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 9, 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 9, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode.

During the question and answer session please press star 1 on your touchtone phone. Today's conference is being recorded, if you have any objections you may disconnect at this time.

Now I'd like to turn the call over to Mr. John Albert. Sir, you may begin.

John Albert: Good afternoon or good morning depending on where you're calling in from. You're joining the - one of a continuing series of open-door teleconference events with CMS regarding Section 111 mandatory MSP reporting.

This call specifically is to address the workers compensation insurance industry. There will be other specialty non-group health plan - in terms of the short-term calls at a future date.

Please stay in touch with the www.cms.hhs.gov/mandatoryinsrep web site. There's a list serve if you haven't subscribed to it that will allow you to receive alerts regarding new documents going up on that web page.

Today's conference again is specifically to address the worker's comp issues specific to Section 111 reporting. We're going to have a presentation by Miss Pat Ambrose to talk about some of the more technical issues including the

registration process which will begin for worker's comp insurers beginning on May 1.

The web portal is currently up and running and accepting registrations from group health plans at this time, as of April. And again for workers comp, liability and no-fault insurers their registration would begin on May 1 of this year.

The other speakers in the room include also Miss Barbara Wright and Mr. William Decker and again myself - this is John Albert. I don't really have much else to say other than to turn it over to Pat and get right into it. We will be addressing a lot of the questions that we've received on the CMS resource mailbox.

As a reminder people are trying to contact us individually or directly to best ensure that we receive your questions and answer them please, you know, abstain from trying to contact us directly but send them to the CMS resource mailbox.

There's a link at the bottom of the homepage that's called Opportunity to Comment. That is the link you should go to that has the address of the mailbox as well as other information on how to format those comments to CMS.

Barbara Wright: Is there an actual link right now or do they still have to go to the document?

John Albert: They have to go to the document.

Pat Ambrose: There is a document that says Opportunities for Public Comment. You need to go into that document.

John Albert: Yeah.

Pat Ambrose: ...for the resource mailbox information.

John Albert: So again we can't stress enough that those - that is the best way to communicate your questions, concerns, comments to CMS; those are seen and organized by all here on this team that's in charge with implementing this legislation.

So as you'll hear shortly we've listened and are trying - going to try to answer a lot of those questions before we get into the general Q&A session later on. So with that I'd like to turn it over to Pat Ambrose that's going to go over some of the more technical questions we've received to date.

Pat Ambrose: Okay, thanks John. As John mentioned, the Section 111 COB secure web site is available or will be available for liability, no-fault and workers compensation, RREs, to register starting on May 1, 2009. The site is up for GHP RREs to register.

Please do not attempt to perform your registration earlier than May 1. We're not able to provide you with the appropriate technical support that you may need.

However, you may go to the login page or the homepage for that site to view some of the materials that we have posted out there regarding registration. The URL for the site - for the COB secure web site you'll see the COB secure web site often abbreviated as COBSW. The URL for that site is www.section111.cms.hhs.gov.

First you'll be displayed a login warning. Click on I Accept and you'll be able to view the homepage. On that homepage there are various menu options in particular the How To.

If you click on the How To menu option a drop-down menu will display and I'd like to direct you particularly towards the How to Get Started document and the How to Invite Designees document that's posted out there.

There will be a user guide in addition to the reporting user guide that's already been published there will be a user guide for the COB secure web site. However you must first obtain a login ID and password and log into the application before you can see the actual user guide. That's a security requirement that we were not able to get around.

However, next week we will be publishing the first set of computer-based training courses for the liability no-fault and workers comp RREs. These CBTs will be available and will provide an overview and detailed information on how to perform registration on the COB secure web site. Again that registration begins May 1, 2009.

When you come to the web site the first step is to click on the New Registration button. This new registration process will assign an RRE ID. You must perform this step for every RRE ID that you need in order to report for Section 111.

During the new registration step it's absolutely critical that you provide information for your authorized representatives and not another user of the COB secure web site. Your authorized representative is defined in the various documentation that I've already noted as well as your user guide - reporting user guide.

Typically this is an executive of the RRE. They must sign the profile report and agree to the data use agreement and ultimately will be held accountable for compliance of Section 111 reporting.

It's also critical that you note that this authorized representative for your RRE ID is never a user of the COB secure web site. Instead your users will be account managers and account designees. Also during new registration the system will assign an EDI representative to be your main contact for technical issues.

The next step after you have completed the new registration step is that the COBC will validate this information and then send a letter via the US Postal Service to your authorized representative with a personal identification number or a PIN. The authorized representative must give that PIN and the RRE ID assigned to their account manager.

The account manager for the RRE ID performs the next step, the account setup step. The account manager will bring the PIN and all the information they need to complete the account setup step back to the web site and click on the account setup button shown on that homepage.

This step must be done by the account manager. The first time an individual performs this step they will obtain their login ID and password. Subsequent times that you must complete the account setup you will obviously not be prompted to create a new login ID and password; you only need one login ID and password for the web site no matter how many RRE IDs you'll be working under.

During account setup we assign the file submission timeframe, you provide information about your account. If you select the Connect Direct option over the AT&T Global Services Network or (AGNS) you will be prompted to provide full information about your (AGNS) or (AGNS) account during that step so make sure you have that information on hand.

And I encourage you to please read the user guide and the how to get started prior to attempting to complete that step. You cannot perform the new registration or account setup if you don't have a complete set of information available.

You cannot save a particular completed new registration or account setup step and come back later and finish it. If you can't finish it at the time that you started all your data that you previously entered will be lost and you'll have to start the process over again.

However both steps should - once you have the information on hand should really only take someone about 15 minutes to perform that step. One thing I'd like to note and will remind you later is that we do ask for the National Association of Insurance Commissioner's company codes related to your RRE ID and any subsidiary information that you might be providing.

If you do not have an NAIC code, or National Association of Insurance Commissioner company code just enter five zeros. You must perform the new registration and account setup steps for each RRE ID. During this time you can report any issues to your EDI rep if one has been assigned or contact the COBC EDI department number at 646-458-6740. That number is also under the Contact Us menu option of the web site.

One last thing is as you go through new registration and account setup while you won't actually during that time be able to see the COB secure web site user guide there are help pages on every single page you're displayed that should answer the questions that might come up while you're doing your data entry.

I'd like to talk a little bit more - we've had some questions about how many RRE IDs a particular responsible reporting entity needs to set up. Generally this is dependent on the number of claim input files you need to submit per quarter. You might have different claim systems in completely different data center locations that you need to create your claim input files for Section 111 reporting in.

And to make that process simpler and easier to transmit and processing your response files and so on if you are unable to roll up your claim input file into one and report under one RRE ID you may register for more than one RRE ID by going through the new registration and account setup step for each.

You might also be using agents to report on your behalf and these agents might have their own data processing system under which they're submitting your Section 111 files. If you're using multiple agents to report multiple files then you need more than one RRE ID.

You may set up multiple RRE IDs and use the same authorized representative for each. You may also use the same account manager for each and subsequently the same account designees may be associated with all your RRE IDs or you may separate them as is necessary.

You do not have to register for an RRE ID for every separate subsidiary company that you will be reporting for if you are submitting the claim input

file for all the subsidiary information in one file. In that case you only need one RRE ID and only need to register or go through the new registration and account setup steps one time.

There's no limit to the number of RRE IDs that you may obtain however we recommend that you limit it to absolutely the fewest number possible. As I said you have to perform new registration and account setup for every single RRE ID separately. In addition the account manager for each RRE ID has to invite designees separately by RRE ID.

So if you have five RRE IDs your account - and you need to invite the same account designee who might be an agent reporting on your behalf if you need to invite that same individual to work under each of your five RRE IDs the account manager will have to go through the process of inviting that account designee to each of the five.

So you can see that just in terms of managing users associated with your RRE IDs you want to limit that number and make it dependent strictly upon the number of claim input files that you're submitting per quarter.

I'd like to talk a little bit - we've had a lot of questions about the query process that will be made available to RREs for Section 111 reporting. In order to start sending your query files these are the steps that need to be taken. After May 1 you register on the COB secure web site and perform new registration and account setup for each of your RRE IDs.

After the account setup step is completed for each of those RRE IDs we will email the authorized representative and account managers named the profile report that reflects the information that you provided during account setup and new registration.

That profile report must be signed by the authorized representative and returned to the COBC. Until that time your RRE ID is in the status of setup. Once the COBC has received the signed profile report and acknowledged that in the system the RRE ID status will be changed to a testing status.

At that point in time, after July 1, you may start submitting test files for Section 111 including your claim input files and your query files. Once you have finished and passed the test requirements that are in the user guide for the claim input file the RRE ID is changed to a production status.

However, we cannot accept production files until October 1. So you need to have your testing completed, pass your testing requirements, be changed to a production status for the RRE ID and then after October 1 you may start submitting production files including production query files. Your actual production claim input file - the first time that it's required for reporting is after - is in your file submission timeframe after January 1, 2010.

