcome any additional feedback after you review the new user guide.

I did note also that no numbers, no numerals will be accepted in City fields. We talked about that on previous calls, but make sure that you're prepared to make or if you haven't already made that change to not submit numeric characters in the City field.

There is a notation that I believe we talked about before May about – and I put this in the Do's and don't section. When you supply the exhaust date for no-fault, reaching the no-fault insurance limits on, most likely you should be studying the ORM termination date too.

We've seen some claim reports where RREs are submitting an ORM indicator equal to Y, zeros in the ORM termination data and an actual exhaust date in the no-fault – in the exhaust date for no-fault insurance limit field. And that doesn't really make sense to us. Maybe there is a circumstance, but I can't

really understand why there would be an exhaust date for no-fault insurance limits if your ORM hasn't been terminated also. So just a reminder; that is not a requirement that they both must be set and both must be set to the same date, but it seems to make sense that they should.

The other thing that I wanted to remind everyone and point out is that, in those special sections of the claim input file for the representatives, the claimant information, claimant 124, and the claimant representative 124, at the start of each of those sections is an indicator, the representative indicator, the claimant one indicator and so on, that tells us – that provides information about whether there is such a representative claimant or claimant representative and if not that indicator is left blank or if so with spaces.

When that indicator is filled with spaces then the entire remaining section for the representative or claimant or claimant rep should either be left blank, spaces moved to the entire section or default field by field to either blanks or zeros depending on the data type.

There is a blurb at the top of each of those sections explaining that and I'm making changes in the user guide in each filed to explain that some of the error codes will be triggered if you supply a space in the indicator, but then you go on and supply say representative 10 or a representative name. If there is an inconsistency there then the system is assuming, making assumptions that you haven't filled the rep layout correctly, so make a note of that.

Going forward, it also was noted we're adding the compliance flags that were added in January 2010 for the 10 address editing, however those compliance flags will be defiant or not used as of October 1. So you're going in and will come back out in some later version of the user guide. Of course we added the 10 reference file error codes and the layout for the new 10 reference response files.

John Albert: All right, why did we add them in and then…

Pat Ambrose: Well, the compliance flags are going in since they will still remain in effect until October and then – so that we have them properly documented. They are published in a word, dated back in November 2010, but the change is going in

October for the 10-response file and the 10 error codes that will be returned on that, virtually replayed following those compliance lags that were added.

Speaking on addresses, I'd like to suggest that you validate your 10-reference file addresses now, take a look at the compliance flags that you might be receiving back. On your claim response files, go to the United States TOEFL service Web site and use their tools there.

There is one in particular that actually is intended I guess for booking of the Z plus four fields, but it also validates your address. It is matching your address to the US TOEFL service database of valid addresses and it will pass back or return back to you a scrubbed address so to speak, using the appropriate abbreviations that the TOEFL service recommends and also make sure that your address matches a valid deliverable address and so I highly recommend that you take the time to scrub those addresses, just those, the 10 reference files prior to October and that will certainly increase your rate of success when – come October when we beef up our address validation for the 10 reference file.

Also remember that you can send a 10-reference file off schedule so to speak. There is no file submission period and no limit to the number of 10 reference files that you can submit. So you may submit more than one per quarter, you may submit it without your claim input file and that might be a good way to get it cleaned up now.

The other thing about the US TOEFL service standards that I wanted to mention is that – and there is information out on their Web site about this, but name and address fields generally are limited to 40 bites, even though on our input file for the 10 reference file, we're accepting 70 for the name and 50 for address lines one and two. We recommend that you try to stick to using just the first 40 bites of those fields and using eight separate words within those, each of those fields. Again, that's for the names and address lines one and two.

It's – I'm not saying that it's an absolute requirement. We are going to take the full address that you give us, name and address and scrub them, but it's

likely if we run out of room we're going to – we could be cutting of some information that you might have supplied if you went beyond the 45.

We really don't have information to share on the ICD-10, the upgrade to ECD-10 diagnosis codes right now, but we are working on. Please send your questions and suggestions to the resource mailbox. Most likely there – the rules will be that there will be a certain point going forward such that an RRE must submit ICD-10. I can't yet whether our – we will have to convert ICD-9s that they previously sent to ICD-10s on updates. I am not ruling it out as a possibility. If that will be a requirement, certainly I'm working toward providing RREs with every possible tool and possible mappings to help you out there. We certainly do understand the level of effort involved in that.

Something else that is most likely going to be true, is that on one claim submission you cannot mix ICD-9 and ICD-10 codes. There is room for an indicator on the file now, on the claim input file detailed record that was intended to indicate whether ICD-9s or 10s were being submitted and then you'll see an extra two bytes after every ICD-9 diagnosis code one through 19, as well as field 15 for that matter, where we intend to increase those fields from five bytes, to the seven bytes required by ICD-10.

In the meantime, again send your suggestions, questions, concerns, scenarios to the resource mailbox and go out to the links that are provided in the user guide on the CMS Web site. There are in fact some files out there, some GEMS or GEM files that actually show mapping potential or suggest you could – suggest it cross walks from 9s to 10s and all kinds of interesting information.

Now that information on that, those CMS Web site pages pertains mainly to providers and suppliers who are submitting claims to Medicare, not section 111, but we will provide you with guidance on what you – that requirements for section 111 will be.

Another note that I am making in the user guide and I also wanted to bring up on this call has to do with disposition code 51. As you all should know,

disposition 50, disposition code 51 reflects the fact that we could not match your entered part information to Medicare beneficiary.

Now this does not necessarily mean that the injured party is not a beneficiary. It just means that we could not match the information you submitted to a Medicare beneficiary. And so what I want to stress here is that you, the RRE need to check the data that was submitted on that, whether it be a query or a claim record to make sure that the information that was submitted was accurate. We are seeing claim records being submitted where the first and last names are flipped.

Obviously, that's going to present a problem in the matching. We are seeing other issues to, where you know missing, invalid data etcetera. So I just wanted to point out that just getting a 51 doesn't necessarily mean that that person is not a Medicare beneficiary. You have to be confident in the data that you've submitted before you can draw that conclusion.

John Albert: And as a reminder, those data elements are the first initial of the first name, first six characters of the last name, date of birth, gender and a corresponding either HICN or SSN. The HICN or SSN must definitely be valid, but three of the four of the remaining first one characteristics must also match to that HICN and/or SSN, yes on our database to confirm the match and that again comes straight from the security enrollment database, which is our official source of you know – because they handle enrollment for Medicare, but that's the official source of beneficiary identification. Again, if you flip the first and the last name around, you're most likely not going to have a match, because you miss two of the four other characteristics though.

Again, check your data, because a lot of people assume, oh I got a 51 and (inaudible) and we want to stress that if you really do think they are, but you don't get a match, chances are you probably need to investigate first instead of validate that the information you submitted wasn't in fact accurate to begin with.

Pat Ambrose: OK, thanks John and for the record, when we say the word HICN, that's H-I-C-N, which is the Medicare Health Insurance Claim Number.

John Albert: Sorry about that.

Pat Ambrose: Quite all right. I just – sometimes when you read the transcript, things look a little strange. Lets see, some other changes actually that are coming up, that we talked about previously on these calls, in the July, our field day July release, which will be implemented on July 11, 2011, we will be posting that list of valid ICD-9 diagnosis codes out on the section 111 COB secure Web site, under the reference materials menu option. This is a file that reflects taking the text files off the CMS Web site of valid ICD-9 diagnosis codes that are posted for providers and suppliers.

Those – and the link I won't read, but that's in the user guide and we take versions 25 through 28, obviously, drop the duplicates, keeping the most recent description. Drop any codes that begin with the letter V as in Victor and drop any codes that are on the excluded, the list of excluded ICD-9s in the section 111 user guide and that results in than what we refer to as the ICD-9 diagnose codes that are valid for section 111 reporting. So this file will be posted on the COB secure Web site under the reference materials menu option as of July 11, 2011.

Direct Data Entry will be available for all our use that opted in to that reporting option as of July 11, 2011.

John Albert: Was that as worked on.

