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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: William Decker
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1:00 p.m. ET

Operator: Good afternoon, my name is (Jonathan) and I will be your conference operator today. At this time I would like to welcome everyone to the MMSEA Section 111 NGHP technical conference call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number one on your telephone keypad. If you would like to withdraw you question press the pound key. Thank you. Mr. William Decker, you may begin your conference.

William Decker: Thank you very much operator. Good afternoon everybody or good morning to you wherever you maybe. My name is Bill Decker, I am with CMS in Baltimore, Maryland. This is the NGHP National Town Hall Teleconference Call scheduled for today.

This call is concerning itself with technical issues about the reporting process for Section 111 reporting as it relates to non-group health plan reporters, NGHP reporters. In short form that means that this is an NGHP technical call only. We will not be entertaining any policy related questions nor will we be attempting to answer any policy related questions when we are doing our initial opening presentations.

Today is Wednesday the 16th of November, 2011. Our next NGHP national teleconference call will be Wednesday the 14th of December, 2011 that is a month from now roughly speaking and it will be a policy and technical call that is on 14th of December, we can open it up to policy questions if you should have any and technical questions if you should have any. I repeat that today's call will be limited to discussion of technical issues with reporting and

we will only want to be answering questions related to the technical issues about Section 111 reporting for non-group health plans.

There are other folks here in the room at CMS and Baltimore with me including Barbara Wright and Barbara is here to help us work through the questions that you may have for us today. Also on the line in New York City is Mr. Jeremy Farquhar and Mr. Jim Brady, they will be the principal answers, principal responders today because they are with our coordination of benefits contractor in New York and are actually responsible for the day to day operation of all the technical aspects of Section 111 reporting.

Jeremy and Jim will be giving a presentation after I have finished with my general announcements which will be shortly and after their presentation we will open it up to your questions should you have any. You will be permitted to ask one question and then you will be permitted to follow that up with one follow up question. That is one primary question, one follow up only and then we will move on to the next questioner.

I remind everyone on this call once again that this is a teleconference it is not a reading of the instructions and policy descriptions that are in the Section 111 MMSEA Section 111 NHGP user guide or otherwise posted on the official Section 111 website, it is that user guide and that website that has all of the official Section 111 reporting and other information and if there is a conflict between what is said today during this call and with something that has been published and posted to the website, what is on the website will prevail not what we are saying here today. With that caveat I will open up the call to Mr. Jeremy Farquhar and Mr. Jim Brady and they will make a presentation to you at this point and gentlemen please proceed.

Jeremy Farquhar: Thanks Bill this is Jeremy Farquhar just a few general announcements to start and then I will dive into some of the questions that we received via the resource mailbox. First just a reminder we have said this before on these open door phone calls we want to remind RREs, when submitting ICD-9 codes on your claim input files please be sure to input only those codes, which specifically reference injuries related to the claim for which the RRE is responsible.

We have been made aware of instances where RREs are simply taking all ICD-9 codes of an EOB and submitting them on their claim files. An EOB for treatment may contain ancillary codes unrelated to the specific injury sustained for which the RRE is responsible. For example an RRE may be responsible for broken arms sustained in an accident yet the EOB also contain codes related to hypertension or diabetes or something of that nature. Only the codes related to the broken arm should be submitted on Section 111 file.

Inclusion of such ancillary codes as the aforementioned could result in subsequent claims unrelated to the accident to be inappropriately denied. And speaking of claim denials COBC and CMS continue to receive reports of claims being inappropriately denied due to the existence of non-GHP accidents records posted via Section 111, even in circumstances where only specific and appropriate ICD-9 codes have been reported. CMS is continuing to focus on outreach and education for both providers and Medicare administrative contractors in an effort to put a stop to such inappropriate claim denials.

Another announcement regarding 51 disposition codes. Most of you should be familiar with 51 disposition codes, those of you that are file submitters anyhow when we do not find a match based on the personal identifying information you provide on your input files you receive a 51 disposition in return. This is just a reminder that just because a 51 disposition code may have been received it doesn't necessarily mean that the RRE is off the hook. It is important that RREs ensure that personal identifying information being provided for such an individual is accurate.

The 51 disposition is received because incorrect personal identifying information is provided and the RRE fails to report claim information as a result, it may not run a risk of being considered non-compliant. So it is important that RREs go back and they confirm that the information that they had actually submitted to us on their files is in fact accurate just because he has got a 51 doesn't mean that the person isn't a Medicare beneficiary it could be that your information is off.

William Decker: Yes Jeremy this is Bill Decker, I have to break in here just quickly and announce to everybody that what Jeremy just said is most important. If you get a 51 disposition code on a response file, you need to check the information that you sent to us and correct whatever it is that produced that 51 to the best of your abilities, you need to be able to do that because if you still have a claim to report and you may have a legitimate Medicare beneficiary out there that you need to be reporting to claim about we need to know that and just because as Jeremy said you have got that 51 it doesn't necessarily mean that you are off the hook.

Cynthia Ginsberg: You may have entered it incorrectly, your information maybe correct but you may have entered the first name in the last name spot and the last name in the first name spot so you need to not just verify that you have the correct information, but that it was entered correctly in the records.

William Decker: And for the record that is Cynthia Ginsberg also with CMS here in Baltimore and Cyndi maybe dropping in every so often during this call herself. Jeremy back to you.

Jeremy Farquhar: Thanks Bill. One final announcement before I jump into questions. We have recently received reports of claim records being submitted in instances where actual responsibility for the claim is yet to be determined. At times an RRE may maintain a record pertaining to a particular incident for which responsibility for payment is still being investigated, we have encountered situations where RREs have been submitting claim records for such instances using big or non-specific ICD-9 codes only to subsequently determine that they are not responsible for such claims.

After determining that they have no responsibility there isn't any delete transactions to remove the claims posted via their prior files, this is entirely inappropriate. An RRE should not submit a claim until proper determination and responsibility has been made. Submissions prior to that point of time may lead to the beneficiary's claims being inappropriately denied and may also cause problems for our Medicare secondary payer recovery contractor.

So until you determine that you are actually responsible for the claim, do not send us anything just because you are investigating a claim does not mean that you should be submitting them on your claim input files, it's very important.

Barbara Wright: Jeremy this is Barbara Wright, I would like to interject on this one, remember that we are setting in conjunction with ORM particularly for worker's compensation we've heard that this is often true. If by state law they are required to pay while the claim is under investigation then yes they do have to report ORM even though there could subsequently be a determination that they are not responsible. Similarly, if something is on appeal, if they have to pay while it is under appeal then again that needs to reported, they have a chance to take corrective action if the appeal was in their favor.

So what you said is generally true. If there isn't any settlement judgment, award or other payment including assumption of ORM, no you shouldn't be reporting but if you have particularly a responsibility to pay ORM, you do need to report to us even though you haven't "finally resolved the claim".

William Decker: This is Bill Decker, the genesis of this question was actually from some information that we received at the coordination of benefits contractor. Where it was quite clear that there wasn't anything to report and there wasn't going to be anything to report because what was being submitted on the input file was a place holder claim for statistical purposes only.

This is clearly an inappropriate submission and should never come into us as a entry on a Section 111 input file is just not ever going to be anything that should be there. The reason we knew about this situation was because we had such a high percentage of delete activities that occurred afterwards when the RRE was deleting all the inappropriately submitted files it had originally submitted. This is busy work basically for the CLBC, but we should not be doing it and you should not be sending us anything that you are not clearly ever going to actually have a claim report on. OK Jeremy back to you.

Jeremy Farquhar: OK. Thank you and I apologize for the lack of clarification in that respect. To jump into some of the questions that we've received since our last call via

the drop box that were technical in nature. First, question was received requesting clarification regarding reporting timeframes for DDE submissions.