So you may actually submit production query files during October, November and December and process those query responses, prepare for your claim input file and submit your first production claim input file either during your reporting timeframe in the last quarter of 2009 or wait until that required reporting timeframe in the first quarter of 2010.

Later on in this call Barbara Wright will talk about a recent alert that is published or it has been published or will soon be published on reporting multiple TPOC amounts and some changes that we need to make based on feedback that we've received on these calls regarding updates then to previously reported TPOC amounts.

Before that thought I'll go through a few of the questions that have been submitted to the resource mailbox technically related and try and answer some of those questions for you if you'll bear with me while I bring up the first question.

The first question is related to how CMS lists the ORM indicator as the key field that requires if you need to change the ORM indicator that you actually need to submit a delete and then an add on the claim input files to change that. Remember that submitting a delete transaction always is to remove erroneous information that you have previously submitted.

The ongoing responsibility for medicals indicator once set to a Y always remains set to a Y. In other words, the first time that you submit a claim for which you have assumed ongoing responsibility for medical, you submit that claim record with the ORM indicator of a Y.

If subsequently - or when subsequently your ORM terminates you submit an update record still with that ORM indicator equal to a Y and on that update record indicate the ORM termination date or the date that the ongoing responsibility for medicals ended. So the indicator remains a Y on that initial add and the subsequent updates.

If you have erroneously reported ongoing responsibility for medicals on a claim and you do not have that ongoing responsibility then a delete transaction is in order. Hopefully that explains the use of that particular field. The reason for this is that we do treat records with ongoing responsibility slightly differently from records that include a one-time TPOC amount in terms of our processing so that our Medicare claims processors can take into account this other insurance that might be primary to Medicare.

There was another question related to that about - actually let me go on, I'm sorry. No that's okay. Here's a question that was submitted recently: At the time an RRE completes their registration can that RRE immediately request an extension in the permissible testing phase?

The most important thing to do is stay in contact with your EDI representative about your testing status. The testing period begins once we've received the signed profile report back and logged that into the system and the RRE ID status has been changed to a testing status.

And of course we're not starting testing for these files until after July 1. Your testing then may continue up until the point that your first production claim input file is due.

The next question related to that was: CMS documents the records, the matching criteria in the NGHP user guide. RRE ID is not listed as a matching criteria. We do actually use the RRE ID as a key in a sense in our system, however, the reports are all done, your claim input file is reported by RRE ID so all the instructions are assuming transactions related to one particular RRE ID.

Obviously if responsibility for the claim transitions to another RRE they would reporting that under a separate RRE ID.

Another question was related to multiple TPOCs which we'll address and updating subsequently those multiple TPOCs which we'll address shortly.

There was a question about must you register each of your subsidiaries separately and each have their own RRE ID. And that is not necessary; you may have one RRE ID depending on how your claim input files will be

submitted. During that new registration step we do ask for information about the subsidiaries that you're including in your report.

Concerning multiple claims for the same individual will we have to report each claim separately or should that be one record? Separate claims in your claim system should be reported as separate claim record reports under Section 111.

Barbara Wright: Keep in mind that the record - you have an insurance type as one thing. So if you have part of the insurance that's no-fault under CMS's definition and part that's liability insurance that's two records automatically for that person out of the same claim.

Additionally if your claims system keeps everything connected with the claimant under one claim but for instance it's a two-car automobile wreck and both drivers are insured with you and you keep that in one claim you would have a different record for anything that you're reporting on the policy for Driver 1 versus Driver 2 so.

Pat Ambrose: And obviously your claim reports are by injured party who is a Medicare beneficiary as well.

There was another question about the email notifications that you will receive regarding being in a testing status for more than 30 days. That email notification goes to the authorized representative and the account manager. Any email notifications sent to the account manager right now the account manager is the only user that will receive that notification not account designees. It's the account manager's responsibility to notify their account designees accordingly.

After you've submitted files any user associated with the RRE ID, any account manager or account designee may view the results of test file processing and production file processing on the COB secure web site.

The particular email reminder about this testing status is just informational. Again I've already described the time period that you have for testing and you may test up until the point of when your first production claim input file is due.

There was another question related to the 45-day grace period and reporting a claim for which an RRE has assumed ongoing responsibility for medicals. That same 45-day grace period applies to reporting a claim with ORMs. We cannot necessarily check and provide that compliance flag related to late submission but we're still expecting that timely submission of those reports.

But just so that you know once you have assumed responsibility for ongoing medicals on a claim you still have that 45-day grace period to figure out whether that claim needs to be reported under Section 111.

There was a question to please confirm the date in which the Medicare beneficiary query will be available and I believe we've addressed that. That's the - in testing that's a July date and in production in October.

Here's a scenario particularly related to workers comp so please bear with me as I actually read the scenario to you. This was submitted by an RRE saying that we have accepted workers comp - accepted a workers comp claim in which we start paying medical bills. Do we report that to CMS in the next reporting period and indicate that ongoing responsibility for medicals is yes or the ORM indicator is equal to a Y.

At a later date the claimant is owed payments for an impairment rating and elects a partial settlement which leaves the medicals open. In the next reporting period do we report this settlement as a TPOC? Do we then report the termination of ORM once the two years for the requirement for leaving - the state requirement for leaving ongoing responsibility medicals has passed?

In all are three reports required for this scenario? In this particular scenario you would first report the assumption of ongoing responsibility for medicals with an action type of zero and add - the ORM indicator would be a Y. You have not made that TPOC payment yet so the TPOC amount would be zero and the TPOC date.

Then when you make this partial settlement, this TPOC amount, you would provide a second report with an action type of 2 as an update. The ORM indicator must still equal Y and you would report that actual TPOC date and TPOC amount.

Lastly once the ongoing responsibility for medicals has ended you would make one last and third report with an action type of 2 for an update. The ORM indicator is still equal to a Y. Please provide the same TPOC amount that you had reported, TPOC date and amount that you had reported. And on this third report include your ORM termination date to indicate that ORMs have ended.

The next question had to do with the Medicare identifier for Medicare beneficiaries. The individual Medicare identifier for Medicare beneficiaries, which is the health insurance claim number often referred to as the HICN or HICN or HIC number.

This number while it does - it is referred to as the health insurance claim number it actually is a unique identifier for that individual and not related to individual claims for that particular person. So that is the one identifier just like the SSN is the one identifier for an individual at SSA.

There was another question about if there is an instance where we have to report an additional TPOC amount and there is critical information that needs to be updated that quarter as well do we send the TPOC record with action type of 3 and the critical information with an action type of 2, in other words, asking should I submit two separate reports?

For one thing we are changing and hopefully improving the way that you will report your multiple TPOCs. But do note that when you are reporting an update record please include all the most current information; we won't require two separate reports for that type of reporting or that type of situation.

We were asked if there will be specific test windows assigned to each RRE ID. Again these are not specific test windows. The test window is from the date that we have received your signed profile report to the date that your first production claim input file is due.

When can we expect to receive the list of test Medicare beneficiaries? I don't have an exact date for that but we will be sure to provide that information in a format that will be easy for each RRE to obtain in plenty of time prior to the testing commencing.

John Albert: Just one thing to add is in terms of testing and response files that - it's been mentioned that it's to ensure that you receive a relatively quick turnaround of your test file that if you can submit it on the Friday before you will be - you should get that test file back that following week whereas if you submit it

closer to the beginning of the week it's not guaranteed that you would receive the response in that same week, so.

Pat Ambrose: There was a question about if there is an agent potentially reporting on behalf of many RRE IDs will we make an attempt to assign the same EDI representative to all of those RRE IDs. We are investigating that and will try to accommodate that. We do understand that when it comes to agents reporting that it would be a lot simpler for both parties both CMS and the RRE or the agent to have one main contact.

So the answer is yes but we haven't exactly figured out how we will make that assignment. It is possible for us to change EDI representatives in the system. So we will address that as we get closer to that setup.

There is no association, though, in terms of the file submission timeframes assigned and multiple RRE IDs. There is no association that is essentially system-generated in order for us to spread out the reporting.

So an agent who's reporting on behalf of multiple RRE IDs will have a separate - the RRE ID will have a separate reporting timeframe throughout the quarter. We will not roll up all of the submissions into one particular file submission timeframe by agent or even by overlying RRE. It's strictly done by the RRE IDs.

There was a question about why the key fields on a matching record - whether those key fields include the last name, date of birth and gender or rather the first initial, last name and date of birth and gender but in our event table we are not including those fields as key fields.

Really for us the HIC number or that individual identification number for the Medicare beneficiary is the key field. We use the name, date of birth and gender in the matching process along with either the HIC number of the SSN. If the last name of an individual changes in your system you are not required to send us an update with that information specifically because you received that last name change.

Again I refer you to the criteria in that event table for what would trigger an update and those key fields that would then require a subsequent delete/add. The name and gender and date of birth that we have for Medicare beneficiaries comes from the Social Security Administration.