Pat Ambrose: At least by July 11, if not before. Yes, I think we've announced previously on these calls that if there is an RRE that would like to participate in a pilot that's been ongoing for Direct Data Entry that they should contact the EDI department, that it would not be a problem to add additional RREs to the pilot process.

Now that pilot process is in the production environment, so you must be submitting production claims. There is no test environment or ability to submit test claims for Direct Data Entry and no testing required, so – at any rate.

We have a fix going in also. For some RREs we see an error that was not documented in the user guide, namely the SP32 and this occurred when the ORM termination date equals the CMS date of incidence under a certain circumstances, that that (crash) will go in July and as stated previously, RREs should just resend those records that they received in SP32 on. That was a system issue on RN.

As I mentioned before if you received either a disposition code or an error code that is not documented in the user guide. You need to contact your EDI representative immediately and provide information about that. Generally speaking, there have been things that we've had to tweak in the system since this was a new process for us. Some of those errors are coming back from a system that we interface with.

We're also making a correction to the CJs. There are seven error codes. That is the error code that is triggered if the TPOC amount, that's T-P-O-C. The TPOC amounts do not – on the claims submitted do not exceed the interim reporting threshold. There is no TPOC interim-reporting threshold for no-fault insurance, however the system was applying that threshold to no-fault claims erroneously and that's the fixed.

As always – Oh another couple of things that are being added. This one I don't have as much information on, but we're adding a new threshold here and this will only be triggered if the total TPOC amount on a claim being submitted or the no-fault insurance limit being submitted exceed $100 million and that should be a highly unlikely scenario and we've seen some erroneous entries on those fields and obviously, that could cause some problems and particularly the MSPRC and their recovery efforts and so on.

One thing that I want to point out about all the dollar fields in the – on the claims input file, is that the last two positions are to reflect a sense, the digits after the decimal point. So if you are – and there's examples of this in the user guide. So please be cognizant of that fact that we're asking you to submit dollars and cent positions in those fields. Obviously, no decimal, but there is an implied decimal so to speak. So please review those examples and make sure your utilizing those fields properly.

There is a default also I should state, because if I don't someone will probably remind me later. The no-fault dollar threshold, there is a default value for that of all 9s. You may put in all nines and all zeros when there is no such default and obviously, we're not going to trigger this new threshold for that.

At any rate there should be no programming necessary on your end. It will be the same threshold e-mail that will be triggered, the file will suspend. You don't need to contact your EDI representatives and talk about the situation. I expect this will happen once in a blue moon. It should not be a frequent occurrence, but at any rate that is planned for July release and more information will be provided in the user guidance or what.

We're also updating our password rules for the COB secure Web site. This is our CMS, HHS government federal security regulation, very official stuff we have to adhere to. I know I should not make fun of it. It is serious that we adhere to these security standards.

So the next time, you as a user of the COB secure Web site when you need to change your password or require to change your password, either because it expired or you chose to change it, after the July release, after July 11 you'll be held to these new standards, which are not particularly onerous. I won't go to them, but the user guide, rather the COB secure Web site user guide and help pages will be updated to give you guidance on that.

OK, I do have a couple of questions that I would like to cover, that were submitted to the resource mailbox and they were technical in nature. The first had to do with – it's really one that I answered already, whether there's an ability to go into the DDE system with sample data to practice so to speak or test out the Direct Data Entry and know that is not possible.

The direct – there is no test environment available for RREs for Direct Data Entry, however I think your going to find it very simple to use and intuitive as well and of course this person didn't know that they have taken the computer base training, the CBT modules for it, which is wonderful.

You will note that as your entering claims with Direct Data Entry, you're able to enter the information and save it and not submit it to the COBC until you're fully comfortable with what you have entered. So possibly that feature of being able to enter and say prior to submitting the claim will help you in particular.

Let's see, there was a question about dealing with driving an ICD-9 diagnosis code. This came from a workers compensation plan or ensure who has – is trying to report on some rather old workers comp cases, but they are required to report since ORM is still open and ongoing and the ICD-9s that they have on the claims that were submitted years ago by providers to that work comp plan, are ICD-9s that are not actually balanced for section 111 reporting. They are not on the version 25 and subsequent. So they were asking what they should do.

They don't think they'd be successful going back to the physician that submitted those original medical claims and they are probably worried about that, and there is no need to do that. What the RRE should do is convert those ICD-9 themselves to a valid code or select – go to the list of valid ICD-9s and select current valid codes that are acceptable for section 111.

You do not, you are not limited to reporting ICD-9 that come in on medical claims that are submitted to the RRE. The ICD-9s are there, that is one valid way of driving them, but they are really there for you to describe fully the illness, the nature of the illness injury – of the alleged illness injury on the claim report. So you may just go through the valid codes and select one that appears to be applicable to the illness or injury associated to that claim.

Another question came up, where an RRE has claimant – has a claimant one information to submit. The Medicare beneficiary who is the inter party is deceased and there is another claimant, an additional claimant that is a family member, but this family member happens to be born in Venezuela and does not have a social security number, therefore they do not have a tax, an IRF tax identification number or an SSN that can be supplied.

So my suggestion to you in that circumstance is either to plug that 10 seal with all nine. I think that will get past the edit, requiring that the 10 for a claimant be a numeric nine digit number or don't supply the claimant information at all, but that's probably not the best thing when it comes to recovery, I think the MSPRC would like to know about this other claimant, but if your unable to provide the required field, provide the claim report with just the beneficiary or inter party information and not the claimant one information, that's what I would do.

Another question came in about the valid ICD-9 codes and this question pertained to the codes that start with the letter V as in Victor and this RREC is the V codes on version 28, on the CMS Web site at – you know on those lists of ICD-9 diagnostic codes that are posted by CMS for providers and suppliers that submit Medicare, claims to Medicare.

First off, we don't use those files just straight, unadulterated. So you need to read through section 11.2.5 of the user guide, which talks about the codes that we exclude. From that, those versions out on the CMS Web site, we have certain exclusions for section 111 reporting. So again, and specifically we exclude the V codes and the codes that are in appendix H and if you look at the verbiage in appendix H it also indicates that we didn't list all the V codes there, but they are assumed to be excluded.

Now we can advise on a specific code that you should use if, instead of or in lieu of V codes, but there are definitely E codes, codes that begin with the letter E, that you can use in the event of exposure. This individual was talking about particularly I think about the field 15, the cause, the alleged cause of illness or injury.

The other thing that I would suggest is that you take a look at the computer based training modules for the ICD-9 and then as we stated previously on these calls, a default or an E code that you could use in the case of or the event of exposure might be E0008, E0009, there is also some general accidents E codes, E8498 and E8499 that you might use as well if your having trouble finding an E code. So hopefully that provides you some information related to that.

Another question came in about, an ROE was just acquired, some addition companies and how do they go about reporting for those companies that they have just acquired? This kind of depends on your – how your going to report your claim input files. If you already have an RREID and these companies are actually subsidiary companies, then you may include the claim reports for those newly acquired companies under that existing RREID.

You may use the parent company's past identification number in field 72 and on the two reference file or you could use the subsidiary test identification numbers. I encourage you to review section 8.3.2 and in section 2.2 step 2 where it's talking about setting up various RREIDs in determining your reporting structure. So you don't necessarily have to set up a separate RREID. It really depends on your reporting structure and whether these acquired companies are subsidiaries, etcetera.

OK John, that's all I have from my presentation.

John Albert: Do you have anything? No. OK operator, we can open it up to question-and-answers. Again, please limit your question to one and one follow-up and if you have more, please jump back in the queue to give everyone at least one chance at the microphone.

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

And your first question comes from the line of (Bonnie Mustard) from Farmers Insurance. Your line is now open.

Bonnie Mustard: Thanks guys. Actually I should have taken myself off. I think you addressed my question. I was going to ask about the SP32 and I thought I had heard that there were other area codes, but I think you indicated that that's going to be updated, so thank you.

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

(Susan Kornblit): Hi. We had issues with the response file that we received and I sent the question to our EVI rep and we got a response yesterday, but I still there is something wrong. We had identified four – at least six cases. Four of them are for the claimant, where we got an 01 in the query response file from last September, OK. When we submitted these claims in our initial claim input file, all these cases got 51 that was the same data that was submitted. Hello.