If you are reporting via DDE then a claim maybe submitted at anytime, but at least within 45 days of the establishment of a TPOC or assumption of ORM. The RRE had questions regarding situations where an attempted claim submission is not accepted. If the reporter has submitted the claim via DDE, but the claim interjected due to errors, they should do their best to correct those errors and resubmit the claim as soon as possible.

If the claim is not accepted within 45 days of the establishment of the TPOC or assumption of ORM then it may technically be considered a late submission. However an audit trail will exist reflecting the RREs attempts to submit the required data and as long as it appears that the RRE had exercised due diligence in their attempts to properly report there should be no real reason for concern.

Next question we have received a number of questions regarding the amount of time that it should take for claim submitted via DDE to receive response. The amount of time that it should take to receive a response may vary but in most cases the response should be received within approximately a week to two weeks. However, when a claim with ORM is submitted the process through which the claim data is posted is the essentially the same as it is via the standard file submission process.

ORM data is posted to an external database known as the common working file or CWF. Upon submission of an ORM claim via the DDE process we passed that out to CWF and must wait for a response to be returned prior to providing a response to the RRE.

There are occasions although the volume is quite minimal where it may take a more extended period of time to receive a response back from CWF, even rare occasions we may not receive a proper response. Within the standard file submission process we will automatically cut a response file after approximately 47 days. However, via the DDE process we don't generate response files and therefore there is no hard cutoff at present.

We are current investigating claims that are taking an extended period of time to complete processing and are working to determine the most appropriate way of handling these scenarios. An RRE that has claims that has been reflecting as in process for an extended period then there is no reason for a concern from a compliance standpoint, but please continue to sit tight until provided with further guidance. We will be –

William Decker: Further guidance could come from your EDI representative if you choose to talk to that person.

Jeremy Farquhar: Correct and many RREs have and that is where some of this has come from. So, yes we will be letting you know shortly hopefully how we intend to proceed with these and how we will be handling them and if there is anything further that you as the RRE need to do.

Another question received was regarding the annual re-certification of RREs profile report data. At January 2012 and henceforth on a yearly basis RRE will begin to receive communication via email requesting that they confirm the accuracy of their profile information that we currently have on file. Email communication will include a copy of the RREs profile report and the profile will include when applicable any updates that the RRE may have requested since their initial registration.

The email will be sent to both the authorized representative and the account manager. If all the information within the attached profile report is accurate then all that will be necessary is for either the authorized rep or the account manager to reach out to their EDI rep to confirm as such.

On receiving that information the EDI rep will update our systems to indicate that all current profile information is accurate. If there are inaccuracies to require correction then the authorized rep or account manager must also reach out to their EDI rep, in such cases they will need to provide their rep with any necessary updates. After updating their requested information the EDI rep will regenerate the profile report which will once again be transmitted via email. At that point in time the authorized rep will required to sign and return a copy of the updated profile report, the signature must come from the

authorized ramifications. Failure to either confirm the accuracy of the data or report correction and returning newly signed profile may result in a temporary deactivation of the RRE ID.

However, if your RRE ID is to be deactivated due to lack of response once we do here from you and you do confirm that your profile information is correct or we generate a new profile report and upload a newly signed copy we will undo that discontinued status in your bill to move forward. But, please take heed when you receive these emails it is very important that you respond because it could prevent you from being able to log in to the websites, submit your files and so on if we don't receive the response.

Anyway, this specific question received in this case was regarding possible scenarios where the authorized rep may no longer be with the organization therefore attempts to contact them via email maybe unsuccessful. The RRE requested to be considered also sending this communication to the account designees, unfortunately at this point of time we don't intend to do so but as noted previously the account manager will also receive a copy.

It is not just going to the authorized rep. Hopefully there will seldom be situations where an RRE will have no current authorized rep or account manager on file with us. REE should be well aware that should either of these roles be vacated that they require to let us know in order that we may replace them appropriately. However, should there ever be an occasion where an account designee is aware that both roles have been vacated and we have not been provided with appropriate replacements then we would urge them to let their EDI rep know as soon as possible.

At that point of time they will be properly instructed regarding if it is necessary to replace the prior individuals in most cases if we don't have the account manager or authorized rep communicating with us about this type of thing we would require something on company letterhead in order to make the appropriate updates.

OK, the next question we received from an individual referencing a statement found within version 3.2 of the NGHP user guide regarding the availability of

the compiled list of all acceptable ICD-9 codes that is supposed to be posted out on our secured website under the reference materials menu option. They indicated that they couldn't find the list.

Please note that at present you must be logged into the website in order to access the aforementioned list. Prior to log in into that site the reference material menu is visible and there are some items available within that menu, but there are numerous options that are only accessible after login into the website, the aforementioned listing is one of those options. So if you have been looking for the list of acceptable ICD-9s and this is the list that we compiled that contains all of the different versions from 25 onward. That is found once you actually login, so try login into the website and look forward again and hopefully should find it at that point.

Another entity had a question regarding scenarios where they would have a special compromise and release settlement, they would limit the responsibility for medicals to somewhere between one and two years. There was an initial question as to whether the future ORM termination dates should be submitted at the point in time that the compromise and release was initially determined. The submitter had expected that the answer to that question was no and that is correct. No possible or appropriate to send ORM termination date that falls that far into the future. The RRE would need to wait to report that termination date to no more than six months prior to its actual occurrence.

However, there is also some speculation as to whether a TPOC could be submitted at the time of the initial compromise and release. Now the details regarding the scenarios in question were not entirely clear, but if there is an actual settlement separate from the ORM being reported then the TPOC should be reported at the point in time that that TPOC is actually established. The RRE should not wait until the ORM terminates to report the TPOC data.

Another RRE questioned when CMS will be releasing current list of excluded ICD-9 codes reflecting the changes and accepted codes referenced in the latest version of the user guide and updated list should be posted to our secure website as of January. We received another email from an entity that it noted that they just had become aware of their Section 111 reporting responsibilities.

There are small groups that may have only about eight or ten claims on an annual basis. They expressed their confusion with the entire process and enquired if they are simply informed that they can utilize to submit the data to us?

First off, one thing that maybe worth mentioning here is that CMS is currently in the process of revamping the non-GHP user guide in order to make it more manageable and user-friendly. The guide will be broken down and reorganized in smaller pieces pertaining to more specific aspects of the reporting process. It is expected that the revamped guide should be published at some point during the first quarter of 2012. Another document that may act as a quick reference guide is also being worked on as well as fax pertaining FAQs pertaining to numerous technical aspects of the reporting process. So those should be available on the short-term as well and should hopefully be helpful for any RREs still struggling to understand their Section 111 reporting requirements.

And more specific reference to the RRE that submitted this question there are couple of different ways in which an RRE may fulfill their Section 111 reporting responsibilities. Our Direct Data Entry or DDE reporting option would seem best suited to this organization. I recommend that this entity review Section 15.5 within the current NGHP user guide regarding DDE. The current NGHP user guide maybe found at the CMS Section 111 websites, which is www.cms.gov/mandatoryinsrep and it's under the liability insurance, self-insurance, no-fault insurance and a workers' compensation NGHP section.

If the RRE has questions or is in need of assistance in signing up for DDE reporting they should be contacting their signed EDI rep assuming that they've already registered to report if this entity is yet to register then instructions for registration can also be found within the aforementioned user guides. They may also follow the COBC EDI hotline at (646) 458-6740 with any questions.

And the next question pertains to proper reporting of ORM termination dates. The RRE that submitted this question was looking to terminate ORM for Med bay coverage, which they had previously reported. Under their contractual

obligation they are only responsible for ORM for a period of one year or until benefits are exhausted, whichever comes first. They noted that they had send letters to the MSPRC indicating termination of ORM and they had also submitted the ORM termination dates via their Section 111 files.

