TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: August 25, 2010

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
August 25, 2010
12:00 p.m. CT

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

At this time, I would like to welcome everyone to the MMSEA Section 111 Conference Call.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then one on your telephone keypad. Due to the call volume, we will ask that you please limit your question to one question and a follow-up question. Thank you.

I would now like to turn the call over to Mr. Albert. You may begin your conference.

John Albert: Thank you, operator.

Good afternoon or good morning, depending on where you're calling from. This is the MMSEA Section 111 Non-Group Health Plan Open Door teleconference. This call is geared to both policy and technical questions, issues, et cetera. Normally we separate the calls by either policy or technical, but because of the summer months and it's harder to get people on, we decided to combine them into one call per month during the summer. Starting this fall, in September, we'll break them up into two calls a month for policy as well as technical questions and answers, et cetera.

Again, this is Non-Group Health Plan which is for Worker's Comp liability, no-fault, insurance – insurers are required to report under the Section 111 provision.

I also want to quickly state as I do on all of the calls that on occasion we may say things or get into discussions that may conflict with some of the written guidance on the Section 111 Web site which is the official repository of all official CMS guidance regarding Section 111 reporting. If we do conflict with that, we need to make sure to state for the record that the guidance that is published is the correct guidance. We, you know, we're human and we sometimes make mistakes. But again, as this evolves, the guidance is continually updated to reflect current policy, instructions, et cetera.

We'll begin with the presentation from Ms. Pat Ambrose. I don't know. Did you…

OK. And we'll probably then go straight into a Q&A session. We have the usual group of people here – Pat, Barbara, Bill Decker, myself and others.

And with that, I guess if you're ready, Pat, then we can go.

Pat Ambrose: Sure. Thanks, John.

First, just reminders about the Section 111 Mandatory Insurer Reporting Web site at www.cms.gov/mandatoryInsRep, there is an updated notice for the remaining 2010 teleconferences that John was talking about. That notice is dated July 30th 2010. And it can be found on the NGHP page. Version 3.1 of the User Guide is on the NGHP page and dated July 12, 2010.

Remember that NGHP or Non-GHP specific alerts and downloads are posted to the NGHP Alerts page. And also, remember that the Mandatory Insurer Reporting tab that you see on the left-hand side of the Overview page is used as an archive, and older downloads and alerts are moved there.

Now for some things that can be found on the Section 111 COB secure Web site, that Web site is www.section111.cms.hhs.gov. Note that it is cms.hhs.gov. That Web site URL has not been changed to remove the HHS in between there.

At any rate, on that Web site, there is a set of files that contained the error codes and descriptions. We are currently working on updating those files.

They're found under – the Reference Materials menu option on the log-in page. And right now the error code files that are out there are based on version 3.0 of the User Guide and we are updating those error files to base them on version 3.1. So you'll see that we have Excel and Text files out there. And we'll get those updated, error code files, posted as soon as possible.

I'd also like to remind you that we have test beneficiary data on that same Section 111 COB secure Web site log-in page. Again, that's the Section 111 COB secure Web site log-in page under Reference Materials. And note that these test beneficiary data, it's available in an Excel and a Text file also and it includes Medicare coverage certain end dates for these fictitious test beneficiaries so that you can set up appropriate test conditions, including testing the disposition code 03.

Now some announcements or information related to direct data entry, please review the information in the alert dated May 25th 2010 and also in the User Guide version 3.1. We are working on developing Computer-Based Training modules or CBTs. And we'll release those and plenty of time to review that information prior to January 2011. In fact our goal is to submit at least some introductory CBTs prior to October 2010.

So information is soon to be released to give you an idea of what the screens will look like and how you go about setting up your registration information or your RRE information for using the direct data entry option and thins of that nature.

A complete User Guide and Help pages will be made available for the direct data entry option when the application is implemented. In fact, we will be adding the information about direct data entry to the existing Section 111 COB secure Web site User Guide. And then of course, every page will have a help page associated to it with it for you to use as you're going through the application.

Now that said, I know a lot of you are anxious again to get started, to see what the direct data entry option looks like so you can make a determination as to

whether you will use it or not. There are some information about whether you should use it or not in the Alert and the User Guide information. But as far as what you will need to be prepared to enter as far as data, take a look at the existing User Guide version 3.1 since all the same fields will be required when you do the direct data entry as are required for file submission.

So please review all of the requirements in the User Guide. And of course, skip over anything that is specifically file related. But all the requirements about what claims are to be reported, what injured parties are to be reported, when you should report and so on, all of that information is the same as what's currently published in the User Guide.

So review the requirements in the User Guide and also pay particular attention to the field description in the file layout in the application – I mean in the appendices. Because as you go through and enter data into the direct data entry system, the same requirements will be applied to those fields. So whether a field or data or information is being provided on a file or direct data entry, we will use the same set of requirements as we edit that data and as we, you know, make requirement determination.

So again, essentially the same rules apply. You will get – as you're entering a claim using direct data entry, you'll get most of the data validation edits, live, real time as you go from one page to the next rather than getting an error code as in the User Guide. But again, to see how those fields are going to be edited, please review the error codes table in the User Guide because that's essentially what the system will be based on. So as you're going through and entering your claim information online, you will be prompted to correct data as you go.

So, again, we'll get information – additional information out there as soon as possible in the form of a Computer-Based Training module. If you're signed up for the CBTs, you will receive a notification – a notification e-mail when the direct data entry CBT is available. If you're not signed up, go to the MandatoryInsRep Web site and look at the left-hand menu where it says "MMSEA 111 Computer-Based Training" or "CBT" – in parenthesis. Click

on that link. Go to that tab and follow the instructions for registering for the CBTs.

When you sign up for the CBTs, there's no requirements that you take all of the courses. You can pick and choose and take whatever courses are of most interest to you.

Another announcement regarding abandoned RRE IDs, we've talked about this before. If you registered for an RRE ID that you no longer need and never intend to use for production reporting, then please contact an EDI representative or the main COBC EDI department number. That number is 646-458-6740. You can also find that number on – in various places on the Web site.

Please contact the EDI department and ask that your RRE ID be deleted if you no longer intend to use it. Many organizations have determined that they are not RREs for Section 111 reporting since the publication of the Who Must Report alert. So if you will not be reporting for Section 111, you do not need to complete the registration process or testing, and again please call to have your RRE ID deleted.

I will go over during this time some changes that need to be made to the version 3.1 of the User Guide. If any of you do notice typographical errors or other problems, please feel free to report those either to your EDI representative or to the CMS Section 111 dedicated resource e-mail box.

The first such correction that I need to make has to do with the only fields for which we'll accept parenthesis at this time are the description of illness injury, field 57; the policy number, field 74; claim number, field 75; and the plan contact department name, field 76. The User Guide will be updated for this information as it now implies that, in parenthesis, "are accepted in all alpha numeric fields unless otherwise specified." And it turns out that is not correct.

So, again, the fields in which we will accept, parenthesis, include fields 57, 74, 75 and 76.

Another typographical error identified in the User Guide refers to the data you may start signing up for direct data entry. That date is October 2010, not October 2011. There was a phrase or a statement in the User Guide that referred to you may register for DDE starting in October 2011, and it should have said October 2010 obviously because the direct data entry option will become available to RREs who sign up for it in January of 2011. Please see section 15.5 of the User Guide.

We are developing a new CBT on ICD9 diagnosis codes to address questions submitted regarding the use ICD9 codes, how to select or derive them, what codes you might use in particular situations and so on.

If you are signed up for the CBTs, you will get an e-mail alert when this new course is available. We are still looking at the requirements for ICD10 codes. But note that the conversion to the use of ICD10 codes will not be made until 2013.

My understanding, there were some questions about that conversion to ICD10. Again, you don't have to worry about it just yet. But when we do get geared up to convert to ICD10 and we must implement that in, I believe it's October 13, we are not planning on requiring RREs to go back and convert all of the previously reported and accepted ICD9 codes and convert them to ICD10. So when you send an update for an older record, you may continue to submit the ICD9 and the system, COB system will convert that to an ICD10 as appropriate. So there'll be a date though for new reports at which you must start submitting ICD10 codes.

So more information on that, but hopefully that alleviates some of the concerns that folks had regarding having to go back and update all old previously reported and accepted records.

Remember that there is no longer a requirement to send an empty claim input file when you have nothing to report for a particular quarter. Empty files will still be accepted, but they're not required. There are several places in the User Guide that need to be updated to be in synch with that new requirement. But

that – and those – thank you for those of you who pointed that out, and we'll take care of that in the next version of the User Guide.

So again, empty files are not required. They will be accepted, but there is no need for you to send an empty file each quarter if you have nothing new to report.

There were some questions related to the submission of more than five TPOC amounts, more than five total payment obligations to the claimant amounts. First, I ask that you review the definition of a TPOC in section two and the field description for fields 100 and 101 in the file layout of appendix A of the User Guide.

