TRANSCRIPT
TOWN HALL TELECONFERENCE

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Bill Decker
April 6, 2011
1:00 p.m. ET

Operator: Good afternoon. My name is (Ryan) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, MMSEA 111 NGHP conference call.

All lines have been placed on mute in order 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 and the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Mr. Bill Decker, you may begin your conference call.

Bill Decker: Thank you very much, (Ryan). Hi, everybody. My name is Bill Decker and I am with CMS in Baltimore, Maryland. I have with me Mr. Bill Zavoina, Ms. Barbara Wright, Ms. Pat Ambrose and other staff from CMS.

This is a Section 111 and NGHP Policy call today. And we're going to talk about policy issues relating to Non-Group Health Plans reporting under Section 111. Almost all of you who are on this call are probably familiar with what this call is about, so I'm not going to give that much more introduction.

And, right, for the record, today's date is April 6, 2011 and we're starting at a little bit after 2:00, East Coast Time – a little bit after 1:00, East Coast Time, certainly. Mine maybe starting later but everybody else is starting now.

The next call for Non-Group Health Plans, the next NGHP call for Section 111, the next teleconference call will be May the 4th, which is actually next

month, and there will be no call between now and the 4th of May for NGHP RREs.

I do want to let everybody on the call know that there is a new NGHP alert posted since the last town hall call, which was on March the 9th. The new alert is labeled October 2011 TIN Reference File – Response File and an Address Validation Information for NGHP RREs. It is an alert that'd designed to tell you that beginning in October, 2011 there will be a different – there will be new processes in place for both reporting and for our management NGHP TIN and NGHP TIN Reference Files and our management of address validations related to TIN. So please take a look at that alert. It's up on the NGHP Tab on the Section 111 Web site.

I also want to say that there is a revised NGHP Curriculum for CBT – Computer-Based Training modules. So that was posted on March the 11th. You should go to CBT tab and take a look at that if you have not already.

And that concludes my opening remarks. I'm going to turn it over now to Pat Ambrose, who will talk a little bit about some of the things that are related to somewhat technical issues. Pat?

Pat Ambrose: Thanks, Bill.

Yes. Just a few brief announcements related to technical issues that have come up since the last call.

A question was submitted about the interim reporting thresholds for workers' compensation and liability and what happens when those thresholds expire. No retroactive reporting is required as a result of the thresholds expiring. So we'll try to make some – the language in the user guide more clear in the upcoming version of the user guide more clear on that. So if a claim right now is not reportable due to the reporting thresholds, that same claim two years from now when the threshold expires, it's still is not reportable. The most recent information on the reporting threshold is in the form of an alert on the NGHP Alert page of the Web site.

There also have been some issues where RREs have submitted an ORM Termination date that is equal to the date, CMS date of incident on the claim, and we have a bit of a system issue related to this. That should be an acceptable condition, but right now you will get an unexpected and undocumented error (SP 32). We are in the process of correcting this so that you may submit CMS date of incident equal to the ORM Termination date or vice versa and not receive that error. In the meantime, I don't have an exact date for when that correction will go in. But in the meantime, please re-submit the claims in which you have received that (SP 32) and eventually it will be cleared off and reprocessed.

There were some questions about the Beneficiary Lookup function on the COB Secure Web site, the Section 111 COB Secure Web site. I just wanted to point out that when you perform the Beneficiary Lookup, if the beneficiary is – or if the inter-party information you enter is not found, you will get a page which across the top displays the fact that the information was not found or a beneficiary – or a matching beneficiary was not found. Otherwise, you will get a page that's labeled Beneficiary Lookup Response Page with information related to that individual including their Healthcare Insurance Claim Number, also known as the HICN.

So I've made a note that we might need to make this functionality a little bit more clear when a match is found, but realized that when it's not matched it's very clear. So hopefully that clears up those questions for you.

Another question was submitted asking what action an RRE should take if they need to change their authorized representative. There's information on this task on multiple places. For one, you could go to the Section 111 COB Secure Web site. Click on I Accept on the log-in warning and the log-in page displays. And on that log-in page, which the URL, by the way, is www.section111.cms.hhs.gov. On that log-in page, across the top, there are menu items. One of those menu items is labeled How To. And underneath, if you click on that menu item, a dropdown list appears and there's an How To Change Your Authorized Representative, and other pertinent information there.

Also, see Section 8.3.3 of the NGHP user guide. That section is about what you need to do if RRE information must be updated. And then I also encourage you and remind you to contact your assigned EDI Representatives with questions like this. Quick e-mail or phone call to them could get you an answer very quickly.

One last issue that was reported, an RRE noted that certain ICD-9 Diagnosis Codes that are on Version 25 of the various list of valid diagnoses on the CMS Web site. There are some codes that are on Version 25 that do not exist on Version 26, 27 or 28 and when the RREs submitted those diagnosis codes, the record was rejected with errors. And this appears to me to be a valid issue, a valid problem.

We are missing some codes from Version 25 on our master list of valid ICD-9 codes that we use in the system for validation. So I have reported this issue and it's being worked on to correct that. So the list or the set of valid ICD-9 for Section 111 reporting should include Versions 25 through 28 minus the V code, minus the excluded codes that are in Appendix H of the user guide.

In the meantime, I'm not quite sure when this fix will be made. But in the meantime, please report this type of issues again to your EDI Representatives. And secondly, the particular codes in question are shown as five-digit codes on Version 26 and subsequent. So it could be possible for you to revise your claims submission, to use the five-digit version of those codes as opposed to the four. And I do apologize for the error.

That's all I have. Bill, back to you.

Bill Decker: Thank you, Pat. Before I turn it over to Barbara, I do want to mention – I should have done this earlier, that anything that we say on this teleconference is true as far as we know it, but if it conflicts with information that is posted on our Section 111 Web site, the information on the Web site has precedence of what we say here. Sometimes we misspeak or it can be misinterpreted. Please take a look at the information on the Web site if you have a question about interpretation.

And with that, Barbara, I will turn it over to you.

Barbara Wright: Thank you, Bill.

Before we open it up for questions, I just wanted to give you an update on some of the issues that you know are outstanding for those that are on the work group that were dealing with the December 5, 1980 issue. We did send out invitations. As we said before, we only send one invitation to each entity. You may link together as many people as you wish including if you're a law firm, one or more of your clients, if you're working with them on an issue. But we ask that you only call in on one line.

We have a limited number of lines and we have over a hundred people participating. There is no way we would be able to do this call if one entity uses up (inaudible) of the lines or uses extra lines. We simply wouldn't be able to have any more calls period, so we do ask that you link together other people. If you send in a request and you didn't get any invitation, then there's someone else in your law firm or other group that is participating and we suggest that you do an e-mail to find out who on your organization is participating.

With respect to error and omission policies, employment liability practices, other policies typically professional responsibility insurance, we are still examining what release we may be able to give entities in that situation. We are looking for a way to be able to eliminate some or all of the reporting for situations which typically do not have medicals at all. There will be caveats, though, in if medicals are specifically claimed, et cetera. Then it will need to be reported and go through the regular process. If there are medicals that are being paid for, same thing, but we are looking for a way to give release for most of the situation which wouldn't involve medicals. And we have been having internal meetings to address that.

We understand there are entities that still have concerns about the Foreign Insurers Alert, any comments that have been sent of on that are under consideration and we have further meetings that we'll be holding so that we will get back to everyone.

Lump Sum Indemnity Payments for workers' compensation. That has not cleared yet. We still expect to have at least one meeting on that before we have final language.

Let's see. The next thing I wanted to talk about is we have a draft on a couple of calls Accident and Health Policies, et cetera, but we continue to receive some questions on them. So I'm going to ask Bill Zavoina to address the last couple of questions that we had (inaudible).

Bill Zavoina: OK. The first one asked whether or not things like Group Cancer Policy or Group Critical Illness Policy need to be reported. And the answer is, no, they do not need to be reported, but the (MSC) rules still apply. We don't want to end up confusing these with more general policies basically in the Group Health Plan context.