They also claim that in speaking with the MSPRC that they refused to close - the MSPRC refused to close off file record unless the benefits had exhausted or a signed letter from the treating physician were provided. First off, it is important to know that if an RRE is attempting to make an update in this manner to a Section 111 record that they should not be contacting the MSPRC to do so.

Update such as applying ORM termination dates should be made via the standard Section 111 reporting process. An emergency update must be posted between Section 111 reporting periods then the RRE may also contact the COBC call center at (800) 999-1118 and the CSR will take the update over the phone.

Now it has been noted in their correspondence that the ORM termination date had been reported via their Section 111 file submissions however, I would urge the RRE to review their response file, which they should have received to ensure that the update they submitted had actually applied successfully.

Just because you submit and update on your Section 111 by an input file doesn't mean that update actually apply you need to take a look at your disposition codes and if you receive an SP disposition you need to be taking a look at the error codes that you received in conjunction as you are going to need to make corrections and resubmit that record. If an RRE has questions about the response and they should be reaching out to their assigned EDI rep for assistance.

In this situation, the MSPRC should not have instructed the RRE that they couldn't terminate their ORM coverage based on their local statutes or contractual obligations if the RRE in fact no longer had any obligation to be paying ongoing responsibility for medicals. But, contacting the MSPRC to accomplish this was not actually the appropriate course of action.

Barbara Wright: Jeremy, this is Barbara Wright I would like to interject on this one a little bit. One of the problems with contacting the MSPRC for this is their function is not limited to dealing with our CWF records or Common Working File records. They also have recovery cases and systems tied to that and the fact that ORM might have terminated doesn't mean they don't have a recovery claim associated with that.

So it's even possible that there was simply a misunderstanding of what was said because they can't close a case simply because the record should be terminated. So that is just yet one more reason why anyone can insure or someone who is speaking on this behalf needs to be contacting the COBC. There are too many issues on the MSPRC end for them to address this appropriately. Thank you.

Jeremy Farquhar: Another question we received was regarding the proper reporting of TPOC amounts. This RRE had referenced scenarios in which there maybe liability cases where there are several different liability insurers. They indicated that each carrier maybe responsible for a particular portion of a total settlement and that the amount each would be responsible for will be clearly defined.

The question was whether they being one of the several liability insurers should be reporting just the TPOC amount for which they are responsible or if they should be reporting the combined settlement amount rather than both insurers. And Barbara feel free to correct me if I'm speaking out of turn here but if the amount of settlement owed by each individual insurer is clearly defined then they should report only the TPOC amount for which they are responsible because that would be my understanding.

Barbara Wright: This is Barbara again and it's not that I disagree with the concept that Jeremy is trying to get across, but I do disagree with the choice of the words. You said if the amount of the settlement owed by each individual insurer is clearly defined, they only report their amount that's not necessarily true.

Clearly defined could include a settlement for, which entities had joined several responsibility, but they allocated a certain amount to each insurer. In a situation like that they would, each of them would have to report the total

amount if you have insurers that have separate settlements, they are only going to be responsible for reporting purposes for that particular settlement, but an allocation in the settlement is not binding on us and that's not sufficient to ignore reporting responsibilities.

William Decker: And this is Bill Decker. I do believe we've said that a number of times on these calls previously. I also think that's pretty clearly outlined and discussed in the user guide that it shouldn't really be that much of an issue for most RRE reporters.

Jeremy Farquhar: OK. Last question, our question/suggestion we received was regarding the e-mails that are systematically generated for designee invites. This particular question came from an agent group and they were asking if it might be possible to include the RRE ID for the entity to which the invite was related within the emails. This would make it easier for them to manage these invites as they may receive many invites from numerous RRE's. This is well noted and it's something that we are taking into consideration and may consider as a possible feature enhancement and that's all I had so, I'll turn it back to you Bill.

William Decker: Hey, thanks a lot Jeremy. That's our presentation for today that's pretty good we've managed to pull that in about 35 minutes, maybe a new record for us on technical call. Operator we will open it up to any questions that we might have at this point.

Operator: The first question comes from the line of Susan (inaudible) New York State Insurance Fund. Your line is now open.

(Frank Salvo): Yes hi, this is actually (Frank Salvo) from New York State Insurance Fund. You guys had mentioned before about, you know recording accurate ICD-9 codes which we've been working on with our people. Unfortunately, we are now getting inundated with calls from Medicare beneficiaries where they're saying that Medicare is refusing to pay all bills, while our claim is open and these are cases where, when we've checked we determined that we did report the right codes, for instance we reported codes for back and the claimant's treatment that you know, this is based what the claimant tells us that they are

getting treated for things like cancer other diseases that Medicare is refusing to pay for.

And our people have actually got on the phone on a couple of occasions with people from the COBC and there seems to be this common language where they're telling people that we have to close our case and obviously that means we have to give, they are saying we have to give you guys an ORM term date in order for them to be able to pay any medical treatments that seems to be the mis-norm and it is going on and we did send that into the question box, but we're really struggling with this and we're trying to help these people as best we can.

Jim Brady: Hey Salvo, this is Jim Brady over at COBC. And I think you know that certainly is not the answer we would expect somebody to give you, but if you wouldn't mind giving us a call offline and I can get the specifics we can follow up. But, no you shouldn't be closing it to address this, that's not the resolution.

(Frank Salvo): Who should we contact?

Jim Brady: You can call Jim Brady and my phone number is area code (646) 458-6682 and I'm in the user guide so, find it there too.

(Frank Salvo): OK, thanks Jim.

Jim Brady: OK.

Operator: Your next question comes from the line of Susan Bolster from Zurich. Your line is now open.

Susan Bolster: Hi, this is Susan Bolster and I'm calling regarding a comment Jeremy that you made for the disposition code 51. My understanding back in January when we started to get the 51s back was because anything we submit for reporting has already come back on queries as being a positive hit for Medicare eligible claimants. But, we were explained back in I think it was late October, mid November 2010 I think it was where CMS changed their criteria for selecting

Medicare eligible claimants. So, instead of getting back on those three we're getting back a disposition code of 51.

Jeremy Farquhar: OK yes, and that is different scenario than what were attempting to or what I was attempting to reference at the beginning of the call. So, that is a known issue in those cases you know, that you're identifying information is appropriate, you're getting a 51 and that's OK. You should continue to submit those individuals until you receive a hit once you receive an actual accepted disposition code of 01 at that point of time you will know that it's then time for you to submit that individual on your claim file.

At present if an individual has only Part B coverage with no Part A entitlement we're unable to accept coverage records and so, we're returning 51 dispositions for that reason. Eventually, we're going to be making a change where we will be able to accept those coverage records for individuals that have Part B alone and once that change has been made you'll begin receiving it and accepted disposition on your response file. So, there is nothing that you're doing wrong there please continue as you have been.

We just wanted to make the point that it's important that you confirm that the information that you're submitting to us is actually valid because sometimes people do actually give us incorrect personal identifying information and we don't post records as a result and that is a problem.

Susan Bolster: OK, I just wanted to make sure that there wasn't something to change because when this first came up it was elected to just remove the indicator so it starts querying again. So, that then when we get a hit then we can report.

Jeremy Farquhar: That's right and that's exactly what you should do.

Susan Bolster: OK all right. Thank you for the clarification.

Operator: Your next question comes from the line of Marsha Negro with Frederick. Your line is now open.

Marsha Negro: Hi, there is a little bit of confusion in discussing with other parties with regard to Medicare beneficiary information when we get back a hit and the last name

is not correct but everything else is. When we do file that report, that report will be rejected if we don't use the beneficiary's last name as listed in Medicare records, is that correct?

Jeremy Farquhar: Well no, not really but the way the matching process works is you need to add either a valid social security number or a valid Medicare HICN. The HICN is our preferred identifier but if you don't have the HICN we can match on the SSN.

Marsha Negro: OK, so as long as the HICN is on correctly you're not going to be sending us a error on the record.

