TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: September 15, 2009

SUGGESTED AUDIENCE: Group Health Plan Responsible Reporting Entities – Question and Answer Session.

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FTS-HHS HCFA

Moderator: John Albert
September 15, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After the presentation we will conduct a question and answer session. To ask a question at that time please press star 1. Each participant will be allowed one question as well as one follow-up question. Today's conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the meeting over to Mr. Bill Decker. Sir you may begin.

Bill Decker: Hi everybody, my name is Bill Decker and I am with CMS in Baltimore, Maryland. Good afternoon to the GH Group Health Plan Section 111 National teleconference call. This call is to be - on this call we will entertain questions about both policy and technical issues.

I want to make one quick announcement for all the non-group health plan people who are on this call right now. This is not for you. If you ask a NGHP question we are very likely not to answer it. So you might just want to leave this call at this point and call us in on our next non-group health plan call.

We have with us today a bunch of people, a group of people here in Baltimore who will be working with me on this call today. First we have Pat Ambrose, second we have Barbara Wright, third we have Bill Zevonia, and fourth we have Cindy Ginsburg. Everybody who is out there on this call at this point should be a group health plan registrant or someone interested in a group health plan exchange process for Section 111.

It may be of interest to all of you who are on this call that as of this morning we had 1783 RRE IDs assigned for Section 111 and this is a good number. We expect to get a few more but we'll probably not get many more than that. With that I'm going to turn this call over to Pat Ambrose and she will walk us through some recent technical issue updates.

Pat Ambrose: Okay thanks Bill. First of all recent postings made to the Section 111 Web site page which can be found at www.cms.hhs.gov/mandatoryinsrep. The HICN or Medicare health insurance claim number, HIC number FN model language was revised and was posted on the What's New page dated August 18, 2009. So again that's the model language for the HICN and SSN collection reposted on August 18, 2009 on the What's New page.

In addition to that since the last GHP call we posted an alert regarding the receipt of multiple account designee invitation emails. That can be found in the Downloads area of the reporting do's and don'ts section page or tab. In particular please review the two notes in this alert and register as soon as you receive your first account designee invitation email.

The issue that came up were people who were invited to multiple RRE ID received multiple invitation emails and within each of those emails is a token link that the account designee is to follow to come to the Website to register. We encourage you to upon receipt of the first account designee email invitation email to follow that link and register as soon as possible to avoid any confusion. There's no particular problem related to this, it was just a point of clarification.

The COBC has received several requests to switch account managers with account designees after registration is complete. We recommend that the RRE retain the account manager role and invite agents as reporting agents as

account designees. This is not a requirement but is recommended so that the RRE retains a certain amount of control over the reporting process.

Even though most emails only go to the account manager, any user including account designees associated to the RRE ID may check on file status for the RRE ID after logging in. So give this consideration please before requesting roles to be changed.

Some announcements related to the HIPAA eligibility wrapper or the HEW also referred to as the HEW software. This is the free software supplied by the COBC to convert files into the X12 270 271 transaction set for use with the query only file. Please be sure to obtain and use the most current version of the HEW software with your Section 111 RRE ID, that is if you plan to use it. If you're using your own S12 translator you do not need this software.

There were some problems reported with using the old version of the HEW software that was used by some former DDSA partners in the past with their new RRE IDs. Any of those issues would be cleared up if you obtain the most recent version.

Please note that to obtain the mainframe version of the software you may contact the EDI department or your assigned EDI representative. To obtain the Windows PC server version of the software, that can be downloaded after logging in to the COBC secure Website or from your EDI representative. Both sets of software come with installation documents that will guide you through the process.

We also recommend that if you are using the Windows PC version that you do not change the (INI) file provided with the HEW software particularly the values used for field and record delimiters for the X12 270 transaction set.

Okay I also wanted to note that when you receive the mainframe software the installation guide does provide samples, job control language for running this software on the mainframe. Again that installation guide includes sample JCL.

Input files to the HEW software must be in an MS-DOS text file format, not a UNIX based text file format. If you are using the secure FTP file transfer and automating your downloads you may find that when you download a response file a query only response file to a UNIX box it may automatically be changing it into a UNIX based text file.

At this time we're going to add some options for the HTTPS download process. Your secure FTP software should be able to be configured such that when you download the response files they will be in an MS-DOS text file format. However, if they are not a workaround would be to open the file in Word Pad and save the file by selecting the MS-DOS text as the file type.

Also just a general reminder that computer based training modules on the Section 111 process have been developed and are available to all RREs and their agents. To sign up for the CBTs go to the Section 111 Website and on the left side of the page click on the link for MMASEA 111 computer based training and follow the instructions on that page.

You will receive an email invitation to the CBTs after you provide enrollment information. There is no charge for the CBT courses and you will be automatically notified of new or updated courses as they are rolled out. We are continually working on these CBT courses to keep them up to date with the user guide and again you'll be notified as changes or new course are rolled out.

A couple other announcements related to outstanding issues, we're still working on revising the X12 270 271 companion guide that you need if you're using your own X12 translator rather than the HEW software for the query only file. That - those changes will be updated soon.

The changes include instruction to submit the actual file in 80 byte records and some other information to clarify how to format various segments in loop. This information can be obtained through your EDI representative in the meantime so if you're struggling with the transfer of the query only file in the X12 270 271 format please contact your EDI representative for help with that.

We are also working on some further instruction related to RREs who are ceasing or transitioning business to another RRE as well as RREs who may be changing agents and a different reporting agent will continue on with their reporting for Section 111 at a certain date going forward. More information on this is being worked on and will be posted to the Website.

There still is an issue, an outstanding issue related to applying the plan sponsor TIN in the employer TIN field on the MSP input file. At a minimum you must use the plan sponsor TIN when the GHP is a multi or multiple employer plan that is operating under an hours bank situation. The user guide is not strict about this requirement and an update to the user guide is pending.

Now that currently is the only condition where we ask that you provide the employer or rather the plan sponsor TIN in the employer TIN field. Again that's multi or multiple employer plans operating under an hours bank situation like a Taft-Hartley plan.

We may expand the use of the plan sponsor TIN in the employer TIN field to other multiple employer plans that are not hours bank based but that decision has not yet been confirmed.

We've had some questions on previous calls related to what to submit on your TIN reference file in the case that the employer does not have a U.S. based address and may not have an IRS assigned tax identification number. That information or that issue is still pending as well.

Also CMS is working on requirements for health reimbursement accounts reporting, HRA reporting. That is still pending. Registration for HRAs or reporting of HRA information does not need to begin until this spring and reporting a year from now so we're still working on the requirements for that.

There have been some questions related to employer size and the calculation of employer size and how to submit that on your MST input file. We are developing a computer based training module and adding additional materials for the COB Website to help provide clarity on this topic.

We'll make an announcement and if you've signed up for the CBTs you'll get a notice when that employer size CBT is available. In the meantime later on in this discussion I'll provide a reminder about some Website links we've provided in the user guide that can help you with that determination.

We are also planning on adding some further explanation of the values defined for the coverage type fields on the MSP input file and what disposition codes you should expect when you are using those coverage type fields.

There has been some confusion about which particular values would result in both a disposition and a RX disposition code and which would just result in the RX disposition code and which would result in just the plain or regular disposition code for the hospital medical coverage. So again we're looking to clarify that information as well.

A question, now I'll launch into some of the questions that were submitted to the Section 111 Resource mailbox, try to provide answers and then we'll open it up to a live question and answer session.

A question was submitted by an RRE who is speaking to the self-insured as of October 1, 2009 and later. As of that date they will be fully insured and they were questioning whether they should continue their file testing with CMS. And in answer to that, your defines as the RRE for the period of January 1, 2009 through September 30, 2009.

You must report GHP coverage for Section 111 for active covered individuals who are Medicare beneficiaries or are in contact with an agent to do so on your behalf. The insurer or other TPA acting on the insurer's behalf will become the RRE as of 10-1-2009 from the description of this scenario and is responsible for reporting coverage as of October 1 and subsequent.

Depending on the details of the transition, the original RRE may report termination dates as of 9-30-2009 and the new RRE or its agent reporting on its behalf may report effective dates for the GHP coverage on the MSP input file as of 10-1-2009 if that is when the transition is being made even for continuous coverage.

This way the correct RRE and employer TINs will be associated with the MSP occurrences. If the new RRE is responsible for claims with dates of

service prior to 10-1-2009 then instead of terminating the previously submitted and accepted records they may send updates with matching key fields to update the TINs associated with the coverage periods previously submitted.

Remember if you're submitting a new TIN you need to also submit a record for it on your TIN reference file if you haven't already done so with the proper name and address associated with that TIN.

If this is the case you may be able to make arrangements to have the new RRE submit the original report. However, please note that your initial MSP input file is due during your file submission timeframe in the second quarter 2009 prior to 10-1-2009. So if this - or rather the third quarter, excuse me. So if this information will not be submitted on time you should notify your EDI representative of the circumstances to avoid issues with compliance later.

Again we'll be providing some more information in an updated user guide about transition of RREs and transition of reporting agents that you should find helpful in this situation.

There was a question submitted as to whether CMS is considering providing Medicare Part D coverage information in the query response file to RREs who report for Section 111 only - under only the basic option rather than the expanded option. Only GHP RREs selecting the expanded reporting options will receive Part D enrollment information on the Section 111 response file.

