TRANSCRIPT
TOWN HALL TELECONFERENCE

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

DATE OF CALL: APRIL 28, 2010

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

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: John Albert
April 28, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Sarah), and I will be your conference operator today.

At this time I'd like to welcome everyone to the MMSEA 111 NGHP conference call.

All lines have been placed on mute to prevent any background noise. After the speaker's 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: OK, thank you.

First, for the record today, is Wednesday, April 28, 2010. This call is a Non-Group Health Plan Section 111 Policy teleconference. We have other conferences scheduled for more technical section. Please refer to the Mandatory Insurer Reporting Web page for those dates.

As usual we will first start out with some presentations of materials and then we'll move into our Q&A process later on to answer your policy-related questions. We ask also that you provide your name and the entity you represent as part of the question-and-answer session.

Also I would like to remind everyone to please continue to utilize the CMS Resource mailbox that is available to folks on the Mandatory Insurer Reporting Web page to submit their questions. We take all of these in and use them to either address them right here on these teleconferences or through the various written guidance that's on the Mandatory Insurer Reporting Web page.

I also wanted to announce I think as we have in the recently past is that we are now starting to receive production files. As you know, there was a delay in the requirement to submit files until January of 2011. But the process is available for those that want to start submitting production files. We strongly encourage folks to submit data to us now versus later because it's one more way to test the process for both U.N. or CMS.

I also wanted to provide an announcement that we did kind of touch on in previous calls regarding the potential of offering an alternate process for people to submit data. We're formally announcing through an alert forthcoming that we will be rolling out a direct data entry option through the secure Web site effective January 1, 2011. Again, there will be an alert coming on this with an instruction and guidance in the near future. We're going to be rolling this out more gradually as it's still under development right now. But again, it will be ready January 1, 2011.

This process will be geared more toward the small occasional reporters versus the large file submitters that we have as well. You know, the data requirements will be the same for both the direct data entry option as they are for the current electronic file submission process that is available. But again, for the small or occasional reporters, that option will be available come January 1st 2011. We'll also, part of the alert or future alerts, will include instructions on how to let CMS know that you wish to utilize that option.

There will be a cap on the number of entities allowed to use that in terms of size, but that has not yet been determined. But again it will be geared more toward the small occasional reporter.

Other than that, I'm going to turn over to Pat Ambrose who has a few announcements that are more technical in nature. And Bill Decker is going to answer some questions that have come in regarding the SSN. And then Barbara Wright is going to answer some of the other policy questions that have come in.

Pat Ambrose: OK. Thanks, John.

First off, a correction was made in the system recently that will affect the editing of TPOC dates on both test and production claim Input files. The TPOC date must be greater than the CMS Date of Incidents. If it is less than or equal to the CMS Date of Incidents, the corresponding TPOC date edit will be posted and the record will reject. The error codes that are affected for this are existing error codes for TPOC date fields one through five. And namely those are the CJ03, CT01, CT11, CT21 and CT31.

Again, we have modified the edit for the TPOC dates to require that this TPOC date be greater than the CMS date of incidence field. I think that obviously makes sense since you can't settle the claim prior to the date of incident and it's highly unlikely that you're settling it on the date of incident.

So that change went into the system already. And again those edits have been updated, those error – the edits for those error codes. This is – the reason we put this in right now, it's not really a change in requirement; it's something that we really should've edited for right from the start.

The requirement for an RRE to submit an empty file or otherwise notify the COBC on the COB secure Web site when they have nothing to report for a particular quarter will be removed. Empty files will be accepted but will not be required. And by empty file I mean the claim input file being submitted with the header, no-detail record and a trailer with the zero record account.

So again the empty file submission, if an RRE has nothing to report for a particular quarter, is not required. However, it will be accepted if submitted.

There's a typo in Version 3 of the User Guide related to the TIN Reference Field 13 through 15. The field descriptions for those fields, they are for the Foreign RRE Address fields, the second, third and fourth line. For example, the second line, the description reads the second line of mailing address of a foreign employer. Obviously that should have read that this is the second line of the mailing address of a Foreign RRE. So again, the typo involves the use of the word "employer" in the description for those fields that should have said RRE. Those were fields 13 through 15 on the TIN Reference file.

Another announcement, as you know, there is test beneficiary data available for your use on the Section 111 COB Secure Web site. We will be updating this test data to show you the entitlement dates for those test beneficiaries. This will occur on or about May 21st.

We're doing that so that RREs can set up test conditions using the test beneficiary data to test getting specific disposition codes and the '03 disposition code in particular. This would be reflective of you get an '03 disposition code if the TPOC date is after the entitlement has ended for the Medicare beneficiary, or if ORM started and continues after the Medicare beneficiaries entitlement has ended.

So there's again this test beneficiary they're putting – being put out there. And we will show you the entitlement date just for the test beneficiary so that you can test the use or the receipt of that '03 disposition code.

And one last reminder we've had, we still continue to get some questions about the ICD-9 diagnosis codes. As you know, the requirements for the ICD-9 diagnosis codes are documented in Section 11.2.5 of the User Guide. I encourage you to review that section since most of the questions being submitted could be answered there.

Every ICD-9 diagnosis code that you submit in Field 15 or in the diagnosis code fields 1 through 19 starting in Field 19 of the Claim Input file must be on the list of valid ICD-9 diagnosis codes. The valid codes can be found on the CMS Web site. There's a link to the page on which those can be found. And in fact there are fairly explicit instructions on how to go to that page and download the ZIP file in which these diagnosis codes lists are provided and then exactly what text files to use.

In those ZIP files you will see ICD-9 diagnosis codes as well as procedure codes, and obviously only the diagnosis codes are to be used for submission of claim input file.

Now in Field 15, you must submit an E code. This must be a valid E code according to being on that list of valid CMS diagnosis codes that I just mentioned and it must not be on the list of excluded codes in Appendix H.

And those excluded codes are also found on the Section 111 COB Secure Web site.

The diagnosis codes entered in fields one through nine and Diagnosis Code 1 through 19 starting in Field 19 cannot be V codes. They cannot be E codes and they cannot be excluded codes. And of course, they must be valid codes.

The use of ICD-9 diagnosis codes is not required in these fields until file is submitted in 2011. And the requirement relates to any file submitted and processed as of January 1st 2011 and subsequent, regardless of what ORM dates you might be reporting and regardless of the date of incident you might be reporting, and regardless f the TPOC dates. It is strictly a mater of claim information that is submitted on or after January 1st 2011 must use the ICD-9 diagnosis code and use the code that is considered valid at that time.

If you've already submitted a claim and you have no reason to send an update to it, you don't have to send an update change or previously submitted diagnosis code if, perhaps, for some reason it falls off the list of acceptable ones. But if you do submit an updates, you need to check that update record before submission to make sure that the diagnosis codes included on it are all still valid. Otherwise, you'll need to update them.

Lastly, we realize that in some cases you may receive medical claims from providers, from hospital and physician that have ICD-9 diagnosis codes that CMS does not consider valid for Section 111 reporting. So you won't be able to submit necessarily, exactly the diagnosis codes that are submitted by a provider to you.

That said, it's not necessary to use the diagnosis codes on actual medical claim. Our use of the ICD-9 diagnosis codes for Section 111 is a means for the RRE to describe the nature of the illness, injury or incident and the alleged cause. So you may and most likely need to set up a process to either map other codes that you use in your internal claim system such as body part codes or something of that nature, map those to ICD-9 codes. And you may also have to set up some sort of process to translate a description into an ICD-9 or have a claims adjuster select one from the valid list of codes.

We've also mentioned in the past that there are – there is available on the Internet. If you do a simple search you'll see some software available to help you in the selection of an ICD-9 diagnosis code. Some of it is actually available free of charge. We don't recommend any particular software, but it is out there and there is no problem with you using any of that available software.

So with that said, I will turn it over to Bill Decker.

Bill Decker: Thank you very much, Pat.

Hi, everybody. My name is Bill Decker. I'm with CMS here in Baltimore. Good day to you all.

I'm going to address only one subject area on this call – this afternoon. Since our last NGHP call, we've received a number of questions and a fairly large number – surprisingly large number of those questions involved various issues concerning Social Security Numbers, how to collect them, should they be collected, I'm having trouble collecting them, and a variety of issues around the collection of and the reporting of SSA.

I think I can answer all of them, address all of them in general with one series of statements. First of all for everybody out there, remember that this is a program that involves Medicare beneficiaries. We're interested in hearing from you about your interaction with Medicare beneficiaries.

Every Medicare beneficiary will have a Medicare Health Insurance Claim Number, a Medicare HICN or HICN. We sometimes refer to that as the HIC number. We sometimes refer to it as the medical ID. It's all the same thing. It's the number that identifies an individual who is enrolled in Medicare to the Medicare program.

If an individual who is a Medicare beneficiary and is participating in Medicare is receiving services for which Medicare may pay or be responsible for, that individual is required the his or her Health Insurance Claim Number, the Medicare HICN, to an insurer or a provider that asks for it. There isn't any

other way for the Medicare program to have a clear idea, an absolutely clear idea about an individual status in Medicare without that number.

It is equivalent to any other insurance companies' health insurance claim number. Anyone would ask for Health Insurance Claim Number for Blue Cross Blue Shield Michigan or for AETNA or for a Kaiser plan on the West Coast. And just as they would do that, they would be asking any Medicare individual for the Medicare ID number, the Medicare HICN.

That is routine and anybody who is enrolled in any of those insurance programs should have no problem with providing their Health Insurance Claim Number to anyone who needs it and has legitimate reason for asking for.