Pat Ambrose: Ah yes, we're listening.

(Susan Kornblit): Yes well, I nearly passed out when I saw this and this is only some of the cases that we got 51 and I mean, you know we didn't go through all 250 cases, but four of the cases where the same claimant has got all those same matching data on it, the same in the query and the same in the claimant file.

Now the answer that I got on that case was, this members entitlement ended November 30, 1981 and our system was updated. But the thing is, the claimant is now – was born in 1950, would make her like 61. The queries that use Medicare eligible. If her entitlement ended 1981, that's 30 years ago. I don't – that doesn't make sense.

Pat Ambrose: Well, it's possible for people to be entitled to Medicare for reasons other than age.

(Susan Kornblit): Right. But the thing is we got the 01 in the query. Are we going to get an 01 in the query and a 51 in the claim response if anything and if it followed the rules of what we have in the claimant profile, it should have gotten an 03, not a 51.

Pat Ambrose: Yes, correct.

(Susan Kornblit): Now, I don't know how many of these cases that we got back that this applies to, but the answer didn't make sense and I don't know what to do, because we here, we're telling our people if we're sending it in, in the claimant profile that means we for a match OK and we want them to concentrate on identifying what's wrong, but here everything is correct, it matches what we got in the query.

Pat Ambrose: OK, so first off we made some changes in the October, November timeframe in our query matching process and compared to the claim matching process and what this decision codes might be returning. So that is – that can explain some differences that you might have seen in the past.

Secondly, since the query is taking place at one time and the claim submission is taking place at another time, there are circumstances where information on file for a Medicare beneficiary unfortunately could change. We have no control over that, but that could happen. Now it's really not – your particular situation is really not the most horrible situation and that you still need to be prepared to handle a 51, this decision code on your claim response file regardless of what you got on the query and that is regardless of whether we have a system issue with the matching or not.

(Susan Kornblit): Right, because I don't understand what that means.

Pat Ambrose: Well, I'm going to tell you.

(Susan Kornblit): OK.

Pat Ambrose: What you need to do when you get a 51 back on a claim report, if the claim reflects ongoing responsibility from Medicals that remains open, the RRE still has ORM, you have to continue to monitor the status of that Medicare or of that injured party.

(Susan Kornblit): Right, we know that.

Pat Ambrose: OK.

(Susan Kornblit): But the answer is – but the question really is we're sending the same data element and we're getting a 51 saying that the claim was not identified as a Medicare beneficiary when in the query it was.

Pat Ambrose: I understand that, I understand that, but I believe in part there is a timing issue between when we put in that change to the matching versus when you submitted your claim file and I do apologize for that.

(Susan Kornblit): Well, will that change though?

Pat Ambrose: Well, you might – I don't, I can't say off the top of my head, I didn't quote it so I'm sorry, I'm not prepared, I'm not prepared to answer it in detail, but it really, it doesn't matter. As far as the actions that you need to take and how do you need to program your system, you need to continue to either send queries for that individual and then when you receive an 01 send a claim, you know following the directions for a 51 disposition code in the user guide. I mean it really is as simple as that. You could also alternatively just continue to send the claim, but that might be more of a…

(Susan Kornblit): Because allegedly we have the same data that the query response returned to 51 on.

Pat Ambrose: Well, I mean, have you resubmitted a query on this individual lately?

(Susan Kornblit): No, because when I resubmit if I get an 01 and even in the user guide it says we don't need to resubmit an 01, because we'll always get an 01.

Pat Ambrose: Right. Another option that you might have would be to go out to the COB secured Web site and use that beneficiary look up.

(Susan Kornblit): That's not working and I sent that into our EBI rep April 7 and I just checked mail and it's still not working.

Pat Ambrose: All right. Well, to make things simpler. I mean, I know you called in before and you've had your questions and we did follow-up. I know for a fact that your examples were examined and that information was provided to your EBI rep that was supposed to be provided back to you, I know that all occurred. I hear you, I understand that your not happy with the results and the information that I'm giving you now, so what I'm going to ask you is if you could give me your RRE Id, I'll make sure personally that we follow up again with you subsequent to this call, because there is really nothing else I can do right now.

(Susan Kornblit): OK, well here's – can I just give you one other response that we got with the situation. You know the other situation is four cases for the same claimant and another case it said, this is the same situation where we got the 01 in the

query and a 51 in the response with the same data. It says this numbers record was updated April 2011, no entitlement exists for the member. Looks like you want me to contact the member and have them get in touch with SSA and have them correct their record, but it's the same information as in the query again. I don't understand that answer.

Pat Ambrose: I mean, again I think most of those examples had to do with the timing of your query and your claim. I'm really going to have to ask you to give me your RRE Id and we need to move on to another caller. Thank you.

(Susan Kornblit): All right. You want it now, it's 18493.

Pat Ambrose: Thank you very much and we will get back to you.

(Susan Kornblit): OK, thanks.

Operator: Your next question comes from the line of Larry Sundeen from Fara. Your line is now open.

Larry Sundeen: A question about SFTP. Part of a committee with IIBC with a lot of our peers representing hundreds of RREs and we're still seeing problems with this FTP slowness. Sometimes files vanish from your servers after we have screenshots and confirmations of transmission and occasionally we're seeing incomplete file transfer.

So basically I'm just wondering, do you still have plans for improvements? I can say we have seen some improvements. We used to have an issue with folders not being created right after this RRE was put into production. That seems to have been resolved, but these other issues seem to linger.

Pat Ambrose: Yes, I can speak specifically that we do have some modifications going in. The July release, this coming July to assist us or to correct issues that we've had with file transfer and moving files from the SFTP server to the COB system and things of that nature.

We also have an ongoing effort to beef up so to speak, the infrastructure behind the SFTP server in the entire Cob secure Web site infrastructure. So

there are steps being taken. I assure you that it is not until, until this FTP process is running smoothly and efficiently and reliably, these efforts will not cease, but yes, they are – there are some activities currently underway to improve the situation and as you noted, some improvements have been made, so you know we're happy for that.

Bill, did you have something to add to that?

Bill: Hi, this is Bill Becker everyone here at CMS. I just wanted to add that CMS is also aware of the same issues that you raise in your questions while here and we're also working with the COB contractor, very closely to get these problems addressed as quickly as possible. It's the main interface between the RRE reporters and our data systems and we do as you do, want to have it functioning as smoothly and as efficiently as possible. We are doing the best we can with our contractor to make sure that there aren't any glitches and to minimize those that we do find.

Larry Sundeen: Well, thank you. Sounds great.

Operator: Your next question comes from the line of (Ellen Iqbal) from (Chaban Fund). Your line is now open.

(Ellen Iqbal): Hi, we have an issue with our first response file, where we had a – one record that had a decision code of 50. We kind of worked through it with our EBI rep and the manager and he kind of gave me a fairly good explanation of I guess how the records get processed, but my concern was that the user guide says this should be a rare occurrence and our filing we have 347 records in it. So I guess I'm a little baffled about why that would happen. Plus this particular record, there was two or three other records for the same claimant that did get processed.

Pat Ambrose: Right. I'm not sure of the particular circumstances you have here, but there are – I'm not surprised to hear that you – for the same inter party you might have claims that complete, claim reports that complete successfully and others that get held up.

I guess maybe I need to adjust the language in the user guide to say it's not rare so to speak. But I – you know I thought it was going to be and I would appreciate and I do appreciate your feedback on it and I would encourage RREs and agents that are seeing this – you know to provide that feedback, because I think I need to understand it a little bit better personally, so that I can describe it better in the user guide and I'd like to know you know of the frequency and so on.

So and you know that language saying rare, I guess is a not well defined or a very specific term. So maybe I can try and get some better statistics from our development team about how often you might see it, so that it's – you know we don't raise a red flag when we don't need to.

Could I take you RRE Id, so that I can follow-up with the COBC?

(Ellen Iqbal): It's 18282.

