TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: November 16, 2009

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

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FTS-HHS HCFA

Moderator: John Albert
November 16, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. All participants are in a listen-only mode. During today's question-and-answer portion of the call, please press star 1 to ask a question. Please when your name is called please pronounce your name and your company. Today's call is being recorded. If you have any objections, please disconnect at this time. I will now turn the meeting over to Mr. (William Decker). Thank you. You may begin.

(William Decker): Thank you very much, operator. Hi, everybody, good afternoon. This is another national teleconference call for group health plan reporters that will be reporting under the requirements of Section 111.

This is again a group health plan call, not a non-group health plan call. If you are an NGHP RRE or thinking about being one, this is not a call for you. You can leave now and come back tomorrow in fact when we have the NGHP call.

For all you folks who are group health plan RREs, welcome. This is - today's date is November the 16th, 2009. We will have another call this year on December the 10th, 2009 so get your questions ready for that call.

Although no additional group health plan calls are presently scheduled, none are announced or scheduled on the Website - we are considering scheduling at least one and perhaps two early in 2010 because we will be issuing a revised edition of the group health plan user guide in December and we want to be

sure that if you have any questions about the new material that's in there, we can answer them for you.

And we will probably at this point I'm pretty sure that we'll have another GHP teleconference call sometime in the month of January although we haven't settled on the date yet.

I don't have much of other preliminary information to go over with you. I do want to just touch on one thing, again we continue to get questions about Social Security numbers on a variety of issues around Social Security numbers and most of them we've already addressed in these calls.

We want to reiterate to all the GHP insurers out there that we get information from beneficiaries and others who contact us and ask us why it is they're being required to supply their Social Security numbers to insurers.

The insurers are saying to them either directly or strongly hinting indirectly that the Social Security numbers are required because of Section 111 reporting and we say again in this call as we have been in the last couple of months on the other calls that there is no requirement in the Section 111 statute for the collection of Social Security numbers in order to report your data to us under the terms of Section 111 requirements.

There just is no requirement of that and we would appreciate it if you wouldn't suggest to folks that there is a requirement under Section 111 for the collection of Social Security information.

We repeat again that the primary ID for Section 111 reporting is the Medicare health insurance claim number, the Medicare HICN and that you can supply us with Social Security numbers of folks if you want us to check our data files

to see if anybody whose information you're sending us is a Medicare beneficiary and we'll be glad to find out and let you know if we do find someone who is a beneficiary.

We also remind folks that in any case, where folks who are under the age of 45, we don't want you to send us Social Security numbers in lieu of a HICN for reporting purposes if someone is under the age of 45. We need a HICN only for less than 45-year-old folks.

So that's the SSN announcement for today and we have in the room with me right now (Pat Ambrose) who is going to be speaking with you in just a couple minutes and we also have with us (Bill Zevoynia) who will be chipping-in from time to time.

We expect to have a couple of other folks joining us in about a half an hour to 45 minutes and when they get here, I will let you know who they are so for now though, this is (Bill Decker) and I'm about to turn it over to (Pat Ambrose). (Pat)?

(Pat Ambrose): Okay, thanks, (Bill). I have some general announcements and then we'll open it up to question-and-answer as (Bill) indicated. First off, a correction is being made to the X-12 270, 271 companion guide for those RREs that are not using the (Hugh) software that fit the eligibility wrapper and instead using their own X-12 translator for the query-only file.

The change involved the 2100C DMG subscriber demographic information segment as being situational. This segment should be sent when the value in 2100C-NM109 is not known and the birth date can be used to identify the subscriber.

This change will be posted in the X-12 270, 271 companion guide to the Website in a revised version soon. Another change related to the query-only file format is that we are updating that file format to add optional document control number fields that RREs may submit on input records and the COBC will return on response records.

These fields will allow an RRE to better match-up input and response records. This change will be implemented in January 2010. The X-12 270, 271 companion guide that I mentioned before will be updated with this information as well as the HIPPA eligibility wrapper or the (Hugh) software.

Again, use of these fields will be optional so RREs may continue to use the old version of the (Hugh) software or the new. The changes will be documented soon in the updated version of the user guide that (Bill) mentioned that we're trying to get out by the end of this year.

CMS has determined that the plan sponsor TIN must be submitted in the employer TIN field 21 of the NFC input file record for all multi-employer, multiple-employer GHPs and not just those using an hours bank arrangement like a Taft-Hartley plan.

The current user guide indicates that you should use the plan sponsor TIN in the case of a GHP based on an hours bank type of arrangement. That is being expanded and also it is required that RREs use the plan sponsor TIN for the employer TIN field 21 of all multi-employer, multiple-employer GHPs and not just those using the hours bank arrangement.

Each plan sponsor TIN used that needs to be accompanied by a corresponding TIN reference file record with the plan sponsor TIN, name and address and a TIN indicator of S for sponsor.

RREs must adhere to this new requirement with files submitted in the 2nd Quarter of 2010. That's files submitted during the timeframe of April through June of 2010 or before.

You must resubmit all affected MSP input file records previously accepted with an 01 disposition code with updates having the new plan sponsor TIN and a new TIN reference file must accompany that with any new TINs that you're using.

Again, both new MSP input records and TIN records must be submitted in order for the change to be applied to the individual MSP occurrences and those updates only need to be applied to records that were previously accepted with an 01 disposition code.

So that was an issue that's been outstanding for awhile and has resolution and it will be documented in the upcoming user guide. Requirements are being finalized to allow RREs to submit records associated to foreign employers who may have no TIN or U.S. address.

These changes will go into effect in April of 2010. You should have already reported these foreign employers by this time using a pseudo TIN so until you're able to report them as will be documented in the user guide for changes we'll implement in April 2010, you should submit these records with a pseudo TIN for the foreign employer in field 21 employer TIN if that foreign employer has no TIN, and put a Y in the TIN indicator of the corresponding TIN reference file record.

You may default the employer address to the RRE's address on the TIN record for the time being. Again, that's just a temporary measure until you're able to report these records correctly starting in April 2010.

Please note that most non-U.S. or foreign employers that employ U.S. citizens actually do have an employer identification ID or EIN assigned to them by the IRS which they use to report income information on these employees to the IRS for tax purposes.

The EIN is a TIN, is a Tax Identification Number and sometimes is referred to as a Federal EIN or FEIN and it is to be reported as the employer's TIN in field 21 if they have such an EIN and on the TIN reference file record with the TIN indicator of E if the foreign employer has that EIN.

The upcoming changes to handle foreign employers will include allowing the RRE to submit a pseudo TIN for the foreign employer. We're adding an additional TIN indicator value of B for foreign employer TIN records being submitted with that pseudo TIN.

And then we're also adding a new set of free-form text address fields to accommodate foreign employer addresses since there's not general consistency for countries that you might have to - addresses in countries that you might have to report - but we will provide these free-form address fields that will accommodate that.

As we've already mentioned, please expect an update to the GHP user guide by the end of the year. Changes will include the plan sponsor and foreign employer changes that I already have mentioned.

The addition of a new optional office code or site ID so that multiple TIN reference file records can be submitted under one TIN for the purposes of associating more than one address per insurer or TPA TIN.

Another change includes the addition of a new optional recovery demand address on the TIN reference file that can be supplied if the RRE wants their courtesy copy of the recovery demand sent to a location other than that used for claim. A further explanation of the employer size field will be included in the user guide.

We previously had avoided a lot of explanation regarding employer size since it has not actually changed - the end of key roles related to that - are not actually changed by Section 111 but we do understand that it's a complicated issue and we want it reported correctly under Section 111 so we will be adding more information on how RREs should go about filling that indicator and what to do about reporting subsequent changes to employer size.

I'm also going to talk about that more in this presentation. Note that if an RRE does not have an employer size information available, then they should default it to the largest size of 100 or more which means that setting that employer size field indicator to a value of 2.

I've already mentioned that the user guide will include updates to the addition of the DCN fields to the query-only file. We are also removing disposition code 55 which indicates that a record is not matched to a bene due to a name-key mismatch.

It turns out that this disposition code 55 is not possible and not ever returned. Now if someone has an example of getting a 55 disposition code back, certainly I would be interested in knowing that so please provide that

information to your EDI representative but at this point in time, we're planning on removing documentation related to those disposition code 55 since we don't believe it ever happens.

We are also adding to the user guide clarification of the coverage type field which will indicate which code values include drug coverage and which don't. This hasn't been clearly defined in the user guide.

Other clarifications are being added in the user guide that have been discussed previously on these calls. We'll also add some language related to what an RRE should do if it ceases business and therefore ceases Section 111 reporting or if Section 111 reporting is transitioning to another entity such as a different TPA and how that transitions to go - should be made - and be reported.