That is the bottom line essentially on the Medicare ID number. If you're telling us about a Medicare beneficiary, we expect to get that Medicare ID number, the Medicare HICN. You should have, really have no trouble collecting it from anyone. There isn't any reason why someone who has a claim with you and who is a Medicare beneficiary wouldn't give it to you.

In the rare case where you do have some sort of a problem with getting a Medicare ID number about an individual, you can submit to CMS that individual's Social Security Number and certain other small body of information all clearly identified in the User Guide. We can then look for that individual on our database. And if we find that individual in our database, we will have a Medicare Health Insurance Claim Number for that individual and we will return that to you. You then will have the individual's Medicare ID number and we can go on with interacting with you on the basis of using that number.

That is why we tell you from time to time that you may send that Social Security Number to us, a Social Security Number to us if you are trying to establish Medicare participation. Otherwise, we just need to have Medicare Health Insurance Claim Number. That's all we actually have to have and it's all we actually really want to have. There are certain cases where we can use the SSN, but we want the Medicare Health Insurance Claim Number.

If there is a particular case where a particular insurer cannot get either a Medicare ID number or an SSN, in such case after you've exhausted your own processes of trying to obtain that information for your use and for ours, if you can't get it, you need to document what you have done to try to get it and to keep that documentation on file. In that way, if there ever comes to a point when we ask you what about that person, you can say we tried to get it, we couldn't get it, and this is why and this is what we did.

And that should – that in fact can cover you when we get back to you if we ever do find a particular case. That is why we have those forms up on the Web site that you'd ask and then help you to ask folks for their identification to be used. We remind people that the form that is on the Web site that you can use to ask someone for a Medicare ID number is a form that it can be – can be altered for your own use.

And you're not obliged to use it exactly as it is presented to you. You can change it. Our point is we need to have the Medicare ID – the Medicare IDs, the Medicare HICN and the Medicare HIC number, the Medicare H-I-C-N, whatever it is we're calling. That's what we need to have. It's not the SSN we need; it's that Medicare ID number. However you can get that to us, that's what you need to be doing. And that should cover all the various questions that we got in from the last time we had the call.

And so that covers my part of this presentation, I think, and I think Barbara Wright now has something she'd like to say to you too.

Barbara Wright: Good afternoon.

The first thing I'd like to talk about is not specific Section 111 questions. It's the fact that we're continuing to receive questions about the MSP Recovery Process in the mailbox for Section 111.

So I'm going to start back at the beginning again and state that Section 111 added new additional reporting requirements for certain entities. It does not replace or eliminate any other obligations, but it is different.

If you are a plaintiff attorney or representative and you were reporting to the COBC to identify a pending claim, you should not stop that process. Doing that allows you to obtain conditional payment information. It means that any demand if we have a recovery claim will be issued as soon as possible after we are notified of a settlement judgment award.

The fact that the plaintiff attorney is doing this in a particular case doesn't eliminate Section 111 reporting requirements for the applicable RRE. By the same token, if a plaintiff attorney doesn't do this, the self-identification, they are at a disadvantage in terms of information. Plus the statute actually requires repayment within 60 days after there is a settlement judgment award or other payment. So you should be taking steps to fulfill that obligation.

The Responsible Reporting Entity is not required to do to report. They can do their Section 111 reporting. But again, if a plaintiff attorney hasn't self identified and a responsible reporting entity does a separate contact with the COBC to identify a pending claim, the advantage is that there will be conditional payment – conditional payment information available sooner.

And so there are advantages to both sides in having the case reported through the self-identification process as well as the Section 111 process. If you want to know more about the COBC's activities in terms of reporting through self-identification, you can go to the COBC's Web site which is listed in the User Guide.

If you're particularly concerned with the recovery process, the Medicare Secondary Payer Recovery Contractor has a Web site with a lot of information on it and several new tools. Their Web site is www.msprc.info, I-N-F-O. There are several presentations on there including an explanation of the entire recovery process. There are new toolkits up there you can click on whether or not you're involved as an attorney or a beneficiary or an insurer, and it gives you lots of information. It explains their process flow documents up there, their information about proof of representation and consent to release.

And so if you have questions about the recovery process, that's where you need to go. And as an additional point, there is going to be a Webinar

tomorrow, the 29th. You can check the MSPRC's Web site. But I believe the time is 1:00 to 3:00 pm. They may still have lines available. So 1:00 to 3:00 pm Eastern Standard Time which – or I guess it's Eastern Daylight Savings Time now. But the information about the call is available on the Web site. Again, that's www.msprc.info.

OK. In terms of Section 111 matters, Appendix G, which we talked about changing, has not been released yet. What we were talking about changing is the bolded paragraph under the description for liability insurance. We hope to have that out within the next 10 days. What we expect at this time – again, wait to see the final. But we expect to simply remove that paragraph that starts out, "Special considerations" and replace it with the reference to the language of what should be done with respect to deductibles. And it's currently stated in the alert that was issued, I believe, February 24th? John, was that the…

John Albert: Yes.

Barbara Wright: February 24th.

So that's for Appendix G.

Fields 58 through 62 that were originally captioned Product Liability, there was an alert issued on December 23rd that made it clear that those fields do not need to be filled in that they should have zeros until we provide further instructions. Since we haven't yet provided further instructions, leave the zeros. We will give you adequate notice before we will require you to put anything else in those fields. We got several questions about that.

Pat Ambrose: Barbara, if I could just say that the field should be left blank rather than zeros. Spaces are the default values. We're not using them.

Barbara Wright: OK. OK, no problem.

Clinical trials – and we have actually had meetings on just about one of these issues this week. So we are looking at them.

Clinical trials, language is still in the clearance process. As far as I can tell at this point, we have one last step. And we're hopeful it will be out soon.

The periodic indemnity issues dealing with Workers' Comp or no fault, again, we still expect to have those out soon.

Risk management, we had further discussions this week. And there will be a revised draft that we'll be clearing here hopefully again within a short period of time.

Mass Torts have received a number of questions about we do expect to have more meetings for those who requested that they'd be in this group. Are they going to start within the next couple of weeks? No. I do expect to have at least one meeting before the end of May. I will send invitations to everybody who is in the group before.

Since we aren't using fields 58 through 62 until we have further information, that will – the meeting of the group will tie into what will eventually go into those fields.

Surprisingly, we received more questions about entities that have more than one responsible reporting entities that have more than one line of business. We've said from the beginning, as long as it's an NGHP line, liability, no fault and Workers' Compensation, if you're an RRE for more than one line, you may choose to do them all under one RRE or you may choose to do them under separate RREs. You cannot combine GHP and Non-GHP under a single RRE ID.

We received several questions in the last group that asked whether or not government entities were subject to Section 111 reporting. As it was in the alert on RREs on who must report, government entities are subject to Section 111. There's a specific statement in that document that mentions that.

A few questions that have come in more than once that we haven't gotten back on yet. We've had a question about situations where an entity is offering severance pay and they want to know whether or not that has to be reporting for NGHP purposes because it has a general release. If it does not specifically

mention medicals, and as long as it is somehow not releasing their responsibility for Group Health Plan in which insurance – in which case we would have a different concern, a general release for severance, no it doesn't have to be reported.

And we will look at adding that to language that we've got.

Let's see. I would ask so that we don't end up having the questions restated again, Alden Group and Railroad Risk Management Incorporated have some questions they sent into the mailbox that we're still looking at. So I'll tell you ahead of time, I'm not prepared to answer them today. So please don't ask them on the line again today.

And I guess at this point, unless John has something to add, we can go forward with questions.

John Albert: Now, just one – just real quick reminder that I always try to bring up on these calls too, and that is I would remind everyone who are in the process of implementing their requirements that if you are not getting what you need from your EDI rep, please refer to the escalation clause for further assistance. We've gotten a couple of complaints about, you know, not getting a response or whatever. But it turns out that the people calling or writing were not aware of the escalation clause. Again, there's a clear process in the User Guide if you're not getting a call back or whatever from the EDI rep in how to escalate that to get you prompt service. So please refer to that.

But other than that, if that's – if, operator, we can go straight to Q&A?

Operator: At this time I would like to remind everyone, in order to ask a question, press star then the number 1 on your telephone keypad.

Your first question comes from Diane Philips from Concord Philips. Your line is now open.

Diane Philips: Yes. Hi.

We've got a question that we submitted to the mailbox that concerned general liability, self-insured entity when they are served with a claim, but the self-insured entity is a name insured on anther entity's policy which they then basically tender to the company who is holding a certificate that shows the entity as a named insured. And our question is if we are a named insured on a general liability claim.

Pat Ambrose: What insurance policy is ultimately paying? What I will say is the fact if you're using tender in term that – in the meaning that someone else has assumed responsibility and you're tendering that claim to them because they've guaranteed to indemnify you. If you're an RRE and that policy is paying, then whoever would be the RRE for that policy is the one who reports. And an indemnification agreement doesn't change our rules.

Diane Philips: OK. So if we're a named insured and therefore their policy is paying, then they become the RRE even though a settlement agreement may include us in the release?

Pat Ambrose: If the only – the policy that's paying the RRE for that policy needs to report. And keep in mind the general rule that we've said for…

Diane Philips: Right.

Pat Ambrose: …self-insured retention or if it's excess insurance, who is actually, you know, who the excess insurance is actually paying, et cetera. But the general is that tendering because you've got – an indemnity agreement doesn't change our rules.