Pat Ambrose: 18282. So and that way I can follow up and see what the circumstances were behind your particular report and also as I mentioned earlier on this call, I have updated the user guide to ask more information about what to do in a circumstance of getting a disposition code 50, but I'd still like to believe that it doesn't happen that frequently.

(Ellen Iqbal): Yes, because I was totally surprised, because like I said, I consider 347 records a small file and it took them actually more than the 45 days to get the file back to us. Even after 45 days, you know the one record wasn't processed yet.

Pat Ambrose: Yes, I hear you. OK.

(Ellen Iqbal): One other quick question. I know you were talking about a change to the password, is that a format requirement change that's effective in July. I missed part of what you said.

Pat Ambrose: what do you mean format.

(Ellen Iqbal): You day that after the July release there is going to be some sort of password requirements or…

Pat Ambrose: Yes, this is for login IDs on the COB secure Web site that you use as a user of the Web site as well as for SFTP transmission. And as you know you have to keep those passwords up to date or you know current, they have to be changed ever 60 days. And the next time you go to change your password; the requirements will be slightly different than the current password requirements.

(Ellen Iqbal): It doesn't mean like it has to be a certain number of letters or numbers of something like that.

Pat Ambrose: Yes, yes it is the matter of; you know a mixture of various characters, the appropriate mixture of various characters and so on. I don't have the requirements right in front of me to know exactly what they are, but they are not anything – I did review them and I didn't see anything that's going to cause you a problem. You have to update that password manually anyway so.

(Ellen Iqbal): All right. And that's another issue we have. Is there any way that the ability to change the password can be automated, because this requires manual attention on our part.

Pat Ambrose: No, I'm sorry.

(Ellen Iqbal): It causes us to not be able to truly automate our submissions.

Pat Ambrose: Yes, I understand that. It's a government – a federal you know security requirement. If you, for other Medicare related systems if you are SFTP you have the same requirement to maintain your login ID and password in a manual, so called manual fashion. They just don't allow the automation of updates to a password, at least not at this time. So you know we can't allow it, we wouldn't get our security authorization and be allowed to function or operate.

John Albert: Those are federal IT security requirements. You know, as you read in the news everyday, I mean that's the reason why those get ramped up higher and hither ever year because of the data we are dealing with and …

(Ellen Iqbal): I realized that, it's just. It almost would be more secure if we can let our system do the password change so that a person didn't have to do it.

John Albert: And I am not going to disagree with you on that.

(Ellen Iqbal): OK. That's it. Thank you.

Pat Ambrose: Thank you.

Operator: Your next question comes from the line of (Nickie Lohan) from (LWCC). Your line is now open.

(Nickie Lohan): Hi, our question goes back to the same issue as the person from New York had earlier. We had four claim files that came back with the Disposition 51 after come back as a 01 on our quarry file and we actually did what you suggested, we used the beneficially look up as well afterwards. So we had the quarry file with Medicare eligibility, the quarterly file showing the Disposition of 31 and then afterwards the beneficiary lookup which did return a hick in number to us implying Medicare eligibility.

So what we did was we took copies of those records and screen shorts of the beneficiary look up and sent it to our EDI rep, is that the proper next step since we could not resolve it ourselves and we confirmed the data matched exactly.

Pat Ambrose: Yes, ma'am that's exactly right, far more effective that reporting it can be on this call. Yes, and your EDI rep will follow up in that kind of factory fashion, and if not there is an escalation process in the user guide.

(Nickie Lohan): And the only other question I have is our next quarterly file is due in about a week and a half from now. If we don't have a response back by then, is it safe for us to just resend those four claims as adds just out of a precaution.

Pat Ambrose: Not only safe but highly recommended.

(Nickie Lohan): OK, that's what we will do thank you.

Operator: Your next question comes from the line of (Wendy Rader) from State Compensation Insurance Fund. Your line is now open.

(Wendy Rader): Hi, I am calling – I don't know if this is a policy question or technical question. I tried to ask it last time but somehow they star one didn't get me into the question queue last time. So, the question has to do with when you are discussing multiple injuries being reported in a single record for TPOC and the user guide – to me I understood that as requiring a single record per injury.

But now we have this new idea of multiple injury per record in the claims input file. And so I wouldn't know does that also apply to ongoing ORM report. Can we, I mean if we have situations were we had more than one injury but we only made up one claim. Can we report both those injuries on that when record in the CIF?

Pat Ambrose: Yes, I mean the claim reporting is to be done by entered part of Medicare beneficiary, by policy, by insurance type meaning no fault, workers compensation versus liability by policy number, by claim number. So we are making the assumption that you know if you are taking it down to the policy number, claim number and insurance type that that you know essentially defines the unique situation. It is not by injury.

We want you to submit all the injuries ledged injuries related to that claim that are you know in the case of TPOC or some as our claimed and/or released by that TPOC and then on the ORM you are to ask that leave to report on all the injuries, all the alleged injuries for which the ORM is assumed. So example, workers comp and then employee who is a Medicare beneficially is injured on the job, they break a wrist and they break a bone in their back. I don't know.

So there is two injuries, you have one brokers comp claim, the same data of incidence, the same obviously injured party etc bout and let suppose in that circumstance you assume ongoing responsibilities from medicals for both of those injuries, you would report one claim record, but with at least two diagnosis codes to describe the broken risk and the broken back.

(Ellen Iqbal): But normally we do make up a separate claim file for each injury and so that's the way were normally reporting these things even though you know it may, all those other things are the same but.

Pat Ambrose: Normally for Section 1011 or normally for some other reporting.

(Ellen Iqbal): Well, normally for our, we make up one claim for each injury and that's the way we have been reporting them. And we don't combine them into one record unless you know they are not separated into separate claim spreads, our own separate claims.

Pat Ambrose: When you say claim; that is your claim in your own shop. Well technically you are to report by claim. So if you have different claim numbers, you know we would be expecting two different reports.

(Ellen Iqbal): Right. OK.

Pat Ambrose: But I think we have another.

Male: Question, what are you defining as a claim. Are you talking about a specific diagnose code.

(Ellen Iqbal): No, there would be – it would be a particular injury that occurred and that may have caused several diagnosis codes in the same injury.

Male: OK, so basically you are saying, if there were three core diagnosis codes associated with the injury to a particular incident you are setting that up with four separate claims.

(Ellen Iqbal): No, that's not what I meant. What I said is, OK lets say a lot of times what happens in California as we have a specific injury alleged on a day when something happened and then they will also file a continues trauma claim for the year before that injury, before that specific injury. And so we do make those up as separate claims in now, but at various points in the past they may have been made up as one claim. One claim number for both of these alleged causes of action.

Pat Ambrose: Yes, I mean however you set it off, is fine and then report them and then report it accordingly. I mean we do not want you sending separate Section 1011 claim report, claim report record should I say, detailed record for ever separate injury just you know, if they are on the same claim in your shop then submit one claim record with multiple injury.

John Albert: I hat the example you mentioned, what did you use it to date of incident.

(Ellen Iqbal): We would have used the specific, because when at the ET we used the ending data of the ET as the date in entering. So they would both be the same. And I would …

John Albert: But you said, you said – OK, I guess here is where I am stating to get a little confused again. You said, lets say an incident occurred July 1, 2010 and then they later came back and said there was something that proceeded that beginning July 1, 2009.

(Ellen Iqbal): Right and all during that year before.

John Albert: OK, so they are all on the same calm form which year or data are your referring, 2009 or 2010?

(Ellen Iqbal): Well, for us are on two separate claim forms.

John Albert: Yes say the past they did it as one.

(Ellen Iqbal): Right, they would have – two separate claim forms or we would might have put them in one file because they both had the same data of entry in our system.

John Albert: But the date of, what did they did, are they aligning a separate entry type, just the July first 2009.

(Ellen Iqbal): Well, yes they ask specific injury would have been something that, you know the think acutely happened that day, where as the continues trauma injury, they are saying it happened gradually over a period of time proceeding that.

John Albert: OK, but then the earliest date would have been the date that they side, the progressive injury started.

(Ellen Iqbal): Right, that's your defiantly of data of incident, but our definition.