You must process your response files. This is a separate topic. We talked about this on the last call. It's critically important that you actually have code in your systems to process the response file that the COBC returns both for your query-only file, your MSP file, and your non-MSP file we're particularly concerned about RREs processing the response file for their MST input file.

This response file contains critical information regarding your Section 111 submission. Please process your response file from the last quarter first before sending your next quarterly file submission, even if that means that that next file submission might be late.

If you're experiencing difficulties with it, CMS would rather have the response file processed and the next MSP file submitted properly rather than on time since the accuracy of the data is more critical to that timeliness. If you're going to be late submitting an MSP input file, please notify your EDI representative.

Another announcement that we've made in the past, you are only to submit delete records in the case where the record was previously accepted with an 01 disposition code.

There is no need to send a delete transaction for a record that was not previously accepted so there is no need to delete a record that was sent but not accepted and in fact it will be returned with an error if we can't match that delete record to an existing MSP occurrence.

Remember that you are not to delete a record when an individual's GHP coverage ends, but rather send an update with a termination date. Another announcement related to file submission, files that are completely rejected for say a missing TIN reference file or missing - or has a significant number of records that are rejected due to no matching TIN reference file record.

For example, if you send in an MSP input file with insurer or TPA TINs for which there is no corresponding TIN reference file record with an I TIN indicator, you will get all the MSP input records associated with that rejected back probably with a SP-25 that indicates invalid insurer name.

In these circumstances, we ask that you contact your EDI representative and make the corrections and resend your files as soon as possible. Do not wait for the next quarter to fix a serious problem such as this and again, please work with your EDI representative regarding resubmission.

So I'm referring to files that MSP input files that are completely rejected or a majority or a significant number of records are rejected. If you have any questions, again please contact your EDI representative.

Another announcement related to file submission, if you have mistakenly included retirees on your MSP input file, do not wait until your next file submission to correct this.

Please contact the EDI department or your EDI representative immediately. If you incorrectly report information for Medicare beneficiaries who are not active covered individuals and are in fact covered by - they're not actively working or covered by a spouse who is actively working, as you know Medicare should be primary in that case.

Any claims that are submitted then to Medicare for that individual, any claims that are submitted as primary will be denied for primary payment so it's critically important.

Obviously it causes a lot of problems for Medicare beneficiaries in the Medicare call centers when an RRE erroneously submits retirees on its MSP input file.

Obviously this can happen due to data processing errors or not having accurate information from employers on who's covered by accident employment and who isn't but again it's critical that once you have discovered that you have submitted retirees or those covered by a retirement plan rather than be current employment that you must send in delete transactions for those on an MSP input file as soon as possible so again, contact your EDI representative regarding that type of issue.

If you erroneously registered for an RRE ID that you no longer need or have since abandoned since you started the registration process over, please make sure that you have asked an EDI representative to have that number deleted.

Most unused RRE IDs we've identified and sent out targeted e-mails asking for a status on those RRE IDs and if they are indeed abandoned or not. If you know that you have one lingering out there that you're not going to use going forward, please contact your EDI representative.

Another announcement related to the secure file transfer process. Many people have experienced some performance issues related to the secure file transfer process and I want to assure you that CMS and the COBC are working very hard to get those problems corrected.

They are mainly related to a software product that we're required to use and trying to work out the various issues with that particular product. In the meantime, if you're experiencing problems with secure FTPs, here are some suggestions. Please note that if an authentication error is received, that should be reported to your EDI representative.

On the other hand, if you're having timeout-related errors, do not perform a directory listing. Users processing secure file transfer or SFTP in a batch mode should refrain from specifying the LS command.

Specify - in addition to that - specify the RRE ID mailbox as part of the secure file transfer protocol address, as part of the FTP address. For example, use section111.cms.hhs.gov/ followed by your RRE ID and that is a nine-digit number including any applicable leading zeroes.

Specify this forward slash nine-digit RRE ID number with the leading zeroes as the remote site folder when creating connection parameters. If any of this is confusing and again if you're experiencing difficulties with secure file transfer, please contact your EDI representative for further assistance.

They can help with the authentication errors and can provide more information on the information that I've just provided. One issue that is still outstanding is the healthcare reimbursement account reporting. CMS is very close to finalizing requirements for that reporting but we're not able to provide you with any additional information on that at this point in time.

Before we open it up to the question-and-answer and before I address some of the specific questions that were sent to the CMS mailbox, I'm going to go through some information about employer size reporting. It should try and provide a better explanation of how to calculate employer size and how to set that employer size indicator on your MSP input file.

We are updating the user guide to provide more information on employer size reporting and we're producing a computer-based training module or a CMP module that will add to the GHP curriculum for this issue or topic.

Remember that in the meantime, employer size rules can be found at 42 CFR 411.101 and 411.170 and you can also find information in the CMS Medicare manuals at www.cms.hhs.gov/manuals/downloads/msp105c01.pdf. There's also a general link to the CMS Medicare manuals.

That link that I read off, the Federal Register location and these links where you can find on the CMS Website, the MSP manuals are all in the user guide so you can review some information there while we are continuing to work on updates to the user guide and that computer-based training module.

To start out with, when you're calculating employer size, you are counting employees. Include all employees worldwide if the company happens to be expanding in just the U.S. but it's all employees everywhere, full or part-time even if they're on vacation or on disability or on maternity leave.

Again, that count of employees is also documented in the MSP rules that can be found at those sites that I gave you just a minute ago, but reporting a change in an employer size is not as simple as just reporting the effective date of when the actual number of employees changed.

It is to be reported with effective dates as to when the change actually affects whether Medicare could be primary or secondary. Medicare is the secondary care to GHPs for the working age where either a single employer or 20 or more full and/or part-time employees is the sponsor of the GHP or contributor to the GHP or two or more employers are sponsors or contributors to a multi-employer, multiple-employer plan and at least one of the employers has 20 or more full and/or part-time employees.

The 20 employee or more requirement is met if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year so when the number of employees first exceeds 20 or more, a change to employer size is not immediately submitted.

The change in employer size is not recorded until the date the employer has had 20 or more employees for 20 or more weeks in a calendar year. The effective date submitted would be the first day of the 21st week that the employer has had 20 or more employees in a calendar year.

(William Decker): Provided they did not have them in a prior year.

(Pat Ambrose): Provided that they did not have them in a prior year, thank you, (Bill). Note that the 20 weeks do not have to be consecutive, a change that involves employer size increasing to 20 or more employees is likely to occur mid-year.

Medicare is the secondary care for claims for beneficiaries under age 65 who have Medicare because of a disability and who are covered under what is referred to as a large group health plan or an LGHP through their current employment or to the current employment of any family members, so the disability rules are different from those related to people who are entitled to Medicare due to age.

Medicare is the secondary care of benefits if a single employer employs 100 or more employees or if the GHP is a multi-employer, multiple-employer plan that covers one employee and it employs 100 or more employees.

The employee-or-more requirement is met if the employer employed 100 or more employees on 50% or more of its business days in the previous calendar year. That's just the previous calendar year and not the current calendar year, the previous calendar year.

Therefore, the employer size changes related to 100 or more can only occur effective January 1st and it depends on the number of employees throughout the previous calendar year so setting that indicator, some different logic needs to be used as to the 20-employee threshold and the 100-employee threshold.

As I mentioned before, employer size changes must be reported in a manner slightly different than most other changes for Section 111 are reported. For example, when an employee retires, the termination date on the update transaction submitted reflects the actual day the employee retired.

When the employer size changes occur, the termination date generally will be later than the date the actual employer size change occurs. The termination date is later because of the way Medicare regulations work.

When employer size changes, RREs will need to determine if the change in size impacts the order in which benefits should be paid. If Medicare is becoming primary or secondary under either the working age or disability provision, update transaction for all affected active covered individuals must be submitted.

The determination of the primary payer should be made in part by applying the employer size regulation. Again, that can be found at 42 CFR 411.101 and 411.170.

If employer size increases from less than 20 employees to 20 or greater or employer size increases from less than 100 employees to 100 or greater any previously-reported records accepted with an 01 disposition code must have an update transaction submitted to terminate the existing record, the existing MSP occurrence, and an add transaction must be submitted to reflect the new employer size.

If the employer size decreases from 20 employees or greater to less than 20 or employer size decreases from 100 employees or greater to less than 100, any previously-reported records that were previously accepted with an 01 disposition code must have an update transaction submitted to terminate the existing record - the existing MSP occurrence, that is - and an add transaction must be submitted to reflect the new employer size.