At this time we provide back Part D information on your MSP response file as well as your non-MSP response file for expanded reporting. The query only file does not accommodate returning Part D enrollment information at this time although that is a change that is pending for the future. So in answer to

the question in order to receive Part D prescription drug coverage, Medicare prescription drug coverage information back on any response file for Section 111 reporting, the GHP RRE must be registered as an expanded reporter.

A question was submitted would it be a requirement for group health plans to submit social security numbers of under aged dependents, example of 14 months old, if they aren't Medicare eligible ESRD or disabled based on the new regulations.

And the answer is actually no. RREs are required to report Medicare beneficiaries or active covered individuals on the MSP input file. In fact if you submit a record for an individual under age 45 with no Medicare health insurance claim number or HIC number on the record it will be rejected with an FP 99.

I mentioned earlier a question was submitted about HRA, health reimbursement accounts. And anyone who missed that announcement, the HRA reporting requirements are still pending.

Another question was submitted related to what does an employer do if a third party administrator, the RRE is requesting missing social security numbers to comply with Section 111 but the participants for whom the requests are directed do not have a social security number. Also another question related to this is if an individual is not eligible to obtain a social security number what to do under those circumstances.

As we've stated on previous calls, if the individual does not have an actual SSN they cannot be a Medicare beneficiary and do not have to be reported. A record must be submitted with at least a HIC number or a social security

number. If you have neither, do not submit the record until such time as you can obtain that information.

Please refer to the compliance documents and model language related to the collection of HIC number and SSN on the Website. There is a May 26, 2009 alert entitled Compliance Guidance Regarding Obtaining Individual HIC Numbers and/or SSNs for GHP Reporting. That can be found in the Download section of the What's New page.

Also as I mentioned earlier on this call there is a revised model language dated August 18 for the collection of HIC number and SSN and that can also be found in the Download section of the What's New page. And I'd also like to refer you to the compliance document on the GHP page of the Website dated September 16, 2008. That should help answer questions about the collection of HIC number or SSN and subsequent submission.

I have to put the call on hold for a minute. We have a sidebar to discuss here. I was just being corrected. The compliance document that I referred to on the GHP page is dated December 16, 2008 in case I misspoke.

There was a question about automating the process of picking up Section 111 response files from the Section 111 secure FTP server. The questioner was asking whether they could get delete authority in their mailbox in order to after they have picked up a file be able to delete files. Currently log-in IDs do not have rights to do that.

Please see the user guide, Section 8.1.2. The response files contain a time stamp that is generated when the COBC creates the file. You can use this time stamp to automate your secure FTP software to pull files with time stamps after the last date that you check. We have discussed this with other reporters

and confirmed that can be automated. There is no plan to give log-in IDs the authority to delete files from the mailboxes. Any response file posted to a mailbox is deleted or removed by the COBC after 180 days.

A question was submitted that I think I'll just read verbatim. We have a group that purchases two fully insured plans from us. The first is an EPO and the second is a hospital only product with a prescription drug option. All members of their group chose one of the two options and we as the RRE would be responsible for sending MSP information on behalf of those members. The group also provides a self-insured, self-administered medical product that coincides with the hospital only product that we provide.

The group is questioning if they need to register separately as an RRE for their self-insured, self-administered product and submit the members again since all appropriate MSP information for their members has already been submitted by us. The group wants to do the right thing but does not want to add confusion to the process by sending duplicate data.

If I understand the circumstance correct that information, the information regarding the self-insured, self-administered product because it is medical only coverage and kind of goes hand-in-hand with the hospital coverage, that entity is an RRE, the self-insured and self-administered plan is an RRE and it should report and in theory it should be different - a different coverage type being reported.

The initial RRE would be the - or insurer would be reporting the hospital only coverage with a coverage type of hospital only and the plan who is the RRE for the medical only self-insured, self-administered would be reporting with a different insurance coverage type reflecting medical only.

In this case it's not duplicate reporting and in fact two MSP occurrences would be created under the different coverage types because that insurance coverage type is one of the key fields for an MSP occurrence.

Another question asked, the mailing address associated with each TIN should be the address to which healthcare insurance coordination of benefits issues should be directed. This mailing address will help CMS and others to direct correspondence to the most appropriate contact at the GHP responsible, reporting entity, or employer plan sponsor.

There was some confusion about where there is a demand recovery or questions on the coordination of benefits would you contact the GHP or the employer. The demand goes to the employer; however there is a courtesy copy that also goes to the RRE, insurer, or TPA in this case so hopefully that clarifies the issue there.

Another couple of questions were related to employers or other plan sponsors being confused about whether they should register as an RRE. Some are even asking the RRE, the insurer for the insurer's tax ID and, you know, were attempting to go through the registration process. It sounds like a circumstance where this employer or group is not defined as the RRE in this case.

To clear up the confusion there I recommend that you point them to look at the alert to employers that's on the overview page of the Section 111 Website, it's dated May 6, 2009. And refer them to the definition also of a GHP responsible reporting entity that's in the user guide in Section 7.1.1.1., 7-1-1-1 that is, and also the definition and legislative language that can be found in Appendices F and G.

We have some - another question submitted asking if an RRE were to default the social security number to all zeros, how would the system react. Would the records get an actual FP error and be counted toward that error threshold or would it be rejected with a Disposition Code 51 because no match obviously would be found on an SSN with zeros in it.

If you look at the requirements in the file layout for the MSP input file it indicates that in the case that you do not have a valid SSN, social security number, for the covered individual that this field should be defaulted to all spaces, not all zeros.

So basically I'm recommending that you do not submit all zeros and default the field to spaces. And obviously if you're submitting it you need to - with spaces in the SSN you need to have the HIC number and the COBC will do the matching to Medicare beneficiary data based on that HIC number.

There was also an email sent indicating that an RRE found that the late submission flag was set on a lot of records on the response file for their very first initial response file. We're looking into this. There may be a system issue related to the setting of those late submission flags.

One thing that we can say obviously we'll correct this problem but there are no automatic fines being imposed. Right now we're interested in getting through this initial reporting process and smoothing things out before CMS acts on any compliance issues.

What I would ask is that anyone who notices a problem with the late submission flag or any other compliance flags related to the TINs that you submitted on your MSP input file that you provide examples related to

specific records back to your EDI representative in order to aid us in researching that problem.

At this point I again need to put the call on hold just for a minute for us to talk internally here and we'll be right back with you. Thanks.

We'd like to cover one more question before we open it to the live question and answer session. I apologize for the delay. This question was related to the ability to supply only one address associated with both the insurer TPA TIN and the employer TIN on the TIN reference file. In some cases people are stating that they need to provide different addresses depending on the particular record being submitted; however only one address is available per TIN on the TIN reference file.

Right now the only way around this would be to register for multiple RRE IDs and you may then report a separate TIN reference file with the same TINs but different addresses. We don't have any other means of assisting you in that regard at this time.

Bill Decker: Okay Pat, thank you very much. Anyone else have anything they would like to add before we move to open questions? Okay then Operator we're ready to start taking questions. Thank you.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question please press star 1. Please remember to unmute your phone and record your name clearly when prompted. Please also include the company you are with. You may withdraw your question by pressing Star 2.

As a reminder, each participant will be allowed one question as well as one follow-up question each. Once again if you would like to ask a question please

press star 1. Please stand by for our first question. Our first question comes from (David Pitman) with Zenith Administrators. Your line is now open.

(David Pitman): Good afternoon. I sent an email message about this subject but since you didn't respond to it I'm going to ask on the phone. Some of our information, some of the information we provided to you turned up on a Website that is run by the Wisconsin Physicians Service Insurance Corporation and it's instructing providers to send their claims to us.

We are a TPA and it's telling them to send claims to our corporate address which is the only, you know, we could only put one address in the TIN file which is obviously not the correct address. The correct address would be the plan sponsor information because they're multi employer plans and that's where the claims go, not to our corporate headquarters.

So first of all my question is are there any other entities other than Medicare that would display - that would have and display the information we send to you and is this really what they should be - should they be identifying every RRE as an insurer when in fact we told you we're a TPA?

Bill Decker: We're going to put you on hold (David), just a second.

(David Pitman): Sure.

Man: We'd like you to provide a little bit more information about why you had registered as the RRE if you are not a claims processing TPA.

(David Pitman): We are a claims processing TPA but the address that we provided is our corporate headquarters. We have 20 some different branch offices that each have their own addresses for submitting claims. And since we mostly

administer multi-employer plans the address that the claims would go to would be the branch office where those claims are administered.

Pat Ambrose: Well at this time as we mentioned before we're only able to take one address associated with your TIN on the RRE, I mean rather on the TIN reference file. Perhaps that address could be updated to an address such that you could centralize, receive the information there and then pass it to your branch offices as necessary.

I will log this issue about needing distinction between addresses under the same TIN on the same TIN reference file. And then the other option is I think you pointed out in your email was registering for multiple RRE IDs which is kind of an organizational or control nightmare. So at this point that's one suggestion that I happen to have from a technical standpoint of finding a centralized address that could take this information and forward it to the proper claims office.

(David Pitman): And what about the question of are there other entities like Wisconsin Provider Services that the information we send to you is then forwarded to them?

Man: The information isn't necessarily posted or forwarded to Wisconsin Physician Services, it's posted in - CMS's system of records indicate that a Medicare secondary payer situation exists that identifies the name of the plan sponsor/employer and where claims are to be sent and that's why you're getting the claims. It's a record to make sure that Medicare doesn't pay the claims that you're responsible for paying before Medicare.

