TRANSCRIPT
TOWN HALL TELECONFERENCE

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

DATE OF CALL: July 25, 2013

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
July 25, 2013
1:00 p.m. ET

Operator: Good afternoon. My name is (Nicole) and I will be your conference operator today. At this time, I would like to welcome everyone to the MMESA Section 111 NGHP Conference Call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Mr. Albert, you may begin your conference.

John Albert: Thank you, operator, and good afternoon, everyone. For the transcripts, today is July 25, 2013 and this is the Section 111 NGHP Town Hall Teleconference. As I state in on the other calls, just as a disclaimer, there are times where we may say things that on the call that dispute or contradict to what is in the official user guide on the website. Again, the materials that are on the website constitute the official instruction regarding Section 111. As we do or have in the past, we will start off with some opening presentations and then move in to our Q&A session. And we ask that folks try to limit their questions to one and one follow up and then go back and get in the queue just to allow everyone an opportunity – a chance at the microphone.

We'll be starting off with the presentation by Jeremy Farquhar of our Coordination of Benefits Contractor and then we'll turn it back over to several of us here at CMS. And then, again, we'll go in to the Q&A.

So with that, Jeremy, I'll turn it over to you and you can begin.

Jeremy Farquhar: OK. Thanks, John. First off, most of you are likely aware,

but for those who might not be, CMS recently reorganized their website and there are new URLs for the Section 111 Mandatory Insurer Reporting pages. They're now separate and distinct links for group health plan, GHP, and non-group health plan, NGHP, reporting. The new NGHP Mandatory Insurer Reporting page is located at go.cms.gov/mirnghp. Once again, that's go.cms.gov/mirnghp.

There have also been changes regarding access to the computer-based training, CBT modules. Unfortunately, at the present, the online video versions of the CBTs are not available. However, all training materials are readily available in PDF format and maybe accessed without any need for registration.

Currently, all training materials may be accessed by clicking on the training materials link located – excuse me – located at the upper left hand side of the NGHP Mandatory Insurer Reporting page. It may also be worth mentioning that an updated version of the NGHP User Guide has been published since our last town hall call. The current version is 3.6 and was published on May 6th. You may download the current version via the link labeled NGHP User Guide found on the NGHP Mandatory Insurer Reporting page. The only significant updates relate to the addition of information previously published in alert format, most notably the March 24th alert regarding changes to required data elements.

The following is a recap of the changes referenced within that alert. The data elements which I'm about to reference are now optional as opposed to required fields. First off, alleged cause of injury or illness. That's field 15. This field is now optional but please be aware that if a value is provided that it will still be subjected to validation. If a code is provided and that code is not valid, it will still trigger an error. Subsequently, claimant fields 107 through 118 and claimant representative information fields 119 through 132. Previously, when reporting on a claimed link to a deceased beneficiary, an RRE would be required to provide claimant information and when applicable, claimant representative information. This is now changed. Claimant information is still accepted although it is no longer required. With that said,

if claimant or claimant representative information is provided, we still edit that data for completeness.

In a nutshell, if an RRE chooses to report claimant and claimant rep information then the old edits will continue to apply to these fields. Partial information or invalid data provided within these fields will still result in error is being generated. This holds true with the exception of claimant TIN and representative TIN fields. Claimant TIN and representative TIN fields will no longer be required data elements regardless as to whether a claimant and claimant representative information is submitted.

In other website related news, there had been three recent NGHP alerts published. All of which pertain to the transition from ICD-9 to ICD-10 diagnosis codes. All three alerts may be accessed by clicking on the NGHP alerts link on the NGHP Mandatory Insurer Reporting page. It's important that you review all three of these alerts carefully. The first of the three alerts was published on June 11th and includes technical information regarding the following topics, claimant with file record layout revisions, revised claim input file, and direct data entry reporting requirements summaries, and validation of submitted ICD diagnosis codes.

The second alert was published on June 24th and includes technical information regarding free implementation testing as well as the new ICD indicator field and ICD diagnosis code reporting requirements. And the third alert was published on July 11th and contains information on excluded ICD codes.

Please note that along with the new list of excluded ICD-10 codes, there are also two new additions to the list of excluded ICD-9 codes. The two newly excluded ICD-9 codes are 9598 which references other specified sites including multiple injury and 9599 which references unspecified site injury. And those will take place – the exclusions will take place as of October 1, 2013 for the new ICD-9 codes that is.

The following is a summary intended to provide a high level overview regarding important items included within the aforementioned ICD-10 alerts.

Beginning October 1, 2014, CMS will begin accepting ICD-10 diagnosis codes on production claim input files. ICD-10 codes will not be accepted on production file submissions prior to that date. After October 1, 2014, CMS will accept either ICD-9 or ICD-10 diagnosis codes for claims with the CMS date of incident prior to April 1, 2015.

RREs are encouraged but not required to report ICD-10 codes beginning 10/1/2014. ICD-9 codes will continue to be accepted for claims with the CMS date of incident between 10/1/2014 and 3/31/2015 but a new 02 compliance flag will be generated. This compliance flag is simply intended to function as a warning of the impending requirements to report ICD-10 codes for claims with CMS dates of incident 4/1/2015 and later. If ICD-9 codes are submitted on a claim record with a CMS date of incident of 4/1/2015 or later, they will be rejected.

An individual claim record may be submitted with only one version of ICD codes. A record submitted with mixed ICD-9 and ICD-10 codes will be rejected. You can have ICD-9 and ICD-10 codes mixed within the same file but each record has to be ICD-9 or ICD-10 specific. A new ICD indicator field will be added. It will be located in what was formerly field 18 of the claim input file which had previously been labeled as reserved for future use. A value of ‘9’ will be submitted to indicate the use of ICD-9 codes and an indicator of ‘0’ will be submitted to indicate the use of ICD-10 codes. Submission (on those face) field ICD indicator will also be read as an indication of an ICD-9 submission.

So if a value other than ‘9’, ‘0’ or space is submitted in the ICD indicator field, it will generate a new ICD indicator error. That error will be CI31. Submission of a value of ‘9’ or space in conjunction with the CMS date of incident of 4/1/2015 or later will also generate a CI31 error.

While ICD-10 codes may not be submitted on production claim input files prior to 10/1/2014, RREs will be able to begin submitting test files containing ICD-10 codes as of 10/1/2013. While testing for ICD-10 is not a requirement, it is highly recommended. Testing is the only way to ensure that an RRE is capable of successfully submitting ICD-10 codes on their claim input file.

And subsequently, processing claim response file is generated as a result of those ICD-10 submissions.

Next, I'd like to make an announcement about the annual profile recertification process. As some of you may already be aware, we encounter problems with our profile recertification process earlier this year, and subsequently, the process had been placed on hold. Issues experienced previously have now been resolved and we expect to resume recertification shortly. That being the case, we just want to provide you with a bit of advance notice. Our tentative date for resumption of the profile recertification process is currently September 1st.

And I have one last quick note before I'll move in to the some of the questions received via the CMS drop box since our last town hall. That's on occasion we're receiving questions about entering data into systems which are not maintained by CMS or the COBC. Many Section 111 non-GHP RREs work with agents that assist them with their reporting responsibilities. Some of these supporting agents have online interfaces via which Section 111 RRE may input data which they will subsequently pass along to the COBC after performing edits and assisting the RRE in various specs.

If you're an RRE that is working with an agent group with this nature then be please be aware that COBC and CMS are unable to provide the systems with questions regarding issues and (currently) while attempting to submit data via your agents online interface. Neither the COBC and our CMS have a working knowledge of the interface via which you provide your reporting agent with data. For assistance with those matters, you will need to contact your reporting agent directly. But of course, for assistance with the direct data entry, this is the – excuse me – for assistance with the direct data entry system maintained by the COBC and CMS, be with small volume reporters are able to directly report their data via our own online interface, please don't hesitate to contact your assigned EDI rep. Or if you're unaware of who your assigned EDI rep is, then you may contact our EDI hotline at 646-458-6740.

Next, I'd like to jump in to some of the mailbox questions we received since the last call. As I have noted earlier and as referenced initially in the March

24, 2013 alert, then subsequently in the recent update to the NGHP User Guide, certain data elements such as the alleged cause of injury, claimant and claimant representative information are now considered optional rather than required fields. And a time since our last town hall call, the CMS drop box has received numerous questions regarding the changes to these requirements. I'm going to address those questions now in an effort to alleviate any persistent confusion.

The first question right as follows. The alert of 3/24/2013 makes field 15, alleged cause of injury, an optional field. If the claimant then previously submitted with a valid alleged cause of injury and accepted, will there be an edit error if an update such as an additional (TPAC) to that claim contains blanks in field 15? And the answer is no. If the update to that claim which had previously been accepted with a valid alleged cause of injury is submitted now with field 15 populated with spaces, it will not cause an error to be generated and the update should be accepted granted there are no other issues with the records.

Similarly, if record had been submitted previously and had been rejected due to an invalid alleged cause of injury in field 15, it is not necessary to provide a corrected code when resubmitting the records. If field 15 is populated with spaces, then the record will be accepted when resubmitted. However, please remember that if a value other than spaces is supplied in field 15, it will be subject to the standard ethics. And if the code provided is not valid, it will still cause the record to be rejected and for an error code to be generated.

