TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: October 19, 2011

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: John Albert
October 19, 2011
1:00 p.m. ET

Operator: Good afternoon my name is (Denise) and I'll be your conference operator today. At this time I would like to welcome everyone to the Section 111 Non-Group Health Plan Policy 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 press the pound key. Thank you, Mr. John Albert, you may begin your conference.

John Albert: Thank you operator, for the record I would say it is Wednesday, October 19th, 2011 and this telephone conference is specifically targeted to our policy questions related to the implementation of the Section 111, Mandatory Insurer Reporting requirements. We have a couple of presenters before we go into our Q&A session.

First up will be Group Health Incorporated, which is the COB Contractor, they do have some technical information to provide as we are getting ready to go live with the January reporting requirements. They have a few things to present. I will repeat that technical information on the next technical NGHP call, but we thought it was something that we should put out there today. Also Ms. Barbara Wright is going to provide some information regarding some of the recent alerts that came out.

I also have to mention the disclaimer that there are times where we may just say things that are in conflict with the written material of the section 111 website, the mandatoryinsrep website, if we do until it is published on the website that is the official CMS guidance as of today. We apologize if we you know, mention things that are maybe conflicting with some of the material that's out there right now.

The next technical call for NGHP is November 16th, 2011. We realized that the number that we had out there, we did some postings, we inadvertently removed today's teleconference telephone number, but again the number is the same for today's calls only for the 16th as well as future one on December 14th. There was an alert posted dated October 14th, that has the information about the upcoming NGHP calls to the end of the year.

I am going to allow the COBC folks, Jim Brady and Bill Ford to go ahead with their presentation followed by Barbara and then I also have a brief announcement as well as some information that people were looking for. So, with that I will turn it over to Jim and Bill.

Bill Ford: Good afternoon everyone this is Bill Ford from the COBC. I wanted to start off this Town Hall by alerting you to the in-reference response files. I know we have received a lot of calls on this. Many of you probably received multiple TIN reference response files, annual multiple claim response files. With new TIN response file validation, we did experience some issues regarding the onerously generated TN-01 and TN990s errors. As a result there were a number of RREs that received incorrect data in their response files.

For the historical perspective on Monday, October 3rd, we had released all of the TIN and claim files that had been on hold since September 22nd. After releasing them on the 3rd on Wednesday the 5th we discovered that we had flagged some valid records with TN-01 invalid TIN errors.

Subsequent review of the code found an issue in the logic of the program. That code was corrected and elevated to production on Thursday, October 6th. At this time, we also reset all the TIN files to reprocess. We subsequently discovered that the only TIN files that we reprocessed on 10/6 were the ones that were in a complete status. Any TIN files that were still in process were not reprocessed and therefore they weren't subject to the elevation of the code corrections. To ensure that all the TIN files had gone through the corrected logic we ended up reprocessing all TIN files on Sunday, October 16th. We also reprocessed the claim files from that same time period.

After that we performed a final manual review of the files that had triggered 20 percent error threshold to be absolutely certain that all edits triggered were appropriate and those files were subsequently released for processing. So as of Friday, 10/14 all known coding issues had been corrected and elevated to production. All files were released from threshold on Tuesday, October 18th.

Again, you probably received multiple TIN response files and multiple claim response files if you had, the last one you received is the correct one. And again, if you have any specific questions about the files you receive either call your EDI rep or you can call me and that will be all in response file. Then going forward, we believe we have corrected every issue and everything should be OK. We are also receiving a lot of questions and I'll go through with that, cancel the questions that seem to be; you receive more than once.

One has to deal with the annual e-mail of the new profile report. Section 8.2 and 20 were updated to state that starting as January 2012, the RRE profile report will be e-mailed to the authorized representatives annually. Based upon the receipt date of the last signed profile report, the RRE will be asked to confirm via e-mail that the current information is correct and failure to confirm this information can result in deactivation of your RRE ID.

Questions were received and this is a four part questions of who from CMS will be sending the e-mail notification? Will this be the e-mail address that the RRE authorized rep responds to, to confirm the changes to the profile report. The information needs to the changed that the authorized rep complete a new profile report and e-mail it back to CMS.

E-mail will be sent from COBVA and you can reply to the same e-mail address, but you can also respond directly to your EDI representative. If information needs to the changed, the authorized rep should contact their EDI rep. How long does the RRE authorize rep have to respond to this CMS e-mail before the RRE ID is deactivated? CMS include a notification to the account manager and Account Designee may advance with the deactivation.

If deactivated what is the process to reactivate? The system's response is, the system will generate a non-receipt e-mail if the signed profile report is not

returned to the COBC within 30 days. The account managers will be included in the e-mail notification, but not the account designee. If your account is deactivated and you need to reactivate you will need to call your EDI representative.

The question on the annual report is, will CMS monitor the e-mail notification to the RRE authorized rep in the event it has bounced back as invalid or rejected due to filtering? The COBC will monitor the e-mail notification, usually it is the COBC that will be generating mails.

Another couple of questions regarding the TIN reference response files and the question was, will they get to receive two separate response files, one for the TIN response file and one for the claim response file. And yes you will receive two separate response files.

Another question had to do with recovery and the question is, we have been receiving an increased amount of request for payments from various Medicare Advantage Plan, the requests are often thousands of beneficiaries that they do not provide the date of incident or a claim number. The response is, we do share the data that is provided in your claim input file with the MSPRC. However, the MSPRC does not do recovery for Medicare Advantage Plan and the COBC does not have a data exchange of this type with Medicare Advantage Plan. All I can suggest is you work with those Medicare Advantage Plans to …

John Albert: Those are the issues you got into?

Bill Ford: Right. This is a question, I am not really exactly sure how to pick question, but it says please confirm that if an entity signs the data use agreement or section 111, if that entity is authorized to utilize the information obtained from the query process, the claimant is Medicare beneficiary, will their purpose of determining conditional payments owe to CMS and determining if the case may fall within the CMS review threshold or submitting a worker's comp Medicare, set-aside the CMS for review and approval? The simple answer to that is just if you use the query process, you identify a Medicare beneficiary and there is a conditional payment owed to CMS within that.

Barbara Wright: The simple answer, this is Barbara Wright is that what is described in that incoming is an act of representation and you cannot be recognized as a representative simply because you send a query.

Bill Ford: This question has come up on several calls recently. In the past CMS has stated that they want a good clean data reported via section 111 as this is necessary for proper coordination of benefit, will CMS please provide their opinion on whether CMS wants an RRE to report a claim via section 111 if they do not have all the required data elements. The claim will not be accepted by CMS and will be returned with an error. CMS want RREs to submit claims data that they know will not be accepted.

Incomplete claim records should not be reported. Submitting an incomplete claim record will not be obliged because the claim never was accepted. So, Yes you really need to send in complete claim records in order to receive an 01 disposition code. We did also receive a couple of questions regarding beneficiary look-up and query files and a couple of people had mentioned that if they have a valid (inaudible) they have a valid -- the backing criteria, the four key fields, they are saying they are matching on three of the fields and still getting the non-match, that's usually doesn't happen.

And I did it myself this morning, I performed beneficiary look-up on deceased beneficiary using the SSN the initial, last name, correct gender and I put an incorrect data for it and I got as a beneficiary match. I think what might be happening is that certain people are querying me they are using the zero gender code. To use a zero gender code will default that to a one. So if you have a zero gender code and you have a e-mail and a wrong date of birth you actually miss on two fields, so I think that's the big part of the issue that people are having with the beneficiary look-up for the query function. And with that we will turn the meeting back over to John Albert.

John Albert: Thanks guys, one thing before Barbara is going to talk about some of the alerts that went up, we just wanted to give a heads up on this particular issue, for one of the things that people have been asking for is the way to reports of GPA, address for purposes of mailing, recoveries too and we do have a tentative improvements to the process for April, our April release that would

allow those that want you to provide a separate demand address for NGHP reporting's similar to what we do for GHP right now.

We found it is still tentative, we are trying to workout the final details and schedule the release, but we wanted to give you all a heads up as early as possible so that you can start planning for it. We are trying to give at least six months advance notice of any kind of change to the process, but we are going to most likely be including, a separate set of fields to allow you to provide a GPA mailing address to CMS and that can be forwarded on to folks to just deal with the issue of who gets the demand versus who doesn't fill these stuff so we will provide more information and upcoming alert that should be out fairly soon, but I just wanted to give everyone on this call a heads up to be looking for that. I think it will make some folks pretty happy that we are able to you know, figure on the ways to do that without having to turn the process upside down so.