You need to understand that usually, for one settlement, judgment, award, other payments were claimed, there is only one TPOC reported. Even if the settlement is paid out in installment payments, the whole settlement is to be reported in TPOC amount one. CMS doesn't want each installment payment reported separately.

Also make sure you understand that you are not to report reimbursements paid to medical providers such as hospitals, doctors and the like, for medical services and supply claim related to Work Comp or no-fault, for example. That is considered Ongoing Responsibility for Medicals, or ORM, and all you report for ORM is a Y in the ORM indicator and no actual dollar amount. Now it is possible for a claim to have not only ongoing responsibility for medicals and the TPOC amount, and you may report the ORM indicator equal to a Y and the – any associated TPOC amount on the same claim report.

Now all of that said, it's my understanding that having more than five TPOC amounts to report should be rare occasion. But if you have reviewed the definition of a TPOC and truly have more than five such settlement, judgment, award or other TPOC payments for the same claim, for the same injured party, then add the sixth and subsequent TPOC amounts to the TPOC amount five-field on the auxiliary record. That means that TPOC five will contain the fifth and subsequent TPOC amount, the total of those. Put the latest most recent

TPOC date in the TPOC date five on the auxiliary records and submit an update transaction.

TPOC fields one through four should contain the same information previously submitted. Remember that your TPOC fields are positional.

Also, an RRE asked about the funding delayed date field related to the TPOC, the sets of TPOC fields one through five. There really should be no need at this point to use the funding delayed date field. But if you do, the fifth funding delayed field should reflect the information for the most recent TPOC that you're reporting on the claim.

See the last paragraph of section 11.5 in the NGHP User Guide version 3.1 where it covers most of this information.

Now I've got some items to follow up from the last call. First off, ICD9 codes, the Web site link where the list of valid ICD9 codes and associated effective dates for each list can be found in section 11.2.5 of the User Guide where it talks about the requirements for ICD9 codes. The list of excluded ICD9 codes is in appendix H. And it did not change between version 3 and 3.1 of the User Guide.

The diagnosis files on this Web site link on the CMS Web site are the ones with DX in the name. If you want to use the most current list in Excel format, you could use the D27L-O-N-G_S-H-O-R-T_DX_110909.xls. So again, that file name in Excel format is D27LONG_SHORT_DX_110909.xls.

I don't recommend that you use the CSD file since it looks like they lose the leading zeros at least when I view it. And I – you know, you have to match exactly on the first five bytes of the diagnosis code in those files.

Now what I recommend that you use is the text format since that's what's used in the COBC system for Section 111 files. So the text format can be found in the version 27 ZIP file that's entitled, "Version 27 Abbreviated Code Titles Effective October 1, 2009, Updated July 29th 2009 – Updated 07/29/09." So when you download that ZIP file and open it up, you'll see a

text – two text files. You always want to use the file with the "DX" in the name. And so you would use CMS27_D-E-S-C_S-H-O-R-T_DX.tx.

Now if you didn't get that name, that file name is in the User Guide. So go to 11.2.5 of the User Guide and hopefully you'll be able to follow those steps and find the text file that you need. Again, I recommend that you use the text file, but both the Excel and the text file contain the same set of ICD9 codes that CMS considers valid for Section 111 reporting.

Now that said, let me just review ICD9 Code Reporting. Again, there's obviously a much larger, longer list of ICD9 diagnosis codes. CMS then starts with that and creates a set of ICD9 diagnosis codes each year that it considers valid for Medicare. That's the file, the text and Excel files that I was just referring to. And again, that's explained in the User Guide.

Now once – first, you check your ICD9 code against that file to make sure that it is on that file. If it's not, it's invalid. If it's on that file, then take another step and check it against the excluded ICD9 diagnosis codes in appendix H. If it's excluded, it's not valid. If it's not on the excluded list, you're good.

Then you have to look at the requirements for the individual fields you're putting this ICD9 diagnosis code in, namely field 15, the alleged cost. That is – that must be an E code starting with the letter E, as in Edward. And then the diagnosis codes that you put in fields 19 through 55 for diagnosis code 1 through 19, those may not be an E code and those may not be a V code. They may not start with E, as in Edward, and they may not start with V, as in Victor. Otherwise, they then just need to be a valid code as found on the text or Excel file mentioned earlier and not an excluded code.

There's other requirements related to ICD9 codes that are explained again in that section. Right now, if you're submitting a production file, you could submit field 57, the description of illness injury in lieu of sending diagnosis codes. But once we get to January 2011, you must submit both an E code in field 15 and a valid diagnosis code in field 19 and subsequent.

So again, take a look at that section of the User Guide. Please contact your EDI representative if you have additional question.

Another follow up from last month's call had to do with the gender code of zero for unknown. It is true and we stated previously that if you submit a gender code of zero for unknown, the system converts it to a one and attempts to matching using a value of 1.

So, in essence, there's no reason for you to even submit a zero. I encourage you to get a valid gender code for the injured party. A zero is treated just like a one for matching purposes. Someone was indicated that, "Oh, well then you're not really matching on three out of four." We are, but again, we're converting that zero to a one since we don't know what to do with an unknown gender code either.

One last issue from last month's call had to do with records – claim records being reported with no ORM. So the ORM indicator equals an N and the response file record return included some applied fields such as the MSP effective and MSP termination dates. And the User Guide says that our non-ORM claims, those fields should not be returned.

This is not really a problem and you can disregard the information that is provided, passed back in those fields. That has no bearing on your processing for these non-ORM claims. However, we are making a correction in the system to zero out those values on response records that are returned with no ORM.

OK, one last reminder before I get into some Q&A that was submitted to the e-mail inbox. Please submit your technical specific or specific technical question to your EDI representative first. Specific technical issues related to your file submission can't be addressed effectively if they're sent to the CMS Resource mailbox or elsewhere. We've had some folks submit some of these questions to staff that support the Computer-Based Training, for example, and that is not appropriate and those individuals are not geared or equipped to answer your question. You'll get a much faster response to your specific technical issues if you contact your EDI representative and follow the escalation procedures in section 18.2 of the User Guide if necessary.

So for example, when we've received questions regarding why certain queries were or were not matched to Medicare beneficiaries, that kind of question really needs to be reported to your EDI representative to research. We're looking for you to submit more general and policy questions to the CMS Resource mailbox.

OK, some questions that were submitted since the July 28th call, the first question has to do with reporting when the injured party is deceased, particularly fields 104 through 132 of the detail records for claimant one. The question reads, "Do we only have to report if a deceased is a Medicare beneficiary themselves? Do we need to verify whether the other claimant is a Medicare beneficiary? What if the deceased is not a Medicare beneficiary, do we need to verify whether the other claimant is a Medicare beneficiary?"

I know that there are some confusion about our use of claimants. But claims are to be reported for Section 111 where the injured party, which is also considered a claimant in the insurance industry although not on our file layout, the injured party is a Medicare beneficiary. So if the injured party is a Medicare – if the injured party or Medicare beneficiary is deceased, then report the applicable claimants as defined in the User Guide, (the estate), other family members, et cetera.

The Medicare status of these other claimants, claimants one through four on our file layout, as defined for Section 111 is not relevant. Again, the Medicare status of claimants one through four is not relevant to Section 111 reporting. What's relevant is the injured party is a Medicare beneficiary.

So the key is that you determine first who the injured party is. Then determine if that person is a Medicare beneficiary. If not, you don't need to report the claim information. If so, then report their information in the injured party fields. And if they are deceased, report the other claimants.

Another question was asked about submitting an individual's last name contains a space. So for – in their example, their last name is comprised of two words and there's a space in between and that space falls in the sixth position of the last name. And they were asking how should that be

submitted. And it should be submitted with the space. Basically, we're matching to how the name is stored on the individual's Social Security or Medicare card. And if it shows – if their last name shows with the space in it, then you should submit that last name exactly as it appears on the card and exactly that way.

The next question has to do with, does ORM reporting require any reporting of actual periodic payments or is reporting only required when ORM is assumed and then when it is terminated, but with no actual payments reported?

So ORM does not require that the actual periodic payments be reported; just the fact that ORM exists by submitting in the Y, in the ORM indicator, and then submit and update record or otherwise with the termination – the ORM termination date when ORM ends.

Another question was being – is being asked about the difference between a reporting agent, account manager and account designee for reporting purposes. A reporting agent is a company, but an individual from that company is often named as the account manager or account designee where the RRE account managers and account designees are user role on the Section 111 COB secure Web site. And they must be specific individuals that accept the terms of the user agreement on the Web site and as they register for their log-in ID.

So please read section eight of the User Guide and the How-to-Get-Started download on the menu of the Section 111 COB secure Web site for full explanation.