Next question, it is now that the claimant and claimant representative information are optional, is the following example correct? The injured party is deceased. There is an executor of his estate and an attorney representing the claimant. Do we understand – excuse me – do we understand correctly that since the injured party is deceased, there is no injured party representative to report and we are no longer required to report the executor as the claimant one with the attorney as the claimant one representative? Or should have the ex – it should have the executor or an attorney be listed as the injured party representative even though the injured party is deceased?

Let me start by saying that the change to make the aforementioned fields optional has had no impact on the way the data should be reported if the RRE has the information and chooses to submit it. If the reporter has complete claimant and claimant representative information, then we welcome the submission of that data. If the RRE chooses to report the information, then it should be reported just the same it had been prior to the change in requirements. In this specific case, as the injured party is deceased, the executor of the estate could be submitted as claimant one and the attorney could be reported as the claimant one representative.

The following questions cover similar territory to the last but differs a bit and therefore warns being addressed separately. It reads as follows, please advice whether injured party representative information, fields 84 through 96 on the claim input file detail record, should be completed if the injured party is deceased. Being that the injured party is deceased, it's unlikely that there would be an injured party representative to report. It's much more likely that there would be a claimant representative as opposed to an injured party representative. Reporting as claimant and claimant representative information is now optional but it is welcome if the reporter has all the required data.

Finally, the following question also relates to changes in required fields submitted (with us) in regards to the CMS alert dated March 24, 2013 optional fields. I have a question regarding Section 3. It says that the field for a claimant tax identification number is now optional in all circumstances. It seems to indicate that a query can be made without this information. Is that correct? If it is, then does an RRE also not need to collect this information including the Social Security Number from a claimant?

First, it would seem important to clarify that claimants are not necessarily Medicare beneficiaries and our process does not attempt to perform a query utilizing the claimant TIN or SSN. In order to perform a query on the Medicare entitlement status, we do require either a valid SSN or a valid Medicare HICN. Our present process cannot positively identify a Medicare beneficiary without an SSN or Medicare number. However, please allow me to reiterate, if we are provided the claimant TIN or SSN, that information is

not utilized to perform a query. Only the injured party SSN would be used to inform a query regarding Medicare entitlement status.

RREs are no longer required to report the claimant SSN under any circumstances. Claimant information is no longer required in general but maybe reported if the RRE chooses. If an RRE does elect to report claimant information, we will edit that data for completeness with the exception of the claimant TIN field. If the optional claimant information is reported, then all claimant fields other than the claimant TIN field must be appropriately populated in order to avoid the generation of errors and the rejection of that claimant.

We've also received questions regarding these specific default diagnosis codes, no INJ which is intended for use in extremely limited and specific circumstances. Prior guidance should indicate that when the no INJ diagnosis code was utilized but both the alleged cause of injury, field 15, and the ICD diagnosis code 1, field 9, had to be populated with that no INJ code. Now that the alleged cause of injury field has been made optional, when reporting on a situation which requires the use of the no INJ code, the ICD diagnosis code 1 field must still be populated with – populated with no INJ but the alleged cause of injury field may be populated with either no INJ or spaces. Either value will be accepted.

OK. Moving on to other questions not directly related to the change in required fields, we received additional questions relating to the use of the no INJ code in relation to the transition to the ICD-10 reporting. Specifically, some submitters had question whether the no INJ code would still be accepted under ICD-10. And the answer to that question is yes. In a very specific and limited situations, where it may be appropriate, RREs may still utilize that no INJ code under ICD-10. For further information regarding those specific situations where the use of no INJ is appropriate, please refer to Section 6.2.5.1 in Chapter 4 of the current non-GHP User Guides.

The following question is in regard to situations involving the workers' compensation, ORM exclusion outlined within the ORM reporting summary Section 6.3.1 located in Chapter 3 of the non-GHP Guide. The question was

as follows, we have a claim we reported due to the existence of ORM and the medical payments were over the $750 thresholds. And later due to New York second injury fund, SIS, New York reimburses us for a portion of the medical and the ORM threshold drops below $750. Does CMS want us to submit a delete? The answer is no. If the RRE is reimbursed for a portion of the medicals and the toll payment drops below the $750 or for whatever reason is determined that the total payment has turned out to be less than $750, the RRE should not delete that claim.

Regardless of the fact that the total payment may have dropped below $750, the RRE would still have ORM. And once reported, that claim should remain. The claim may only be deleted if it is determined that there had never been ORM and it had been reported entirely erroneously. If and when ORM terminates, the RRE should submit an ORM termination date but the record should remain on file.

The following question is in regards to query file processing. What is the current response time for MMSEA queries? And is there a way to submit an expedited query? The response time for – excuse me – the response timeframe for a query file submission is 14 days. There is no way to expedite a particular submission by a request. But more often than not, the response will – the response file will actually be returned within about a week.

While it is impossible to expedite the processing of a query file, if an RRE needs to determine the Medicare entitlement status of the specific individual or a small group of individuals, they do have the capability to query them manually via the online beneficiary lookup tool. The online beneficiary lookup is available via the actions dropdown menu found on the RRE listing page after logging on to the Section 111 COB secured website. RREs are allowed up to 100 online lookups per calendar month.

OK. The next question in response – is in response to a letter received from the coordination of benefits contractor. The letter was addressed to the RRE and stated that the information had been received, that – excuse me – the information had been received by the COBC indicating that ORM for the accident record which had been submitted via Section 111 may have

terminated. The letter requested the RRE to contact the COBC either via phone, email, or fax to confirm if ORM had terminated and provide an appropriate termination date if they had. The RRE that had written to the mailbox indicated that ORM had not terminated and they were unsure how to proceed.

Please note that these are standard development letters that the COBC will send if they received information from another source indicating that ORM may have ceased. Oftentimes, this may stem from a beneficiary phone call via which the beneficiary has insisted that the record should be terminated. The COBC is aware that terminating the record may not be the appropriate course of action. And we'll look to confirm with the RRE prior to making any updates. If you are an RRE and you received a letter of this nature, then you may have cont – then you may contact the COBC and inform them if the record should actually be terminated or simply instruct them that the ORM has not terminated and that the record should not be updated at the present. The COBC should not update the record without your consent. Therefore, if ORM has not terminated, then you may also simply ignore the letter. If no response is received, the record will appropriately remain open.

Finally, in response to the alert published July 11th regarding excluded codes for ICD-10 and the addition of the two new excluded ICD-9 codes, 9598 and 9599, we've received a couple of questions about the latter. The individuals who had written into the mailbox were questioning situations in which an accident had resulted in death at the scene or en route to the hospital. In the past, some RREs had been utilizing the 9599 code in these situations where the accident had resulted in an immediate or near immediate death. The questions were about how these claims could be reported if 9599 were no longer accepted as a valid code.

The answer is that the RRE will need to investigate in order to determine the injury sustained which ultimately cause the fatality. ICD-9 or in the future ICD-10 codes which identify the specific injuries which ultimately cause the death of the beneficiary will need to be determined and submitted on that claim. Neither 9598 nor 9599 are sufficient codes for Medicare's purposes. And aside from the aforementioned scenarios, they are often simply used by

RREs who may not have a valid diagnosis code readily available rather than expanding the effort to follow up and derive a proper code.

In cases where these codes are submitted for living beneficiaries, they have 10 (CD) caused significant hardship for those beneficiaries as it will typically result in Medicare's denial of any and all claims even though the claims in the question may not actually have relation to the illness or injury for which the non-GHP RRE is responsible for payment.

And that was it for me so I'll turn it back over to you, John.

John Albert: All right. Thanks, Jeremy. I guess the one person – I was going to mention something you already took care of for us so thank you. So I guess – so we can go into the other Q&As that we have here. And Barbara is going to start off. Barbara Wright, excuse me.

Barbara Wright: Thanks, John. So the first thing I'd like to talk about is ORM and the physician letter of attestation that we published on our websites making it clear that if the primary care physician would attest that essentially the beneficiary did not require further treatment, then the ORM could be terminated.

We've been hearing allegations regarding what various of our contractors are saying about that letter. And what I wanted to distinguish for you is the difference between whether or not that letter needs to be submitted by you as an RRE and whether or not the letter is needed. We're hearing allegations that different contractors are simply saying that letter is not needed, that the record can just be termed. And what I want to make clear is if an RRE has reported ORM and the ORM is not otherwise ceased under state law, et cetera, if the idea is that it's open, and the only reason to close it under our rules would be the physician attestation, the RRE does have to have that letter. But the RRE does not submit that letter to CMS. They simply take care of it through their normal reporting for Section 111.

And that's the point, there appears to me some confusion on when either insurers or insurers with beneficiaries on the line have talked to some of the

contractors, they'd pick up on the phrase not needed or the term not needed and assumed that the reference is to the idea that no one even needs to have the letter period. And that's simply not true. It's a matter of what needs to be physically submitted to us. The RRE has to have it. They need to maintain it as documentation. If there would ever be any question but they do not submit it when they term the records.

The next thing I'd like to mention along that similar in line is the issue of denied claims. We continue to see some reports of denied claims and one thing we have not stressed in the past that I would make clear is anytime a beneficiary actually has its claim submitted for payment and it's denied because of an MSP record, they have the ability to appeal that denial. You know, if it's the denial because they happen to have GHP insurance that's primary, they're not going to successful because it's still going to remain denied under that. But if you have a situation as sometime you've been alleged where it's obvious that the claim is not related.