If there is a mismatch between your information and Medicare's information the injured party really needs to update their information at SSA so - and most likely will be doing that if they have notified you of a name change. So the next time you send your record in we should be able to make that match with the name change.

We do encourage you to save the health insurance claim number of the HIC number that we return on response files in our systems and submit that but on subsequent reports whenever possible.

There was a question again going back to RRE IDs; can we have - if an entity has liability - is reporting liability and workers compensation and it would be better for you to submit separate claim files by line of business you most certainly can register for two separate RRE IDs.

Your organization is the overall RRE but you may register and obtain two RRE IDs that are associated with your organization and report our workers

comp claims under one RRE ID and liability claims or whatever the case may be under another.

You may also obtain two RRE IDs and report one set of workers comp claims under one RRE ID and another set of workers comp claims under another RRE ID. We tried to provide the flexibility that you need based on, you know, the various scenarios out there for your claim systems and agent reporting.

When you set...

Barbara Wright: I was just going to say keep in mind if we haven't already mentioned it that however many RRE IDs you set up you then must report on them quarterly even if you have nothing to report. You will be sending an empty file for any RRE IDs that don't have anything to report within a particular quarter.

Pat Ambrose: And to add to your multiple RRE IDs you may have the same authorized representative named for each RRE ID and the same account manager named for each or you may choose to use different individuals as you see fit; you have that flexibility as well.

There was a question about the disposition code 50. I'd like to review that information briefly with you. First off a disposition code 50 is a very unlikely, rare scenario.

We have to accommodate for the fact that after the 45-day period for which we are to produce a response file since we are communicating with other Medicare systems we may not have received a response back from those other Medicare systems and may not be able to complete processing of the record and report back a final disposition code to you.

Again this is very, very rare. You are instruction then when you do receive a 50 to send the same record that you sent before. A question came up was what if something has changed with that claim in the meantime? I will update the user guide to indicate that we would like you to submit the most current information related to that claim when you resubmit it after receiving the 50. Again it's a very unusual circumstance.

Barbara Wright: Question about the alleged missing codes? That there weren't - there was something who sent in a question about certain codes were missing from the record layout and it wasn't a matter of so much of them being missing as it's reserved space for future use?

Pat Ambrose: Oh yeah, someone did mention that there seemed to be a gap in the error codes that we have provided in the user guide. And that gap was intentional and there are some changes coming to those error codes as well in the next version of the user guide mainly because of changes that we're making to the reporting of multiple TPOCs.

I think at this time I've covered most of the questions that I can at this time. And I'd like to turn it back over to John and Barbara.

John Albert: I'll just add one point of clarification regarding the SSN matching and that is that as long as the information submitted is or was a valid set of matching criteria that should match to our system. I mean obviously people throughout their lives can have name changes etcetera but all of those changes are (cross logged) through the SSA database.

So if somebody divorced and remarried and their last name changed we would have both of those so whether you submit an old name or a new name as long as it was accurate for that person at one time we should be able to match them

and basically validate that that SSN is in fact for, you know, John Smith, married, whatever, gender male. So I just wanted to add that.

And with that Barbara Wright is going to go over some issues as well and then we'll hopefully have still plenty of time to do a general Q&A session.

Barbara Wright: If you haven't opened it already or been to our web site today we do have an alert posting about reporting multiple TPOC amounts for liability insurance, no-fault and workers compensation. The question was raised at the last call: You've now provided us with instructions on how we can report more than one TPOC for a particular record but what if we need to change one of those that we reported? How are we supposed to do that?

We said we'd take the question back and look at it and we did. And we wanted to come up with a solution that would involve the least amount of change as far as any coding efforts, etcetera that you're doing. And also one that would be easy to follow and give you the most audit trail.

And what's reflected in the document we have out there right now is what we hope accomplishes both those goals. To put it in its simplest form for those of you who are more non-technical like me, is instead of reporting the second TPOC in the TPOC field what we've done is take the auxiliary record and in filler space that was there we have added the ability to report on TPOC2, TPOC3, TPOC4 and I think 5 as well Pat?

Pat Ambrose: Yes.

Barbara Wright: And you will also be able to do any updates to those TPOCs right in those fields. The auxiliary file right - originally we said you would only be submitting that if the beneficiary was deceased and there was more than one

claimant with respect to the pending claim once the beneficiary - the individual was deceased.

Now you will also use it if you have to report multiple TPOCs. Once you use the auxiliary file if you need to submit another report on that record you must (unintelligible) submit the auxiliary file. And that's short and sweet what it is. Is there anything else you'd like to add Pat?

Pat Ambrose: No not at this time.

Barbara Wright: Okay. That's the update for that. We've been getting a number of questions that appear to be repetitive so there's a couple of points I'd like to go over. With respect to the threshold that we issued in an alert for ORMs a number of the questions seem to indicate that they believe that threshold was on a bill by bill basis so that if they got a bill for $50 they looked at that and they'd apply the threshold then if they got a bill as long as it was under $600 they'd look at that; they weren't looking at them in total.

The ORM threshold is a total for all claims, all billed items. You're looking at your claim as a whole. So if you weren't aware of that please be aware of that.

Secondly we had some questions that were more concerned I guess with editorial issues. They thought that we were inconsistent; for instance they said that because there was not the word 'and' between each of the criteria we listed that that was inconsistent with us saying all of the following criteria. In any case you must meet all four criteria.

For lost time, where we said no more than seven days, that was not intended in any way to mean that there could also be a claim for lost days. We used

seven because states have varying time limits. And to the extent we were able to find out those time limits nobody had more than seven.

The waiting period I believe in some states is two and some it's three and some it's five so we just arbitrarily picked seven calendar days but we don't intend that there be any claim for payment for those lost days. Again all payments need to have been made directly to the medical provider.

Our concern there is in setting this threshold we don't want open ORM records where it's highly unlikely that we will have made any payment or will continue to make payments in the future. If someone goes to their workers comp entity and files a claim with respect to any bill then there's at least some likelihood they'll have all those bills sent there.

As long as it's being paid to the provider; we need to avoid a situation where they file a claim because they know their workers comp entity will pay them directly and at the same time their doctor is billing Medicare. So that's the reason we've got that criteria in there.

With respect to the $600 I received a fair amount of data yesterday and we're still awaiting some data from the workers comp research institute. And as we said before hopefully we'll be able to raise that dollar limit.

We had a couple of questions that said in one or more ways what if we're paying a medical and it's not really - and it's not closed but it's not really ORM; do we need to send an update each time we pay? To us that certainly sounds like an ORM situation. You're continuing to pay on an ongoing basis.

If - whoever sent that question in if you have more details and can explain it differently we'll be happy to look at it. But the description - if you're paying bills on a continuing basis you are essentially in an ORM situation.

We had a question about Native Americans, sovereign nations and whether or not this statutory provision applies to them. Yes it does.

We continue to receive questions about the fact that we won't let an authorized representative be a position. And what we can just repeat is we can't have that because of security considerations. And to the extent the questions come in repeats the fact that we subcontract everything out or we outsource everything out.

Someone somewhere in your organization at some level has the authority to be making those binding contracts and taking that action. That person presumably would be your authorized representative.

We had questions about our choice of a code set and whether or not people can use ICD9 - ICD10 at this time. For purposes of Section 111 reporting you may only use ICD9 at this time. And when we switch to ICD10 we will give advance notice so that any adjustments can be made.

We did not choose some of the other codes because there were issues that we discovered from CMS's perspective including legal issues. So the code set determination is final. If you're not currently using ICD codes of any type you do have the ability to have somewhat of a learning curve; we do provide for text in lieu of the codes in the beginning. So you have a choice there.

We also had questions about which books or how someone should go about purchasing their information about ICD9. We are not going to make that type

of decision for you. We gave you a web site where you can go to find information. So that is a choice that you will need to make as an RRE.

Someone asked about old data with respect to ongoing responsibility for medicals because they weren't previously computerized so should they have to provide this information or that it would be a burden.

We did limit the look-back period as much as possible, it's 1/01/09. We're talking about cases that are active which means arguably you're paying on them now and therefore you should have the ability to either have or obtain the information.

We've said if they are closed on your records prior to 1/01/09 then you do not have to report that ongoing responsibility unless and until there's a reopening action at which point you would report it. Our decision on that is basically final as well.

There is still data that entities are reporting that they don't currently obtain or they don't routinely obtain. But our data set is basically final. And if you don't obtain that information now you need to be looking at how you can and will obtain it in the future.

We had a number of questions about group trust as opposed to specifically using self insured pools etcetera. We will look at revising the language in the user guide. But basically whether you consider it a trust or a pool the criteria we set there for the pool or trust to be the reporting entity would be the same.

Someone asked whether joint powers authority for workers compensation, does it follow the same rules as the other JPAs? In the description of the

various scenarios for workers comp we specifically addressed JPA so please look in that list which is on page 20.

We have a couple of states at least where we've been asked legal issues in terms of their state statute and we're looking at it. Texas is one for example where workers compensation is not required and there's a concept of (possible) non-subscribers.