We're also asked whether or not the following group policies need to be considered and reported, Accident Policy and Hospital Identity Policies. And here, it gets a little more complicated. It depends on how the policy is structured and how it is administered, and accident policy could be (inaudible) policy depending on how the policy language is.

And hospital identity policies are in the Group Health Plan policy if there's any form as employer involvement and the acquisition or payment of the policy, and even if the policy ends up being written as individual policy. So, again, it depends on the context for the accident policy and the hospital identity policy.

Barbara Wright: And could you clarify, Bill, when you talk about the Group Cancer policies and Group Critical Illness Policies, you were saying we've specifically said they don't get reported under the GHP reporting requirements where we have told people that those policies still need to pay primary as appropriate.

But in terms of NGHP reporting, specifically what would you say about the Group Cancer Policy and Group Critical Illness Policy?

Bill Zavoina: I just – again, they're going to depend on exactly how the policy is worded. Generally, at the policies that I've seen, I would not think needed to be

reported. But there may be language in a policy that will cause it to be considered either (no faults) or liability.

Barbara Wright: OK. I think that we can open it up for questions right now, unless Bill Decker, you have nothing.

Bill Decker: I have nothing else to add, no. Not at the time being anyway.

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

Your first question comes from the line of Nancy Riley from Johns Eastern Company. Your line is now open.

Nancy Riley: Thank you. I would like to ask a question. I sent an e-mail about it and I'll just do a brief summary of it.

If we are settling a workers' comp claim, we include any and all claims that they may have had over the years. And some of those were either denied or they were – the statutes of limitations have run. When do we need to include a TPOC on other claims?

Barbara Wright: Well, how are you settling if you have a single settlement now and it's covering a whole group of situations, part of it is going to depend on what you've already reported for those other situations that they were all one that involved ORM and you reported that and you now have termination dates to report association with that, you'll need to do that.

And if there's a TPOC that's covering the whole gamut, then you're going to need to report that TPOC presumably with the earliest date of incident that's involved and with appropriate diagnoses codes for everything that's been claimed in all of the settlements that you're having in all of the different incidents that you're covering under that settlement.

Nancy Riley: Typically, what we do in the State of Florida is, if a claim that has a back injury and they have a leg injury and they have a neck injury, and these are

different dates of accidents, but the primary – and the statute of limitations may have run on three of those. And then we're settling a claim to protect us from them coming back on anything else, we include all dates of accidents.

We don't include specifics as to the injuries but we include the wording. This settlement includes all dates of accidents.

Barbara Wright: Well, our (touchdown) is what claim (and/or) release.

Nancy Riley: So if the statute of limitations has run and we're including that…

Barbara Wright: Remember that in order for Medicare to recover or have a recovery claim, it's not whether you're, quote, "legally liable," it's whether or not primary payment responsibility has been established. If the statute of limitation has run but someone (sues) and they received a settlement judgment reward or other payments, the fact that the statute of limitations has run is not relevant for all Medicare secondary payer purposes.

Nancy Riley: So if we had a claim from 1983 that was closed in – let's say '89. And then in 2011, we settle the claim for 2006 and we included all claims. We would have to do a TPOC on a 1983 claim?

Barbara Wright: Well, part of what you're telling me is you already settled some of these claims before and presumably you have releases on those back then. To the extent that you are settling something that wasn't settled and you're settling it with the TPOC payment, then you have an obligation to identify essentially the earliest of these dates of incident and report the diagnosis codes there associated with what you're settling, with what's been claimed (on the release).

Nancy Riley: OK. Even if they're not actually claiming it and we include it in the settlement, we need to report it, is what I hear you saying.

Barbara Wright: You seem to be wanting to take both sides of the (street), one that you're releasing if that's somehow that has no effect. If something is being claimed and/or released, then it needs to be reported if they're getting a settlement judgment or award or other payments for it.

Nancy Riley: OK. I assume I understand, but I'm not really clear yet. Thank you.

Barbara Wright: Operator?

Operator: Yes. Your next question comes from the line of Jeff Ewald from Botsford Hospital. Your line is now open.

Jeff Ewald: Hello. I have a question.

We have – we're Botsford Hospital in Michigan and we registered our hospital. And the question is, our claims for our malpractice claims are paid out of the malpractice trust that's where Wells Fargo is our trustee. The trust is self insured. All Wells Fargo does is basically tells us if we're over or under-funded and we need to fund it accordingly. And then we instruct them to pay the malpractice claims out.

My question is on the profile report, do we need to put Wells Fargo anywhere given what I just said? Like as (inaudible) agent or does Wells Fargo now – the trust, the malpractice fund has it's own tax ID number and it's listed on Botsford Hospital's name. But I'm not sure – this just recently came to my attention that we may want to consider putting Wells Fargo somewhere on the profile of our report. Right now, it's just as Botsford Hospital with our (GIN) number.

Barbara Wright: Are you talking about putting them on the profile report as somehow your agent?

Jeff Ewald: Either as an agent or does Wells Fargo need to go anywhere on the report?

Barbara Wright: If you're talking about putting them as an agent, you would only put then as an agent if they were your agent for purposes of reporting. And you don't seem to be using them in that context.

Jeff Ewald: No, we're not.

Barbara Wright: From what you've said on the phone right now, I think we here in the room believe that you haven't described the situation where Wells Fargo itself is the RRE. In which case, we don't need to know about them.

Jeff Ewald: OK. All right. I was just reading it said who must report and it says an applicable plan and I just – I just want to make sure that doesn't mean the actual trust, if you will, or the claims are being paid out of maybe…

Barbara Wright: I think you maybe need to review the section as a whole. You know, (where, look), you have described – what you described doesn't – from what we've heard appear that that was the general rules that are in that section as a whole.

Jeff Ewald: OK. All right. Then, I'll just keep it – keep it as our hospital RRE and go from there. Thank you.

Barbara Wright: You're welcome.

Operator: Your next question comes from the line of Alexandra Sage from Wisconsin Mutual Insurance. Your line is now open.

Alexandra Sage: Hi. I've got a question on clarification for ORM Termination special exemption in which we need to get the doctor's release of people from treatment related to injuries from an accident. We have a lot of people that are just treated and released from ERs and it's very difficult to get one of those releases because most ER physicians release them to the Primary Care physicians to follow up as needed.

So just looking for some clarification regarding what Medicare needs for claims in that respect?

Bill Zavoina: We need something from their primary treating physician that said, No further treatment is necessary.

Alexandra Sage: Even if they never followed up with their primary care physician?

Bill Zavoina: Then you'll still list this for ORM.

Alexandra Sage: OK. Thank you.

Barbara Wright: But remember on this, many of these may fit under – if they're workers' compensations, they may fit under the exception for reporting ORM for workers' compensation. And that dollar threshold along with their other requirements, but the dollar threshold with that is $750. If the industry as a whole has information showing that that will not cover most emergency room visits and they want to bring that – they want to bring documentations to our attention, we might consider raising that threshold for that particular exception somewhat.

We, at this point, still did not intend to have a similar threshold for no fault because it's not the same type of issue. But that hopefully many of yours would fit under that exception.

Alexandra Sage: Thank you.

Operator: Your next question comes from the line of (Jennifer Creedon) from (CMMS). Your line is now open.

(Jennifer Creedon): Hello. My question is, if you have a claim that you realized should have been reported and you've just done your first reporting, how should you handle that?

Barbara Wright: You can put it on your next quarterly file submission.

(Jennifer Creedon): OK. At this time, there's not going to be any penalties for that?

Barbara Wright: Right. There's no automated – you know, we realized people are just getting up to speed and there's no automatic penalty imposed or anything like that for late reporting. You are likely to get a compliance flag on the claim, but at this point, it's informational and obviously you already know why you're receiving it, so…

Bill Zavoina: We encourage everyone to report on time, sometimes people get into your situations then we encourage people to report.

(Jennifer Creedon): Absolutely. It's a large company and, you know, they're reporting a lot of claims and (I want to kind) of put through the cracks, so I just wanted to ask about that.