John Albert: But, yes you have to use our definition.

(Ellen Iqbal): Right, right I understand that. So in the case where we have both of those in one claim file we would have to use the year at the beginning of that as your data of incident but for our data of injury, we would both have the same data of injury for us because there is two separate files in your file, your claims input file.

Pat Ambrose: Where you just talking about the CMS data of incident and the injury. I mean the industry data of incidents.

(Ellen Iqbal): Well, yes, I was trying to draw that distinction because that's why I think, you know.

Pat Ambrose: You know what, we don't even want the industry data of incident. I'll just be blunt about that, the only one that counts for anything at all is that CMS data or incident; they give you in that claim. So if you are struggling and trying to figure and modify your reporting based on an industry data of incidents, that's an optional filed on that claim detailed record, I am going to tell you that it is FYI informational, it does not even get used once you have submitted – once you submitted that claim records. So ...

(Ellen Iqbal): OK, so my only question had to with making sure that, you know it was OK for us to combine, you know different injuries into the same claim file and report it as one for you.

John Albert: But you had to use the earliest data using our definition of data of incidence.

(Ellen Iqbal): OK, yes I got that.

Pat Ambrose: OK, great.

(Ellen Iqbal): OK, thanks.

Pat Ambrose: Thank you.

Operator: Your next question comes from the like (inaudible) from Terrebonne Parish Consolidated Government. Your line is now open.

Female: Good afternoon. My question has to do with sending quarry files after your interdiction, and its specifically on the threshold limits of the number of the records you have to send in keeping in mind that we have to keep sending in any ongoing open claims to keep rechecking then for possible submission to CMS.

I have a little bit of conflicting information on confused list, last time we submitted a quarry it sale for exceeding a 100 records threshold but on the computer base training it said something about 200 records and if that is the issue and you have to continue submitted all open claims, there are some instances where you may have more than a 100 records in a quarter or a mass to submit in a quarry. Can you kind of clear that up for me?

Pat Ambrose: I think I can. The quarry file is only limited to 100 records in a test environment. So when you send a test quarry file your limited, but a production quarry file does not have that limitation.

Female: OK.

Pat Ambrose: Also, and the 200 versus 100, the test claim inputs file is limited to a total of 200 detail in auxiliary record. We bumped it up because of that; you know there could be two records per claim report. If you are using the auxiliary record, so for text claim input files they are limited to 200 detail an auxiliary records. For test, the quarry files are limited to 100 quarries and in product there are no such limits.

Female: So in product, if I sent a product quarry it should not have any threshold limits.

Pat Ambrose: Right. Now you can only, the only threshold is how often you send it. So production quarry file can only be sent once per month.

Female: Correct. OK, all right that explains it all. I appreciate it.

John Albert: I guess the main thing is to make sure that you know you inform (COBST) that you are ready to move into product environment so that you can do the quarry, you know above and beyond.

Female: Right, and we are already in product.

Pat Ambrose: Its actually true that you are in a testing status you can send product quarries. Both production and test quarries and test claim files. Obviously, you can't send a product claim file until you are in product, but that's the deal.

Female: OK, all right I appreciate it. Thank you all so much.

Pat Ambrose: Your welcome.

John Albert: We don't even require a test quarry.

Operator: Your next question comes from the line of John Miano from Golden Lamb. Your line is now open.

John Miano: Good afternoon everyone, John Miano. Just a couple of quick questions for you, Pat back in February you'd identified ICD-9 as the, probably the most frequently encored rejection error.

Now that we are done with the first quarter of reporting, are there any statistics available with regard to say for instance complaints percentages or anything having to do with most frequently encounter ours. Because there is a lot if information flying around out there in the industry, and I don't think that it came from CMS.

Pat Ambrose: You know we have not released any statistics regarding frequency of errors or rate as compliance or that sort of think. We certainly are looking at the data and we certainly have that information available, but it is not being shared.

John Albert: Its not something that we would generally share, just because again you know everybody has their own interaction with CMS and we don't even want to be put in the position of appearing to share data with the public regarding the

success of one particular, RE or insurance type things like that. But I mean we look at that data.

John Miano: Is their overall…

John Albert: Certainly is – and do outreach according to – that's to develop new materials, guidance, outreach etc so.

John Miano: Because I mean at a recent risk management conference, there was someone advising that the overall industry average rate now was only about 20 percent.

John Albert: We don't even know what that means.

John Miano: The insurance, the acceptance to claim into files.

John Albert: That's (inaudible).

Pat Ambrose: That is completely unsounded.

John Miano: Yes, that's right.

Pat Ambrose: And I don't know where they got that information, but not from CMS.

John Miano: Right. Good, good. I through that was the case but I wanted double check. And the second question I had, back in oh gosh! Probably about two or thee weeks ago, we got no response from our EDI, one of or EDI representatives advising us that there was system error that occurred that cause a number of REs to revert back to the setup status. I am assuming that's being resolved, but is there a way of obtaining a listing of those REs that may have been pushed back to setup so that we can pursue the correction or have they already being reached out to individually.

Pat Ambrose: I am not familiar with that satiation at all. So I can't say, what I would say is make that request of our EDI representative and escalate it up the chain as necessary.

John Miano: OK, very good. That's all I had.

Pat Ambrose: OK, great.

John Albert: And none of us here are aware of that particular issue, so hopefully it was resolved.

John Miano: All right, thank you.

Pat Ambrose: OK.

Operator: Your next question comes from the line of (James McHull) from (TTNE). Your line is now open.

(James McHull): Hi, I wanted to add on, I got disconnected somehow in the middle of that call, that was talking about the two injuries being handled on the same file. My question is similar to that, in that you could have an employee who has an attorney who makes files may be 12, 15 applications for various dates of injury.

It's a short gun approach to litigation. As the case moves along there is one file that's considered a master file and when the case is settled and ORM entered into the master file is designated as the file that will provide future medical treatment on there. I am mostly referring to cases that are legacy cases; you know 30, 40 years old. That's all we have as the master file.

Pat Ambrose: Did you say that.

(James McHull): And so our intention is to report every body part with a external cause cord for each claim that was made and then ICD-9 diagnosis codes for each body part that was excepted, but we intend to use the master injury date for the recording purposes, because we simply – we don't even have those all, what we would refer to as companion files.

Because all they were were shelves that was set up had a claim number, they had a data of injury. Now money was ever paid on them and they were merely closed and dismissed most of the time – legally dismissed but not always, just a convention of how claims have been handled – future medical claims are handled.

(John Albert): OK, but the question them becomes, I suppose you what ever you chose as the master file was picked on July 1,2010 but there were 50 claims filed for dates prior with injuries. What are– would you assume any responsibility for those injuries or just injuries that occurred after July 1, 2010?

(James McHull: Well, the stipulated agreement, which is what's called an award issued by the judge would outline the body parts that were accepted and that ORM has been agreed to.

John Albert: Wasn't these of the body parts that were excepted, injured prior to the date that you are claiming this master liability file was created.

(James McHull): Well, in most cases, before that data, there was no treatment asked for or given, right. An attorney meets with the client and interviews him about his like history, about his life work history.

John Albert: My records ask you to report it, the date of injury – the first date of injury when it occurred. That's why I am asking if there was an injury that occurred, in January 1, 2007 and you ended up assuming responsibility for that injury. And you would report the date of January 1, 2007 with respect to that injury.

Now if you're dealing with injuries both before and subsequent to the date of your master file, then I would think if you only wanted to reported one date you would have to report the date, as the earliest set of injuries for whom you have fulfilled responsibilities.

(James McHull): Right that would make sense; I don't have an issue with that.

(John Albert): But then you're just telling me that may not have been what you have done, because if you ask the file which is has been on a later data that's the date you are using in reporting.

(James McHull): We haven't done anything because we're still testing, but I am just trying to point out that there is a fact of life out there that you are not going to have other dates, you're not going to be able to get them, right because what was filed the data of injury was the span of employment. From April 1, 1961 until June first 1985, that's the data of injury that was claimed.

(John Albert): OK, so then you will use that first date.

