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 21, 2009

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

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FTS-HHS HCFA

Moderator: John Albert
April 21, 2009
12:00 pm CT

Coordinator: Thank you for holding. Parties will be on a listen-only mode until the question and answer session of today's conference. At that time you can press star 1 to ask a question. This call is being recorded, if you have any objections you may disconnect.

I'd like to introduce your first speaker, Mr. William Decker.

William Decker: Thank you Operator. Good afternoon everyone or morning if you're in a different time zone than I am. My name is Bill Decker and I'm with CMS in Baltimore, Maryland. I'm opening up this call today which is a Section 111 NGHP call. Today's call is for Section 111 NGHP people - people who are going to be or entities that will potentially be responsible reporting entities.

This is not a GHP call. If you are a group health plan reporter and looking for Section 111 information today is not the call for you. Today we are going to try to limit the subject matter covered by this call to liability insurance including self insurance and no fault insurance.

Last week we did a call on workers comp and we will do another call later on registration. But for today we're going to go over the subject of liability insurance including self insurance and no-fault insurance.

There will be another call for NGHP reporters; it will be the 12th of May and it will be limited to registration issues. Two days later, the 14th of May, there

will be another NGHP call and that will be open to any questions at all about any of the non-group health plan subjects we are going to be dealing with here through the summer.

The next group health plan call, the next GHP call, for those of you who are about to leave this one is scheduled for May 6, a Wednesday, and that's for all you GHP reporters out there, that's the time for your next call.

Today at the table with me are Patricia Ambrose and Barbara Wright and Bill (Zebonia); all three will be speaking to you at various times during the next couple of hours. But we're going to get started on today's call with remarks from Pat Ambrose and I'll turn it over to her now.

Pat Ambrose: Okay thanks Bill. I'm going to cover some information about the registration process on the COB Secure Website that applies really to all RREs and then some other technical issues and turn it over to Barb.

The Section 111 COB Secure Website often abbreviated at COBSW is - will be available for the non-GHP or the liability no-fault and workers compensation RREs to register on May 1, 2009. The Website is up for registration for GHP RREs but we ask you to please hold your horses and not register early; please wait until May 1 to begin your registration.

The Website URL is www.section111.cms.hhs.gov, when you go to this URL you'll first be presented with a login warning. If you click on the I Accept link at the bottom of that warning you'll be able to view the homepage. You could go ahead and take a look at that homepage now before you get started on registration because there is some information posted under the menu options particularly the How To menu option on that homepage that you might find helpful.

Under the How To menu option you'll see a How To Get Started link that will take you to a document about information about registration on the COB Secure Website and also a document or a link to a document called How To Invite Designees that you may find helpful in terms of inviting other users to become associated with your RRE ID.

I ask that you do not use the September 24, 2008 registration process download on the CMS Mandatory InsRep Webpage. That has outdated information in it however we do have CBTs or Computer Based Training modules available for liability, no fault and workers compensation RREs. If you go to the Mandatory InsRep Website, www.cms.hhs.gov/mandatoryinsrep on the left menu you'll see MMSEA 111 Computer Based Training.

Click on that link, it will take you to a page about our Computer Based Training program and give you information on how to sign up. Again the Computer Based Training modules (for) the registration process are now available for you to review. The modules include a demonstration essentially of the registration and account setup process screen by screen showing how each field is filled in so if you have any questions about what information that you need prior to beginning registration you can take those courses to find out.

The first step on the COB Secure Website is the New Registration button. Through this process, after clicking that process, you will be assigned your Responsible Reporting Entity or RRE ID. During that process you will name your authorized representative. Your authorized representative is typically at the executive level of the RRE organization.

See the profile report and the data use agreement that's a part of that profile report, that's the agreement that needs to be signed by the authorized

representative so you need a person who has the appropriate authority to sign the RRE and that type of agreement, there's no other contract associated with Section 111 reporting.

Note that your authorized representative is never a user of the COB Secure Website. During the new registration step the COBC will also assign your EDI representative. After you complete registration you may request to have - if you are registering for more than one RRE ID you may request to have all your RRE IDs assigned to one EDI representative.

If you make a mistake during new registration and do not name the appropriate individual as your authorized representative you will need to contact your EDI representative to get that changed.

Upon successful completion of the new registration step on the COB Secure Website the COBC will send your authorized representative a letter via the US Postal Service with a Personal Identification Number, or a PIN. The authorized representative then gives that PIN to the individual the RRE has determined to be their account manager.

Step 2 on the COB Secure Website is performed by the account manager. This is the account setup step. The account manager returns to that same URL, clicks on the button for Account Setup. They must have the RRE ID and the PIN that was assigned.

This process assigns your file submission timeframe. We had some questions regarding how the file submission timeframe is determined. This is not based on when you actually register, it's based on the answer that you provide to the number of yearly paid claims or claims paid annually by the business reflected under the RRE ID that you're registering.

This is in order for the COBC to spread out the reporting over the - by size of reporter over the course of each quarter. If you register for multiple RRE IDs you could get a different file submission timeframe for each of those RRE IDs.

Now note that this is strictly an estimate, this number of paid claims per year; it won't be validated in any way. It's a figure though that will give us an idea of the size of the files that you will be submitting under the particular RRE ID.

Note that you must complete the new registration and the account setup steps for each RRE ID that you plan to register for or that you need for submitting your Section 111 files.

During the account setup step you must have complete Connect:Direct file transmission method information if that's what you're using. Please refer to the user guide for more information on that. Also note that if you're providing a National Association of Insurance Commissioners code - or that those processes ask you for any IC number you may default that number to all zeroes, five zeroes if you do not have one.

After successful completion of the account setup step the COBC will email a profile report to your authorized representative. The email will also be copied to the account manager. And the email will contain as an attachment the profile report. The authorized representative has to sign the last page of that profile report and return it to the COBC. Once the COBC has recorded the receipt of that signed profile report the status of the RRE ID is changed to testing and testing can begin.

If you have any issues during the new registration and account setup steps please contact your assigned EDI representative. If you have not been assigned an EDI representative yet you may contact the COBC department number at 646-458-6740.

Again I'd also like to refer you to, as you're going through these steps on the COB Secure Website you will see help pages attached to each step in the process. There's information on how to complete each page on those help pages. There's also a menu option on the COB Secure Website called Contact Us where you can find that same number that I gave for the EDI Department.

I'd like to spend a little bit of time talking about how many RRE IDs you might need to register for. There's no prescribed number or prescribed method of assigning RRE IDs by CMS for Section 111 reporting. What it really depends on is the number of separate claim input file submissions you need to make per quarter.

For one RRE ID you can only submit one claim input file per quarter. So you might have separate claim systems with separate data center locations. You might have - and therefore need to - for practical purposes send two separate claim input files since it wouldn't be practical to roll those two separate claim files up into one and submit it under one RRE ID. So you could register for two RRE IDs based on those separate locations of your data centers of the claim systems from which you would be transmitting your files.

You may set up separate RRE IDs by line of business if you so choose. So you could have one RRE ID for liability, one for no fault, one for workers compensation if you so choose however you do not have to do that you could submit one claim input file for all your lines of business within it.

You may be submitting separate claim files because you're using different agents for reporting purposes. You don't necessarily need to do that but if your claim file are being created by separate agents and transmitted from separate locations each quarter then you would need a separate RRE ID for each of those claim file submissions done or performed by your agents.

You do not need to have a separate RRE ID for each subsidiary company in your organization if you will report them all together. However if you have a subsidiary who's acting completely independently and will report independently from the parent organization it's perfectly acceptable to register that subsidiary for a separate RRE ID and report it separate from the rest of the organization.

Also when you're registering for multiple RRE IDs you may name the same person as your authorized representative for each RRE ID or it could be a different person who plays the role of authorized representative for each RRE ID.

Likewise if you have multiple RRE IDs you may name the same person as your account manager for each or you may use separate individuals for each RRE ID. One thing to note though that an authorized representative can never match or be the same person as your account manager and an authorized representative can never be a user of the COB Secure Website.

In addition if you're registering multiple RRE IDs you may use the same tax identification number or TIN for each of those multiple RRE IDs or you may use separate TINs for each. Note that there is no matching that's done between the TINs that you provide at registration and the TINs that you end up submitting on your claim input file and your TIN reference file.

There's no limit to the number of RRE IDs that you may register for and report under but for both our purposes and the RREs the fewer the better. This will ease the management of these reporting entities. Note that as you start to invite other users to have access to the RRE ID account you must invite those users per RRE ID.