For instance, someone is being treated for leukemia and their injury on the record is a broken ankle. If they appeal that denial on that basis, I would expect that they will win an appeal. There is – it shouldn't be needed to go all the way through but there is a complete administrative appeal process with several levels including ultimately judicial review if the amount of controversy is met.

The second related issue along that line is denied services where a beneficiary is telling you that they've been actually denied services. It's not that Medicare denied payment for the services, they've – they've had the physician or other entity refused services. We don't have an absolute fix for that for you but certainly it would be worthwhile to make sure the beneficiary has access to or has a copy of the Med Learn articles we have told you about related to that that they could show to their physician or hospital.

And the other thing I don't know if anyone has tried. Again, we can't guarantee it as a solution is whether or not if you gave the beneficiary a letter stating that you have reported this open record but then the open record, the ORM, is specific to X, Y, Z injury. That's something you might wish to try.

That's all I have on that right now. Some of the areas sort of more high arching as oppose to just a single question. As we received a number of questions about the SMART Act and how it affects this process and what regulations are out there.

In terms of regulations, when CMS is doing an advance notice of proposed rulemaking, an ANPRM or NNPRM or final rules or even a federal registered notice, we're not allowed to comment whether we are or are not doing that notice or the content of that until there is at least something on the unified regulatory agenda at which point we still can't tell you specifics but we can tell you that document is in progress. The site you need to go to for that generally is – if I can find the right thing – is www.reginfo.gov. And what that – you can also find it simply by Googling the Unified Regulatory Agenda and then the term CMS. But what it lives on that, it won't – and want – those are ones that are in our process – officially in the process.

And right now, the requirement in the SMART Act that an ANPRM be done with respect to civil money penalties under Section 111 is on that Regulatory Agenda. I believe there are at least two other MSP related regulations either – whether it's under something in the final rule, a pre rule or proposed rule. But you can check that out and that's a site that you may want to monitor every so often if you have a question about whether or not we're doing a particular regulation.

Similar to that, because I mentioned the SMART Act before, is a lot of the questions were asking specific facts about our specific actions we planned to take with respect to what's in the SMART Act. As we make any changes or do anything related to the SMART Act, we – anytime instructions are going to change, we will give appropriate notice. At this point, there's nothing that we have changed in our instructions that affects you at this time. So, we won't be addressing any specific SMART Act questions.

Last but not least, as we have said in most of these calls, the extent we received questions that are related to MSP recoveries in the mailbox, those are outside the scope of this call. And we won't be addressing those.

Another topic we've had a lot of questions about – or a number of questions about is amended complaints. And I wanted to let everybody know that we're working on language for an alert related to amended complaints. And actually that's the one that we might have out to finish hopefully within a couple of weeks.

We continue to look at and work on whether and to what extent we can give some relief from reporting for many of the things that are currently reported with the no INJ code and situations in general where the RREs or others in the industry have said, "There really aren't medicals associated despite the fact that there are releases that are releasing medicals."

I want to read you a short list of the ones that are under consideration for whether or not we will make any changes. Yes, there's a particular type of insurance that's not listed in what I'll read to you that you believe is a situation that basically, rarely if ever, has medicals associated with it then feel free to send it in to our question box, our dedicated mailbox and let us know about that. It would help to have that as soon as possible. The list that we've been asked about so far currently includes employment practices, liability insurance, (DNR), or directors and officers liability insurance, professional liability insurance, other than medical malpractice insurance, fiduciary liability insurance, errors at admissions insurance, and of course, consortium issues.

The extent we addressed consortium, it will probably be in a separate alert because we see some distinct things related to consortium that wouldn't apply to all the others. So, we are working on an alert for that right now.

We received several questions related to clinical trials and I wanted to reemphasize a few points. It's not a situation where all clinical trial situations need reported to us. What we're really looking at are situations where there's an injury or complication arising out of the trial and the clinical trial sponsor or other entity essentially promised in the agreement for the trial or another agreement, they would pay for all care relating to the trial including injuries or complications that are arising out of the trial. We're aware and we haven't made any change. We don't believe it involved MSP. When you have a

situation, let's say for example, the clinical trial requires an x-ray every three months. And that x-ray is medically reasonable and necessary. My understanding is that our current rules allow Medicare to pay for that Medicare beneficiaries even if the trial is paying for it for people that are not Medicare beneficiaries or don't have other insurance that will cover it.

So, remember that this is really only related to injuries or complications arising out of this trial. It's once they have a reason, you're not reporting just because you have a clinical trial agreement that says it will pay for these types of situations. That doesn't mean he report it for every single beneficiary in the trial. It's only when you actually have the situation arise.

We got a number of questions that were related to RREs. One question was asked, I believe, twice. We were asked what liability insurance ORM is. And although we don't see it being reported very often, it's relatively rare compared to workers' compensation or no-fault situations. It's basically when you have liability insurance that for whatever reason the liability insurer has assumed our ORM. One of the first place we heard about this was a particular state government that was self-insured and it let us know that it routinely treat clams that are below a particular dollar level like no-fault. In other words, they don't investigate. They don't do anything. They basically just pay period. And they asked us whether they should be reporting that as no-fault. And we said, "No. You know, it's under your self-insurance, it is liability insurance. But since you're doing it as an ongoing responsibility for medicals, you have to report it as such."

Let's see. We've – several of the questions appeared to be from entities that are new to the process. And they were asking very fact specific questions in terms of if I had beneficiary A that did this, and I had insurer that did this, et cetera, then how many RREs do I need? How many numbers, et cetera? And most of these questions probably because they seem more new to the process, they hadn't gone back far enough or they hadn't read – potentially hadn't read what was in the user guide. Your initial question has to be who's the RRE? Compare that to the facts to start with. Most policies where you have a deductible and an amount above the deductible, our instructions make it clear

that it's going to be an insurer that reports both the deductible amount and any amount above that. And they're both reported under the policy number.

So we would ask that people go back and read those sections more carefully particularly the sections on who is the RRE and then the sections on what needs reported and when. Within that section, there is specific language that deals with stock loss of insurance, excess insurance, et cetera. For the most part, who physically makes the payment is not a driver in terms of who's the RRE. But there is some exception with that – with respect to stock loss, excess insurance, et cetera. So please be sure to read those sections.

Another area that we had a number of questions on were risk management write-offs. With at least two or three of those questions, the facts they gave indicated that they weren't so much talking about a write-off situation as they were talking about an ORM situation. It was one where the hospital said that it was paying the bills to all the outside doctors that were related to a mistake. That's an ORM situation. That's not a risk management write-off situation. So, you need – you need to be sure to be looking at what you're actually doing. Is it a situation where you're writing-off that? In which case, if you're a provider or supplier, make sure that you were following our billing rules so that Medicare is not paying inappropriately for this. And if you're doing risk management write-off where you include the amount that's being written off as a primary payment from another entity, in this particular case, it's technically from yourself as a self-insured entity. You should not separately be reporting it on the Section 111 reporting.

I think those are all the general things I have right now.

John Albert: And there was – this is John. Thanks, Barbara. There's one more thing. Someone wrote in and asking about the query process that NGHPs can use and asking whether it could be expanded to include, for example, a yes/no for Part D. And unfortunately the answer is no because Section 111 applies only to Part A and B but also more importantly as a – we had to get those even the ability to get the ability to provide a yes/no answer cleared to our HIPPA office. And because NGHPs don't have the same type of relationship with the claimants as, let's say, a traditional GHP does with its insured, we can't give

out more information. But the primary reason, though, again, as a – because we'll be able to scope at Section 111. So unfortunately, the answer for that is no.

Barbara Wright: We also received a separate question that was specifically asking about guidance for 111 and related to Medicare advantage plan compliance. And as you should have taken from John's answer to this, Section 111 is applicable only for fee-for-service Medicare Part A and B. There are some situations where we take Part D information with connection with the GHP.

John Albert: Yes. Yes. And that's – and that's, I know, a voluntary option for the GHP folks.

So, other than that, I think, operator, we can – anyone out there? We can go straight to the phones and start the Q&A session with the attendees.

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

Your first question comes from the line of (Tanya Golf). Your line is open.

(Tanya Golf): Yes. We recently had a case where there were multiple of co-defendants involved with the settlement. And we were – one of the co-defendants was advising us that we should use the same CMS date on incident that they were using. It involved a pressure ulcer – I think that was involved at the three – that was at all three different co-defendants are being treated with all defendants. And I just wanted to get your advice on what you thought about that approach.

Barbara Wright: I would think that in most cases where you have a situation that's a specific injury, you know, while they're in the hospital or something like that, there should be the same date of incident. What I can't tell you is to say, "Well, yes, you need to use the same one that defendant access using in your defendant." (Why?) You presumably should talk to each other and decide what the appropriate one is but you need to make sure that you're using the date of incident based on our instructions in the input file. And you can find

that, you know, that file in the record layout. It's not as it's – for instance, if someone falls and it's not diagnosed until two days later, you shouldn't be using the date of diagnosis. If it's tied to the fall, you should be using the date of fall.

So, I'd say – I would say you need to use a reasonable consider thought process. And, yes, generally, it should be the same date but it's not one defendant has control over that. You should be making sure that you're all using the appropriate one. I know – I know that sounds somewhat wishy-washy but we don't really have a way to give you an exact answer for your situation. And there is no – we can't say who controls that. But make sure to the best of your efforts that you're following what's in the guide and the appendix.