Diane Philips: Right. But in the named insured status, we just wanted to confirm that because of insurance, that's just how insurance works that that makes them the RRE. And that's my understanding from…

Pat Ambrose: I'm not sure I can say anything other than the fact, you know, it's the policy…

Diane Philips: The policy to pay.

Pat Ambrose: …and our rules…

Diane Philips: OK.

Pat Ambrose: …that apply to that particular policy, whoever would be the RRE.

Diane Philips: OK. That answers that question.

Can I ask one quick question about ICD-9? When we have a claim that has a general release, they haven't actually alleged that there's any medical, but we're requesting a general release. Do you have some guidance for us on what ICD-9 code to use when there's not actually specific allegation of medical?

Pat Ambrose: This is Pat Ambrose.

I do not have a suggestion…

Diane Philips: OK.

Pat Ambrose: …on the – you know, assumption is that you're reporting on claims where medicals are claimed and/or released or by virtue of the settlement are released,

Diane Philips: Yes.

Pat Ambrose: And that there is an injury that can be described.

So, you know, personally, all I can suggest is picking the best one possible. And I don't have a particular recommendation if there is no injury. So I would have to then defer to Barbara on any further guidance.

Bill Decker: I mean the point of having, you know, using the code status is that we don't have to come back and ask what was it for because…

Diane Philips: Sure.

Bill Decker: …if we don't know what it is, then we would have to develop again. So that's why…

Diane Philips: Sure.

Bill Decker: …we have, you know, implemented the increasingly common use of that code set for a universal descriptor of accident, an injury, illness, et cetera. So…

Diane Philips: OK.

Barbara Wright Albert: I will say – I will say one thing about codes though with respect to question that came in about a prior transcript. It said that we said or I said that you should be reporting the code related to responsibility that you accept it. Now whether we made it clear or not, my intent if I said that was to say when you're reporting ORM, it's critical that you report the codes that you've accepted responsibility for. But when you have a TPOC, first of all in most cases, you're not accepting liability at all. But secondly, for a TPOC, you definitely need to report codes for the alleged injury.

Diane Philips: OK. That helped.

Thank you.

Operator: Your next question comes from William Tamingga from Global Aerospace. Your line is now open.

Christopher Trapani: Hi. My name is Chris Trapani. I'm here with Bill Tamingga.

We have a question concerning the collection of Social Security Numbers as just to expand on what was discussed earlier. The form that was issued back in August for collection of this information from claimants, Section 3 is the Refusal. First question is since they have the right to refuse and based on the discussion earlier, I guess that means that there's no regulation or statute that requires people to disclose their personal information. Is that correct?

Bill Decker: There is a statute at the federal level that requires Medicare beneficiary to supply his or her Medicare HICN.

Christopher Trapani: OK.

John Albert: By their very – by their very nature of them being Medicare beneficiaries, they are bound to cooperate with any entity involved in coordination of their benefits.

Bill Decker: That's right.

Christopher Trapani: OK.

Bill Decker: That's what we said at the beginning of this call.

Barbara Wright: But someone who's not a beneficiary…

Bill Decker: Right.

Barbara Wright: …isn't bound by that rules.

Bill Decker: Right.

Barbara Wright: So these forms where an effort for situations where someone is not cooperating with you would give you a paper trail of what you've done to obtain that information and to be able to document your steps. Even if it's – we mailed this out and we even mailed it twice once by registered mail and they didn't return it, you document your record. Ad as Bill said then if a question ever arises, you can explain and document what efforts you went through to obtain the information.

Bill Decker: Right.

Christopher Trapani: OK. If someone saw in Section 3 refusing to provide the information, but we go out and obtain, you know, via let's say a public record search their Social Security Number, is there a regulation or statute that protects us?

John Albert: Well, from our perspective, if you know they're our beneficiary, we require you to report them. I don't think that we can give you legal advice…

Bill Decker: Right.

John Albert: …on what methods you're using.

Christopher Trapani: OK. I think that answers the question.

Bill Decker: OK.

John Albert: Thank you.

Operator: Your next question comes from Lorraine Siegel from Chubb Group. Your line is now open.

Lorraine Siegel: Hi. You answered most of my questions regarding the ICD-9. So would it basically – we should really go for the link that you have on the CMS Web site…

Pat Ambrose: Yes.

Lorraine Siegel: …for the ICD-9 list of codes so we're always using the correct ones?

Pat Ambrose: Yes.

Lorraine Siegel: So that's what we should -OK. And one other question, if an incorrect one is sent like, you know, who's ever going to be doing the selection of the ICD-9, are we going to be held to that or are you going to question it?

Pat Ambrose: If an incorrect one is submitted, in other words, if one that is not considered valid is not on that list is submitted or one that's on that list but is what we call an excluded code that are listed in Appendix H – and you're going to get an error returned on your claim report record. So the response record for that claim report would get an FP disposition code and a corresponding error code for that ICD-9 diagnosis code or the alleged cause field that you might have submitted the invalid code in.

And…

Lorraine Siegel: But what if we selected a valid code but it was just the wrong, you know, it was just the wrong selection?

Pat Ambrose: We'll never know. I mean, honestly, I presume in later during a recovery process, if they're using this information that yes, there might be some questions. But…

Barbara Wright: If there was…

Pat Ambrose: … – essentially we'll never know.

Barbara Wright: I mean if a question was raised about a code that was submitted then on the backend, they would have to result that if it resulted in claims inappropriately being included in a recovery demand.

Lorraine Siegel: All right. So we wouldn't be held just because we may have accidentally used the wrong code or sent the wrong one.

John Albert: I guess that's – I mean you're kind of drifting into the compliance arena and, you know, while we don't have specific parameters regarding what is we consider to be non-compliance versus, as you say, accidentally…

Lorraine Siegel: I mean we're compliant and we sent the codes, but we may have just selected the wrong, you know, it is a valid code but just not the right one.

Barbara Wright: Well, I mean I think Pat's given information on updates before if you discover that you've done something erroneously. On the other hand, what you're describing is obviously something completely different than if a particular RRE was submitting the same codes on every single claim, or submitting a particular one code on every single – in other words…

Lorraine Siegel: Yes.

Barbara Wright: …they weren't even attempting.

Lorraine Siegel: Oh, yes. No, no, no. OK. OK.

Barbara Wright: (Inaudible).

Bill Decker: Right. And be aware everybody on this call that CMS does have its regular coordination of benefits contractor and other contractors to take this

information and process it. We also have a Data Validation group that looks at those in sort of a retrospective review of the information coming in to give us information about the nature of the validity of the data coming in. We take a look at it and do a variety of – examine it on a variety of different ways to see if what the information that is coming in, whether or not we believe if it is valid and whether or not we believe we may have to change our procedures based on that data.

So that does happen. But in your specific case, you asked about an ICD-9 code that was simply not the correct code for the correct situation although it was valid for our purposes. We wish you had sent us the right one. That's all about what we could say.

Lorraine Siegel: OK. Thank you.

Operator: Your next question comes from Victoria Vance from Tucker, Ellis & West. Your line is now open.

Victoria Vance: Good afternoon. Thank you.

I have two very discrete questions. One relates to the opportunities to do early reporting before January 1, 2011 for RREs that are so inclined. And I understand that that's recommended. My question is if an RRE chooses to do early reporting, are they bound by any certain window of time, that seven-day window that they will have to follow next year? Is there anything that would restrict when they can do a submission in 2010 and how often per month or per quarter?

That's my first question.

Pat Ambrose: You are – RREs are supposed to adhere to that seven-day window, the assigned file submission time frame for any quarter that you're reporting whether it's now in 2010 or later when it's required in 2011.

Now, that said, what happens when you submit a file out of that submission window is that it generally suspends – it depends on the exact timing. The file might be suspended with a threshold error saying that it was sent to early. It

might be considered sent to late and – or not to late but sent late and processed right away. And your EDI representative can release the files for processing.

So what I would do if you're – if you want to report a production file now, we would highly encourage you to do so and encourage you to adhere to the seven-day window. But if for some reason you can't, you may still submit that file and then talk it over with your EDI representative and they can release it for processing.

Bill Decker: In fact, it might be a good idea for you to talk to your EDI rep before you submit on the first time around. It's good idea to do that in general, but just so that your EDI rep knows what it is you're doing and knows that you're coming in and knows that you may be either on schedule, we hope, or maybe a little off schedule from time to time. As long as we know what you're up to, we're generally fine with it.

Victoria Vance: Great.

The second question, I picked up I think a hint that the threshold amount – I just want to be sure that I'm correct about this. For claims that may be under $5,000, there's an exemption, if I can use that term, for reporting through 2011. My question is, is it under 5,000 or equal to and/or under 5,000?

And the same thing with the following years, is it less than and equal to or is it just strictly a less than reference?

John Albert: Do you remember where the site is in the manual? We'll find it. But…

Pat Ambrose: Well, I mean I have it here. It says claim reports for the last, most recent TPOC dated prior to January 1st 2012 with TPOC amounts totaling 0 to 5,000 inclusive…

Victoria Vance: OK.

Pat Ambrose: …are exempt from reporting. So in other words, initial claim reports or add records with no ORM where the ORM indicator is equal to N where the most

recent TPOC date is prior to January 1st 2012, with a total TPOC amount less than or equal to 5,000 will be rejected.

Victoria Vance: OK.

Barbara Wright: Pat, could you give everybody the section number for all the threshold?

Pat Ambrose: Yes. There's a section on the interim reporting thresholds in the User Guide. And that's Section 11.4.

Barbara Wright: You should look at that because there are different thresholds if you're talking, for example, ORM for Workers' Compensation.