(David Pitman): So Wisconsin Physician Services doesn't actually house this information, they just get it from your database when they need it?

Man: I wouldn't say that Wisconsin Physician Services gets it. I mean, that's the part that I'm just not understanding.

Pat Ambrose: Well they are able to view it.

Man: They are able to read only it as our decisions and other suppliers as well as providers when they provide services to a Medicare beneficiary. Among the things that they can do to see if Medicare is the primary or secondary payer is access the system of records to determine if we've already identified the Medicare secondary payer situation.

(David Pitman): Okay thank you.

Coordinator: Our next question comes from (Debbie Smith) from Wisconsin Physician Services. Your line is now open.

(Debbie Smith): When sending CMS our first data file we provided as the insurer the TIN of our ASO groups that we administer and not our TIN serving as the group's TPA. Because of this the ASO groups are receiving claims at their offices for processing. They're in turn calling us for help and then when we call CMS for information or to how to correct the data on the members we're being informed that they can't provide us with the information because we're not the insurance company on record due to again sending the wrong TIN.

Who can we contact to get this fixed as quickly as possible instead of waiting until the next quarterly file gets processed? Because we're getting daily calls.

Pat Ambrose: Well I was going to give you the response about how you could on your next file submission update the TIN and associated address but I see that you're looking for a more immediate answer.

(Debbie Smith): Yes because we're getting like I say daily calls from the ASO groups and the members who are getting upset because again we can't get it fixed.

Pat Ambrose: What I recommend that you do, there is the possibility of submitting a file off cycle and in fact you probably could submit and have us process just a TIN reference file off cycle. We have to make special arrangements for that. If you submitted it now it would suspend for a threshold error stating that you've submitted more than one file during the quarter. However it is a threshold error that an EDI representative can override and allow that file to process and it seems like a circumstance where this is called for.

So I would contact your Section 111 EDI representative and tell that EDI representative that Pat Ambrose suggested this as a solution that you submit a TIN reference file and I will - if they have any questions about that. Again it will suspend for a threshold error but the EDI representative could release it and allow it to process. Typically we don't do that because we assume it's an error that two files were received but in this case I believe it's called for.

(Debbie Smith): Okay we will get in touch with our EDI representative.

Pat Ambrose: All right, thanks.

(Debbie Smith): Thank you.

Coordinator: Our next question comes from (Elbert Tolson) with (Tucker) Administration. Your line is open.

(Elbert Tolson): Yes thank you. It's probably been mentioned before but I didn't copy it down. What is the first live date for our TPAs to send live files and not the testing file? And how many testing files do we send?

Pat Ambrose: I'm sorry, could you repeat the question -- the first production date?

(Elbert Tolson): Okay when is the first - yeah the first - I call it live, the first production date.

Pat Ambrose: That should be on your profile report. It can also be viewed on the COB secure Website. All GHP RREs at this point should have submitted their first production file by the end of this month, by September 30. So it's this quarter that your initial file is due. If you think that it's going to be late you should be in touch with your EDI representative so that they have a record of that.

(Elbert Tolson): Okay, that's fair. And how many test files are we required to do? I am sending - I am doing my second one now.

Pat Ambrose: Yeah in the user guide there's a testing section. Basically you're required at a minimum to send one initial MSP input file with a TIN reference file and then a subsequent update TIN reference file so it's a total of two, I mean, subsequent MSP input files so it's a total of two MSP input files and one TIN reference file depending on the circumstances.

Now with those files you have to pass the testing requirements as outlined in the user guide which is posting 25 add records in one initial file submission followed by a subsequent file that then updates, that adds five more occurrences and updates five others and deletes still five others. And that again, take a look at those requirements, testing requirements in the user guided.

(Elbert Tolson): Okay thank you.

Pat Ambrose: You're welcome.

Coordinator: Our next question comes from (Helen Moyer) with Guardian Life Insurance. Your line is open.

(Helen Moyer): Hi, I need some clarification about who's primary versus secondary in a specific situation. If I have an employer group that started out January of '09 with 55 employees and then on 10-1-09 the employer group falls below 20 lives, it's my understanding that for the remainder of 2009 and all of 2010 the group health plan remains primary even though the group dropped below 20 lives.

Man: Correct.

(Helen Moyer): Okay.

Woman: I do need to note that 20 - we're talking about employees, not covered lives.

(Helen Moyer): Yes, yes. Now the question I have is if on 11-1-09 a new individual, a new employee or a new dependent is added to the group and that person is Medicare eligible, is the group health plan primary for that newly insured person?

Man: Yes.

(Helen Moyer): It is, okay, because that's not what we were told when our claims area called Medicare. So we thought that it was on a group level, not on an individual level, but I wanted to make sure that was the case with you guys.

Man: It is on a group level.

(Helen Moyer): Okay, wonderful, thank you so much.

Coordinator: Our next question comes from (Tammy Meyer) with Unity Health Insurance.

(Tammy Meyer): Hi, the question that I have is in regards to the response file that we received. We received 47 FPES errors and I think the reason we're getting these errors is because the members were in a group that had less than 100 employees and they were disabled so Medicare would not be prime?

Man: That's correct unless you're part of a multi-employer plan where any employer has more than 100 in which case you would be reporting the size as more than 100.

Pat Ambrose: Yeah but, you know, if you've reported the employer size as less than 100 then these individuals are entitled to Medicare due to disability that - the system does - that's part of the logic for the FPES error.

(Tammy Meyer): Okay but Medicare would be prime in these situations, right?

Pat Ambrose: Not if the employer is less than - the employer is less than 100?

Man: If the employer has less than 100 then Medicare would be primary unless you have the multi multiple employer situation we described.

Pat Ambrose: Yeah, so if you're seeing the FPES error and you believe it was set incorrectly if I'm understanding.

(Tammy Meyer): Well I'm thinking that we probably want to - shouldn't have sent these members because Medicare is prime. However, we didn't know that on these embers because they never notified us. So we're getting the HICN number back on these members but the Medicare A and B effective dates of 12-21-99 so it's like you're saying they have Medicare but you're not really giving us the Medicare Part A and B effective date.

Man: Well no, they have Medicare, it's just that it's not a Medicare secondary payer situation. So if you had more detailed information you wouldn't have had to report those individuals. You only have to report those individuals for which you are in fact primary.

(Tammy Meyer): Right and I understand that but what I'm getting at is the fact that you're giving us the HICN back. I would have thought you would have gave us the date that they had Medicare Part A and B.

Pat Ambrose: Yeah she's not referring to the MSP effective date but rather the entitlement.

Man: No but the effective date wouldn't necessarily have helped her.

(Tammy Meyer): Well it would help us in determining that really the member should have had Medicare set up as prime for them.

Pat Ambrose: Well we're going to have to investigate on what gets returned on that actual response record. But what I could say is you could submit a query or use the Basis application to get that information.

Man: Also remember that you're counting the 100 in the prior calendar year, not the current calendar year for purposes of the disability provision.

(Tammy Meyer): Okay.

Man: Now before you go away or before we lose you, we're going to put you on hold just for a second and we'll be right back.

(Tammy Meyer): Okay.

Man: It sounds like the response dates are somewhat tied in to the MSP date, not the Medicare eligibility date.

Woman: It sounds like the fields are actually - they're Medicare Part A effective, Medicare Part B effective. I know there's one MSP effective date but separate ones (unintelligible).

Man: Oh okay, so I see what you're saying.

Woman: Because now we would have to go back to these members and say when did you actually get Medicare because we don't have that information. We didn't have it, we obviously didn't know it.

Man: Well it sounds like we can call it into Basis.

Woman: Sure, what I was saying if it sounds (unintelligible) normally you're sending us back the information but you have it come back.

Man: Right.

Man: All right we're back. We're looking up something here and then I think we'll have an explanation for you.

Pat Ambrose: We're just confirming that the reason for Medicare entitlement is return back on the query. I can't speak to the Basis application off the top of my head but I would assume it does also, it does give you back values for age, DRFD, and disabled.

Man: So as you look and you've got someone who has Medicare on the basis of disability, you don't need to report them unless it's a situation where you as an individual employer have 100 or more or you're in the multi multiple employer group situation and any single employer has 100 or more. So that's when you should make your cut. Look at the type, look at the basis for their Medicare coverage to help you in whether or not you submit someone.

(Tammy Meyer): Right, and I understand that we shouldn't have submitted them. I'm just stating that we submitted them because we didn't know and now you're giving us the information back that says that yeah, they do have Medicare but you're not supplying us the Medicare A and B effective dates that you have a spot for on the file.

Pat Ambrose: Yeah again, I'll have to go back and confirm but, you know, I'm not disbelieving you by any means at all. So but again through a query you could obtain that information.

(Tammy Meyer): Right, it's just one extra step.

Pat Ambrose: Indeed, indeed.

Man: Thank you.

Coordinator: Our next question comes from (Jason Hyman) from United Healthcare. Your line is open.

(Jason Hyman): Hi, thank you. I had a really quick question, actually it's more of just a confirmation. I needed to find out for federal government employees, what is the appropriate tax ID number that we are supposed to be submitting for those?

Man: Different agencies have different tax ID numbers.

Man: (Unintelligible).