(Tanya Golf): OK. So – but it couldn't – potentially after looking at the guide – in the user guide, it could be a date before that they're actually even admitted to our hospital?

John Albert: Yes.

(Tanya Golf): OK.

Barbara Wright: They're arguably could be. That is – the date of incident isn't driven by when a particular entity treats. It's driven by when the incident occurred.

Male: Yes, (inaudible).

(Tanya Golf): OK, thank you.

Operator: Your next question comes from the line of (Jim McGraw) from CG&E. Your line is open.

(Jim McGraw): Yes, hi. I just have a quick terminology question. I want to make sure or clarify that when you're saying the alleged cause of injury, you're also referring to the external cause code, ICD-9 code?

Jeremy Farquhar: Yes, that's correct. It's the – it's the cause of injury. It's field 15. You're – presently, they are the eCodes that you would submit.

(Jim McGraw): Correct. I'm glad to hear that because this has been a very frustrating thing for us because sometimes we just can't find one that fits.

Jeremy Farquhar: Yes, that's – that's partially the reason why they're being excluded now.

(Jim McGraw): OK. I just wanted to clarify, thank you.

Jeremy Farquhar: Yes.

Operator: Your next question comes from the line of (Lisa Riley) from CCMI. Your line is open.

(Lisa Riley): Hi, this is (Lisa Riley) with CCMI. My question is regarding the two new excluded ICD-9 codes. Well, you used to publish a list of accepted codes that we could download. Will that still be the same? Will that be updated with those exclusions?

Jeremy Farquhar: There will be – there's the – are you referencing the combined list that's published on the COB secured website via the reference materials?

(Lisa Riley): Yes. I think that's …

Jeremy Farquhar: Yes, those should – those should be – I believe they are still in the listing that we have now but we will be posting an updated list. The updated list to that, I think, doesn't go until January. So until January, they're still going to be on that list but we should have an updated listing published in January and they will no longer be on that list.

(Lisa Riley): OK.

Jeremy Farquhar: So you have to keep in mind October 1, 2013 through the end of the year that they are – they're still on the list but they are on the excluded list. They're the only two codes that you'll actually find on that listing at that point in time that are actually excluded. So they're – they'll be that short period of time where they're still appearing but it will be updated.

(Lisa Riley): OK, thank you.

Operator: Your next question comes from the line of (Merlyn Sniffers) from (Inaudible). Your line is open.

(Merlyn Sniffers): Thank you. Yes, we have a question regarding reporting loss of consortium claims associated with (light) claims. It's understanding that – it's on the clarification given during the last CMS town hall conference that if the released names a spouse or any other family member and language is included, that releases any and all claims. We are to report the spouse or family member's claim separately from the injured party's claim. Is that correct?

Barbara Wright: Yes. If the – if the spouse or other family member or whoever is filing the consortium claim, if they are giving a settlement and they are or were a Medicare beneficiary, then that's a – that's a separate input. Just the same as if you have the underlying injured party (inaudible) for want of, you know, a better term right now. Let's say (Jim) is hit by a car. He could have more than one claim submitted. If he had (TPAC) and ORM, for example, he might be having one record submitted for liability and a separate one submitted for the no-fault or Med Pay part because those are different types of insurance. Or …

(Merlyn Sniffers): Yes.

Barbara Wright: … if you want to make it more complicated for (Jim), he could have at least three or four if he had more than one insurance policy that was paying or if he had – or if the liability insurance actually continued the ORM once that Med Pay run out. As we said in the user guide, I know in at least one or two places, the number of records that need reported depends on how many policies are involved, how many different types of insurance are involved, how many people are actually getting settlements, et cetera. So, yes, the consortium claim is reported separately.

(Merlyn Sniffers): OK, thank you.

Operator: Your next question comes from the line of (Michael Ferreros) from (Inaudible) Services. Your line is open.

(Michael Ferreros): Hi, how are you doing? I'm calling in regards …

John Albert: Good.

(Michael Ferreros): I'm calling in regards to an email that I have sent. We had manually queried on the COB website through individuals for the Medicare beneficiary status, and the result for all of beneficiary not found. And mind you, we had the correct information input in the query. However, from further discussion with the EDI rep, we were told that these individuals were in fact Medicare beneficiaries and that we should go ahead and include them in our report. And they did in fact go through and received an 02 disposition code.

So, in speaking further with the EDI rep, they said that the reason some of the deceased members do not get a hit in the query file is because the system is not receiving updates for people with a date of death before a certain time. And she said that they are requesting that change be made so that we would receive information regardless of the date of death. And my questions are, has this issue been fixed? If it has not been fixed, what are we suppose to do when we get beneficiary not (found)? Are we always supposed to reach out to the EDI rep? And if it hasn't fixed, what about historical instances in where we came across beneficiary not found?

Jeremy Farquhar: Those – that is true at the present that what is happening is we received our feed – that our feed source if the beneficiary has been deceased for more than 27 months, we don't receive an update on that beneficiary. You're only pretty much going to find this. And I think I may had actually looked at your example specifically after the EDI rep had passed them along. And I think they are all – all examples where the beneficiary had been deceased maybe for more than a decade. They – you know, they were back to like 2001 and 2002 dates of death and what not. It's – it is going to be fixed. We have a change request out there to change the way this operates. So eventually we will have them updated in our system as a regular course.

At the present, there's really – I mean, I don't think that we can expect to reach out on every not found. If you happen to know somebody that is indubitably a Medicare beneficiary that has been deceased for some period of time, you know that they were a Medicare beneficiary and you're trying to report on them, usually it's the 12580 type stuff because it's so old if they're deceased, I guess, like exposure and what not. But if you know that somebody should be a beneficiary and you're not getting a hit and it's a situation like that, if you reach out to us and provide us with the information, we can investigate. And if necessary, we can ensure that they're manually added to our system so that you can report appropriately.

I know that's not an ideal situation but that's a work around until the process changes where they do pull information on individuals who have been deceased for more than 27 months. So we can add them if you are making us aware of them. I mean, I don't imagine you'll see this very often. It's very rare. I hadn't actually come across any of this until those recent examples. But that is true. And, you know, if you – if you don't have no reason to expect that the person was a Medicare beneficiary, by all means, don't reach out every time you received a not found. It's only if you're – if you know that they were a Medicare beneficiary and they ought to be showing up and they're not. You can reach out and we can assist and then let you know if it's one of those scenarios.

Barbara Wright: OK. If your records indicate that the person was in fact totally disabled or that they had attained age 65 before they died, et cetera, those would be your most likely indicators that, yes, they were most likely a beneficiary. And also, Jeremy is right. But it's not just the 12580 issue, it's basically a lot of the exposure, ingestion or implantation. Quite often those have a significant timeline between the original date of incident and when there's actually a settlement.

(Michael Ferreros): Thank you. And this is the last part of the question as far as – well, what – I mean, are we going to be responsible for this going forward once the system changes? I mean …

Jeremy Farquhar: You know, I mean – I can't see that – we can't hold you responsible. If there's an individual – if they're not on our system and you get a not found when you query them and your information is accurate that you would submit it to us, we can't possibly hold you responsible. I don't think you're going to find very many of these. Like I said, it's going to be very rare. But there – I don't see that there's any way that we can hold you responsible if we don't even have their information on file to provide you with the positive match.

(Michael Ferreros): Thank you very much.

Operator: Your next question comes from the line of (Carry Langart) from Clinical Trial. Your line is open.

(Carry Langart): Hi. Thank you very much. We have had a lot of questions surrounding clinical trials. And the issue is, and you touched upon it a little bit before as to what adverse events or injuries in a trial to report. Are they all adverse events that occur or only those that (occur) to be possibly or probably related to the study device or compound? And then secondly, it seems that this has not been enforced. Is this something that is going to be looked into and enforced going forward in the future?

Barbara Wright: OK. If I understood the first part correctly, I can only repeat that we're looking at situations where the injury or complications have rose out of the trial. There is no way that we can give you an absolute definition of what that means within the context of a particular trial. And it also basically comes in to play where there's been a promise of payment, guarantee, et cetera for everything related to the trial including such injuries or complications. What we've seen in the past is normally is there's situations (with us) – promises made and the clinical trial was paying for everybody for anything including – let's say a particular clinical trial – I'd give you something really ridiculous.

Clinical trial caused everyone to have a limp that could be cured by physical rehab and a particular pill. And everybody who wasn't a Medicare beneficiary, the clinical trial was paying for that treatment but it was continuing to bill Medicare with respect to that treatment for anyone who was a Medicare beneficiary. That would be inappropriate. If the clinical trial was

paying for all that care, when it's a complication or injury arising out of the trial, then you cannot treat the Medicare beneficiaries differently.

(Carry Langart): Right. I mean, does …

John Albert: But …

(Carry Langart): You know, I think a lot of the RREs, the pharma companies are waiting until a claim is made against them or a bill is submitted to them. But my understanding is that Medicare wants the RRE or sponsored to be proactive and your report (inaudible) they block future payments on that ICD-9 or soon to be ICD-10 codes so that Medicare doesn't layout that money or the conditional payment. Is that true? Are you expecting the sponsors and RREs to report this as they become aware of the injury or adverse event?