Barbara Wright: We are going to go on mute for just a second. On the deceased beneficiary issue and not receiving back a query reply that indicates their beneficiary. If you have examples of that please send them to your EDI rep. This issue was raised in another context as well, so we are trying to gather examples and see among other things whether the lack of the response has something to do with how long ago they were deceased as opposed to whether they were recently deceased. So, we are still looking into that. John.

John Albert: OK, that's all that I have so, I'll just turn right back to you.

Barbara Wright: Thank you John, the first thing I wanted to mention is all the alerts that were posted approximately September 30th, first of all on the what's new page there is one dated September 30th, 2001, that's Medicare secondary payer program important updates, part of that is not relevant to Section 111, but we had the documents that gave all of that information and in the interest of getting the information up as soon as possible the entire document was posted on the web's new page.

It mentions an alert or a delay in the implementation of certain liability, settlement, judgments, awards, or other payments and the reporting. There is

policy guide related to December 5th, 1980. The issues there in terms of whether or not we have a recovery claim. There is an alert related to qualified settlement funds under 468B of internal revenue code and then there is a policy memo regarding physician's certification for liability insurance and future medical issues.

The first three, the delay, the 12/5/80 policy issue and the qualified settlement fund documents are all posted on the mandatory insurer website. The physician's certification is posted on the COBC's website. With respect to the 12/5/80 alert, please know that there is one error on that and we are in the process of posting a revised copy of that issuance.

The sole difference is on the second page of the alert, it's the column where it says, application of 12/5/80 policy, the word on is used in that column, in other words the phrase will be like exposure ended on 12/5/80 or exposure did not end on 12/5/80 that is not the correct standard, it is being corrected so that that column will have exposure ended before 12/5/80 or it did not end before 12/5/80. So, so you should be aware that that document should be closed hopefully within the next few days.

Another issue that's come up several times in the question is the use of old alerts. We get questions that may say I can't find the risk management alert or I can't find the clinical trial alert, where is it? Every time we do a revised version of the user guide with rare exception of the existing alerts they are incorporated in that user guide and at the beginning of that version of the user guide it has a list of what all the changes are. So, if there is an old alert that you are not finding, it should be in the current version of the user guide. The other thing is in questions coming into the 111 mailbox.

We are seeing more questions that are just entirely out of scope for section 111. Everything from general recovery questions to a question from a beneficiary with the case about with the question about their specific recovery claim. Those should not be coming in to this mailbox and those type of questions will not be addressed on this call. John, that's actually all I wanted to announce right now. If we want to go ahead with the questions, if you don't have anything else.

John Albert: No I don't, I will just reiterate again that please help us help you, do not clog up the mailbox with non-section related questions because all it does is slow down us getting the information out to those who need it related to section 111 reporting requirements and we don't respond to them.

So anyway with that operator we can turn it over for Q&A. We ask that folks on the call limit themselves to one primary question and one follow up so we can give other people a chance to microphone, we have fairly large attendance today so we would appreciate if you could help turn it round. So, operator.

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

Your first question comes from (John Nino) from (Golden Lamb). Your line is open.

(John Nino): Yes, hi, this is (John Nino) with (Golden Lamb). I had a question regarding the policy. Claims that were submitted voluntarily last year that may have had ORM dates or ORM term dates that occurred prior to January 1st, 2010. How should those be dealt with if they voluntarily reported and accepted at this point? Do we need to populate or delete those transactions? What needs to be done with those voluntarily reported claims?

Bill Ford: If the information was correct, you should simply leave the information alone. The rules for MSP haven't changed. We tried to be as flexible as possible in terms of starting up the mandatory reporting, but if the information is correct, we actually needed for claims processing or other reasons regardless of whether or not it's prior to the implementation date.

Jim Brady: I mean, if the date is valid, I mean, whether its Section 111 or not I mean, there are requirements to coordinate benefits outside of Section 111 that are separate in the reporting requirements so considering that particular, you know, incident being reported to CMS correctly, so.

(John Nino): I mean, would there -- quite frankly, I mean, if say for instance that, you know, by virtue of the specification it's out of range in terms of the ORM rather than sending a delete would it be acceptable to say send an ORM termination date that occurred prior to January 1st, 2010.

Barbara Wright: If it actually -- if it really terminated, then yes, terminated, but not -- you cannot, if it was legally open and prior to the required reporting date you would have for whatever reason normally closed your record administratively. Once you have reported it, leave it alone because it is correctly, legally open for our purposes and to put a term date on it we actually be saying something that's false.

(John Nino): Right. And this would be a circumstance where the ORM had actually terminated prior to the January 1 of 2010. So ...

Barbara Wright: If it had actually legally terminated, then you arguably should open record as well as the term date at the same time, but you can't do a record update and take care of it.

(John Nino): OK. Now, say for instance that a claim was accurately reported to you the first time with an ORM of yes and an ORM term date that, you know, ended prior to January 1st, 2010, you would not recommend deleting that record because it was in fact legally received and is correct if it was accepted?

Barbara Wright: Yes.

Bill Ford: Yes.

(John Nino): OK, fine, that's all I need. Thanks so much.

Operator: Your next question from the line of (Wendy Radar) from State Compensation. Your line is open.

(Wendy Radar): Hello, my first -- my question is in the June 29th teleconference you said that WCIO nature of injury occurred should not be used to drive ICD 9 code, but I just want to clarify whether or not the WCIO body part code can be translated into ICD 9 diagnostic codes for fields 19 through 55?

John Albert: Jim or Bill, do you have an answer on that or is that something you would have to look at?

Bill Ford: Yes, I mean, from a technical perspective I don't know if there is a one to one correlation. There's no reason you couldn't use those as part of the data that we used to arrive at ICD 9, but we don't provide a crosswalk between the body part codes and the ICD 9.

(Wendy Radar): Well, my question is whether or not a simple crosswalk that we made ourselves is adequate for deriving the ICD 9 diagnostic code?

Bill Ford: As long as it gives you confidence because you are reporting a valid ICD 9 that reflects the injury to the beneficiary, yes.

(Wendy Radar): OK.

Jim Brady: We don't know that I mean, but we are just saying that if you are confident that that crosswalk that you developed, satisfy the reporting requirements, then so be it, but we can't really comment on --

Bill Ford: And we don't need the better.

Jim Brady: Yes, we don't need to better, so.

(Wendy Radar): OK. And I have a follow-up question, on one of the new events in user guide 3.2 on page 98, it's that ORM ends on one entry that continues on another. Now, I'm interpreting the two injuries to be actually different body parts that resulted from the same injuries event or set of conditions and so let's say we stipulate to future med being on some body parts that we settle by compromise and release posing out future med on other body parts.

Now, previously you had said when we reported TPOC, we should report all alleged body parts, but now is it correct to understand this to mean that that these would be mutually exclusive then. We would report because we can report on two separate lines now. We would report the ones where we are keeping future med with the ORM still open and would not include those in our TPOC report for the same injury?

John Albert: Jim?

Jim Brady: Well, from a technical perspective I don't have an answer to that one. I guess, are you asking if you have an ORM basically?

(Wendy Radar): Well, no. See, we have understand that even when we keep future medical open if we have a court order saying that with either a stipulation or a findings and award you are calling that a TPOC even though it doesn't cancel our med. I mean, simply that you have been contradictory on that point, but assuming that they are both TPOC, they are both finalization but one is keeping future med open on certain body parts.

The other is terminating future med with the -- and that would be the compromise and relief which is clearly a TPOC, but previously you said, report all body parts claimed or alleged with the compromise and relief TPOC or any TPOC. But now I just want to know are these now mutually exclusive for body parts or do we repeat the some body parts with the TPOC that were not closing out future med?

Bill Ford: So, you're saying you're submitting these as two separate records?

(Wendy Radar): Yes, because you now allow that, right, with the new event.

Bill Ford: So, if they are in fact two separate records, then each of them would have to be able to stand on its own and have all diagnostics that go along with that record.

(Wendy Radar): Well, that really doesn't help because I mean, these are one injury and we are splitting them up into, you know, half of them get future med and half of them don't.

Barbara Wright: Jim, this is Barbara Wright. Let me try and you can tell me whether this fits with all. I think what my answer would be and I'm not the technical person is that for the ORM we need to have reported anything that's still open but for the TPOC you need to report both what's open and what was alleged that's closed. In other words, the TPOC needs to include everything and ...

(Wendy Radar): OK. That's the answer to my question.

Barbara Wright: And the question then for you Jim, would be whether reporting these on two separate records goes through the system OK and I guess for the person that called in did I reflect it accurately or not?

(Wendy Radar): Yes, that's what I wanted to know.

Jim Brady: So I mean, in terms of -- from a CV perspective we will able to hold those records separately. They shouldn't cause any problems on the back end. We can definitely handle it from the front end.