The question goes on to ask, can an RRE have more than one reporting agent? And the answer is yes, you may have more than one reporting agent. Since these reporting agents are likely to be sending in separate file, the RRE would likely need two RRE IDs, one for each agent file submission. However, if you have one agent taking over for another, you may have the new agent start using the previously assigned RRE ID. It really depends on the transition

whether these two agents will be reporting for you at the same time or whether one is taking over for the other.

There are some information on that in the User Guide under Transitioning Reporting, Transitioning RRE IDs and the like. Again, that's in section eight of the User Guide.

There was a question related to direct data entry and whether a reporter who has not or an RRE who has not yet registered and plans to use the direct data entry, whether they should wait until October to register. And my recommendation is that yes, you wait until, I believe it's October 3rd. But it's sometime early in October when that registration will be made available. And it would make sense to register then and sign up for direct data entry during the initial registration and account setup rather than registering now, selecting a file method and then having to change it later.

But you can. If you're already signed up, you can change to direct data entry option after the release in October goes in.

The next question…

John Albert: Just remember that if you don't register, you can't get technical support from the EDI department, et cetera.

So that's the only thing I would say about that. I mean, I agree with you, Pat, that yes – I mean if it's at this point in the game, if they're not registered, they're not going to have access to all of the support that someone who is registered would have. And again, we remind everyone that technically, all RRE should have registered last year for this process.

So – but again, I just want to – I just want to put that out there, so…

Pat Ambrose: OK, thanks, John.

Another question related to direct data entry came in about, do you recommend that an RRE who expects to only have a very occasional claim to report, that they register now? If – what I need to refer you to is the note at

the bottom of section 8.1 of the User Guide where basically if an RRE has nothing to report and doesn't anticipate having anything to report any time in the near, you know, future that the RRE does not have to register at this time. If you expect to have something to register, I mean to report come January 2011, then you should be registering as John indicated.

So again, take a look at that note at the bottom of section 8.1 for further guidance on that.

The next question had to do with whether a small report using the direct data entry option could use the direct data entry option as a query tool and query individuals prior to settlement, judgment, award, or rather payment. The direct data entry option is not a query tool. It obviously does match the information you supply to the file of Medicare beneficiaries. But it is not to be used as a query tool early on in your claims process.

If you enter information for an individual and the system checks whether they are a Medicare beneficiary or not, that does count against the limit of 500 transactions, that is described in the Alert and the User Guide.

That question went on to ask if there was some other, you know, if you're not to use DDE for query purposes for – you know, basically for query purposes, is there some other option? And there's not another query option available unless you use the file submission method for Section 111. RREs can self-report claims through the COBC 800-number. That process has not changed. And you also could make use of the model language that is posted on the Mandatory Insurer Reporting Web site and ask the injured party directly, whether they're a Medicare beneficiary or not.

Lastly, another question about small report using the direct data entry option, and would they still be able to use a reporting agent to assist them with direct data entry and entering the information on the RRE's (Decaf)? Yes, it is possible for an RRE using the direct data entry option to invite a reporting – an individual from a reporting agent to be an account designee user of the COB secure Web site. And then that individual will have access to the RRE

and be able to enter claim information and maintain claim information using the DDE.

Another question had to do – changing topics, had to do with address formatting and how critical is it that things like the apartment or suite number go in the second address line of the claim input file. Basically, the most critical address is the RRE's address on the Tin Reference file that will be used in the demand – recovery demand processes. So you need to get the address for the RRE that you or associated with the Tin and office ID combination that you use on the Tin reference file. It's critical that you adhere to that address requirements for the fields, the address fields on the Tin Reference file.

For the other addresses in the – on the claim detail and auxiliary record for representatives and claimants and the like, the requirements are not as strict there at this time.

There was a question submitted related to the threshold amounts. And I refer you to section 11.4 of the User Guide for the rules regarding threshold and what will be accepted and as of what date. The questionnaire noted that as of January 1st 2014, the thresholds are eliminated for TPOCs after – on or after that date. And they went on to say that, is it possible to allow RREs to report all payments without paying attention to the threshold and without being penalized for doing so? It is not possible to allow RREs to report all payments without regard to the TPOC thresholds. But there's no penalty per se. You'll just get an error code and that claim report will not be accepted or saved by the COBC.

Let's see. This question was asking they were – the questionnaire was wondering if the edit on page 108, stating that the most recent TPOC date on the claim must be within 45 days. The file submission date will be suspended for the initial file submission. You know, obviously you're doing some retroactive reporting in your first file submission and are required to do so in first quarter 2011. And yes, the system will be adjusted to take that into account and not setting compliance flags on those claims that you're reporting retroactively.

Another question went onto ask about a claim that – for which there is two coverages, bodily injury and uninsured motorist, so bodily injury liability and uninsured motorist liability, and whether the RRE should send two claim reports for the same claim, for the same insurance type, one for each or should they combine these as one TPOC, two separate TPOCs and are they – the issue would be whether it's two liability payments on the same policy even though they're the same type. If there are two separate policies, they do need to report them separately. But otherwise, we have no problem with them combining them just as they do for no-fault.

OK, so they should – if it's the same policy, they should combine those TPOC amounts or combine the reporting and on one claim report like they would for the tip in med pay for no-fault.

So – and that this questionnaire was also asking about no-fault. And the User Guide already has guidance related to combining the no-fault limits on a particular claim. So I refer you to that in 11.10.2 I think you'll find it. And we'll go back and make an update to the User Guide about the – combining liability amounts there too.

Another question came in. This was – this was brought up, I guess, in the July 28th conference call. And it was regarding what fields must be sent with a delete. And the interpretation of this individual is that when they're sending a delete, they have to send all other claim information previously submitted on the Add Record. And what we're – what we're really getting at is when you're sending a delete is that that delete record will, for the most part, be edited the same way that the – an add and an update would be.

So you don't have to send exactly the same values for the non-key data for the delete. Obviously, the key data must match so we can match up the delete to the correct record, so you can send the most current information that you have for related other fields, other non-key data.

So, again, you don't have to send the same values for the non-key data on a delete; just values that will pass the edit essentially. Most of the edits get

applied to delete. So that's why the guide was worded that way. And I've made a note to adjust the language for that.

This same individual went onto state that they were – they're not feeling like they're given the flexibility that they need to update incorrectly submitted policy and claim numbers. And, you know, I'm not exactly sure where we indicated that you could not send an update to change your policy and claim number. You should in fact. So, you know, if you want to, when you submit your questions on, note exactly what section of the User Guide you're looking at.

But to answer your question about, let's suppose that you've submitted an incorrect policy number or an incorrect claim number and you need to correct that information. You may send an update to correct a policy or claim number. In the Event table, you'll see where it states when you're making an update for non-key fields that it says submit the same or updated information for all other fields when you're sending an update again for non-key fields. That would actually be true for the key fields as well.

In the event for correcting a key field that says "Submit all previously submitted information as required," and this probably should have read, "Submit the most current information in all other fields as required."

So the point is, is that for non-key fields when you're sending an update, you may send the most current information and we will certainly want you to send an update record to correct the policy and claim number. You don't have to go through any special delete/add process. You should just send an update with the new policy and claim number for that.

There's another question submitted. This individual states that they were reviewing version 3.1 of the User Guide and had a question related to the TPOCs and the current states liability policies. This question relates to how we are storing data in our claim system and how that data should be allocated to the claim input file. We currently have a claim system that allows for multiple claimants on a single claim, which could result in a loss. For example, an insurer then insures a bus with seven passengers would typically

set up as one claim with seven exposures and therefore seven claimants. In this particular case, all seven claimants are Medicare beneficiaries. And they were asking how to report that.

So these claimants are considered injured parties for Section 111 reporting. And you are report by injured parties. So you would send seven different claim transactions, one for each injured party, and you would have the same conceivably policy number and claim number for each if that's what you've got in your system.

So I refer you to the User Guide 11.10.2 where estates records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, et cetera. And you again may submit in this scenario seven records, one for each individual injured party or Medicare beneficiary. And each of those records might have the same policy and claim number reported.

Someone pointed out that confusion over fields 106, 107, 108 and 109 on the claim input file detail records. This is not an error in the User Guide. These fields redefine each other. In other words, you use either fields 106, 107 and 108 or you use field 109. They take up the same physical place on the claim input file detail records. And you decide whether you use fields 106 through 108 or field 109 according to the rules that are provided there in the field description. And it's dependent on the value that you're using for the claimant one relationship. And I ask that you contact your EDI rep for more information if you're still confused about that redefinition.

Someone else pointed out that we might have an error in the special qualified exception for ORM assumed prior to 1/1/2010. This is in section 11.9 of the User Guide I think. There is an example, in the third example box where it states as of January 1st 2010 and subsequent, the claim is still "technically" – and technically is in quote – open and ORM continues. But the RRE hasn't made a payment since August 2009.