Jeremy Farquhar: Well, there is more that is the first part of it and then you need to have three out of four of the following need to be correct. Your first name, last name, date of birth and gender. So, if just your last name was incorrect and first name, date of birth and gender was good and then you had a valid SSN or HICN, then you would continue to receive a match when you submitted them we would not reject that record.

Marsha Negro: However, if that - now we are doing the claim submission and the person's name is Brown on the Medicare roll but when we submit the record because now we have a Medicare beneficiary and we have a TPOC and they're using the name of Smith and everything else is correct, will that record be rejected?

Jeremy Farquhar: No, that's what I'm trying to say. No, it would not. We would like you to update your information and send us the appropriate last name because what we're sending you back on your query response is the information that social security has on file for that particular individual unless you have information that their name has just recently changed due to marriage or for some reason and maybe social security hasn't made that update yet then we would recommend updating your system with the last name that we provide back.

But, if that last name is wrong and you still have three out of four those other fields and a valid social or HICN then it will not be rejected, will match on it again on your claimant profile and if there are no other problems we'll accept that claim.

Marsha Negro: Thank you, you clarified that for us. Thank you.

Operator: Your next question comes from the line of Wendy Radar with State Compensation. Your line is now open.

Wendy Radar: Hello, I'm not sure this is really a tech call but it has to do with the user agreement I mean the data use agreement. So, what we'd like to know is whether or not we can use the information from the query process to determine which people we need to have MSAs for when we settle our claims.

William Decker: I'm sorry, this is Bill Decker which people do you have to have what for when you settle your claims?

Wendy Rider: In MSA.

Barbara Wright: You wish to use it for something other than Section 111 purposes correct?

Wendy Radar: Well, I consider that coordination of benefits which is what this is all about. So, I'm wondering if it's within the purpose.

William Decker: Well it is not a technical question first of all so we really shouldn't go where this question is going to take us. I will say that in general Section 111 reporting is about is Section 111 reporting not about anything else. And you should only be using the functionalities available to you through Section 111 reporting. In support of that if you have can frame this question in a more specific way and want to actually send it to me in an email you can do that, send it to me directly.

Barbara Wright: And into the mailbox.

William Decker: Or send it to the mailbox directly, right and we will take it up next time. But, generally speaking we do not like to - we do not recommend or suggest that people should use anything in Section 111 reported process or anything, but reporting under Section 111.

Barbara Wright: If you submit the question also make sure you are very specific about who will be using it for what. If you're an agent for an RRE and you as the agent wish to use it to determine at MSA information for and MSA business you run

or anything else even if we allow the RRE to use it for that purpose that wouldn't allow you as an agent to independently use it for something else. So, when you send the question, please do be very specific.

William Decker: And I would also mention that you know, specific to the worker's comp even though this is not the venue for it but we have a worker's comp Medicare set aside portal coming and keep an eye on your inbox because there will be communication about that going out very shortly to folks like your self. So, that may also address the issue.

Wendy Radar: OK and then I have a follow up question and we did send this into the resource mailbox and it has to do with the fact that well there seems to be a contradiction and instructions in the user guide in that you request that we submit back to you the name that we got from you are the applied name, but some of those applied names have like an embedded dash in them which is contradicted by the field level rules and would give us an error code. So, then I suppose that you want to us to clean those names according to the field level rules even though if that will make them not exactly the same as what you gave us back, is that correct?

Jeremy Farquhar: I mean you could and it would probably still match sufficiently. But, if you received it back from us in that fashion then you should also be able to submit it back to us.

Wendy Radar: But, we can't we get an error message if we do.

Jeremy Farquhar: OK then…

William Brady: This has got an embedded hyphen in the last name, is that…

Wendy Radar: Or the first name.

Jeremy Farquhar: If you and I'd be curious to look at some examples of that and if - I mean we probably shouldn't be passing back to you anything in a format other than what you should be submitting to us. So, if you stripped you know the hyphen out or the special character out and send it to us then it should be fine at this of point.

William Decker: But, we would like to see it because it is not, you know we haven't heard this one before and that's surprising. So, we'd like to take a look at it.

Wendy Radar: OK, so you want me to send it directly to one of you instead of the mailbox?

William Decker: Yes, in this case this is a specific issue, yes.

Jeremy Farquhar: And our email addresses are in the Section 111 guide under the escalation procedure.

William Decker: Right, no PHI please but as much specific that you give us.

Jeremy Farquhar: Or if you need to send us PHI or if you need to give us PHI you can give me a call. This is Jeremy Farquhar.

Wendy Rider: What PHI?

Jeremy Farquhar: Personal Health Information basically like the Medicare HICN or Social or anything of that nature we don't like to be exchanging that type of information via email. So, if you wanted to give me a call and give it to me over the phone that's acceptable. But, or if you want to relay an example to us via the use of a DCN or something and what file it was on.

Wendy Radar: OK thanks.

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

Bonnie Mustard: Yes, thank you. I just wanted to follow up the issue the previous caller brought up regarding Medicare beneficiaries being denied benefits in contacting our claims adjusters particularly you know, we have in cases where we have ORM we can't terminate because we don't have the letter from the doctor, our file though has been administratively closed because the individual, you know has agreed they've stopped treating but, we don't have anything from the doctor.

So, that the file gets closed and then they go for something that is completely different than what we were covering or what our ICD-9 represented and they are contacting us and saying we have to pay for this. And it's very, very, very time consuming on our part to try to assist these individuals and they get very confused and very frustrated with us and I'm just wondering you know, Mr. Brady you know, we have this huge number of these situations and I'm not even sure internally how to shorten them so that we could get the examples to you as they are happening but it is happening and it's a big concern.

Jeremy Farquhar: Jim, are you going to address that?

Jim Brady: Yes, I mean in the microcosm of your example if you want to reach out to me we can definitely take a look and see what's going on. The bigger issue I mean obviously as Jeremy stated at the beginning of the call, you know CMS is working with the maps and working with the providers to get the word out on how to handle these situations in both regards. But, you know we can definitely take a look at your examples and see if you have anything different going on.

Barbara Wright: And this is Barbara Wright again. The thing I'd like to emphasize I think we've said it but I'd really like to emphasize is that contractors do not have our permission to routinely deny all claims simply because there isn't open NGHP record. They should at best be denying claims that are related to the alleged incident based on our prompt payment rules.

So, any situation where the allegation is that they're denying things that are totally unrelated should not be happening with the ORM situations. We do take this very seriously we have a couple of efforts underway to redo to eliminate this type of thing, but no one should ever give an inference or an implication that the only way to handle this is to terminate a record because terminating the record isn't the solution in most of these cases.

Bonnie Mustard: Right and I might just add I don't know that what I'm hearing and this is you know, not first and I don't deal with the individuals when they have these issues personally. But, what I'm hearing is that they told by that they get told that they need to come to us to approve they're going to the doctor for the

issue that's wrong with them or they need to be approved before they get the treatment that we're going to make the payment for it. And on course you know, in many cases these are individuals who are on Medicare for a reason and you know, some of that is elderly and other reasons and they, you know perhaps there is some confusion on their part.

So, I think it's just trying to figure out what do we do to – because it becomes very time consuming and when I look at how many cases of ORM we're going to have open. Well, for example Michigan quite literally forever you know, this is going to be an issue it is going to continue to come up until we find a resolution.

Barbara Wright: To the extent contractors acting inappropriately we'd obviously like to get it cleaned up. One of the things I would mention though is if a beneficiary comes in and says that they have actually had a claim denied, that's totally unrelated is anytime we deny a claim a beneficiary has full appeal rights on it. And in no other venue they can always appeal that denial. If they are not getting satisfaction in any other way they do have the opportunity to appeal that particular claim denial.

William Decker: And this is Bill Decker, one of the things you just mentioned was that they're being told that the beneficiary apparently is being told by some entity that they need prior approval before they get treatment. Do you have any information that not necessarily you want to share on this open call but what entities are actually suggesting to a beneficiary that they need to get prior approval before they get further treatment?