The effective date used in the add transaction is not to be the date the employer size change actually occurs, but rather it must be equal to the date Medicare becomes secondary under the working, aged or disability provisions if employer size is increasing or the date Medicare becomes primary under the working age for disability provisions if the employer size is decreasing.

The termination date used will always be the date before the effective date as calculated in the step above.

(William Decker): (Pat), let me make a comment. It is not necessarily the nature of the employer's contract with the insurer or the group health plan that is determinative of whether or not it is a single employer health plan.

It is CMS' policy that if an organization such as a employer association has facilitated the employer's acquisition of the group health plan coverage in any way, and that it is a multiple-employer plan even if each individual employer receives a separate contract.

You need to be aware of whether or not the plan is considered a multiple-employer plan or a single-employer plan and you cannot rely solely on the nature of the employer's contractual relationship with the insurers.

(Pat Ambrose): Okay. I also wanted to mention or reiterate here again that the COBC system does not track employer size for you and changes to employer size other than what you report in that indicator.

Some of you might have realized that if you follow the reporting instructions that I just went through that in some cases when you submit add records, you may not have those add records accepted.

And what I want to refer you to is the GHP user guide section 7.2.9.2 where there is a section entitled Special Consideration for the FPEF Error Code and just reading from the user guide now, on the MSP input file you are asked to submit a code in field 16 employer size to reflect the size of the employer sponsoring the GHP associated with each active covered individual.

A value of 0 indicates the employer has less than 20 employees. A value of 1 indicates 20 to 99 employees, and a value of 2 indicates the employer has 100 or more employees.

The COBC Obviously it causes a lot of problems for Medicare beneficiaries in the Medicare call centers when an RRE erroneously submits retirees on its MSP input file.

The COBC uses the value provided in the employer size field when determining whether the GHP coverage is primary to Medicare and thus establishing MSP occurrences.

In some cases, an MSP occurrence is not created, for an example if an employer is reported to have less than 100 employees and the beneficiary is entitled to Medicare due to disability, Medicare will be the primary payer in any case and an MSP occurrence will not be created.

(William Decker): (Unintelligible).

(Pat Ambrose): Yeah. I'm just referring that if you report a 2 for greater than 100 employees, then we are going to assume that that applies both to a single employer or if that - you enter to the multi-employer, multiple-employer plan.

So in these situations, the COBC will return a disposition code of FP and put FPES in one of the SP error code fields on the corresponding response file record so usually when processing an FP disposition code, you are to correct all errors and resubmit a record in your next quarterly response file, the FPES error code requires special handling and it is an exception to this general rule.

So when you receive an FPES error on a response file record, check that the employer size submitted was correct, update it if the employer size was submitted incorrectly, and continue to resend the record on all subsequent quarterly file submissions until the individual is no longer covered by your plan or an 01 disposition code is returned.

Since the employer size may not change, you may continue to receive a response record back with an FP disposition, an FPES error code for these situations.

The reason we recommend you continue to send these records getting an FPES error is that the reason for the Medicare beneficiary's Medicare entitlement may change which may result in a different MSP discrimination.

All that said, collecting this information we do understand is a difficult task. If I were an RRE and I had to go about collecting employer size information, I would survey my employers related to the GHPs I'm reporting under at least once a year, but then go on to instruct employers to notify the RRE of any significant changes.

For example, if they're hovering around the 20 threshold or the 100 employee threshold, they may need to - well, 20 threshold - they may need to notify you mid-year because again that depends on 20 weeks in the current or preceding calendar year.

So employer size changes for that 20-employee threshold may end-up needing to be reported with an effective date that's mid-year changes related to the 100 employees or more due to the disability rules being based only on the number of employees in the preceding calendar year only need to be reported as of January 1st.

I know this is a lot of information. I'm going to go on to try to answer some of the particular questions that were submitted related to employer size and other things.

But in the meantime, if you have continued questions or you have additional questions related to employer size, please send them to the CMS mailbox and we can - so that we understand what confusion still rests out there and can address it.

So send in your questions and we'll continue to address them both in the user guide to CBT and on these calls. Now on to questions that were actually submitted to the CMS mailbox. Several questions were submitted regarding reporting changes in an employer size.

In the first such question, the RRE realized that an employer it had been reporting with an employer size of less than 20 is actually associated with a much larger entity and the employer size should have been reported as over 100 so the employer size in this example didn't change in this case but rather an incorrect employer size was reported originally and must be corrected.

So in this example given there are three companies that essentially make-up one entity. Now each of these three companies or subsidiaries has its own (tap) identification number or TIN. You may report the MSP records under the separate employer TIN but report each record with the same employer size for the overall employer size.

That is reflecting the total of all that belonged to the same overall employer or parent company. The employer size is reported as an indicator as we mentioned before. One of the companies - the smaller one - was reported with

an indicator of 0 for 0 to 19 employees and the other two were reported with an indicator of 2 for 100 or over employees.

The records previously reported with an employer size of 100 or over for the larger companies are fine since the employer size indicator is still the same even with the combined employee counts.

The records reported for the smaller company were reported with the incorrect employer size and need to be corrected and resent to reflect the size of the entire overall employer within an employer size indicator of 2 for 100 or over employees.

So to correct the employer size, not to report - this is not reporting a change that has happened subsequently to employer size but to actually correct it - first you must delete any MSP records that were accepted with an 01 disposition code previously submitted with the incorrect employer size of 0.

Most of them were probably returned with either a 51, (knocking) national Medicare beneficiary or an FP with the FPEF error code that I covered previously.

(William Decker): That's a delete, not an update?

(Pat Ambrose): I haven't gotten to that yet but yes, they would be deleting them in fact, yes. And this actually is in user guide but I just, you know, to make a correction of this nature, but I just wanted to reiterate it here.

So most of them probably for that smaller company were returned with an FP - those records submitted for a Medicare beneficiary anyway - were returned

with an FPEF error code since the employer size was such that Medicare would be primary and not secondary so no MFP occurrence was created.

So you only need to send deletes if you previously received an 01 disposition code and this is in this specific example. Then in the same file but on records following the delete, submit add records for all the active covered individuals who are Medicare beneficiaries.

It depends on your reporting, how you're reporting, whether you're using the query finder file method or reporting all active covered individuals, but resend those from all those records from the smaller company with the corrected employer size indicator of 2. The system will then make a new determination of MFP and return responses accordingly.

The next question I'm going to read through and then provide an answer. I apologize for so much information and having to read it but I want to make sure that I'm clear on what question is being asked.

On our system, we update employer sizes annually, the questioner has said, so there is a potential that a size change will result in more than one MFP transaction being sent for someone if the enrollment period being reported stands a change in employer size.

The first part of their question is do we only have to send multiple MFP transactions for someone if the employer size change spans the reporting quarter? Their question goes on to state what should happen if the size changed prior to the reporting quarter?

Do we just send the coverage related to the most recent employer size and report coverage back only as far as there was a change? For example, we have

a member that meets reporting criteria, an active covered individual, is a Medicare beneficiary, and during the middle of our reporting quarter, the employer size changes from less than 100 to more than 100 employees.

We would create two MFP transactions in this situation, one for the less than 100 period coverage and one for the greater than 100 period of coverage. If the member was returned with a 51 disposition code for no match in the subsequent cycles or files that they're submitting - quarterly files - we would resend only the latest coverage information with the greater-than-100 employee size. We go on to ask if this is correct.

Additionally, if someone turns 45 or if the case right now is 55 and is being reported for the first time and they had coverage back to January 1st, 2004, and as of January 1st, 2008 there was a size change from greater than 100 to less than 100 employees and that size has remained to the current date as have other aspects of the individual's coverage, do we only have to report coverage back to 1/1/2008 which would be the most recent employer size change, or do we have to report coverage back to 1/1/2004 with another MFP transaction?

So in order to answer this, the first primary report on an active covered individual, you have to report multiple records of GHP coverage if there are multiple associated employer sizes for the coverage period that you're reporting, so you could be submitting multiple records on that - multiple add records - on that initial report.

Obviously the first one should have a termination date. The second one might be open-ended. Remember that the employer size is being supplied using the indicators for 1 through 19, 20 to 99, and 100 or more so records are to be reported by those categories and the reporting quarter really doesn't matter.

At the time of the report, you should submit any changes that are applicable with the associated effective and termination dates that I spoke about previously.

Also note that updating employer size on an annual basis is not completely sufficient when addressing the 20 or more employee guideline since it depends on the size for 20 weeks in the current or preceding calendar year.

Updating employer size on an annual basis will work when addressing the 100 or more guideline as employer size is based on employees throughout the entire past calendar year and the effective date for that kind of change is always January 1st, therefore.

If a record is returned with a 51 disposition code, that means the person was not matched to a Medicare beneficiary and you should follow the instructions that are in the user guide for that position code.