Barbara Wright: We expect that where the contract agreement, et cetera assumes responsibility for that type of situations and, yes. And you're aware that that type of complication or incident has a reason, yes, you should be reporting the ORM. The purpose of ORM is to keep us from inappropriately paying claims where someone has already assumed responsibility. A lot of MSP recovery particularly for liability insurance, no-fault insurance, and workers' compensation loss or plan relied upon simple self identification prior to the mandatory reporting. And the mandatory reporting was to give us better information both up front where responsibility had already been assumed as well as situations where it hadn't been assumed and was established by virtue of a settlement, judgment award or other payment.

(Carry Langart): OK, thank you very much. I appreciate it.

Barbara Wright: OK.

Operator: Your next question comes from the line of (Diane Phillips) from (Carolina Cassidy). Your line is open.

(Diane Phillips): Yes. I guess we're still confused on this reporting for beneficiaries that are deceased. And are you saying that we no longer have to report when a

settlement liability, (TPAC) settlement would be made to their heirs, their estate or whatever?

Barbara Wright: No, we never said that. Liability settlements need reported regardless of whether or not the beneficiary is deceased because your reporting requirements for Section 111 are dependent on whether they were or are a Medicare beneficiary. I understood the earlier question that we were just answering to be a situation of when a query had been done with respect to this underlying injured party that our systems had not returned a matching Medicare beneficiary. And what Jeremy was addressing was a situation where the person really was a beneficiary that our system caused some miscommunication.

And, Jeremy, can you confirm that's really what you were talking about?

Jeremy Farquhar: Yes. Yes. And that's totally unrelated to the changes in reporting requirements that we referenced at the beginning of the call which I – which I think is what really ties in to what you're questioning, you know. Liability needs to be reported still if the beneficiary is deceased but you don't have to report their claimant or claimant representative information any longer. That's no longer required. So you would have reported the estate possibly as claimant one. And if estate had a representative, maybe that would be the claimant one representative.

You have to report that claim still for that deceased beneficiary but you do not have to report the estate and claimant one and the estate's representative and the claimant representative one in that type of information. It's just the claimant and claimant representative information which is no longer required on those reports.

(Diane Phillips): OK.

Barbara Wright: I think you have to be careful to think about how CMS use the term claimant in that situation. Jeremy is talking about – and correct me if I'm using the wrong term, Jeremy – what is in essence an auxiliary record to the main claim input that is used only in situations where the under – where the injured party

is already deceased. It doesn't stop the rep – that initial input file. It's whether or not there has to be the separate auxiliary record accompanying it.

Jeremy Farquhar: That's correct. Yes, it's correct.

(Diane Phillips): OK. I think where we've been a little confused is that oftentimes a person is deceased at the scene instantly. And so there is no, obviously, no Medicare payments made but we still go through the whole estate and et cetera reporting.

Barbara Wright: I would beg to differ a little bit even when they're deceased at the scene, frequently they may be transported by ambulance. They may not be pronounced dead until they're actually in the hospital. I mean, it's not – we wouldn't necessarily have the same level of claims that we paid. But we often have claims associated with beneficiaries who died immediately or almost immediately after an accident.

(Diane Phillips): OK …

Barbara Wright: Before …

(Diane Phillips): I appreciate it.

Barbara Wright: Before what most people would think of as treatment.

(Diane Phillips): OK, I appreciate it. Thank you.

Operator: Your next question comes from the line of (Wendy Travis) of (OneBeacon Insurance). Your line is open.

(Wendy Travis): Thank you. My question relates to ANH death and dismemberment claims and how to report those settlements. We have benefits that are paid – the benefit is a set sum – a set dollar amount but rather than one payment at the time of settlement, it's paid in monthly installments until that set sum is reached or other circumstances are met such as the beneficiary remarrying or something like that which would cause those payments to cease. So clearly,

they're not ORM payments. It is a (TPAC). But the final amount of the settlement is not technically known until that final installment is made. So …

Barbara Wright: If you …

(Wendy Travis): So as you can see, it makes sense to sort of report the (TPAC) amount as the full benefit amount sort of similar to reporting a structured settlement. But we just wanted to ensure that that was proper.

Barbara Wright: Oh, that's what I was going to refer you as the definition that's in the input file. Basically, if you don't have a way to actually calculate it like, for instance, I think the definition says that's based on life expectancy, you need to report either the projected life expectancy or the minimum payout which is – whichever is greater, the same type of thought process would apply to what you're saying.

(Wendy Travis): OK, thank you.

Operator: Your next question comes from the line of (Todd Vincent) from Central Mutual Insurance. Your line is open.

(Todd Vincent): Yes, thank you. I have a question on ORM termination date. We have – a lot of our policies are ISO forms. And they contained Med Pay provisions. That basically say we will pay for the medical expenses there incurred within three years from the date of an accident. Can I use that date which is three years from the date of the accident as the ORM termination date even if the ORM is not exhausted?

Jeremy Farquhar: Well, you shouldn't be reporting it until after you reached that date. You know …

(Todd Vincent): Right.

Jeremy Farquhar: … certain circumstances can change.

(Todd Vincent): Yes. Yes, I understand. And we wouldn't report until that date. But what has me a little confused is, you know, basically we would be done – we would not

pay for any services after that date but if we got a bill after that date, we would pay. And in reading the user guide, it says the ORM should remain open if it will subject to a further request for payment.

Jeremy Farquhar: (Inaudible) …

Barbara Wright: The implication in that was – and our intent was that we were talking about that there could be additional services performed that would be subject to but not – that we were talking about potentially pending bills. Because we use the ORM date in relation to date of service, not in relation to the date something was billed to us.

(Todd Vincent): OK, fantastic. That's what we've been doing and I'm happy to hear that. Thank you very much.

Operator: Again, if you'd like to ask a question, please press star one on your telephone keypad.

Your next question comes from the line of Kerri Weingard from Clinical Trial. Your line is open.

Kerri Weingard: Hi, my only question is about lending finds against (inaudible) …

Jeremy Farquhar: We can't hear you at all.

Kerri Weingard: (Inaudible).

Jeremy Farquhar: We can't hear you at all.

Kerri Weingard: I'm sorry. Can you hear me now?

Jeremy Farquhar: Yes.

Barbara Wright: Yes.

Kerri Weingard: Oh, I'm sorry. My question is that for clinical trials, we'll find (levied) against the RRE for non-compliance of reporting in 2013, 2014 we – sponsors

are stating that no finds have been levied to date and that there is, you know, very little compliance.

Barbara Wright: Anyone who is intentionally non-complying is putting themselves at risk. We have the ANPRM that I mentioned. That is on the regulatory agenda. You can refer to the SMART Act itself to see what is supposed to be covered in that ANPRM. The initial requirements of Section 111 were passed back in 2007. This is a potential, you know, change to what's going on and also to how we would do regs but we have never agreed that anyone who's simply not complying is off the hook.

Kerri Weingard: OK, thank you.

Operator: Your next question comes from the line of (Merlyn Sniffers) from (Inaudible). Your line is open.

(Merlyn Sniffers): Thank you. The CMS User Guide states when ORM ends, basically no-fault limit has reached or the RRE otherwise no longer has ORM, the RRE reports an ORM termination date. There was some discussion apparently during the last CMS Town Hall teleconference regarding a requirement to obtain a letter from the primary care physician to document the ORM termination date.

On liability claims, obviously, if an obligation to pay ongoing medical bills has extended to an unrepresented injured claimant, in an effort to control the loss and the injured party and may later he may retain an attorney, we might consider that that ORM has now ended. When a liability settlement is a possibility, we may also rescind our offer to pay ongoing medicals. This is a circumstance wherein we would like to be – we will be really unable to obtain a letter from the primary care physician because treatment would likely be ongoing. Would CMS make an exception to the requirement to obtain a letter from the primary care physician to document the ORM termination date in such a circumstance?

Barbara Wright: I think you're potentially confusing when that letter is used.

(Merlyn Sniffers): OK. Help us.

Barbara Wright: That letter is really used when you have a situation where you have an entity that has either accepted and continues to accept or is required by law to accept or by a settlement or a judgment or award to accept ongoing responsibility for medicals and that ORM has not otherwise terminated. And the best examples of state that has like lifetime no-fault or lifetime workers' compensation benefits and let's say it was a relatively minor injury that …

(Merlyn Sniffers): Yes.

Barbara Wright: … no one really expects treatment to be required for that person's lifetime. The RRE cannot terminate the ORM just because he believes the person is not treating – because he could be treating and not being billed for it. He can't terminate it just because he thinks well that injury never has any share beyond five years. That's a situation where if the beneficiary gets a statement from their primary care physician that treatment is no longer required for that injury, then you can terminate the ORM. But otherwise, if you can legally terminate the ORM, if it's a liability situation where you temporarily assumed ORM but that …

(Merlyn Sniffers): Yes.

Barbara Wright: … ORM's responsibility has ceased either because your agreement for that has ceased or for some other reasons, then you should go ahead and submit the term date. We're not trying to control what you can or can't do legally. What we're saying is where you have a legal obligation either by agreement or by state law, et cetera, then you can't term ORM until either that obligation has termed or you have the proof, you know, the documentation that there's no further care required. Does that …

(Merlyn Sniffers): Got it. Yes, it does. Thanks so much.

Operator: Your next question comes from the line of (Beverly Lima) from Illinois Risk Management. Your line is open.