Barbara Wright: Because that is like something more an insurance company or doctor would say.

William Decker: Right.

Bonnie Mustard: Right. And I think some of it is the actual doctor's offices are telling them that. Our operation is so large I'll have to go out and ask for you know, the most specific recent examples and suggest that if there are some that are you know, that you referred to them they are unresolved maybe I can take you know, one or two of those to Mr. Brady and see if we can identify…

William Decker: All of the providers who have Medicare provider IDs that is they can build the Medicare program for the services that they provide to beneficiary have been trained on how to properly build, not that means that they will actually do that and not that means that everyone on the providers office staff knows exactly what to do. But, we are well aware of the fact that there is some provider retraining probably this is going to have to go on here. That's going to be one aspect. Thank you for all the information you have given us and do talk to Jim, maybe there is something that there is a mechanical problem that we could find.

Jeremy Farquhar: And if nothing else your examples will be helpful in fixing the problem.

Bonnie Mustard: OK. I will put that message out and see and get some examples to you. Thank you.

Operator: Your next question comes from the line of Ingrid Blankevoort with UMIA. Your line is now open.

Ingrid Blankevoort: Hi, I got a question in regards of September 30th alert. Do you change the, you know, the default date, you know, the delay I guess. My question is that an option or is it required. So, if there is a claim between 5,000 to 100,000 dollars, you know, in January 2012 will they get rejected or will this still be accepted?

Jeremy Farquhar: It's an optional delay for the new threshold in the alerts. So, you can report under that dollar amount, you still need to be over the interim thresholds, those interim thresholds still stand and they are documented in the user guide if you are familiar with. Maybe as long as it is above the interim threshold and you can submit it if you wish it should be fine.

Ingrid Blankevoort: OK and the interim is I believe still $5000, right?

Jeremy Farquhar: Yes, this is right.

Ingrid Blankevoort: OK, that's it.

Barbara Wright: And Jim just, if that was Jim or Jeremy or Bill, if you look at the actual alert in the paragraph that's right below the chart in the alert, the very last thing is parenthetical that says note, this delay is optional. So, it is in the alert telling you that, but I think, it was helpful to add that it has to be above the interim thresholds.

Operator: Your next question comes from the line of Catherine Dickenson with Husch Blackwell. Your line is now open.

Catherine Dickenson: Hi, just a quick follow question on something that was addressed earlier. We have a situation, a lot of client in toxic torque claims were they have old claims that are insured usually in deductable policy or full coverage policy, but there is some dispute along the line as to whether or not the claims are covered.

So, there is an agreement reached between, you know, the defendant and the insurer that they will just put the cost to defense, put the cost of settlement. Under those circumstances, even though they are insured claims, do you still want the RRE to report part of the amount of the full amount because it's kind of an offshoot as a policy itself.

Barbara Wright: I am not sure what do you mean by they have agreed to split it.

Catherine Dickenson: Perhaps, the dispute as to whether or not the claims are covered. It's not a policy they are saying, these are the tax exposures, are not covered, we are saying they are so they say, OK, the insurer will pay 60 percent of settlement, we will pay 40. So, the deviation from what the converge was originally of the policy, but because the parties don't want to litigate whether the claims are covered, they come up with a little bit different agreement.

Barbara Wright: Who is this that is splitting the amount?

Catherine Dickenson: It will be the defendant. So say, if company access asbestos **case** and they are insured from 1955, do you know what, you know, we don't know if these claims are covered or not, it's such an old claim, we will pay 60 percent, you guys pay 40, you know, we have a policy in place with them from back then it is just the coverage is slightly different then what was outlined in the original

policy. So, I mean, technically, it would be a deductible policy, the insurer should report everything, but since it is a little bit different, it has caused a lot of confusion with a lot of it.

Barbara Wright: Well, I think, you are going to have to look at how your settlements are done in that specific case. If basically, it's going to be written as one settlement and shows that it's essentially the insurers paying it whether you are indemnifying them for 40 percent or whatever or not. If the, you know, insurer is coughing up the settlement making the settlement then they can report the entire thing. If it's being structured so that it's really two independent settlements then you have got potentially two independent reporting responsibilities.

Catherine Dickenson: OK. So, you are going to treat it more like a general policy where you are looking at who is actually paying the claimant.

Barbara Wright: But, I am not going to get into physical payment, what I am saying is you have to look at what you actually reach for your settlement agreement whether it's a single settlement that you are jointly in several reliable under, whether it is two separate settlement agreement. If you decided OK, the insurer is going to do a settlement for X amount and the defendant is going to do something separate, you are really going to have to look at how you crafted in that particular case.

Catherine Dickenson: OK.

Barbara Wright: And then fit within the rule. I mean, we are most concerned with getting the, you know, full data. We are not necessarily, looking to have things duplicate reported. So, when things get this factually specific, you really need to work it out on a case by case basis.

Catherine Dickenson: OK. And I have kind of unrelated follow up questions. Can I call to follow up? With the direct data reporting, just to clarify we still need to be reporting into the first quarter of the next year even thought it's technically available now and you can still report within 45 days?

Jeremy Farquhar: That's for liability TPOCs only.

Catherine Dickenson: Yes so, if I allocate on October 1st, I still don't have to report it until next year even though that 45 day window would fall before next year.

Jeremy Farquhar: The liability TPOC do not need to be reported until beginning in the first quarter of 2012.

Catherine Dickenson: Very good. Thank you so much.

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

Peter Foley: Hello all. Just an observation Mr. Brady, this is a large problem and it's across the country involving numerous insurers and self insured who are finding these beneficiaries are not being afforded treatment because they are being told that they can't have any coverage because there has been ongoing responsibility for medical reported to CMS.

This is not a single incident and farmers are not a typical, the state fund is not the only one and we at AIA are requesting that our members and our members of AIA taskforce report back to the beneficiaries that they should contact their congressional representative and inform them of what is going on here because as Farmer's point out on the call already, these people don't understand that the insurance industry is reporting claims to CMS, they also have done and understand why they are not getting benefits and they believe that the property casualty insurance industry is responsible for this and the only way we can make sure that other people become aware of it is to contact their congressional representatives.

And I hope that you will find a solution to it because we are told early on before reporting started they we should report as many ICD-9 codes as possible. Now, we are advising the report as few ICD-9 codes as possible so that you will have less of a chance of having this occur with one of the people you are reporting to the COBC. That's just an observation I thought I would share with you.

Barbara Wright: To the extent Peter that you are telling them to report to Congress or notify Congress when they are getting denied claims, it's certainly would be helpful

if they are being very specific in terms of, did their doctor tell them that they can't be covered or did they actually get a Medicare claims denial because there is a difference between the Medical profession giving out inaccurate information and Medicare actually denying claims.

Peter Foley: Thank you. I would note that.

Jeremy Farquhar: Hey, and just one other technical point to bring out on the diagnosis, and I don't think you were trying to say anything other than this, but just to sum up, really they should use the correct appropriate diagnosis it is neither, every possible nor just the bare minimum, you need to use the right one and that's really, that should be the best defense against having these kind of issues.

Peter Foley: Jeremy, the problem with this, it lies in how people made the decision to get those codes. It was, some insurers looked at this and said I don't know that I want frontline adjusters picking those codes and putting them in, for fear I will give the wrong code.

So, some people have frontline adjusters doing it, other people went to their medical bill systems and started feeding, from the medical bill systems which would take the top 20 codes and send it to you and you would get the top five and that could include hypertension and so then they found that up and they had to go back and in turn off systems that they had setup to do it automatically.

So, there are various problems internally in some of the systems too, I agree. But, one state in particular Texas where you don't have the ability to turn off ORM and Michigan no-fault where you don't have the ability to turn off ORM to see higher prevalence of these beneficiaries being denied benefits.