Victoria Vance: Yes.

Barbara Wright: And I don't believe we have any threshold if it's ORM for no fault.

Pat Ambrose: Correct. No fault, there is absolutely no threshold related to no fault at least that I can think of.

Barbara Wright: So you should take a look at that whole section on thresholds.

Pat Ambrose: Indeed.

Victoria Vance: Very good. Thank you.

Bill Decker: Thank you.

Operator: Your next question comes from (Wendy Rader) from State Compensation. Your line is now open.

(Wendy Rader): Hi. I'm asking a question about Workers' Compensation insurance. And this would be on a claim where a work injury is alleged – and that includes medical treatment – but after investigation, the carrier denies it. And leaving that aside the issue of temporary ORM during discovery, am I correct that because we denied it, we're not going to report the ORM? Is that correct?

Barbara Wright: If you paid while the claim was under investigation, then you would be reporting that ORM.

(Wendy Rader): Right. But leaving that aside, if we deny liability for ORM and there is no…

Barbara Wright: Well, if you – stop a second. If you actually paid ORM, you have to report that. If you're saying that you're denying liability but you're reaching some type of settlement so there is a TPOC amount, whether or not there is a determination or admission of liability, that TPOC amount still must be reported.

(Wendy Rader): OK. Well, that's my next – the next part of my question. But I first wanted to make sure that I was correct on the ORM part.

Barbara Wright: Well, on the ORM, if you continue to pay ORM and you're continuing to deny liability, you have to report the ORM.

(Wendy Rader): Well, if we deny ORM, we normally don't pay medical treatment. It would be an error of some type if we do. But...

Barbara Wright: Well, then you would be reporting it while you're paying it. And once you've terminated it, then you would term the ORM.

(Wendy Rader): OK. Well, I'll move on to the next part of my question.

The question is about a denied case and then it goes to trial and the judge agrees that there was no compensable work injury. So we got to take nothing. Are we to report a zero dollar TPOC? Is it interpreted that that judgment releases medicals and therefore it's reportable?

Barbara Wright: You don't report zero TPOC amount.

(Wendy Rader): OK. OK, I guess that's it.

Barbara Wright: OK.

Bill Decker: Thank you.

Operator: Your next question comes from Emily Shields from Morgan Lewis. Your line is now open.

Emily Shields: Hi. The first question that I have, it relates back to what you all were talking about earlier with regards to the collection of the HICN number. We've had some opposing counsel refused to provide that, insisting that the HICN number is always the same as the Social Security Number plus the letter A.

I did a little bit of research online and it appears that that is supposed to be the case generally but that there are exceptions to that. I wanted to get clarification. I do always have the Social Security Number in the cases that I have. And is there a default that's telling me to use that plus the letter A going to be right in most cases? I just need some kind of clarification so I know how to proceed.

Bill Decker: I'm about to say no, that's not right.

Emily Shields: OK.

Pat Ambrose: It could be, but it isn't necessary.

Emily Shields: OK.

John Albert: I mean if you have the correct Social Security Number for that individual – you know, you tell us about (John Smith) and you have (John Smith's) date of birth, age, you know, whatever, gender, all that, and the Social Security Number and it is a valid Social Security Number for (John Smith). We can cross-lock that to a Medicare Health Insurance Claim Number.

Emily Shields: I understood that.

John Albert: Yes. But…

Bill Decker: But that's not what we want to do.

John Albert: Yes.

Emily Shields: Right.

Bill Decker: The beneficiary, the Medicare beneficiary is required to supply the Medicare ID number to an insurer or other – or other legal entity that's asking for it. If

a lawyer or a state or some other entity says that they don't want that person to do that or they don't think that person should do that, while interesting, that does not let the Medicare beneficiary – it does not release the beneficiary from supplying the information. When they've become a Medicare beneficiary, they agree to provide their HICN to people who need to have it. And that's the way the federal law reads on that.

Emily Shields: OK. I will continue to make my case on that.

My second question is once we have submitted information to you – and this might be considered one of the recovery questions; I'm not exactly certain. Is it possible to write a letter to the COBC or Medicare's regional office with all of the necessary information to get an affirmative statement from Medicare as to whether or not there are any conditional reimbursement payments owed? And if it's already been paid back or there aren't any to start with, if it – will they actually tell us nothing is owed?

Barbara Wright: First of all, you would never write to regional office for that. This is Barbara Wright. As I said at the beginning of the call, if you want conditional payment information, the case – the case has to be self-identified to the COBC outside of the Section 111 Reporting Process if you want that information before there's already – before there's been a settlement judgment award or other payment.

Emily Shields: Yes.

Barbara Wright: If you are a Workers' Compensation entity or a no fault insurer and you self-identify that case, then when the MSPRC develops the conditional payment, they should be sending you a copy of that conditional payment information as well as the beneficiary.

If you are a liability insurer, you have no standing unless there is a settlement judgment award or other payment. That is when anything comes into play. So if you want – if you're a liability insurer and you want conditional payment information before there's a settlement judgment award, then you have to go to the Consent to Release process and get the beneficiary's permission for us to give that information to you.

And that, again, I would refer you to the MSPRC's Web site and go through their PowerPoint presentation on the whole recovery process including proof of representation and consent to release.

Emily Shields: So if – so if as an RRE, I want to have some affirmative understanding from the Medicare beneficiary as to whether or not there are any conditional payments owed. Are they able to provide me with a letter that says no, nothing is owed? Will they get something that says zero or we have…

Barbara Wright: It will never have that before there's a final settlement judgment award or other payment.

Emily Shields: Assuming there is one though.

Barbara Wright: OK. Two things; if there is a situation where a beneficiary is continuing to treat, we make conditional payments write-up until there's a settlement judgment award or other payments. So we don't have a final conditional payment amount until then.

Emily Shields: OK.

Barbara Wright: The MSPRC supplies interim conditional payment information. And the beneficiary once they report the settlement judgment award to us, then yes. If they've self-identified, they're going to get their demand much quicker than if the settlement is only reported through Section 111 because there's a time lag.

So they can show you their demand letter once they get one.

Emily Shields: OK. So if they have a demand letter, I know that they can provide that to me. If they don't get a demand letter, at what point are they allowed to assume that no…

Barbara Wright: We really need to cut this off. This is not a call about the recovery process. And I have referred everybody to the appropriate sites. So you really need to go read that information.

Emily Shields: Unfortunately, it seems to leave a few holes. But I appreciate your effort.

Barbara Wright: OK.

Operator: Your next question comes from the line of (Mark Seabolt) from iSPACE Incorporated. Your line is now open.

(Mark Seabolt): Hi, good afternoon.

A couple of quick questions about the empty file; are you prepared to receive the empty file now? Can we start sending them?

Pat Ambrose: Yes, but you're not required to submit an empty file. We will accept it and process it and, you know, return those corresponding response.

(Mark Seabolt): OK. So if we don't send the empty file and we don't have data to send, what is the other way to let you know that we don't have data? Is there anything else that we have to do to not get the compliance e-mail sent out?

Pat Ambrose: No. There's nothing you have to do. You don't have to send an empty file. We were going to add something to the COB Secure Web site to allow your account manager to indicate you had nothing to report for a quarter. But you don't have to do that either. We did not add that function.

So the User Guide needs an update as to some other materials. But, you know, essentially, if you have nothing to report for a quarter in which you are required to report starting in 2011, you do not have to submit an empty file or notify the COBC in any way. Just don't send anything if you have nothing to report.

(Mark Seabolt): OK. You said 2011. If we're reporting production now…

Pat Ambrose: Well, reporting – yes, if you're in production now and you don't have something to report during your quarterly file submission time frame, then just don't send a file. Don't do anything. If you want because we've already automated the process to send an empty file, you may do that and it will be accepted.

(Mark Seabolt): OK, great. So there's no danger of a compliance e-mail being sent out. And if it does, can we safely ignore that e-mail?

Pat Ambrose: I would – if you got a compliance e-mail, I would contact your EDI representative because no one should be receiving – no Non-GHP Section 111 RRE should be receiving an e-mail or a letter at this time that says you have not submitted a production file and you were required to do so.

So if you get one, you should contact your EDI representative. If you get one prior to 2011, there must be a problem. But you should not be receiving that.

Bill Decker: But it's not your problem.

Pat Ambrose: Yes, it's not your problem. Exactly.

(Mark Seabolt): OK, understood. So then after 2011 starts, will you be implementing the compliance e-mail then?

Pat Ambrose: Obviously, that has to change. It's, you know, you won't get an e-mail warning or a letter that says that you haven't submitted a file because you may not have even been required to submit. So yes, you're right.

Bill Decker: Right.

Pat Ambrose: …that that warning process will obviously need changes such that we don't send them out.

(Mark Seabolt): OK, great. Thank you very much.

Operator: Your next question comes from the line of Susan Jordan from Broadspire. Your line is now open.

(Susan Broadspire): Hi, yes. My question involves the RRE alert that came out on February 25th. And it was stated in a subsequent call that you were anticipating potentially sending out a revised clarification of that alert. Is that still expected?

Barbara Wright: Are you talking about the one about who must report, who's an RRE?

(Susan Broadspire): Yes, that's correct.

Barbara Wright: That's what I was addressing at the beginning of the call. The clarification we were talking about was in the attached Appendix G. Under Liability Self-insurance, there's a paragraph that starts out "Special considerations for liability self-insurance which is the deductible," et cetera. That paragraph as I said at the beginning of the call, that paragraph is going to simply be eliminated with the reference to look at the special considerations where there's a deductible to look under the main part of that alert or when it's incorporated in the User Guide to look in the User Guide instructions.