Man: Right, right. OPM has issued a guidance on that I think to all the agencies that were reporting and I believe we're using OPM's tax ID. I'm not sure.

Man: If the coverage is through OPM provided coverage.

Man: Yeah right, as long as it's OPM coverage, that's right.

(Jason Hyman): Okay so the OPM provided is the one that we should be looking at?

Man: Yeah, if you have a federal employee who has group health plan coverage that is sponsored by or provided by or arranged by our Office of Personnel Management because of the individual federal employee, then if there is a coordination of benefits issue that is involved with Medicare secondary payer, I believe the solution we came up with is to use the OPM tax ID number.

(Jason Hyman): Okay, that's what I needed to know, thank you very much.

Coordinator: Our next question comes from (Christine Shue) with Penn Western Benefits. Your line is open.

(Christine Shue): Yes, we're a third party administrator and our client base is exclusively self-funded healthcare programs. We are still in the testing phase which by the way is going very, very slowly. But at any rate with the questions coming up about the TIN reference and what I'm hearing on that, I'm a little concerned about the approach we've taken.

We are the TPA, we do process the claims here. In our TIN reference file we had submitted our test file the plan sponsor's TIN and address information. But, you know, I was thinking the address would be used exclusively for coordination of benefit questions or recovery letters which those do currently go to our plan sponsors. But it sounds like if we send that type of information to you that it sounds like they're going to actually start receiving claims being directed to those plan sponsor locations. Is that correct?

Man: The claims themselves, the original claims should be going to the address that you provided for the receipt of claims which should be your address.

Pat Ambrose: The TPA TIN and associated name and address, the RRE TPA or insurer TPA TIN on that file. So in other words you should have not only records for the plan on your TIN reference file but also a record for your TIN and name and address.

(Christine Shue): Okay.

Man: Because that address, whatever that address is, is also where the courtesy copy of the demand to the employer would go. It's the insurer TPA courtesy copy of the demand would also go to that address.

(Christine Shue): Okay, all right. I was concerned about that. I wanted to make sure we weren't going to run into the same situation as it sounds like other TPAs are doing with claims being for us misdirected and it really causes a slowdown in claims processing.

Pat Ambrose: Yeah you just want to make sure that you put your TIN in the insurer TIN field on the MSP input file records and then also have a corresponding record with your TIN name and address on the TIN reference and you should be good to go.

Man: And whatever address is on the TIN reference is the one that's going to be visible to providers and suppliers and it's where demands will also be sent.

(Christine Shue): And it still is going to slow down claims because just like the other gentleman that called earlier, we have PPO arrangements set up here. We're regional and typically our processes have been our ID cards are all set up that claims go to the PPO and at the first for repricing per the contracts before it comes here for processing.

So it sounds like it's going to mean that we're going to be dealing with getting claims here first and having to send to the networks which is going to still slow things down and be a bit more inefficient.

Man: How many regions do you have?

(Christine Shue): Well we're in the southeast region but I would say about 97% of our participants are participating in a PPO network and we deal with probably six or seven different PPO networks.

Pat Ambrose: I've made a note to add an indicator in the future to the GHP TIN reference file that would allow you to submit multiple records for the same TIN.

Man: You mean multiple addresses?

Pat Ambrose: Yeah multiple addresses so you'd, you know, have the TIN listed more than once distinguished by this what we refer to as an office code or site ID. We did that on the non-GHP side of the house but we did not do it for GHP reporting since that had never been necessary in the past or at least not to my knowledge had been an issue. But we hear you loud and clear that it is an issue and I'll add it back. I can't say when this change will be made but it's duly noted.

(Christine Shue): Okay.

Man: Actually the complaint from the industry in the past from the insurer TPA is we want everything to go to one address and it's not going to one address. So, you know, obviously we're finding out there's at least a percentage of the industry that's sort of in between there.

(Christine Shue): Well when you talk about the - especially the self-funded market you're going to find all different kinds of combinations of how claims are handled and with these network arrangements where the processing begins. So, you know, you probably - it's good that you noted that because basically what we need is some flexibility within the files to be able to handle different scenarios.

Pat Ambrose: Exactly, okay.

Man: You might note that if your ID card is shown to the provider or supplier of the service then the ID card indicates that claims processing should begin by

sending it to a specific address, the provider or supplier typically will comply with that and send it to that address.

(Christine Shue): Yes and they should, but, you know, if we've got a situation where - and this happens a lot, they lose that copy of the ID card or they don't keep things updated they might go out to your site, you know, and do that lookup you were talking about. And then, you know, and plug in that, you know, address that they see currently and that's where we'll run into some problems.

Man: Right, part of this can be avoided as you indicate by making sure the member are educated and make sure they keep their cards and always present them to the provider of service.

(Christine Shue): Yes.

Man: We're going to go offline just for a second and we'll be right back to you. We're back and lo and behold we don't have anything else to tell you.

(Christine Shue): Okay.

Man: I'm going to send your suggestion, thank you.

(Christine Shue): Thank you.

Coordinator: Our next question comes from (Mary Ellen Haynes) with Medcost Benefit Services. Your line is now open.

(Mary Ellen Haynes): Thank you. We are a third party administrator administering self-funded health plans and recently we've been hearing from many of our plans who have been receiving letters from Medicare coordination of benefit contractors

asking or directing them to go to a specific Website and complete a data match questionnaire.

And we were under the impression that as the RRE for these groups we will be performing the appropriate reporting for them and are not exactly sure what this is about. The number that's provided in the letter, when we call that number the individuals there don't seem to know anything about Section 111.

Man: (Unintelligible).

(Mary Ellen Haynes): I'm sorry?

Man: One of the provisions that you're talking about is what's called the IRS CMS SSA data match. That is used to be done by a combination of an electronic file submission and paper. That is done by the employer. The employer provides information on that, that is not Section 111. Section 111 is a separate and distinct reporting process that you as the RRE are responsible for making.

Man: When the RRE process and Section 111 reporting is in full gear and we have verified that we're getting good data, then it's - what CMS is looking forward to is we would like to ask Congress to sunset or get rid of the data match provision for employers once we can ensure that we're getting good data through Section 111. But until that's done employers will continue to get the data match questionnaires.

(Mary Ellen Haynes): Okay, on the questionnaire then when they access that information, is it specific asking them very specific questions about specific individuals?

Woman: Yeah.

Man: Yes.

(Mary Ellen Haynes): Okay, all right. That's what I needed to know, thank you.

Coordinator: Our next question comes from (Michelle Kiser) with BMI. Your line is now open.

(Michelle Kiser): Thank you. Yes, we have an association plan here that we administer with quite a few lives and are we reporting that under a multi employer, it's school districts and municipalities that are together under one plan and would we...

Man: (Unintelligible).

(Michelle Kiser): I'm sorry?

Man: It's a multiple employer health plan.

(Michelle Kiser): Okay.

Man: Which means for purposes of reporting the size of any one of the members of that plan you need to report size based on the largest employer in that plan. If any one of them has more than 20 you have to report as though they all have more than 20. If any of them has more than 100 employees you have to report as though they all have more than 100 employees.

(Michelle Kiser): So our report lists out each of the employers and then if we have one with 500 then we list all of them with 500?

Man: Yes.

(Michelle Kiser): And they - we report each of their tax ID numbers and not the tax ID number of the master plan?

Man: Under the current rules that's correct. As Pat indicated, we're still taking under advisement whether or not we will let plans be listed in that instance.

Pat Ambrose: The plan sponsor.

Man: The plan sponsor.

Man: The one exception to that is if it is a Taft-Hartley type plan with an hours bank arrangement. There we have indicated reporting of the plan sponsor.

Man: In the employer information part of the record layout.

Pat Ambrose: So yes, you are reporting the separate employer information, employer TIN, and - but in the case of this multiple plan, multiple employer plan, the employer size indicator is based on the largest employer in the plan. And every record submitted under that would have the same employer size indicator even though you're reporting a unique employer TIN on each record.

Man: This is where the small employer exception issues come in working agent and if there's any single employer that's more than 20 if the plan wishes to request a small employer exception it needs to go through that process. And there's language regarding the type of record we build and references to the COBC Website where entities can find out more about requesting the small employer exception.

(Michelle Kiser): Okay, thank you.

Coordinator: Our next question comes from (Quadine Mydock) with Health Net Insurance. Your line is now open.

(Quadine Mydock): Hi, I wanted to see if there's been any guidance issued with respect to an employer group refusing to provide requested TIN and/or other information.

Man: An employer group refusing to provide requested information of what sort?

(Quadine Mydock): Like their TIN, well especially their TIN but, you know, it could be anything. We send the letters to them, we've requested multiple info from them, the TIN, their employer size, their COBC contact info. So we've had some reports of employers pushing back and refusing to provide the data.

And then there's also the situation where the employer might be one of the smaller employers where the TIN is actually the social security number of the employer, the owner, and they may refuse to provide it because of that instance.

Man: Are you talking about in situations where they're part of a multi or a multiple employer plan?

(Quadine Mydock): No.

Man: And they actually have more than 20 employees and it's still the SSN? We can issue demand letters without the TIN. I mean...

Pat Ambrose: We can't (unintelligible).

Man: I know.

Pat Ambrose: Aren't they compelled by, I mean, there's federal regulations that compels the employer to submit here.

Man: Well and they have to have it. It's the RRE's obligation to report these so you need to work out some sort of arrangement to obtain it from your clients.