If you get a 51, you should continue to send only the most current coverage record reflecting the most recent effective date of the employer size change since their Medicare coverage won't in theory overlap the prior period anyway or instead, you could query this individual and not send an MFP record until the query response indicates that they are now matched to a Medicare beneficiary.

Of course either way, you must be sure that you are sending the correct information for that individual for matching purposes such as their name and birth date and so on.

Now the first time you report an individual, you are required to report back to what their coverage reflected on the effective date for Section 111 reporting which is 1/1/2009 and subsequent and the effective dates related to that.

You may have to initially report multiple records to reflect a coverage that was in effect on 1/1/2009 and any changes since to something like employer size.

So in the example given where this individual was originally covered January 1st, 2004 but the employer size changed as of January 1st, 2008, both being before 2009 and the employer size remains the same until the present time, you would report a record with an effective date of 1/1/2008 since that would reflect their coverage that was reflective of how they were covered as of 1/1/2009.

If the employer size had not changed and was the same on 1/1/2004 through 1/1/2009, you would report an effective date of 1/1/2004 but that isn't the case here. If the employer size changed after 1/1/2009 say on 1/2010 and we're in the year 2010 reporting, you would send multiple records.

The first would be a 1/1/2008 effective date and a termination date of 12/31/2009 and a second record with an effective date of 1/1/2010 and the new employer size.

You would then maintain only the open record with the effective date of 1/1/2010 going forward. Again of course, it's the sense that you are reporting in 2010 since we don't accept future dates in the effective date.

Note also that you can use the entitlement, the Medicare entitlement dates returned on the query and the MFP response file records to help you process the disposition codes and determine what you need to send going forward.

Another question submitted related to employer size, if the employer size reported on an MFP record conflicts with the employer size that the COBC or CMS has on file and that size was the result of a data match questionnaire, do you send an indicator of that conflict in size? If not, what would occur?

So this RRE is wondering if based on different information related to employer size and the employer might have a return on their data match questionnaire, what happened?

This information is not tracked in the COBC system in this manner and no notification of a conflict between employer size reported by Section 111 and an employer via the data match will be provided back to the RRE.

The system will only use the information gathered from the Section 111 report while determining whether to create an MFP occurrence for that Section 111 report.

If there is a matching MFP occurrence already posted out on the common working file or see to be left by the data match process, the Section 111 report could overlay or update that MFP occurrence that was created from the data match and vice versa.

Essentially the last report or last record or last set of information processed wins; however, an actual delete record must be sent to remove an MFP occurrence already posted.

If no delete is sent via Section 111 or reported to the COBC in some other manner such as by a Medicare beneficiary on the phone, then that record will remain.

Here's another question on a new topic, not employer size. I'm working with a number of employers that self-fund their employee health plans and also pay their own claims. As a result, these employers have been required to register as RREs.

Many of these employers are only paying claims for those employees that work overseas and some are being told by their EDI representative that they do not have to report these employees.

Some conflicting information may have been provided in one of our conference calls and so the question really is whether they need to report these employees or not.

Employers that have self-funded, self-administered GHPs for their employees are often defined as a Section 111 RRE. See the definitions of an RRE in the user guide for more information on that.

RREs must report active covered individuals that are Medicare beneficiaries that are covered by an employer-sponsored GHP, in other words provided most likely by a healthcare insurer in the U.S.

It doesn't matter where these individuals live or work. The employees working overseas could conceivably come to the U.S. to get healthcare services and when they do, the GHP may be primary and Medicare secondary.

It might be that your EDI representative did not have an adequate amount of information about that particular circumstance but by virtue of these employees working overseas, that is not pertinent to whether they should be reported on Section 111 unless the input files are not.

Another question goes on, please advise if Section 111 includes FIN insurance, accident and health and FIN as blanket accident insurance plans, the policyholder would be the school which the student attends.

This type of insurance policy is not reportable under GHP Section 111, mandatory reporting as the insurance is not an employer-sponsored GHP. They may be reported under non-GHP but we'll stick to the GHP issues on this call.

Please advise if this law applies to limited medical plans purchased by someone who is a member of an association not affiliated with an employer. My answer and (Bill Zevoynia) may correct me is no, Section 111 only requires reporting of GHP coverage related to employer-sponsored plans or GHPs.

(Bill Zevoynia): You've got to be very careful here when we're starting to talk about an association. An association may include individuals who are technical not employees but are self-employed using Schedule C and in which case that association facilitated the acquisition of the insurance, then that would be a group health plan and that self-employed individual would need to be reported.

(Pat Ambrose): Okay, and also in the user guide and as I previously mentioned, there's more information and CMS definitions of GHP in the CMS Medicare MFP manual that can be found on the CMS Website and the Federal Register sites that I've

provided previously and can be found in the user guide, so if you didn't catch all of that, hopefully you can find that information in those places.

Another question came up regarding what was posted on the do's and don'ts page of the mandatory insurer reporting Website and particularly related to submission of retiree records which we spoke about previously.

The question goes on to ask how do we report retirees who are working and are covered under an active - not a retiree - plan? So a retiree essentially by our definition is not working and is covered by a retirement plan rather than being covered by either their own or a family member's current employment.

The individual described in this question is working and should be reported on the MFP input file since if they are a Medicare beneficiary, the GHP provided to their employer may be primary and Medicare secondary so that individual would classify as an active covered individual.

Maybe the confusion is the age. It doesn't matter. If someone is over 65 and they are still working, they are considered an active covered individual.

(Bill Zevoynia): The other thing that can happen here is that people get confused with the idea that someone who's retired from place A is now later going to work at place B and place B provides group health plan insurance for that "retiree" which is great because now the person is an active covered individual under our definitions and if that former retiree is also a Medicare beneficiary, that reporting is now subject to the Section 111 reporting - that coverage - is now subject to the Section 111 reporting.

The individual could still be a retiree and covered by some sort of a policy under the old employer. That doesn't matter to us. As long as that person is

covered currently as an active worker by someone else and has GHP coverage, that's reportable under MFP.

(William Decker): Also the fact that if you have a retiree return to work for the employer, either as the consultant or as the back line employee who works sufficient hours that they wouldn't qualify for new health plan coverage as an employee, the fact that they continue to have their new health plan coverage that pays, that has to be reported as primary group health plan coverage to Medicare because they qualify for group health plan coverage as an employee.

It's in their regulations with respect and I believe we referred to them as re-employed to deal with this.

(Pat Ambrose): Okay, next question is a different topic related to reporting of TIN numbers. A TPA is asking this question so in this example, the RRE is a Third Party Administrator or a TPA.

One of their clients is an insurer as defined according to the CMS requirements for that and is an entity that in return for the receipt of premium assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments.

As such, the TPA processes the insurer's claims but the actual payment of these claims comes from the insurer's own bank account. The TPA's question is whether they must report the tax identification numbers of the insurer's clients who receive group insurance policies from the insurer or merely the Tax Identification Number of the insurer itself.

I'm assuming in my answer that the insurer's clients they are referring to - the TPA is referring to in this question - are employers sponsoring GHPs for their employees.

The TPA is - if that's true - then the TPA would submit their Tax Identification Number or TIN being the RRE and the insurer TPA sends the 022 of the MFP input file and on TIN reference files, records - TIN reference file record with an I TIN indicator - and submit the employer's TIN, the clients of the insurer, in the employer TIN field, 21 of the MFP input file and records for each employer TIN on the TIN reference file records with an E TIN indicator.

In this particular example, the insurer's TIN need not be submitted at all. Generally speaking, CMS sends the recovery demands related to other GHP coverage to the employer that sponsors the GHP and a courtesy copy goes to the insurer or TPA depending on who processes the claim.

The employers are then responsible for working with their insurer and TPA to address the recovery demand and respond to CMS. The ultimate responsibility falls on the employer to pay back Medicare but the insurer TPA is of course responsible for working with them to respond to CMS so I hope that answers that question definitively.

Another question was submitted noting that on the HICN SSN collection GHP model language form, it was noted that the reference to parent while retaining the record was dropped while references to dependent child and domestic partner were retained and this person was asking - would like to confirm that dropping the reference to the word parent in the form - was that intended and to be a substantive deletion and in particular the Medicare regulations, you

know, include parent as a family member as well as a spouse including a divorced or common law spouse and so on.

The answer to this is that dropping the language of parent from that form was more or less inadvertent and has no particular meaning, a parent is defined as another dependent - possible dependent.

The question concerned me because you really should be using the reporting requirements as outlined in the user guide and not inferring requirements from the model language.