(James McHull): So the date of injury on the final settlement document is what we would use, because the settlement document is all that we have. We don't have those prior pleadings and couldn't, and they wouldn't be usefully to Medicare anyway even if we had them. Because it wasn't a situation where someone stated treating on that date, right they are just trying to capture any possible date during a period of employment.

John Albert: How can you be sure that they haven't received any treatment that Medicare paid for prior to the date of your master file?

(James McHull): I couldn't say that, but these are people who have insurance who wouldn't be getting Medicare in the first place.

John Albert: Well, you don't know that. You don't know that.

(James McHull): No, I do know this.

John Albert: … somebody would have billed Medicare rather than the other insurance because the other insurance told them to do so.

(Male:) I mean, that's why Medicare – that's why we require that earlier date, because again Medicare may have paid an awful lot of claims before them and that's you know the date that we define as the Medicare, you know the date of incident as defined by Medicare, not by you know any other.

(John Albert): Well, you already said, you already made a ruling (inaudible) trauma that it's the date, its not the date that's prepared, it's the date that the person started needing treatment for that condition. Even though the date of injury is spread is a 30-year span, so which one do you want.

(James McHull): How do you what are the bases for your statement that the person never received treatment for the last injury prior to the date.

(John Albert) Because they denied that they had treatment, if they had other treatment we would have gotten those records and we'd be trying to push it off on to Medicare.

Pat Ambrose: Well, may be.

John Albert: Well, may be somebody did push it off, either back here that's what we are trying to discover.

(James McHull): We're talking about a self-insured employer here. So (Cross Talk) using their health insurance or they are falling under workers comp. It's not a situation where they are not insured, so they wouldn't be going to Medicare.

Male: (Inaudible) technical question.

(Male): Hey, listen. I'm sorry, but we don't have all the people here that we we'd like to have for this particular discussion, because this is getting into more policy – as a policy enrolment and we want to give the other folks on the call a change to get their technical questions answered. Obviously, we can continue this discussion at a later date. We have future upcoming policy call in about two weeks or so. But we are going to have to move on with this, because again we are trying to get the technical questions answered today.

(James McHull): So technical refers to what, computer related?

John Albert: Yes, or just how.

(James McHull): Or technical in terms of the claims.

John Albert: Well, technical in terms of who the, you know how the record is completed and filled out and then the other technical support issues related to interface with CMS.

(James McHull): All right. Well I didn't understand that, I apologize.

John Albert: No, that's OK, because I mean its – (inaudible) there is always kind of a blend on lot of these questions anyway. We don't have all the right people here to engage in this particular discussion. So.

(James McHull): Well, it is a huge issue because we will have to address it somehow.

Pat Ambrose: If you – I know that the previous caller on this topic submitted a question to the resource mail box, if you haven't done so, it would probably be a good idea for you to also. And then it is more likely that it will addressed on that policy call coming up later on in May.

(James McHull): All right.

Pat Ambrose: OK.

John Albert: Thank you.

Operator: Your next question comes from the line of Kathryn Dominquez with Mitchell International. Your line is now open.

Kathryn Dominquez: Thank you. Good afternoon. I would like to ask a question about the way that we receive notification from CMS regarding savior and threshold air reports. I know possibility in past somebody has discussed the fact that the e-mail going to the account manager isn't always adequate or appropriate.

And has their been any more discussion on those e-mails possibility going to account designees and admission to the account manager, because people go in vacation, people are out sick, people have problems go on sick leave etc and also the fact that an e-mail is not the easiest thing in the world to automate where some kind of response file would be much more appropriate to tell the computer system that hay we got your fine and there is problem with it, or yes we got your file and everything is OK.

Pat Ambrose: Could you hold on a minute.

Male: Hey, this is CMS from back, all we can do at this point in time is take your request under advise, but it is something that we actually have something

opened up to look at. So, we don't have definitive answer to give you at this time.

Kathryn Dominquez: Wonderful, if you need any background, or anything I would be happy to help to help out.

Male: OK, thank you.

John Albert: A lot of people would.

Kathryn Dominquez: OK, thanks.

Operator: Your next question comes from the lien of (Evita Griffith) from Brown & Brown. Your line is now open.

(Evita Griffith): Hi, my question also is regarding the threshold error that comes. I guess, well I am speaking from a point of, a little bit of a frustration event and I have discussed that with a few of our EDI reps as well. We are agent from multiple ROEs and sometimes we are getting the e-mails that are coming back that the threshold has been reached, although when I examined.

Well I can't determine exactly what might be the issue and sometimes or often times they, the trouble causes for the threshold air unlisted. So it kind of forces my hand to release that file thorough the ROEs, instead of the EDI reps knowing so well that its going to coat errors in that file. So I am really looking for some guidance what to do in that situation.

Pat Ambrose: So your file has been suspended for which threshold there.

(Evita Griffith): Sometimes I don't know.

Pat Ambrose: OK, so lets see. You have a user ID for the COBs secure Web site, right.

(Evita Griffith): Correct.

Pat Ambrose: And so you can see the status of the file there.

(Evita Griffith): Right.

Pat Ambrose: Your not, the threshold e-mails has a specific error message on it but since you don't get that e-mail you are not aware of what the issue is correct.

(Evita Griffith): No, I get the e-mail, but the cause of the error aren't listed in the e-mail. Sometimes they are, sometimes they are not and when they are not I am forced to just really have file released.

Pat Ambrose: Yes, I guess I am curious about that, because I though that you know like the 20 percent, a file that's suspended for more than 20 percent of the record to being an error, I though that the e-mail listed out actually error codes. Are you saying you don't see that?

(Evita Griffith): That's right.

Pat Ambrose: I'll have to go hack and check on that, that was my understanding, yes and so that you should actually you know see that and then of course there is other thresholds that don't apply to actually error cords but the threshold message itself should indicate why the threshold was triggered.

John Albert: (Inaudible).

(Evita Griffith): I've gotten multiples. I can gather up some and those e-mails and forward them if you would like.

John Albert: To your EDI rep I guess.

(Evita Griffith): OK.

Male: Multiple are, are any IDs the only one with the …

(Evita Griffith): No it's my fault, I have many.

John Albert: Yes, they are an agent.

Pat Ambrose: And dealing with that. Yes I am not quire sure of what, I mean at any rate though, what I was going to say and then we will figure out how we follow up. Your EDI rep should be able to provide information about you know what's wrong with the file. Now they aren't necessarily going to be able to

search though millions of records and say, you know record number 56 has this problem in this field but they should be able to view certain information. So, and help you though that threshold error, whatever it may be.

(Evita Griffith): Yes, it's not been the case. The answer that I have been giving on multiple occasions is that, they don't know until the file is released and processed what might be wrong with the file. So I am just, I've gotten – I have no information to get at that times.

Pat Ambrose: OK, perhaps if you could provide, here I will make this suggestion. In the user guide there is an escalation procedure and (Mr. William Ford's contact information is there and if you cold send him an e-mail directly and let him know that we had this conversation on the Town Hall call and that I recommended that he contact you and in that way we can get more information and to the bottom of it.

(Evita Griffith): OK, I'll get some information together and certainly e-mail him with that.

Pat Ambrose: OK, that would be great. And mention that you spoke to me about it and that you know, I'll follow up with him after that. Great thank you.

(Evita Griffith): Fantastic, thank you.

Operator: Your next question comes from the line of (Cindy Hall) with (A&E Solutions). Your line is now open.

(Cindy Hall): Hello. I actually had two questions, they are not necessarily related, but I will try and be brief as possible. You announced that you are going to be making a change to the versions of the new software, but one of the most common concerns I guess is that in the announcement you've indicated that there is no new data requirements really between the two visions. So, what's really the compelling reason to require us to upgrade to a new visions.

Pat Ambrose: CMS across the board is, had issues or indication that all systems and business partners, whatever at interface with Medicare with CMS using the S12, format have to upgraded to that 5010 version and that's all I – the only compelling

reason I have is that, it's a CMS wide requirement that also effects section 1011 so we have to wait here to that requirement.

It should be ever straightforward.