So if you have 50 different RRE IDs and you need to invite another user, known as an account designee, to each of those 50 RRE IDs your account manager will have to go in and perform that invitation 50 times over. So obviously you can see that the fewer the number of RRE IDs the better. And I would recommend that you limit it to strictly the number of files that you need to submit per quarter.

Also as far as registration goes you can register for additional or new RRE IDs after June 30, 2009. The registration and account setup process will remain functional indefinitely on the COB Secure Website. So you might need a new RRE ID due to a new company, some other reason that you need to separate your claim file reporting and so on.

See the note in Section 8.1 of the user guide which states that an RRE does not have register if they don't expect to have anything to report. However once you do have something to report you need to register in a timely fashion in order to test and make that claim report in a timely fashion.

Next I'd like to cover a few items related to the alert on the liability, no fault and workers compensation Section 111 Web page. This alert is related to multiple TPOCs or multiple Total Payment Obligation to Claimants. The alert is dated April 7, 2009. Due to feedback that we've received on the file layout and reporting requirements we've changed the file layout to add four additional TPOC or TPOC date and amounts.

These have been added to the auxiliary record. These will be positional. Use the TPOC fields on the claim detail record first. You don't need to submit the auxiliary record unless you have other claimants or additional TPOCs to report. The action type of code of 3 or action type value of 3 is going to be removed.

In order to report additional TPOCs for a claim that you've already reported one on you would send an update transaction with an action type 2 and put your additional TPOC amount in the subsequent fields found on the auxiliary record. We ask that you continue to report the other TPOCs in the locations that were previously submitted.

Examples of this and details have been spelled out in that alert and will be added to the user guide in the next update. Remember that a TPOC amount is essentially a settlement amount not an individual medical claims payment amount. And in fact those medicals are not included in your TPOC amount so we're not asking - there's only five total TPOCs, these are essentially for separate settlement amounts related to the claim not for individual medical claim payments.

Some other information in addition to version 1 of the user guide as I noted see the alert on the multiple TPOCs dated 4/07/2009 it's also important that you see the alert that's dated 3/20/2009. You'll find that on the liability, no fault, workers compensation page of the Mandatory InsRep page. That alert dated 3/20/2009 includes information on extended testing timeframes, thresholds for reporting and other important information.

Based on some feedback that we've received we've created a list of acronyms or abbreviations that we've been commonly using and will post that with the Computer Based Training modules and add those to the user guide.

Another announcement or explanation I'd like to make based on questions about the email notifications that are generated by the system; these email notifications either go to your authorized representative or to your account manager or both of those individuals. Essentially any email that's a warning in nature will also - will go to both individuals and the day to day emails related to file receipt and the like will just go to the account manager.

We're not able at this time to add more flexibility related to that email delivery so your authorized representative and account manager need to make sure that they forward those emails to the appropriate individuals. Now note though that you don't really need the emails in order to function or to report properly for Section 111.

All users associated with the RRE ID including all account designees can go to the COB Secure Website, log in and get a status of file information, the results of file processing. All users associated with the RRE ID may contact the EDI representative and so on.

I'd like to make a note that you should see the field descriptions for the claim detail record field 15: Alleged cause of injury incident illness; and field 19: the ICD9 diagnosis code 1. For the links or the URLs to the CDC Web sites where the ICD9 documentation can be obtained free of charge.

These links are functional. CMS will publish at a later date a list of ICD9 codes that cannot be used for Section 111; certain default codes will be excluded as valid.

The ICD10 set of diagnosis codes is not yet in production. CMS will transition to the ICD10 by October 2013. So when we initially go live with liability, no fault and workers compensation reporting for Section 111 we will be using the ICD9 codes and not accepting the ICD10 codes until a later date.

When we implement the ICD10 for a while we plan to accept the ICD9 and the 10 codes for a certain period of time to allow for a transition and then eventually convert over to strictly using the ICD10.

I'd also like to go on to answer some of the specific questions that were submitted to the CMS resource mailbox for Section 111. A questioner asked about the disposition codes that you see returned on the query response file. Only a disposition code of 01 or 51 will be returned on a query. You will never get a 50 disposition code on a query response file. The COBC will always complete processing your query response file before returning it.

Another question was asked about the disposition code 50 that you may receive in only very rare cases on the claim response file. Again the 50 is only returned in very rare cases and only on a record by record basis.

This occurs when the COBC may not finish processing your claim input file within the prescribed 45 days. Only then you will receive some records with a 50 disposition code. When you get a 50 resend the record in the next quarterly submission with the most current information you have for that claim.

The original record that you sent on the previous quarter's file will still complete processing at the COBC behind the scenes. But - and so your next record when you send the record again on your next quarterly file if it's sent as an add transaction it will be treated as an update. You might get some

errors on delete because if the delete went through the first time then you obviously - we would not be able to delete that record again.

But I really want to stress that this is only in very, very rare circumstances that you would get a disposition code 50. When you resubmit the next quarter it is possible that that record might be marked as late but most likely not since the original record will complete processing. There's no automatic calculation of a fine for late reporting so as long as you have documentation as to when you originally sent the claim there should be no need to worry about that.

Questions were asked regarding the ORM indicator and the ORM termination date; ORM standing for Ongoing Responsibility for Medical. There was some confusion pointed out over the ORM indicator being a key field so I'll try to see if I can clear that up.

In the normal course of reporting events the ORM indicator is set to a Y on the initial and all subsequent claim reports when you're reporting ongoing responsibility for medical. When ORM or Ongoing Responsibility for Medicals is terminated you are to send an update record with a 2 in the action type and the ORM indicator should still equal a Y or still be filled with a Y.

And on this update you provide the ORM termination date. Now the ORM indicator is a key field for CMS so if you initially reported a claim with an ORM indicator of Y but then determined that was incorrect and there never was any ORM assumed and you need to change that indicator to an N that's the only time that you would go through the process of sending a delete record with the Y followed by an add transaction with the N in the ORM indicator.

Now if there was never any settlement, judgment or award or any ORM, Ongoing Responsibility for Medicals, you would simply send a delete for that claim and would have no subsequent add record with an ORM equal to N.

The ORM indicator equal Y means that the claim currently has or at one time had ongoing responsibility or the RRE had ongoing responsibility for medicals. We post these records for Medicare claims processing so that they can be used to determine - to check for claims with the same injury and Medicare then can avoid primary payment as applicable.

Our key for these records is knowing that there was at one time ORM hence the indicator being key to our processing. The ORM indicator is not an on/off switch; once on it remains on unless you erroneously reported ORM and you never had ORM in the first place. To turn ongoing responsibility for medicals off in a sense you would send the termination date, the ORM termination date but leave the indicator on.

Questions were raised concerning the testing time period for Section 111 reporting. The testing timeframe is from the point the COBC marks the receipt of the signed profile report after you've completed your registration and account setup on the COB Secure Website. And the first - and so it's between that point that the COBC has marked that it's received a signed profile report - between that date and the first day of your first production file submission period.

Now even after the RRE has passed the testing requirements and the status of the RRE ID is set to a production status you may continue testing. The 30-day warning email that the COB sends out after you've been in a testing status for 30 days is merely that a warning email; it's just to make sure that the RRE is staying on top of testing.

This email goes to the authorized representative and the account manager. However you should keep your EDI representative informed of your testing progress throughout. You have more than 30 days in other words to test.

A question was submitted regarding whether the RRE ID is part of the key for claim reports and if it is used in the CMS matching process. Essentially yes it is but since all the instructions and the files are submitted by RRE ID we didn't bother to include that in it - in those instructions.

A question was posed as to whether the 45 day grace period for reporting applies to claims where ongoing responsibility for medicals is assumed. The user guide seems to only provide the 45 day grace period for claims with a TPOC amount. Actually the 45 days, that grace period does apply to reporting claims under which the RRE has assumed ongoing responsibility for medicals.

We don't have a date check; we don't know the actual date that you assumed the ongoing responsibility for medicals so you will not get that compliance flag related to late reporting however you do have - you may assume that you have this 45 day grace period.

A question was asked about what the COBC will do when the Medicare beneficiary matching routine - or in the Medicare beneficiary matching routine - when the individual's name contains a space or a hyphen. The system does not remove spaces or hyphens so we're matching whatever name is coming in on a query file or on a claim input file against whatever name we have for Medicare beneficiaries.

Medicare has supplied name, address, gender, date of birth information for Medicare beneficiaries from the Social Security Administration so if there's

any discrepancy the injured party or Medicare beneficiary needs to go to the Social Security Administration to make any corrections to names or other information.

Another question was asked about the query response since the disposition code of 01 on the query response file does not distinguish between claimants who are currently Medicare eligible or were previously Medicare eligible and the RRE has ongoing responsibility for medicals should we submit that claimant's record? Yes the answer to that is yes.