Now, the – and they're confused about do I report or not report because it looks like exactly the same scenario as the example above. It is not the same as the example two above it. Please go on to read the next part because that's

where the differentiator is. The RRE considers this claim actively closed and removes it from their file of current, open, active claims on October 1, 2009. Unlike example two above it which was the claim was closed and removed after January 1st 2010. So since the claim was considered closed by the RRE prior to 1/1/2010, the ORM does not have to be reported unless the RRE reopens it.

Another question came up about sending e-mails to account designees. This has come up before. Rather than changing our e-mail process, we're instead looking into handling this by using a set of file notifications that would go back to the mailbox for the RRE and could be picked up by an account designee or a reporting agent. So instead of sending e-mails to designees, we're now working on creating a series of notification files that would parallel the e-mails about file processing status that are currently sent to the account manager.

Now I don't have a date for when this change will go in. It certainly won't happen for January 2011. So in the meantime, you need to plan on having your account manager for the e-mails to the appropriate parties when they receive them. If that account manager is not an appropriate person to perform in that function, then you might consider changing your account manager to someone who does fit the role as described. They are supposed to be a person who's managing your overall process, so they are responsible for forwarding e-mails where they need to go. But again, we're looking at a better long-term solution to that that will – that will be more satisfactory than a series of exchanged e-mails.

Let's see. There's a question again about the claimant one fields of 106, 107 and 108, and when to use those. In this particular example, they stated that there may be certain situations where claimant one reflects the beneficiary's state. However, a formal state was not set up. How do they go about reporting?

We've talked about this on previously town halls. In the case of no formal estate, you would use an E for the relationship, the claimant one relationship, I

believe it's called, and you would use the beneficiary's name, Social Security Number, et cetera, in the claimant one field so that answers that question.

Another question was asked on, "Please advise how reporting should be handled when a deceased beneficiary has more than four claimants since our file only allows for the reporting of four claimants." Again, only in the case of a deceased beneficiary are you reporting claimants one through four. If you've got more, just report four. We ask that – no, yes, just report as many as you have space for – on the current file layout.

Another question went onto, this individual pointed out that we have changed the requirements for GHP, for Group Health Plan, such that they're only allowed to query on a quarterly basis starting at a certain point going forward. That is not true for non-GHP. Non-GHP RREs will continue to be able to query on a monthly basis. So there's no change to the frequency of query file submissions for non-GHP.

One last note, a question came in asking if I have incomplete information for a claim report, should I go ahead and submit it knowing that I'm going to get an error and then resubmit it when I get the rest of the information. And the answer is no, there is absolutely no point in reporting a claim that you know is going to fail. You need to get that information as soon as possible and submit it as soon as possible on your next quarterly file after you obtain that information. But there is no point in submitting a claim just to get an FP error and an FP – or rather just to get an FP disposition code. We don't keep track of the fact that you send it. So it's really just a waste of your and our processing time.

So with that, I think I'm finally done. And I will turn it over to Mr. Bill Decker.

Bill Decker: Hi, Pat. Thank you very much.

…few comments to make on the questions that we – that came in. I always get to answer the SSN question. And so I'll answer them.

First of all, let me reiterate this common or what should be commonly known by everyone. You need to send us either a Medicare HICN, a Medicare Health Insurance Claim Number, the Medicare ID number with any information you're sending about a beneficiary. Or you can send us the individual's Social Security Number and we can check again the Social Security Number and individual's name, age and sex code and date of birth, and see if that individual is a beneficiary, one or the other.

If you don't have either, don't send us any information about the individual because there's nothing we can do with the information you send us. We want to have you send us Health Insurance Claim Numbers. That's our gold standard identifier and that will give us access to anyone who's a Medicare beneficiary.

We can use an SSN. That essentially answered the first question we had on the SSN issue.

The second question is a question that came in from a national firm saying that their council in California was giving them pushback on collecting SSN. And I think their question just basically says that there's a California rule of court that states that SSNs are confidential ones; therefore, they do not have to be disclosed.

Again, we say that we need to have your HICN, your Health Insurance Claim Number for anybody reporting to us. You can send the Social Security Number if either you don't have any Health Insurance Claim Number or not sure if the individual is a Medicare beneficiary.

And the other fact that I can tell you is that in cases where there is federal law that requires information to come in from folks that the federal law will take precedence over the state law – in this case, the Social Security identifying laws. I would ask – I would ask Barbara Wright to speak to that just a little bit more than I can because she has more close relationship with the law than I do.

But that's generally the case. If a state is saying – if someone is saying the state law says we can't send you the information, if the information is required under federal law, that takes precedence over the state law in general.

And, Barbara, if you have anything else to add to that.

John Albert: I think you said it well. Certain to the point.

Bill Decker: Apparently not.

So that answers that question. There was a second part of that which industry peers had comments about all of this. But basically the answer to the question is if we require because federal law requires it, then federal law takes precedence.

And now I will be happy to turn it over to Barbara Wright.

Barbara Wright: There was one other question related to Social Security Number or HICN. One of the questions that came in said the data claimant who testified under oath that they were not a Medicare beneficiary and they received a HICN on the query response file. And they're asking what their next steps should be.

John Albert: I mean basically the – you know, there are individuals that are signed Medicare Health Insurance Claim Numbers that never actually attain enrollment in Medicare. This can be a short-term, disabled, ESRD, et cetera. But again, you know, if they testify under oath, I mean, you know, we can't tell you what to do. It's just that if they have a HICN, odds are they probably are a Medicare beneficiary. And, you know, our advice would be to send a report to us on that individual. If they're over 65, definitely do so because they're almost certainly a Medicare beneficiary if they have a HICN.

Bill Decker: If you have information about someone who is reportable that is, in the case they're a Medicare beneficiary, then you should report them regardless of what they say.

John Albert: Yes. Regardless of whatever term of their entitlement may have been, so…

Bill Decker: Right. OK.

Pat Ambrose: OK. The first thing I'd like to mention is the so called Mass Torts Workgroup. We're working on that this morning and based on the current request to be part of that group, we have more than an 8-1/2-by-11 sheet of paper of solid e-mails that want to be part of this workgroup. This call needs to be an open-mic call or it can't really be a workgroup-type call if we have people that have to line up to speak. There's going to be no continuity to the discussion.

So we want to try and cut it down some. So one thing I'm asking anybody who's on the call right now, and I will ask it in an e-mail probably tomorrow, is any of you that have more than one individual listed with us, you need to pick a contact and tell us who this is going to be.

I remember, for example, I think there's one law firm that has at least four to five people listed. And since I don't have these numbers in the e-mails in any type of order, I'm not going to go through them one by one for hundreds of them. I do need you to identify a contact and we can see how far down that takes it.

The other thing I would say in general, if any of you, if you're on this workgroup, if you're from the same entity or you're working in partner with someone else, if you would call in on a single line. That being said, if we can cut this down enough, we're looking to do the call the end of – the end of next week or in the following week. I will be sending some materials out ahead of time.

Keep in mind that this workgroup is focused on Mass Tort issues tied to the Section 111 reporting. We've had some people come in and say, "I'm a plaintiff attorney and I think I'm getting inconsistent information on policy." This is not a workgroup for you. This is not a workgroup to discuss recovery policy or to discuss our rules. This is to discuss specifically policy and how it ties into reporting requirements.

Let's see. That's really it as far as general announcements. We have some questions that we wanted to touch on.

We did notice in the incoming questions in our mailbox, there at least a few entities that are writing in with all these, the questions that are basic questions that they should be well beyond at this point. If again, if you're new to this, you need to go through our Web site and read the User Guide. Some of the questions are as basic as do we have to report by insurance type. All these types of questions are covered in our User Guide. So we're not going to go over everything at that level again.

On Never Events…

John Albert: We also recommend the CBTs as well.

Pat Ambrose: That's true.

John Albert: As a way to digest it bit by bit.

Pat Ambrose: We had a question come in about Never Events. And the question was asking about zero billing. It says the provider can't bill for the particular service. So according to our new alert, the provider would be zero-billing Medicare, showing itself as primary.

If they're required to bill such as an institutional provider even when they're not receiving any money, then yes, they will be zero-billing us.

They went on to ask about related services. And they were talking about viewing subsequent outpatient treatment related to the Never Event to be ORM and reportable under Section 111. And they asked how Medicare could say post Never Event related outpatient treatment is covered under general medical rules, and yet Section 111 implied that such treatment is ORM.

Keep in mind for all this reporting that coverage doesn't necessarily equal payment. So we're talking two completely different concepts when you're talking about whether or not Medicare coverage is a service and then you're talking about whether or not MSP rules apply and whether someone else is primary.

Bill, did you have anything to add to that?

Bill Decker: No, that's good.