Barbara Wright: Also, keep in mind that we have said in the past that for ORM you may limit the ICD-9 codes that are reported to what you actually accepted responsibility for, but if you are reporting a TPOC you need to give us codes related to everything that's been alleged. I mean, we did add that distinction in there so that for ORM we would have a narrow range of codes since we are using those more for front-end claims processing.

Jim Brady: Just to pick on something that Barbara has said earlier in the call that when the – if it is a situation where they are getting a claim denial, wait on that, use the instructions on what to do and how to appeal that denial. So, there is always that safety valve but.

Peter Foley: Well, the other point that we are hearing is that it takes time to get through to the COBC. In June this issue was raised and we were told to call the COBC and what we are hearing from representatives now is that getting through the phone lines is difficult and usually told to fill out a form and wait 60 days to see what happens that they are not automatically turning back the benefits, turning them on after you get through to the COBC.

Jeremy Farquhar: Yes, just to clarify that I mean our average speed of answer is itself a minute, we don't have people waiting on hold for any significant period of time and we hate paper more than you do. So, we are not telling people to fill out anything and send it to us. We fill it on the phone. So, if you have got specific examples related to that I can definitely follow up on them.

Barbara Wright: Yes, keep in mind that if it's a situation where the claims processing contractor has done an inappropriate denial calling the COBC doesn't mean they can flip a switch and turn the benefits back on because the benefits were never turned off. If there is an appropriately opened ORM records, COBC can't change anything. It's the claims processing contractor that needs to correct their error.

Jeremy Farquhar: We can't adjust the claim. We can only deal with getting the facts into the record.

Barbara Wright: And that's one of the reason I have specifically mentioned that the appeal route is there on individual claims.

Operator: Your next question comes from the line of Shannon Nessier with Hanson Bridgett, your line is now open.

Shannon Nessier: Hi. My question is actually pretty simple. You had mentioned the RRE profile update emails would be sent out. Is there a set timelines for those or those just going out on rolling basis?

Jeremy Farquhar: There will many, they will begin going out in January, basically if the way it's set to work at present is if you were registered for reporting prior to January of 2011 that email will be going out to you in January of this coming year, January 2012. If you had registered after January 1st of 2011 then the profile email will be generated on the anniversary when we received and uploaded your signed profile. So, say you submitted a signed profile to us, but not until March of 2011, the email for recertification wouldn't go out to you until March of 2012, but it will be triggered on a yearly basis, based on that anniversary.

Jim Brady: Based on the last time you signed and re-received your profile report.

Shannon Nessier: OK. Thanks.

Operator: Your next question comes from the line of (Ellen Itzel) with Jobinson. Your line is now open.

(Ellen Itzel): Hi guys. Just a quick, I just want to follow up on some compliance, errant compliance flags that came out in our Third Quarter file. Just wanted to check that, that issue has been resolved.

Jeremy Farquhar: Yes, all of the erroneous compliance flags that we were generating at this point in time should - those issues should be resolved. We did have some that were generated post October and we have had fixes to oblige to resolve that since that point of time.

The compliance flags that were going out in the past in an almost all cases were for records that received disposition codes other than in 01 or an 02 which technically shouldn't generate compliance flags ever and you know, if you were to see a compliance flag on the past file and they were for record for receiving, you know, an 03 or an error disposition then you could safely ignore them regardless because those are really, they shouldn't have been generated. But, there should no longer be any of those erroneous compliance flags at this stage of game either, so if you are about to send a file, it should come back.

(Ellen Itzel): OK. Good. And I just want to comment. I know some of the people that said they get 51 back from their claim submissions when they had a good query. I know, the last issue, the user guide was updated because I know the issue that I has was that we had a gender failing that it was assuming the male that only happens during query.

Jeremy Farquhar: Right, yes, we don't default the value on anything other than the query file and that was misrepresented in my presentation.

(Ellen Itzel): So, people are aware, I don't know. If that's a general knowledge kind of thing that people are aware of that, you know, but it was an error for you know, the first however many issues.

Jeremy Farquhar: Right yes. So, just to clarify for everybody else on the call when we receive, there is a value of zero that is listed within our documentation for gender which means there are ways to unknown, really, it makes very little sense to ever use that value I would recommend against it, but if we receive a value of zero for the gender on the query file submission we default that value to one, which equates to male because there is no unknown value, EDI value for unknown and so we need to equate it to something that we can translate properly.

It was, I think, erroneously indicated or implied in prior versions of the user guide that we also defaulted that zero to one for claim input files and that was never actually correct. We do not default to the gender value at all on a claim input file.

So, if you were to send a gender of zero on your claim input file and then maybe one of your other values that happens to be off your first name or last name then you would get in an non-match on your claim file even though it had been submitted on your query process, there is a possibility you could have got an hit because we might have defaulted to value of one for male which might have been appropriate. It was a little confusing, so that is clarified in the new guide. We only default the value on query file submissions and not on claim files.

(Ellen Itzel): OK, great. Thank you.

Jim Brady: So, sending a value of zero on a regular input file for gender code automatically gives you one error and that's why you really don't want to do that.

(Ellen Itzel): Well, I guess, my point was then why was it made an option at all?

Jim Brady: Good question and a good point.

(Ellen Itzel): Not allowed to send it, you need to send a valid gender then zero should never have been an option as a value?

Jim Brady: In our view that is maybe something that we will think about for the future.

(Ellen Itzel): OK, great. Thank you.

Operator: You next question comes from the line of Doug Holmes from UWC. Your line is now open.

Doug Holmes: Hi, this is Doug Holmes with the UWC. Just kind of a follow up to Peter's point what is the latest thing that you have in writing or will we get another alert that's more specific on ICD-9 code reporting. I can think of just a number of different scenarios where would be confusing in resolving the problems that have been hitting a lot of my members as well. What's the best thing in writing as of right now or can we anticipate something new?

Jim Brady: The user guide goes into extensive details (inaudible).

Doug Holmes: Well, I know it does. But here, but the question that's coming up is, let's take three possibilities, what you have doesn't really fit you look at it doesn't really fit neatly the code then what is your responsibility with respect to reporting.

Jim Brady: So, let’s take one, I know you said you had three, so let us take them as you ask them. So, one are you talking about the cause code or the actual.

Doug Holmes: OK, it could be either, it can be an error either way but –

Jim Brady: The reason I ask you is that in the user guide it does actually give you some guidance on the cause code that you know, there are cause codes that you can use in those cases, the diagnoses itself you need to be specific and you know, there are 10,000 codes to chose from. There ought to be something that describes the medical condition of, the person who is being treated for.

Doug Holmes: But if it doesn't then I guess that's one of the questions?

Jim Brady: I mean it shouldn't ever be possible that there isn't an ICD-9 code that addresses the medical situation. The ICD-9 has been out for a very long time, it's used by you know, an awful lot of people, of lot of medical -

Doug Holmes: Yes, this is in the same, there are really three. So, one is if it doesn't, nothing seems to fit, number two is fits in parts, but doesn't fit in part and the third one is the code fits part of the diagnosis but not all of it. What are those, how do you deal with those three and you know, sort of, one hand we are trying to meet our reporting obligations but they are being modified to better enable the COBC to its work. So, that's what I am looking, these are the three that came to mind that arise and people are confused about.

Jeremy Farquhar: I mean really the only thing that you can do if you don't have the explicit ICD-9 off of in EOB or something of that nature that you know is the appropriate ICD-9 linking to this specific injuries to do your best to find an ICD-9 that most closely resembles what your injury is.

Jim Brady: Make sure that somebody is looking at the ICD-9 along with injury themselves, I truly believe that you will find in every case that there is an ICD-9 that reflects what you have got.

Doug Holmes: OK, so, you are not putting at anything new that you think the user guide covers it as best as you can, is that.

Jim Brady: I do.