Barbara Wright: OK.

Bill Ford: Yes, so I mean, they would post on our system as separate record, so.

Jim Brady: Yes, and that's not a problem. It's a dire situation.

Bill Ford: Right.

(Wendy Radar): OK, thank you.

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

(Bonnie Mustard): Thank you. My question is for the query. When we get a Medicare beneficiary and I think it was discussed at one point that some of these might be because the query is not specific to when their coverage begins or when it ends and so we are wondering if there's a letter that the Medicare beneficiary gets showing the date that their Medicare beneficiary coverage begins or if it ends, the date it ends?

Bill Ford: Their Medicare cards has the effective dates on it.

Jim Brady: Well, Part A, Part B effective dates, but I guess, the query do give them -- well, it seems like an odd situation that I mean, if you have any examples, I'd be happy to look at them but Yes the Medicare ID card tells them their Medicare effective date.

(Bonnie Mustard): Yes, I think we've had a few cases where the, Yes, the person said, no, I wasn't a Medicare beneficiary on the date of the accident.

Barbara Wright: You don't have beneficiary on the date of the accident. If you're going to get a query responses they were beneficiary at any time and there are often situations where someone's not a beneficiary on the date of the accident but they certainly are by the time their claim settles.

(Bonnie Mustard): I think we had an example where the query said yes and then the file back from you said, no. I'll have to see if I can pull those in.

Bill Ford: Well, that can happen I mean, I said, you know ...

Jim Brady: Like there are situations where that is the right answer, but if you want to take the example and give Bill a call you can actually walk it backwards and talk you through what he says.

(Bonnie Mustard): OK, thank you.

Operator: Your next question comes from the line of (James Bulger) with Johns Eastern Co. Inc. Your line is open.

(James Bulger): Hello and good afternoon.

Bill Ford: Good afternoon.

(James Bulger): I have a question about a self -- it's a liability matter. If a self insured liability RRE pays medical bills on behalf of the claimant, they do not have anything in writing as far as paying those bills releasing anything and there is no fall through MedPay policy, can they terminate the ORM liability upon payment of those medical bills?

Bill Ford: Are they legally terminating their responsibility? We are not ...

(James Bulger): They don't require -- they do not ask for any type of release in writing. It's strictly goodwill based.

Bill Ford: If the obligation has ceased, then you can terminate the record. We can't define for you exactly how that's going to happen in a self insurance situation particularly where you have nothing in writing.

(James Bulger): OK. So then the second question would be if they do pay the amount of $5,000 on a goodwill basis, are they then opening themselves up to possible claims from CMS if there are future medicals?

Barbara Wright: You're saying if you are paying the bills to different ones, it sounds like what you should be reporting is ORM so whenever you terminate it to the extent that we have an open record shown at any time it's possible that we could deny a claim until we had proof that the insurer wasn't going to pay it so might you get a claim, yes. Do we control whether or not you have the obligation, no.

(James Bulger): OK. That's all I have. Thank you very much.

Barbara Wright: You know, it could simply be a matter of timing in many cases.

(James Bulger): OK. I appreciate it.

Operator: Your next question from the line of (Larry Sundin) with (SAI). Your line's open.

Stacy Lamprecht: Hi, good afternoon. My name is Stacy Lamprecht and I'm with F. A. Richard & Associates. We've been getting some calls from people and they're claimant and they are saying that they went in for medical treatment unrelated to the claim that we are currently handling for them and the claimant is being told that they cannot receive treatment because a "file needs to be closed" and they are then pointed to the MSCRP to find out what that claim is and when they contact them they are just being told the claim just needs to be closed. So, that's causing a lot of confusion on our end because we don't know if they are referring to the claim that we submitted or is it a claim prior to the claim that we submitted?

Barbara Wright: Do you happen to know whether these are cases where you opened an ORM record or submitted an ORM record or they just ran once or you may have a claim pending?

Stacy Lamprecht: I believe that they are ORM.

Barbara Wright: OK.

Stacy Lamprecht: Is that what I should look into first?

Barbara Wright: Well, I mean, it would help us know how the record got posted because remember if they are telling you that type of complaint when all you have is a case pending and you haven't submitted an ORM record, then you couldn't possibly have caused anything to be posted unless you did a separate self report direct to the COBC. But it's not a matter of just -- if they are having a provider, a physician or other supplier tell them they can't get treatment because of an open record, that is not a Medicare physician and the physician should not be saying that.

They have the ability to bill any time there's an open record. They have the ability to bill conditionally. If it's workers compensation or no fault, they should always have proof that the insurance is not going to pay but that's the reason we ask you to submit the diagnoses codes. The claims processing contractor should be using those codes to determine whether or not to deny a claim. They should not be denying all claims and providers, physicians and other suppliers should be aware of that fact, you know, the rules and the procedures tell them that they can bill conditionally.

Bill Ford: One of the thing that Barbara just touched on is the obligation on the part of the RRE to make sure that you do give us a specific valid matching diagnosis to the condition. Sometimes what happens is that people use very big generic diagnosis codes that then resulted in claim denials but not related to the claim.

Stacy Lamprecht: OK. Who could I refer a couple of these claims to because I think we have done things correctly on our end, the diagnoses codes were sent in on ...

Jim Brady: So, if you want to give Bill Ford a call, number is in the user guide and after one weeks samples, we can check them out and let you know what we think.

Stacy Lamprecht: That's perfect. Thank you very much.

Barbara Wright: We did receive from another source another one of the questions came in said that the MSP, they called the MSPRC about how they should electronically close a file and will let that the ORM field had to be checked no in order for CMS to recognize that no fall was no longer responsible and it's my understanding, I need John and everybody to correct that once you report ORM even when it terminates, you do not change that to check no.

That remains yes and you have the term date and so we just want to make sure everybody's aware of that. And the MSPRC should not be giving you directions on how to do Section 111 reporting. We would ask that if there are any other incidences where that happens, that you would report that I rep.

Bill Ford: I guess another thing to add is that in terms of somebody's billing issue a lot of times the best course of action is to go back to Medicare claims processing contractor who made the decision to accept or deny a claim, you know. Also if there a claims payment issue those really need to go to (inaudible) Medicare who then usually work with the claims processing contractor to resolve the issue. CMBC, MSPRC are not claims processing contractors.

We recognize that issue exists for whatever reason and I expect the best that we can say at least from the Section 111 report is as Jim mentioned please provide as much detail as possible through the ICD-9 codes so at least we have a complete and accurate picture of what should be denied and what should not be denied because that is also a problem because it becomes, you know, an issue where (inaudible) across the board if the code is very vague, so that's the way to (compensate).

But other than that we do recognize and continue to be, you know, issues here and there with inappropriate claims denials by our Medicare claims processing contractors and that is how beneficiary is instructed to contact (inaudible) Medicare who are then supposed to work with, if it is a claims processing

issue with the service contractors. We are in the process of being to script something like that to address some of the confusion that's out there.

Barbara Wright: Next question.

Operator: Your next question comes from Jessica (inaudible). Your line is open.

Female: Hi, thank you. I'm calling about exposure issues related to the December 5th, 1980 date. My question is can a reporting entity rely on the representation of an opposing party as to the dates of exposure?

Barbara Wright: You need to satisfy yourself that the guidance and the alert is met I mean, in terms of evaluating your claim writing we offer in that alert or in that policy memo the basic rule is that whatever claims are released or effectively released we potentially have a recovery claim.

What we did is carve out an exception because under MSP, we do not have to establish causation, we need to show that there is a demonstration of primary payment responsibility which is done through a settlement judgment or other payment combined with what's claimed or released or effectively released. What the policy memo does is carve out an exception where the exposure or ingestion or implant was removed before 12/5/80, and no one has specifically claimed the release that exposure and the only thing that raises the issue of a potential claim is a broad channel release. In that case we said that we are not going to pursue a recovery claim.

If you look at it from that angle that you are looking at a situation where no one claimed or released that and you have no evidence of it. We are giving an exception when there's a broad general release. Otherwise, you know, if they claimed it, it's not a matter of we are going to debate the evidence and revaluate it if they specifically claimed that we have a recovery, right. So, we are not going to give you a guarantee either way. This is the policy you and whoever is the claimant need to work it out what you are going to do.

Female: OK. As a follow up, what about a scenario where multiple defendants are in a suit and the reporting defendant and the plaintiff agree that there was no

exposure after 1980, but one of the other defendants tries to establish that the reporting defendant was exposed after 1980?

Barbara Wright: I'm not sure why a defendant would want to add to the length of his or her risk exposure.