Pat Ambrose: OK. We had one question coming in from a county in a particular state. And they said that they knew they had to report denied claims. But do we have to report denied claims that have already been ruled non-compensable or they're hearing then closed, et cetera? And first of all, we don't know exactly what's meant by denied here. In some instances, an entity will speak to us and they'll be using the word "denial" over and over again. And they're talking about whether or not there was an admission or a determination of liability. And that's not relevant to us. What's relevant to us is whether it was a settlement, judgment, award or other payment regardless of whether or not there was a determination of liability.

Our rules kick in for reporting when there's been a settlement, judgment, award or other payment, including the assumption of ongoing responsibility for medicals. So that's what you need to do or look at in terms of whether or not you have to report. If by denied you mean that there was never a settlement, judgment, award or other payments including responsibility for ORM, pending claims do not need reported if they haven't reached the settlement, judgment, award or other payment category.

OK. We had a couple of questions come in that once again are talking about notifying us in connection with potential claim. That would be the same answer I just gave, dealing with situations, whether there has been some type of resolution or partial resolution…

Bill Decker: The notification on your Section 111, they may want to notify COBC during the tenancy of the claim.

Pat Ambrose: And Bill is correct about that. As we said on other calls, the Section 111 reporting doesn't eliminate or change our other policies and procedures. So typically, self-identifications are a coordination of benefits for pending claim is done by a beneficiaries attorney to the coordination of benefits contractor or the COBC.

In some instances, it's done by the insurer or the Worker's Compensation entity. And the COBC can still be notified of potential claims. If either side

is looking to obtain any information in terms of interim conditional payment information, the only way – even interim information will be available before there is a settlement judgment reward or other payments and if there has been the self-identification to the coordination of benefits contractor.

And also, I would – when I mentioned Bill before, I was asked to make sure I identified him as (Bill Vevogna) to differentiate him from Mr. Bill Decker who has also been speaking.

We had a question asking about a settlement where there was an agreement for a flat sum of 10,000 or 20,000 or whatever with an additional agreement to pay related medical bills up to a certain amount over a particular period of time and they wanted to know how to report the additional medical payments so a flat sum let's you – let's say it was $10,000 as the TPOC with an agreement to pay additional 2,000 over the next three months for related medical bills. In that case, you would be reporting the $10,000 as a TPOC and you would also be reporting ORM and following all the rules for ORM with respect to the additional $2,000.

Bill, could you address the one question about (inaudible)….

Bill Decker: The question asked is they are writing off the entire amount of the claim, do they have to report and not submit a claim to Medicare? They need to submit a claim to Medicare, they would show that they – the charges were they would also show that they received as a payment from liability insurance the total amount of the charges and this becomes an OK, Bill, is this required for hospitals and anyone else who is actually required to submit a claim if for no other reason than your 1831J requirements on tracking spells of illness.

Pat Ambrose: Bill, when – you're stating – submit a claim, in this case, you are talking about a claim to a Medicare…

Bill Decker: (MAC) contractor.

Pat Ambrose: OK, so a Medicare health claim that…

Bill Decker: To claim for, I guess payments or reimbursement, whatever their – where it is this week.

Pat Ambrose: OK.

Pat Ambrose: You also addressed – we had a fairly lengthy question about occupational accident policies.

Bill Decker: I don't understand where all this confusion on accident – occupational accident policy coming from. This issue was addressed quite a while ago. These are policies that are issued to owner/operators of trucks where injuries sustained in an accident whether they were at fault or not, they do not make payments to other parties who may have involved in the accident or anyone else. It's strictly for the owner/operator that does satisfy our definition of no-fault insurance because the last time I checked, if you were the owner/operator of the truck, the truck was your property and the injuries were sustained on your property so therefore no-fault revision kicks in.

I fully agree that it is not medical payments insurance or any other of the other examples that we listed in the regulations but I would note that we stay in the regulations specifically that this insurance includes but is not limited to that list was not meant to be exhausted.

Pat Ambrose: List in the regulation?

Bill Decker: List in the regulation and I would encourage folks who are still confused to look at 42 CFR 411.50 and the definition of no-fault insurance.

Pat Ambrose: OK. Another question we had come in was situations where beneficiaries are in something like an HMO program, they're in Medicare Advantage, et cetera, and the question was whether or not these people are simply Medicare eligible but not really a beneficiary and we had discussed this.

As we've said before, anyone who's part of Medicare Advantage Plan is still on Medicare Advantage and there are very…

Bill Decker: Medicare beneficiary.

Pat Ambrose: I'm sorry, Medicare beneficiary. And there are very limited or occasional situations whether by error or otherwise that someone who's in a Medicare Advantage Plan also gets something paid by fee-for-service or they may have gone in and out of the Medicare Advantage Plan. So, the fact that someone is in a Medicare Advantage Plan does not eliminate your reporting requirements.

Barbara Wright: In other words, if they are covered by Medicare Advantage Plan, they are a Medicare beneficiary and are reportable on Section 111 in the file.

Bill Decker: Yes.

Barbara Wright: OK.

Pat Ambrose: I guess we've – let me check through one more of this. I guess we'd like to open it up for your questions. One last point before we do that, we do have a couple of participants in this calls that have submitted a list of further examples for who is the RRE when you're looking at the insurer versus the insured, et cetera. So we're reviewing the additional examples that they work together to send in and once we look at them, we may add more examples to what we have available on the website.

Bill Decker: Operator, we can open up for questions.

Operator: At this time if I would like to remind everyone to please limit their question to one and one follow-up question. If you would like to ask a question, please press star one on your telephone keypad.

Your first question comes from (Bonnie Masters) from Farmers Insurance. Your line is open.

(Bonnie Masters): Yes, thank you so much. I just want to confirm, (inaudible) is that the equivalent of a Medicare Opt Out HMO program like Secure Horizons and PrimeCare Kaiser?

Barbara Wright: I don't know the names of every…

Bill Decker: Can you describe Medicare Opt Out a little more explicitly. It just sounds like you're saying they're asking out Part A and B and going into C. Is that what you're meaning?

(Bonnie Masters): Well, we really were not familiar with the HMO, the Medicare HMO, but the federal who was running the HMO, we've identified someone who were first to being at in a Medicare Opt Out HMO and I was looking – I don't recall that's having come out as a discussion item and so I was out, you know, trying to Google it and it looks to me like they are Medicare beneficiary but again has never heard that reference for…

Bill Decker: If they have a Medicare HIC, they are beneficiary. I mean, it sounds to me that these are people that opted out of fee-for-service and enrolled in a Medicare Advantage Plan which is the terminologies for me, what I've heard or conversely, they are in an HMO at this time run by Medicare and they opt out of the HMO coverage to get some sort of specialized or specific coverage on an opt out basis which basically anyone can do in an HMO as long as they're willing to pay for it.

(Bonnie Masters): OK.

Bill Decker: So they're essentially – but the bottom line is that they're in a Medicare HMO, they're going to be a Medicare beneficiary.

(Bonnie Masters): OK. I wanted to clarify that. Thank you so much. I have other questions but perhaps at the end I can pop back in again.

Pat Ambrose: OK. And in terms of the concept of opt out in general, beneficiaries sometimes that there's a particular provider or supplier who is opted out of the Medicare program if the beneficiary goes to see that provider or supplier not only does Medicare not pay that provider or supplier, they also won't pay as a beneficiary for that claims. There's a whole opt out where they're not participating.

But again, their beneficiary status is what determines whether or not you need to report.

(Bonnie Masters): OK, whether they're going to see a doctor outside of – that Medicare won't pay?

Pat Ambrose: That's not relevant to what you're (detracting).

(Bonnie Masters): Right. I hear you. OK, thank you so much.

Operator: Your next question comes from (Allison Holley) from (Johnson and Coleman). Your line is open.

(Allison Holley): Yes. I have a question regarding asbestos cases where all the exposure happened before 1980. And I've read what you have in the user guide, I'm just wondering if you release claims post-1980 with regard to future medical so all the exposure every agrees is before 1980?

Pat Ambrose: What we've said on the last call, is that one of the issues that we're looking at, there's a difference between whether or not something might be available as a defense to recovery claim we assert and what your responsibilities for reporting are.

As of right now, the responsibilities for reporting are if medicals were claimed or released on or after 12/05/80. What we're looking at – we'll be looking at in the so called Mass Torts Group is there a way that we can accommodate the wishes the industry in terms of simply not having to report any situation where there is really no exposure on or after 12/05/80. The problem has been so far is that when we talk to various parts of the industry, we get contradictory information which makes it clear there would be many situations where they would simply not be reporting or we in fact would have a recovery claim. So, it's still an open issue that we're looking for a way to better hear both the industry and us but I can't give you a flat no, you don't have to report it.

(Allison Holley): OK. Can I follow up really quickly?

Bill Decker: Yes.

(Allison Holley): Is this the same with comp claims whether the exposure is before 1965?