You need to refer to the definition of an active covered individual and provide the proper relationship code when reporting these individuals so the MFP rules can be applied and MFP occurrences applied correctly so again, that dropping the records to parent has no significance as far as your Section 111 reporting.

One final question. I'm sorry for taking up so much time. The last question is asking for the FSN mandate, what else can be accepted if the dependents or spouse have no FSN?

First off, there is no FSN mandate as (Mr. Decker) explained at the beginning of this call. We do need either the, you know, we want the health insurance claim number and if that's not available and you're unsure of someone's Medicare status, you may submit an SSN to help you determine their Medicare status, there is no SSN mandate as a result of Section 111.

We want again the HIC Number to be reported which is the Health Insurance Claim Number or HICN to be reported for Medicare beneficiaries. If that isn't available, you have to send (10-BUs) to determine a person's Medicare status.

If the dependent or spouse has no SSN, they are not a Medicare beneficiary, and therefore they do not have to be reported. In order to become entitled to Medicare, you must first have a Social Security number so if someone responds to you that they have no Social Security number, then you really have no worries because you don't have to report them.

They can't be a Medicare beneficiary and so with that, I'll turn it back to (Mr. Decker).

(William Decker): Thank you very much, (Pat). That was probably the longest one of those introductory remarks that we've had on any of these calls and we thank you all for taking the time to listen and we hope that it was all clear.

You may have some questions and we'd be happy to take your questions now. I do want to make one announcement. We have been joined in the interim by John Albert and he also may be chipping-in with some answers as we go through the rest of this today. There are other staff members here to and if they deign to reply to any questions, I'll ask them to identify themselves before they do.

Now, operator, we will be happy to take any calls that are waiting for us to answer and once again for all you callers out there, please give us your name and the entity that you're affiliated with, who you work for, and remember that we're asking you to keep it to one question with one follow-up. Okay, operator, you can open it up for calls now.

Coordinator: Thank you. If you'd like to ask a question, please press star 1. I have (Carol Leachman). Your line is open. Please state your organization.

(Carol Leachman): Regents Blue Shield of Idaho and I was wondering when will the October 27th transcript be posted onto the Website?

(William Decker): Transcripts that are not posted on the Website now will be posted as soon as the Website reorganization is finished. That process is well along and will be finished shortly.

If you desire a particular transcript, you can send an e-mail to the Section 111 mailbox identifying the transcript that you're interested in and we will provide it to you directly.

You won't have to wait for it to appear on the Website. Just because the transcripts are not on the Website does not mean they are not available and we actually have transcripts from the earlier calls.

They get done pretty quickly, actually. We just haven't been able to put them up on the Section 111 Website yet so if you do want to have that transcript, let us know through the mailbox and we'll get a copy of it off to you.

(Carol Leachman): Okay, thank you.

Coordinator: Your next question comes from (Rich Glass). Your line is open. Please state your organization.

(Rich Glass): Hi, my name is (Rich Glass). I'm with (Infinisource). We are an administrator of Health Reimbursement Arrangements, HRAs, and had a couple of questions. I'll state the first one and then the follow-up after your answer.

We understand that there is some guidance in the user guide regarding HRAs but when you register, it's not entirely clear. There's a May 1st deadline but we've tried to register earlier and was told that it was premature.

We were wondering if there's going to be a separate user guide or any other piece of guidance specific to HRAs because those have been kind of carved-out of the requirement as far as the timeframes go.

(William Decker): The HRA - thank you for your question, your first one - the HRA quoting requirements aren't finalized yet. There's a variety of reasons for that. Since they aren't finalized yet and we haven't published anything in the user guide or anywhere else about how an HRA should report, we are not asking HRAs to even attempt to register to report yet and that's why you were told it was premature.

HRAs are considered GHP for Section 111 reporting purposes but they are a type of insurance coverage that is not particularly standard. I'm sure you can appreciate that and we are - and the final process is now putting together the directions for how they will be reported.

But until such time as we do have those directions and they are posted to our Website, we're asking folks not to register if all you do is HRA reporting. If you are a group health plan insurer that has an HRA product as part of what you offer to insurers, you should register now.

(Rich Glass): Okay, as a follow-up, we're in the process - a lot of these HRA plans renew on January 1st and so a typical exercise during this time of year is to gather up data regarding participants and most HRA administrators I think in the past have not had an effort to collect dependent data which will now be required under this Section 111.

Should we go ahead and do that now or wait until the guidance comes out and what are the consequences if we request it later and the participants don't want to provide the Social Security numbers or any other identifying number like a HICN?

(William Decker): That's a two-part question. I'll take the first part first. Since we don't have anything officially on our Website, we can't officially tell you what to do.

Unofficially, I would certainly think that since you will have to report at some point under some way, shape or form that it would be a good idea to begin to collect the necessary information as you will undoubtedly have to report to us, much of which will look very much like all the other GHP reporting that others are doing.

If now - the second part of the question is what if people resist supplying information to you that you may need, in this case specifically the SSN information or HICN information, a Medicare beneficiary using health insurance including Medicare or MFP insurance coverage for claims needs to provide the insurer with their Medicare ID number.

That's a federal law, requirement as part of the Medicare program. It's just logically giving your health insurance claim number to your health insurance payer. If you don't have a HICN and you want to query Medicare to see if an individual is a beneficiary, you can ask them to supply their Social Security number to you.

If they choose not to, if they refuse to, you can ask them to sign that model language that we referenced in one of the earlier questions today that's on the Website and if you have the individual complete that form and you get a copy

back, as long as you keep the copy as documentation of an attempt to collect information, that will keep you in compliance with our reporting requirements.

(Rich Glass): Okay. Thank you.

Coordinator: Our next question comes from (Denise Martin). Your line is open. Please state your organization.

(Denise Martin): Guardian Life. Hi, my question is when will the user guide be - the updated user guide - be available so that we can read over the information you just gave for reporting the change in group size?

(Pat Ambrose): I think it's probably going to be very close to the end of December before it actually gets posted to the Website after the language has been added and the proper reviews and then reposting of it to the site, just realistically I think it'll probably be the end of the year.

Hopefully we'll have the computer-based training modules published before then to that would be an option to review and then the Federal Register or the regulations related to it and the (ski) manuals on the CMS Website are other options for gathering additional information about it.

(Bill Zevoynia): And the computer-based training modules specific to the employer group size?

(Pat Ambrose): Yeah, and it has examples on how to report a change in employer size with update and add records and the like, so you know, like I said, my best estimate is the end of December.

(Denise Martin): Okay, thank you.

(William Decker): While we're reviewing the CBE text and that's pretty far along. We're pretty close to having that available for all of you out there who would like to be able to do - walk through the computer-based training on employer group size. We should have that relatively soon.

Coordinator: Our next question comes from (Larren Anderson). Your line is open. Please state your organization.

(Larren Anderson): Health Partners. When we send in the files, how soon after we send in the file is the information used in the CMS claim system to deny claims if they're, you know, if we're secondary versus primary?

(Pat Ambrose): It could be, yeah, in some cases it could be within a week or less.

(Larren Anderson): Okay.

(Pat Ambrose): Obviously we are setting effective and termination dates as per the information that you send us, so the claim date of service would be compared to the MFP occurrence effective and end date of when it's provided.

(Larren Anderson): Right, and that's good because we were just asking because we had to send some corrections for groups, retirees and so they're asking how quickly that would go into effect.

And now is that from - how long from the - when we send in the file and they - the EDI rep says it starts processing? Is that - so it's a couple of days from that date or …

(Pat Ambrose): Yeah, yeah.

(Larren Anderson): And then - now if a member calls in directly to CMS to change their status because they know Medicare is prime, not us, because they had their claim denied, are we then meeting to somehow also send that information in or if our claims reps called the - switch it on the next file?

(Pat Ambrose): You need to correct it on your Section 111 file, absolutely.

(Larren Anderson): Okay.

(William Decker): If you don't correct it and send it again, the same error will occur so we strongly advise that regardless of whether if (Benny) comes in and basically beats you to the correction, that you still change it and submit it anyway.

(Larren Anderson): Right.

(William Decker): Because the information that (Benny) provides may not be as accurate as the information you have on your record.

(Larren Anderson): Right. You know, that's only if we know the member called in but some are calling indirectly we believe, but …

John Albert: I'm sure they are. I mean, if someone gets their claim denied, it definitely triggers a phone call to the COB (unintelligible). I'm glad that - this is John Albert - I'm glad you brought up this question because again, it is absolutely imperative if there's anyone out there, they've learned that they've sent erroneous records to the coordination of benefits contractors through this process that they contact their EDI department immediately to get that process rolling to basically - the quickest way to fix it is for someone to send a

correction file, so please don't wait on that because it definitely has a direct impact on beneficiaries when claims start being inappropriately denied.