Female: No, I'm sorry. I mean, when there are multiple defendants and the non-reporting defendant tries to establish that. The reporting defendant products were -- that the plaintiff was exposed to the reporting defendant's products after 1980.

Barbara Wright: I'm having a hard time wrapping my head around exactly what you said. If you want to send in an example to the mailbox with specific facts, we'll look at it further but it's basically going to be an issue between the defendant for a particular settlement judgment award and the plaintiff for that.

Female: If there's multiple defendants, you won't look to the claims of the other defendants?

Barbara Wright: I don't know what you mean by look to the claims of the other defendants. Presumably, they are defending not making a claim. I mean, what I personally hear you saying is as part of their defense they appear to want to shift the blame and save the exposure that fault was really the exposure through another one of the defendants but no, we don't go out and evaluate every single case and effectively re-litigate or renegotiate it.

We have the right concerning a particular settlement, judgment or reward. We look at what's claimed or released are effectively released and we have carved out this one exception where the only basis a reason for us looking to demonstration of primary payment responsibility was a broad general release. We have said in that situation we won't pursue a recovery plan.

Female: OK, thank you.

Operator: Your next question comes from the line of (Keith Damon) with PCI. Your line is open.

(Keith Damon): Thanks. This is kind of a follow up to the previous question. I think part of the confusion in there appears to be quite a bit among the membership let's say somebody has an exposure from 1940 to 1980 and a particular carrier wrote a policy or that an insurer ended January 1, 1980 or at 1979. Carriers are thinking my liability involves a period where I was on the risk.

Barbara Wright: Remember that MSP is not based on whether or not there has been legal liability determine.

(Keith Damon): No, but the confusion is, is who reports what when you have a series of defendants that are on the risk at different points in time. I was going to suggest Barbara that you might want to have a separate call at some time for the mass part folks to answer any questions rather than them taking up a lot of time on the general calls.

Barbara Wright: I guess what I would say is if people have specific questions on that memo, please head it, please put in the subject line 12580 memo and submit in the mailbox so we can gather those, but I guess what I would reiterate with respect to what you said is let's say a policy ended in 1979, but nonetheless that party was sued and part of the beneficiary's complaint was I continued to be exposed at this location through such and such.

If that insurer settles with them, we have a recovery claim against that settlement. It's not based on when their legal liability ended for the particular exposure that's claimed our recovery claim is again looking to what was claimed or released with the exception we mentioned before.

(Keith Damon): Very well, I'm sure you'll get questions. Can I switch gears and ask another question?

Barbara Wright: Yes.

(Keith Damon): Also service software you are using check on addresses?

Bill Ford: Yes.

(Keith Damon): There are some questions of whether people are getting errors when people are looking, when you are looking for precision that they don't necessarily have. Let's say you have a law firm and you have their street address but it's in a 30 storey building and you don't know what their suite number is, you know. You have enough to contact them and deal with them by mail but it sounds like your edit will pick that up and say wait a minute we don't have enough information; is that correct or incorrect?

Bill Ford: It actually depends specifically on how that zip code or really the zip+4 is constructed. If that building is segmented in such a way that the post office doesn't deliver individually, you know, they just drop off in some central area that requires specifics then we would not be able to find a +4 of that address so there are circumstances where that's a problem, but that's not the case in every building certainly, but …

(Keith Damon): And if you have some confusion because folks aren't used to having to try and use …

Jim Brady: Have the data at that level, agreed. I mean, if you got or if your folks have specific examples, we can probably help them out either by looking to see what we may have in the system or looking to see what triggered that edit. It might help them resolve.

John Albert Hey, Jim, this is John, in terms of a postal software, I mean, I guess, I mean the process that we are using to validate his address this is not maybe as rigorous, I guess what I'm saying that we're, you know, we're just looking to see is in fact the address exist, right. I mean …

Bill Ford: We are looking to see that it's deliverable and there are certain addresses where the post office doesn't consider it to be deliverable without a little more information to make it a plus 4.

(Keith Damon): OK.

Jim Brady: It does affect certain very big buildings, it does affect cases where the building is split into sub entities. Like I said, Keith, if you have got specifics you want to give me or Bill a call, we could probably decipher them and once I guess,

the good news is once you're a constituent resolve that address, then that one's off the board forever, so.

(Keith Damon): OK, thank you.

Operator: Your next question comes from the line of (Marsha) (inaudible). Your line is open.

(Marsha): Hello, I have a quick question about reporting liability claims. If we have a claim that settles for $150,000 and we have a Medicare beneficiary and a wife that is I mean, a loss of consortium, do we report that and say for example it's a $90,000 settlement and a $60,000 loss of consortium do we report -- we do report. I'm asking (inaudible). We do report the entire $150,000 settlement against the Medicare beneficiary's claim.

Bill Ford: Yes, if it's a joint settlement.

(Marsha): OK. There is some confusion. A few folks thought we had to set the claim for the wife, but we would report the entire settlement inclusive of the life claim under the Medicare beneficiary's claim.

Bill Ford: Right and if they are both beneficiaries, actually report the full amount for both of them and -- as we said in a number of calls there are some issues that are going to have to be resolved in the backend when we actually pursue a recovery claim.

(Marsha): OK. So, what you are saying is if they are both Medicare beneficiary, even if she has no bodily injury claim, we would report that under her name as well, even though you getting the report under the Medicare beneficiary entire settlement being reported as a Medicare beneficiary that has the actual bodily injury.

Bill Ford: Assuming based on how this is played out in prior calls that the wife is releasing medicals, yes. If the consortium is for the wife and she has released medicals and again if medicals are claimed or released or effectively released.

(Marsha): Wait a minute. Medicals for whom, her husband or herself?

Bill Ford: Herself. If it's only releasing medicals for him, then only his have to be reported.

(Marsha): Truly speaking, OK. Then on speaking loss of consortium as it stand out. If she does not have a bodily injury claim as she is not releasing any medicals. We would just report under the Medicare beneficiary claimant who have the medical.

Bill Ford: Right. Assuming she didn't claim or release.

(Marsha): Right, OK, I understand. Thank you.

Operator: Your next question comes from the line of Susan Jones with Pendulum, your line is open.

Susan Jones: I have a question about two of the fields that we report for each claim record. The first field is that alleged cause of injury or illness. We are realizing that it wouldn't be unusual for a claimant to include multiple allegations of injury like for instance ...

John Albert: You are fading out. Is there any way you can increase the volume on your side, we are having a hard time hearing you.

Susan Jones: I'm sorry. Can you hear me better now?

John Albert: Yes, you are just fading out.

Susan Jones: I'm sorry. So, we are finding with the alleged cause of injury field that we could have multiple codes that we would want to list there. There would be multiple allegations and so we are having a hard time determining what's the best code to use in that field. Do you have any suggestions?

Jim Brady: Really, I think you need to make a distinction on which is the root cause, which is the (inaudible) to all the others. If it's the accident or if it's the whatever started all of the others and you can include that one in the cause code.

Susan Jones: OK, OK.

Jim Brady: Did that help?

Barbara Wright: Jim, can they put extra e-codes in the x-codes or not?

Jim Brady: The other code, the x-codes yes, but not with the Es. The other E, the other fields besides from the first one for E codes, there is only one clause. I saw the actual diagnosis codes are more important so those are the ones that I could ...

Susan Jones: OK, OK. Well, I appreciate that answer. And then my second question is on the claimant 1 relationship field. Can you clarify for me the difference between estate individual and family individual if we have -- it's just that, you know, it's just a son and he is representing the deceased individually and on behalf of the estate, is that family I mean, is that estate individual?

Jim Brady: Well, it would seem like that would be the appropriate code.

Susan Jones: That's what it sounds like to me and then family is when you would have in the complaint when you have like maybe multiple siblings on behalf of the estate, right, and that's when you would say family?

Jim Brady: I would say that does sound appropriate.

Susan Jones: OK. Thanks.

Operator: Your next question comes from the line of (Anne Chandler) with (inaudible). Your line is open.

(Anne Chandler): Hi, this question is in reference to the recently released alert regarding the qualified settlement fund. Is this is alert partially purposed to provide a reporting exception for qualifying bankruptcy trust that were wholly funded prior to the October 1st, deadline?

Barbara Wright: Could you repeat the question?

(Anne Chandler): OK, I'm sorry. That was really a long question. This is about the qualified settlement funds alert and what I'm wondering is, is the practical effect of this

alert to give a reporting exception to bankruptcy trust like I'll give an example, the Johns-Manville Asbestos Trust that would have been wholly funded prior to October 1st, 2011. Does it essentially give the reporting exception to those trusts?

Barbara Wright: And does that trust qualify as a 468B?

(Anne Chandler): Let's assume that it did.

Barbara Wright: What?