(Quadine Mydock): Right and so that's the issue is it's the RRE's obligation to report it but if we're not getting compliance from our clients then...

Man: You're the one that's at risk.

(Quadine Mydock): Okay so there is no safe harbor or whatever you want to call it on the behalf of the employer such as there is for an individual that may not want to provide their social security number.

Man: Not that I'm aware of.

Man: Not that we're aware of on a larger issue. The individual not providing us their social security number, if the individual is a sole proprietor business and is in an MSP situation and that individual's SSN is in fact the individual's tax ID number then we need to have the tax ID number regardless of the fact that the individual may not want to give it up because it's actually a social security number. That - the issue there is that that's what the IRS says and we don't have any work to work around that.

In cases where an individual doesn't want to provide an SSN because they have some - just because they are a covered life but they don't want to provide an SSN to a reporter, that's one - that's a very separate issue. If it's a business owner and the business owner's IRS ID is his social security number is in fact

the IRS tax identification number, that's got to be provided. There isn't any way around that.

Man: Also remember we would at least expect for GHP purposes the people that are refusing to provide the SSN are the people that essentially are saying I'm not a Medicare beneficiary and therefore don't believe they have to report it. Where they actually are a Medicare beneficiary, they do have a legal obligation to provide it to you and we would assume that in virtually all cases they will in fact provide it to you in that situation.

Man: If it's any consolation, you're the first person who has told us that you're getting pushback on the TIN. So that's very interesting to us and we'll take that under - take that as very useful information. Thanks.

(Quadine Mydock): Okay so...

Man: If it will make you feel any better...

Man: It probably doesn't make you feel any better.

(Quadine Mydock): Well right because the only thing is, I mean, at the end of 2009, the first file in 2010 we can no longer send the pseudo TIN, and if we have been unsuccessful in obtaining the TIN from the employer or client, what do we report?

Man: We'll have to get back to you on that.

(Quadine Mydock): Okay thank you.

Coordinator: Our next question comes from (Denise Delwell) from Paramount Healthcare. Your line is now open.

(Denise Delwell): Yes, I have a question regarding information we're receiving on our response file. We received a number of records with the SEE response code field number 81 populated with a value of FN. And when we requested some type of clarification from our EDI rep to why we were receiving that, because we don't have any multi employer groups. We've verified that with our marketing department. We don't have any groups that fall in that definition.

And basically the explanation we received is if you are sending us employers who are members of an SEE and they have not been provided their number s of yet meaning an application is still in a pending status, you will receive those error message codes as an FYI to contact those employers for confirmation or verification. None of these - on the input file, none of these employers groups have a group size that's under 20. They all...

Pat Ambrose: Can I stop you and ask you this. On your input file are you submitting something in the C HICN field? Because that is the trigger in the system for it to check whether there is a small employer exception.

(Denise Delwell): Right, no.

Pat Ambrose: And what I'm thinking is if you fill that field in it might be checking all these records even though you have no - there is no small employer exception.

(Denise Delwell): Right, no we're not populating that field at all.

Pat Ambrose: Well then you should, you know, if you're not populating the MSP input record with the C HICN field, if you're leaving that blank, you should not be receiving a C response code.

(Denise Delwell): Okay well we received 26 of them out of the 98. We're still doing our testing and we have received like I said 26 of them which encompass like 12 of our employer groups and they're all large. I mean, some of them totally have over 100 members.

Pat Ambrose: Yeah it really is inconsequential when it comes to the employer size field in this case. So the one thing that I ask you to do is go back and check to absolutely make sure that you have not filled anything in that C HICN field. Even if it's junk or whatever it should be defaulted to spaces.

And then if it is spaces and you're still getting this C response code value of FN, I want you to send that to your EDI representative and tell them that they should, you know, that needs to be investigated and if they have any questions to contact Pat Ambrose. They know how to get a hold of me.

(Denise Delwell): Okay, I'll do that. Thank you very much.

Coordinator: Our next question comes from (Frances Spikes) with Health Design Plus. Your line is now open.

(Frances Spikes): Hi, good afternoon. This question may have been answered in the past and I'm just, you know, too cloudy in the mind to remember. But I need some clarification.

We are a third party administrator and we only handle medical, we do not do dental, vision, drugs. However, our clients, ERISA self-funded, are in charge

of their own eligibility. As a matter of fact they have outside eligibility vendors that they interact with and then the vendors send the eligibility file to us.

For some of the drug vendors, Medco, etc., etc., we then send the eligibility file to them. Who is responsible for sharing the eligibility data relative to drugs, etc., etc.? Would it still be us or would it be Medco, Caremark, whatever?

Man: Are you participating in the expanded option? Are you talking about submitting drug information to CMS or are you talking about information coming from CMS?

(Frances Spikes): We are wondering who would share the eligibility related to drugs, etc. if you don't actually handle those claims.

Man: As part of the regular group health plan or is this a separate group health plan, a separate plan?

(Frances Spikes): Well the drug piece would be separate. It would be paid by someone else, dental, etc., the same way. We only pay the medical, we only pay hospital.

Man: It's all part of the same group health plan?

(Frances Spikes): Yes they are part of the same health plan but administered by different vendors.

Pat Ambrose: And you're reporting as a Section 111 RRE?

(Frances Spikes): Yes.

Pat Ambrose: And you have selected the basic reporting option?

(Frances Spikes): Yes.

Pat Ambrose: Okay.

(Frances Spikes): Is, I mean, can - is that good? Can we do that?

Pat Ambrose: Absolutely. You're not reporting any drug coverage information nor is it required for Section 111 and it sounds like you might not have that drug coverage information so you just need to report on the medical, hospital medical coverage that you provide.

Man: And we're not sharing any drug information. Since you're under the basic option we wouldn't be sharing any drug information with you either. So the circumstance you described from our perspective the drug coverage is irrelevant. It's not part of the Section 111 reporting the way you set it up.

Pat Ambrose: Nor is the dental.

(Frances Spikes): Okay so then we would map to I guess A, hospital and medical, end of story, short way to go, right?

Pat Ambrose: Yeah as a basic reporter and you'll get back Medicare A and B coverage information on your response file and if you were to use a query file. You will not use the non-MSP file and yeah, that's pretty much it. And you can ignore any of the RX fields that are on the input and output file.

(Frances Spikes): Okay, thank you so much.

Pat Ambrose: You're welcome.

Coordinator: Our next question comes from (Daniel Vines). He's individual.

(Daniel Vines): Hi, I'm a group health plan subscriber and my wife is 43 years old and she's been a dependent on my health plan since 2005 and she's currently on it right now. She is not eligible for a social security number. Will she have to be removed as a dependent on my health plan because she cannot supply a social security number?

Man: We have put on our dedicated Website which is www.cms.hhs.gov/mandatoryinsrep. We have a model language form there that when someone is not a Medicare beneficiary or doesn't have a social security number they can complete that and give that to their employer/insurer, whoever is asking them for the information. And from our perspective that's our position.

Pat Ambrose: There is no requirement for her to lose her Medicare coverage, I mean, her GHP coverage as a result of Section 111 reporting. And we've said on these calls previously and it's in the user guide that Section 111 RREs are only required to report information for Medicare beneficiaries and of course they have to find out who is a Medicare beneficiary.

And in this case as Barbara indicated she can complete this form and indicate that she is not a Medicare beneficiary. And so the RRE or your insurer has no obligation to report her information and certainly no obligation to drop her coverage.

Man: We have also said earlier in this call and I believe it's in the manual as well that an individual who doesn't have a social security number will not have Medicare coverage.

Pat Ambrose: So they're not reportable. Does that help?

(Daniel Vines): Yes but will they not be fined $100 - $1000 a day?

Pat Ambrose: They will not. She is not a Medicare beneficiary so there is no failure to report on their part since the GHP coverage could not possibly be primary to Medicare since she's not eligible for Medicare. So no fines could possibly be imposed upon them for not reporting her information. And again, please see that model language form that's on the Website.

(Daniel Vines): Please give me the direction of that again. You see, they're telling me that they're going to drop her January 1.

Pat Ambrose: That is just incorrect.

Man: You also need to make sure when you're corresponding with them that you make it clear that she doesn't have a social security number and why she doesn't have it. But our Website is www.cms...

(Daniel Vines): CMS.

Man: Yeah like cookie, monkey, socks, .hhs like hand, hand, socks, .gov short for government. And then you do a forward slash to the right and it's the word mandatory followed by insrep short for insurance reporting. So it's mandatoryinsrep. And Pat did you say that form is on the What's New tab?

Yeah they're - when you get to our main Website there are additional tabs and there's one that's called What's New.

Pat Ambrose: They're on the left hand side of the page.

Man: And the tab for What's New has this specific form on it. If you did a search on model language it would probably find it as well.

(Daniel Vines): Okay.

Pat Ambrose: Who by the way is your insurance company?

(Daniel Vines): It's (P-Health) administered by Blue Cross. And they've just made it utterly clear. I've tried every way in the world to try to - because I couldn't believe it. It was just take my wife off my insurance.

Pat Ambrose: And it's Blue Cross Blue Shield of...

(Daniel Vines): (P-Health) and administered by Blue Cross Blue Shield of Alabama.

Pat Ambrose: Okay, thank you for your information.

(Daniel Vines): Okay, thank you very much.

Coordinator: Our next question comes from (Mary McCalla) from Group Health Cooperative. Your line is open.