And the other question I had is, if you attempt to report a claim and you received an error message for that claim, does it still count as reported, you know, properly and timely and then you correct it in your next report?

Pat Ambrose: No. It technically does not. So you do need to correct the errors and resubmit it and it will, again, appear to have been reported late. You know, the requirement is that you report good information on a timely basis. So getting a claim – reporting a claim and having it rejected with an SP error doesn't give you a pass on timely reporting. So…

(Jennifer Creedon): And should you try to correct whatever is wrong with it before your next reporting cycle or do you have to wait to that next reporting cycle?

Pat Ambrose: At this point in time, you need to correct it and resubmit in your next quarterly reporting submission period.

(Jennifer Creedon): OK. And is this the type of thing you should call your EDI rep about or should you just do it?

Pat Ambrose: I think you should just do it since it's in the user guide. You know, if you look at the section on processing your claims response file and disposition code (SP), you know, it's pretty clear there that that if you get a disposition code (SP) and there are errors that you need to fix that you turn around and resubmit that.

Now, that said, if a large percentage of the file is an error, it actually will suspend with the threshold error and you then are – if you get a threshold area, you are to work with your EDI representative and they might suggest if you're able to correct that and resend right away that you do that off cycle sooner than your next quarterly file. But that's something that, you know, had worked out between you and your EDI representative.

(Jennifer Creedon): OK. So I should be looking to see whether it was an (SP) error or a threshold error?

Pat Ambrose: That does make a difference, yes. The threshold errors, you need to contact your EDI representative to discuss the situation and talk about what to do going forward. Now, you're going to get it an (SP) error in either case.

Bill Zavoina: The threshold error means that everything on your file was not taken in. It was basically all rejected and sent back to you, because the number of errors on the files exceeded the minimum acceptable threshold for errors.

So subsequently, that's far more serious than having one or two records with a couple of errors on a file.

(Jennifer Creedon): Several things can happen. The question is being rejected as being replete with errors?

Pat Ambrose: OK.

Bill Zavoina: Yes.

Pat Ambrose: And just to be clear, a couple of things can happen when if you have a file that has a large percentage of errors that, you know, over 20 percent of those records have errors and are returned with (SP) or would be returned with an (SP) disposition code before we continue and process the file, we suspend it with a threshold error. You talk to your EDI representative about it. Then they can release the file and have it processed through completion or whatever records will process will and the rest will be returned in error.

On the other hand, the reason that we suspend it with a threshold error is, maybe there's some major problem and that file should not be processed at all. So the alternative is, the EDI representative and you could decide that that file actually needs to be deleted and not processed.

And so, you know, you need to work out those details and follow the instructions of your EDI representative. But if – if there is no – if this is just a smaller percentage of records that are in error and they're returned on the file,

there is no threshold error involved, the normal procedure is to correct the errors on records returned with the disposition code (SP) and resubmit them in your next quarterly file submission.

(Jennifer Creedon): OK. Thank you very much.

Bill Decker: OK. I just want to say one thing before we go any further that that was a very interesting question and a very good response off of our team here. However, it's a technical issue. Not a policy issue and we really want to keep this call to policy question.

Female: OK.

Barbara Wright: Operator?

Operator: Yes.

Barbara Wright: Before we go to the next person, we have another issue we want to bring up here.

Operator: OK.

Barbara Wright: If the last caller is done, we'll go ahead.

We've received some inquiries about apology and disclosure programs and Bill Zavoina is going to address those.

Bill Zavoina: As we understand that in the (realm) of medical malpractice insurers who have programs that they say are designed to help individuals who have experienced an adverse medical event and who do not file a formal liability claim against the provider, physician or other supplier. The program can (involve) apology disclosures and possible payments for various things to or on behalf of the affected, adversely affected individuals.

They believe that these are not reportable because the (end of) key liability provisions do not apply because no formal complaint was filed against the liability insurer. And I believe no formal assumption therefore of liability has been made. We disagree with that. It would fall under the other payment

(inaudible) on our pre-settlement judgment awarder. Other payment made by the liability insurer that certainly is another payment we'd need to be reported.

The other thing that I found interesting is the folks were saying in the discussion of the program that they pay just the deductibles and (co-insured) associated with whatever other insurance the individual may have. If the Medicare beneficiary that would constitute taking into account their Medicare entitlements, which is specifically prohibited. They would have to treat those individuals as if they have no other insurance. They cannot consider the fact that they had Medicare. They were – they got to pay the whole (price).

Thank you, (Barb). Go ahead.

Barbara Wright: Operator, we can go back to questions.

Operator: OK. Again, if you'd like to ask a question, please press star and the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Your next question comes from the line of Shay Bond from State of Missouri. Your line is now open.

Shay Bond: Oh, yes. We had a – I had a question on the no injury diagnosis code. Is that only for liability purposes?

Bill Zavoina: Yes.

Shay Bond: OK. So that shouldn't be used at all in reporting workers' comp.

Bill Zavoina: Correct.

Shay Bond: OK. Well, we have – how do we handle the situation where an injury gets reported and it appears that we would have ongoing medical and it ends up being no treatment for such? We don't – we don't have like a diagnosis code or something like that to file.

Barbara Wright: Well, you have. It's whatever the alleged injury is, whatever you're accepting responsibility for and that's what you're reporting. If it gets billed as an error,

then the purpose of having the ongoing responsibility for medical indicator is so that the claim would essentially get rerouted to you.

Shay Bond: So if they file an injury that we can tell is to their knee, we would file obviously the (E code) for the cause of injury and then would we just choose the diagnosis code that had to do with the knee?

Barbara Wright: Yes.

Shay Bond: OK. And then if they ended up having no treatment…

Barbara Wright: You'll need the ORM record open until you have no further responsibility.

Shay Bond: OK. OK. And I don't know if this is the forum for this question or not, but we have an individual who's actually – his accident involved a (death) and he is listed as a Medicare recipient. Do we file that?

Bill Zavoina: Was he treated for the injury?

Shay Bond: He was in an airplane accident and was dead upon arrival.

Bill Zavoina: Well, they probably charge for saying he was dead upon arrival.

Shay Bond: OK.

Barbara Wright: I mean, you know, there may be a plane wreck, who knows? But, I mean, we were asked this in probably a different circumstance of like a car wreck, et cetera. And a lot of what we see in those situations is a person may have been transported by ambulance, there may have been – whether they're minimal or not technically services billed by the ER or by the hospital, et cetera.

Bill Zavoina: By the EMT units or whatever.

Shay Bond: OK. OK. I think that helps. Thank you.

Operator: Your next question comes from the line of (James Boulder) from Johns Eastern Company. Your line is now open.

(James Boulder): Thank you. Good afternoon.

I have a question related to a liability claim involving a self insured RRE. They make a goodwill payment of medical limited to the first visit only. My question is would termination of the ORM after paying the amount of total billed be proper?

Barbara Wright: OK. It's not clear from what you've said that that is an ORM record. If you're not assuming responsibility, if you're saying that you're making a single payment with no intent to pay anything else, then that is a TPOC payment and you would be reporting it as such, and it would be subject to any threshold.

(James Boulder): OK. Then what – what would be the liability claim with ORM? Can you explain that?

Barbara Wright: We expect those – we expect most ORMs to probably be no fault or workers' compensation, but we have had situations brought to our attention where there are some ORMs for liability.

One example is we know there's at least one state where they handle part of their self insurance, they actually run it like it's no fault. So for that portion of their program, they do go ahead and pay on an ongoing basis even though it's because it's self insure it is liability insurance. So that's one example.

The other thing would be, for instance, you have a liability situation and instead of doing any type of cash TPOC or lump sum settlement, they may be a settlement where the hospital or another entity says whoever, you know, is the (defender) or the claims being made against is self insured. They may say, well, the settlement we're not going to pay you anything but we agree that we will pay any medical expenses up to X dollar amount that you incur within the next five years. That would be a situation where they essentially have assumed ORM.