(Anne Chandler): Assuming that it did, would that be the ...

Barbara Wright: If it qualifies, then yes, it would have an exception for reporting where the funds in issue were paid into the trust prior to that date.

(Anne Chandler): OK and what was that just general policy and reasoning behind the alert regarding the qualified settlement funds as a whole?

Barbara Wright: We had received a number of questions about reporting specifically with respect to qualified settlement funds. So, we went back and look at the issue and this is what we determine would be the agency's policy.

(Anne Chandler): OK, thank you very much.

Operator: Your next question comes from the line of Huston James from State Department. Your line is open.

Huston James: Hi, we would like clarification on page 61 of the user guide which says if you have a TPOC settlement, judgment, award or other payment which includes payment to provider, physician or other supplier on behalf of the beneficiary, you should report such payment as part of the total TPOC amount. Also the total TPOC amount is reported after settlement, judgment or award or other payment , not individual installment payments for that TPOC.

What our question is that Montano law requires an automobile liability insurer to pay injured third party's medical expenses in advance of the settlement and liability for the accident is reasonably clear and it is reasonably clear that the

medical expense is casually related to the accident. For Section 111 reporting does CMS consider these payments in advance of the settlement of the liability claim to be TPOC, ORM or either?

Barbara Wright: From what you said they sound like ORM. You have responsibility to pay them on an ongoing basis. If that's what I hear you're saying right now and that would fit the definition for ORM.

Huston James: The payment is in advance of a liability settlement. Would that make a difference?

Barbara Wright: No, you would have an ORM and then you would ultimately have a TPOC awarded as well.

Huston James: OK, thank you.

Operator: Your next question comes from the line of (Walter) (inaudible) with Countrywide Insurance. Your line is open.

(Walter): Hi, just another question on the use of the ICD-9 codes. As at the time of reporting, we don't know the exact diagnosis. Can we report a more general code and then update it later once we find out (inaudible)?

Barbara Wright: That question I'm not sure whether you are the same person that sent it in to the mailbox. One of the problems with the question when it came in is when would you know the exact diagnosis if you don't know it by the time you sell. Remember that you are not -- if you have ORM, then your reporting while the claim is potentially still pending for other purposes although ORM maybe the end of it.

But if you have a situation where you're getting a TPOC settlement, judgment or award etcetera, you are not reporting that you maybe doing your query ahead of time, but you are not doing your Section 111 reporting unless there is a settlement, judgment, award or other payment which would include ORM. So, can you explain why you wouldn't know the diagnosis then but you would somehow know it later?

(Walter): Well, we shouldn't be reporting it until the settlement is declared.

Barbara Wright: Right.

(Walter): Right.

Barbara Wright: No reporting for Section 111 purposes takes place until you either have assumed ORM and have to report that or with ...

(Walter): Right, that coverage it would be ORM.

Barbara Wright: OK, and if you are taking responsibility presumably you are taking responsibility for a certain type of bill not every medical condition the person might have if they were in a car wreck I assume you aren't necessarily paying bills for pre-existing cerebral palsy or something.

(Walter): (Inaudible).

Barbara Wright: I'm sorry. We didn't hear that.

(Walter): (Inaudible).

Barbara Wright: OK, but there has to be some description of the illness or something so that you would know which ones you would pay and which ones you didn't. If someone tripped and broke their ankle, you are not going to pay presumably, not going to pay for a pre-existing head injury or something that they might have had from some other source.

Remember that in order to report ORM and report a diagnosis code you don't have to have a bill and have it diagnosed as code on that bill. You have responsibility for developing and determining what the diagnosis code is. So, whatever injury they are claiming if that's what you are paying for, then you need to submit the diagnosis codes for that. Does that help at all or, you know, you're sort of frowning we are not sure what the question is.

(Walter): It's just, you know, I think with the volume of (inaudible) that comes in the -- it's an issue of the time of setting up the claim as through, you know, we

really don't have the diagnosis, you know, we just got the claim reported and, you know, the claimant is claiming multiple injuries and ...

Barbara Wright: We said you need to report as soon as you have assumed responsibility and it seems so to a certain extent until you know what you are assuming responsibility for.

Jim Brady: How is that you would -- when is it you know what you are actually paying for, what injury you are paying for?

(Walter): Really, when the bill comes in and we have the codes on the bill.

Bill Ford: Have you made a payment before that point?

(Walter): No.

Barbara Wright: Well, it's not a matter of them waiting until they make payment as they know and they assume responsibility.

(Walter): (Inaudible) wouldn't know what it was.

Barbara Wright: But again, what we are saying is you don't have to wait for those codes on the bill. If they come in, they file a claim and they said, I fell going down the steps at the neighbor's home and I hurt my leg. If you are assuming responsibility then, put in codes having to do with the leg. You can't update those codes when you get more definite information.

(Walter): OK. All right. That's -- OK as long as we can update them. What you are saying basically is that we are only reporting items that we expect to be responsible for.

Barbara Wright: For ORM we said, yes. Limit your codes to what you are assuming responsibility for, what you expect to pay for. When you are reporting a TPOC, you must give us codes related to everything that was alleged.

(Walter): OK. OK. I think that answers the question.

Barbara Wright: Thank you.

(Walter): Thank you.

Operator: Your next question comes from the line of (Emily Shober) with (inaudible). Your line is open.

(Emily Shober): Hi, can you hear me OK? Can you hear me OK?

Bill Ford: Yes, we can.

(Emily Shober): OK, great. We are doing -- we are a government entity. We are doing our own reporting for government liability claim. My question has to do with when we have a claim that meets the threshold of TPOC or and the first spending, the injured parties of Medicare and Medicaid recipient. And it's above the threshold of the 100,000 or whatever it is at that time. And it's reported on our quarterly report. But, say for ...

Barbara Wright: Considerably below a 100,000 now. If …

(Emily Shober): What -- I'm sorry?

Barbara Wright: I thought it was $100,000 threshold.

(Emily Shober): Doesn't matter if there isn't alert recently that there is a change in threshold?

Barbara Wright: But, there has never been a threshold of 100,000. It's generally 5,000 for TPOC reports.

(Emily Shober): OK. Is there -- well actually that's was not my question, it was that I am confident that wasn't alert a few weeks ago upon your website that changed into I can -- I can email that to you, and there are some changes on our threshold or TPOC Health Insurance.

Jim Brady: You don't have to email it to us, we know that, the dealers know, let's get to the ...

(Emily Shober): OK. OK. Sorry, just hear me up. Lets just take examples of $1 million is paid to the claimant and their attorney. And on the report, we get the

disposition cover, everything is fine, we reported it correctly. My question is basically what then, are we involved in the collection process, as far as collecting the Federal Government share of the payouts?

Barbara Wright: If its liability insurance or general recourses that we routinely pursue recovery against the beneficiary settlement through a demand to the beneficiary.

(Emily Shober): OK. So, we would not be (inaudible) or included in the process in any way?

Barbara Wright: Generally, no.

(Emily Shober): OK, OK. And so, that's basically my question. So I've been trying to ask that question by email for months now. So, thank you so much for giving me answer to that. And then, I guess and now I'm little concerned that I have the threshold on the TPOC amount.

Barbara Wright: Before, you are talking about this -- alert they had to do with delay and implementation of, you know, slightly different that's a phase in issue. And its wholly for liability TPOC its not an across the board issue.

(Emily Shober): OK. We are just doing our own in-house reporting of liability, our workers comps has handled?

Barbara Wright: This is limited to liability TPOC then yes. The phase and thing about reporting that's in the most recent alert is correct.

(Emily Shober): OK, all right. So, we've been also worried about our TPOC quarterly reporting the TPOC amounts settlements, we are not worried about anything about after that point, we are done.

Bill Ford: When you are reporting on, I mean -- there is always a chance that someone to come back for additional information that generally know I mean it was just, you know ...

(Emily Shober): Well -- settlement agreement will be fine. So they won't be coming back with some more money.

Bill Ford: No, no I'm just talking about those issues with the information you reported?

(Emily Shober): OK.

Bill Ford: As you reported accurately you should never hear from us again.

Barbara Wright: In general, you are not going to hear from us again.

(Emily Shober): OK. And another related question is , I talked to some attorneys about possibly changing our release form to say if you are Medicare & Medicaid recipient. And you maybe Libor or something or you may capture importance from Federal Government. Is that -- is there any discussion of that has that been asked, as my question been asked before? You got some of the guidelines?

Barbara Wright: We are not going to dictate the content of your releases. So, what we will say is we've heard various stories about what insurers are allegedly doing now. But, the point is CMS once that has the information will make it determination about a recovery claim and specifically for liability insurance as I said are normal process or most routine processes as to do a demand to the beneficiary with respect to his or her settlement. They are more likely situations for No-Fault or Worker's Compensation where we may issue a demand to the Worker's Compensation entity.