(Susan Broadspire): OK. So it will eventually come out in its formal fashion…

Barbara Wright: Yes.

(Susan Broadspire): …with that paragraph eliminated?

Barbara Wright: It will.

(Susan Broadspire): OK. And then my second question, you mentioned earlier on the call that an alert will be forthcoming on entities that we'd be able to manually key in claims. We received an alert notification on the 26th of April, and when I go out to the site we can't find any alert. Is that possibly the alert you're talking about that's not posted yet?

John Albert: No. No, it's not.

(Susan Broadspire): Was there an alert issue this week?

Bill Decker: We received a notification that there is new material on the Web site. I'm pretty sure that that's what that was about and I'm pretty sure of the notification you got.

Let me start by saying we did not yet post any alert about direct data entry.

John Albert: And there's no time frame in those…

Bill Decker: And there's no time frame for us to do so yet. We just announced that it's going to become available.

Occasionally, when we put new material on the Web site, if the system is working right here at CMS, we send out a notice to everyone who has signed up that there is new material available on the Web site. But it could be anywhere on the Web site. It could be for GHP; it could be for Non-GHP. It could be just a general notice of upcoming call. It could be anything. It doesn't – it is not necessarily keyed to any particular subject.

Barbara Wright: So what you need to do is go to the What's New page because..

Bill Decker: Yes.

Barbara Wright: …the person who's handling, putting stuff up on the Web site tries to make sure that every time something is to go forward that the What's New page describes what that item is and where it's located.

Do know that occasionally, we've seen instances where when a new time is going out, that alert shows up the day before the item actually does. So, you know, if you check the What's New page and it doesn't say anything is new, you might want to check the What's New again the next day.

(Susan Broadspire): OK. And we did that, but for some reason this time we didn't find it. But yes, we saw the timing issue where sometimes you would see it posted slightly later than we might get the e-mail notification. But this time, we were unable to locate anything new on the What's New page. So I thought I would ask.

John Albert: Yes. Yes.

Pat Ambrose: I'm looking at the What's New page now and the last entry there is April 21st. And I believe that we did get a notification…

Bill Decker: For that one, yes.

Pat Ambrose: …for that one. And then I think there's been a subsequent notification, and I don't see an update on the What's New. So we'll have to look into that and verify what happened there. So…

(Susan Broadspire): OK, great. I appreciate it.

(Susan Broadspire): … – I think we've identified what your confusion is.

(Susan Broadspire): OK, great. I appreciate it.

Bill Decker: We, you know, (inaudible) all the notifications for all the various Web sites that go up. And yesterday I reported to you that I got about 20 notifications for different Web sites. We're not entirely sure what happened there.

But it may just be that it was not a new notice at all.

(Susan Broadspire): OK, thank you. I appreciate that.

Bill Decker: We apologize for the confusion.

Operator: Your next question comes from the line of Suzi Sabogal from Paul Hastings. Your line is now open.

Suzi Sabogal: Hi. This question has been addressed before and I believe the last time I heard an answer to it, it was – that it was still being looked into.

Basically we have a situation where an employers lays off 50 employees and offers them severance in exchange for a general release of claims.

Barbara Wright: We addressed that at the beginning of this call today.

Suzi Sabogal: I'm sorry. I couldn't hear some parts of the call in the beginning. How was it?

Barbara Wright: Yes, what we said was if it's a situation that is truly severance and there's simply a general release…

Suzi Sabogal: Yes.

Barbara Wright: …that it doesn't need to be reported. Now we certainly would have a concern…

Suzi Sabogal: Yes.

Barbara Wright: … – sort of a side issue is if the severance thing is releasing them from Group Health Plan obligations, then we might have a separate concern that's not related to the NGHP reporting. But several alone should not trigger NGHP reporting.

Suzi Sabogal: OK. But if there's a Group Health Plan that you issue, it might – it presents a different issue.

Barbara Wright: Well, it would trigger NGHP, but we might have a concern with the GHP.

Suzi Sabogal: Concern with the GHP. OK, thank you very much. I appreciate it.

Operator: Your next question comes from the line of Susan Bolster from ZURICH.

Susan Bolster: Hi. We are aware that there's no Medicare beneficiary age threshold. However, we were surprised when we reviewed the query results that more than half of the claimants who returned with the HICN were under the age of 65. As I'm sure you're aware, the insurers will be colleting numerous data elements per claimant in order to meet its reporting obligation under Section 111, claimants who may not even have active coverage.

Since NGHPs aren't provided the active dates of coverage via the query results, if the claimant has ORM, the RREs will have to report quarterly until either the claimant has active coverage or the ORM terminates.

Is it the intent under Section 111 to provide NGHPs with all claimants whose Social Security Number matches to a HICN whether the claimant has active coverage or not?

Barbara Wright: Is it – could you repeat just your last sentence?

Susan Bolster: Is it the intent under Section 111 to provide NGHPs with all claimants whose Social Security Number matches to a HICN whether the claimant has active coverage or not?

Barbara Wright: If they're under 65 and they match to a HICN, the vast majority of the time, they are going to be active. As a general rule, Social Security does not approve someone for disability unless they have a situation where they're expected to be totally disabled, unable to do any substantial gainful activity for at least a year or the condition is expected to result in deaths.

So the vast majority of individuals under 65 who get Social Security based on disability stay on it for the majority of the rest of their life. And they do in fact get Medicare. If you get a HICN returns, most of the time, that person is still going to be receiving Medicare.

Susan Bolster: Because it seems when we were looking at the HICN, some of the BICs, the Beneficiary Indicator Code, might be that of a child. So talking to Social Security it sounds like while the parent could be getting Social Security benefit?

Pat Ambrose: Two things.

Susan Bolster: OK.

Pat Ambrose: Children can get benefits through – well, that would be Group Health Plan. So if you had a child that was getting Medicare coverage because of ESRD, they could also be in an auto rec. So there could be situations where there's NGHP for a child who's getting Medicare. But keep in mind that the BIC Code C, unless things have changed since I was at Social Security a long time, the C is also used anytime a child gets something on their parents' record which includes disabled adult children.

Susan Bolster: Yes, we understand that. But could it be though that they could just be getting Social Security benefits but not Medicare benefits? In other words…

Barbara Wright: They should not be returning a HICN if they're not getting Medicare.

John Albert: Correct.

Pat Ambrose: They would not be in our Medicare database.

Susan Bolster: So they should not be coming back. So all the ones we are getting should in fact be under Active Coverage?

Pat Ambrose: They should but not…

Susan Bolster: OK.

Pat Ambrose: …necessarily. I mean it is possible for a person who's entitled due to disability for that entitlement to end and then start up again later for another reason or for disability again.

John Albert: For example, ESRD can be terminated after a certain period of once there's a successful transplant. Similarly, someone, an adult or a young adult who's disable for – who gets benefits because they're expected to be disabled for at least a year, if they ever got a HICN, it means they were disabled for at least 30 months. But if they improve enough so that they have, for example, a trial work period or for other reasons eventually their benefits are cut off, or there are a few conditions where if they're met, the person is automatically assumed to be disabled. And I'm not sure how the trial work period works in those situations, but there may be periods when they lose benefits.

But the vast majority they have been – if you're getting a HICN, generally, we would expect that to be active coverage.

Susan Bolster: OK. Because if in fact, let's say we get the HICN back and we go to report, it now comes back with the disposition code of 51, now we would have to add its ORM. Then we would have to continue reporting on that claimant every quarter because we don't know when that active coverage could start again.

Pat Ambrose: That condition should not happen. If you get back in '01 on the query, then when you submit the claim record, the only possibility – it would be matched and you would not get a 51. You might get an '03 which means that one, it's that that their Medicare entitlement doesn't overlap the dates on the claim.

So if ORM started after their entitlement ended and they are currently – as of the date of incident going forward are not currently entitled to Medicare, then you could get an ’03. And that is a circumstance where you do need to continue to send the claim record as long as you have or retain ORM since we don’t know when that person might become eligible or covered by Medicare again.

Susan Bolster: OK. So if we got an ’01 in our query, we should not be getting back 51s on the reporting.

Pat Ambrose: Correct.

Susan Bolster: OK. OK, very good. Thank you.

Operator: Your next question comes from the line of (Lori Schelko) from McGuire Woods. Your line is now open.

(Lori Schelko): Hi. Thanks for taking my call.

A couple of my questions have already been answered. But I’m wondering if there’s a way to become a part of the Mass Torts Group. I was not part of it to begin with and I would very much appreciate the opportunity to be part of it now.

Barbara Wright: If you want to be included in that group, please send an e-mail to the Resource mailbox. Put in the subject line “Mass Torts Group.” Tell us who you are, give me contact information, including whether you represent like plaintiff’s bar, defendant’s bar, insurer, Workers’ Comp, whatever.

(Lori Schelko): Great, thank you.

And just I know the call is probably a month over but, Bill, at least for me when you speak, you really go in and out; no one else is. So maybe if you could move closer to the phone, that would be helpful. Thank you.

Bill Decker: Yes, we’re (wondering) about that all the time. So thank you.

John Albert: Going in and out may have nothing to do with being closer to the phone line.

(Lori Schelko): Maybe it's just you who's varying the details.

Thank you for your time.

Operator: Your next question comes from the line of Jim McMorrow from PgE.

Jim McMorrow: Hi. I wanted to second that. Whoever discussed the Social Security Number questions at the beginning, you started off with your voice fine but by the end of it, you were mumbling. So if you could please pay attention to that. It's very frustrating.