(Mary McCalla): Hi, this is a question that we've submitted to the Resource mailbox a couple of other times but we're not quite sure we have the answer so it's about the number of worldwide employees going above or below 20. And we just want

to know, when we report the date of the change should we use the actual date the number of employees went above 20 or should we report the date the number of employees have been over 20 for 20 weeks or under 20, whichever, and that's consecutive weeks, right?

Man: No it is not consecutive weeks.

Man: It's any 20 weeks in the current or preceding calendar year I believe. I'm looking it up as we speak.

Pat Ambrose: However, it is the latter that - once you've determined the employer size has been at that level for that condition, that's the date that gets reported -- not when the actual number changed.

(Mary McCalla): Okay.

Man: And then once that number is met you have a responsibility for a certain period of time. It's not just immediately when you drop below 20 that it changes.

(Mary McCalla): Right, so it's the remainder of this calendar year and all of the following calendar year, correct?

Man: What's that?

Man: Could you repeat your question again?

(Mary McCalla): Yeah so our responsibility continues for the remainder of this calendar year and the following year, all of the following calendar year?

Man: Yes.

(Mary McCalla): Okay. So the next question would be then typically we only find out about these types of changes once a year at renewal. So how often do we need to report these changes in the number of employees? Can we just report it on the next quarterly input file after we find out about the change in the number or after we find out that the number has changed and has been that way for 20 weeks?

Pat Ambrose: Yeah you would report an - in this case look at the event table and you'd be submitting a termination date under the old employer size indicator and an add record with an effective date of the new employer size indicator.

(Mary McCalla): Okay.

Man: For the most part if they were below 20 and you weren't reporting them at all it's going to be a new record unless you're in a multi multiple employer plan. If your employer is below 20 you're typically not going to be...

(Mary McCalla): Sure.

Man: When Pat gave her answer to you she mentioned the event table. Are you familiar with that?

(Mary McCalla): Is that in the guidance?

Man: Yeah it's in the user guide.

(Mary McCalla): Okay we will check on that.

Man: Yeah absolutely.

Man: And I confirmed that it is not consecutive weeks, any 20 weeks in the current or preceding calendar year.

Man: Would you like a regulatory site?

(Mary McCalla): Yes, that would be very helpful.

Man: 42CFR411.170.

Man: 42CFR411.170.

Pat Ambrose: That's also in the user guide as well. There are sections that discuss employer size in the requirements and you'll see reference to that legislation as well.

Man: In terms of when to report once an employer has gone beyond that size, if you're only checking once a year obviously you need to report it as soon as possible. But the longer the delay is in terms of you reporting the more likely it is that you're going to end up with recovery demand letters because we will have been paying inappropriately. So, you know, you need to be checking appropriately so that situation doesn't really occur.

(Mary McCalla): Right.

Pat Ambrose: And we are developing a computer based training module to add to the list of the other CBTs that we have to help with this.

(Mary McCalla): Yeah that would be really helpful, it's been hard for us to sort out what exactly we're supposed to be doing. And our system doesn't currently track

this information so it really is an additional burden on us. Okay thank you so much.

Coordinator: Our next question comes from (Mark Deragardbedian) with Harvard Pilgrim Healthcare.

(Mark Deragardbedian): Yes, thank you for taking my questions. My first question has to do with the Basis paperwork. We sent that back to our EDI rep back in July and we did receive an update from the EDI supervisor that they - that you were experiencing some technical issues, this was on 8-4, and now it's 9-15 and to date we have not heard anything as far as the status of Basis.

Pat Ambrose: You sent your question in with your RRE ID, correct?

(Mark Deragardbedian): Yes we did actually send a question in as well.

Pat Ambrose: Do you mind, I could look it up but you could give me your RRE ID over the phone and I'll have somebody follow up with you.

(Mark Deragardbedian): Sure, it's 11048.

Pat Ambrose: 11048?

(Mark Deragardbedian): That's correct.

Pat Ambrose: Okay I'll ask someone to follow up with the status. I'm not aware of a backlog or a system issue related to Basis so I'll have to follow up and we'll get back to you.

(Mark Deragardbedian): Okay great. The last question we have is regarding SP32. We did submit our first response file. We did receive some of those errors and we just had a question as far as fixing those errors.

We actually did follow up with our EDI rep and we were told that because the coverage period predates the individual's Medicare entitlement then you don't need to continue to send the records but that seems to contradict what's in the GHP user guide which states that we do need to continue to send the records to CMS.

Man: You also sent this in to the mailbox didn't you?

(Mark Deragardbedian): We did and we did get a response from our EDI person but I just want to raise the question just because it seemed to contradict what was in the GHP user guide.

Man: All coverage ended before the date in question?

(Mark Deragardbedian): That's correct. So our thought was obviously we can't fix the record and we were told not to continue to send the record which makes sense logically but in the user guide it looks like it states to continue to send the record.

Pat Ambrose: Okay so I'm sorry, I'm just catching on here. Your GHP coverage for this individual has ended.

(Mark Deragardbedian): Right.

Pat Ambrose: And it ended prior to this individual becoming entitled or covered by Medicare?

(Mark Deragardbedian): That's correct.

Pat Ambrose: You may indeed not send that record any longer and I'll take a look at the user guide to see what we can do to clarify that.

(Mark Deragardbedian): Okay.

Pat Ambrose: Unless you were to cover them again but if they're no longer an active covered individual there is no need to continue to send them.

(Mark Deragardbedian): Okay.

Pat Ambrose: Maybe if what's unclear is that, you know, once you've made a report and gotten a response back and you understand, you know, what the conditions are, if that individual no longer meets the definition of an active covered individual then you don't have to report them on the MSP input file. You know, that's what we're trying to get across here.

But I think I know where you're talking about when you get the FP disposition we're saying correct the error and keep sending and it would be an effort of futility in this case.

(Mark Deragardbedian): Right, that's what we thought but we wanted to clarify it. It's on Page 163. If that could be updated that would be great.

Pat Ambrose: Yep, we'll take care of it, thank you.

(Mark Deragardbedian): Thank you so much.

Coordinator: Our next question comes from (Rob Driskell) with Health Net Corporation. Your line is now open.

(Rob Driskell): Hi, thank you very much for taking the call and I think that some of the topic matter of my question has been asked and answered to some degree. But I just wanted to clarify a couple of points because we've been trying to sort out the difference between employer versus plan sponsor as far as TIN indicators go.

And it sounds like from the discussion that we've had today that associations would be multi employers with the hours bank arrangement and therefore a plan sponsored TIN should be used. Is that correct?

Pat Ambrose: Yeah, we're talking about multi employer, multiple employer plans that use an hours bank arrangement like a Taft-Hartley plan although it might not be limited to just Taft-Hartley plans.

Man: Some of the agent plans are typically not hours bank arrangements.

(Rob Driskell): Okay.

Man: Then if you don't have an hours bank arrangement the current instructions continue to require you to submit the individual employer's TIN and information.

(Rob Driskell): Okay and that - right, that answers I think the second question that I was going to ask. In the case - in that case where there's not an hours bank arrangement then we would go ahead and use the employer's TIN number or the employee's TIN indicator, excuse me.

Pat Ambrose: Yes.

(Rob Driskell): All right, thank you.

Pat Ambrose: Okay thank you.

Coordinator: Our next question comes from (Ron Cook) with Alternative Insurance. Your line is now open.

(Ron Cook): Yes, we're a TPA and I sent our initial file of 100 records on June 30 through your Website because the record count was under 20,000 records. I contacted our EDI rep assigned to us to ask has the file been received and she has emailed me back there was not an isolated issue and has not been resolved. I've sent a couple more emails. She keeps telling me the same thing, that this has not been resolved. So three months later, can you give me an idea of when this can be resolved?

Pat Ambrose: Yeah I'm not aware of what the particular issue should be. You should have been able to resubmit that test file. Were you uploading to - were you using secure FTP or HTTPS?

(Ron Cook): I was using your www.section111.cms.hhs.gov and uploading there.

Pat Ambrose: Okay. Could I have your RRE ID and I'll follow up?

(Ron Cook): Sure, it's 11571.

Pat Ambrose: Okay. We'll certainly look into this and get back to you.

(Ron Cook): All right, thank you so much.

Coordinator: Our next question comes from (Susan Deckel) with Network Health Plans.

(Susan Deckel): Hi, this is (Susan). My question is how many of the 1783 RREs have been successful in the first quarter reporting?

Man: Thank you for the question. We don't actually have that data here. I think the last time we checked it was something like in the range of 500 or so. But at the first quarter reporting is not finished for most of these RREs yet.

(Susan Deckel): Oh well the reason I'm asking I guess, I'm experiencing the same situation as the previous caller where we have submitted a file in production and it was - we submit using FTP, the MSP file did not successfully go via FTP. So I submitted via the Website and it's been what, like at least two weeks and we are not hearing anything back.

We are in Period 2, so in about 3 weeks we have to submit our second quarter production file. I'm not sure if we're going to be able to get a response file back before our second production file is due on October 8.

So I have been working with my account manager. She continues to let me know that they're working on it on her end but I have no update to know how to proceed.

Man: When you first submitted your first production file you said that it wasn't accepted, it didn't get accepted?

(Susan Deckel): Yeah, it failed.

Man: It failed and do you know why it failed?

(Susan Deckel): No. So then I'm assuming it was the size so then I went and submitted it via the Website.