We understand at this point that's for workers compensation. They can either purchase workers compensation or they can be self insured for workers compensation through a particular certification process under state law and if they don't have that whatever plan they have cannot be represented as being workers compensation; that's specifically prohibited.

We are still looking at the issues there but in short where we expect to come out is anyone who has a particular plan if what they're purchasing is liability insurance as defined under out definitions they will report it as liability insurance.

If they are self insured for liability purposes under our definition it will be reported as liability insurance. If their plan includes any type of no-fault insurance as defined by CMS for purposes of no-fault insurance then it will be reported as no-fault.

So we don't expect that the analysis will end up changing what we've seen so far is arguably you could have any one of those situations. In fact the overview that the Texas Association for Responsible Non-subscribers publishes on their web site as a report would imply that some entities may even purchase some type of a group health insurance as part of their overall plan. It doesn't specifically address that but it implies I could be part of it.

To the extent any employer even if they're thinking of it as more of a workers comp context, if they've purchased - if they have group health insurance under CMS's definition of what a group health plan is and it's a situation where Medicare would be secondary then they would need to report that under the group health plan reporting rule for which, as we've said, there is a separate user guide, separate file out, etcetera.

And that brings into account one other thing, we'll repeat what I believe we've said on at least one other call; all of you really need to concentrate on our web site and consider that your ultimate source.

We are seeing more situations where different individuals or entities are presenting positions and either attributing them to us or simply, you know, stating a particular rule without attributing it to us and the statements are inconsistent with what's in our guide.

If you see anything that you remotely consider inconsistent you need to pay attention to our guide, not to the independent advice you've seen. I guess that's all we can really say about that.

We have some other issues that we're still working on. I know people are waiting for more information on mass tortes and product liability. We are looking to cut the information on product liability way down and presumably may - not will - may limit it to mass tortes situations.

What I would invite anybody to do and we have had some groups that have already done that, if you believe that there's a particular definition of mass tortes that should be used feel free to send that in through our resource

mailbox. I realize that workers compensation entities may have less interest in this particular area but I wanted to at least mention it.

We were asked about the situations where a judgment is above any policy limit. Again this wouldn't necessarily apply strictly in all workers compensation states but it certainly could apply to like the Texas situation where they perhaps had a combination of workers compensation and/or they had liability instead.

Any time there's a judgment above policy limits that's being paid we would consider that to be self insurance and it would have to be reported as such. We've been asked about offshore captives or in the same context as, for example, subsidiaries, are they reportable? And as far as we're concerned offshore captives are reportable. Are there actions? Settlement, judgment, award or other payments are reportable.

We are looking at further limitations in terms of - and we'd like more information if we can get specifics on situations where cases settle for fees and cost. If they clearly settle for fees and costs the injured party is not actually receiving any money at all, we would consider excluding those from reporting.

We've at least discussed the idea that potentially we could view that if there were an attestation that no monies were actually being given out, that they did actually all go to fees and costs. Again this may not be a particular issue for workers compensation as much as liability but we did want to let you know about it.

We are still working on the model forms and hope to have that out by the end of the month. We've done more than one draft so we did want people to know we're actively working on it.

We have received some suggestions for changes in definitions with respect to the user guide. We do look at and review any such suggestions. But if the suggestions change the structure of what we've set up then we at this point clearly would not be accepting them. If we believe that they are actually a more simplified way to say something we might add those as additional language.

And I think that's about it for the things I wanted to mention right now. If we could - Operator, if we could open it up for questions?

Coordinator: Thank you. We will now begin the question and answer session.

If you would like to ask a question please press star 1. To withdraw your request please press star 2.

Once again if you would like to ask a question please press star 1.

Our first question comes from (Anthony Karocko) from One Insurance Company.

(Anthony Karocko): Hi this - am I on?

John Albert: Yes.

(Anthony Karocko): Yeah, hi. (Tony Karocko) from One Beacon. Barbara, I know that you said that the data requests are now locked in and you're not going to change

anything. I just wondered if you had any further contemplation, as you know there was quite a feedback on your occupational disease requirement in terms of first exposure versus the exposure that hits our policy and what we're responsible for.

Has there been any consideration of substituting first exposure to the (actual) exposure we're responsible for?

Barbara Wright: No because of what we explained I think at least in a couple of the earlier calls. CMS needs to use that earlier date in terms of developing any recovery claims.

(Anthony Karocko): If we don't have that exact information can we use the word approximate before the date? We may not know the date or the year but we have an idea, quote/unquote.

Barbara Wright: If it's - where it clearly will not cause any harm as long as it's before the person's date of entitlement to Medicare. But beyond that we can go back and look at that issue again but I think you may have to institute something that allows you to specifically ask the party if you don't have it.

(Anthony Karocko): Well unfortunately (unintelligible), that's all right. The next question is in the very beginning of the call-in you talked about the testing procedures and after you get test status you go into production status but you won't accept any production records until after 10/01?

If some of our test data flies through as correct will we have to resubmit that after 10/01?

Pat Ambrose: No.

(Anthony Karocko): Are we changed to a production?

Pat Ambrose: No, once you're in a production status you do not have to retest if that's your question?

(Anthony Karocko): Well yeah, in other words, we submit a record, in it's in test status, the record is approved, then it switches to production status...

John Albert: Yeah.

(Anthony Karocko): ...but it's not 10/01 yet. After 10/01 we don't have to resubmit it correct?

Pat Ambrose: Yeah, let me back up and say that testing and production status is by your RRE ID, it's not related to the claims that you're submitting. Anything that you submit on a test file is processed. We return a response file and then essentially we throw it away. You have to resubmit any claim that you might have - if you were using real data in your testing process you have to resubmit that real data come time for your production file.

(Anthony Karocko): Okay, that would be after 10/10?

Pat Ambrose: Yes.

John Albert: Yeah.

(Anthony Karocko): Okay.

Pat Ambrose: We're just not, you know - our system will not be ready to process production files until 10/10.

Barbara Wright: Also I don't remember if Pat mentioned it or not but I think there's a relatively small limit of individuals that can be submitted in a test file.

Pat Ambrose: A test file is limited to 100 records. You may continue to test and sent - even after you have passed the testing requirements and your RRE ID status is set to production you can continue to test though.

(Anthony Karocko): Okay. All right, thank you very much.

Coordinator: Our next question is from (Anthony Filiato) from Signal Mutual.

(Anthony Filiato): Yes, good afternoon. Miss Wright, in earlier calls and in conversations you had mentioned the - that you were going to speak with the United States Department of Labor in concern - concerning some of the federal programs. In our case here at Signal Mutual the long shore program that we're concerned about.

And I have not seen anything since. I understand a meeting has taken place. I was wondering if we can expect anymore information in regard to the federal workers compensation programs?

Barbara Wright: We did receive some data from them relatively - not data, some information from them relatively recently about the various (programs) under their purview and we are - that's under review right now.

(Anthony Filiato): Okay so in other words we should be just - should we be expecting something - a change or not or plan to go forward as is or...

Barbara Wright: Well to the extent that you are - have an individual responsibility as an insurer as opposed to an action on behalf of the government at this point it looks like pretty much you'll be going forward.

(Anthony Filiato): Okay.

Barbara Wright: The government is on its own looking at what it believes it needs to (unintelligible) which seems to be a little bit more their focus.

(Anthony Filiato): Okay. Thank you. And I just would like to also just reiterate what the gentlemen earlier stated about the occupational disease claims and knowing what the first date is. As we stated before, I'm sure many people have, you're asking basically for an impossibility. And we'd really like you to go back if you could and look at that.

We want to give you the information we have obviously but we don't want to make it up.

Barbara Wright: We prefer you not make it up either.

(Anthony Filiato): I know, that's what we're saying but there's no - and we don't intend to - but it's just that it doesn't exist. It does not exist. I don't know when a longshoreman was first exposed to asbestos and neither does he. I just know when he was last exposed because it's within my policy period.

Barbara Wright: I understand your concern.

(Anthony Filiato): Okay. All right, thank you.

John Albert: Thank you.

Coordinator: Our next question comes from (Cory LeBranch) from LA Workers Comp.

(Cory LeBranch): Hello, I apologize for asking this again but my phone dropped out earlier. I think you answered my question. If there was an instance where we had to report an additional TPOC and we also had to update some of the critical information such as the ICD9 codes would we send two records or one record and - in a particular submission?

Pat Ambrose: We'll ask that you send all that information in one update transaction. The - you'll see that we posted a new alert out on the web site regarding reporting of multiple TPOCs. And in that alert we're actually removing the action type 3 so updates will just be action type 2.

And when you're submitting additional TPOC information you may also include on that update record other updated claim information.

(Cory LeBranch): Excellent, thank you.

Coordinator: Our next question comes from (Frank Sarland) from New York State Insurance Fund.