I have two questions. I'm still trying to get a handle on reporting the initial exposure date on cumulative trauma and occupational disease. I'm in California and California has some strict rules about how far back you can go to bring in other employers a cumulative trauma or occupational disease. It's one year from the last date of injurious exposure. And you guys want us to tell you the initial date of exposure, and I don't know that we will ever know the answer to that question. The employee is probably not going to answer it because that could raise a statute of limitations argument that they failed to report the claim timely.

So what are we supposed to do especially in cases where it's an orthopedic CT where really the initial exposure is they have a lift – a job that requires lifting? And you could even go back to their date of birth in essence that that's the first date of exposure to a CT claim. So what is it that you're after?

Barbara Wright: I guess I'm not used to hearing the term "exposure" in an orthopedic claim.

Jim McMorrow: Speak up.

Barbara Wright: I'm not used to hearing the term "exposure" in an orthopedic claim. Are you saying that there's…

Jim McMorrow: If you have a job that entails heavy lifting or keyboarding or anything, that's an exposure to an orthopedic cumulative trauma. So we do not generally get specific dates of injuries for those types of claims. We get a date that they first knew or should have known that their symptoms are related to their work.

And they have one year from that date to file the claim, and no entity is allowed to go back more than 365 days from that date to bring in other defendants because the courts do not want litigation between insurance companies over liability.

So it's just you're going to win some, you're going to lose some. So you can only go back 365 days from the date that the employee first knew or should have known that they have a cumulative trauma disease or an occasional exposure to bring in co-defendants. So the employee is not going to say, "Well five years ago I started lifting at this job. It was a heavy job and I had pain," because that gives rise to a statute of limitations argument that you should have filed the claim five years ago.

Barbara Wright: OK.

Jim McMorrow: So what is it that you want? Generally for us, it can never – the initial exposure date that we give you could never really be more than 365 days from the date of incident.

And then what's rather common also is you have a specific date of loss where somebody tripped and fell and had incurred a strain. And then at the same time, their attorney will file a cumulative trauma claim that runs the last year of injurious exposure. So you have actually the specific claim and the cumulative trauma claim. It's the same body part. The attorney's are doing this to make sure that they can get the most benefits for their client.

So I don't know what you want for that.

Barbara Wright: Have you submitted – and you're probably going to say yes. Have you submitted this question to the Resource mailbox?

Jim McMorrow: Several times. I'd never gotten a response.

Barbara Wright: I don't remember seeing – I remember a couple of questions, but I don't remember a question as articulate as what you've said on the phone right now.

Jim McMorrow: Yes. I'm pretty certain I sent the same questions to my EDI rep and she said she was going to submit it to. I'd be happy to send it to somebody if you give me the way to send it to.

Barbara Wright: Can you send it to the mailbox and specifically label it as Cumulative Trauma Injury in the subject line?

Jim McMorrow: OK. So am I gathering that when you guys are talking about exposure, you're more referring to occupational disease type claims where it's a toxic exposure or some exposure to the environment?

Barbara Wright: Most of the time when we've been referring to exposure in most of the people we've been speaking with, yes it has been exposure like asbestos, benzene, vinyl fluoride, PCBs.

Jim McMorrow: Right.

Barbara Wright: I don't – we need to look at your cumulative trauma situation. I don't think we've thought of it in terms of an exposure claim.

Jim McMorrow: OK, all right. Well, that makes more sense because it was – I'm having difficulty understanding what it is you want.

My next question is, and it refers to a caller I don't know – the caller did not identify what state they were from. But they were talking about a situation where a claim is filed. While the claim is being investigated for whatever reason, they are providing medical treatments. In California, you either accept the claim within 14 days, you delay it and you have 90 days to investigate and then you can – or you can accept it.

Recently I know, 2004, the state passed the law that required employers provide up to $10,000 worth of medical treatment during that period of delay. There's no admission of liability. There's no acceptance of ongoing responsibility for medical care. In fact, it could be the situation where the employee goes into the hospital and has a surgery and we're only going to pay up to $10,000. It's up to the hospital to figure out how they're going to split up the $10,000 when the bill is 500,000 or whatever it is.

You don't mean to imply that because of the state rule that medical treatment be offered during the period of delay that that constitutes an ORM?

Barbara Wright: Actually I think we do. If you're actually paying for ongoing medicals, then we need to know that because we should be secondary to that.

Pat Ambrose: Yes, that is addressed in the User Guide in the sense that, you know, if you're paying even though it's not result that you…

Jim McMorrow: So that means ORM is going to be the date of injury in that case.

Pat Ambrose: Yes. You know, you will report the date of injury, report the claim…

Jim McMorrow: But we haven't agreed to ongoing medical responsibility.

Pat Ambrose: But if you reach your dollar threshold, then you would send in a termination for…

Jim McMorrow: So that means that every file has to be reported to you because most claims are delayed.

That's not true. Not most. Most cumulative trauma claims are delayed because it's a medical question whether it's this claim or the other claim the employees had in their history. So quite a few indemnity cases are delayed because we need to go through the state's process for obtaining medical opinion on the injury. And during that period of time, payments can be made.

We won't know whether we'll make the payments. We just send a letter to the employee that notifies them – it's a state letter, so the language is required – that tells them that they have up to $10,000.

Barbara Wright: And that's why we need you to report it so that if we're mistakenly billed, we deny it.

Jim McMorrow: Right. But by the time you get the bill, you may have accepted the claim and/or denied the claim. And the 90 days may have run, so we're not going to be – we have no ORM.

So to me, I distinguish between state-mandated benefits that have nothing to do with accepting liability and ORM to me is an agreement to be responsible for ongoing medical.

Bill Decker: No such agreement is taking place.

Barbara Wright: ORM to us is that you in fact have assumed responsibility either by state law or voluntarily. You are responsible for paying on an ongoing basis for medical that needs to be reported to us.

Pat Ambrose: Now it's possible as we said…

Jim McMorrow: So that means every claim then, because every claim – even from the date of acceptance. Let's say somebody falls and breaks their leg. So today, and we send them to the doctor. We've agreed to pay for that medical. You want us to report ORM at that point and not when we agree to future medical?

Barbara Wright: If they're a Medicare beneficiary. We are secondary to Workers' Compensation.

Jim McMorrow: Yes, well these – well, that won't be the case because these are people that are working. Otherwise, they couldn't have a claim. So there couldn't be a Medicare beneficiary…

Barbara Wright: If they're not – if they're not Medicare beneficiaries, you're not reporting them to us at all. If they are not and have never been, I should say, a Medicare beneficiary.

Pat Ambrose: And you can be a Medicare beneficiary and still working if you're over 65 and be covered by Workers' Compensation. In fact, there might be ones…

Jim McMorrow: No. No, no, no. You're still – your primary insurance is going to be your employer if you're still working.

Pat Ambrose: I'm afraid you might be mistaken about that.

Jim McMorrow: No, I actually – I looked it up. In fact my boss is over 65 and he had to sign the paperwork, he has to sign up for it. But if you go to the – if you go to their Web site that if you're employed, then your employer's insurance is primary as long as you're employed.

Pat Ambrose: Are you talking Group Health or Workers' Compensation? I mean we're…

Jim McMorrow: I'm talking Group Health. So I'm saying an injured worker, an employee who's working who's under a Group Health Plan and has a Workers' Comp Injury…

Pat Ambrose: Well, I think the…

Jim McMorrow: …could not be a Medicare beneficiary.

Pat Ambrose: Wouldn't the Group Health Plan…

Barbara Wright: Yes, they actually can. I mean we have someone in our division who's a Medicare beneficiary. And if he's injured on the job here, he will have Workers' Compensation. And yes, that Workers' Compensation would have to be reported.

Group Health Plan is primary to us in many situations. There are limited number where it's not, even if someone's Workers' Compensation is always primary to Medicare. If there is responsibility for the payment of Workers' Compensation, it must be reported if the person is or has been a Medicare beneficiary.

Pat Ambrose: Yes. The Workers' Compensation and the Group Health might be primary to Medicare. Both.

Jim McMorrow: It definitely is. I know this for a fact.

Pat Ambrose: What we're saying is the Workers' Compensation needs reported.

Jim McMorrow: That's (inaudible) to everything that you guys have been saying for two years because you've always said at the point in time where we agreed to ongoing

responsibility for future medical. You've never said that we were required to report…

Barbara Wright: (Inaudible) assume…

Jim McMorrow: …in the middle of a claim before we even accept future medical where we're paying for all the Medicare costs as we go, and we are paying all the bills that come in. You've never said before that if someone is a beneficiary, which I can't even imagine, a retiree has a year to file a claim so as opposed a retiree could do that.

But this is the first time you suggested that before the claim is settled and future medical is agreed to.

Barbara Wright: I guess for purposes of this call, we need to agree to disagree if you'd like to write in more detail to mailbox. None of us here believed that we have ever implied that – ongoing payment for Workers' Compensation does not have to be reported if the person is or has been a beneficiary because that's a basic premise of what we've been talking about.

Jim McMorrow: Right, and you've been talking – well, I'll send n my e-mail.

That's all the questions I have.

Barbara Wright: Thank you.

Operator: Your next question comes from the line of Rob Proctor from State Farm Insurance. Your line is now open.

Robert Proctor: Hi. This is Rob Proctor at State Farm. On behalf of all other callers, I'd like to apologize for the prior call.

We would appreciate your guidance on a clarification regarding Section 11.9 on the MMSCA qualified reporting exception on what constitutes an open claim. And I'd like to just kind of give you a scenario and see if I can get your take on how we should do these.