Pat Ambrose: Is this – no. I think you're mixing two things up. When we're talking this 12/05/80 dates, that's…

(Allison Holley): Liability.

Pat Ambrose: That's an effective date for no-fault and liability insurance. Medicare has always been secondary to Worker's Compensation since the inception of the program…

Bill Decker: Regardless of when the exposure was.

Pat Ambrose: Regardless of the data's incident or exposure.

Bill Decker: Correct.

Pat Ambrose: Yes. So, when they say 1965, they're really starting – talking about beginning of the program. In other words, if it's Worker's Compensation, it's always going to be reportable. No matter what…

(Allison Holley): Even if it's before 1965?

Bill Decker: Yes. If the exposure was during World War II and did not continue afterwards and it was Worker's Compensation, the fact that they're receiving a service once Medicare was established means it's reportable.

(Allison Holley): OK. Great. Thank you.

Operator: Your next question comes from (Lisa Riley) with CCMI. Your line is open.

(Lisa Riley): Hi. I had many of the question last month and I think I know the answer but I just want to go on to verify. Pat, you had said that for TPOC, if you have one settlement even if you pay that out overtime, you're supposed to report that in TPOC 1 which I truly understand, but a question came up with some of our clients that are in bankruptcy. Now, the state is paying those claims and they're paying varied amounts – different amounts depending on the money that they have at the time.

I just want to make clear that with bankruptcies, if the state is obligated to pay out that settlement whether they established to $50,000 at the beginning or there was an award or whatever, that's paid out no matter how long it takes them to pay out, would I still report that as one lump sum settlement as $50,000 in TPOC 1 and not worry about additional TPOC?

Pat Ambrose: We're going to put you on hold for just a second.

(Lisa Riley): Thank you.

Pat Ambrose: I just wanted to confirm that we were all in accord here. In a situation like this where bankruptcy is really when the funds are available so you're going to be reporting in that case multiple TPOCs.

(Lisa Riley): OK. Even…

Barbara Wright: When they know the amount's they're going to pay and who are they going pay.

Bill Decker: And the funds are available to pay.

Barbara Wright: OK. In bankruptcy only situations we're talking…

Bill Decker: Bankruptcy/liquidation.

Barbara Wright: OK.

(Lisa Riley): OK. So, even at the beginning, if we know that they're going to pay out a total of $50,000 but it's going to be done over time, it may take five years to do that, I'd still need to go with the individual payment amount?

Pat Ambrose: In a bankruptcy situation. In a non-bankruptcy situation, setting up a structured settlement does not relieve you of the obligation to report the total amount to start with.

(Lisa Riley): I understand that.

Pat Ambrose: OK.

(Lisa Riley): I was just hoping I could treat the bankruptcy the same way instead of having to worry about continually updating that TPOC five every month.

John Albert: Operator, this is John Albert. There's something that we needed to announce that we forgot to bring up earlier before the Q&A session and it's not been put out on the website yet but the September 15th NGHP Policy Call has been moved to September 9th.

Pat Ambrose: And I'm going to add on to what John is saying, I meant to talk about it earlier. It's not going to be held on the ninth either.

John Albert: OK.

Pat Ambrose: There's a conflict there. And so I what I meant to say is if anything supposed to ignore that, we should have something up within a week or so but the ninth among other things is too close to the day.

John Albert: OK.

Pat Ambrose: So, we will be putting – opposed to the due date for September.

John Albert: OK. So, anyways, I guess I'm not…

Bill Decker: So, the bottom line here is though that the call announced on the web for the 15th will not be held.

John Albert: Yes, will not be held.

Bill Decker: Look for an alternative new date for that call.

Pat Ambrose: And to wrap up that last call, did I understand, Barbara, that we will be hosting an alert related to the bankruptcy liquidation and TPOC reporting that we discussed?

Barbara Wright: Yes.

Pat Ambrose: Yes. OK.

So, operator, if we could go on to the next caller, please.

Operator: Certainly. Your next questions comes from (Karen Saller) from the Ohio Bureau of Worker's Compensation.

(Karen Saller): Starting January 1, 2011, when we do not have to send in the description of illness any longer – it's going to be filled with spaces – then we'd be sending as a non-key field update. And our question is does that mean in the field 15 for the e-code – will that become a non-key field update then?

Pat Ambrose: I think it already is listed in the event cable as one of those fields that we asked you sent an update for. The diagnosis most certainly is and I have to, you know, rather than keeping everyone on the call, there's no…

(Karen Saller): Seven point – seven point three is not listed there.

Pat Ambrose: The alleged cause is not listed there?

(Karen Saller): No.

Pat Ambrose: But the diagnosis code…

(Karen Saller): Yes, the diagnosis is.

Pat Ambrose: Yes. OK. And that's the way that it will be as of 01/01/2011 as well – now and then.

(Karen Saller): Will this be the diagnosis code?

Pat Ambrose: I mean, it's a not a key field but it's, you know, when that changes, you're required – when the diagnosis code needs to change, you're required to send updates. Yes, you can always send an update for other fields.

(Karen Saller): Right. But the e-code will not be – if that should change, we don't have to send you an update (training session) if that would be only thing that changed?

Pat Ambrose: Correct.

(Karen Saller): OK. And then, the other question we have is that during our testing we've received the E-mail saying that our file is ready to be picked up but it seems that when we get the E-mail, the file isn't out there right away. Is there a way that it can be – could we have an automated once we get that E-mail then we're going to kick off to try pick up that file and the past two or three times, it's been like hours before it even got out there.

Pat Ambrose: OK. I'll take that under advice. I'm not sure if the two – how they are synced up. You know, it make sense to me that one process is saying all right, this file's done, issue the E-mail and then the file is being loaded to your mailbox and it may take some time. That's also a question that you could submit to your EDI representative. I don't have any answer for you today. We'll take a look at it.

(Karen Saller): OK. And we did send it to her and she said it just takes a while.

Pat Ambrose: Yes, so maybe if you could instead of kicking off your process immediately, have it delayed for few hours and then kick it off. Perhaps you could automate a delay in that process. That's my only suggestion to you at this time.

(Karen Saller): OK. Thanks.

Operator: Your next question comes from Deborah Daniel from the Alfa Insurance. Your line is open.

Deborah Daniel: Hi, thank you. For the submission to – the submission period is like March 22 for the first quarter, since we have to start – actually reporting after January 1, 2011, am I correct that we will wait until March 22 to actually submit our file?

Pat Ambrose: Yes, you are correct.

Deborah Daniel: OK. Thank you very much that's all I have.

Pat Ambrose: You're welcome.

Operator: Your next question comes from Tracy Gooden from Davis Memorial. Your line is open.

Tracy Gooden: Hi, I have a question regarding an inpatient claim. If we have a patient that is in our facility and there's an incident where something happened and we've got liability against that claim and we adjust off a portion of that – for example, for patients in here with an appendicitis and breaks her finger when they're putting the bed down and we are going to adjust off that x-ray, do we submit the original Medicare claim with the total amount before the adjustment or do we go ahead and make our adjustment and then submit the amount to Medicare?

Pat Ambrose: The current billing instructions require – have a methodology for reporting other payment which is primary to Medicare and any reduction in your claim because of self-insurance issues such as you just named is considered primary payment so you need to follow the normal billing instruction. Do I have all those at my hands right now? No.

Tracy Gooden: OK. So, that's in the user guide then?

Pat Ambrose: No. That's in Medicare's regular billing instructions. This user guide is how to do Section 111 reporting and what the information about the risk management was is if you have the situation where in essence by virtue of self-insurance to risk management or otherwise has primary payment responsibility to Medicare so that you've reduced the claim then you need to record that appropriately in your billing to Medicare and you've always have that requirement even outside of Section 111. What we said is when you're properly following that, then you don't need to do a separate reporting for purposes of 111.

Barbara Wright: So, these are what you're suggesting at all.

Tracy Gooden: OK.

Pat Ambrose: I think I need to go back and re-read the language about the risk management and if you still have a question, if you can make it a little bit more detailed and send it to the mailbox?

Tracy Gooden: OK.

Pat Ambrose: OK.

Tracy Gooden: All right, thank you.

Operator: Your next question comes from (Susan) with the New York State Insurance Fund. Your line is open.

(Susan): Hi, I have one question and a follow up. Can the DCN be the same for delete and subsequent add record?

Pat Ambrose: The DCN's supposed to be unique by record on the file, so it really should be different or I mean I think it needs to be different. My understanding of that requirement is that every record on your file has a different DCN.

(Susan): All right, so if we – if it's delete and subsequent add, it should be different DCN?

Pat Ambrose: That's my understanding, yes.

(Susan): All right, different. OK. And the second question is something that I had asked about last time. If we submitted two TPOCs and one was reported an error, do we still have to continue sending an auxiliary file?