(Frank Sarland): Yeah, hi. Okay we had a couple questions; the first one, trying the query process - in order to try to, you know, get a match. How does your system handle last name on the first - if in the first six characters it has a dash or possibly a space in between two letters like the name La Pointe with a space in between the A and the P?

Pat Ambrose: We do not - when you submit a last name we don't remove any spaces or hyphens, dashes and so we're matching basically on whatever is submitted.

And what we are matching against is what the Medicare beneficiary has given their name or provided their name to Social Security.

So - because that - any information about the name then filters down from the Social Security Administration to the Medicare files. So if on their Social Security card or their Medicare health insurance card their name has a dash in it then that's what we're matching it up against.

(Frank Sarland): All right so it's however you have it. Okay because that's something we have a concern as far as the matching. We have, in New York State and I guess a lot of other worker's comp is we have third-party settlements where the claimant has settled a third-party action and we go into a credit taking position.

And at that point we don't have ongoing medical responsibility although the claimant may be getting treatment it's their responsibility to pay for that treatment at that point. It can then change at some point further on down the road where we would again have ongoing medical responsibility. Just trying to figure out how we need to report that.

Barbara Wright: Are you saying that you have a situation where you get a settlement, judgment or award that includes medicals at that time but they have the ability to re-file later or are you saying something different?

(Frank Sarland): Okay we get - we have responsibility to pay workers comp. The claimant settles his or her third-party action. When they settle that third-party action and get their recovery what we call is it a net recovery, we go into a credit taking position until they exhaust that third-party recovery.

Barbara Wright: In other words they're not settling with you, they're settling their liability insurance claim.

(Frank Sarland): Correct.

Barbara Wright: Okay well if you have not assumed responsibility for ongoing medicals and you have not made a TPOC then at that point you have nothing to report. But if and when they would file a claim with you if you assumed ORM or you have an additional TPOC yes you would have to report that.

(Frank Sarland): No but I'm saying we reported it as our ongoing medical responsibility and then - and subsequently they settle that third-party action and we go into that credit-taking mode.

Barbara Wright: Okay, if you had reported it and you don't have any ongoing responsibility at a particular point in time then you need to report the termination and you need to report an update action or a reopening action if and when you have ORM responsibility in the future or an additional TPOC.

(Frank Sarland): Okay. And also again regarding the reporting process - and in case they live outside the country is it the proper assumption to assume that we really don't need to be checking on them? I would assume that they wouldn't be on Medicare if they're living outside the US?

Barbara Wright: I couldn't hear you - who you said was outside the United States?

(Frank Sarland): Claimants living in other countries outside the US. We have a lot of claimants that live in other countries.

Barbara Wright: That's not true because people who are beneficiaries often, even if they spend most of their life outside the country, if they're covered by Medicare and they can come back here and have the bills covered by Medicare for that reason alone many of them come back for medical care. We need to know about people whether they're currently living in the United States or not.

John Albert: Obviously they wouldn't be taking Medicare while in another country but if they come back they could take services and those benefits with Medicare would have to be coordinated.

(Frank Sarland): Okay. And on the alert, the $5000 TPOC threshold that's mentioned there, is that workers comp, would that be comp and medical - total comp and medical?

Barbara Wright: It's back to when you've done TPOCs you should be looking at them cumulative if you're giving a settlement for both, yes.

(Frank Sarland): Okay thank you.

Coordinator: Our next question comes from...

((Crosstalk))

Man: Yeah, hi, thank you. My question has to do with the situations where we have ORM in a state with lifetime benefits. And as far as I can tell I don't think we've ever established how we're supposed to determine a (termination) date when we have no clue, in a case where we may - someone was 20 years old or 30 years old how long their lifetime is.

Barbara Wright: What the user guide offers right now is if you have a statement from the treating physician that further medicals are not expected then you can terminate. Or if you have what's in the threshold right now -if you have an ORM situation that meets the four criteria then you're not reporting that to start with.

Man: Okay but what about the situations where it would be reportable and...

((Crosstalk))

Man: ...you know, we're going to close our claim because we don't anticipate that we're necessarily going to see anything but the person is, you know, 30 years old and they've got lifetime...

((Crosstalk))

Barbara Wright: Under the user guide right now you have the responsibility to continue to monitor that case for beneficiary status unless your responsibility either terminates for example under state law or you have documentation that the individual does not require ongoing treatment.

We did put that in. If people have other suggestions, ways or when it should terminate, what proof we should have you obtain before you close the record we will consider that. We're not trying to make it hard for you. We don't want people who at a, you know, we've got to make it more than a sprained wrist since have at least $600 right now.

But we don't want the person who had two broken legs and is only 25 - we're not particularly interested in having you have to have to monitor that for 20 or 30 years. But if you have responsibility under state law unless we can come

up with an additional different way to document it right now your choice is to get a statement from the treating physician and then you can terminate your monitoring responsibility from our perspective.

Man: Well and I guess the way that we're trying to handle this is to determine up front whether or not we have that lifetime responsibility. Of course we're going to have an agent that's going to handle this for us. We'll provide them the Y to indicate that we do have the ongoing responsibility. We want to be able to give them a termination date. And one of the things we've thrown around is what if you just pick a date out into the future that's going to take them to 110 years old or something of that nature?

Barbara Wright: Oh you can't submit a termination date until they're actually terminated. So and if they're not a beneficiary right now - are you talking about one who is or isn't currently a beneficiary.

Man: Is not a beneficiary.

Barbara Wright: If they're not a beneficiary you are not reporting them right now, you are monitoring them to determine when and if they become a beneficiary.

Man: Right and what I'm anticipating here is decades out, you know, all of us that are sitting around talking about doing this now are not even going to be around working claims dealing with this. And we're trying to come up with a systematic way to handle that.

And so if you have a case where 40 years from now they do, you know, are eligible and you start reporting it we still had no way of saying when to terminate it because we have no way of knowing and tracking a person's lifetime...

Barbara Wright: Well but that's...

Man: ...you know, when they're going to die.

Barbara Wright: Well I agree. But in terms of - it seems to me and that's why we're open to other suggestions whether or not it's a routine part of your claims practice now - we've been told for some entities that it is, that they routinely would like to get a statement regarding whether or not treatment is continuing.

We're saying that if you get that type of statement you can stop monitoring right away.

Man: Okay and I understand that. So let me ask this maybe in a little different way: What if we set our code up to say yes we have ongoing responsibility. It monitors itself for 40 years and then all of the sudden that person is on there, we report it and we just never follow up with the termination date?

Barbara Wright: If you put it in to automatically monitor it and have it automatically feed and report that's fine with us. I won't be here in 40 years either.

Man: Y2K all over again.

Barbara Wright: But it wouldn't it - I mean if it's...

Man: I'm just wondering if there's going to be any harm if we do report which that's probably the most important thing from your standpoint that we do the report...

((Crosstalk))

Man: ...track it.

John Albert: The only harm would be is if for some reason that ongoing medical responsibility did terminate and you didn't tell us because then we would be inappropriately denying claims for primary payment.

Barbara Wright: Well he's saying he's in a state with lifetime medicals.

John Albert: Yeah, okay but I'm just saying that...

((Crosstalk))

Man: Then what I'm thinking here is that at the point that - let's say that that happens, at the point the person dies let's hope they're not going to somehow turn in something to Medicare anyway.

John Albert: Right.

Man: So I'm wondering if it's a no-harm situation then.

Barbara Wright: My concern is in terms of claims processing here. If it was really something like, again, we have to make it more than a sprained wrist but it was something that cost at least more than what our threshold was but it was something that clearly wasn't going to require ongoing treatment or future treatment what we're looking for is suggestions from you or anyone else is what else besides a statement from the treating physician could we reasonably rely on to decide that the medicals should in fact have been terminated?

John Albert: Can you hold on for just a second?

Man: You bet.

Barbara Wright: And so in any case, you know, this is still one of the background things we're thinking about. But any suggestions anyone has about a reliable way to be reasonably sure there won't be additional medical care, you know, that would be helpful.

Man: Yeah, I appreciate it. I don't have any suggestions other than to try and just cover a person's lifetime with it and say hey let's just assume they're not going to live past 110 or something like that.

Barbara Wright: And we agree that that takes care of your problem but in terms of us having an open record if they're truly not going to have anything that's associated we don't want a beneficiary that's 66 years old that breaks the same leg again to necessarily have the claim denied if it's not related or has a problem with that leg so that if treatment with regard to that injury truly is complete we would like some way to not have those records.

Man: Yeah and we of course, if we have one of the guidelines that says we can, you know, not have to report we'll go that route. But I'm just trying to figure out what to do with the ones that we do have.

Barbara Wright: Well I'm not - we're not adverse to - I'm not saying that you have the data to pull on this. If there's even some way to tell like if someone doesn't get treatment for X number of years the odds keep going down or something; something that we can actually rely on and say this is what we made a judgment call based on.

Man: Okay. Well if anyone comes up with someone hopefully you'll get it reported out there for us.

John Albert: Well we appreciate your feedback.

Man: Thanks.

Coordinator: Our next question comes from...