Man: The first thing to do there would be to have discovered why it failed. Simply sending it by an alternative route may not have fixed the original problem. There is no way of knowing now at this point.

(Susan Deckel): Well my account manager does have a snapshot from our FTP site that there is a file existing out there, an MSP file. However it's not showing up where they need to see it.

Pat Ambrose: Well we're not going to be able to answer, you know, the specifics of your case on this call.

(Susan Deckel): No but I guess I'm - what is the protocol if you are not able to get a successful response out before our second file or second production file period?

Pat Ambrose: Yeah, I mean, you look to your EDI representative for guidance in that. Most likely since you are correct, you're coming up fast and furious on when your next quarterly file would be due. And so, you know, most likely it would make sense to - you need to play some catch-up here and work with them in terms of is that original file going to be processed and are you going to receive a response file for it. Then you'll get that, process it, and submit the next quarterly file as soon as you reasonably can do so.

Again we're not looking for imposing fines or something of that nature, we're trying to smooth out this reporting process so as long as you're working with your EDI representative even if you are late submitting your files, you know, that's okay as long as they're kept in the loop and they have a record of that.

I don't know, you know, what might be happening with your particular file or the particular circumstance. Again, we could take your RRE ID and see what we could do to follow up.

(Susan Deckel): We have escalated. How long is the turnaround usually for escalating?

Pat Ambrose: It should be just a couple of days. So if you've escalated to the EDI supervisor and/or manager, you know, you need to give them a reasonable period of time, a couple of days. But, you know, and then take it on up the line. But again I'd be happy to take your RRE ID right now and see what I can do for you.

(Susan Deckel): Our RRE ID is 10506.

Pat Ambrose: Okay 10506, all right thank you.

(Susan Deckel): Thanks.

Coordinator: Our next question comes from (Sue Padgett) from ATPA. Your line is now open.

(Sue Padgett): Hi, we have actually two questions so can one of these be a follow-up?

Pat Ambrose: Sure.

(Sue Padgett): Well we are getting response files where CMS doesn't seem to like our effective dates so it's coming back with an SP31. What are we supposed to be doing about that? Those are our effective dates.

Pat Ambrose: And you're sure that it's formatted. Is it a future date or is it...

(Sue Padgett): No these are like - well for example we have - yeah we're a third party administrator and we have many plans that have open ended eligibility. It's not necessarily month to month. So somebody becomes effective in say August and there is no term date because it will be updated the following month.

Pat Ambrose: Yeah that's fine. I'm just asking if the - we can't accept a future date so, you know, if the file is processed today we could not accept an October 2009 date in the effective date. You know, the reporting has to be subsequent to the effective date so that's one thing that I'm checking for the SP31. Another possibility is that the format of the date is incorrect and I assume that you have verified that the format of the date is fine.

(Sue Padgett): Yes we have.

Pat Ambrose: Okay, the user guide also states that this error may be returned if the individual is found to be a Medicare beneficiary but the GHP coverage dates fall completely outside the Medicare entitlement period. Has - so they might have been for example entitled to Medicare for disability and no longer and your GHP coverage is subsequent to that.

I think it might be possible that they're, you know, currently not eligible for Medicare - the Medicare coverage in other words doesn't overlap the coverage you're reporting. And it's possible that you're getting the SP31 in that error which I know is a little bit not intuitive but we're kind of tied to the systems that we have to interface with.

You know, so then that would lead me to the question of how many, you know, what percentage of records are you getting this? On all of them or just a few, a handful?

(Sue Padgett): I think we didn't get that many, just a few.

Pat Ambrose: Yeah so I'm guessing that that's the case. Now the record should have also provided you the response record with Medicare entitlement dates. Now we heard earlier in this call that someone else who got an SP error did not get - they got a HIC number back but they didn't get the entitlement dates back on the response record. But do check the MSP response record and the Medicare coverage dates and see what they are. And if the Medicare coverage ended prior to your effective date you will get this SP31.

Now the user guide goes on to say to continue to send this record even though you can't change anything because they could become entitled to Medicare again. And in that case then your coverage, especially if it's open ended, may overlap eventually.

So that's, you know, basically if you've got the right dates and, you know, and you can check those Medicare entitlement dates just to validate that's why you're getting the SP31, then just send the record again. And, you know, I know it's kind of counterintuitive to receive an error for something that really isn't an error but this is one of those special cases.

(Sue Padgett): So then how do we determine what CMS thinks the coverage period is? I guess that...

Pat Ambrose: On the response record, I'm bringing that up now, the MSP response records, you should be getting back dates of Medicare coverage.

(Sue Padgett): That's what you're talking about then when you see that phraseology in the directions here. It's that Medicare...

Pat Ambrose: Yeah coverage has ended most likely because they were disabled now not eligible for or entitled to Medicare due to that and then your effective date is subsequent to that Medicare termination date. And, you know, the systems that we're interfacing with return this error code and, you know, it's just one of those exceptional cases.

(Sue Padgett): Okay. My other question was just if somebody could please explain what the difference is between Disposition Code 51 and SP Code 75. They seem to be kind of saying the same thing. And we sent this off to our representative but did not receive a response.

Pat Ambrose: All right I'll have to look up that. I don't know SP 75 off the top of my head.

(Sue Padgett): It just says invalid transaction, beneficiary does not have Medicare Part A benefits for the time period identified in the RRE's update file. If there is no Part A entitlement there is no MSP. No correction necessary, resubmit records with this error on your next file.

Pat Ambrose: Yeah that - you received an SP 75 back in your file?

(Sue Padgett): I believe we - yes we have received many of them.

Pat Ambrose: Yeah you should not be getting an SP 75 back in your file. It's a COBC responsible error. I'm not quite sure why you're receiving it but the only alternative, it's not something you can fix so the only alternative is just to resubmit those records and expect to possibly see it again. I'll have to follow up on that one. I don't know.

(Sue Padgett): Okay thank you very much.

Man: In the user guide it's marked as COBC responsible which means that there's nothing you can do.

(Sue Padgett): Okay we do - it's just that we should not be getting it at all, okay I gotcha. Thank you so much.

Pat Ambrose: Okay.

Coordinator: Our next question comes from (Judy Wilson) with HEPA. Your line is now open.

(Judy Wilson): Hi, (Sue)'s questions and mine overlap except that I'm pretty sure we didn't get the Medicare coverage dates in our response file. We looked for them and didn't see them.

Pat Ambrose: Okay, yeah. I think what I'm hearing, you know, and I'm only speculating, is that if the record is returned with an SP disposition code and an SP error that the system is not - while it's recognizing that this person is a Medicare beneficiary it's not supplying the entitlement dates for Part A and B back on the response record. And I'll have to look into that.

Man: (Unintelligible).

Pat Ambrose: Yeah I think that.

(Judy Wilson): Because we do need to know what you consider the dates to be.

Pat Ambrose: I completely understand and, you know, I - it's new to me today, the first time I've been hearing about it so I've got it on my list to follow up.

(Judy Wilson): Okay thanks.

Pat Ambrose: Yeah you - that is a good point. Someone mentioned here that you are able, and I know it's an extra step, but you are able to query these individuals or possibly look them up via Basis - the Basis application if (unintelligible).

(Judy Wilson): Well we had planned to query before our first production file but like so many other callers it took a really long time to get a first file through and we were, you know, beyond the deadline at that point.

Pat Ambrose: I understand, okay well we'll look into that and see if we can't, you know, modify the system to add those entitlement dates to the response record on the MSP response. I expected them to be there so like I said it's the first time I've heard about it today. Do you have another question?

(Judy Wilson): No.

Pat Ambrose: Okay.

Man: Thank you.

Coordinator: Our next question comes from (Barbara Killison). Your line - from (Sunguard), I apologize. Your line is now open.

(Barbara Killison): Hi, I wanted to go back to something that was talked about fairly early in the call. People were talking about getting the STES error on groups that were 100 or less. And when I read the user guide I don't see any selection criteria for an individual that talks about group size. And the error says to keep

submitting it because the group size might change. But it sounds to me like you guys said don't send it.

Pat Ambrose: Yeah there is some inconsistency with our instruction related to that. I've tried to clarify it.

(Barbara Killison): Okay but it's okay to send it, is that correct?

Pat Ambrose: Yeah.

(Barbara Killison): Okay good, thank you.

Coordinator: Our next question comes from (Jeff Estes) with VIVA Health. Your line is open.

(Jeff Estes): Hello. We were noticing that today is the last scheduled conference call for group health plans. And one thing that we were thinking was that it would be a very good idea to have another call sometime in early 2010 as kind of a lessons learned or to kind of go over issues that have happened after the first and second initial test files have been sent.

Pat Ambrose: Yeah could you hold just one minute please? We need to have a sidebar.

(Jeff Estes): Sure.

Pat Ambrose: Okay I just needed to confirm that we are scheduling additional calls for October, November, December at least for GHP. They just have not been published, the dates haven't been published yet but we do plan to at least hold these calls through the end of the year.

Man: And if we have sufficient interest we may continue them at least once per quarter beyond the end of the year.

(Jeff Estes): Okay very good, we'll look for those.

Pat Ambrose: Next question, any more?

(Jeff Estes): No that's it, thank you.

Coordinator: One moment please. Our next question comes from (Jane Barram) with Anthem Blue Cross Blue Shield. Your line is now open.