So those would be a couple of examples for liability insurance ORM what. I'm sure there are others that we, you know, don't know of at the top of our heads.

(James Boulder): OK. So whether the said amount we've agreed to then that's going to be reported as ORM liability.

Barbara Wright: Yes. Remember, TPOC is when you're actually – you do a settlement and you're making that payment to the individual essentially as opposed to you're continuing to pay out on a continuing basis.

Bill Zavoina: Other example might be and it doesn't necessarily involve you agreeing upfront to a specific dollar amount. Just (like) the case where clearly you're going to end up having to pay. The accident was videotaped. There's hundred witness just including (inaudible) judges, et cetera.

So you just say, OK, we know we're going to have to pay. Go get your treatments. It's going to bill us. And so you're getting the bills and you're going to be paying probably up the policy limits. As ORM (without) you having agreed in advance with specific dollar amount.

(James Boulder): OK. I appreciate it.

Barbara Wright: You're welcome.

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

John Miano: Good afternoon everyone. John Miano with Gould & Lamb. My question today have to do with bankruptcy.

I would like to get some additional clarity around the subject of what an RREs responsibility is in regard to bankruptcy. Just using an example where you have an RRE that essentially goes through bankruptcy proceedings and states have taken over the administration of those claims.

Now, where the state funds have responsibility for payment of those claims, would the state funds be the RRE in that circumstance or would it still be the bankrupt entity?

Male: I have to remember what he said on top of my head (inaudible). We're doing a quick research here. We'll be right back with you.

John Miano: It's on page 23 of the user guide, subsection 7.1.

Barbara Wright: What I would say as a general thing that we forgot to mention in the beginning is we do have some pending questions about what happens in situation where there are qualified settlement funds associated with bankruptcies and we are still looking at language to address that specifically.

The other general comment is entity that is the RRE, the basic rule is that they cannot transfer or otherwise change their status as an RRE.

John Miano: Oh, (again), I could understand that if the – if the carriers, say, for instance, are self insured, still had any latitude or input with regard to the direction or payment of the claim. But if the state fund has taken over that responsibility of determining when a claim is payable and how much to pay, I would think that the state fund would then be the RRE.

Barbara Wright: Well, part of the question is, and this is why everything is very (fact) specific, how do they take it over. If for instance there's a settlement and there's a qualified settlement funds that after the result of that why isn't part of your settlement mechanism to make sure that the qualified settlement fund or whatever funds being set up is giving you as the RRE the appropriate information you would need to report.

You can't simply say I'm entering into this so I no longer have responsibility. That's the basic concept.

John Miano: The concept I believe that we're discussing here would be more or less an entity like a carrier who has become insolvent. And therefore state funds have taken over…

Bill Zavoina: Does the state fund making payment on behalf of?

John Miano: Yes. They would actually be responsible for paying, you know, distribution payment allocation, et cetera. So I don't believe there would be another financial input or a direction as to the administration of those claims by entity, and entity that for all intents and purposes doesn't exist anymore.

Barbara Wright: Now, is this different from the situation that we addressed which is on page 26 I think in the guide about state established assigned claims fund, et cetera. I mean, you know, it's a little bit hard to tell where you're drawing the line in this particular (space).

Female: (Inaudible).

Barbara Wright: And, you know, there's also language about liquidation if you didn't look at it. I mean, we try to address the variations and at least for your question you focus on just this one section and there's several things in this section that deals with aspects of what you're talking about.

John Miano: Yes, I understand. You know, once again, that's kind of my dilemma here is that bits and pieces apply from different parts of this section. But what I'm looking for kind of (just a) little more clarification or guidance towards this specific scenario. So I suppose we can take it offline but I just was – just thought (inaudible) here and see if there's anything we can discuss.

Barbara Wright: I think I don't remember seeing here that question. I think if you would send it in to the dedicated mailbox with as much specificity as possible.

Male: And mention that we've discussed it on this call.

John Miano: Indicate whether it's a Chapter Seven or a Chapter 11 bankruptcy. OK. All right. We'll do. Thank you very much.

Bill Decker: It would be hard for us to get into much more detail than that because we need to reference back to the information that's on the Web site rather than trying to construct an answer for you specifically here on this call because it may not be the best answer that's available.

John Miano: Understood. Just a quick question before I let you go. In the event that there is any kind of a governmental department shutdown after this weekend, is there any impact at all on the processing of mandatory insurer reporting data? Is there any anticipation of, you know, running with limited or (inaudible) or how that might affect you?

Bill Decker: We don't have an official (put that in quotes) answer for you yet. It's Wednesday. We probably wouldn't have an official answer for anybody on this question until some time on Friday.

However, we don't anticipate there would be any issues with the continuation of either reporting on your part or processing reporting by our contractors at least, certainly, initially.

Barbara Wright: I mean, the shutdown or potential shutdown is – it includes federal employees where we have contractors that are already funded, they are going to continue to do their work.

John Miano: Just what I thought. Thank you so much.

Operator: Your next question comes from the line of (Barb Jackson) from (inaudible) Mutual Insurance. Your line is now open.

(Barb Jackson): Thank you. I have a couple of questions.

The first one involves no fault claims as ORMs. Keeping in mind that we totally understand that Medicare is a secondary payer, but also with our concerns of having to pay something twice, the issues come up again about if we have a small med pay limits of, you know, let's say $5,000 and we already know this person has $10,000 worth of related medical bills. And we also know that they're Medicare eligible.

We have been kind of running under the presence that we should get information from Medicare, conditional payments letter, everything before releasing that no fault payment even though we're aware that it's there because we want to avoid having to pay it twice should you guys – should Medicare pay something before we do.

Barbara Wright: One – one way to avoid paying it twice is that if you are paying providers billed directly if the Medicare secondary payer recovery contractor would come to you and say, you know, we have this much in conditional payment.

What they routinely ask for if you say it's already been exhausted is they say we need to see your payment ledger, who did you pay and when. And to the extent you made those payments to providers for bill, then that's proper exhaustion. It's only when the check is cut directly to the beneficiary that then, you know, we need to look whether or not that was actually used for medical expenses.

So a lot of no fault simply pays directly to the providers which avoid, you know, as far as I can tell most of the issues you're bringing up.

(Barb Jackson): Yes. OK. Thank you very much on that one.

Now, the second one, the second question, it's a little bit more involved, but I am talking about no fault and an ORM and a TPOC situation. For example, we have a policy that has a no fault limit or med pay limits and, again, we'll use the example of $5,000. And we also have a liability component to that. So we have a TPOC to report, you know, after October 1st. Thinking ahead here.

We pay the med pay limit out and the ORM is exhausted. And then let's say next year, in 2012, we go to settle the liability claim or the TPOC portion of it. We will occasionally use open end or open medical releases where we will – let's say, we say we'll cover any related expenses. In addition to the settlement amount, let's say $10,000, we'll cover any related medical expenses incurred over the next 90 days up to $2,000.

We're wondering – we're kind of under the impression from some early on discussions last year that that would create another ORM, that $2,000 part, that open medical.

Bill Zavoina: Yes.

(Barb Jackson): Is that – is that correct?

Bill Zavoina: Yes.

(Barb Jackson): Under liability, Barbara, that…

Barbara Wright: It's still the point that you are assuming ongoing responsibility for medical. And if that – I think we just gave that as one of the types of examples to the gentleman who asked when you would have ORM for liability. And that was actually the example we gave.

(Barb Jackson): Yes, Barbara. I understood that. It would be a second ORM, not a reopening of the original ORM.

Barbara Wright: Well, you're going to have different…

(Barb Jackson): That's what my question is.

Barbara Wright: OK. You're going to have different files submitted depending on which – each record you submit shows what kind of insurance it is. If you're paying this under your liability insurance, then it's going to be reported as ORM for liability. From what I understood you say earlier, I assume the first ORM was no fault.

(Barb Jackson): Yes, ma'am. Can you tell me what – and I apologize, it's more of a technical question. What's the difference? How do you differentiate between a liability ORM and…?

Barbara Wright: There is an insurance (trade field) and it has a code for no fault separate from liability.