((Crosstalk))

Coordinator: ...line is open.

Woman: I'm sorry, we originally called in just to report that we were having trouble hearing but I will ask a question while I've got the line. You use the phrase in the document - in the user guide a couple of times, address/resolve or partially addressed/resolved. What is the distinction between those two conditions?

Barbara Wright: Don't look at them as absolute conditions. The problem was people at first they said okay let's use the word 'settle' if they've been settled or partially settled. But settle can have distinct legal meanings. What we were trying to get at was addressed or partially addressed as you've made at least some decision about the case that either resulted in an ORM or a TPOC.

If you had an ORM but they're still filing a claim for some type of settlement for something else then arguably the claim is only partially resolved or partially addressed. People complained about the word resolved because some people wanted to say well that means it's resolved in total.

So don't read too much into partially addressed and partially resolved or resolved and addressed; they were the most generic words we could come up with to indicate essentially you've made some decisions that either resulted in a TPOC or ORM. Does that help? Guess not.

Operator?

Coordinator: Our next question comes from (Rhonda Carpenter) from Progress Energy.

(Rhonda Carpenter): Hi. I have a question - or actually probably more of a statement on that ongoing responsibility for medicals that you said that - I didn't submit that question but I think what they mean like in Florida you can - you have 120 days to investigate the claim. So while you're investigating you're treating this employee to find out if it is actually a work-related injury or illness.

So I think that's what that person means by, you know, they're treating it but they haven't, you know, said yes this is our claim and it is work related and we accept it.

Barbara Wright: You have - I think we said in the user guide somewhere and we can try and go back and look - if you assume responsibility for payment - some states require that you do that during the investigatory phase - we said then establish the ORM and term it when the investigation stops if you don't keep going.

(Rhonda Carpenter): Okay. And the second question is on the - for - let's see where it's at. It's the ORM that had to meet these particular - that we didn't have to submit if these things fell in place, the medical only, (lost time), things like that. And all payments have - or have been made directly to the medical provider what if, for example, an employee paid for a prescription and we reimbursed that employee for that prescription?

Barbara Wright: We will take prescriptions under advisement but, I mean, our thought was all payments to the extent the drug industry works a little bit differently do you have the capacity to pay directly...

(Rhonda Carpenter): Yes.

Barbara Wright: ...to pharmacies or not? Is there some particular reason why you wouldn't?

(Rhonda Carpenter): We do. If the employee for some reason did not know that we have a system when they go to the pharmacy to pay for it. But all they had to do was say, you know, our employer goes through this particular vendor then it would have been paid for. And maybe the employee didn't know that.

Barbara Wright: We'll look at it but we may not be able to do anything with it because we now have Part D for people who are Medicare beneficiaries so we could run into the same issue if things aren't being reported.

(Rhonda Carpenter): Okay.

(Deena Walcrom): This is (Deena Walcrom) also here with (Rhonda), can I ask a question?

John Albert: Sure.

(Deena Walcrom): This is about registration. Our company is self-insured for liability and no-fault as well as workers comp so for the responsible reporting entities how should we handle that when we register? Do we just like is each type of insurance going to be handled separately by you guys or do we just register one time under the RRE and then each different type of payment that we're making...

Pat Ambrose: We don't care if you want to have workers compensation, liability insurance and no-fault insurance under the same RRE ID you can do that because you will be specifying the insurance type on the individual records. If for your convenience you want to split it either because of systems or because of geographic considerations or anything else you're free to do so.

Similarly even if it's a single type like if all you did was workers compensation you could split that out by geographic region or by subsidiaries or whatever. You're free to do it whichever way you want. No one can mix GHP with the non GHP.

(Deena Walcrom): Okay. Okay but the other types outside of GHP we could just register one entity and then when we submit the claim - because there may be different agents doing it.

Pat Ambrose: Well that's where you need the multiple RRE IDs perhaps. First off realize that you're sending one claim file per quarter with all the claims applicable under one RRE ID. So if you had one system that's processed or contains or holds all of your liability, work comp and no-fault claims and out of that one system you were going to create your one quarterly claim input file for Section 111 and send it to us then all you would need is one RRE ID to report under.

But if you have three separate systems by line of business or 10 separate systems where you - and multiple agents and you need to send us 10 separate files per quarter from all these different locations, so to speak, then you need 10 different RRE IDs.

(Deena Walcrom): Okay.

John Albert: We can't accept multiple files from the same RRE ID each quarter.

Pat Ambrose: But one file can contain work comp, no-fault and liability claims all mixed up together on it.

(Deena Walcrom): And if we have different companies handling that now it would be easier just to do it...

Pat Ambrose: If you want to make - if you want to have a separate agent for each of those companies that's fine. We have heard some anecdotal information that some entities that have multiple systems are going to have their information rolled into a single RRE ID before they submit it. If you want to do that that's fine too but if you want it separate you can keep it separate.

(Deena Walcrom): Okay. But you can roll it right before you submit it quarterly, you could roll it, is that what you said?

Pat Ambrose: Again, yeah, that's your choice but you may only - you will only submit one file per quarter so you either need to roll everything together or you...

John Albert: Per RRE.

Pat Ambrose: ...per RRE ID so you would either need to be able to roll it under one RRE ID and submit it all at the same time or you'll have to have multiple RRE IDs.

John Albert: It's truly your choice in terms of how you get the data to us. The main thing is that again you can't have the same - you can't have more than one file submitted under the same RRE ID. So if you're using in your case several

agents to report different parts of your business then you would have to have a separate RRE ID for each of those.

(Deena Walcrom): And so subsidiary companies are paying these things say for all three different categories does the RRE need to be different names with a different number or can you have the same name RREs with different numbers?

Pat Ambrose: When you register you may, for multiple RRE IDs, you may put in the same name for the RRE and actually the same PIN. The system - the CMS system for each new registration you perform on the web site will assign you a separate and unique RRE ID and that's what then you put on your files.

(Deena Walcrom): Like if you want to do that for your workers comp you'd have that number and then...

Pat Ambrose: Yes.

(Deena Walcrom): ...so on and so forth.

Pat Ambrose: Yes ma'am.

(Deena Walcrom): Okay. Thank you guys, you've been very helpful.

John Albert: Al right thank you.

(Deena Walcrom): Thank you.

Coordinator: Our next question comes from (Sean McIntire) from (Keenan) and Associates.

(Sean McIntire): Yes, thank you. I was just curious - I know we can only report and query once a quarter and once a month respectively when we're in production mode but how often can we send test files in the testing period?

Pat Ambrose: There's no limit.

(Sean McIntire): No limit.

Pat Ambrose: Again remember that your test files are limited to 100 records each but there's theoretically no limit to how many you send a particular week or month.

(Sean McIntire): Okay thank you very much.

Coordinator: Our next question comes from (Bill Thompson) from the (Harpers).

(Bill Thompson): Hi, I have a few questions. The first one has to do with the query and has to do with situations where we have self insured for example (unintelligible) so we might have two RRE numbers that apply to that particular (unintelligible).

Pat Ambrose: We're having...

John Albert: We're having trouble hearing you; you're breaking up a little bit.

(Bill Thompson): Oh sorry, is that better?

John Albert: Much better.

(Bill Thompson): So my question has to do with the query and a scenario where we have a self insured that has a large retention and then the excess policy over that so

there's potentially two RRE numbers. When we do the query can we just use the carrier's RRE number rather than to have it...

Pat Ambrose: If you - the excess policy, if that excess policy is being paid back to you then there isn't going to be any direct reporting or RRE - separate RRE for that separate policy, it would simply be reported by you under the same RRE that you use for your self retailed liability unless you have some reason you want to report it separately.

(Bill Thompson): Well I'm talking about a scenario where the first layer of a $1 million is purely self insured.

Pat Ambrose: Right.

(Bill Thompson): But that we might be in a position where we're reporting or we're a designee on behalf of that entity and we're doing a query. So there could be potentially two RRE numbers associated with that query. But I think for us administratively it'd be easier if we could use the carrier's RRE number.

Barbara Wright: You're talking about your functioning as an agent?

(Bill Thompson): Yeah.

Barbara Wright: Okay. And you're an agent for RRE X...

(Bill Thompson): For the self insured.

Barbara Wright: Yeah. And the self insured has an excess policy right?

(Bill Thompson): Right.

Barbara Wright: Okay. If that excess policy makes payments to the self insured then it's part of their report; they would have no particular - as far as we know no particular reason to have one RRE for their initial self insured part and a second RRE for their excess coverage policy.

(Bill Thompson): All right well maybe I'm missing something but I thought in scenarios where the first layer of a $1 million where they (unintelligible) to the claimant directly that they're going to be an RRE for...

Barbara Wright: Okay but what I said is if the excess policy pays the self insured entity and then they pay the client or claimant then they're the RRE both for that initial self insured layer as well as the excess money...

(Bill Thompson): Okay.

Barbara Wright: ...the excess policy.