You will get an 03 disposition code on the claim response if the beneficiary's entitlement period ended before your ORM or your ongoing responsibility for medicals began. However the individual may become entitled to Medicare at any point in time so you would need to continue to send that claim input record on an ongoing basis. And that should be covered in the user guide. We'll make sure that further clarity is added.

There was a question about reporting of the TPOC date and amount for no fault, (TIP) or Med Pay claims when there is also an ORM termination date. Since (TIP) or Med Pay claims don't have a settlement typical of liability and workers comp claims we are required to report TPOC date - are we required to report TPOC date and amount when ORM terminates?

I might defer in part to Barbara on this but first I'd like to say that if there was no settlement judgment award or other TPOC payment made on the claim - on a claim that has ongoing responsibility for medicals you may never have a TPOC amount to report on that claim.

You would just submit the update transaction with the ORM indicator equal to a Y and the ORM termination date. Also submit any no fault exhaust date

information as applicable. And if there was no TPOC related to that claim, no settlement amount related to that claim you would have zeroes in the TPOC date and amount as default.

Barbara Wright: When we get to the next part of the presentation we're going to go over a number of issues related to questions on ongoing responsibility for medicals as well as TPOCs so we'll make sure we address Pat's question again in that context.

Pat Ambrose: Okay. A request was submitted to clarify the use of the Medicare health insurance claim number or HICN often pronounced HICN. Each Medicare beneficiary has one current HIC number or HICN. This is the unique identifier used by Medicare to identify a Medicare beneficiary. Even though it's called the health insurance claim number it is the unique identifier for the individual used by Medicare not an actual claim number.

The assigned HIC number can change from time to time but we will always be able to match an old number to the most current and always return to the RRE or their agent the most current HIC number on record. CMS asks that RREs and their agents use the HIC number whenever it is available in lieu of the SSN.

The HIC number is always returned on the query and claim response files when the injured party information reported is matched to a Medicare beneficiary.

Several people asked about what will happen when an RRE changes agents or starts reporting under an agent subsequently. There's no accommodation made by the CMS or the COBC to provide the new agents a file of the claims

previously reported. This transition needs to occur between the RRE and the agent.

The RRE's account manager can add individuals from the new agent as account designees and then remove the previous agent's account designees at any time. If the file transmission method is HTTPS up or download from the COB Secure Website or secure FTP then the new agent can access any response file that remains out there in the directories or mailboxes.

These files remain on the COB Secure Website for 180 days. The Connect:Direct response files were sent directly to the former agents so they're not available to the new agent through the COBC or the COB Secure Website.

You will not be able to retrieve a complete set of previously submitted claim records from the COBC and so you need to work with the agent and RREs need to work together to make this transition.

A question was asked about the key fields and whether the injured party's name, date of birth and gender are considered key fields or not. Actually they are not considered key fields, they are fields that are used in our matching process. The HICN - or HIC number is really the key field. We use the name, date of birth, gender and SSN to find that HIC number, match to a beneficiary and then match to the claim report and at times to what we refer to as MSP or Medicare Secondary Payer occurrences or information.

So the event table is correct, you do not need to send an update or a delete/add if the name changes. If you do send an update record for - triggered by some other field changing you should send the most current name information - the

most current information for that injured party at the time of that update report though.

The name theoretically should have changed at the Social Security Administration and then been passed on to Medicare and we'll be able to use it in our matching process to the Medicare beneficiary. Again we encourage you to save the HIC number, the HICN returned and submit that on subsequent update files whenever possible.

A question was asked about when a copy of the HIPAA Eligibility (Wrap) or the HEW also I pronounce it the HEW software will be - can be obtained. You may obtain a copy after your account manager completes account setup. This software can be supplied by your EDI representative to either the account manager or an account designee.

Note that the software is free of charge. The COBC is responsible for maintaining it and will make updates and issue updates to it only as needed. It runs on a mainframe and a Windows PC server platform, not on Unix. We are working to make more documentation and the actual software available or downloadable from the Website as soon as possible.

Also note that this is an X-12 270-271 format or a transaction set. That must be used due to HIPAA requirements. Since this is a HIPAA - meaning - that acronym being HIPAA - this is a HIPAA compliant file format or transaction set for healthcare entitlement queries. There's no HIPAA standard for what we need to collect on the claim input file so we're not using an X-12 or an (anse) X-12 transaction set for that purpose just the flat file as described in the user guide.

A question was asked about the difference between an authorized representative and an account manager. Please see the user guide and also the How to Get Started under the How To menu option on the COB Secure Website. Again the authority's representative is not a user of the COBC Secure Website. They are the individual that has ultimate accountability for the Section 111 reporting for the RRE.

The account manager manages the day to day file transfer and more technical related issues. The account manager is a user of the COB Secure Website and the account manager is responsible for managing other users who have associated. Basically the CMS security model requires that this be two different individuals and essentially by signing the profile report the authorized representative is approving the account manager.

A question came up regarding what individuals can be named as the RRE's authorized representative, account manager and account designees. Who should play these roles in other words on the COB Secure Website. There was an example given where an RRE is an insurance company who uses a third-party administrator or TPA to process and pay claims.

The TPA will take care of the reporting for the RRE but the TPA is also using a data services company as an agent to do the actual file transmission to the COBC for Section 111.

So under this scenario you might consider, for example, an individual obviously from the RRE being your authorized representative, an individual from the TPA being the account manager and then one individual or more individuals from your agent being account designees. Again see on the Web site the account - how to invite designee download for further explanations.

Okay that's all I've got and now I'll turn it back over to Bill Decker.

William Decker: Thanks a lot Pat. I'm about to turn it over to Barbara Wright who is going to give you a discussion of something that she wants you to know about. But before I do I do want to remind people on this call that this call is about liability insurance including self insurance and no fault insurance. And when we get to the question period confine your questions to the best of your ability to those subject areas and not to workers compensation.

The other thing I just want to ask our listeners to do when they do get to the question period is that remember that there are lots of people who want to ask questions and if you can keep your own sets of questions down to a manageable level it would be very much appreciated by the people who are in the queue behind you. So now I'll turn it over to Barbara.

Barbara Wright: Thank you Bill. Pat mentioned that we will be posting a list of acronyms for purposes of the rest of the discussion today though probably the six acronyms that we're most likely to use are NGHP or liability insurance, no fault insurance or workers comp. NGHP also stands for non-group health plan; ORM which as Pat as referenced is ongoing responsibility for medical; TPOC which is total payment obligation to the claimant.

DOI which is date of incident; RRE which is responsible reporting entity, the entity that's required to do these submissions under Section 111 and COBC which is our coordination of benefits contractor, the contractor that is actually responsible for taking this data it.

A couple of points I'd like to make first is we did receive some questions about where people are continuing to have a concern about data that we believe that we need. They say they don't currently collect it and they more or

less would like us to say that they don't have to supply it. We're not in a position to do that. We've defined data based on what we need for our coordination of benefits purposes and for our recovery purposes.

To the extent we disagree with any comments that come in please do not consider that we're being dismissive of your concern; we do need to know what your concerns are but a statement that you don't have it doesn't help us; it doesn't change our need for it. What we need you to do is help us figure out a way to work around something if possible.

And in that vein what we'd like to invite everybody to do that's interested in this is two areas we've said that we're continuing to work on are mass tortes and product liability. And for mass tortes what we need for those of you that are interested and we have received some suggestions already that if you would like to submit your suggestion on how a mass torte should be defined please feel free to submit it to our mailbox.

It would help if in the subject line you put mass torte definition. We've received suggestions ranging from anytime there's a claim for 100 or more against the same insurer to a definition which suggested anytime there's one or more claimants and essentially you have the same exposure, ingestion etcetera. So we need any suggestions in that line sooner rather than later so we do invite you to submit them.

The same thing for product liability, right now in the record layout it asks for certain information when there's product liability situation including the brand name, generic name etcetera. And we're trying to cut down or narrow down what we want to consider product liability. We have said in prior calls that just because someone happens to have a frayed cord on their toaster so that

there's some type of object involved, we don't mean that that automatically includes product liability.

So again or if you have a definition of what you believe product liability should encompass we invite you to send that in; subject line again product liability and definition and if you have a particular reason why you want to narrow it that way please feel free to do so.

We are - we're getting continuing requests - and we haven't ruled it out - we've been asked whether we will consider eliminating the product liability field for workers compensation. And depending on what the final narrowing ends up being we could. That's not a promise at this point but it's saying that it is still under consideration.