(Barb Jackson): OK. That answers my question then. Thank you very much. I appreciate it.

Barbara Wright: So if you had – just to reiterate, if you had ORM to report on the same policy that you were reporting, ORM for no faults report on the same policy where you also had a liability TPOC, you're actually submitting two records, one that each of them marked with the appropriate insurance type.

(Barb Jackson): Yes. So in my question example, we'd be doing three records, the no fault ORM, the liability ORM, and the TPOC?

Barbara Wright: No, actually two. The no fault would come in under the no fault insurance type and then the liability would be reported with ORM equal Y and your TPOC amount. And then later when your ORM is terminated, you would

send an update. On that update record, you would still have the TPOC amount that you reported previously and you would have ORM equal Y and you would include an ORM termination date.

(Barb Jackson): OK. All right. Thank you.

Pat Ambrose: Yes. Just a little follow-up. The field that we're referring to is the Plan Insurance Type Field 71, a code of "D" as in Dog is for no fault, an "L" stands for liability. And again, if you have a claim of one insurance type, you can report ORM and TPOC on the same Section 111 Claim Record.

Barbara Wright: Remember that we've said all along that you can have multiple records having to be submitted for the same individual for the same claim. If you have, for example, a car wreck and someone is a beneficiary, that's not really anything that you're worried about.

But you are the insurer for the policy for both – for both cars involved in the wreck, you could be paying no fault and liability under both of those policies, so you could actually have a total of four records to be submitted or more.

Pat Ambrose: Yes. It's by policy, by claims, by insurance type.

Barbara Wright: Do you have a follow-up question or is that it? Operator, I guess you can go on to the next person.

Operator: OK. Your next question will come from the line of (Karen Strung) from (Rodia, Inc.). Your line is now open.

(Karen Strung): Hi. I have two questions.

My first question is in the case where you're involved in a lawsuit involving multiple descendants, so there's multiple descendant companies, our company being one and there ultimately ends up being a settlement for hearing loss of contractors that worked at our various facilities. And each company's descendant is apportioned or responsible for a portion of that.

In that case, are we reporting – as my understanding that we need to report our share of that settlement, but I wanted to confirm that. So that's my…

Barbara Wright: The answer is yes – the answer is yes, no answer. The manual currently says that when there's a joint and several liabilities situations that each of the entity has to report the total for all of them. You can look at the specific language there. There's been some confusion by the industry on our intent with that.

What it will be changed to make clearer is the fact that we're not talking about when multiple entities have some type of general joint and several liabilities under state law. What we're talking about is when there are joint and several liability for a particular settlement judgment award or other payment. Then all entities that are jointly and severally liable for that particular settlement judgment award or other payment must report the total, not their individual share.

Does that help?

(Karen Strung): Yes. I guess it would – it would depend on the language of the agreement then and how it's structured. If they're separate – if they're separate settlement agreement with each dependent, then I guess it would be…

Barbara Wright: They would each report their own settlement.

(Karen Strung): Separately. Then if it's together and I guess if there is, you know, legally we're jointly and severally liable in the sense of the terms of that settlement, then we would all need to report the total.

Barbara Wright: Yes. And it would have to be, you know, further (readied) out in the back end.

(Karen Strung): OK. OK.

Bill Zavoina: Don't forget that you also have to consider a judgment, what the judgment made that from the various insurers (inaudible) x dollar be forthcoming or was the judgment that from insurer A so much and from insurer B so much and so forth.

Barbara Wright: Well, I mean, that would be a factor on whether they were jointly and severally liable.

Bill Zavoina: Right. (I guess what I'm saying there) was limited strictly to settlement.

Barbara Wright: No. But the basic concept, if you have separate settlements and separate judgments, et cetera, then each report is under their own. But if you've got one that is joint and several liability, then you're each reporting the total.

(Karen Strung): OK. And then in a case like that or in any case where you have a self insured settlement including medical benefit for potentially eligible Medicare recipient, would you ever have to do a Medicare set aside?

Barbara Wright: Set asides are beyond the scope of this call.

(Karen Strung): And so how would we answer – how would we get that question answered?

Barbara Wright: You need to look at CMS' publications or issues where they address this or if you have specific question you should contact your applicable regional office.

But there are rules posted about CMS' general concepts for set asides for workers' compensation on the COBC Web site. You may want to take a look at that.

(Karen Strung): Oh, I'm sorry.

Barbara Wright: … for general guidance.

(Karen Strung): No. This has nothing to do with workers' compensation.

Barbara Wright: I understand that. What I'm saying is they're putting forth concepts about set asides. This is the process we have specifically for workers' compensation, but you can still look at it in terms of the type of principles that are there.

(Karen Strung): Well, I think if we look at it and it says workers' compensation, in my mind it wouldn't apply to a self insured liability claim then.

Barbara Wright: I – I don't mean to cut you off, but liability set asides are not the topic of this call.

(Karen Strung): OK.

Barbara Wright: What we've said on other call, is CMS does not – CMS requires that Medicare's interest be protected. CMS does not – not mandate the specific mechanism for that protection.

(Karen Strung): OK.

Barbara Wright: And that is about the best I can do on this call.

(Karen Strung): OK. Thank you.

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

Marcia Nigro: Hi. This Marcia Nigro from Sedgwick.

I think you've answered this before, but they've asked it again so let me make sure I have it. The question, right, is concerning workers' compensation. And there – I didn't realize there are some convoluted ways to issue – resolve a case.

But in this instance, they're wondering – our (PPD) awards including in the TPOC, if for example there is a TPOC for a body part that may not be covered or is covered partially. Do they just – so we're wondering just are we supposed to include that in our TPOC?

Barbara Wright: The instructions right now say that, you know, any TPOC amounts due need to be reported, and what I said at the beginning of the call is we're still looking at if there's some language that we can narrow the reporting requirement in conjunction with TPOC worker's compensation situation for indemnities involved.

Marcia Nigro: OK. So the answer is to be – we'll get a better answer later on down the road. In the interim, should we just report it?

Barbara Wright: Yes.

Marcia Nigro: OK. (If we had) any questions you guys will come back to us anyways?

Male: Yes.

Marcia Nigro: OK. OK.

Male: Operator?

Operator: Are we ready for more questions?

Male: Yes.

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

(Susan Columbus): Hi. I just had one quick question. I tried checking that beneficiary lookup, and there's no next door – any tabs on it, so we – I just – I thought it was supposed to be functioning?

Pat Ambrose: It is. For our (EIDs) that are not signed up for directed entry or (DDE).

(Susan Columbus): We're not signed up (inaudible) places.

Pat Ambrose: OK. OK. So if you should log in and on the RRE listing page, under actions beneficiary lookup should appear, and…

(Susan Columbus): Right. It does but there's no button saying next and whatever.

Pat Ambrose: OK, I'm going to have to ask that you please take a screen print and send that to your (IDE) representative and we will look into it as soon as possible.

(Susan Columbus): OK. All right. Thanks. That's it.

Operator: Your next question comes from the line of (Ryan Warner) from (New) Mexico Mutual. Your line is now open.

(Ryan Warner): Hi. In the state of New Mexico, our workers' compensation, we are liable for the injury for the injured worker, and our first quarter submission we sent in a claim to you guys, (inaudible) cause of injury, indicating injury, (fall from) other, with an (ICD 9) as an ankle injury. Now, our claims director just

yesterday got a phone call from this particular claimant that – accident back in like 2000, that he had a Medicare claim that was being denied, something about a knee replacement. And earlier you guys had indicated that, I believe it (was Shay) that the claim was being rerouted to the insurer.

In this type of a case, shouldn't Medicare be rerouting or sending the claim back to us?

Bill Zavoina: Medicare doesn't send the claims – OK, when we say the claim will be rerouted, is the Medicare contractor that receives the claim will go back and tell the provider or fiduciary writer or supplier that submitted the claim that Medicare can't pay because there's another responsible party. That party can then look on the (CW Web) record to see who that identified party is, and then it is the provider physician, or, rather, supplier that would then send you the bill.