(Cindy Hall): It shod be, I think the only think that is just some, this is like – clearly in my mind is, if there is no change in the differences and there is no differences in the file while we have to be on that version. So, I'm just, can we anticipate. May be there had been a correct and if there is some variants between the data or anything.

Pat Ambrose: This, upgrade. Are you, like you are referring this upgrade to the issues that were brought earlier on the call with discrepancies with quarry file?

(Cindy Hall): No just that, you know we have the new version that everybody has to state using, you know in the near future that there is no difference between the file, all the data is the same. So why does everybody have to go to the new version, it just seems really strange that if there is no change on the layout and I just wanted to make sure that we are understanding that there were no changes in the data requirement.

Pat Ambrose: Well, the only chance, now we – I guess I shouldn't say categorically. On July 1 we will publish the companion guide for those people using there own S12 translator and that companion guide will tell you how to match those 270 and how we will math the 271 coming balk and it will note any changes that are made. Right now the only change I know is that version numbers going from 4010 A1 to 5010 A1, but I am not telling you that, that is absolutely the only chance until that companion document is published.

The key Hue thoughts were, you want have to do anything because it takes care of that for you. I can say for the Hue Software where those using the Hue Software inserted of their own translator, all you will have to do is as long as you are using version two of the Hue right now in the file labs, in the user guide that corresponds to version two, all you will have to do is download or obtain a copy of the version three of the Hue Software and install it and run it and that's it.

And I hear you, I don't know – you know you are not going to get a different answer. I am afraid that, like I said we are required by CMS to perform this upgrade and I cant give you any more information on it.

Pat Ambrose: I mean the standard quarry, quarry that are all that you know we use, does not use all the data elements of the 270, 271 users. But it should be transparent to your, the new version of the software that we will use and we will convert it into the correct new format that for you should be invisible.

(Cindy Hall): OK, all right. My second question kind of, I am really sure if its policy or technically that's walking that fine like, but I am going to go ahead and ask. In section 12.3.2, new document the threshold there is on when you are processing files and if a file exceeds 5 percent of the late, the file is suspended from further processing. If there any possibility of getting that percentage increase, because the low volume submitters that really can be an impermanent on their processing.

Pat Ambrose: Yes we do understand them and have received the question before the decision that CMS has made is that we are sticking with the 5 percent for the timbering and certainly will continue to look at the satiation and file coming in and reevaluate that, potential at a future date, but.

John Albert: Yes, I mean only because, I mean we – essentially for the (NJ) street files we don't really ever anticipate that to be any delete transaction to begin with, so that's just kind of a, you know a sales state for us to make sure that, you know people know what they are doing to begin with. It's a good change for us to talk with the ROEs and make sure there is not a problem of understand.

We realize obviously, for a small file that could be one or two records could kick that out but for now we have to stay with that because we have a long history of GHPs processes that predate second 11 by may years and that threshold has proven to be a pretty good indicator for potential issue.

(Cindy Hall): OK. Thank you for taking my question.

John Albert: But we will, as we do with everything we reevaluate these from time to time and surly once the section 11 NJ fee reporting becomes a little bit more fully implemented, we will come back and reevaluate it accordingly.

(Cindy Hall): OK. Well thank you for taking my questions.

Operator: Your next question comes from the line of Emily Cook with McDermott Will & Emery. Your line is now open.

Emily Cook: I have a question regarding total write-offs of all Medicare chares on hospital claims form risk management purposes. In those circumstances, is the hospitals required to submit a claim to Medicare reflecting the total write-offs or may the hospital instead submit the write-off as a TPOC report. Hello.

John Albert: Yes we here, I think there is anyone.

Pat Ambrose: Could you please submit that to the mailbox, if you haven't already and address it on the next call, in the 18th. You know we don't have the coverage here to answer that question. I am sorry.

Emily Cook: OK, I have already submitted it. So I will await the next call. Thank you very much.

Pat Ambrose: That's fine.

John Albert: OK. Thanks.

Operator: Your next question comes from the line of Peter Gunn with Applied Underwriters. Your line is now open.

Peter Gunn: Hi. My question is about, depositing code three and air cored SP31. When I read there discretions in the user guide, they seem like they are the same family and I asked my EDRs about it and she told me, just they are the same thing, treat them the same way. But I still don't understand why we get one instead of the other. Can you explain that may be or..

Pat Ambrose: Well, I don't know if you really want to know, but we do interface with some other systems and our, where we posted the information is not the (MSPRs)

this is the common working file of CWS which I often refer to as Old & Moldy and anyway it does its job by some, it has some (inaudible) requirements at time and at any rate.

So the 31, my understanding was for future days and we don't have the capability of talking – and it really isn't worth the explanation other than just say that we at the COBC have not found a good way of handling that ourselves and we certainly you know continue to look at those circumstances but I pretty much stand by what its saying in the user guide and unfortunately as you in that case of getting the SP31 after resubmitting the claim and the error should just go away the next time.

Peter Gunn: So what you are saying is, if we just continue to submit it the error will go away in the SP31.

Pat Ambrose: Yes, that's my understanding. I mean, I have got a document is there that way, correct. I mean isn't that you're read of it fro SP31

Peter Gunn: It says just to resubmit it.

Pat Ambrose: Yes, and you know I guess I don't want to boar everybody and I also you know what to, if I were to give you an accurate explanation I wanted to have that to be absolutely technically correct and I am not necessarily prepared of the top of my head to do that, but I do know that what's I the user guide is the action that you should take both for the 03 disposition code and the SP31 and I am not going to be able to give you know real reasonable explanation as to why you get the SP31 and not an 03. I am just sorry about that.

Peter Gunn: OK. That will work.

Pat Ambrose: That was great, thank you. I know so.

Operator: Your next question comes from the line of (Bonnie Mustard) with Farmers Insurance. Your line is now open.

Bonnie Mustard: I apologies I was on mute. I apologies. Yes I had a question. We don't know if this is related to the individual to receive confirmation of someone being in

Medicare beneficiary on their quarry file and then getting the 51 when they actually submitted the individual that in our recent quarry file, we received indication that individuals for Medicare beneficiaries and as we contacted some of them have been very adamant that they are not a Medicare beneficiary.

Pat Ambrose: And never have been. Are they individuals that never have been Medicare beneficiary or if their entitlement is just ended.

Bonnie Mustard: They are very armament. They are not a Medicare beneficiary and have not been.

Pat Ambrose: OK.

Bonnie Mustard: And we have contacted our EDI reps and they looked at the records and said it looks to be correct and so we are going to go ahead and treat them as if they are, but I guess I'm just wondering you know if this is somehow, you know related to the issue that these individuals are having where these is an O1 on the clarity file and then coming back as not a Medicare beneficiary.

John Albert: I mean there are reasons people either don't know or don't tell the truth one think you know stating, but if we have – if we match to a – and all that I mean you know for purposes of CMS records and SSA that is ligament information. If there is a problem with that information that we receive, then it's up the beneficiaries themselves to go and correct it.

Now obviously, There are some other quotes in the system that occur, you know have occurred here within CMS but first step is that, that beneficiary if they truly believe they are not and never have been a beneficiary and you present them with you know the hick number, the name, date of birth, and gender and you know that's – they validate those information. One of the first things they need to do is probably approach social security office because there are been occasions where information is wrong, social security as well. And for CMS we don't really care because SSA is the official repository of that information and it's up to – to work that out.

Now of course other reasons are that you know the person just may be wrong or not telling the truth necessarily, then there is the other issue that like we talked about earlier the issues with the disposition code and some of those cops that we've seen are. And so that's why in all of these cases they really need to be quoted to your EDI department and have them investigate and see what they can find out and then hopeful that's bubbles up to us here at the COB leadership as well CMS that we can find out, you know OK what is the real issue here, is it internal CMS system issue, is it a COB issue or is an SSA issue or is a penny issue.

Bonnie Mustard: Well, I just wanted to mentioned it, we will follow it as you recommended but I did want to mention that is something.

John Albert: Yes, and then we are very well aware – I mean not just the people on the call we received this question numerous times and unfortunate it never won single right answer in very case for all of these circumstances which is why they really do have to be individually investigated on a case to case.