The next thing is we're a little bit surprised but we're continuing to see questions that seem to assume that this Section 111 reporting just meshes in with everything else Medicare Secondary Payer involves. One of the most recent questions we received was a statement that they understood that the two thresholds involves with worker's compensation were $25,000 and $250,000 so could they assume they had the same thresholds for liability insurance.

We want to caution you again that Section 111 is completely separate and apart from other Medicare Secondary Payer requirements. The threshold that individual was referring to we assume are the workload thresholds that have been established in connection with CMS's workers compensation Medicare set-aside arrangement process. They have nothing to do with Section 111.

You will not be able to take information from other sites such as COBC or the MSPRC and assume that those are Section 111 rules. You do need to go to our

dedicated Webpage and read the implementation instructions for Section 111 there.

We are also continuing to get questions about very fact-specific situations of whether or not something is reportable. And someone will give an example and say so I'm assuming this is not reportable.

What you need to go back to is you need to go back to our definition of liability insurance, our definition of no fault insurance, our definition of workers compensation and no fault and if you believe that some particular program etcetera that you're involved in does not qualify as any of those then and only then if you want to bring that to our attention fine.

But we are not going to assess every particular insurance arrangement in the world and tell you why or why not about whether it's not covered. Among other things we're not getting sufficient information in the question to even begin to do that.

But in most instances the information provided in the questions gives us no reason to believe it's not liability or no fault or workers compensation. So if it's any of those it is reportable as long as medicals were either claimed or released or any settlement judgment award or other payment had the effect of releasing medicals.

We've had some questions about the ICD9 codes. And one of the questions related to whether or not the entity had the codes - what they referenced as early enough in the process. And the tone of the question seemed to indicate that they still thought they had to report the case to us before they settled or before they assumed responsibility for ongoing medicals.

There's - just because - if you don't have medical bills at the beginning then presumably you either aren't paying any and you haven't taken ongoing responsibility for medicals or you haven't reached a settlement judgment aware or other payment that would constitute the TPOC.

Remember that we do not want reporting - or we don't require reporting until there is a settlement judgment award or other payment. It's not for your cases that are just pending. You have to have made some determination to arrive either at the ORM or the TPOC.

One of the questions was asking in terms of SSN. They said they understand that they had to have a release from the beneficiary in order to do a query as to whether or not the individual was in fact a beneficiary. Not true; if you have the Social Security Number or you have a HICN you will be able to use it in our query process. So I'm not - we're not sure where that particular question came from but that's the answer.

There were a couple of questions that had to do with segregation of data; they tended to gather around the idea the query file, can we just do all our querying under one RRE ID or for the agent for two RREs can we do all the querying under just one of the two because ultimately both of them might be an RRE with respect to the same individual.

In the privacy agreement that is agreed to and signed there is assurance that data will be segregated and you will not mix information for different RREs. And that's what you need to be sure to do.

Okay. Ongoing responsibility for medicals versus the TPOC, the total payment obligation to the claimant, we may skip around a little but there have been at least 10 or 15 questions addressing - sometimes multiple of the same

thing addressing various issues here. One of the questions was when ongoing responsibility for medical stops do we include the amount of the ORM payments we've made as part of a TPOC amount?

The simple answer to that is no. What you're paying under the ongoing responsibility for medicals, you're paying on an ongoing basis. It's considered separate and apart from the total payment obligation to the claimant which as Pat stated you may or may not ever have. You may have cases where all you do is assume ongoing responsibility for medicals that you eventually terminate.

The second one along the same lines - and this one we may need some more explanations from those of you in the audience. We had more than one question that talked about situation where they were paying the - the entity was paying the ambulance, was paying the doctor, was paying the hospital but then turned around said but this isn't ongoing responsibility for medicals and we haven't settled yet.

And we feel that we're missing some facts in that scenario. Is that a situation where you're paying while something is under investigation? In which case we said if you're paying while it's under investigation you need to report it as ORM and when the investigation is over if you're not - if you've decided that you're not going to continue paying then you report the termination of the ORM or you need to take a closer look at your fact situation if the reason you're paying fits within CMS's definition of no fault insurance then yes that also has to be reported as ORM.

So I can remember just off the top of my head at least three or four questions with sort of this same fact scenario. If you want to send us in more detail tell us why this would not be ORM, why you don't believe it's no fault then

perhaps we could give you more detail. But right now the questions are sounding as though they are situation where ORM has been assumed.

Okay with respect to the TPOCs several questions went back to more or less how it's structured. We're looking at a single payment obligation regardless of how the payout is structured. So if you have a situation where it's $150,000 settlement that's going to be paid out as an annuity you report the $150,000.

As we said in the file layout your calculations of the TPOC amount is looking at the lesser of the minimum payout that will occur - I'm sorry - the greater of the minimum payout that will occur or the amount that was used to purchase the annuity which ever is greater. You do not subtract attorney fees out of the TPOC amount.

If you have a situation where you have a - let's say you have a liability settlement, it's $100,000 and you know the attorney charges 30% for fees. You still report - you as an RRE still report the $100,000. The only time you'd be paying attention to what the attorney fees are if you have a situation where you arrive at a TPOC amount of $100,000 and you agree separate and apart from that to pay a set amount of attorney's fees directly to the attorney then in that case again you're just reporting the TPOC.

You would not have to report the attorney fees - the beneficiary's attorney would be required in dealing with us with respect to any recovery to tell us that the fees were not borne by the beneficiary. We use information about attorney's fees and other procurement costs and we do a pro rata reduction with respect to our recovery when we're recovering from a beneficiary but only where those fees and costs are directly borne by the beneficiary.

And in a situation where you have an agreement to pay those separately and directly then the attorney would be obligated to let us know that so we wouldn't improperly take a reduction.

Pat already covered the fact that for ORM there is the 45 day grace period. Another question was when you have multiple TPOCs how does this play in with the threshold that we published in the alert subsequent to the user guide. And you are looking at the total of those TPOCs together so if you had a situation for whatever reason that you had a $4000 TPOC and then later you had a $2000 one you would need to report the total as $6000.

Our expectation at this point is that we would just have you report those two as a single TPOC amount rather than having you filling out a TPOC 1 for $4000 and a TPOC 2 for $2000.

This is another area that we would appreciate prompt comments on. If you believe from a system standpoint that where you have to give this cumulative amount that it's a problem for your reported as a single amount that there's some strong reason that you would want to continue to report it as TPOC 1 and TPOC 2 we need to know that because our inclination right now is when you don't report it until you go over a threshold that the amount that gets reported is a single TPOC once you've gone over that threshold.

There was a question asked about ongoing responsibility for medicals and they asked if only certain treatments or a certain modality of treatments that coverage was terminated did they terminate the ORM. And the answer is no. This situation could go either way; if you have an additional injury added or you have something that changes you have the ability to update the ICD9 code.

We received several questions about hearing loss questioning because Medicare doesn't generally pay for hearing aids that - did this have to be reported Yes it does if it otherwise is reportable with regard to thresholds or anything else or with respect to ongoing responsibility for medicals because there could be other associated services that under certain circumstances would be paid by Medicare so we do need the report sent in.

There was also a question about TPOC - what if we pay part of the TPOC to the beneficiary and we part to a hospital; do we report the total or do we report just what we pay to the beneficiary. When we're talking about the TPOC we're really talking that you're making payments to or on behalf of the beneficiary.

So if there was a settlement - an actual settlement versus ongoing responsibility for medicals where you were paying $100,000 to a hospital you would need to report that to us. Just because you made the payment directly to a provider doesn't eliminate that obligation.

But let's get back to ORM again, if you've assumed ongoing responsibility to medical - for medicals those payments directly to a provider you are not reporting those individual payments to us, you're just reporting the existence of the ongoing responsibility for medicals.

Okay there were some general questions about if a settlement is under the reporting threshold but you know that the individual's medicals exceeded that threshold if it's a settlement, for example, there was a cap on a liability policy of $20,000 and you knew the medicals were more than that. People wanted to know whether they had to report the actual associated medicals as a settlement; no, you're reporting the settlement judgment award or other payment, you're not reporting the amount of medicals.

Along that same line were questions that have to do with allocations by the party - or parties to something. We had questions that came in and said well can we just ignore any payments that we make that are non-injury related or we have situations where the service is not covered by Medicare. And we have said on page 57 of the user guide if you look at that there's a discussion about allocation by the parties that CMS is not bound by those allocations.

What you need to look at is if you have a situation where medicals are claimed or released or the documents involved have the affect of releasing medicals then you need to report.

If you have something that's strictly, for example, a fender bender, you have a situation and someone has an exorbitantly expensive car so all you did was bend the fender but it's going to cost $7500 so the amount - the amount would have been reportable. If that's not claiming or releasing medicals then no you're not reporting that situation.