Doug Holmes: OK. One other question, I am wondering if there is, if we can expect that there will be some changes as result of the section 10109 of the affordable care act provisions, they are looking at standards right now and wondered if

there is a time frame or you have an expectation there might be some changes that come from that.

Jeremy Farquhar: We are not familiar with section 10109, I don't know if.

Doug Holmes: Well, there is actually hearing on the 18th from the National Committee on Vital and Health Statistics and one of the things they are talking about is standard for health information and they have included in there list of things, any issues including ICD-9 reporting. So, I thought you might be familiar with that or might have come into play here in foreseeable future.

Jeremy Farquhar: We have no information here about that or any comment on that so.

Jim Brady: We have no comment and no information. Yes, all right.

Doug Holmes: OK.

Operator: Your next question comes from the line of Tiffany Pickens with Phoenix Aviation. Your line is now open.

Tiffany Pickens: Hi, I am an RRE that uses a TPA and I understand that with the TPA we can only query monthly. So, in the instance that we need to rush our claim we queried through the Section 111 beneficiary look up and I am just wanting to know how accurate is that data?

Jeremy Farquhar: Well the beneficiary lookup, it is accurate although we have recently found there are, this is a little tricky. At the start if you were listening earlier in the call you would have heard us discussing situations where we are at present not able to post coverage records for individuals that have Part B Medicare Entitlements alone when there is no Part A Entitlement.

At the beginning when we first implemented the beneficiary lookup option, the beneficiary lookup option was still giving people a match even if the individual had no Part A coverage which we had since addressed because you know, although the person is Medicare beneficiary we don't want this to conflict and confuse people who are looking at the file submissions. File

submissions will give you a 51, we are not able to actually post records for these individuals and that's why we tell you and give you a 51.

They had made an update, we had corrected that, so, that they were in sink shortly after the implementation of the beneficiary lookup and just within the past couple of weeks we had been given some examples where it appeared that the beneficiary lookup may once again be out of sink in that respect in order to currently investigating.

Jim Brady: So, to that end if you have got a specific example that you are concerned about please give Jeremy a call.

Jeremy Farquhar: Yes, I have seen only a couple of examples but it is something that we got our development team investigating at present. So, if you have examples where you are getting different results on the query file, what results to take from your TBA versus what you are looking up via the beneficiary lookup online then please let us know.
Other than that there they should be entirely the same but there is that small discrepancy at this point of time.

Tiffany Pickens: And I apologize we had a thunderstorm warning, I had to leave the call momentarily so, I missed that at the beginning, but this situation is during our normal query we received a positive match they were a beneficiary and then when we did our quarterly submission in September the record was rejected on the no fault, that no, this person is not a beneficiary. So, then with the CMS beneficiary look up it also states that the person is not a beneficiary anymore. With that discrepancy we were just concerned about which way to go?

Jim Brady: When did you – do you know when the individual was queried for a Medicare entitlement initially? Was it 2011 or was it – or could it have been then prior dating back to 2010?

Tiffany Pickens: They actually were not a beneficiary initially and their status changed from No to Yes in around August.

Jeremy Farquhar: OK. So, that sounds like if you are seeing a discrepancy at that point then that is one of the situations that I was just referencing. So, if you wouldn't mind like I think we (inaudible) in the user guide within the escalation procedure this is Jeremy Farquhar, my email address is there, you can email me or you can give me a call my phone number is listed and or I can give you my phone number now it's (646) 458-6614. If you would like to give me a call with that example I will take a look at it and we can use that in our investigation.

Jim Brady: We will call to let you know completely one way or the other what the status on it.

Jeremy Farquhar: Yes, if it is an individual that has Part B coverage only I can look it up and tell you OK, the reason why you are getting a 51 return on your query response, query files submission response that is and on your claim file submission response that would explain it. So, please don't hesitate to give me a call and we can take a look.

Tiffany Pickens: Thank you.

Operator: And the next question comes from the line of Elizabeth Hartwig from Broadspire. Your line is open.

Elizabeth Hartwig: Hi, good afternoon. The CMS alert indicated that the company information from the TIN file was going to be checked against the US postal service format. Is the CMS registration website requiring that from your registration that it is in that United State postal service format at this time?

Jeremy Farquhar: No we don't get the information in that fashion during the registration process. So, you could register with an address that may not pass as deliverable address when sent in on your TIN reference file. So, that's not something we check during that stage but when you do send that, did you send that same address on your TIN reference file, it is going to go through an address validation process and if it's not and on the USPS database or it's in conclusive if there are numerous matches and they can't determine which is the appropriate delivery address or things of that nature.

Jim Brady: And you are not giving us the…

Jeremy Farquhar: Yes.

Elizabeth Hartwig: Are there any plans to change that, so, that the registration website requires that as well?

Jeremy Farquhar: Not at this point in time.

Elizabeth Hartwig: OK. Thank you, I appreciate it.

Operator: Your next question comes from the line of Emily Sayed from NC School Board Association. Your line is open.

Emily Sayed: Good afternoon. To follow up with the previous question, if our ORM, contractual obligation is over, but our limits are not exhausted can we put a ORM termination date and do we need to contact the COBC?

Jeremy Farquhar: You are no longer responsible for medicals. Yes, if you have an ORM termination date as of which point in time you are no longer paying for these particular injuries related to this claim then you may send an ORM termination date on your section 111 files. If need be in a emergency, if you need to give us an update in between your file submissions then you may call the COBC call center at (800) 999-1118 and we can take the termination date via that method as well.

Barbara Wright: And we have said on prior calls that when you are legally no longer responsible, whether that is because it is exhausted or understate law you are no longer responsible etcetera. It doesn't have to be solely by exhaustions.

Emily Sayed: OK. Would we need to get a letter from a doctor?

Barbara Wright: If it's not exhausted and your responsibility still continues let's pick one of those date, I think they have talked about Texas and Michigan where there is lifetime medicals.

In that case if you want to be able to terminate the record we have offered the option that if the treating physician certifies that the person is not going to require any further care related to the alleged incident etcetera then you can go

ahead and terminate the record and you know, if you are having trouble getting that directly and a beneficiary has a concern on what's happening with their Medicare records, they can always obtain that from their physician. There is model language for that, that's now on the COBC website, Jim correct.

Jim Brady: Yes, I think that's where it is. But that alert will actually steer you towards that.

Barbara Wright: I am sorry, I should have said alert, not model language.

Operator: Your next question comes from the line of Kathleen Kennerley with Aria Health. Your line is now open.

Kathleen Kennerley: Yes, hello. I would like some clarification regarding the TPOC amount that should be entered by a co-defendant in a suite. You talk about when joint and several liabilities is present and an example I am thinking of is there is a verdict let us say of a hundred thousand dollars and granted each defendant could be liable for the entire verdict based on the rules of several liability. However it's been a push in that one defendant will pay $50,000 the other defendant would pay $50,000 if each defendant put about $100,000 wouldn't that appear to CMS that Medicare beneficiary is receiving more money than there actually are in the settlement?

Barbara Wright: That's one of the issue we have said that needs to be handled by the backend. It would be equally bad for us, if each one put down $50,000 and then two of them didn't pay, so you know we…

Kathleen Kennerley: But I don't understand – could you clarify that a little more, please? Because if…

Barbara Wright: Basically what we said is from our standpoint, when there is a joint and several liability like you described each entity needs to report the amount full and it will be sorted out on the backend. The beneficiary's attorney is certainly going to make it clear to show us the settlement agreement or whatever they need to, to make sure they are not charged based on $300,000 settlement if it was actually a total of $100,000. So, that's an issue for our

recovery people to resolve. We have a bright line rule for purposes of reporting.

Kathleen Kennerley: OK.

Operator: Your next question comes from line off George Poulin, from Liberty Mutual. Your line is now open.