(Emily Shober): So to summarize your answer you don't speak about function really you are -- it's up to each entity as far as release forms?

Barbara Wright: We are not going to tell you what's in your release forms. And we are not bound by anything that's in your release forms in terms of -- if there would be a situation where we needed to speak directly to Worker's Comp or No-Fault or even a rare situation for liability, the fact that you would say you the beneficiary must indemnify that would be between you and the beneficiary. IF we had a reason to speak to you, we would still speak to you.

(Emily Shober): OK. All right, thank you very much.

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

Catherine Dickenson: Hi. Thank you for taking my question. And this is with regard to the qualified AD release. And the term brought generally number of times in there and this is sort of a defense attorney perspective. Can you give some definition of that or what you consider to be a general release versus something a little more specific. I mean just to give you some context before settling Asbestos case usually let's say you are releasing all exposures, you know, in this state onwards. This can't cover ourselves and would you consider that to be too specific?

Barbara Wright: I don't think we have a set definition. We've seen releases that run the gamut, ones that will say I released all medicals for all exposure anytime as opposed to, you know, one such said, I'm releasing exposure on or after 12/5/80. You are going to have assess that on a case-by-case basis depending on those specific facts. And, you know, the memos going to have to speak for itself. I'm sorry that's not ...

Catherine Dickenson: I think what's kind of happening then as well as defense are going report let me say in working a lot prospect and plaintiff and if not -- a lot of guys here are what you mean by broad generally is my personal or guide says to where that weren't approved it's being alike. So, I'm a little concerned as to how its play out, but maybe we just have to think about.

Barbara Wright: OK.

Bill Ford: Thank you.

Operator: You next question comes from the line of Crystal Brotski with PMSI. Your line is open.

Crystal Brotski: Hi, this is Crystal. I just wanted to confirm with the liability TPOC delay alerts, if the same logic was going to be applied with adding multiple liability TPOC together to meet those amount?

Barbara Wright: Jim, can you or Bill address that or just do we need to get back to them on that?

Jim Brady: No need to get back to them on that.

Bill Ford: Crystal, you want me to send that question in an email?

Crystal Brotski: Yes, that's fine.

Bill Ford: That would be great.

Crystal Brotski: And just one more thing on that at the -- towards the end of that alert. It states that after full implementation of reporting requirement that CMS would give the normal notice to propose rule making process for establishing penalties. And can you elaborate on that at all or?

Barbara Wright: And which alert did you say that was in?

Crystal Brotski: The liability TPOC delay alert?

Barbara Wright: OK.

Crystal Brotski: You know, I checked the last -- I became very alert?

Barbara Wright: I guess I wouldn't add any particular credence or importance to the word normal. There is some rule making process for establishing any penalties, there is a process for regulations to be developed and published in the federal register and it normally involves an NPRM before a final rule. A notice of proposed rule making and CMS plans to do formal rule making for further direction all the penalties that was all that sense was really meant to convey.

Crystal Brotski: And there is no date in mind on when all those guidelines would be released and penalty will start being imposed.

Jim Brady: That is all we can say at this time, unfortunately.

Crystal Brotski: All right. Thank you so much.

Jim Brady: They will expand on their own.

Crystal Brotski: Thank you.

Bill Ford: When you send to Bill -- note just if you could give a specific example we can finally (inaudible). Thanks Crystal?

Operator: Your next question comes from the line of (Jerry Harial) with Louisiana Insurance. Your line is open.

(Jerry Harial): Thank you. My question concerns the 12/05/1980 date. If we have a plaintiff who worked for multiple contract or let's say he was a union for bore one maker pipe cutter. And he is clearly working in a place where over the years where he has multiple exposures to asbestos, chemical plants things of that nature. The petition does not allege that he has exposure post 12/05/1980. However, when we kept the social security print out, he continues to work through the same three, four, five different contractors. If we take a general release noting that there is no exposure alleged day after 12/04/1980, is this reportable loss or settlement because we don't know what the exposure are after 12/05/1980.

Barbara Wright: It seemed to me, if you look at the alert one of the three boards is that the exposure in just didn't impact and before 12/05/80 and at least on the facts that you just presented your information if anything look likes the exposure continue. You said you have information that he was exposed to various employers and stuff and he continued to work on that. So, unless you have information that is foxed, why would you assume.

(Jerry Harial): OK. I don't have because I don't know, I know the contractors he worked for, but I don't know who or where he worked subsequent to 12/05/1980.

Barbara Wright: Well, you have a obligation to determine the facts and, you know, that's really all we can say. If you look we were attempting to carve out an exception where the exposure did not in fact continued, and it had been specifically released, we wanted to you know, give some people some certainly that if all that was being based on was a general release then we weren't going to pursue a recovery claim. But, we are not going to sit here and say that we are the evidence you have most likely indicates exposure continued that's somehow we don't have a recovery claim.

(Jerry Harial): Even if they won't release that information then we are to assume when I say they don't release it, plaintiff counsel does not release that information, we are too assume that there was continuing exposure.

Barbara Wright: It's in Plaintiff's counsel's interest to work with you on those because they are the one that don't want us that recovery claims, against their client or against their client settlement.

(Jerry Harial): No, unfortunately plaintiff counsel is not always as cooperative as you think they maybe?

Barbara Wright: Well, I'm just saying in this particular case. If they are going to leave you with information, and that leads you to think there was exposure it isn't. If they don't want a recovery claim by Medicare then it's in their best interest to particularly be speaking to you about this issue and resolving it with you. So, if it was a problem before on this particular issue with this alert. Hopefully, it will the problem will take on different tone or different center, because it's clearly in their interest to, you know, work with you on this particular issue.

(Jerry Harial): Thank you.

Operator: Your next question comes from the line of Romeo (inaudible). Your line is open.

Female: Hi, good afternoon. So, client ask this question recently, if a claim has been -- a roster has been filed against the number of defendant, and one of the defendants by either law or contract or we should rephrase that another party that is not named to the lawsuit or even if they are named to the lawsuit, assume the defense of let's say of my clients either through law or contract in the events of a settlement or judgment. If my client who did not pay to the plaintiff because someone else is responsible for that payment. But their name is part of the caption and their name is included in the release, would they be obligated to report that settlement or judgment.

Barbara Wright: Are they self-insured, I mean if they are self-insured and they are the ones that are settling something then yes, they have reporting obligation if there is an insurer involved, you need to go through the RRE examples that are in the

user guide. If whoever is "taking over the defense as you were stating it" if that's sort of situation where that's the insurer than you need to look whether it would be RRE is the insurer in that case.

Female: It may not necessarily be an insurer relationship, it maybe a contractual relationship where there is another party that ...

Barbara Wright: You cannot shift the RRE responsibilities simply by contract. So, if you have someone that is an RRE because they are self-insured and they have an agent that is working with them or someone else, they can't simply shift the RRE responsibility to them. So, you really have to determine in a particular case whether you have got an insurer who is really the RRE or whether your entity who is self-insured no matter who is working with them on the case is still the RRE and has the reporting responsibility.

Female: No I understand that, but what I am trying to get at is my client whether they are self-insured rep, they are self-insured up to a certain amount, there is somebody else, it is not their insurer, but a third party, let's say another manufacturer, someone at one point that they were in contract with and through terms of that contract they owe, a defense and indemnity to my clients so they are responsible for making any payments.

Barbara Wright: The defense and indemnity didn't make them the defendant from what you have described, it doesn't sound like that entity would be the RRE. Your client is still - the defendant is still the one that is settling it, the fact that someone else is funding it or helping them or aiding them are required to pay for the lawyer doesn't change the fact that your client is the defendant and if he is self-insured no matter how they get their money, they are still the RRE eventually. Again it goes back to the concept that you can't shift the RRE. You cannot simply by contract shift the RRE responsibility.

Bill Ford: Yes OK, I am not sure that I make it very clear, but I will let somebody else perhaps I will write and send it in to the mailbox.

Operator: Your next question comes from the line of Stacey Baker with Continental Western, your line is open.

Stacey Baker: Hi thanks for taking my phone call. This is about TPOC amounts and I am sure this has been answered at some point in time, but I wanted some clarification for our company. TPOC amounts in a liability settlement. If our general release is for 9000, but let's say, 7500 goes to the injured party and their attorney, 1200 goes to another carrier and 300 goes to a provider, do we report that entire 9000 or do we only report the 7500 that went to the injured party?