We have an electronic claim file that includes multiple coverages, injury coverages and property damage coverages, et cetera, under one electronic claim file. And we have claims for example where the medical portion will be concluded. But there's other ancillary events like salvage and subrogation that can take place for months. And so what I'd like – for example, we have a claim, an ORM claim where we made payments in 2009. And those payments in the medical activity concluded in 2009. But we have salvage activity on the total loss of vehicles or subrogation that will go on for months into 2010.

So technically, that file is on an open claim listing for electronic purposes. Here at State Farm, however, there's no medical activity taking place relating to the ORM activity. And our question was when you read the – I think it's Page 79 of the User Guide. It says if the claim was actively closed or removed from current claims records prior to January 1, 2010, we're no required to report that.

Well we have a large number of claims that the ORM activity was concluded. But those files are on our electronic claim system. And I guess I'd like clarification that it's your intent for us not to report those where there's only administrative items or non-medical related activities that would cause our files to remain open. Is that…

Barbara Wright: Let me ask you a basic question. You said the medical activity is concluded. Could the person legally still submit an additional claim to you and have it paid if it was related?

Robert Proctor: Yes.

Barbara Wright: OK. Well, then it's open for medicals. I mean our concern is, you know, if you still have responsibility for medicals, then it needs to remain open. If you have a situation where the person had completed treating and you had documented in your file that, you know, their personal physicians said no more treatment would be required and you failed to close it completely on a clerical oversight, then fine.

But, you know, the question I just asked, here you've got an open claim that they could in fact submit additional medicals for. In that case I believe you're stuck, might be the appropriate term.

Robert Proctor: OK. All right.

I have one other question. Apparently, we do receive claims that come in with no ICD-9 code. And that the scenario I was given was an officer tells somebody to go get checked out. And they go to a medical provider who gives them a very cursory bill that if it has an E code, it simply says motor vehicle accident, but there is no ICD-9 code given whatsoever. And they have no specific injury.

There is an ICD-9 Code 959.9 that just says unspecified injuries. And our question is, is in those particular cases, if we can identify a specific body part, is 959.9 intended to be accepted in those cases?

Pat Ambrose: Is that code on the list of valid codes on the CMS Web site and is that code also – I don't see it on Appendix H.

Robert Proctor: It's not excluded. And yes, well I know there's the whole you can derive an ICD-9 code to a body part. But there is no body part. And we apparently have some of those claims where we probably wouldn't make a contact on those. They're minimal, no other treatment or anything like that. So we're not calling a person to say was it your head, you know, anything like that. So…

Pat Ambrose: Right. I mean what I'm saying from a technical perspective, as long as it's on the list of valid codes and it's not on the excluded codes list, it would be accepted on the claim report.

Robert Proctor: Yes.

Pat Ambrose: And that – I mean I'm only going to answer – I can only answer – this is Pat. I can only answer you from a technical perspective and, you know, that code would be accepted.

Bill Decker: CMS is interested in knowing what are (those) we may be paying for. An unspecified injury is an accepted code. It doesn't give us a lot of information. But if that's all you've got, that will – we will accept the code.

Pat Ambrose: If it's all you got, part of what the recovery area would do if they were looking to see if we had a recovery claim is they would be looking to see whether there was care associated that was billed to us, even if it was the hospital checking amount. But the point is...

Robert Proctor: So the claim is going to send a bill for that, you know, examination.

Barbara Wright: So having the date of incident and that code would still be useful.

Robert Proctor: Yes.

Pat Ambrose: If you have a choice between doing an unspecified code and something more general, you need the specific code and possibly the general code. But you should be specific when you can be because it eliminates situations where we might have to contact either the beneficiary or in limited circumstances, the RRE for further information.

So you want to be specific when you can. But yes, go ahead and use that code as long as it's not an excluded code if that's all you have.

Robert Proctor: OK, thank you.

I have – I actually have one follow-up to my first scenario about the closed claim. If we had to close a file that was closed off of our active claim records in 2009 and a piece of mail came in in 2010 that was administrative in nature, again not related to the activity, so the file was closed in 2009. But in May of 2010, a stray piece of mail or something came in. Our system reopens that file because it has to accept that piece of mail into our computer. So we have apparently quite a few reopen files that were closed.

Now when it reopens, it's now again on our open claim listing. Would those fall in the same scenarios we talked about before? The file was closed. It was off of our active claim listing in 2009, but in 2010 reopened merely for the

acceptance of a non-medical related activity such as a stray piece of mail that could relate to the car, salvage title, subrogation, et cetera. Is that…

Barbara Wright: And there are current instructions. If you still have responsibility for medicals, the answer to that would be yes. If you'd like to write it up separately and send it and then ask whether or not we can consider an exception, we'll think about it.

Robert Proctor: OK, thank you.

Operator: Your next question comes from the line of (Ruehlin Allen) from Morgan Lewis. Your line is now open.

(Ruehlin Allen): Hi, thank you. Actually, earlier caller asked the question that I was most interested in.

We've been trying to get on the toxic tort group before and we've sent that e-mail in and we still don seem to get the letter…

Barbara Wright: We haven't had any meetings for a few months.

(Ruehlin Allen): OK.

Barbara Wright: And as I said earlier in the call, I hope to have at least one some time in May.

(Ruehlin Allen): Could you confirm the e-mail address that we need to send that to? I just want to make sure that we – it's very important to us.

Barbara Wright: I don't know it by memory. I always have to look it up.

If you go to the Overview page on our Web site an scroll down to the document that talks about opportunity for public comment, it gives the mailbox there.

Pat Ambrose: You'll also see it on the – in the second paragraph of the What's New page.

(Ruehlin Allen): OK. Thanks so much. We'll look for that.

And that call will be posted on the Web site?

Barbara Wright: No. I will send invitations to the people who are participating. I can only – you know, there's a limit on how many lines I can get. It is not open to all RREs. And if I reach a capacity limit at some point, I won't be able to take more people in the group.

I mean it's a group that normally it's open mike for everybody. So we have to – be able to have a conversation. I obviously can't get have a thousand people on the line where everybody is just talking.

Bill Decker: Right. Think of it as a standard conference call rather than one of these moderated calls.

(Ruehlin Allen): OK, that makes sense.

And then last question, are those transcripts out there anywhere (inaudible)?

Barbara Wright: There are – there are no available transcripts from those meetings.

(Ruehlin Allen): OK, thanks so much.

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

(Keith Tatlin): Hi, Barbara, this is (Keith Tatlin).

A question, the risk management alert that's under in clearance, is that going to address the gift card issue?

Barbara Wright: Yes.

(Keith Tatlin): OK. Now switching to the HICN number question, have you considered posting on the Overview section the reference to the federal law that you keep saying exist?

Barbara Wright: We'll look at that, (Keith).

(Keith Tatlin): OK. And the question I had from folks is, is we get a lot of non-responses where somebody doesn't say yes or no so whether they have coverage. And what sort of documentation are you looking for in our file…

Barbara Wright: Well, if…

(Keith Tatlin): …if we're certified mail or something like that?

Barbara Wright: As we've said in the past, we don't expect those forms to be your first approach to someone if there's…

(Keith Tatlin): No, no. I'm saying that if we haven't gotten a non-response for a variety of ways, how…

Barbara Wright: OK. And…

(Keith Tatlin): …document non-response rather than the refusal?

Barbara Wright: Certified mail is not a bad idea. I mean we aren't requiring that, but you need to show at minimum what your standard business practice is and have some type of documentation that you did it. So if the easiest way to keep track of that is certified mail or some other form, pick which one you want but be able to document what was done.

(Keith Tatlin): OK. That's all.

Barbara Wright: OK. Thank you.

Operator…

Operator: Your next – your next question comes from the line of (Bonnie Mastarett) from Farmers Insurance. Your line is now open.

(Bonnie Mastarett): Thank you.

I had a question that goes back to something we have discussed on a prior call. When we were to – at one point in time, we had discussed how do we assure first report to CMS when it takes multiple TPOCs to break the threshold. We

discussed it on the November 17th call. And Pat had said at that time we were asking about it, let's say it takes three – let's say it takes four amounts to get to the threshold. And the threshold is broken for the first time with that fourth payment on April 1st of 2011.

We understood from that call that payment on 04/01 of 2010 would be reported as TPOC 1 showing the total amount that gets it over the threshold based on that cost. But when I look at the User Guide, there was no update in the User Guide clarifying it. And there's some concern that maybe we should be reporting them as multiple TPOCs all at one time after that 04/01 2011 payment.

Pat Ambrose: So is your question if you had – let's say you had three TPOCs that were each 2,000. And so you're over the 5,000 when you hit the third one. Is your question, should those three TPOCs be reported as TPOC 1, 2 and 3 at the same time or should you be reporting a single TPOC of 6,000? Is that your question?

(Bonnie Mastarett): Absolutely my question.

Pat Ambrose: It really depends on whether they're separate TPOCs or not. I mean remember that your total payment obligation to the claimant might be $6,000 but you have a payment plan such that you're paying it out in installment payments, right? No?

Barbara Wright: Installment payments are a single T…

Pat Ambrose: Well, that's what I was going to say. The installment payments do not reflect separate TPOC. So, you know, what I'm saying is that it all depends on whether they're separate settlement amounts with separate TPOC dates or not.

(Bonnie Mastarett): OK.

Pat Ambrose: If they – if they are separate, then you'd report them, all three of them on that initial claim report in TPOC 1, TPOC 2 and TPOC 3 fields.