(Bill Thompson): Yeah, no I'm talking about a scenario where the excess layer pays their own piece of it and then - directly to the claimant then the excess policy pays directly to the claimant if the claim gets...

((Crosstalk))

Barbara Wright: Okay well in that case the only way you'd be querying for both is if you're an agent for both of those - both for the self insured entity and for the insurer for the excess amount.

(Bill Thompson): Right. So my question is can we just use the one RRE number or do we have to use both?

Barbara Wright: If you look at the privacy language you need to keep data from different RREs segregated.

(Bill Thompson): Okay. Well that's my answer then. Okay and a question on product liability, field 58, have you given consideration to accepting workers comp claims from having to report on product liability or mass torte scenarios?

Barbara Wright: Yeah that is, as I mentioned earlier, one of the things we're looking at as we're looking at narrowing the language.

(Bill Thompson): Okay. And then similar question, in field 59 I was looking for a clarification and a description code on the far right, the bolded language, it looks like you're looking for an immediate report if the - if 58 is answered number 3 as mass torte.

Barbara Wright: Yeah.

(Bill Thompson): But then in the bolded language below it says that you have until 1/01/2011 if the field is 2 or 3.

Barbara Wright: That would - well if you look 3 is mass tortes only meaning right now. But field 59 where it says January 1, 2011 it says once you hit that date you have to give us that information regardless of whether or not it's a mass torte.

(Bill Thompson): All right.

Barbara Wright: In other words if it's a product liability situation at all once you hit January 1, 2011 you would need to give us the information. The only time you wouldn't

give it to us if it's not a product liability situation. And of course that's the language we're working on narrowing.

(Bill Thompson): Okay so in other words we need to report right away if it's a 3?

Barbara Wright: Yes.

(Bill Thompson): Okay, thank you. And now, just some clarification on fields for the date of incident, the field 12. We have some claims that we've discussed before that are probably a little bit outside of the normal scenario like for example employment cases with psychological injury or professional liability cases so trying to figure out what we're going to use for a date of incident in those cases.

I mean you could have someone being fired from their job but they might be incurring, you know, alleging psychological injury at any time over a period of a year or two. And similarly in a professional liability case someone might miss the statute of limitations which would cause the malpractice case to be filed but, you know, the underlying (DI) could be a completely different time.

Barbara Wright: Could you hang on a second?

(Bill Thompson): Sure.

Barbara Wright: Could you send something to our resource mailbox giving specific examples and if you have suggestions of how we should do that we'll look at that.

(Bill Thompson): Okay I sent something but I'll send - I'll elaborate on it. That's all I have, thank you.

John Albert: Thank you.

Barbara Wright: Thank you.

Coordinator: Our next question comes from (Deana Grange) from (Ladacass).

(Deana Grange): Hello. I just had a couple questions. On using the ICD9 no one has to be certified to use that; can anyone use it?

Barbara Wright: Yes.

(Deana Grange): Okay and then on determining date of - the defined (unintelligible) for CMS if it's a cumulative trauma claim do we get that date from the doctor on the first exposure or from the employee themself on the first exposure?

Barbara Wright: Well give me an example; are you talking about someone who had a bad leg and then they were at work and they hurt it worse or are you talking about the reverse?

(Deana Grange): No more of like someone who maybe has a cumulative knee injury and the are an electrician or a plumber and they've been doing that work for 10 years and there's really no - for us we have a date of accident of when the disability manifests but you want the date of the first exposure so it - I mean, someone in that line of work it could be the first day of work.

Barbara Wright: I think we need to go back and discuss internally whether we need to clarify language. Remember that if someone hurts their knee - like you said it's a cumulative injury but the knee went out finally this year. The only time we were looking at exposure or ingestion etcetera was you're talking exposure if

someone had an airborne pollutant or they had something that got on their skin. You're talking ingest generally for pharmaceuticals.

You're talking implant, for instance, one of the things in the last number of years there were some (pedigal) bone screws that were - very large litigation on that there were alleged severe back problems with anyone who had these implanted. That was an implant type thing; we needed to know when the screw was first implanted.

The ingestion type ones have been a lot of the drug ones and exposure have been like exposure to radioactive waste. Or the gel implant ones, one of the allegations there, we used implant but the exposure concept also came across because there were instances where the gel implants had ruptured and had left the material in someone's body.

So if you have someone where they've essentially injured their knee or fallen or whatever that's normally going to be your date of incident; does that help?

(Deana Grange): No because a lot of times the doctor will even say, you know, it's cumulative, it's from years of exposure, it's repetitive.

Barbara Wright: But it's not from exposure to something. It's not from exposure to a chemical or exposure - you're talking about exposure to their job and that was not what we meant by exposure.

(Deana Grange): Okay, okay, okay but when I read this it said associated cumulative injury. And I think it even says - so you're not talking about any exposure as far as repetitive injuries to lumbar, carpal tunnel...

Barbara Wright: No, for instance carpal tunnel we're not talking about when they first started to type, no. So could you give us what page that's on and we'll go back and...

Woman: Field 12 on page...

((Crosstalk))

(Deana Grange): Page 87 in field 12. Okay.

Barbara Wright: Well but the - actually there we were talking - the example was an occupational disease and I don't think we were thinking of like bad knees as an occupational disease. We were thinking about things more like asbestos and if there's cumulative there. So it would fine if you wanted to send us a couple situations where you think our language has caused you a problem and we will reconsider that to see if there's any way we can clarify it a little.

(Deana Grange): Okay great. And then going back to the gentlemen who - we also had the same concern, we owe medicals for life here in Kentucky but you obviously are not going to have people that are going to treat 10 or 12 years down the road on a broken leg I think was the example.

Why can't there be something like three to five years no medicals paid and then we could take it off the monitor list. But then if a medical does get paid we could then put it on - back on the list much like we do now on the files that are closed prior to 1/01/09.

Barbara Wright: Well help us think of something other than just time or other than, you know, a physician's statement that would be a little bit more proof. What we don't want is situations like for instance someone hurts their knee severely and it's

taken care of right now but they're clearly going to need a knee replacement in 15 years.

You know, that one we probably should have an open record so that as soon as they start to have complaints associated with that knee and stuff we are not paying inappropriately.

(Deana Grange): Right, yeah, okay. Well the only problem with that is sometimes I think treating physicians may be a little reluctant to put in writing that the gentleman may not need any future treatment on that part. Okay, I'll submit my ideas, thanks.

Barbara Wright: Okay.

(Deana Grange): Bye, bye.

Coordinator: Our next question comes from (Cecelia Windshell) from Crawford.

(Cecelia Windshell): Yes, thank you. We had a couple questions first on the RREs. If a company has a deductible program which they fund is the carrier allowed in that situation to assume that reporting responsibility and report that claim under the carrier's RRE ID?

Barbara Wright: If it doesn't fit within the scenarios we've put in the user guide no. I mean if someone is reporting inappropriately that potentially raises a compliance issue and it certainly raises problems for us because then we've got duplicate reporting.

(Cecelia Windshell): Okay, thank you. And then the next one goes to your TPOC amount. If the - w were interpreting the TPOC amount to be an amount at a point of

settlement but with the interim threshold if we have a claim in which we are paying medical but we have not reported it yet because it has not met the threshold and then it does meet the threshold and we then report that claim because there's no other dollar field does it look to you as though we reported it late?

((Crosstalk))

John Albert: ...ongoing responsibility.

Pat Ambrose: You're asking about the late submission. We actually don't flag a claim that comes in being reported when you're reporting only ongoing responsibility for medicals. There's no date for us to actually check to see if you reported it timely. However you are instructed to have on record, you know, information that would prove that you reported it when you reached the threshold.

So, you know, if I'm understanding it correctly you have no TPOC amount to reported because you're just making payments - medical payments. And then once it reaches that threshold then send us the add record with the ORM indicator of Y. If no settlement amount has been made then you have to TPOC so you'd have zeroes in the TPOC date and the TPOC amount. And the system is not going to mark that as late.

(Cecelia Windshell): Okay. So we just continue - we just would report it at that time and then if let's say it was a jurisdiction that in several years we do settle it that settlement amount itself is what we submit not that amount plus any previous medical payments, right?

Barbara Wright: Correct.

(Cecelia Windshell): Okay. Thanks very much.

Pat Ambrose: Now I think - and please make sure on that update record with that TPOC amount that you are reporting for the settlement that the ORM indicator remains a Y and that you provide them the TPOC date and the TPOC amount in that same update record.

Barbara Wright: Now remember though if you took the example Pat just had where you were continuing to pay where you had ongoing responsibility I guess at that point you've turned it into a case where it's not going to fit those thresholds because it's not only medicals.

(Cecelia Windshell): Right, potentially yes. Okay and then one other question on RRE. If the program is a self insured retention but the carrier is funding it is the carrier able to be the RRE?

John Albert: We're still here.

Barbara Wright: We're making our (unintelligible) the second we answer this. The scenarios we gave you for workers compensation, which of those do you think it fits under or don't you think it fits under what you just said you don't think it fits under any of those.