(Larren Anderson): Yeah, and we are and so the pile is quicker than calling by phone to the COB reps?

John Albert: Yes.

(William Decker): Because sometimes these files, they might have quite a number of incorrect records.

(Larren Anderson): All right. Thank you.

John Albert: It really depends on the information that comes in, what actually taken when, but …

Woman: Now if there's a few retirees, the EDI reps (unintelligible) call them and they take care of the changes rather than …

((crosstalk))

Woman: … so we're talking to EDI rep and not calling in to …

(Pat Ambrose): Yeah, it's important that to reiterate that anytime you have identified that you've reported incorrectly and in this case the retiree in the see input file, contact your EDI representative right away and seek their guidance as to how to go about making the correction, whether it should be done programmatically or however.

(Larren Anderson): Yeah, I mean, because they told us that for small numbers, we sent both a large file and for small numbers, they told us to call the rep but I just didn't know. It sounded like when you call, they tell you it's a 15-day lag before the providers can resubmit claims and you're saying it gets fixed within a couple of days.

(Pat Ambrose): Yeah, I mean, you know, it depends on what particular things are going on. There are records that sometimes recycle while we're trying to update (see the V west) but generally speaking, a delete transaction gets processed pretty quickly.

(William Decker): The other thing for everybody out there to know is that this is a situation which we are highly attuned to and we make every effort to correct it as quickly as we can also.

It is true that some - as (Pat) said - some records do take as much as 15 days to process through but that is not standard and certainly not normal when we are trying to fix the situation where retirees were sent on an MSP file incorrectly for example.

You need to absolutely talk to your EDI rep in that case and move as quickly as possible to get the situation corrected.

(Larren Anderson): Good. Thank you.

Coordinator: And the next question comes from (Joe Clune). Your line is open. Please state your organization.

(Joe Clune): Blue Cross/Blue Shield of Mississippi. My question, I'm the one that submitted the question to the policy mailbox about the three groups and one

small group and two large groups and how we got information suggesting that they may be part of not really the same corporation, it's a little more nuanced than that. Apparently they have the same owner but they are three separate companies.

(Pat Ambrose): Okay, yeah, and my answer, I was not trying to weigh-in on whether they were the same employer or not but we do have our resident expert (Bill Zevoynia) here to give us some particulars. He could probably expand on that.

(Joe Clune): Basically the small groups said we are a wholly-owned company by this man, let's call him Mr. Smith, and he owns the hunting lodge and everything and employs all the 14 employees but because Mr. Smith is also 80% owner of that large company, they feel that the small company should be deemed primary as well because they're owned by the same person.

Should we just take their word for it and report them accordingly or should we just, you know, we weren't sure of how we should treat this because we had no idea or no indication that it was technical a multi-employer group.

(Bill Zevoynia): Technically.

(Joe Clune): I'm sorry?

(William Decker): Each one of these - the situation you gave is going to be fact-driven - and based on what you said, I don't have enough facts to give you any guidance. I mean, the fact that an individual may hold multiple companies does not make those companies subsidiaries to one another.

(Joe Clune): Correct.

(William Decker): Whoever depending on how he holds them, whether it be to set-up a holding company to hold them, whether it be - it holds somehow or other as subsidiaries or divisions of another company even though they are set-up as separate companies - I mean, you need much more information to report what the address is.

(Joe Clune): Okay.

(William Decker): Incumbent upon you would be to try to obtain as much information as you can and make a recent judgment and consult with us if necessary.

(Joe Clune): Well, I think our legal department had already done that and they'd determined that they felt that the group - since the group felt that they were part of this multi-employer group that we should just go ahead and report them as a multi-employer group - but they did ask me to check with Medicare to see if basically Medicare's …

(William Decker): The system's determination that they're part of the same group, that language - accept that.

(Joe Clune): Okay.

(William Decker): The key is that they reasoned the termination.

(Joe Clune): I believe our legal department talked with their legal department and just said okay, we agree.

(William Decker): Okay.

(Joe Clune): All right. Thank you.

Coordinator: Your next question comes from (Gel Zelmer). Your line is open. Please state your organization.

(Gordink Masters): Hi, it's (Gordink Masters) speaking for Blue Cross/Blue Shield of Michigan. Our question is, is many providers here in Michigan subscribe to, I guess, vendors that provide GMS information theoretically derived from the common working file and we've had situations where what the provider is looking at from the source of information and what's on the Section 111 file is different in regards to coverage.

The most common example is the Section 111 will say the person has Part B. The provider's records will indicate this person has never had Part B coverage ever at all, so we're getting some conflicts.

In some of these situations, we've called the COBC contractor to see what their records have to say. Most of the time they agree with what the Section 111 record says but there's even instances where what they indicate as the coverage for these individuals is different.

So in cases of these conflict, of course the question that is arising, which source of information is correct and that's really our first question.

(William Decker): Who is the entity - who are the entities reporting the Part D as in dog …

(Gordink Masters): Oh, no, B as in Bob.

(William Decker): Bob, okay, pardon. B coverage? That's different.

(Pat Ambrose): One thing I can say from a systematic perspective is that Medicare maintains the - well first off, Medicare gets its information from the Social Security Administration and then that information is maintained on the Medicare Beneficiary Database, MBD and COB accesses MBD in order to keep that information in its system up to date and make its determinations for Section 111 reporting.

Certainly when you're talking to the COB call center and they should have the same information as Section 111 unless it has subsequently been updated or changed so that the only times those two sources should be out-of-sync are for that reason.

Now there are many other systems that use the Medicare Beneficiary Database as well. How they go about using it, whether they always have accurate, up-to-date information, we can't really speak to. There certainly is the potential for a discrepancy.

John Albert: Yeah I mean - this is John - I mean the end users of that central CMS database have to receive timely updates and notifications and sometimes that doesn't occur and that as anyone knows with changes makes somewhere, it can sometimes affect an output somewhere else but occasionally there are times when that data is out of sync.

It could be out-of-sync by a day or a few hours or it could be out-of-sync by a couple of weeks or months, I don't know, but it does happen so right now, COB has tools in process to investigate through other processes to get confirmations of how we provide feedback to our MDB regarding potential issues with data transmission errors.

(Pat Ambrose): So it sounds like you've already reported discrepancies and I presume they would be followed-up on accordingly at the COB.

John Albert: At least they're not MFP records. You're saying - you're talking about whether or not there is Part B coverage.

(Gordink Masters): Correct.

John Albert: Those records are not maintained by the COB contractors. Indeed, someone may not hold as Part B coverage on a given day, but it may be either restored or retroactively applied if any not a very - variety of circumstances.

If someone - if according to my records - someone does not have Part B coverage on a given date when a claim is submitted to Medicare, that claim is simply denied.

(Gordink Masters): Okay.

John Albert: As a Part B claim.

(Gordink Masters): So in these situations then, if we were to - because there's not many - but if it does turn out that the provider and ourselves are having a conflict regarding coverage, if we call the COBC contractor and they give us information regarding that coverage, we consider that then the source of truth and we should go from there.

John Albert: The source of truth at that particular moment.

(Gordink Masters): Of course.

John Albert: And we have to be careful. There are any number of incidences where someone may be in lack of a better term I think they call it self-pay status for Part B or state is paying their Part B premium, and for whatever reason there is a delay in posting the premium, the coverage is effectively voided but then it's re-established when the check has finally arrived and processed.

And also remember that there are time windows where individuals can apply for Part B and there would be a retroactive effective date.

(Gordink Masters): Okay. Now in situations where what the Section 111 update said and if we contacted the COB contractor are different, who do we raise this to?

John Albert: With respect to what?

(Gordink Masters): If there's a different in the Section 111 results considering coverage.

(Pat Ambrose): By what - by that you mean there's a difference between what you received on your Section 111 response file versus what a customer service rep at the main COB contractor number gave you.

(Gordink Masters): Exactly.

(Pat Ambrose): In that case, I would report that to your EDI representative and obviously make sure when you're reporting personal information of that nature that it's done in a secure fashion.

(Gordink Masters): Of course.

John Albert: Can you hang on just for a second? I'm going to put you on hold and do a little sidebar and we'll get right back to you.

(Gordink Masters): Okay.

John Albert: All right. That's fine. We're good. We're all on the same page. Just keep in mind that the customer service reps and the Section 111 reporting are not necessarily the same functionality.

You're getting the information from generally speaking the same place but you really do need to go back to your EDI rep and check with them and get the latest information from them if you're interested in the Section 111 reporting angle of it.

(Gordink Masters): Okay.

(Pat Ambrose): John, did you have one more question, of the drugs?