Barbara Wright: But your question is raising a slightly different issue. What should happen, if there is an open record with (ORM) and let's say it has code one for ankle, and let's say the code for knees was two, the claims processing contractor should not be denying any claims for services related to the knee based upon that open record. So if that – if that is happening, then the claims processing contractor is making an error in it's processing, and that's something that, you know, the beneficiary needs to go back to the claim processing contractor.

(Ryan Warner): OK, that's what we were thinking, that we just wanted to clarify the – so thank you.

Male: Operator?

Operator: Yes. Your next question comes from the line of Jim Price from Aon Global Risk Consulting. Your line is now open.

Jim Price: Yes. Thank you for taking my call.

I just have a brief question. Can you refer me to the specific statutes or regulations that require a primary payer to protect Medicare's interest?

Bill Zavoina: Well, you're the – a primary payer, you're supposed to pay before Medicare and you're supposed to be able to be sure that Medicare can recover…

Barbara Wright: I think he's looking for the…

Bill Zavoina: … from you, so I don't know what – you know, it's in (42 USC 1395 YB), in (inaudible) provision.

Pat Ambrose: Primary payers have an obligation to pay primary, so – I mean, that, by definition, protects Medicare's interests. They need to pay a (inaudible)…

Jim Price: OK, I was just – I was just trying to get to the specific statute or regulation that required a primary payer to protect Medicare's interest. I know it's often been said, and I was just trying to find that specific regulation or statute.

Pat Ambrose: Yes. What we're saying is that when you pay appropriately, you are protecting Medicare's interest. So I'm not sure what else you would like us to say. The site Bill Zavoina just gave you, (42 USC 1395, little y, parenthesis little b, close parenthesis) are – is the Medicare secondary payer statute.

Jim Price: Thank you.

Pat Ambrose: There are some references in the user guide to those statutes. Take a look at section 5.4 of the user guides and…

Bill Zavoina: (Inaudible) we have.

Pat Ambrose: Yes. Possibly that appendix there and also section – I'm sorry on – you might find section 19 helpful as well, in case you didn't get those specific sites.

Barbara Wright: You know, the – a statutory language that is in user guide at the end, I believe, is limited to the new (MMSEA) section 111 reporting language, and that was simply an amendment to the full statutory provision for Medicare secondary payer which we just gave you the site for.

Jim Price: OK, but not able to cite to a specific within the general statute?

Barbara Wright: I'm afraid none of us know it by heart, off the top of our head. It's not, you know, a short provision. If you read through it, you'll see, you know, that primary payers are required to pay before Medicare, and what I think…

Jim Price: OK, I – OK, I appreciate – I appreciate that clarification. Thank you.

Operator: Your next question comes from the line of Linda Trefethen from Johns Eastern Company. Your line is now open.

Linda Trefethen: Hi. Thank you for taking my call.

This question relates to work comp and work comp settlements and a question was asked earlier about it, but I just want to make sure that I'm clear on it. If we are settling a workers' compensation claim for, say, a 2010 date of injury, that particular claim is the only claim that we currently have (ORM) on. But the claimant or the injured worker has prior dates of injury that we did have (ORM) for a long time ago, but either the statute of limitations has run or there's been – well, the statute of limitation has run. There's been no treatment on any of those prior claims.

The earlier caller had asked this question, but I just want to make sure I understand it, that when we settle the 2010 date of injury, we settle all claims. So they're – we're going to be settling claims that date back to – they're in our system maybe from 1990 that we don't have currently (ORM) for but we still include all prior claims in the settlement documents, which would include any claim from 1990 or 2000 in our settlement. We…

Barbara Wright: What we understood the prior caller to say, and therefore you, is that this was now a TPOC settlement. So there's now a dollar amount going out, and if part of that was being claimed and/or released our additional injuries from other accidents, then they all fall under that settlement and we said you should report the earliest date of incident and you need to report diagnoses codes for all of the settlements, because you're not just settling that injury if you were specifically releasing other injuries as well. You are – you are doing a settlement which is affecting more than one accident.

Does that help or (inaudible)?

Linda Trefethen: Yes, it does. It – so really, whether we had (ORM) on them or not at the current time is irrelevant. Whether the statute of limitation has run is irrelevant.

Barbara Wright: Yes. The…

Linda Trefethen: The fact (that matters)…

Barbara Wright: Yes. The fact of the matter is you have a new TPOC settlement for which you're including a release for multiple injuries, so we need the information about all those injuries reported with respect to that settlement.

Bill Zavoina: If your settlement only included the 2010 claim, you're – you'll find you don't need to include the other stuff. But if you're going to include the injuries and the dates of incident from the claims going back to 1990, you got to include it.

Linda Trefethen: Now, if we just say all prior claims and we don't spell out each date of injury (inaudible)…

Barbara Wright: If those prior claims – if those prior claims are for other injuries, then they're included.

Bill Zavoina: And you have to report them.

Linda Trefethen: OK. Thank you.

Operator: And your next question comes from the line of (Nancy Cardinale) from (inaudible) and Health. Your line is now open.

(Nancy Cardinale) from (inaudible) and Health, your line is now open.

(Nancy Cardinale): Hi. Can you hear me?

Bill Decker: Yes. Hello?

(Nancy Cardinale): Yes. OK, great.

I have a question about reporting TPOCs and goodwill gestures. My question is right now there's the $5,000 threshold for goodwill gestures so that anything under that does not need to be reported. And I'm wondering how a situation should be handled where a goodwill gesture is given, such as say a $10 parking pass or something that would clearly not be reportable but then a claimant's filed, and at a later date the claim is settled for an amount in excess of $5,000.

Would the TPOC report need to include the value of the goodwill gesture from, say, two or three years earlier that wasn't reported at the time because the threshold was in place?

Pat Ambrose: You know, wouldn't they, Barbara, be considered two separate TPOC amounts?

Barbara Wright: They would be, but keep in mind that the scenario you described, I think you should also read the language that was published as a separate alert about risk management, and I'm not sure, Pat, if you know where that is in the user guide now. I mean, make sure that you're following the rules for risk management in general.

For example, if the entity is a hospital, then they have an obligation in terms of their billing for what you were calling the goodwill gesture.

(Nancy Cardinale): Right. And I understand that. That's – I'm kind of differentiating between write offs and goodwill gestures. I know a write off is a different thing and there are obligations with respect to the billing.

What I'm talking about here was like a goodwill gesture is, you know, my understanding is what needs to be reported, there may be times when something of value is offered, such as, say, a parking pass or a cafeteria pass, you know, for $10, either maybe to avoid a claim or if a claim has been – even if a claim has been asserted. Right now, clearly, that's not reportable because it's under a threshold. But, again, if a claim then does get asserted or there's already an active claim, later there's a payment on that claim, it's just not clear to me whether the value of what was previously given should then be included in the total amount.

Bill Zavoina: Can you hang on a second? We're going to go offline, just for a second.

Bill Decker: Thank you. Thank you, (inaudible). This is Bill Decker.

We were just discussing the aggregating up to beyond the threshold. If you had amounts that asserted with that $10 parking…

(Nancy Cardinale): Yes.

Bill Decker: … reimbursement, and then you had a bill – a claim come in for healthcare for, say, $1,000, you're still under the threshold. But then you have a third claim come in on the same incident for $9,000, you're up now to $10,010. You'd have to aggregate all of the previous claims together when you – after you cross the threshold for reporting.

Barbara Wright: And I think Pat Ambrose may have the site available.

Pat Ambrose: Oh. No, I don't. I'm sorry.

Barbara Wright: I thought she did. I'm sorry. But it is addressed in the user guide, though.

(Nancy Cardinale): OK. Yes. I just wanted to clarify that because that's something that could, you know, easy (write) at the hospital. So thank you.

Bill Zavoina: Sure.

Bill Decker: Thank you.

Operator: Your next question comes from the line of (Lynn Holivic from SMOLS). Your line is now open.