I looked at the user guide on page 62 and page 63 and what's on there seems to kind of the opposite of each other. So on page 62, it says, "Once an RRE has submitted an auxiliary record and has been accepted, the RRE must continue to include the auxiliary record with the subsequent update transactions for that claim unless there are no additional claimants to report. And as a second TPOC announced is subsequently zeroed out. It says reportedly previously but the RRE wishes to resend the previous report of any TPOC to the five amounts. That's what it says on page 62, set in bold on the top paragraph.

And then on page 63, and I think at prior teleconferences, it said that we had to report it with zero. So that kind of – is not really coinciding with what it said on page 62.

Pat Ambrose: Well, yeah. That is correct. What's in the user guide is correct.

Female: No. But on the user guide it says two separate things.

Pat Ambrose: Well, I'll take a look at that but…

Female: OK. One is page 62, one is page 63.

Pat Ambrose: OK. But, you know, do you have a question about what you should do to report because I'd be happy to explain that.

Female: That's what I'm asking about. If we have to change any TPOCs, let's say you have one and then you submitted – where you submitted two TPOCs and you realize that the second one is not really a TPOC. Based on the first – on page 62, it would mean that you don't have to submit your auxiliary record anymore but what it says on page 63, you would assume that you would have to submit the auxiliary record with TPOC 2 or zeroed out.

Pat Ambrose: Yeah. It's perhaps too general. It was trying to also cover the case where maybe you submitted four TPOCs and it's only TPOC 2 that you want to zero out. You would submit your detail record and your auxiliary record, zero out TPOC 2 and leave three and four there.

Now, let's suppose that you submitted two TPOCs, so in the past, you submitted a detail and an auxiliary record.

Female: Right.

Pat Ambrose: And now you have realized that you need to remove TPOC 2…

Female: Right.

Pat Ambrose: …on the auxiliary record and there's nothing else on the auxiliary record that applies to the claim any longer.

Female: Right.

Pat Ambrose: So you have a choice of sending an update with just the detail record or you could actually send an update with both the detail and aux record and put zeroes in the aux record. But you are correct and that if all that you need to do is remove TPOC 2, you would just submit the detail record as an update and not submit the aux record. OK?

Female: OK. Thank you very much.

Pat Ambrose: Yeah. Now, I'll take a look at correcting the user guide.

Female: OK, thanks.

Operator: Your next question comes from (Stacey Trumble) with (Lopez and Grace). Your line is open.

(Stacey Trumble): Yes, good afternoon. My question pertains to Field 102 in the record layout, funding delayed beyond TPOCs start date. I was hoping to get a clarification on – number one, whether or not that field is currently in use. I don't think it is but I'd like clarification on that. And if it is in use, could you let us – give us some examples of how that might be used?

Female: You want to take this one?

Male: I believe it's not being used right now that we gave you instructions to fill it with zeroes until further…

Pat Ambrose: Well, it doesn't actually. I never updated the fields to state that. It's not a required field and it just reads now. It's funding for the TPOC amount. One is delayed, provide actual or estimated data funding, fill with zeroes if not applicable.

And we have said on previous calls, that we can't think of a reason now given the current instructions for reporting where you would really need to use this field.

Male: But we'll look at addressing that in combination with the alert we talked about, about TPOCs and bankruptcy, etc.

(Stacey Trumble): Excellent. Thank you. I wasn't sure based on the user guide. I've seen conversations in the transcripts but I wasn't sure from the user guide. It didn't say not to use so I just wanted to clarify that. Thank you.

Operator: Your next question comes from (Carol Gomby) with Banner Health. Your line is open.

(Carol Gomby): Hello. I still have a question about coding, what kind of an ICD-9 code to use. And we have a general release where someone is releasing their own future medicals and they are Medicare beneficiary. And we have to report some kind of ICD-9 code and we really don't want to make something if nothing has been claimed yet and it's just future. So I was wondering if you could do something like add an ICD-9 code that would be accepted that said, you know, (FUTR) or something like that so that we would be able to report these and not just make something up.

Female: If we have an ICD-9 code already, if we already know they have something, then we don't have a problem. It's just when there is nothing that has been stated or told in any way yet, but they are releasing their own future medical.

Male: We'll take your comment under consideration.

(Carol Gomby): Thank you.

Operator: Your next question comes from (Richard Salt) with Fireman's Insurance Funds. Your line is open.

(Richard Salt): I have two questions and they're both related to the worker's compensation line. In worker's compensation, I understand that we do not report ongoing periodic temporary total disability payments. However, there are times when temporary disability is in dispute and is part of a settlement; we pay retroactive temporary disability as part of the settlement. Do we include those moneys in the TPOC amount?

Male: You include the entire amount of the TPOC. If somebody can raise it to defense if we go after funds that their state law required and a certain portion of that was for challenge disability or whatever.

(Richard Salt): OK. So the answer is yes, even though it's PD but it's retroactive and then in dispute.

Male: Correct.

Male: Basically, where the instruction say that regardless of whether you believe it's temporary total, if it's a TPOC payment, you have to include it.

(Richard Salt): Thank you. My second question is, in some states, if there is no beneficiary and a person dies, a payment is made to the state. Is that payment to the state a TPOC amount?

Male: The payment is made to the state like under what – we're not…

Female: It's worker's compensation.

Male: Worker's compensation assume a worker who is injured, falls of a roof and dies, has no dependents and the state worker's compensation law will say if there are no beneficiaries you make a payment to the state of, say, $25,000.

(Richard Salt): Is that a TPOC amount?

Male: Yeah.

Male: And it would still be reportable. That would be the claimant to list in the auxiliary file because Medicare is still entitled to be repaid if it had paid, you know, conditional payments. And those…

(Richard Salt): OK. Even though it's not a payment to a provider, it's a payment to a state agency.

Male: Yes. I mean, most of your claimants aren't going to be physicians or suppliers. They're going to be individuals. I mean, if you're making payments to medical providers, physicians and other suppliers, you're generally in the ORM context. You're not in the context of TPOC.

We've said multiple times on these calls that if you're paying ongoing medical bills, you should be reporting ORM, not the whole series of TPOCs.

(Richard Salt): Yeah, I understand. I should have put it differently. If there any conditional payments, which I would doubt, I'm not quite sure how the COBC could collect from a state as a statutory right to the money. But quite honestly, that would be…

Male: Well, Medicare has…

(Richard Salt): …CMS's problem more than the carrier's problem.

Male: Well, we have a priority right of recovery and any Medicare – any worker's compensation entity has an obligation to make sure our interests are protected so.

(Richard Salt): OK. But in any event, if we make a payment to the state for a death benefit, it is reportable as a TPOC amount?

Male: Yes.

(Richard Salt): Thank you.

Operator: Your next question comes from Susan Bolster with Zurich. Your line is open.

Susan Bolster: Hi. I was wondering back in, I think it's before summer, (George) mentioned about the social security number and if they're a Medicare beneficiary that there's, I think, federal regulation that they're supposed to provide us information. Do we call that, going back to…

Male: Yes. We discussed this in a number of calls earlier in the year. And we – what we said in those days was that a Medicare beneficiary is required to provide a (HICN) to a provider if asked. And it has come to our attention or, more accurately, has been brought multiple times to our attention that in fact there is nothing in federal law that says their beneficiary is required to provide the beneficiary's Medicare ID number to someone who is providing services to the beneficiary or to an insurer.

What we now are saying is that the – it is in the beneficiary's best interest to do that and it is certainly in the providers or the insurer's best interest to collect them.

Susan Bolster: OK. I was just going to say that if you could have given us that side, I would appreciate it but thank you for this clarification.

Male: We would love to be able to give you a citation.

Male: But apparently there isn't one so.

Susan Bolster: OK. I just wanted to follow up on previous call. Thank you.

Male: Sure.

Operator: Your next question comes from (William Camina) with Global Aerospace. Your line is open.

(William Camina): Hi. I'm hoping you can provide some direction towards reporting for deceased Medicare beneficiaries.

We have some instances where there's instantaneous debt and was kind of wondering whether that has to be reported or not.

Male: Basically, yes. We're not going to draw lines in terms of insurers making the determination of whether or not there were any medical services provided. Someone brought up, I think or either it was brought up or we discussed in the context of another call even something such as World Trade Center or something like that where there was an explosion. Some people actually did at some limited service on the ground and died, you know, in various explosions or other things. So basically, you should stick with reporting it and we will stick with determining whether or not we have a recovery claim.

(William Camina): OK. Thank you.

Operator: Your next question comes from (Keith Bateman) with BCI. Your line is open.

(Keith Bateman): Hi. I want to follow up on the answer you gave on the California sample where state statutes has a provision that you can't disclose the social – you don't have to disclose the social security number. You say federal statutes output at some state, and I would agree with that. I challenge you to show me the federal statutes that give the RRE – the right to ask for a social security number.