Barbara Wright: Its been that beneficiary. So the fact that the terms of the settlement may call for you to pay some of it directly to one or more of his providers or someone else, you need to report the entire settlement around.

Stacey Baker: OK, and what if part of that was paid to a Medicare conditional payment, is that included as well, if it is really from the general release?

Barbara Wright: You mean the check was written directly to Medicare as part of the settlement?

Stacey Baker: Yes.

Barbara Wright: Yes, that is part of the settlement as well.

Stacey Baker: That is part of it as well OK. And I had one more question ORM termination date. If we have an alleged work comp injury and were in a state where we have open medical until the statuette of limitation is up, can we use that statuette of limitation state as a ORM termination date as we are no longer liable for paying ongoing medical treatment for that?

Barbara Wright: If your case is legally terminated on that date, but we said even to the extent and I will have to have someone correct me if I get this part wrong even to the extent a term date can be put in advance, we said that that should rarely be done because if you are basing it on statuette of limitations, but let us say you are in a state where it says statuette of limitation is two years, but oh by the way if you need services anytime before that two years is up then the statuette runs another two years, then you have a date certain when it is going to term.

Stacey Baker: Correct, I am saying if you are past that two years, your statuette of limitation is up, can we use that as an ORM termination?

Barbara Wright: If that is a legal basis in your state to terminate your responsibility then yes it is the reason to terminate ORM.

Stacey Baker: OK, great thank you very much for taking my question.

Operator: OK, your next question comes from line of (inaudible) Sidley Austin LLP, your line is open.

Female: Hi, good afternoon my name is (Ronnie) my question is in regards to the 12/5/80 alert and I just wanted to know with regard to the first bullet discussing when Medicare would assert a recovery claim in reporting another with a certain one when exposure on or after 12/5/1980 was effectively released and then on the second page in the exception it says you know, that the exception would be carved out if a broad general effectively releases exposure. What I understood was that earlier today was basically that that CMS would assert a recovery claim or reporting if there is a claim and it is effectively released, but the exception would be effective if there is no claim and there is a broad general release, is that correct?

Barbara Wright: It is effective only if you meet all three requirements, all three bullets. If you look at the exception there is the conjunction between each one when you look at the first page of that alert, the items that are listed, there is no conjunction between those. But to get the exception you have to meet all three of those.

Female: I guess by meeting all three are you saying that it can't be claimed and you can have a broad general release whereas in the first the way to relay is, I mean if you are effectively releasing exposure then recovery and reporting is required., you know, recovery -

Barbara Wright: That is the general rule and then we say if you meet all three of those things in conjunction then we won’t exercise our right with respect to the broad general release, effective release.

Female: OK, so you are saying that exposure ended before 12/5/1980 and there wasn't a claim and there was a broad general release. Is that the correct way of reading it?

Barbara Wright: You are paraphrasing it but yes.

Female: OK, great, thank you so much.

Operator: Your next question comes from line of Robin Kindall with (inaudible), your line is open.

Robin Kindall: Hi, we are wondering if you could give us some clarification on what you want entered when you are adding in estate as additional claimant, there is a field for the address and telephone number and we are not real clear what you are looking for there, are you looking for the address of the attorney, if so, are you wanting the estate attorney, if that is different than the claimant's attorney. Are you wanting a personal representative, what are you looking for in those fields?

Barbara Wright: We are looking for the address where we should officially send any mail that needs to be addressed to the estate.

Robin Kindall: So, if we just pose that question to claimant's counsel and then basically whatever they provide is what we would use.

Barbara Wright: That's fine as long as they are clear that that is where you know, mail for the estate needs to go.

Robin Kindall: OK, thank you.

Barbara Wright: I mean if the estate has a separate representative then you have got the representative field for that claimant anyway. So, often there will be own address, or maybe a relative or anything that is -- particularly if the relative is the executer or there could be both an attorney and an attorney for the liability case as well as an executer for the estate. So, it will just be fact specific, but it is basically where official mail for the estate needs to go.

Robin Kindall: OK, thank you.

Operator: Your next question comes from the line of Emily Green, with (inaudible), your line is open.

Emily Green: Hi, I just wanted to get some clarification on the alert on the reporting exception for exposures ending before December 5th, 1980. When do you view exposures ending in cases where the physical contact with the product ends before 12/5/80, but the toxin remains in the body and any disease ultimately develops after 12/5/80. One example that comes to mind is tobacco, you know, in those cases the person might have stopped smoking before 12/5/80, but the lung cancer for example developed after 12/5/80 will that be viewed as the case involving exposure after 12/5/80.

Barbara Wright: We have said for something like tobacco or asbestos that it is when they stop being exposed to the toxin in terms of smoking or in terms of working in that environment etcetera. Implants are the ones that cause the most trouble for people in that if those are not removed then obviously exposure continues. If it is an implant that is filled with something like let's say breast implants.

If that implant was removed before 12/5/80 and it did not rupture, we consider that exposure ended, but it if ruptured since the allegation has to do with what filled the breast implant, not the sac itself or the capsule then in that case we consider that continues, but for most of the exposure ones you will be dealing with, you are usually talking about an outside source, something that is not in the body and we re-look to when that exposure stopped.

Emily Green: OK, so for the tobacco example if you for example stopped smoking you know, on January 1, 1980, you develop a disease five years later and you receive Medicare benefits post 12/5/80, that case would not be reportable?

Barbara Wright: No, as long as your exposure is based on your smoking, if you are claiming second hand smoke then I think you are in a whole different ballgame.

Emily Green: Right, of course, OK, thank you very much.

Operator: Your next question comes from the line of Johnny Bolton with SVMIC, your line is open.

Johnny Bolton: Thank you, can you clarify some of the timeframes around DDE reportings specifically after a claim report, how long does it take to get the acceptance or to know if it has been accepted or rejected and then if it is rejected how long do we have to report the correction before incurring a penalty?

Jim Brady: I just picked the first question first because that is the (inaudible) when you submit it within 24 to 48 hours you will have your response back to whether its accepted or not. Then it should firstly go into IP status and then it should be a CS status afterwards.

Johnny Bolton: It's IP and CS?

Jim Brady: Yes, right, completed IP for in progress, so basically the DDE function initially the claim moves into a in process status and then goes through the processing, then goes to completed. Forty eight hours should be enough time for it to be completed. If you get an error you should turn around as quickly as possible and basically the burden is on you to get the data corrected as quick as possible.

Johnny Bolton: OK and will that be the 45 days from the TPOC date, what would be the timeframe that we would have to get it corrected before incurring a penalty?

Bill Ford: I mean, the requirements were the electronic files submission and the DDE are the same in terms of turnaround times or when they have to be updated and things like that so.

Johnny Bolton: OK, thank you.

Operator: Your next question comes from line of (inaudible) with Banner Health, your line is open.

Female: Hi, well I have a question that was in on the web's new page, it says beginning in October 2011 CMS will implement an option to pay a fixed percentage a certain physical trauma based liability cases with settlement amounts of 5000 or less, the detailed information will be posted on alert October 21st. First is that going to include worker's comp?

Barbara Wright: Those liabilities cases we are looking at liability insurance only. This is generally outside the scope of this call. As I said at the beginning of the call when this alert went up in order to get the information up speedily we took alert that was prepared for broader purposes, but you know, that is not really part of this call, the information about that option will be on the MSPRC website as soon as it is available.

Female: OK, but you don't think its going to include worker's comp?

Bill Ford: Right, it is focused on liability insurance.

Female: OK, thank you.

Operator: And again to ask a question press star one on your telephone keypad. Your next question comes from the line of Catherine Goldhaber with Segal McCambridge, line is open.

Catherine Goldhaber: Hi in regard to the 1980 date issue, when you were discussing it Barbara you talked about specifically claims. In a situation where a plaintiff alleges exposure from a work history and it is from 1960 to 1985 and there is no claim against any particular defendant then as the discovery shapes up, Acne boilers, all of the evidence of the Acne Boilers in 1975, would Acne Boiler still need to report?

Barbara Wright: We have said that let us claim the release. If you want to have this exception then the industry is going to have to form their claims somewhat to allow them to get those exception. We have not said that you can simply go ahead and claim you know, exposure for everybody and then change your mind later. We have heard both sides from the industry. We have heard one just say well we just always claim everything. But we are trying to give you an exception that means that you have to comport with our rules.

We have also heard from other ones that we always get the information before we file the claims. We don't make it too broad well particularly and doing this or we have changed the process and we are trying to be more focused now. We understand what you are doing trying to give us this exception so

now under us you can't simply claim release where you claim that you had exposure from all these defendants and then change your mind.