(Lynn Holivic): Thank you. I have a question regarding date of birth, or birth date, rather. We've got some older claims who we're trying to get dates of birth but some of these were students that maybe have received a needle stick in our hospital during their training, and we can't locate those students anymore. What do we do about that?

Bill Decker: You can't locate their what anymore?

(Lynn Holivic): We can't locate the student, so we can't get their date of birth.

Barbara Wright: Well, let me ask you this. Is it something that you be reporting as a TPOC?

(Lynn Holivic): I think no. Absolutely.

Bill Zavoina: (Inaudible).

(Lynn Holivic): No, there wouldn't be (no) TPOC, no. Nor (ROM) either.

Pat Ambrose: Then you have nothing to report.

Bill Zavoina: There's nothing to report if you're – I guess…

(Lynn Holivic): OK. That's all I wanted to make sure of because…

Bill Zavoina: I mean, in a situation where you did have something to report, a date of birth is one of the matching criteria, but by itself it doesn't – you know, if the name and gender and all that are good, it would still match, though.

Barbara Wright: Yes. You can get by without the date of birth if (he's) got the last name, first name, social security number and the gender correct.

Bill Zavoina: Yes.

(Lynn Holivic): Well, sometimes we don't even have the social security number. The students are coming in from, you know, nursing schools in the community to do some of their rotations here in the hospital.

Bill Zavoina: Short of – I mean, if you have a reportable incident, I mean, the one thing that is always required is the health insurance claim number or, absent that, a social security number. Without either of those two numbers we can't, you know, confirm the match or whatever.

(Lynn Holivic): See, and this was – these occurred before we were reporting, so we didn't have the information. Now, we have a process in place where we can obtain the information.

Barbara Wright: Yes. But I guess I don't understand is what responsibility have you to send in those cases. Either – did you – did you assume some type of ongoing responsibility for the care for these people or not?

(Lynn Holivic): No. The only responsibility we assumed was the initial testing to make…

Barbara Wright: And I believe there's a provision in the user guide that talks about a service for evaluation purposes (inaudible).

(Lynn Holivic): OK. Yes. I must have missed it. OK.

Barbara Wright: So if you – if you would take a look and find that, I think it'll address your issues. Yes.

Pat Ambrose: That's in section 11.10.2. There is a note there about that.

(Lynn Holivic): OK. I must have just read right over it. So I'll check it again. Thank you very much.

John Albert: Now, for the record, this is John Albert who joined the call from CMS.

Operator: Your next question comes from the line of (Sheryl Denan) from Metro Risk Management. Your line is now open.

(Sheryl Denan): Hi. Good afternoon.

I had a quick question regarding late reporting. If we have a case and we do work (inaudible) at a case where there's no reasonable expectation that a person is Medicare eligible, and we do the query, say, tomorrow and we don't get a hit, and then we go to move and settle the case two years from now and they tell us at that time, yes, I'm Medicare eligible. I've been getting Medicare for a year. Are we in a position or at risk of a penalty for not reporting that earlier if we didn't know and there was no reasonable expectation?

John Albert: No, because under the – under this reporting – this is John again – I mean, you really are obligated to report them, so (inaudible) settlement judgment or award. I mean, if you're talking about – assuming ongoing responsibility for

medicals, the reporting would be due sooner, you know, when you assume responsibility for medicals and they become a beneficiary.

Bill Zavoina: Right. So…

(Sheryl Denan): Well, but that's – but that's my question. If we had – you know, we have ongoing responsibility for all kinds of 20- and 30-year-olds who have moderate to mild injuries, and when we do the (clear) we're not going to get hit. So not only does it not mean, you know, reporting requirements as far as eligibility is concerned but there would be no reasonable expectation to report it anyway, right?

Male: The obligation is checked on an ongoing basis, whether or not the…

Male: (Inaudible)…

Male: …. (inaudible) become a Medicare beneficiary…

Male: We use the query process. I mean, that's why we put that out there, to…

(Sheryl Denan): No – and I completely understand that, and we're totally enthusiastic. We're actually grateful that it exists. I'll be honest.

But my question comes from an ongoing query standpoint. From an administrative standpoint, it sounds like the only way to make sure we are absolutely reporting everything on time is to query every single open file every 45 days. Am I just – is that the only solution?

Male: Well…

(Sheryl Denan): There's no reasonable expectation. Is that the solution?

John Albert: Well, the other option you have is to send them an (MSP add) records, and if they are not a beneficiary, they'll be not…

Barbara Wright: They'll continue to reject.

John Albert: And the service that they…

(Sheryl Denan): Well, but then – but then…

John Albert: … the (quarter) that they become eligible, that (MSP) record will be built, so…

(Sheryl Denan): But my concern – and I believe somebody else touched on it and there was some information turn about regarding threshold errors would not be considered an error and then wouldn't we be at risk of getting our file rejected because of the number of errors?

Pat Ambrose: No. Actually, in that case, if you submitted a claim for someone who is not matched to a Medicare beneficiary, you get a disposition code 51, and that's not included in the error threshold calculation.

I would highly recommend, though, rather than sending the claim over and over again, that you query them once per quarter. It should not be – since you're reporting on a quarterly basis that should not be necessary to report – to query more often than that. So check on their Medicare status via a query or the beneficiary look up once per quarter.

Barbara Wright: Yes. Also remember essentially there's a 45-day grace period build in. I don't know if that means that you can do it less frequently than once per quarter, but you essentially got at least 145 days from when they became entitled. So….

John Albert: And this issue's been brought up before in terms of, you know, what it means for the submitter, especially if you're dealing with a young person who, you know, that the odds of them being on Medicare are not real great. But that's something we are discussing internally.

Barbara Wright: Your issue of no reasonable expectation is you have no reasonable expectation based on the injury for which you've assumed responsibility. That (does mean) that in the meantime the person didn't step out and get hit by a truck and get Medicare based on some other basis, in which case then all of his care or which anyone else is primary would need to be paid by that primary pair. And that's the reason the monitoring have to continue to take place.

(Sheryl Denan): I guess my more basic – and thank you. This is all great information. I appreciate it. But I guess my more basic question then would be if there's no – if there isn't going to be an error threshold for 51s, then it would be in our best interest to code every accepted claim as (ORM) and then just wait for those 51s to be returned to confirm what we already know.

John Albert: I mean, you can do that, but again, the simpler process is just – is to continue with the query.

Barbara Wright: And, you know…

John Albert: (Inaudible) data.

Barbara Wright: Yes, but I'm more concerned about the fact you (then code) everything (ORM). If it's not an (ORM) situation, you should not be submitting (inaudible)…

(Sheryl Denan): No, no, no. I understand that. No, I just meant our accepted cases where we have, you know, medical bills are going and (inaudible) benefits are going, et cetera. OK.

John Albert: In that case, you shouldn't be committing a file dump.

(Sheryl Denan): I'm sorry. Say that again?

John Albert: You should not be submitting a file dump (inaudible).

(Sheryl Denan): Understood.

John Albert: (Which is what) I think with what you were suggesting you would do is just an accepted case you're just going to report and let Medicare figure it out. Figure it out. If your obligation is essentially to determine whether or not the person had – is a Medicare beneficiary.

(Sheryl Denan): Understood, which brought me back to me original question was if, you know, if there's no reasonable expectation and the query comes back with no hit, then what is the obligation to you continued query?

John Albert: Your obligation is to continue to query at least on a quarterly basis.

Male: As long is it has open medical.

John Albert: As long as (inaudible) medical.

(Sheryl Denan): Understood. That makes – that's very clear then. Thank you so much. I appreciate it.

Male: Operator?

Operator: Yes. Your next question comes from the line of Anne Armstrong from Intermountain Healthcare. Your line is now open.

Anne Armstrong: Thank you. I have a couple of questions actually that relate to our provision (inaudible) provider and self insured. And one of (you just) touched on a little bit earlier, I believe, by Mr. Zavoina when he discussed the apology and disclosure policies that some providers are implementing.