(Beverly Lima): Hi, thank you. My question pertains to the relationship – whether our employer is an RRE or not. We have a hospital that had work comp coverage with a carryover called (Lumbermen's) many years ago. That carrier went

into liquidation in May of this year. And so now, they have a loss time claim was active open medical that the employer, the hospital is currently paying out themselves right now. We're trying to figure out, though, who the RRE was because prior to the liquidation, this hospital was purchased by another healthcare system. So would the original hospital be the RRE for this claim or would the health system that they joined be the RRE for this claim?

Barbara Wright: I think your financial advisors or lawyers are going to have to sort out the specific facts on this. From what little you've said, you have at least – I could readily infer and I believe what you said at least implies that your facility is essentially paying a self-insurance, if nothing else right now. And if they're paying a self-insured, then they're – they are in essence reporting or should be reporting liability insurance ORM. If, you know, if they have an obligation under workers' comp because of the way the liquidation works in your particular state or anything, then maybe it's workers' comp ORM – I don't know. Unfortunately, we can't give you advisory opinions on that type of layer on layer of multiple factual issues that really aren't within our province to review.

(Beverly Lima): OK. I appreciate that, thank you.

Operator: Your next question comes from the line of (Leslie) from GAI. Your line is open.

(Leslie): Hello, good afternoon. We have ocean marine liability policies that contained a medical payments coverage. When we are reporting the medical payments coverage and it is accepted by CMS on the acknowledgment report, it's being returned to us as an MSP type liability rather than no-fault. And I just wanted to see who I need to talk to to get those reported back to us properly.

Barbara Wright: I guess one of the questions I would have before Jeremy jumps in is on the input file, you have to identify what type of insurance it is. If you're identifying it is no-fault, then I would ask Jeremy how it could come back to you as anything else. And if you're identifying it as liability insurance, then it's being caused by how you're submitting it. So, Jeremy.

Jeremy Farquhar: Yes. This is – this is not something that we are changing based on what we receive and what we send back. But this is something that you might want to have a conversation with your reporting agent about.

(Leslie): Well, I have. And I was told that they were instructed by CMS to report …

Jeremy Farquhar: Because it's a liability – it's a – you know, the line of business is actually liability and they report it as liability even though it's a Med Pay type scenario. They would report it as liability with ongoing responsibility for medicals in this situation. That's what they're doing and that's why you're receiving a liability back. And then that's fine as far as our purposes are concerned and …

Barbara Wright: Remember, I'd said earlier in the call – someone had asked what liability insurance ORM was. If you have something that you're paying either through self-insured or through a liability insurance policy but the way you're handling it or the way you process it is similar to how you like do no-fault, that doesn't convert the type of insurance to no-fault. It remains liability insurance.

(Leslie): But we are not …

Barbara Wright: So, I mean …

(Leslie): … trying to convert it to anything. My question is why this particular type of policy is treated differently than a CGL policy which is a liability policy.

Barbara Wright: What we're saying is …

(Leslie): But we can report the medical payments under that and it gets reported back to us as accepted as no-fault.

Barbara Wright: I don't know. Jeremy, is this something that we should talk to her offline or not?

Jeremy Farquhar: Yes, we can – we can talk about this offline. I mean, it's – it would seem – but my – this is Jeremy Farquhar of COBC. I think that this

is a conversation that we may want to have involving your reporting agent as well.

(Leslie): No, I agree. I just want to prod the conversation because it's wreaking havoc with our internal report.

Jeremy Farquhar: OK. Well, why don't we set something up offline, outside this call? We can discuss – my contact information is in the non-GHP User Guide under the escalation process.

(Leslie): OK.

Jeremy Farquhar: If you'd like to reach out to me, you can rope in your reporting agent and we can set something in for a future date.

(Leslie): Great, thank you.

Operator: Your next question comes from the line of (John Free) from (Inaudible). Your line is open.

Jeremy Farquhar: We're not hearing anything. Anyone on the line? Got your phone on mute or something?

(Peter Aleman): Hello.

Jeremy Farquhar: Yes, hello.

(Peter Aleman): Hi. First of all, this is (Peter Aleman). It's not (John Free). My question, is there an appeal process to the response filed that we received the report scenario that is non-existent in the submitted file?

Jeremy Farquhar: You should contact your EDI representative to question them about any errors that you think are problematic. And then they can review those errors with you. It's not a dispute process in that we will overturn and say your record is automatically accepted. But we can research and find that there is a problem with the error that was generated then we will certainly address that. You could resubmit if we correct the problem and we may accept your record. Although I don't know that that will be the case. There aren't too many

situations at the present that I can think of or any really where we're generating erroneous errors on our response file. So it's – it is something that we would be happy to review with you at the COBC but you just need to reach out to your EDI rep and provide them with the examples so they can take a look and we'll follow up.

(Peter Aleman): Thank you.

Operator: There are no further questions at this time.

Barbara Wright: We have a few other things that we're on the incoming if you'll give us a few minutes to flip through them to find some of them.

We had a question about self-reporting by an RRE based – there's appear to involve primarily no-fault situations. And they said that they were referring to an alert that said that self-reporting wasn't required for certain ORM type situations. We had had being done in the self-report process for any of you that aren't familiar with that term that we talked about. And the COBC has contacted outside of the Section 111 reporting process. And particularly for no-fault, a lot of insurers were engaged in that and that's particular as what we said. Well, we didn't really understand the alerts that we're doing in self-reporting and we're still doing Section 111 reporting.

I guess our only real comment on that is if you are the RRE and you're doing the Section 111 reporting, you are not required to separately do a self-report on the same instance that occurs. Doing a self-report does not eliminate the Section 111 reporting. So if you want to do only of the two, it's going to be the Section 111 reporting.

Another question we had was situations with plaintiffs or representing plaintiffs. And they were referencing the different requests they get for SSN or health in – or the Medicare health insurance claim number or medical releases or consent to release, et cetera. And with respect to Section 111, what we've said is the RRE needs to determine if someone is or is not – is or was the beneficiary. It's not just whether or not someone is currently on Medicare, it's whether they are or were on Medicare. And if they are or were,

then we need to report them if there's a settlement, judgment, award ,or other payment. What we furnished model language on the web was specific situations where the claimant is refusing the supply either your Medicare number or a Social Security number with the appropriate data point.

To the extent you're being presented any form by the insurer and you're asking us whether it's approved for Section 111, we need to go look at the model language that we have on the web. If they're ask – if they are asking you to do other things than addition to supplying information about Medicare entitlement, that's not part of our Section 111 process. They may want it, desire it or it may be a standard part of their process with respect to settling a liability insurance claim or something else particularly if they're asking you for a consent to release for medical records. But that's not something that's required specifically for the Section 111 process.

I would advise if you're – if you're questioning it, you need to go back and compare the language pretty closely. Because a lot of entities are at least including the picture of the sample Medicare card even if they're not paralleling the rest of our language. So that's just something, you know, for you take a look at. If you have a question, go look at our model language and see how it compares. And also, remember the issue is not just whether or not the person is currently on Medicare, it's whether or not they were on Medicare or are on Medicare.

I'll find few of the others. We're asked a similar question or along the same being was asking whether or not insurers are required to report claimant Social Security or Medicare numbers prior to settling a liability claim. Section 111 reporting is not required until there is a settlement, judgment, award, or other payment which going to include assumption of ORM. But in order for them to make a determination with respect to their settlement to the extent they want to be able to factor in Medicare, what they use this information for ahead of settlement, as most of you are already familiar with, is they use the information with the Social Security or Medicare number along with the last name, first name, date of birth, and gender to query regarding Medicare entitlement. So that's why they would normally be asking for it

before settlement is so that they can know ahead of time whether or not the person is already a Medicare beneficiary.

Let's see.

I'm flipping backwards through 40 plus pages of questions. So, excuse me for the time in between. We had at least one question that was talking about – it was insurance or a GPA that was saying that the claimant had Medicare and Medicare pays for the accident related expenses. But we pay for amounts Medicare didn't cover and other out-of-pocket expenses, out of Med Pay. This whole question is starting off from the wrong contacts. Med Pay is primary to Medicare. It should never just be paying "out-of-pocket" or secondary to Medicare. And the question went on to ask about the threshold reporting and whether or not Med Pay provisions, the payment should be considered as an ORM. Yes, normally they would be ORM. You have a sense of responsibility in your reporting.

And this was just another one where it appeared quite possible that the entity making the inquiry was relatively new to the process. So, again, please go back and look at some of the basic things you haven't already done so.

There was one question about tendering of dispense and RREs essentially asking whether or not if entity A tendered the defense stands for the entity B, that mean that entity B was the RRE. And our general answer would be no. I mean, tendering a defense doesn't eliminate the MMSEA Section 111 reporting responsibilities as we've said in the user guide in general. An RRE may not eliminate their Section 111 reporting responsibility. It's by contract or otherwise. So if they want to attend their defense, then use whoever they're tendering to as an agent, et cetera. We don't have any say in that at all but the ultimately responsibility for the reporting still falls upon the RRE.

Let's see.

I think I have at least one more.

John Albert: Operator, are there any other questions in queue while we're searching of some other?

Operator: There are no questions from queue.