Woman: Could we ask one more question?

(William Decker): You have one follow-up.

Woman: This is relates to on the big numbers that we're submitting on SIO, the RX VIN numbers.

(Pat Ambrose): RX VIN numbers, did you say?

Woman: Yeah. If we have some of those RX VIN numbers that are changing and they're changing as of January 1st, 2010, but that would be like right in the middle of our reporting cycle, do we need first of all do we need to report those FIN number changes to you?

And then second of all, can it wait until our regularly-scheduled file which would be the end of February or do we need to send you a special file notifying you that the VIN numbers are changing?

(Pat Ambrose): No, we do not want a special file. Take a look at the event table in the user guide. That field is not actually - first off it's not required for Section 111 reporting but I understand we do want it and I understand why you're submitting it - wait until your normal quarterly file submission and submit the most current information.

Woman: Okay, so if it's changing as of January 1st, we can submit it on our February 22nd file?

(Pat Ambrose): Yes.

Woman: Okay. Thank you.

Coordinator: Our next question comes from (Amanda Eggart). Your line is open. Please state your organization.

(Amanda Eggart): (Black Pelt). Earlier in the call you had stated that when an employer has 20 or more employers for 20 or more weeks, the group health plan coverage becomes primary on the 21st week.

Before, we've been told by the coordination of benefits contractor that it's actually the first day of the week that they first got 20 employees.

(Pat Ambrose): No. It is not when you first got 20 employees. That is incorrect. Medicare becomes primary on the first day of the 21st week.

(Amanda Eggart): Okay, so if their first …

(Pat Ambrose): So in a sense, you might have more than 20 employees - well, now, I'm going to take it back because (Bill) is looking-up the regulation as we speak - but I mean, what I did say was the 21st and I'm sticking to it unless he can say otherwise.

(William Decker): We're actually looking it up in our table of regulations.

John Albert: No, it is - in each marketing day in each of 20 or more calendar days, so it would be the first day of the 20th week.

(Amanda Eggart): The 20th, not the 21st?

John Albert: Correct.

(Pat Ambrose): Okay, I stand corrected. First day of the 20th week.

(Amanda Eggart): Okay, so even if they say March 1st had 20 employees and continually changed throughout the year and their 20th week was December 25th, we don't become primary until December 25th?

John Albert: If the 20 weeks - if the 20th week that that employer had at least 20 employees commencing on December 25th, then that is the date you become primary with respect to the rest of that calendar year and the subsequent calendar year providing you did not have at least 20 for the 20 requisite weeks in the prior calendar year.

(Amanda Eggart): Okay.

(Pat Ambrose): We'll definitely be adding some examples in those CDT and user guides for this type of thing.

Coordinator: Our next question comes from (Scott Drew). Your line is open. Please state your organization.

(Scott Drew): Blue Cross of Idaho. Good afternoon and I have one question and then a clarification question for follow-up. My main question is about the small employer exception.

On our MFP response file, we received records back that got a disposition of BY and we were surprised to find that several of those records were in large groups with an employer size of two so we would like some clarification about how to proceed with this small employer exception and it obviously doesn't really have to do with small employers.

(Pat Ambrose): Well, first off, you are telling us that you have information about a small employer exception for a particular beneficiary and policy number, employer policy, you know, the matching criteria that are in there.

So you tell us that on your MFP input file by plugging-in the HIC number in the S-E-E or SEE HIC number field.

(Scott Drew): That did not occur.

(Pat Ambrose): There was no SEE HIC number provided?

(Scott Drew): No. We are not using that field as we don't currently have a way to grab or know who is on the small employer exception so we are not filling that field currently.

(Pat Ambrose): Then it's impossible to get the BY back as far as the system requirements go so that - examples of that need to be forwarded to your EDI representative again in a secure fashion.

(Scott Drew): I can do that.

(Pat Ambrose): And your follow-up?

(Scott Drew): Yes, just clarification on MSP and retirees. I understand that we can and should send retirees with ESRD or having ever had ESRD on the MFP file. My question is, well, those same people are also going down on the non-MFP file and I just want to make sure that that's okay that they go on both files.

(Pat Ambrose): Yes. It should be. It should be, because you're only reporting on the non-MFP file. You're only reporting supplemental drug coverage.

(Scott Drew): For retirees.

(Pat Ambrose): Yeah.

(Scott Drew): Yeah. Okay.

(Pat Ambrose): Can I - if you know off the top of your head, do you know your RRE ID so I can give your EDI representative a heads-up?

(Scott Drew): I certainly do. 1301.

(Pat Ambrose): 1301.

(Scott Drew): Yeah, with five zeroes before that.

(Pat Ambrose): Got it, okay, thank you.

(Scott Drew): Yeah. Thank you.

Coordinator: Our next question comes from (Claudine Mydock). Your line is open. Please state your organization.

(Claudine Mydock): (Health Net, Inc.). This is a question for purposes of worldwide employee counts, whether or not a seasonal employee would be considered within that count.

John Albert: Yes.

(Claudine Mydock): Yes, okay, so would they be similar to a part-time employee?

John Albert: Yes.

(Claudine Mydock): Okay. Thank you.

John Albert: Next question? Operator?

Coordinator: Yes, one moment. Our next question comes from (Lucy Winds). Your line is open. Please state your organization.

(Lucy Winds): Hi, I'm from (Health Net) as well. We have a client that already filed as an RRE and they asked previously whether they needed to provide (Health Net) with their information for us to report and we were given the guidance that yes, (Health Net) should still report the information on our file.

Now they're concerned. They want to know if there's a possibility that one of those reports would reject.

(Pat Ambrose): Theoretically, there should be no circumstance where both of you are reporting the same GHP coverage for the same individuals. We have information in the user guide related to a group health plan that has some standalone coverage like vision or dental offered as carve-outs, behavioral health and the like.

And in those cases, the entity that would be the RRE for the behavioral health for example does not register and report because it's not covered by Medicare and not reportable but the main GHP hospital medical coverage would be reported by the other RRE.

So I guess we need more information about what the circumstances are where both of you feel that your RREs for reporting of the same coverage.

John Albert: You're an insurer, correct?

(Lucy Winds): Correct.

John Albert: And who is your client?

(Lucy Winds): No, I don't have the client information in front of me. I'm just passing on the question so you know, I'll need to go and research it further.

John Albert: If your - if the other entity involved is an employer, they could be reporting under an employer requirement but that's not the same as a Section 111 requirement and that's something you'd need to check out to be clear on.

(Lucy Winds): Okay.

(Pat Ambrose): Yeah, so we would suggest that you gather up that information, get the specifics and submit it to the mailbox.

(Lucy Winds): That's exactly what we'll do. Thank you very much.

Coordinator: The next question comes from (Patty Minnick). Your line is open. Please state your organization.

(Patty Minnick): Good afternoon. Blue Shield of California. My question is as regards to Tax Identification Numbers and the part of the initial part of this call was the change of that requirement in utilizing the plan sponsor TIN, in use of the employer, multiple-employer TINs, and I just have to make sure I'm clear on what we're supposed to be reporting.

We have a client or a customer that is the purchaser of health benefits on the behalf of employees. Family members of its contracting public agencies for the State of California, and such this customer is not the employer of record.

But the agencies, there's over a thousand of them, so my question is can we utilize the plan sponsor Tax Identification Number for all of those agencies or do we have to obtain the Tax Identification Numbers for all of the agencies separately?

John Albert: You're saying the purchaser is just the insurance broker?

(Patty Minnick): I wouldn't consider them an insurance broker. They're just the purchaser of the health benefits on the behalf of the employers. It's an overarching - almost like a plan - seems to me like a plan sponsor.

John Albert: This is state government?

(Patty Minnick): Yes.

(William Decker): The state government would be the employer of all the employees of all the different agencies.

(Patty Minnick): Right. This customer just serves as the purchaser of the benefits, the health benefits.

(William Decker): Put the facts down in some kind of a e-mail and send it to the resource mailbox indicating that you were asked to send it regarding this particular issue. I would also suggest that you also look at the CMS Website under coordination of benefits and employer services and read that material and discuss how that relates to your question.

(Patty Minnick): Yeah, and I've done that and we've actually contacted lawyers and gone through that whole process. I just want to be clear on what we're supposed to be reporting.

John Albert: You may have done all of that but you need to tell me what all that was.

(Pat Ambrose): We basically need more information in order to answer your question, more specifics about the circumstance.

(Patty Minnick): Okay. So maybe a clarifying, what is the definition of a plan sponsor?

(Pat Ambrose): Are you asking us to provide?

(Patty Minnick): Yes.

(Pat Ambrose): Well, I'm not comfortable …

(Patty Minnick): Yes, the - yeah, what's the definition of a plan sponsor?