We have a similar program although we don't necessarily call it by that title, where dissatisfied patients for, you know, a variety of reasons – it could have nothing to do with their actual medical treatment – are responded to sometimes by – through our billing. And I asked this question on an earlier call, and I think I refined it because I think I need to understand, if a provider such as the hospital (inaudible) not to pursue the co-payment or the patient's share, is that by definition a reduction in charges? And then would it then…

Bill Zavoina: That's considered a reduction in charges that's – I guess if it was a patient that was injured or something?

Anne Armstrong: A patient could be dissatisfied about the taste of their food. I mean, it may (inaudible)…

Bill Zavoina: OK. But basically it's a liability case situation or a risk management situation?

Anne Armstrong: In some cases a risk manager is involved, in other cases the patient may (inaudible)…

Bill Zavoina: But whether or not a risk…

Anne Armstrong: … the administrator.

Bill Zavoina: Whether or not a risk manager is involved, the issue is you don't want to be sued. Or you don't want to have a liability (inaudible).

Anne Armstrong: (We want – we want) our patients – we want our patients to be satisfied.

Barbara Wright: OK. I guess what we're saying is when we wrote the risk management alert and when the language got incorporated in the manual, we don't care what title the person who actually makes decision have. What we're talking about is when our hospital takes an action of that type, then they need to bill appropriately, which includes identifying reductions, what they consider reductions or write offs or otherwise, that is liability (self insurance) and so should be reported on their claims as…

Male: (inaudible) for liability.

Barbara Wright: … as a liability primary payment.

Anne Armstrong: OK. And then a similar situation sometimes arises where perhaps the patient was charged inappropriately and they bring that to our attention. So maybe a medication got on their bill that that wasn't intended for them or they didn't receive, and we want to address that bill.

Barbara Wright: If that requires an adjustment of the bill – I mean, if you're truly correcting an error and it would change what you bill the Medicare, then certainly you should be taking care of any adjustments to Medicare's bill as well.

Bill Zavoina: But that's not considered a payment from liability insurance unless you're also paying – doing something else for them.

Anne Armstrong: OK. But, either way, the bill submitted to Medicare should reflect these changes?

Bill Zavoina: For – in the first case, you would show that you received a payment for whatever it is you're not charging as liability insurance. In the second situation you would be submitting an adjustment bill correcting the charges you submitted.

Barbara Wright: And if you're only charged with – for a (DRG), it may in fact not involve any changes for either one.

Anne Armstrong: OK. So it depends on how the bill is submitted.

Bill Zavoina: (Inaudible).

Anne Armstrong: (You know, we may) have an encompassing bill that just wouldn't change.

Bill Zavoina: No. You'd still submit that – you would still – I think what Barbara was referring to, it may not affect the payment. But if – you still have to submit the bill properly.

Anne Armstrong: OK. (Inaudible).

Barbara Wright: (You need to) first decide which type of situation it is. If it's a situation such as the equivalent of what we were calling apology and disclosure where you're forgiving or writing off a certain portion of the bill, then you need to make sure that's reflected as a self insurance primary payment on your bill. If it's a situation where there's an error on the bill and you're simply correcting that error, you need to take whatever steps that would require to correct the bill, which may or may not make a change in the actual payment amount.

Anne Armstrong: OK. And then there are situations where we find out subsequent to the bill or, you know, the Medicare claim going out the patient contacts us later and we want to address their concern, and according to, you know, CMS's guidance on other laws, a hospital can – as long as they don't do it repeatedly, can forgo their co pay. So if you…

Barbara Wright: There are – our understanding is there are specific rules for when co pay or coinsurance can be waived. But I – my personal information is, and it may not be adequate, is that there are specific criteria for those, and they don't

include situations where you're doing it simply as a risk management tool or to avoid a lawsuit or to avoid a liability claim.

So if you're – if you're obeying the proper rule for waiver of coinsurance under Medicare guidelines, then you most likely are not following within what we've described as risk management.

Bill Zavoina: Now, if it's a situation where you billed Medicare and then after you billed Medicare you decided, as a risk management decision, you're going to waive the deductible or coinsurance, you would need to submit an adjustment bill where you, in that adjustment bill, you're refuse – you're showing that you received the payment for self insurance liability for the amount of the deductible and coinsurance you're basically not going to charge.

Anne Armstrong: OK, so that would be the proper mechanism as opposed to including it on the claim input file?

Bill Zavoina: Correct.

Bill Decker: You mean (as a) section 1.11 claim input file?

Anne Armstrong: Correct.

Male: Yes.

Anne Armstrong: OK. And then one quick question. I gathered from the conversation, because – and from prior phone conferences, that we're not the only liability carrier that sometimes assumes (ORM). And I also understand that we could limit our exposure by addressing it upfront and saying, you know, we will pay medical bills up to X amount, and then once we reach the X amount we can submit a termination?

Barbara Wright: We are not giving you legal advice in terms of what you can or cannot do for (ORM). What we're saying is we have anecdotally had reported to us situations where a beneficiary reaches a settlement with the hospital or another entity where the settlement says they're – in other words, their liability insurance settlement or the liability self insurance settlement says

that's what's been agreed to, is to have the hospital continue to pay for a certain period of time, or for a certain dollar amount or for some combination. If that's the settlement, that's the liability settlement.

We're not advising you on how you should structure settlements or what you can and can't agree to in terms of settling your liability amount. We're only advising you with respect to proper reporting.

Anne Armstrong: OK. So would it be proper to terminate (ORMs) if a dollar amount has been reached? Like (no fault) carriers may have the dollar amount or some statutory…

Barbara Wright: Yes. I think the two examples that we've discussed and two other questions on this call, if there was a liability settlement, that's – we, the hospital, will continue to pay your medical expenses of all types or for a specific injury, for whatever's being claimed or released, and, if so, we're going to pay for six months or we're going to pay up to $2,000 or some combination. When that limit is really reached, you would then report the termination of the (ORM).

I think we do need to move on. I think you have had your one follow up question and we need to get to other people that are in the queue.

Anne Armstrong: I have. Thank you.

Operator: Your next question comes from the line of Rick Woods from Hanover Insurance. Your line is now open.

Rick Woods: Hi. Thank you. I'm just following back up on the question raised earlier about an open-ended release for medicals. And the person, I guess, brought a scenario that they would pay for medicals up to $2,000 for maybe 90 days, and you indicated that (ORM) would be equal to yes.

Would (we note) – would you enter a no fault limit in the term dates? And would the term date be the 90-day (inaudible) from your agreement? And would the no fault limit be the amount you agree to?

Bill Zavoina: Was this under a no fault insurance that it was agreed to or was – is this under a liability insurance that this was agreed to?

Rick Woods: Liability.

Bill Zavoina: Well then, it's not going to be reported as no fault but it will be reported as a liability.

Barbara Wright: And those (fields) for the no fault policy limits would not apply.

Rick Woods: So you would leave those blank, and the term date would be blank as well?

Barbara Wright: If you were – if you were terminating it based on a date, because you said 90 days, then you're going to need the term date. If you're terminating it based on a dollar limit and you reached that dollar limit before the 90 days are up, then you'd put the dollar limit in and…

Pat Ambrose: No. No dollar limit. It's liability. That dollar limit's for no fault only.

Barbara Wright: You would send an update with the actual (ORM) termination date for when your ongoing responsibility for medicals end.

Rick Woods: And so since it's reported as liability, you don't need a limit? You just need a term date with (ORM) (inaudible).

Pat Ambrose: Yes.

Barbara Wright: Correct.

Rick Woods: OK. Thank you.

Operator: And there are no further questions at this time.

Barbara Wright: OK. Thank you.

Bill Decker: All right. We thank you, Operator, and we thank everybody who is on this call. We hope that we adequately addressed your questions, and if there are no further questions from the group here…

Pat Ambrose: (Inaudible) Operator (to come back).

Bill Decker: Operator, we would like you to come back on the call before you go away permanently and tell us – give us some statistical information.

Otherwise, we thank everyone who called in today and we will be back with you again on an (NGHP) call on May the 4th. Thank you very much and goodbye, and good afternoon.

END