Catherine Goldhaber: And using that same scenario, in that case would you expect that that claimant if he claimed exposure throughout his work history to 1985, but then all the evidence showed the exposure ended in 1975 that's for all defendant, would you still be expecting that plaintiff to be contacting Medicare and advising Medicare of losses?

Barbara Wright: I would because they claimed it. I mean you, plaintiffs or defendants all routinely self-report if they have done that consistently close to 100 percent then we might not have had the mandatory insurer reporting. I mean part of the concept for mandatory insurer reporting was that there was at least evidence or an indication that everything was not being reported ahead of time or afterward and we needed a way to ensure that we were getting a more consistent and fuller representation of what was going on.

Catherine Goldhaber: And one more question on the loss of conversion reporting where all the exposure excuse me, if there is some exposure post 1980 and then John Smith is the injured party, but he is not Medicare eligible and his wife has a loss of conversion claim and she is Medicare eligible, would you still expect reporting from the wife?

Bill Ford: If there are medical claim then they are released to the wife, yes.

Catherine Goldhaber: All right thank you.

Operator: Your next question comes from line of Mike Balm with Nationwide Insurance, your line is open.

Mike Balm: Good afternoon, this is regarding ORM reporting and let me give you a scenario to explain my question, we have a worker's comp claim and say the guy is 30 years old and injures his back and we pay a couple of months medicals and he has done treating, however, we cannot get anything from the doctor saying that his treatment that he is never going to incur anymore treatment which is more common than not. Our understanding is that you

have to continue to run queries on that claimant even though our filing of treatment is finished, is that accurate?

Barbara Wright: Until you can legally close your case yes.

Mike Balm: So, and in most worker's comp jurisdiction, long term fixed dates, there is no end date, there is not a statuette limitation, that it is unlimited benefits. So, in those scenarios just, that is a tremendous burden on the carrier to keep those files open and follow up doing queries and quite often we would have to do that until the people die or become a beneficiary.

Bill Ford: Yes, I mean we understand you know, you are predicament and you know, this is an issue that comes up from time-to-time, but at the same time, I mean we are also obligated to collect the MSP information that occurs and so that's kind of where we are you know, we cant give you any additional information at this time and we continue to look at this issue and we recognize that you know, where you are getting information that can cause some stress.

Barbara Wright: It may aid you in getting the information assuming you don't already do so if you are explaining why you wanted and how it would help the individual if you explain that it was in order you know, to ensure that if and when they are eligible for Medicare that this doesn't interfere with those benefits or something then they would have some incentive to get it because it would be -- if 20 years down the road, they may not be able to go back to the doctor or something , and essentially have to figure out another way to supply the information so I don't know what type of letter or anything is accompanying your request, but you might think about putting something in about the reason why, if you ...

Mike Balm: I understand that and we are trying to draft something, but most doctors do not send anything back saying you know, this person is no longer going to need treatment its tough to get any response from the doctor.

Barbara Wright: But, the individual has some interest in contacting their doctor?

Mike Balm: No there has been, once we will make the payment to them really there is not a lot of benefit for that injured parties and say hey doc can you respond to this

insurance company for me that's not realistic to be honest with you. So more you know, more you know, probably 80 percent of the time we are sitting there with a case that we are running queries on and it could be for 30, 40, 50 years depending on the age of that person. And it just doesn't make sense when there is no treatment going on.

Bill Ford: I mean, you know, section 111 is an evolving process and we hear you and we understand what you are asking for. We have received this comment before and as this you know, evolves we will continue to evaluate the policy in place or reporting, we understand there are other situations where you may not be able to get that information readily and we are looking for ways to help you in terms of reducing your burden on your end at the same time also protecting the Medicare Trust funds as well. So you know, again we don't have anything to offer you on this call but again please know that this is an issue that has come up time-to-time and it is something that we would like to figure out, some possible alternate ways to satisfy our requirement as well as keep the burden on your side all more minimal.

Barbara Wright: And if that includes something outside the box in terms of not I want to use the phrase split the baby, but that's not quite the right one. Obviously or not obviously in states for instance where you would have a lifetime obligation. If someone's original injury caused them to have like a knee replacement and nothing else then that person you know, that there is a reasonable expectation particularly if they are young, but they are going to have another knee replacement sometime and that clearly should be covered by you.

On the other hand, if its something for a particular injury where they broke their arm and it wasn't even you know, wasn't even a greenstick fracture or anything like that, it was a relatively smooth minor break, the likelihood of that requiring further treatment is different. So we haven't ruled out the idea of whether you know, we could limit this to certain types of injury or anything and we are not opposed to receiving suggestions of how to do it.

Mike Balm: OK. And I appreciate that because it really gets difficult getting responses from doctors as when there is only ER treatment, I mean probably get responses from a ER doctor on a patient. So; and one thing you can think

about is you know, if they haven't had treatment for a certain time or with a certain type of injury, something like that to limit those cases for us.

Barbara Wright: Yes, certain period of time one of things we are definitely concerned about is where there has been joint replacement everything because they may go longtime in between that, but evidence shows that they typically do have to joint replacement after a certain number of years. So anything if you can think of ways to help us categorize we would be interested in hearing that, but it needs to take into account situation that would routinely have a long gap in treatment as well.

Mike Balm: OK. Thank you.

Operator: Your next question comes from the line of Marjorie Wilcox with (inaudible) your line is open.

Marjorie Wilcox: Barbara, I wanted to follow-up on the question that asked a little while ago just to make sure I'm understanding on the pre 12/5/80 guidance. If often get the asbestos law suits where there is you know, dozens if not you know, a 100 of defendants that are actually named in the initial complaint and those complaints will have broad exposure allegation that address the entire body of defendants.

There maybe some defendants that only have early timeframes of physical exposure and there maybe some that have post 12/5/80 exposure. If you have a defendant that exclusively the evidence throughout the discovery process is consistent that the physical exposure was only pre 12/5/80, ended in the 1970s. For that defendant, are you wanting to hear from those parties and if the plaintiffs oppose to report to CMS those particular claims because you are going to get a lot of claims reported in that situation for which there is a recovery.

Barbara Wright: You are saying there is no recovery and what we are saying is legally there is a recovery. Our touchstone is what is claimed to release are effectively released. We are granting, giving whatever you want to call it an exception where the only basis for our potential recovery is a broad general release. We

have not come up with any type of exception that we believe can be applied when exposure has actually been claimed.

Marjorie Wilcox: So even though exposure has not been specifically claimed with regard to a certain defendant?

Barbara Wright: Well, it is then claimed by virtue of the complaint.

Marjorie Wilcox: The broad originally file complaint.

Barbara Wright: And that's what I was saying a few minutes ago, we've heard from various attorneys that they are being more careful in terms of how they file complaints and we've heard from many that have said they don't file the complaint until they determine, which ones there is or is not exposure.

Marjorie Wilcox: And if they actually then understanding the historic approach for some folks has been a much more kind of broad inclusive, allegation in the original complaint, what if the plaintiff amends their complaint? And only can include relevant dates prior to 12/5/80. That then takes the place of the originally filed complaint that was less precise.

Barbara Wright: Could you send that question into the mailbox because we haven't specifically addressed, amended complaints.

Marjorie Wilcox: OK. And my understanding then is whenever they have those broad originally filed complaints the plaintiff should be notifying CMS.

Barbara Wright: The plaintiff may or may not do a free settlement notification, but you do have the reporting obligation if it meets the threshold etcetera.

Marjorie Wilcox: OK. One of the other issues that has arisen with regard to the flowchart that's available online, the MSPRC flowchart, it talks about the steps and it does note in that flowchart that after receipt of medical services the beneficiary or the representative is supposed to notify COBC of the accident, illness, or incident?

Barbara Wright: That's how we get notification and that's how we are going to get it prior to settlement with a longer and what we say is the longer anyone delays in

notifying us then the longer it is going to be till we can make any determination or pull claims to give you know, a potential conditional payment amount.

Marjorie Wilcox: OK. So what is the time when they should notify and if for some reason they fail to take that step you would get the notification at time of settlement.

Barbara Wright: Right.

Marjorie Wilcox: OK. All right, thank you. That's helpful.

Barbara Wright: OK.

John Albert: Operator it's now 3 o'clock and we have to end the call because we have other meetings to get to. So this is John Albert again I wanted to thank everyone for their participation. Please stay tuned to the website for any future alerts and to get a reminder about the upcoming call, November 16, 2011, it is a technical call. On December 14th will be a policy and technical call that alert was dated October 14th that has the -- it is the same phone number and pass code as for this call.

Barbara Wright: And that is available also as a downloadable document on the liabilities of worker's compensation tab on the website.

John Albert: And we kind of thank you everyone for participating. And if operator, you could stay on the line up to you let the go.

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

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