Barbara Wright: OK. Another short addition to what was asked about clinical trial, we did get either one or two questions more or less asking if there were specific forms for clinical trial reporting. And no, you have to follow the same reporting requirements as everyone else whether it's done – these are direct data entry process which entities often use if they have a very low volume or whether it's done through – Jeremy, I don't have the right words to describe it. They're not (inaudible) …

Female: (Inaudible).

Barbara Wright: Yes. Whether it's done zero file exchange so there is nothing special for clinical trials or whether the RRE. We did have one question from an entity that appeared, do not be the clinical trial entity itself whether they were some type of clearing house or an entity that dealt with clinical trials are maintained certain data, et cetera. They were asking about assistance and how to start reporting and everything else. And I believe that they're being contacted separately by the COBC's EDI group.

But the point is in clinical trials, if a particular clinical trial has another entity that it wishes to use as an agent, it may do so. And that may or may not solve some of the questions or issues people have been presenting or saying exist because of the blind trial kind of issue of not knowing who particular beneficiaries are.

But if an outside entity or an entity is doing that, they are doing it as an agent. They have to have separate RREs for each entity or each trial for whom they're doing it for. And they are not the ones ultimately responsible for any potential CMP.

Let's see. OK. We had one question where it was talking about a (TPAC) split between a self-insured and a liability carrier. And there weren't enough facts in there for us to really answer the question. When you're talking – when someone talks about self-insured retention, they need to look at what are our definition of self-insured retention is in the user guide. And if you have a

situation that has self-insured retention as we define it versus being what we define a deductible to be, then normally the self-insured report is its responsibility and the insurer would report for the part that's covered under the policy including if there happens to be any separate deductible under the policy.

That clear exception would be if somehow in the settlement or judgment both the entity with the self-insured retention and the insurer are jointly and severally liable for a single sum, you know, before it split in to their proportion of shares, if they're jointly and severally liable for that sum, then they both would need to report the total amount. Otherwise, they'd be reporting their individual responsibilities.

I think – that's about all we have right now. Operator, if there's still no more questions, I think we'll wrap up.

Operator: You do have one question, (Dr. English) from HealthEast. Your line is open.

(Dr. English): Hi, my question is we are self-insured. We have a reserve account set aside to pay any – I'm talking liability now – to pay any (TPAC) settlements. And there's an ongoing debate internally. If we don't use those funds that are set aside in our reserve and, let's say, our patient services area has a pot of money and they – and they use those funds to more or less settle with a patient. And it's above the reporting threshold. Is the non-reserved account – are the non-reserved account funds considered?

They have to be reportable under a – under a …

Barbara Wright: The answer is – the answer is basically yes. If you go back to the statutes for MSP, for any of you that want to look it up, it's 42 USC 1395b – I mean, 1395y(b). Self-insurance, if there's an individual or entity that's engaged in a business trader profession, they are deemed to be self-insured to the extent they carry the risk. It doesn't matter whether they set the money aside in a separate pot or not. So it is …

(Dr. English): OK.

Barbara Wright: It doesn't matter where it comes from.

(Dr. English): Good. OK, thanks for that clarification.

Barbara Wright: OK.

Operator: Your next question comes from the line of (Pamela North) from (City of Charlene). Your line is open.

(Pamela North): My question is related to workers' compensation. If we have two claims for one Medicare beneficiary that we're settling at the same time and we have gotten approval and the courts have said, "Yes, this is OK." How do we or do you have a recommendation on how we apportion the settlement moneys between the two clients? Because in the settlement documents that is not specified and do we need to do that going forward?

Barbara Wright: It probably depends in part upon how you handle it. If you give us a single date of incident and it's the earlier of the two and you include codes for both injuries, then when we did our claim search, we would search for claims related to all of the associated codes all the way back to the original date of injury. You know, we wouldn't have any way to distinguish it. If you give to us with two different dates of incident and different codes for each of the claim, then we would associate claims for each of those.

In terms of apportioning the money, we're not actually bound by any allocations or parties. If they settle at the same time, you'd be reporting among that same report and – I think we'd have to think about it but I'm not sure it would make a real difference. At minimum, you could report just for both of them if you report the total amount that could be taking care of on the backend.

(Pamela North): So are you saying that we should report the amount for one of the claims or for both and that's the same amount for both, the total settlement for both?

Barbara Wright: I'm saying – I'm saying if you report them separately, arguably you should report the total amount for both because we're not bound by your allocations. In other words, let's say the guy had – let's say, he fell down some stairs and

basically his injury was a broken leg. And then he also got hit by a truck and he had all kind of massive injuries and you settle them both at once for $500,000. If you allocate all to the broken leg, we're not bound by that. But if you did it, that would leave us no money to recover against the massive injuries.

So, if you're going to report them separately, your safest way to report it is to report the total amount of both. And make it clear to the party they may have to straighten it out on the backend but the sense it would be an allocation by the parties, we're not bound by it. On the other hand, if you report a single date of incident and use the earliest one include all the injuries, then what the plaintiff may have an argument about is if we include some claims that aren't related to the second injury prior to the actual date of incident for that. Then he would have an argument for removal of those specific claims. I mean, either way it would ultimately work for us. But you need to know that it should not be done in a way that actually hides the amount that's available.

(Pamela North): Should we call and talk with someone at the MSPRC proactively?

Barbara Wright: No, I – no, I don't – I don't think you – I don't think you should. If you're running into any problem on this, you can contact us and we'll take it up internally. But I personally think that your safest bet is to use the earliest date of incident, include codes for all of it, and report the single amount. Because then you're – then you're only reporting it once and to the extent that the plaintiff has any complaint about claims that are included. They can challenge that when they get a demand.

(Pamela North): And if we've already reported both injuries?

Barbara Wright: Jeremy, can she contact you with case specific information? And we'll take it up with the MSPRC.

Jeremy, are you still there?

Jeremy Farquhar: Yes, I'm sorry. I was having a sidebar. It was …

John Albert: Yes. So she can definitely call Jeremy and …

Jeremy Farquhar: Oh, yes.

John Albert: … work out particularly …

Jeremy Farquhar: Yes.

Barbara Wright: Yes. And, Jeremy, you can contact me when you got more details on it.

Jeremy Farquhar: OK.

(Pamela North): And have that …

Jeremy Farquhar: And that's Jeremy Farquhar. My contact information is in the user guide under the escalation procedure.

(Pamela North): Your last name is what?

Jeremy Farquhar: Farquhar, F-A-R-Q-U-H-A-R. I'm the only …

(Pamela North): OK.

Jeremy Farquhar: … Jeremy in the user guide. Yes, under the escalation procedure, there is – there is three of us. I'm the first at escalation point. So you can reach out …

(Pamela North): All right.

Jeremy Farquhar: … to me.

(Pamela North): Thank you so much.

Jeremy Farquhar: OK.

Operator: Your next question comes from the line of (Todd Vincent) from Central Mutual Insurance. Your line is open.

(Todd Vincent): Hi, thanks. Since we had some extra time I thought I'd ask something that's been on my mind. And that's – I just want to confirm that – I'm handling this correctly. We write in a few states where we have lifetime medical like

Massachusetts Workers' Comp. Am I correct that we will have to continue to query those if there are accepted claims basically until the person becomes a Medicare beneficiary and then report that claim unless we have a letter from the treating physician. So in theory, every accepted Massachusetts Work Comp claim, assuming they become a Medicare beneficiary, will be reported at sometime. Is that correct?

Barbara Wright: Yes.

(Todd Vincent): OK. That's – I just wanted to confirm that. Thank you.

Barbara Wright: You're welcome.

Operator: Your next question comes from the line of (Kim Edsel) from AMI. Your line is open.

(Kim Edsel): Hi, I would – I just want to clarify a question that we had earlier or ask a question about the – if you are making payments on a – on a claim – medical payments – this is on the workers' comp claim – and let's say, you know, you quit paying. The claim is getting closed but you have a date that you don't owe payments any further, let's say, three years after the last payment has been made or the last indemnity payment is made. Should you be putting that date in the termination field?

Barbara Wright: Well, first of all, you made it sound as though you're closing the case right now even though you have a future date. And what we've said is whatever you do for administrative purposes isn't our issue, but you may not close the ORM until you have a legal basis to do so. You'd either ask to be to see that legal basis or if you have a situation where no more care is required. Not that they've just stopped treatment but no care is required, then you may term the record.

So – and I think Jeremy also added earlier that you shouldn't be reporting that way ahead of time. You need to report it when your responsibility has actually terminated.

(Kim Edsel): So – and I guess maybe this is where I get confused in. So, let's say, three years down the road, we're not supposed to go back in and put a termination date in that file, correct? We just leave it open and if there's …

Barbara Wright: No. When it – when it has actually terminated, you do need to report a termination date.

(Kim Edsel): So if our files had been closed, let's say, for two years …

Barbara Wright: Again, you need …

(Kim Edsel): I was hoping for a year we close it, it's been closed for two years and we no longer have responsibility at this point down the road because of an statue issue. We can …

Barbara Wright: As far as we're concerned, it's not closed until your responsibility ends. Whether or not you have an internal process that shunts it into a file, it is not active or whatever. And we know a lot of workers' comp particularly used to administrative closely something after the certain period of time, that's not our issue for ORM. As long as you have that responsibility, you have to consider it open. And as monitor if you want to call it and nothing else with respect to ORM either because they're not a beneficiary yet or if you reported ORM, you have to – when you no longer have the legal responsibility result the term – report the term date. If you don't, you may at some point be getting bills for associated care that that don't fall within your responsibility. And that would cause you even more work than making sure that you terminated the file appropriately.