I think that's pretty much it for now. We do want to leave you some time to ask questions and it's a few minutes after 2:00. So Operator if you'd like to open up the questions.

Coordinator: If you'd like to ask a question from the phones press star 1, please un-mute your phone and record your name; to withdraw your question press star 2. Once again it's star 1 to ask a question. Please stand by for the first question. The first question is from (Theresa Len).

(Theresa Len): Thank you. This is a question regarding third-party administrators. If a self insured employer has a group of claims that falls under an old TPA and then changes TPAs at a later date does the old TPA continue to follow-up on the

reporting of the first group of claims that they covered? And does the new TPA then just have the responsibility - if they're being used as an agent.

Barbara Wright: It sounded in the beginning like you were talking about group health plan insurance which is...

(Theresa Len): No, I'm sorry. Only non-group health.

Barbara Wright: If you have someone that is acting as your agent and you want to switch agents as Pat explained there will be provisions for that to be done. If you want to add an additional RRE so that your old agent continues to report on existing claims and the new agent only reports from a particular date forward you can do that too. So it'll really be up to the RRE how they want to structure it.

Remember that in cases probably more liability as opposed to workers compensation...

(Theresa Len): Correct.

Barbara Wright: ...for many of the liability you will only ever be reporting a TPOC.

(Theresa Len): Right.

Barbara Wright: And you will have closed your record so there would be nothing further to be reported.

(Theresa Len): Okay. Thank you.

Coordinator: The next question is from (Theresa Felino).

(Theresa Felino): Hi. My question is on the state)of venue. In a no fault state if our customer is in another state - the Michigan policy - say they're in Ohio and they have an accident. So for the liability purposes the state of venue would be Ohio; we would go by Ohio liability laws but on the medical side we go by Michigan laws so then when we're reporting we have to report based on the laws that we're going to use for payment or is it strictly where the loss happens?

Barbara Wright: I'm trying to remember where that field is. I think we said basically what relates to that - how you're handling the claim. I guess we left it a little bit wider open than that; we said that you should use your best judgment. So if you're bound by the law of a particular state for a particular aspect use that.

Remember that it might not cause as much confusion as your question sounds like at first glance because to the extent you're using one law for liability and one for workers compensation that's going to come in on two separate records so you just put the appropriate state of venue down.

Does that help you at all or do you want to ask a further question?

(Theresa Felino): It does help it just - we just wanted to make sure that then you're not going to question why we have two different states of venue on the same accident for the, you own, on that person.

Barbara Wright: No, I mean, for the most part no. If we had a question in many cases we will be going back to the beneficiaries directly or the beneficiary's representative in conjunction with any recovery claim we have. We anticipate that our need to go back to the RRE s should be very limited and possibly nonexistent as long as they're reporting them, you know, correctly.

(Theresa Felino): Okay. Then you talked about the HEW and when the software will be available. Once we get that software how quickly or how soon will we be able to submit query files?

Pat Ambrose: You're currently slated to be able to submit query files after you complete testing in a test mode during the July through September timeframe and in a production mode in the October timeframe - after October. But you can submit production query files as early as October 1 after testing is complete.

We're actually working on right now your testing requirement state that you must test your claim input file first and be changed to a production status then you could submit production query files. We're actually revising those requirements to kind of separate those two to allow you to send queries in a production mode prior to the time that you might have finished testing your claim input file.

Barbara Wright: But as Pat said we're - at this point we're working on that so we can't give you an exact date for that. As soon as we have any arrangements for that complete we will let you know. But we are working to give you access to the query file as soon as possible.

(Theresa Felino): Okay. And last but not least you mentioned earlier the ORM reporting that if we just have a pending case but we're not making payments we don't report it. We have many situations where there may be more than one auto insurer that would pay on a claim. So one insurer takes the lead and makes all the payments and then periodically or at the end of the treatment period pays back the other insurer pro rata.

So you're saying that if we're not making payment but we know this is going on we still would not report it until we make payment?

Barbara Wright: If you've got ongoing responsibility for medicals, yes, we would like that reported with the exception of the thresholds that we put in the alert subsequent to the user guide which we had a- I think we named four conditions that all needed to be met.

If you had situations - basically we were dealing with what our relatively small medical only claims where you're paying the providers directly. We are still looking to receive additional and still reviewing data we've received. And as stated we hope to be able to raise that dollar threshold for you before the reporting (entity) starts.

(Theresa Felino): Okay. That does it for me. Thank you very much.

Coordinator: Our next question is from (Carol Cook). (Carol Cook), your line is open you may ask your question. Please check your mute button.

(Carol Cook): Thank you. My question is around the thresholds that were mentioned in the 3/20 alert. In looking at the amount of coding that we would need to do to enforce that threshold then have it change it year to year and go back and look to see if anybody now meets the threshold that didn't meet the threshold before, are those thresholds enforced? Do we have to follow those thresholds or can we go ahead and do complete reporting?

Barbara Wright: We will get an answer back to you. We need to check with the backend people of this process.

(Carol Cook): Okay. That was my question.

William Decker: We will follow up with an answer for you at a later date is the subtest of Barbara's answer. Thank you.

Coordinator: The next question is from (Laurie Nielsen).

(Laurie Nielsen): Yes, I wanted to find out on claims that might be like derivative of the person that's injured for example if you have a husband for example who's not a Medicare beneficiary but then the wife has like a loss of consortium claim and she might be a Medicare beneficiary.

Barbara Wright: Again we're talking about medicals that are claimed or released or have the affect of releasing medicals.

(Laurie Nielsen): She would not have any medicals because...

Barbara Wright: Well if she - that's what I'm saying, if she's the beneficiary and there's nothing associated with her consortium claim that ties into medicals or has the affect of releasing medicals and she's the only one that's a beneficiary then we don't need anything reported for her.

(Laurie Nielsen): Okay. Thank you.

Barbara Wright: Wait - could you hang on just a second, don't go away.

(Laurie Nielsen): Sure.

Coordinator: You're not ready for the next question yet, am I correct?

((Crosstalk))

Coordinator: Okay I was just checking, thank you.

Barbara Wright: We'd like to add one thing on the last response; the specific example given to us was one where the husband was not a Medicare beneficiary and the wife was a Medicare beneficiary with only a consortium claim. Let's say they were both beneficiaries.

Again as we said we're not bound by the allocation of the parties and we would not accept a situation where there was let's say $100,000 cap and a decision - the party said well we'll allocate the majority or a large portion of this to consortium with less to the actual injured party. We have a priority right of recovery and just to repeat again we're not bound by the allocation of the parties. So if your example had changed and they were both beneficiaries then we would be looking to recovery.

William Decker: (Only) to the injured parties...

Barbara Wright: Yes, either both were beneficiary or only the injured party was a beneficiary; we would be looking at our priority rights with respect to the total settlement.

(Laurie Nielsen): Okay.

Barbara Wright: Does that add confusion or...

(Laurie Nielsen): Yeah.

Barbara Wright: Well, we've said it and it's on page - what did I say - I think it's page 57 of the user guide where we talked about allocation of the parties. And if you think of it in overly simplistic terms, say there was a $1000 policy cap the husband was the only one that was a beneficiary and the wife wasn't.

Let's say you wanted to say the whole $100,000 was consortium and, gee, he didn't get anything because that arguably would let you off the hook with Medicare. And what we're saying is that's not the right assumption that we have the priority right of recovery against that and we don't pay attention - are not bound by the allocation of the parties. We look to recover our claim first.

(Laurie Nielsen): But who's - who has the responsibility to report that? I only have the responsibility of reporting is that not correct?

Barbara Wright: You have the responsibility to report and we do not intend to change our normal recovery process which for the most part is a recovery against a Medicare beneficiary settlement judgment or award. All I'm saying is that if the husband had been the Medicare beneficiary in that situation the fact that the parties allocated all or most of the settlement to the non beneficiary wife as consortium you would still be obligated to report the total settlement amount with respect to the beneficiary husband.

(Laurie Nielsen): But I wouldn't have any reporting requirement if the loss of consortium is the only Medicare beneficiary.

Barbara Wright: We agreed to that, yes.

(Laurie Nielsen): Okay.

Barbara Wright: But we felt it was fair to bring up the situation where a Medicare beneficiary was having a claim against the settlement.

(Laurie Nielsen): Okay but that's only if I - okay but that would only be an issue if I know that there's a Medicare lien.

Barbara Wright: You don't have to know whether or not there's a lien, you're obligated...

(Laurie Nielsen): Or there's Medicare issues?

Barbara Wright: If any of the claimants is a Medicare beneficiary you need to report the total TPOC amount.