If it's one settlement amount with one settlement date, then you'd report subsequent – write subsequent to that settlement date that TPOC date one amount in TPOC 1.

Barbara Wright: I think the caution that Pat's trying to put forth, if you had a situation where for instance it's an annuity and each annuity is $2,000, you don't wait until Year 3 to report it. You report when you had the settlement, you report the annuity, the total value as we described it in that field when it happened.

If you literally have a situation where you had three separate TPOCs which is relative – our understanding is that's relative rare in liability situations for the same entity to have three separate TPOCs under the same policy, you know, then theoretically it could happen that you didn't have to report it until the third one.

(Bonnie Mastarett): OK. And maybe I can give you the specific example of how you get to what we would call three separate TPOCs.

It is not an annuity. It's a situation where we are talking to the individual. We are securing a release from them, we agree on how much we're going to pay them for the bills they have in hand, and they're not going to see a doctor again. But they still don't have that doctor bill from the emergency room or any of the bills associated with the emergency room. So we're waiting on those bills to arrive.

Rather than make that individual wait until all of those bills arrive and they're comfortable that they have them all, and we say to them we will go ahead and pay you for your general damages and the amount you have in hand of bills, and we will pay you for all of the doctor bills that occurred as a result of your going to the emergency room on so and so date. And that pretty much what our release tells them.

And so the first TPOC or the first payment goes, let's say for example direct to that claimant. The second payment may actually be the payment of the hospital bill when it arrives. And the third payment may actually be then the payment to the emergency room physician for that emergency room visit.

So it's not an annuity and it is actually three separate payments. And it just relieves that individual of having to worry about the bills they do already have in hand and it gives them some sense of security that when those bills arrive from the hospital and other groups that charge them for that visit that they will get that reimbursement or they will get those bills paid, I should say.

Barbara Wright: My first inclination is if you had that exact situation that you could report it as separate TPOC.

Pat Ambrose: Right. And then when that TPOC that sends you over the threshold, then you would report the claim – report the claim record with, you know, all three in separate TPOC 1, 2 and 3.

Barbara Wright: Now where it's not done as a single sum, then the beneficiary may get more questions on the backend. Because if we go out and do a recovery, medical expenses that they've paid out a pocket, if in certain instances we use those a deduction against our recovery claim if there's not otherwise enough money, et cetera. So it may cause more questions on the backend for the beneficiary when we would do a recovery demand. But…

(Bonnie Mastarett): So is it optional to report as separate TPOCs or is it mandatory to report a separate TPOCs?

Barbara Wright: Well, whether you report it as 6,000 or three 2,000 ones, either one, we might need further clarification from the beneficiary and/or their representative.

(Bonnie Mastarett): OK. We just wanted to make sure we do what is acceptable to you. And the User Guide didn't have any clear definition on this.

Barbara Wright: But we do want to reiterate to everybody in general that we don't expect the majority of liability situations to involve multiple TPOCs. And in most instances where you're paying medical bills on any type of semi-continuous basis, that needs to be reported as ORM.

(Bonnie Mastarett): OK. OK. Well, this wouldn't be semi-continuous. This is a known amount. I mean – well, it's an unknown dollar amount but a known time period. It doesn't go beyond as that time period.

OK. Thank you very much.

Operator: Your next question comes from the line of Michael Gardiner from CorVel Corporation. Your line is now open.

Michael Gardiner: Hi, there. Thank you for taking my call.

I had e-mailed the question in March; I just want to follow up on it. The question is, do you guys ever plan to have a field for body side incorporated with the ICD-9 codes? The codes themselves don't specify a body side, so if you want to have a dislocation of wrists, you don't have left or write and I was curious if that's going to be added in.

Pat Ambrose: I thought that was part of ICD-10 or is that…

Michael Gardiner: That could be.

Pat Ambrose: I have no idea. There certainly is no plan right now to add a code to talk about the side of the body related to, you know, to use in conjunction with an ICD-9.

And I do recall on a previous town hall call, I might have misspoken about and implied that certain ICD-9s did specify right hand versus left hand. And I don't know whether they do or they don't. Certainly…

Barbara Wright: We are not going to change the ICD-9 codes that are published. I do remember someone mentioning to me that the ICD-10 may provide for this. I'm sure if you check it out on Google, you may be able to find the answer to that. But we will not alter what the published ICD-9 codes are.

Pat Ambrose: Yes. Now there is a plan, not finalized of course but to eventually convert to using ICD-10 codes for Section 111 reporting. I believe that CMS is making that transition by the end of 2013.

We do not have a plan. There are – we left space on the record layout to eventually be able to accept the ICD-10. But..

Barbara Wright: When we get closer to CMS's implementation, we will provide necessary guidance to the industry.

Michael Gardiner: And it does look like on a cursory-searching Google that ICD-10 will provide for that. So…

Pat Ambrose: Great. Thank you.

Michael Gardiner: …I just want to – yes.

Pat Ambrose: That's good to know.

Michael Gardiner: And can I have a quick follow-up?

John Albert: Sure.

Michael Gardiner: Just to kind of clarify a question that somewhat abrupt gentleman was making before on the exposure aspect, you know, a simple example would be carpal tunnel. You know, I've got carpal tunnel that didn't just happen on a particular date. It happened through repetitive stress over time. And so I think the industry is looking for guidance on does that apply in the exposure aspect and if so, how do we report that? Because if it applies over time, is it the first (inaudible) my current job, first I ever typed something, you know? It's a little more amorphous as compared to poison exposure or something like that.

Barbara Wright: OK. Thank you.

Michael Gardiner: So, thank you.

Barbara Wright: Operator?

Operator: Your next question comes from the line of (Frank Furland) from New York State Insurance Fund. Your line is now open.

(Karen Yu): Hi. My name is (Karen Yu). I'm with the Insurance Fund. And I previously submitted two questions to a common e-mail, but I'm going to ask them again.

What kind of error code would be sent in the response file if an RRE sends an update or delete record and it doesn't match any of the CMS accepted records for that RRE? For instance like, previously you mentioned at a prior teleconference that if you send a record with a delete action and it previously got a disposition code of 50, and you stated that we should resend that same record with the same action type in order to get a real disposition code.

But in the meantime you may receive an error. As the record would have been deleted, it would not match any of the CMS record for that RRE. So what kind of response will we get? What kind of error code will we get in the file if we send any updates or deletes and it doesn't match anything you have?

Pat Ambrose: I do intend to answer all the technical questions that have been submitted in the technical conference call coming up. I think it's May 13th.

That said, off the top of my head, I don't know the code. And rather than take up everybody's time while I look for it, I'll just make a commitment to make sure that we get that answer to you. You would get an FP disposition code. I don't – I don't know the error off the top of my head.

(Karen Yu): OK. Thank you.

My second question is, if we report an ORM termination date and we had previously received disposition code of '01, '02 or '03 on a claim, do we have to report any subsequent changes to key fields' critical information and/or TPOCs?

Pat Ambrose: You said you reported an ORM termination date?

(Karen Yu): Yes. We…

Pat Ambrose: And it was accepted.

(Karen Yu): (Yu).

Pat Ambrose: Then no, there's no…

Barbara Wright: She added at the end of her question, or TPOCs. Yes, you still have to report any TPOC.

Pat Ambrose: Our time is up.

(Karen Yu): OK. So everything except for TPOCs, if we – after the ORM termination date, we have – we don't have to report anymore.

Pat Ambrose: That's correct. If you do not have additional TPOC amounts nor do you have ORM reopening or the claim reopening for ORM, once you've reported ORM termination date, you should be done with it. It's closed, done with, you don't have to then maintain that record going forward with any updates unless again it reopens for ORM or you pay a TPOC – or you establish a TPOC amount.

(Karen Yu): And this threshold amounts for the TPOC would still apply?

Pat Ambrose: The thresholds do not apply to claims with ORM.

(Karen Yu): OK.

Pat Ambrose: And…

Barbara Wright: Well, remember there is a particular threshold for ORM for Workers' Compensation. There is no threshold for ORM for No Fault. I encourage everybody to go back and read the section on threshold.

(Karen Yu): Well we have Workers' Comp. But isn't that like a threshold that says it is not, you know, equal to or greater than $5,000, we don't have to report it?

Pat Ambrose: That's actually true. I mean you could on that Workers' Comp claim. So let's say – I gather what your condition is that you have a claim that was open for ORM, you have terminated ORM and reported termination date. Subsequently, there is a TPOC amount established, and that TPOC amount is less than $5,000.

Barbara Wright: If it's below the current thresholds, you wouldn't have to report that.

Pat Ambrose: You could, but you don't have to.

(Karen Yu): OK, thank you.

Pat Ambrose: Yes.

Barbara Wright: Operator...

Male: These are good.

Barbara Wright: …it's right close on 3 o'clock. Could you tell us how many people you still have on queue for questions?

Operator: There are approximately 20 people in queue.

John Albert: But we're going to have to wrap it up because we have other meetings to get to, et cetera. But I want to just remind everyone that again, Pat mentioned there is a technical NGHP call on the books right now for May 13th 2010. There was a document released dated April 1st that provides the teleconference schedule for policy and technical through June that's out on the Web site.

We'd like to thank everyone for their participation, some good questions. Keep looking for additional information forthcoming. As Barbara said there's a couple of documents coming out soon. Also, there'll be information published at a later date, to be determined regarding the direct data entry option as well.

With that, I thank everyone and have a good afternoon.

Pat Ambrose: Operator, could you come back after the lines are released and let us know how many people stayed on the call?

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

END