Pat Ambrose: And John, you actually reminded me of a circumstance in this research of what's the difference between the quarry and the claim and you know as I said we did make some adjustments to the matching process and looking at Medicare entitlement and enrolment dates and one issue that through us for a loop was the file of Medicare beneficiaries that we get at the COBC in some cases have a Medicare beneficiary with an entitlement date that is actually after the entitlement end date.

So in other words their entitlement affective date is say you know April of 2010 and the entitlement termination date is say February or you know the day before of something like that is earlier. And what we found is, I think there is a circumstance where they might have stated setting up this persons entitlement in that sell though for whatever reason or another.

You know they were determined to be disabled or whatever the case might have been and instead of you know removing the record entirely they kind of cheated the system by messing with the dates and that did through us for a loop initially. So you know jus to give you an example of some of the crazy

things that can happen. But we are continuing to research on this as we said before.

Bonnie Mustard: OK, thank you so much.

(Ben): Yes I think there– there might be a (inaudible) if there is no entitlement date what's so ever. Because again, wither typically for people who are under 65 and working towards entitlement of either disability or ESRD and I know for a fact that the folks that are in our enrolment area that works with us just way, that we do sometimes receive confirmed tick in matches but there is no entitlement date.

But the hick was already set up as part of the application process but they never actually become entitled because they either you know, went of disability or had a transplant or whatever it may be. So those things do occur, but I guess in short in all of these things, I mean if you are pasting information that you know, its submitted on you know what we gave you in a response file we are never going to hold anyone accountably for the issue with our response file. So, lets see next question.

Operator: Your next question comes from the line of (Susan Bolster) from (inaudible); your line is now open.

(Susan Bolster): Hi, I know this is your favorite subject right now, but may be this will help. We were working with you folks with – at this position code at 51 coming back on a claim reporting file and we understand that you did make your changes back in October November which for any quarries prior to that they have been eligible but for whatever reason now though the reporting process, they are coming back as a 51.

Well I also brought it up to I think was (Mr. Farak) or one of them that when you are using the beneficiary look up you are still getting a positive for those that were coming back as just disposition code 51. He didn't realize that it looked like they were still using whatever the old data was or whatever. Do you know if they updated that and so now that process marches your matching process?

Pat Ambrose: Well, that is, its all out matching process, but obviously, it's done in different places that we have the matching that done in the quarry, the matching that's done on the claim file, matching that's done during direct data entry which isn't live yet but it does exist there and then the matching on the COB secure Web site for the beneficiary look up. And I wasn't aware that it was in consistent, I am pretty much on mission now to make sure that it is. So.

(Susan Bolster): It might be why people are getting deferent information because we noticed that right away. So we sent that information to you folks and that's when he realized that these must not be in sync. I'm just wondering if they are in sync now so that we can use that beneficiary look up and that's a little more accurate than what it has been because its based on whatever updates you did back in October. So this might help clarify with other people on the line what's been going on.

Pat Ambrose: So you are indicating that the beneficiary look up is consistent.

(Susan Bolster): It was not consistent before and that my question to you is do you know if that's been corrected that it is.

Pat Ambrose: if it wasn't consistent before I am not aware of any changes to the matching process in with any look up feature lately.

(Susan Bolster): OK.

Pat Ambrose: Not to say that there want be, but not lately. So that I mean – but that's all the information I have. I usually am aware of system changes particularly how they would effect our ROE and on the Web site and so on but – so I haven't seen any changes of that nature.

Marcia Nigro: So is that something your going to look into now.

Pat Ambrose: Yes ma'am.

Marcia Nigro: I know, it's been nuts but I just wanted to bring that to your attention since I was aware of it, that's all.

Pat Ambrose: I really appreciate it, I do.

Marcia Nigro: Thank you.

Pat Ambrose: Thanks.

Operator: Your next question comes from the line of (Joanne Mosca) from (Transtar Incorporated). Your line is now open.

(Joanne Mosca): Hi. I just got one question. We've been dealing with our ADI representatives and it's dealing with the queries, the monthly queries that we were able to submit and it seems like he's been indicating to us that we're only suppose to be submitting them on a quarterly basis now. Is there any plans in the future to do that or are we still available to do it on a monthly basis.

Pat Ambrose: Yes, unfortunately there's probably a little confusion there. We changed the group health plan, GHP reporting such that they may only submit queries on a quarterly basis, but for a non group health plan, for workers compensation default, insurance or liability insurance, RRE, it remains monthly and I know of no plans to change the monthly query for NGHP anytime soon.

(Joanne Mosca): OK and then just one additional question on the e-mail notifications. With the – we submitted our production – first production run back in February and we got a notification that your site had picked it up and was processing and so forth and then we waited several, for several days you know and never got any kind of confirmation back and we never got a response back and then when we went with the – contacted our EDI rep, he indicated to us that there was a problem with the processing on your side. Is there any way that you could possibly notify people that there is a problem with submissions or that there is a problem on your processing side.

Pat Ambrose: I'll certainly take that under consideration you know and pass it along. One thing I mentioned earlier is that changes are going in the July release to improve that transfer of files from one environment to the next, you know taking them off the SFTP server for example and binging them into the system. I don't know what the circumstance is in your particular case were and every now and them something has happened in the past where some files were dropped or whatever, but it's not a frequent occurrence. But anyway I

will – and we do have a bulletin board capability on the COB secured Web site, on the section 111 COB secured Web site and perhaps you can make use of that. That's really what it's intended for, things like that, but…

John Albert: Yes, we want to make sure that you know information is communicated to everyone as timely as possible and that's – I just look forward – this is the kind of stuff that we're looking forward from folks in terms of what they are getting or not getting and what they like to see to help them manage their process as well. We appreciate those suggestions.

(Joanne Mosca): Thank you very much.

Operator: Your next question comes from the line of Marcia Nigro from Sedgwick CMS. Your line is now open.

Marcia Nigro: Hi. This is Marcia Nigro from Sedgwick and this is more of a comment rather than a question with regard to a caller that is having an issue with claimant being adamant that they are not Medicare beneficiaries. We've had similar problems and I would say a good 80 percent of them are Medicare C Beneficiaries and they don't understand the difference.

John Albert: That's actually a very good point. Thank you for bringing that up, because…

Marcia Nigro: That's my aim. That's what we've been dealing with over on our site. So always check to see if it's a Medicare C beneficiary, because then they say, oh is that what it is.

Pat Ambrose: And by Medicare C you're referring to Part C, which is also known as a Medicare advantage.

Marcia Nigro: Advantage, correct, correct.

Pat Ambrose: Like an HMO for…

Marcia Nigro: Exactly and they are paying their premium and (inaudible) whoever is doing it, it is – they are carriers so to speak, so they don't see it as a Medicare.

John Albert: That is a very great point to bring up, because I think that that issue occurs throughout the entire healthcare industry, that they don't realize that part C is in fact a Medicare you know…

Bill: Even though they had to get into part C by coming through Medicare.

Marcia Nigro: Absolutely, they don't get it. They just don't get it. It's not their fault. I mean, you know they don't mind, they just don't understand it.

John Albert: Yes, that's OK and then we have our Medicare STND plans that don't understand the difference between their Medicare plan and a private plan, so…

Marcia Nigro: Exactly, exactly. But that does make my true sense.

John Albert: Anyway, thank you. It's now about 3 o'clock and that's a great point to close up this call. We'd like to thank everyone for their participation. We had some good comments. I mean, now that we've gotten a full quarter of NGHp under our belt, you know this is the kind of stuff that we expect to see with a newer process you know in terms of potential issues. Luckily most of them we are aware of, but it's good to hear about the specific examples or issues that people are seeing here and dealing with right now and we appreciate your frank feedback on anything that we're doing.

Please continue to submit those questions also through the, I don't know your EDI rep and also through the CMS resource mailbox. Again, we go through those before every call to try to pull out things that we can address on these calls before you even have to ask about them and again, that information is rolled into new user guide material, CBTs, etcetera.

Other than that I'll sign off by saying thank you and if operator you could come back on the line after you signed everybody out.

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

END