(Jane Barram): Yes, thank you very much. A while ago we noticed on our first file up that we had sent a person with a HIC number and a social security number and CMS matched on the HIC number, the first initial of the first name, and the first characters of the last number and sex, gender. But the social security number and the birthdate did not match.

And they still came back - CMS still said it was a match. They found the HIC number and they resent the response back as accepted and changed the social security number and changed the birthdate when in fact really the person we sent, the HIC number didn't belong to that person. We apparently had it connected to the wrong person.

So now we've got an accepted record that we really shouldn't have. And we thought the CMS would have come back with an error saying the HIC number and social security number did not match up.

Pat Ambrose: Yeah there are some - basically the - this is a known issue that needs to be resolved.

(Jane Barram): Okay.

Pat Ambrose: If you supply the HIC number we are going to match on the HIC number. If we get no match there then we'll look at the social security number. But I believe in the example that you're providing the system found the HIC number and then it matched three out of four of the criteria for a Medicare beneficiary even though the birthdate was different, you know, like you said the first initial, the first six characters of the last name, and the gender matched. We would consider that a match.

And then we provided back corrected or not corrected I should say, we provided back the information that we have on file for the Medicare beneficiary including the social security number which is not what we want to do. We, you know, realize that, you know, is a problem.

So the matching, you know, there's kind of two issues here. You know, the matching process, we have found, you know, many, many years of performing this match that we don't have a lot of examples of finding the wrong person but we are definitely going to change is not to send you back a different social security number than you sent to us. We're not in the business of updating or should not be providing you with social security numbers. So that is a system change that's pending.

As far as, you know, the match logic, I don't really know what to say about that in that, you know, you supplied correct information and this is an example of where we did actually match it to someone who was not the individual you were trying to report. And I assume that all the data that you reported on the name and birthdate and so on was indeed correct.

(Jane Barram): Yes. So now we end up with a person who really doesn't even - he's not really eligible. We don't know how the HIC number got on that person but that HIC number doesn't belong to that person.

Pat Ambrose: Now the HIC number you supplied on your original record.

(Jane Barram): Right on the original record, we got it from our database and so, you know, we figured out, you know, we assumed it was correct but then when we got the response file back we realized this was not correct.

Pat Ambrose: Yeah and I understand from what you're saying that you also supplied the SSN. So, you know, if we had which we don't use both the HIC number and SSN we would have found that, you know, there was something awry. You know, I'll just have to take this back as - if you had a lot of examples of this, you know, we would be, you know, very concerned.

Obviously you need to update your internal systems with, you know, the correct information. And like I said we have a change pending not to send you back a different SSN than you might have submitted us and then we'll have to take the mismatch so to speak under advisement and look into that.

(Jane Barram): Okay well do you know when that's going to happen, the change?

Pat Ambrose: No I don't have a date for that, I'm sorry.

(Jane Barram): Oh okay.

Man: We are trying to rush it through though, I'll tell you that.

(Jane Barram): Oh you're trying to rush it through, okay. All right could I ask one more question though? It's very similar to this but we didn't understand what a disposition 55 mismatch would be. And if you did get one, what would CMS get back?

Pat Ambrose: You know what, I'm going to remove that from the user guide in the next version. I looked into it and it's - we don't return disposition 55.

(Jane Barram): Oh okay, all right. Thank you.

Pat Ambrose: You're welcome.

Man: Operator could you tell us how many questions you have in queue? It's almost 3:00.

Coordinator: I still have three.

Man: Okay let's try and do them.

Coordinator: Our next question comes from (Janice Mulner) with QVI Risk Solutions. Your line is now open.

(Janice Mulner): Thank you. We're a small TPA and one of our clients is a fully insured self-insurance carrier that is closing their doors as of October 1. Every group that they have had insured will be terminated as of that date if not before. What my question is, all we do for them is process claims. We don't do their eligibility. So as we receive updates through the response file, how will that information - I'm not sure how we can get that information in our system for us to know how to process the claims. I know that's really not your problem but I don't know if we should be reporting them.

Pat Ambrose: Well if their coverage, GHP coverage was effective as of January 1, 2009 and terminated subsequently and they're defined as active covered individuals and all of that then you should report them as add records. If you have a date of when their coverage will be terminated then you can include that termination date as well.

(Janice Mulner): And that's what I was planning on doing, okay.

Pat Ambrose: Yeah that's exactly. If it's the initial report you can send an add record with both the effective and termination dates completed. If you've already submitted an add record with an open ended termination date and had that records accepted then you can submit an update and term the record.

(Janice Mulner): Okay, all right, thank you very much.

Pat Ambrose: Oh and I should note that while earlier I mentioned that we cannot accept future effective dates, future dated effective dates, we can accept future dated termination dates. So you may send that record with the termination date prior to that actual termination date if you choose to do so.

(Janice Mulner): Okay great, thank you.

Pat Ambrose: You're welcome.

Coordinator: Our next question comes from (Jody Lamarko) with Summit Administration. Your line is now open.

(Jody Lamarko): Thank you, I'll be very quick. I know we talked about this earlier today in that they had mentioned employers refusing to give their TIN. We haven't had any

issues like that but we do have just a handful, maybe 50 members refusing, dependents refusing to give us their social, their SSN. So was - is there a directive by CMS of how those individuals should be reported? I mean, we have to have those SSNs populated, correct?

Man: Have you looked at the model language that's on our Website? If these people are not Medicare beneficiaries then they...

(Jody Lamarko): They are, they've got a social. They don't want to give it to us.

Man: No no no, I asked if they were Medicare beneficiaries, not whether or not they had a social security number.

(Jody Lamarko): They are not.

Man: Okay, if they're not Medicare beneficiaries and they fill out that form for you, that's your safe harbor.

Pat Ambrose: And we cannot accept a record that has neither the SSN or HIC number. It will just flat out get rejected. So there's no point form a technical perspective or any perspective really in sending a record with neither of those fields completed.

(Jody Lamarko): Okay.

Man: The hierarchy is if the individual is a Medicare beneficiary the individual will have a Medicare health insurance claim number, a HICN. That must be reported.

(Jody Lamarko): Okay.

Man: If they are not and they have a SSN and they wish - they are willing to have you submit it, you may submit it. If they are not willing to have you submit it they need to sign that form and give that to you. If it's a person who is under the age of 45 we will only accept a Medicare health insurance claim number.

(Jody Lamarko): Very good, thank you.

Coordinator: Our next question comes from (Sabrina Jenkins) with Paragon Benefits. Your line is now open.

(Sabrina Jenkins): Thank you very much. We sent in our test file and we received a response file and in that we received an error code of SP25. SP25 indicate the name that we're sending does not match Medicare records. Now how I'm concerned about this is that when people sign up for our medical benefits frequently they will put a (Charlie) when they're actually (Charles) and they will utilize their middle name instead of their first name. How are y'all handling this or how are y'all finding other TPAs are handling this?

Pat Ambrose: Okay, SP25 is invalid insurer name.

Woman: Correct.

Pat Ambrose: Insurer name. It's the name of the insurer that's on the TIN reference file, submitted on the TIN reference file. And, you know, in that error description there's various insurer names that are not acceptable default type of names like Unknown and None and things like that.

(Sabrina Jenkins): Sure, sure, that doesn't fall under this.

Pat Ambrose: Okay, we are not, you know, other than that...

(Sabrina Jenkins): We should go back to the well and try to find that name, right, or try to get that actual social security name which we are.

Pat Ambrose: No no no, that's where I did want to make sure you understood. We're not editing the name of the insurer that you put on the TIN reference file against the IRS records, just the TIN. When we go to validate your TIN reference records we are only checking the TIN and making sure that, you know, we can find it as a valid IRS assigned tax identification number. It does not have to match the TIN and associated address that the IRS has on file for that number.

Now it does have to have valid characters in the field, it cannot have one of those default names. It also says that you might get that error if no insurer TIN was submitted on the MSP input record so, you know, if it were blank.

Woman: Yeah can we make sure that we have your question correct because you sound like you're thinking of a situation where the first name of the beneficiary doesn't match what you sent in and those SP error has to do with the insurer name.

Man: The insurance company name.

(Sabrina Jenkins): You know, we used one particular group. I would have thought we would have gotten that record on every single row since we only sent one particular group for the insurer. I understand what you're saying but it only happened...

Pat Ambrose: Well yeah then I am pretty confused about that too. So there must be something else going on and what you need to do is provide an example to

your EDI representative and we'll have to have it investigated. I'm not sure why you would be receiving it in this case.

(Sabrina Jenkins): Okay excellent, well I will touch base with her and I appreciate it.

Bill Decker: Thank you very much. Operator that's all the time we have. If there's anybody else in the queue we're sorry, we have to cut the phone call off. I want to thank everybody who has called in and may still be hanging around. We appreciate your calls. We got a lot of good comments today.

And as we mentioned later - late in this call we will undoubtedly be having more of them even though none are posted up on our Website yet. Keep looking on our Website and we'll have future dates published as soon as they're settled on. And before we go Operator - actually before you go can you just tell us one more time how many people were actually on the call in total?

Coordinator: Yes, one moment.

Bill Decker: Thanks.

Coordinator: 320.

Bill Decker: What, 320?

Coordinator: Yeah.

Bill Decker: Okay thank you.

Coordinator: Thank you. Thank you for participating on today's conference. The conference has concluded. You may disconnect at this time.

END