(Laurie Nielsen): So essentially whether the loss of consortium claim is a Medicare beneficiary or not I should report it?

Barbara Wright: No. Let's try this once again, I'm sorry. You have a situation - most of your - you're going to only report when somebody involved in the claim is a Medicare beneficiary and there were medicals claimed and/or released. So your most likely situation is - let's assume they got married at the same age so they're both beneficiaries. Your situation where they're both beneficiaries you're going to report the total TPOC amount with respect to the husband because he's the beneficiary. You're not going to report anything with respect to the wife because she's only got a consortium claim.

Let's take the next situation where for whatever reason they're both beneficiaries and somehow she had medicals associated with her consortium then...

(Laurie Nielsen): Okay but the whole idea of consortium is there is no medical, okay?

Barbara Wright: I understand what the concept is but we would look specifically at what was claimed or released or had the affect of being released. So we're hesitant to make any assumptions for a particular settlement.

((Crosstalk))

Barbara Wright: If you want to go back to your original assumption non-beneficiary spouse who had a consortium claim and her husband was not a beneficiary either and they're the only ones involved in the claim, no you wouldn't have anything to report.

(Laurie Nielsen): Okay. Thank you.

Coordinator: The next question is from (John Spellman).

(John Spellman): My question comes from Section 7.1 of the user guide page 19, a couple of the bullet points there. One of them refers to reinsurance, excess insurance, umbrella insurance and so on where the payments are being made to reimburse - in a situation where they're being made to reimburse the insured party; it's referred to there as the self insured entity.

My question is there may be situations in which a company has - is dealing with primary insurers but handles all its own claims, its own - claim payments then just bills the insurers who then reimburse the company. In that kind of a situation where that's the established practice who does the reporting?

Barbara Wright: We've already said that at least for any deductible amount the self insured entity does that reporting. I don't believe we've addressed the very specific question you asked about situations where the insurer is paying the insured and the insured is making the payment to the claimant. And we do expect to address that in the next group of examples for the user guide.

(John Spellman): All right thank you. That would particularly be relevant in, for example, asbestos mass torte kind of situation where a particular defendant company

might have thousands and thousands of claims across the country and they choose with their insurers to handle it that way where everything is centralized, they make all the payments and the settlement and they sent just then bills to the insurers who would then reimburse them.

Barbara Wright: Okay.

(John Spellman): The second question is the previous bullet point where in the case of multiple defendants all RREs remain responsible for their own reporting. A variance of that would be if there were multiple insurers of one defendant. And again this probably is likely to come up in a mass torte situation like asbestos. And my question is whether CMS is open to modifying the - to some modification which would allow for centralization of reporting in that situation.

In other words multiple payments by multiple insurers to one claimant to settle one claim because of a single defendant.

Barbara Wright: You're asking if we'd be open to having that reported through one RRE?

(John Spellman): Yes.

Barbara Wright: If you've got something like that send us a question and tell us why you don't think that would inappropriately shift the responsibility for the potential CMP.

The exception that we had made so far where we had said if you have a situation where there's - an individual has - an individual or a company has the deductible and then they have policy coverage beyond the deductible we said that although they're self insured for the deductible if that deductible is always paid to their insurer who is then responsible for paying it out that the insurer would report both the deductible and the amount above that.

And in that scenario we're not imposing any additional CMP burden - or at least we don't believe we are because that insurer would already have responsibility as a responsible reporting entity for that claim. We're not sure that we say the same in other factual situations. So if you can line something out for us in detail and tell us why you don't think it would inappropriately shift the underlying responsibility for any potential CMP or Civil Money Penalty, yes, we'd be happy to consider it.

But that's been our concern. We can't - although we would like to centralize and we would certainly prefer only one report part of what we're limited by is the law in terms of who has this responsibility for any, you know, penalty.

(John Spellman): I understand. Thank you. That's all I had.

Coordinator: The next question is from (Michael Kincops).

(Michael Kincops): Hello?

Barbara Wright: We're here. Hello? Operator, we seem to have lost him.

(Michael Kincops): Can you hear me?

Barbara Wright: Yes we can.

Pat Ambrose: Yeah.

(Michael Kincops): Okay. You have - discussed in connection with registration that if an RRE has subsidiaries reporting independently each can have its own RRE ID?

Pat Ambrose: Yes.

(Michael Kincops): And my question is - is can a subsidiary register as a completely separate RRE?

Pat Ambrose: Yes.

(Michael Kincops): Okay. And there's no downside to doing that?

Pat Ambrose: No.

(Michael Kincops): Okay great. Secondly as I understand it each RRE ID can have its own account manger at its end and also the RRE can request that a single EDI be assigned for, you know, for multiple IDs.

Pat Ambrose: Yes.

(Michael Kincops): Okay. Can they also have separate EDIs?

Pat Ambrose: Yes.

(Michael Kincops): Okay very good. Those are my question. Thank you very much.

Barbara Wright: Isn't it fair to say Pat that we don't guarantee that if you register for a separate RRE for every subsidiary we don't guarantee that we can give you the same EDI rep for all of them or the same submission window.

(Michael Kincops): Okay.

Pat Ambrose: Well, yeah, I mean, the way it works is when you go to register and you get your RRE ID the system will randomly assign and EDI representative. At this point that's how it works. And subsequently you may then contact one of those EDI representatives and say I have these five RRE IDs could you change it so that I have the same EDI representative for all of these and they would be going into the system on their end and manually making that change and reassignment.

The file submission timeframe there is not as much flexibility with so, you know, so essentially, you know, you can - yeah, the file submissions are going to be different for those different RRE IDs. And I assume that that should work out okay just because you're sending separate files so sending them at different times it should not really impact your data processing too horribly.

(Michael Kincops): All right thank you very much.

Pat Ambrose: Okay.

Barbara Wright: Also the one other thing that probably is not a downside but could be particularly for small RREs is once you've registered as an RRE we repeat that you must submit a file every quarter even if it's an empty file. So if you have some small entities within your structure and you set them up independently they will have that responsibility every quarter even if they don't have anybody to report.

(Michael Kincops): Okay. Thank you very much.

Barbara Wright: Operator.

Coordinator: The next question is from (Robert Ellsworth).

(Robert Ellsworth): Hello, thank you. I have a couple quick questions here; the first one about registration. Once we register can we change our submission format and a vendor names if that changes at a later date?

Pat Ambrose: By vendor if you mean agent, yes, you can change your agent information. Just to explain a little bit more about that, as you go through the account setup process you're asked to provide some general agent information including the name, address, TIN of your agent and also a contact. Now that contact, when you're doing your account setup and providing agent information, is not naming that contact as a user.

So at any rate though after account setup is completed and the account manager is then able to invite designees the account manager can go in and invite certain individuals to become associated, to get a login ID and password and be associated with that RRE ID.

Also at any time the account manager can remove that person's access to their RRE ID so you can - and in addition the account manager can go in and change the general information about - general agent information so you'll have the flexibility to add and remove both users who are agents of the RRE and also change the - or remove the agent information that was provided during your account setup.

(Robert Ellsworth): Okay.

Pat Ambrose: And I forgot your first question, I'm sorry.

(Robert Ellsworth): The first one was about submission format. Can we change from HTTPS to SFTP at a later time as well?

Pat Ambrose: Yes you may. You need to contact - at this time you'll need to contact your EDI representative to make that change for you.

(Robert Ellsworth): Make changes through the EDI rep?

Pat Ambrose: Yeah.

(Robert Ellsworth): Okay, my second question is if we had a file that was returned with a severe error or too many threshold errors do those files need to be resent immediately during that reporting period or is that sent during the next quarterly reporting?

Pat Ambrose: You know, you'll work with your EDI representative on this. You'll get a notification about - let's take the threshold example - a file that fails for a threshold error will sit there in a suspended state or a suspended status until you work through the resolution with your EDI representative.

For whatever reason if the threshold error - if it's determined that there really is no problem with the file the EDI representative can release it for processing or if there is a problem truly with the file they can delete it and they will tell you whether you should send a file immediately again or not. Nine times out of ten or maybe more often you are asked to submit an additional file immediately so that we can get that information sooner than later.

For a severe error the only option is to delete the file but you'll still be making - having some personal contact with your EDI representative who will, you know, basically make sure that everyone understands why there was this severe error in the first place. Sometimes files get cut off due to transmission errors; sometimes it's an actual file format error.

Once that's resolved or you understand what the problem - what triggered the problem then the EDI rep has no choice but to delete the file from processing and then you are instructed to either send a file immediately to replace it or, you know, depending on the timing and so on and if you're not able to or I don't know what the circumstances might be they might tell you to wait until your next file submission.