(Cecelia Windshell): We don't see where it fits clearly under any of those.

Barbara Wright: Okay so the employer has self insured retention?

(Cecelia Windshell): Correct. But the carrier may be funding that. They may for example only have that in one state and yet then they may have a deductible program in the rest. And so they just have one situation and one funding arrangement.

Barbara Wright: Can you hang on a second?

(Cecelia Windshell): Sure.

Barbara Wright: Can you send us some clear examples of that with...

(Cecelia Windshell): Certainly.

Barbara Wright: Because we're just not following how you're distinguishing that from all of our examples.

(Cecelia Windshell): Okay. All right thank you very much.

John Albert: Thanks.

Coordinator: Our next question comes from (Jonathan Paul) from (Brussard).

(Jonathan Paul): Hi there. I've got a couple quick questions; hopefully it'll be quick and easy anyway. One is regarding the penalties that are involved in the - in the failure to report timely. My understanding from reading the guidelines is that you can only report quarterly is that - that's correct?

Pat Ambrose: Yes.

John Albert: Yes.

(Jonathan Paul): Okay so if one of my clients fails to report a claim on time in their appropriate reporting window then they have to wait another full quarter before they can report, is that right or can they report a missed claim in the interim?

John Albert: They'd have to report it in the next quarterly submission.

(Jonathan Paul): Okay so they would be getting $1000 penalty per day per claim for that entire period of time where they weren't able to report?

John Albert: Well we haven't released any policy regarding CMP but obviously we're not interested in making people not report so we can assess some CMPs. But at this time, I mean, we have - the guidance that's out there regarding CMPs which is essentially just that at risk (amount) we've had. I mean we're not, again as I've stated on many of these calls, we are not interested in CMPs, we're interested in establishing an effective data exchange process that works well and that's what our goal is.

Barbara Wright: And we would also hope that given the extra 45 days that we've added to the quarter each time that you should normally be able to catch it. We understand...

John Albert: Right.

Barbara Wright: ...we understand your concern that...

John Albert: Yeah.

((Crosstalk))

(Jonathan Paul): An I'm not saying you guys are trying to asses fees on people I'm just saying from a perspective of, you know, a client that they're concerned about oh well hey I missed my deadline and now I've got another 45 days and I'm going to

get hit for $45,000 on this one claim. That's a question that's been brought up so I just wanted to...

John Albert: No, and we appreciate that because it's, I mean, again it's - like we're not going to be doing anything like that, that's for sure.

(Jonathan Paul): Okay.

Pat Ambrose: The system is setting those compliance flags for late submission but there's no automatic calculation of a fine...

(Jonathan Paul): Okay.

Pat Ambrose: ...in the system at this time.

(Jonathan Paul): Okay excellent. As far as - in workers compensation claims and liability claims also generally if we're going to settle a claim even one that's been denied in the past and we haven't accepted ongoing medical responsibility for we'll have to get, you know, for individuals that are Medicare/Medicaid recipients we'll have to get an MSA.

Now if we submit information for an MSA to the local CMS office are we - is it necessary for us to put you all on notice right away or do we need to wait until the settlement goes through? How does that work?

Barbara Wright: A couple things, I believe all the workers comp, Medicare set-aside proposals are submitted through the COBC. Isn't that correct John? So it doesn't go to a local CMS office, it goes to our national office or a coordination of benefits contractor.

Secondly if it happens to be a proposed liability Medicare set-aside which CMS may or may not have the workload capacity to review those do go to our regional offices. But that notification is separate and apart from the Section 111 reporting...

(Jonathan Paul): Right.

Barbara Wright: ...if you're reporting - if you're submitting a proposed set-aside that goes through the COBC office where the (RO) is applicable. If you are - if an entity including plaintiff's attorney is looking for a potential conditional payment amount that's something that is done through self identifying to the COBC separate and apart from the (MSP) - I'm sorry, separate from the (WCMSA) proposal and the Section 111 is completely separate.

For the 111 purposes it's only once there's been essentially an ORM or a TPOC.

(Jonathan Paul): Okay. And one final one regarding updates. And I think this one is pretty clear, I just want to be sure I've got it. Regarding the updates we don't - clients don't have to inform you every time they've paid a medical bill or anything like that, right? It's the - my understanding from reading the guidelines is you report when there's the acceptance of ongoing medical and then you report when it terminates; is that correct or...

Barbara Wright: I didn't understand your first part about clients don't have to inform anytime they pay a medical bill.

(Jonathan Paul): That was part of the question; I'm curious as to if I have - if I have a client that takes a - that accepts ongoing medical responsibility for a back injury, let's say. And, you know, they have regular treatment for a while and they

report the claim but then there's a back surgery, right. Do they have to report that back surgery in an updated report?

Barbara Wright: No it - once they - they should be reporting the ORM as soon as they've assumed it or it meets the threshold - if they exceed the threshold criteria we've got for ORM.

(Jonathan Paul): Right.

Barbara Wright: But then they're reporting it as the claim as a whole; they are not reporting individual bill payments. As you'll notice there's no place on there to say how much they've paid.

(Jonathan Paul): Okay so it's - the first time that they accept ongoing medical and then when it terminates.

Barbara Wright: Yes.

John Albert: Yes.

(Jonathan Paul): Okay excellent. Thank you so much. I appreciate it.

Coordinator: Our next question comes from (Kevin Klewize) from Montana State Fund.

(Kevin Klewize): Yes, my question is related to the (Hugh) software and the requirements for running that software? Do we have any specifications on that and when that'll become available?

Pat Ambrose: I'm working on getting you that. After you register and get an assigned EDI rep the software can be made available to you. I'm working on getting more

information about, you know, the operating systems and that sort of thing that you need to prepare to run. With it we're also looking at ways to deliver that software to you as well as the X12 mappings if you're using your own translator in a more efficient manner. So the answer is stay tuned.

(Kevin Klewize): Okay great. And the next part of the question is related to the (Hugh) software as well in that my understanding is that it's going to not only generate the 270 and 271 requests for response processing but also do the transmission to the COB, is that correct as well?

Pat Ambrose: No it doesn't actually physically transmit your file for you. You need to either upload the file using https or send it secure file transfer protocols, SFTP, or over the (AGNES) network using Connect Direct.

(Kevin Klewize): Okay.

Pat Ambrose: That aspect is up to you, the actual transmission.

(Kevin Klewize): Okay. So those are two - so it's really more just a translator in and out that'll be used not only for the query but also for the filing of the report?

Pat Ambrose: That's exactly right.

(Kevin Klewize): Okay, thank you...

((Crosstalk))

Pat Ambrose: And it does run on your own machine and, you know, whether you're using it on a server or your - or an individual PC it does come in two versions but - or a mainframe version and server PC versions so, you know, you'll take the

software, load it and run it on your own machine. And again it does not do that transmission for you.

(Kevin Klewize): Okay, yeah, and the biggest concern that we had here is that, you know, we're not a Microsoft shop so when I hear the phrase PC that's a bit of a concern for me because that means we have to build in house infrastructure to then support that package for converting that etcetera.

So we were hoping that it would be a job (size) implementation where we could run it on our UNIX servers and things like that.

Pat Ambrose: Yeah, I'm pretty sure you can but I'm going to have to get you verification on that.

(Kevin Klewize): Great. Thanks so much for your time.

Barbara Wright: Along a similar line we've gotten - I think we're still getting a few questions people are asking about the availability of the file layout etcetera in the Excel or other means, Pat, can you address just so they have an answer?

Pat Ambrose: Oh, we have no plans at this point in time to take those file layouts and put them into an Excel spreadsheet. You know, I apologize for that but there's issues with publishing documents like that on the web site and, you know, obviously, you know...

John Albert: They could be modified and we don't...

Pat Ambrose: Yeah, there just is no plan to put them into Excel at this time.

Barbara Wright: Operator, it's 3 o'clock, could you give us any idea how many questions are queued up if any?

Coordinator: Approximately 30 questions still, sir.

John Albert: Okay. And how many participants are on right now?

Coordinator: It looks like 512 participants.

Barbara Wright: Okay, I think we're going to have to end the call for today. But remember that next month we do have a registration specific call; it's for all of NGHP and then we do have again a joint workers comp, liability, no-fault call.

William Decker: And if you didn't get a chance to ask your question today and haven't asked it already by sending it in to our mailbox do it now.

John Albert: We are also very interested in feedback on the materials that we've developed so far in terms of, you know, information that, you know, you don't see or is confusing etcetera especially as we roll out the computer-based training modules for non-group health plan reporters.

We want to know again what areas do you think we should focus on in terms of our outreach efforts.

With that I'd like to conclude this call and thank everybody for their participation. And again continue to send your questions, comments to CMS resources mailbox directly. Thank you.

Coordinator: This concludes today's conference call you may disconnect at this time.

John Albert: Thank you, Operator.

Coordinator: Have a great day.

John Albert: Bye.

Coordinator: Bye.

END