(Pat Ambrose): I'm not comfortable doing that off the top of my head on this call but that is something that we could take up and add to the user guide when we document this requirement change.

(Patty Minnick): So as of right now, we could utilize the plan sponsor's TIN for multiple-employer groups regardless of if they're a Taft-Hartley type of plan, based on - right?

(Pat Ambrose): Yeah, I mean, you may start submitting using the plan sponsor's TIN at any time. Remember that you have to submit if you need to change the TIN on records that were previously submitted that you need to send an MFP record and an updated TIN reference file, possibly with any new TINs that you're using.

But again, please document your original question, send that to the resource mailbox with as much detail …

John Albert: And note in the subject line so they've called date or whatever so we can pick it up.

(Pat Ambrose): And then I will also note that there might be some confusion about what we mean exactly when we say plan sponsor to I'll work on getting verbiage for that and needs for that as well, or at least a reference.

(Patty Minnick): Thank you.

Coordinator: Our next question comes from (Stephanie Stami). Your line is open. Please state your organization.

(Stephanie Stami): From (Highmark). I guess my first statement is just that we also are having the same problem with the Part B dates and we have sent to our EDI rep and he's looking into it and our problem is just you got those people that can't get their claims paid because our systems keep updating from the non-MFP file that there's Part B dates, base which is Part B, but the actual Medicare claims area says they don't have Part B so for the other person that's out there, they're not alone.

My problem that I do have though is our small employer exceptions that we have spent on our file even though we do have in our hands the approvals, they all came back denied and our EDI rep is looking at them.

What we're having problems though is in the meantime until this is figured out, when we are calling the number to try and get the information updated and let them know that Medicare is primary, they will not take our information because they're asking us then for a retiree date, even though we're stating to them that we sent them a small employer exceptions.

It's just that they got turned in to MFP cases but like I said, what they do then is they're saying well you submitted it on your file. We need a retirement date and of course we don't have one.

(Pat Ambrose): Well, I'm not quite sure who you're speaking to. If you need to remove an MFP occurrence that was erroneously posted, send a delete record.

(Stephanie Stami): Well, we sent them all. We sent an MFP record but as a small employer exception, we put the HIC number in that field 16.

(Pat Ambrose): But I understand that and you don't feel like it was processed correctly, and so that resulted in an MFP occurrence being created, right?

(Stephanie Stami): Correct.

(Pat Ambrose): And so in order to remove that MFP occurrence, you need to send a delete transaction, not make phone calls to the COB customer service.

(Stephanie Stami): We have sent them all as deletes now in the meantime, until we could figure it out.

(Pat Ambrose): That's fine. That's what you should do.

(Stephanie Stami): But they are not - it's not showing somehow.

(Pat Ambrose): Well, I'm not quite sure why the deletes - did you get a response file back?

(Stephanie Stami): Not yet.

(Pat Ambrose): Yeah, well we'll see what happens on those response records for the deletes. Hopefully they will come back, yes, and I would like to get your RRE IDs so I can give you, you know, we can follow-up with your EDI rep.

(Stephanie Stami): Yeah. He does pass the information. We're under 3904.

(Pat Ambrose): Okay.

John Albert: So remember that the small employer exception is (weighing) employer and individual (specifics).

(Pat Ambrose): Yeah, that's a very good point. In the user guide where it describes how to report that, there's other matching fields rather than just the HIC number, there's other fields that have to match as well too and maybe that's where your problem lies.

(Stephanie Stami): Correct, and that's where we have been checking because we said well maybe with like the tax ID number or something, but they didn't feel that that was the issue and so thanks, but they're looking into it. It's just I'm not sure how to handle the calls because we've already sent our delete records.

In the meantime, you know, people are upset because they're saying, you know, when they call Medicare, they're being told we sent it as an MFP and we can't get it fixed and I just wonder how long until those deletes get.

John Albert: Can you hold on for just a second?

(Stephanie Stami): Sure.

John Albert: Yeah, we have - I'm sorry for that sidebar. Can you tell us how long ago it was you sent your delete file in?

(Stephanie Stami): It was just on the 22nd of October.

(Pat Ambrose): Now, I would have thought that that would have been processed by now but we'll have to follow-up.

(Stephanie Stami): Yeah, well we are still waiting for our July non-MFP files to come back too.

(Pat Ambrose): We are talking strictly the MFP input file here?

(Stephanie Stami): Yeah.

(Pat Ambrose): Okay.

(Stephanie Stami): So I was just saying, I think we have problems all around with ours.

(Pat Ambrose): Okay, well we'll - we've got your EID and we'll follow-up accordingly.

(Stephanie Stami): Okay, thank you.

Coordinator: Your next question comes from (Geralyn Hawkins). Your line is open. Please state your organization.

(Geralyn Hawkins): Hi. (W.A. Truck). I have two questions. Just as a follow-up regarding the beginning of the conference call. Just you make a comment about the next software changing next year and was that in relation to the (career) only format changing to include an optional BPM field?

(Pat Ambrose): Yes, that is exactly with the Hugh software will be updated for and it'll be done in such a way that if you choose not to use the new version with the BCN, you don't have to.

Essentially they're adding versioning and if you want to implement it, you can implement, test and implement at a later date so while it will be available as of January to use that BCN you certainly don't have to.

(Geralyn Hawkins): Okay, and then my second question is in regards to delete transactions. I know the user guide states that you need to have original information on the deletion as what we provided on the original input record.

Is this true for all fields or true only for key occurrence and other fields (too weak) to determine MFP? We're having you can see right now a policyholder information and that may not be what we were doing since. Is that going to be a problem on the lease?

(Pat Ambrose): No. We only - you need to pass the edits for a valid record - if it doesn't match exactly, it doesn't really matter, but you need to get past - if it's a required field, you need to be submitting something to get past that edit on the deletes. What we need to match-up are those - the matching criteria as specified in the guide.

(Geralyn Hawkins): Okay, terrific. That's all I have. Thank you.

Coordinator: Our next question comes from (Mary Overton). Your line is open. Please state your organization.

(Mary Overton): Wal-Mart Blue Cross and Blue Shield and actually a previous question took care of my question.

(Pat Ambrose): Oh, great. Thanks.

Coordinator: The next question comes from (Jean Jerridy). Your line is open. Please state your organization.

(Jean Jerridy): Yeah, (tough health wind). My question is if the insurance company uncovers a case where Medicare has been paying primary and the insurance company should have, is there a way that we can open a COB case or do we wait until the MFP reporting picks that up?

(Pat Ambrose): The MFPRC would take care of the demand in that case. I don't know if they would have someone …

John Albert: What they would want to know is when they call to D.C., they're saying we should be primary, now, prior to waiting for the next submission.

(William Decker): I mean, self-reporting is always encouraged, you know.

(Jean Jerridy): I'm just not sure. How would you go about self-reporting?

(William Decker): Call the 1-800 number.

(Pat Ambrose): On the CMS Website, if you look under Medicare, you'll see coordination of benefits and when you go to the benefits page, there eventually you'll be able to find a how to contact the COB contractor and there'll be a 800 number provided.

(Jean Jerridy): Okay, but we should go ahead and do that and not wait for the MFP reporting to initiate something? We have the case where we were put - thought people were retired and they're really not - and so we want to address that they should have been on the version.

(William Decker): Well, if it's a lot of individuals, then you can just submit it on your next file. If you're talking about like one, I mean, there's no problem there. It's much more efficient to submit and via a file than to call and report that.

(Pat Ambrose): And the records …

John Albert: You also will need to do an update on your or an add to delete depending on the circumstances on your next Section 111 file as well.

(Pat Ambrose): Well, that's what we're telling them to do, so if you have a number of people, we don't really want you to self-report those. We want you to report them electronically on your Section 111 file and if you did not report them before, the records may get the late submission flag on them but there's not going to be any automatic penalty or fine imposed as a result of that.

So if you have discovered people that you have not reported, if it's not thousands, what we'd like you to do is just put them on your next quarterly file.

(Jean Jerridy): Okay. Thank you.

(William Decker): Operator?

Coordinator: Our next question comes from (Chris Sanchez). Your line is open. Please state your organization.

(Pat Ambrose): (Chris), are you there?

(William Decker): Okay, operator, we have to wrap this up because it's now 3:00 Eastern Time and a bunch of us have other meetings we have to get to, so …

Coordinator: There are no further other questions.

(William Decker): Well, okay.

John Albert: How many were on the call?

(William Decker): Yeah, operator, you can close off the call now and then just let us know what the count was and the number of people on the call.

Coordinator: Okay. This concludes today's conference. You may disconnect at this time.

END