(Kim Edsel): OK.

Barbara Wright: Jeremy, anything to add?

Jeremy Farquhar: No, that's – that's – that's all. I mean, that's about it (inaudible).

Barbara Wright: Does that answer your question sufficiently?

(Kim Edsel): I think …

Barbara Wright: It does …

(Kim Edsel): … so, yes.

Barbara Wright: Yes, I mean, I'm sure it's not quite what you wanted to hear but we had several discussions way later in this series of calls where people were talking about well we close or do we do this or they had it for years had a practice so the administratively closing files. And I think we made it clear that you can do what you want internally. But for purposes of the reporting, you have to really be involved with it until it's actually termed.

(Kim Edsel): So I guess – I guess it goes back to my thoughts of then, let's say, two years down the road, we have to go back and put a termination date in that claim because you have a …

Barbara Wright: You have …

(Kim Edsel): … termination date?

Barbara Wright: Yes. Yes.

Jeremy Farquhar: Yes.

Barbara Wright: You must report the termination date when it occurs.

(Kim Edsel): OK.

Thank you.

Jeremy Farquhar: Yes.

Barbara Wright: You're welcome.

Operator: Your next question comes from the line of (Jennifer Petrich) from New Mexico Mutual. Your line is open.

(Jennifer Petrich): Thank you. I had a question, it's kind of related to the previous one about the ORM termination. We write workers' comp in a state which is lifetime medicals. If we negotiate a settlement releasing us from all future medical payment's responsibility, does that override the state lifetime medical basis? I heard you say that we can't close until there is a legal basis to do so. Can I consider that our legal basis?

Barbara Wright: I'm not going to try and guess state laws right here. If your lawyers are basically telling you that that type of settlement is effective to terminate your responsibility under state law. Then I would say, report – you know, report termination of ORM, that's the time of the (TPAC). But I'm – I'm not going to guess behind your state law and how your settlements are actually phrased.

(Jennifer Petrich): Actually, that's a great answer because it tells me where I can go and ask. I can go to our lawyers.

Barbara Wright: OK.

(Jennifer Petrich): Thank you.

Barbara Wright: OK.

Operator: Your next question comes from the line of (Terrie Dobbs) from (Lockheed Martin). Your line is open.

(Terrie Dobbs): Hi. I have only – I never had to report anything that was reportable because of the date changes though this is something new to me. We had a settlement and (inaudible) was not Medicare age but the state and the administrator of the state is his father who is Medicare age. Is this something I report or not?

Barbara Wright: What you're into right now is – what we're looking at for Medicare is medicals. So who incurred medicals related to this injury? If the deceased party was not a Medicare beneficiary and it's not sufficient to say they just weren't Medicare age because someone could be a Medicare beneficiary essentially as an infant if they had ESRD. So one could be a Medicare beneficiary at under 65 if they had – if they were totally disabled. Someone could be …

(Terrie Dobbs): Well I – I'm sorry, plaintiff – the plaintiff – the plaintiff's attorney said that they had a Medicare secondary payer recovery contractor letter saying that no claims were ever picked relate – paid related to this case in the file …

Barbara Wright: That's – OK. But that's – that in – that in itself, what you're describing would indicate the person was in fact a Medicare beneficiary. We could not have set them up in our system if they hadn't been a Medicare beneficiary which means …

(Terrie Dobbs): Yes.

Barbara Wright: … yes, you are obligated to report …

(Terrie Dobbs): Yes. Well, I …

Barbara Wright: … with respect to that beneficiary. In terms of the father who – I guess I sort of have to have asked who the record was setup under these. The injured party, if they were a Medicare beneficiary and they had no claims then you're still going to have to report. But they're going to end up with a zero recovery claim.

(Terrie Dobbs): OK.

Barbara Wright: If you are asking about whether you have to report a record – a separate record for the father, that depends …

(Terrie Dobbs): Right.

Barbara Wright: … on whether – again, if he has some type of consortium claim or some other claim that he was injured, with respect to this whole matter, it gave – you know, it gave the shock of it. He saw it happened and shocked of it, it gave him a heart attack, et cetera, then you'd be reporting a completely separate claim for him.

(Terrie Dobbs): OK. No, it didn't – it didn't indicate that. It's just because he was administrator of the estate, I didn't know if I had to submit on behalf of the

estate. That was – like I didn't know if I did it for the deceased or for the estate. And you're saying …

Barbara Wright: No.

(Terrie Dobbs): … I do have the deceased.

Barbara Wright: It says – the entity that's being paid if they're being paid just essentially as a fiduciary, they're not being paid as being an actual claimant, et cetera based on claimed injuries or anything, then no. Typically, if you have like 10 children who are going to get the estate, no, you're not typically doing 10 separate files for them. But if one of them was claiming some injury associated with it and/or releasing medicals associated with it …

(Terrie Dobbs): Yes.

Barbara Wright: … then yes.

(Terrie Dobbs): Then I would. OK, I got it. Thank you …

Barbara Wright: OK.

(Terrie Dobbs): … so much.

Operator: Your next question comes from the line of (Cindy Hawk) from Kindred Health. Your line is open.

(Cindy Hawk): Yes, I just wanted to get some clarification on the diagnosis codes and the injuries. Sometimes when we get a complaint first and the allegations will be linked, the NLB basically throwing everything at it if I can. But then really the claimant in the end ends up settling for maybe one or two of those items. And I just wanted to make sure that it will be correct then to really only report the injuries based on, I guess, what was alleged and really what the claimant ended up being about at the end as oppose to what the claim was alleged at the very beginning.

Barbara Wright: Yes or no, it depends.

(Cindy Hawk): OK.

Barbara Wright: Where CMS is not required to prove causation or purposes of MSP. Our touchstone is what claimed release are effectively released. Otherwise, every single settlement that's out there we'd have to essentially re-litigate to prove what actually was being paid for. So, what you're looking at is if they claim leg injuries, arm injuries, head injuries, et cetera even though you believe that what you settled for only covered the head injuries, all three should be reported to us. And that's what we would look at.

On the other hand, you're one of the people that will want to be watching for are hopefully within the next few weeks additional alert about amended complaints. If they amend their – if they amend their complaint, it would be whatever rules we put out on that. I mean, I'm sorry, I can't comment on the specifics right now but that would be something you want to be watching for.

(Cindy Hawk): OK, thank you.

Operator: Your next question comes from the line of (Nicole) (Inaudible) from Mercy Insurance. Your line is open.

(Nicole): I have a question regarding the newly excluded ICD-9 codes effective October, so for example, a 9598. If we have a previous claim that has this ICD-9 code and we make a change to it since so it sends an update after that October date, will that claim then reject?

Jeremy Farquhar: Yes, it will. You'll have to attach an appropriate ICD-9 code at the point in time that you send the update.

John Albert: Right?

(Nicole): OK. So is your …

John Albert: Right?

(Nicole): … recommendation that we probably go and look at all the claims that, I guess, having this prior code on it and make the update?

Jeremy Farquhar: Yes, that would be my recommendation. Yes. Was somebody trying to say something at CMS?

John Albert: Oh, I just – I thought I misheard it? I thought she's talking about submitting like mixed ICD-9 and 10 on the same update record.

Jeremy Farquhar: She's – about excluded codes now that they're excluded, 9598 and 9599.

John Albert: Oh, OK. Yes. Yes.

Jeremy Farquhar: If he submitted an update transaction and that's the only ICD-9 code that you had …

John Albert: Yes.

Jeremy Farquhar: … on your claim previously, it's going to reject because it's now considered invalid codes.

John Albert: Yes.

Jeremy Farquhar: So – yes, it would be a good idea for anybody if they reported claims that have simply 9598 or 9599 and they need to send updates for those claims in the future. And now it indicates to me that this is a situation isn't where there is an instantaneous death if you're having to send an update to this claim further down the line, you really do need to go and find the appropriate ICD-9 codes that really should have been submitted in the first place on that claim or it's going to be rejected when you try to update that claim.

(Nicole): Jeremy, if it has that code with other codes, is it going to reject because of that or is it just …

Jeremy Farquhar: Yes, it will. And you should – you should submit it without that code but keep the other codes. Actually, if you – and that's another way in which that code is bad and we do see that at times. You know, you could have that 9599 code on a claim. (I believe) there could be five other ICD-9 codes that are all good and they referenced very specific injuries but the fact that you include that 9599 code on there, along with them, causes the beneficiary's claims to

reject across the board because it's – it's like a blanket code, it covers absolutely everything that's just totally non-specific.

So, yes …

(Nicole): OK.

Jeremy Farquhar: … you want to remove those when you send your updates.

John Albert: Right. And even if you don't have …

(Nicole): OK.

John Albert: … to make this for any other reason, you may want to send an update just to give a better code.

Jeremy Farquhar: Yes, that would be appreciated. Absolutely.

Operator: You have no further questions at this time.

John Albert: OK. Well, it's almost 3 o'clock so we're going to wrap it up. I wanted to thank everyone for participating. And again remind folks to continue to submit their questions, provide as much detail as possible in the – in the 111 mailbox. As you can tell, we do look at all of them and try to respond to as many of them as we can on this call and also through the additional guidance.

With that, thank you and good afternoon. Operator, can you stay on, please?

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

END