But again most of the time you're asked to send it as soon as you can correct the problem and resubmit it.

(Robert Ellsworth): Okay. And then my last question is about ORM. On page 52 of the user guide it referenced not required to report ongoing ORM that's closed prior to January 1. I'm trying to clarify this explanation. So my understanding is that we need to go back and report closed claims from January 1 through July 1 of 2009 that we had an ORM responsibility for and then going forward we only need to report those open claims that we have an ongoing responsibility for; is that correct?

Barbara Wright: Yes and no. I think the problem is with the definition of closed. We had a very strict definition of closed in there that it was only when there was essentially no possibility of further payment and we were told by the industry that many of them routinely closed it administratively or in their records when they had made payment for a year or six months even if they had an obligation for lifetime medical.

What we said is in this look-back period is you need to go back and identify all those that cannot be considered closed under our standard. And you've got the standards as we've set for in there. We did add one since then; we said that even in a state that has responsibility for lifetime medicals if you have a

statement from the treating physician that further treatment is not expected then we're fine if you close that record even if under state law you would have lifetime medicals.

So that's the discrete group we're asking you to do a look-back on. If it was closed between 1/01/09 and July 1, '09 based on state law that there period to get benefits had been exhausted then no you don't have to go back and look at that. It's only ones that would have been considered open under state law and under our requirements that you need to go back and look at.

(Robert Ellsworth): Okay. And then to clarify the period prior to January 1, 2009 if that's something that we've administratively closed by our definition are you asking for a look-back on that as well?

Barbara Wright: No, that's what we're not asking for a look-back on. Based on the information we received that would be a tremendous burden on the industry. We gave you a date that basically should be within what your current books are. If those cases prior to 1/01/09 reopen for any reason then you need to report them at that time.

(Robert Ellsworth): Okay. And then - I mean, this may have been clarified by what you already said but just so I'm clear if we've got a case that is closed prior to our first reporting would we - and it was an ORM case would be send both an initial and a termination for those claims or are you more looking for claims that we would consider closed but you wouldn't necessarily consider closed?

Barbara Wright: Let's try and give two examples. One you had a case where you had ongoing responsibility for medicals that under our definition continued on or after 7/01/09 and you had administratively closed it on May 1. You would need to report that one.

(Robert Ellsworth): Okay.

Barbara Wright: And if you - that same case you had administratively closed it in ’08 you wouldn’t have to report it. On the same token let’s say you had one that you closed it administratively in January of this year and then you closed it based on our standards on July 15. You would report both the initial ORM assumption date no matter how far back that went. And you would report the ORM assumption and you would report the termination both in your first file submission.

Pat Ambrose: Yeah, there’s no assumption date for ORM but...

Barbara Wright: Yeah.

Pat Ambrose: ...the date of incident and the ORM termination date you might be reporting in one record.

Barbara Wright: I would point out that on page 52 though if it’s ones where the ORM was assumed prior to July 1, 2009 you do at this point have some extended period for reporting those for the first time. In other words if the work in doing your look-back takes you beyond probably when your first submission date is that you do - you may delay reporting until the third quarter of the 2010 file submission.

(Robert Ellsworth): That’s correct. I saw that in the documentation.

Barbara Wright: Okay.

(Robert Ellsworth): And then just to give the flip side of the example that you just gave if I had one that was closed by CMS's definition prior to July 1, 2009 that would not be reportable, correct?

Barbara Wright: Correct.

(Robert Ellsworth): Okay. That answers everything I had. Thank you very much.

Coordinator: The next question is from (Celia Winchell).

(Celia Winchell): Yes, thank you. May a parent corporation with a tax ID that has many subsidiaries with other tax IDs, is it acceptable to register and report everything under the one parent corporation tax ID?

Pat Ambrose: Yes.

(Celia Winchell): Okay. And the second one: as the penalties to be imposed on late or incomplete reporting can you clarify what fields are edited to determine the late report?

Pat Ambrose: Could you repeat that question please?

(Celia Winchell): As the penalties are to be imposed on late or incomplete reporting can you clarify what fields are edited to determine a late report?

Pat Ambrose: I'd refer you to the section in the user guide where we are calculating the compliance code for a late submission. But there's no calculation for a penalty at this time.

Barbara Wright: And I would point out that even though we don't - we made it clear that we're not editing on late submission for ORM that we also note in the guide that if you're not submitting it within the appropriate time period you should maintain documentation of why you didn't or why - if for instance the date of incident was in - was July 1, 2009 and you didn't assume ORM until January of 2010 because you were investigating so you didn't report it until your first quarter in 2010 you should be able to document that if we ever audited you for any reason on timeliness submissions.

(Celia Winchell): Okay. And for those corporations that may have medical facilities on site and may treat some things there, how would affect the threshold or does it if there's no billing really involved?

Barbara Wright: If it's part of an assumption of ongoing responsibility for medicals you should still report that ongoing responsibility for medicals because I can't come up with every example but let's say they go to your clinic for two visits and then for whatever reason they live 50 miles away so they go to their own doctor for the third. If you've assumed the ongoing responsibility for medicals you have to report it even though you expect maybe to pick up free services at your clinic.

(Celia Winchell): Okay thank you.

Coordinator: The next question is from (Claire Bellow).

(Claire Bellow): Good afternoon. I have a couple of questions. I'm with Vertical Claims Management; we work with almost all alternative risk type of insurance programs on medical malpractice and general liability type files. And a couple of my questions are this: We have an alternative risk program that uses a fronting carrier that issues the insurance policy that is reinsured 100% on the

backend by the captive, which means the hospital that has made the payment to the claimant is reimbursed by their captive with notice to the fronting carrier.

We are having some issues trying to determine who the proper RRE is in that situation. The claimant is paid generally by the entity that is reimbursed by the captive which reinsures the fund.

Barbara Wright: That's one of the examples that we are putting - that we expect to put in the group that we're assembling right now. And I'm sorry in terms of getting all these words over the phone right now we're frankly afraid to give you an answer - that we'll miss a word. But we do plan on including examples there.

A lot of the fronting when we talked about it informally with some other groups in most cases it appeared that the entity that bought the fronting policy was actually self insured under our terms for what was going on which would make them the RRE. But do not take this statement as a final statement.

If you have a particular example of fronting that you would like us to use please feel free to send it in as well as who you think the RRE is.

(Claire Bellow): Okay. I did actually on April 2 send an email.

Barbara Wright: Okay well I know we have examples here but we...

(Claire Bellow): Okay.

Barbara Wright: ...don't come up with the names of all the people...

(Claire Bellow): Okay.

Barbara Wright: ...that sent them in.

(Claire Bellow): Yeah, because this is - and with the alternative risk program there's a lot of amalgamations of how they structure themselves and so we're really trying to work through with the May 1 deadline coming up who the appropriate RREs are going to be.

The other question - another question I had was what - you mentioned earlier that the Website is open for the GHPs but what happens if you have an NGHP that registers early? Will it...

Pat Ambrose: You'll make me very unhappy.

(Claire Bellow): I'm not sure I always have control over that.

Pat Ambrose: I'm just kidding. You know, it's...

(Claire Bellow): Will it go through? I mean it won't get rejected will it?

Pat Ambrose: Yeah, no it won't.

(Claire Bellow): Okay.

Pat Ambrose: You know...

(Claire Bellow): You don't want it to happen but I happen - I just wondered if, you know, we've got 30 different programs with people registering; I want to make sure.

Pat Ambrose: Yeah, we want to make sure that we're able to provide the technical support that we need. So, you know, please wait until May 1. You'll have plenty of time. And if you do in your analysis of the RRE IDs that you need in the future you need to load another one after June 30 that's completely acceptable to...

(Claire Bellow): Okay.

Pat Ambrose: ...to do the registration process then as you come up with an additional need. So there's no reason to register early.

Barbara Wright: And remember we also said for that - those that based on their history of when they have paid or haven't paid have no reasonable expectation of reporting they do not need to register right away but they do need to register in time to allow a full quarter for testing if at some point they have a claim where they may have to report.

(Claire Bellow): Okay. Is there any thought - and this is perhaps more a request than a question. Where we have insurance programs where the entity, similar to the fronting issue we were discussing earlier, where we may have six or seven entities in a single alternative risk program each of which may end up being their own RRE. But they're all handled in the same claims data; they're all handled in the same loss run.

Under the current structure they may have five different report dates. But they're really one insurance program even though the RRE ID numbers need to be split out for responsibility purposes. Is it possible to try to get those coordinated for reporting purposes?

Barbara Wright: If you're using the same agent and/or account manager, again, Pat mentioned that you can request to have - that agent could request to have certain things handled together.