George Poulin: Thank you. Just to add another voice to the course of other voices about the CMS denials of care to our injured workers. The claimants if they have an open ORM, we too are seeing the same thing, hearing it from our operation managers and the feedback again from the workers is they are calling CMS and CMS is saying that we have an open record and we need to file a request to close the record which is jog in for sending an ORM term and these are not erroneous ICD-9 codes that we have sent, in some instances it is a lacerated finger and the treatment is for cataract to the eye that has been denied. So, I think this is not, obviously a one off, it is systemic.

Barbara Wright: As we have said earlier we are working on it and again we have not given contractors permission to deny all claims for someone who has an ORM record and last but not least as we have mentioned a beneficiary although we are not looking to entertain huge numbers of appeals if the beneficiary has not gotten satisfaction any other way, they clearly have appeal rights on that particular claim denial.

Jeremy Farquhar: And actually George, the couple of examples that I referred that are eluded to earlier were the examples that you passed along to us and we did investigate and pass along to CMS. So, those were valuable.

George Poulin: OK, great. Just one another one, I know this is out for about two years but given the fact that carriers have to spend a lot of time in planning a resource. The CMS conversion from ICD-9 to ICD-10 in October of 2013, I don't know if that's on your radar with everything else you have got going on.

But certainly how are you going to handle that migration especially with all these legacy reports previously sent to you with ICD-9 codes and some of the multiple ICD-9 codes then they could have an ICD-10 after 10 to 1, all those

requirements and so forth. Do you have a timeline and I am assuming 2012 but those requirements are some kind of discussion around that?

Jeremy Farquhar: Right, we are actually we discussed this earlier today with CMS. We are waiting on some of the information on how that downstream systems are going to be handling ICD-10. Some of our decisions are dependent on those. We have a meeting scheduled for early January to work out the details on what period of time we will be able to accept both 9s and 10s from the RRE. It will follow early part of next year.

George Poulin: Sure, well we be seeking any feedback from your reporters like myself or something like that?

Jeremy Farquhar: If you got any thoughts we wouldn't mind hearing them.

George Poulin: Well that will be great because I don't mind sharing them.

Jeremy Farquhar: You know where to find me.

George Poulin: All right, thank you that's all I have.

Operator: Your next question comes from the line of (Clada Strigins) with (Com Services Incorporated), your line is now open.

(Clada Strigins): Hi, yes. My question comes; I do believe it was submitted before. However I need to get some clarification on it. We report on behalf of the state order cash fund. There are responsible for paying the medical or claims up to $50,000 annually with a million dollar aggregate.

My question is number one, once the $50,000 is exhausted to we intern ORM termination date and I believe you just answered that with another caller. My second question, once the anniversary day comes around again do we begin, and we are responsible once again for the medical is that an add or an update, granted it is the same injury, the same date of incident, the same diagnosis.

Jeremy Farquhar: You know, we are not entirely sure that COBC how best to handle the situation and CMS might have any guidance we are not sure if putting a

termination date on Non-GHP record and then reopening the record the following year would be problematic.

Jim Brady: Problems from the recovery perspective.

Jeremy Farquhar: But at the same time I know we wouldn't want to you know, we don't want to open record out there causing denied claims when the benefits for the year have been exhausted.

Female: Right, exactly.

William Decker: This is Bill Decker, CMS. We are thinking about the same question and we will be getting with the COBC after this call to do a little bit more in-depth analysis of it. I would appreciate it if you would send exactly the same question.

Jeremy Farquhar: Actually it's already in the…

Clada Strigins: Yes, it is.

William Decker: That is already in, OK.

Jeremy Farquhar: It was a...

William Decker: It's good, so fairly obvious that there isn't any path answer we can give you here yet.

Clada Strigins: OK, Thank you.

Jeremy Farquhar: We will get back to you directly on this one because you know, it seems a specific question for you.

Clada Strigins: All right thank you so much.

Operator: Your next question comes from the line of (Ves Esslinger) with Kenan and Associates, your line is now open.

(Ves Esslinger): Thank you, we have a lot of smaller RREs that we report on to, the claim files have less than ten record and as a result we get a lot of 20 percent threshold

error rejects of the files because like one item will have a minor error that wouldn't otherwise cause the claim to get rejected but just because there is only 10 files and records in the file, it gets pumped out as having more than 20 percent errors. Is there any possibility of may be getting an exception to smaller files like that instead of having the entire file rejected for one error that shouldn't have otherwise caused it to be rejected?

Jeremy Farquhar: Well, the thing about he 20 percent error threshold is that we will release it upon your request for processing if the situation of that nature. It's just, you know the 20 percent error threshold is there in some part to alert the RRE when there are significant number of errors in case they might know what the issue is, they can catch it and they will like to resubmit rather than to have those process that (inaudible) file.

Jim Brady: So even on the small files, it's still actually a valuable process but that been said, when you know what it is that cause that and you know that it's just one out of ten (inaudible).

Jeremy Farquhar: And the DDI rep will release it for processing for you. If we have situations however you know when we do occasionally have situations where we might have a file that errors out entirely and it triggers that threshold. And in a situation if entire file errors out and it is something that we can determine the reason for and we can clearly explain it to the RRE -

Jim Brady: We would expect you to resubmit that correctly rather than…

(Ves Esslinger): Yes, I understand it, but it just creates a lot of extra work and our rep has been very cooperative in releasing the files, but it does create a lot of extra work for something that otherwise the claim file is just bigger at one or two more claims and it wouldn't have caused it to completely reject. So, I just thought I would ask.

Jeremy Farquhar: Thanks.

Operator: Your next question comes from line Carol Dondi, with Banner Health. Your line is now open.

Carol Dondi: Hello. We are having trouble, we are testing the new translator that is supposed to be used in next year. And it's working fine under Window XP but when we try to do it under Window 7 it works OK, if we run it from a dos command prompt with no option but if we try to run it from a dos command prompt programmatically or with the configuration file then it errors out. And we have sent this to our EDI rep and they said they thought it tested fine but it's not testing fine for us.

Jeremy Farquhar: OK, you can either, you know, touch base with your EDI rep again or you can send me the examples and can give me the specifics, this is Jeremy Farquhar.

Carol Dondi: OK.

Jim Brady: Just to clarify you are trying to run it from a command path as string, you are trying to…

Carol Dondi: We are actually trying to run it programmatically with a configuration file, that is what we have always done.

Jeremy Farquhar: Let me ask you one thing, when was it that you downloaded the copy of the version 3.0 that you are using, do you recall?

Carol Dondi: This is probably might have been even a month ago, couple of days, couple of weeks.

Jeremy Farquhar: If it was prior to I believe let me - I am looking at the calendar.

Jim Brady: We did have a file final version.

Jeremy Farquhar: Yes, we had posted and updated version more recently. If it was a month ago, there was a problem that we were aware of with running the program after the command line. We have since corrected it and I believe it was, it might have been at the beginning of November that we actually posted that…

Carol Dondi: OK, then we will try that and test it again before I send you the…

Jeremy Farquhar: Yes, give it a shot. I think that might solve your problem. But if it doesn't then you can let us know. Yes, send me an email or give me a call and we will look into it further.

Carol Dondi: Great, thank you.

Operator: And there are no further questions at this time. I will turn the call back over to the presenters.

William Decker: Thank you very much operator. That, since there are no further question, we are going to end the call now. It's now 2:45 p.m. actually in the afternoon here in Baltimore we thank you all for joining us. We hope the information we all gave you was useful. We will appreciate if those who have been instructed to follow through up with additional information to us, can do so. So, that we can prepare for the next call and thank you all again. We will have a call once more, as I mentioned previously in December on December the 14th. So, if you want to come back to us on that date, feel free.

Operator we can have everybody sign out or you can sign everybody off now and then put us back in our post call chat room.

Operator: Thank you, ladies and gentleman. This concludes today's conference call. You may now disconnect.

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