(Claire Bellow): Okay. Okay because that does become a big deal. We've got a program that's got 75 different entities and so 75 different report dates in a quarter for one insurance program is a lot when one would be easier.

Also a question on the missing data and the late report questions that have been raised; as we have been going through the required fields for the upload report the vast majority of the fields of information are considered to be required by CMS. Are there going to be guidelines issued at any point as to what missing information will trigger the compliance codes?

I mean it seems to me the TPOC information and claimant information and HICN numbers are more important than the plaintiff's counsel's zip code but they're all required fields. And from a reporting standpoint we may not have that information but we've got the bulk of the inflammation that you want. It's not clear from the guidelines what will issue a rejected file and what won't.

Pat Ambrose: Well if you - in those files layouts any field that's listed as required is required and if you don't - under the conditions described you don't submit a valid data element in that field the claim record will be rejected with an SP disposition code and the corresponding errors that are in that - the errors are listed in the appendix - one of the appendices rather.

Barbara Wright: The note that Pat said the record would reject so if you have...

Pat Ambrose: Yeah, the whole file will not be but a particular record on a file, you know, we can accept one but not another. But, you know, if there is a particular field

that's required on every single claim record report, every single claim detail and you are unable to provide it or some default value every record would get rejected. And so it is documented in that user guide; when it says required it means required. There are some conditions that, you know, it's only required if a certain indicator is yes or no or something like that though.

(Claire Bellow): I understand that they're required I guess my question is what is it that triggers compliance problems? Because...

William Decker: A failed submission will trigger a compliance problem and if you don't supply the required fields you could get a failed submission.

(Claire Bellow): Okay but that, I mean, there's a difference between a compliance flag and a compliance fine, correct?

Pat Ambrose: Yes, right now we're just flagging certain issues on records with a compliance flag. There is no automatic calculation of a fine for Section 111 reporting at this time.

(Claire Bellow): Okay. All right. That is all I had, thank you very much.

Barbara Wright: Operator, could you give us an idea of how many people are queued up for questions?

Coordinator: Right now there's 52.

William Decker: Okay let's keep going.

Coordinator: The next question is from (Bill Thompson).

(Bill Thompson): Hi. I have a few questions. One is on the user guide of page 25. There's the description of information we need for registration which includes subsidiary company information. And I'm wondering what you mean by that.

Pat Ambrose: If you are an insurance carrier that has numerous subsidiary companies an in - while you're under one - let's suppose though you use the same claim system for all of those subsidiary companies and maybe they have separate TINS and separate NAIC company codes that are all rolled up into one NAIC group code.

You may - if you're going to submit all of that subsidiary information together in one claim input file because you, you know, it's easy to produce out of one claim system you'd register for one RRE ID and provide a TIN - at least one TIN to be associated with the RRE ID.

And then when you are asked for a subsidiary information you would list the TINs which might be the same or different from your main TINs that you provided and NAIC company codes and other information. So we're just looking for the list of subsidiary companies with which you - are included in that RRE ID report submission.

(Bill Thompson): Okay but you don't need for us, for example, to list every writing company that we have, do you?

Pat Ambrose: No, no, no, not, you know, not necessarily. I mean, you know, obviously we are collecting things at the NAIC company code level and doing some validation, you know, we're trying to figure out are we getting reports from everyone that we should get a report from.

So, you know, if you are submitting one file for all of your various subsidiary companies, you know, listing out those companies and their corresponding NAIC company codes would, you know, would then indicate to CMS, you know, what you're providing and who's reporting under that RRE ID.

(Bill Thompson): Right so for example, I mean, is it information that basically helps us and you understand what is being submitted under that RRE ID? For example if we submit all our auto and GL claims under one RRE ID and then all our comp claims under another RRE ID would we just put, you know, auto/GL in the one and workers comp in the other under subsidiary company information?

Pat Ambrose: Well we're actually looking for company names that again might be associated with the TIN that you're providing or the NAIC company code that you're providing.

(Bill Thompson): Right.

Pat Ambrose: And, you know, we're - later on you are asked to check line of business but that's only separated by liability, no fault and workers compensation not, you know, necessarily auto, home owners, so on.

(Bill Thompson): Right. But can our subsidiary company information be the same as the company information?

Pat Ambrose: Then I'm not really sure why you would be providing subsidiary information if it's exactly the same.

(Bill Thompson): Well is a required field, the subsidiary company information?

Pat Ambrose: No.

(Bill Thompson): Oh.

Barbara Wright: But if they're including the subsidiaries in that RRE you want to know the subsidiary.

Pat Ambrose: Yes, I mean, you know, we want to know who you're reporting for so that again when we go to look to see are we getting reports from everyone that is required to report to CMS, you know, otherwise we'll probably come looking for - come looking for you.

Barbara Wright: So if you have three subsidiaries and you want to include two of them with the parent company when you register the parent company you'll list the two subsidiaries; you won't list the third one because you're getting a separate RRE ID for it. But for the ones that you want to report under the parent company yes you should provide the company names.

(Bill Thompson): Right because we have probably more like 25 writing companies and I didn't know that we wanted to list all of those.

Pat Ambrose: Well we would be interested in seeing them because again they have separate - those separate - could have separate TINs and they do have separate NAIC company codes. So, you know, we were hoping to get that information from you, yes or expecting to get that information from you.

(Bill Thompson): Right, now I'm a little confused. Before I think you said we need to do it if at the writing company level.

Pat Ambrose: The subsidiary information?

(Bill Thompson): Right.

Pat Ambrose: Well, I mean, generally - I don't know, maybe I'm not really following the full scenario. But let's suppose if you're reporting - you don't have to report at the writing company level so let's put it this way; let's say you have, you know, Acme Insurance Company which I hope isn't a real one out there. And then you have writing companies A and B and they have their own NAIC company codes.

You could - but you want to report your auto separate from your liability. Your could set up one RRE ID under Acme's TIN and you might have under those writing companies - each of those companies you might write auto so you might list both of them as subsidiaries for that first RRE ID. And then you're setting up your second RRE ID for your, you know, other line of business and you would also then be listing possibly the same writing companies under that if they also write that business.

(Bill Thompson): Okay.

Pat Ambrose: Is that making sense?

(Bill Thompson): Yeah, I think so. It sounds like we're going to have to list all our writing companies but I'll try to work through that. Now you mentioned earlier in the call about listing the number of claims we anticipate reporting. Is that total claims or just total Medicare reportable claims?

Pat Ambrose: Total claims.

(Bill Thompson): Okay. And...

Pat Ambrose: And it's just an estimate, not something to, you know, get stressed over.

(Bill Thompson): All right. And if we choose to do a - voluntarily I know the mandatory reporting doesn't start until the first quarter of 2010 but if we want to send a production file in the fourth quarter will we be able to do a couple query files? I know - I think the first production doesn't start until 10/01 for query but for example can we query like in 10/1 and 11/1 and 12/1 and then send in a production file in December?

Pat Ambrose: Yeah.

(Bill Thompson): So we just work with our EDI rep to establish a date?

William Decker: Yes.

(Bill Thompson): Okay. All right.

Pat Ambrose: I mean - the system will first require you to submit based on that reporting timeframe. Now even in that last quarter of 2010 - I mean 2009 if you're - you're not required to send your production file but if you do the system is going to be expecting you to send it during your assigned file submission timeframe. And if you send it outside of that it will suspend for a threshold error and your rep will be in contact with you to find out what's going on.

However prior to that, you know, we ask that you work with your rep to let them know what you're doing. And so when they see that file come in they can handle it.

(Bill Thompson): Will we be assigned a start date for 2010 and also one for the fourth quarter if we choose fourth quarter?

Pat Ambrose: Yeah, if you look at the user guide it's a file submission timeframe for one week period of time out of a particular quarter, a seven day window. And so it's the same for each quarter we're just not going to require a production file until January. And you can send your query file at anytime during the month and as often as monthly.

(Bill Thompson): Okay thanks; that's all I have.

William Decker: Operator. Operator?

Coordinator: Are you ready for the next question.

William Decker: No I think perhaps we'll stop taking questions at this point; we've run out of time. And a couple of our speakers here have other things they need to rush off to so I'm afraid we're going to have to finish this call for today.

I want to thank everybody who was on the call and I'm really sorry we didn't get to all your questions.

Barbara Wright: Remember that we do have two calls scheduled for next month; we have the one call scheduled to take primarily registration questions and we have a second call scheduled just a few days after that and those are listed on the Web page.

William Decker: So we're done Operator. Thank you.

Barbara Wright: Could you tell us how many total call-ins there were Operator?

Coordinator: Yes just a moment.

END