Male: Yes. I think there's a difference between the right to ask and whether or not you're actually going to get the number. We do have model language that's on the website if you're not getting cooperation in terms of getting that number.

(Keith Bateman): I'm saying there's no statutory authority for us to ask that. We can ask, they don't have to answer.

Male: There isn't any specific statutes that says – I think that's what Bill Becker was just going over. There's no specific statutes that says the beneficiary has to give it to you, the insurer.

Male: Correct.

(Keith Bateman): Then we have to go to you, CMS, but not the insurer.

Male: And that – and the model language is out there to help in those instances.

(Keith Bateman): Yeah. I also urge you to rethink the answer you gave on the death benefit payment to the state. That has nothing to do with the income lost or medical. It's a flat payment in lieu of the fact that there's no death benefit and that money is used for second injury funds and things like that.

Male: If it sits within any of our other exceptions, then it wouldn't be reportable. Remember, you know, we said if it has the effects – if medical or claims are released or it has the effect of releasing medicals.

If you've got some type of payment by statute, it's clearly outside those parameters and in no way could ever be conceivable.

(Keith Bateman): That – it only would be for – in the case where there's no dependents for the death benefit. It doesn't exempt payment of any medical that would have been due.

Male: Well, what you're describing, it sounds like more – it sounds more like they could make a legitimate argument based on statute and everything else that it didn't claim a release medicals or include medicals. But when the question was phrased as we understood it more generically.

(Keith Bateman): Now, I understand the problem with the way questions get framed.

Male: So whichever happens to be is the way they need to make their determination on reporting it.

(Keith Bateman): Thank you.

Operator: Your next question comes from (Kimberly Martin) with Connecticut Transit. Your line is open.

(Kimberly Martin): Hi. I think at this point, I just really have a comment that I felt a need to make and I do take exception to the arrogant response which was given as a refusal to answer any generic questions. I'd like to just bring to your attention that all of us are not legal firms; all of us are not these big self-insured agencies that you are speaking to.

You changed the game on May 24th when you introduced the direct data entry option to those smaller providers. And yes, many of us are not aware of all the conversations that went on before and why we're not privy to that is as somebody that's responsible for doing this for the state, we look to contract this out to somebody. We went to a whole competitive bid process over a year and a half ago so that we would be right on top of things but the game kept changing, and it changed again on May 24th. So I just like to say you should be a little more considerate in your comments to people that are just entering the field now.

Male: OK. What I will say…

(Kimberly Martin): So it wasn't a really good statement.

Male: OK. I didn't mean it to be arrogant.

(Kimberly Martin): It was very arrogant.

Male: Well, then I apologize to you.

(Kimberly Martin): Yeah, you should because you're not, you know, there's a lot of other smaller providers out here. You changed the game and know that we're running around, and I'm trying to save taxpayers' money. It was going to cause me about $5,000 a month to report maybe about three claims the way it was before. So now, I'm struggling to try to learn how to do it myself, so that's all I have to say. Thank you very much.

Operator: Your next question comes from (Colleen Egan) with (Broden Jane). Your line is open.

(Colleen Egan): Hi. I just have a quick question. I'm sort of new to this whole thing and I submitted a question about med pay payments on the e-mails, and I'm sure it was a very juvenile question. Do we have a person that we have a $1,000 maximum med pay coverage and we have a person who has $4,000 with the medical bills and she has indicated to us that she has, in the past, been a Medicare recipient but the hospital is yet to turn it over to Medicare? Are we allowed – do we report this payment even if Medicare has made no payments on it? Correct?

Male: Correct. And the point is you won't necessarily know whether or not Medicare has made payments. But if this is no fault unless you're actually paying it out to the beneficiary, basically, you're sitting there waiting to see whether or not your bills and you're going to be reporting the ORM if this is no fault.

(Colleen Egan): Yeah. So that was one – that was indeed my second question. If we do end up paying out this $1,000, what if you reported as an ORM and you report the beginning and end date on the same date since it's been exhausted…

Male: Yes.

(Colleen Egan): …with just one payment or do you report it as a TPOC?

Male: It gets reported as ORM and with the exhaust date. And typically, what the recovery contractor does in terms of whether or not if we end up paying any bills and they look to do a recovery action, the no fault insurer provides information on whose actually paid and whether or not they were, you know, whether or not they were providers, physicians and other suppliers and if they've already paid it out to providers, physicians and other suppliers, we have no particular concern. If they paid it out to a beneficiary, then we look to whether or not we need to take some type of recovery action against the beneficiary if the beneficiary has not actually expended it for medical.

(Colleen Egan): OK. So if we pay it, we have – we are OK to pay it to the beneficiary then as well. We don't have to necessarily make the payment directly to the hospital?

Male: We don't make that choice ever for you.

(Colleen Egan): Oh, OK. OK.

Pat Ambrose: Just to clarify from a technical perspective, this is Pat Ambrose. You report your ORM as soon as it's assumed with the ORM indicator of Y and you're not reporting any dollar amounts. If it's no fault, you would be reporting policy limits as specified.

If, you know, and that is the case that you don't know when your ORM has ended. You know, when you make your initial report, if you don't know when ORM will end or has ended, you would report zeroes in the ORM termination date. Then later send an update record with the ORM termination date when you know that it's exhausted or you've met the policy limits or ORM and otherwise end.

If, at the time that you go to make this on report since you're only reporting quarterly, you might know already that ORM started today and it closed or ended two days later. You can report the ORM for an initial add record that you're sending. You can report an ORM indicator equal to Y and the ORM

termination date and any other fields, you know, as required and that will be the last time you need to report it unless the claim reopens for some reason.

(Colleen Egan): OK. So even though this payment will basically begin and end or ORM all at once because we…

Pat Ambrose: Yeah, yeah. That's ORM and in no fault, that can happen when you have a low limit like that. It could be, you know, your ORM termination date could be very close to your date of incident.

(Colleen Egan): Oh, OK. And you could – could you have to be same name because we name it and it…

Pat Ambrose: Well, now, in theory, yes. But now, let me tell you about a little glitch that we have…

(Colleen Egan): OK.

Pat Ambrose: …in the system. When you go on to read the user guide, you will see that we have a system requirement or kind of a hang up and that the ORM termination date that you report have to be at least 30 days beyond the date of incident even though your ORM might have ended sooner, so you'll just default to 31 days pass your date of incident and you put your actual dates. If it's a no fault claim, you put the actual date that the policy limits were reached or exhausted in that corresponding no fault policy limit exhaust date field.

(Colleen Egan): Oh, OK.

Pat Ambrose: Yeah. So you need to – if we're talking no fault – and so that is covered in the user guide and your EDI representative would be happy to help you with that too.

(Colleen Egan): OK. Well, thank you so much. It's very helpful.

Male: Operator, we have time for one more question.

Operator: Your last question comes from (Emily Hillman) from RLI Insurance. Your line is open.

(Eric): Yes. Thank you. Actually, this is (Eric) from RLI. Here's the situation. Our insured directly reimburses a Medicare beneficiary for related medical expenses prior to 1/1 of 2010. Our insured then submits a claim to the insurer after 1/1 of 2010 for med pay reimbursement, for what the insured reimbursed to the beneficiary. The insurer reimburses the insured, is the report – is this reportable to Medicare?

Male: I think you need to look at the definition of the TPOC date. That's – I could come up with the scenario. You have that fall on either side of the line depending on, in part, whether or not there was a release, etc.

Male: Actually, in this situation, there was no release. So simply the insured reimbursed the beneficiary and there was no claim established at that point in time. And then after the 1/1/2010, the claim comes forth from the insurer for reimbursement of that medical payments that they have reimbursed to the beneficiary.

Male: Actually, I'm changing my mind as you talk. I mean, as you're defining it, there is the claims in the insurer for reimbursement in that claim, but alone, any payment is honored after 1/1/2010 so.

Male: My definition.

(Eric): OK. So you're saying that that is – even though we are paying it directly to the insured, that is a reportable amount to Medicare.

Male: Yes.

(Eric): OK. Thank you very much.

Male: And operator, I was wrong. I was looking at a clock that was set fast in the room. We have time for a few more questions.

Operator: Your next question comes from (Melissa Artwell) from Liberty Mutual. Your line is open.

(Melissa Artwell): Thank you. I was just looking at the website and I notice the last posted transcript of the town hall called is from June 10th. I'm just wondering where the subsequent transcripts released has been?

Pat Ambrose: As soon as possible.

Male: Yeah. Unfortunately, because we pushed a lot of materials out of it, there sometimes are delays in getting some of the transcripts out on the web. But again, we try to get them out as quickly as possible.

And occasionally, and meetings are reshuffled pages due to limitations on how our Internet website just set-up. Sometimes, that was removed temporarily and then repost them, so we apologize for that but we do try to get them up as soon as possible.

(Melissa Artwell): OK. Thank you.

Operator: Your next question comes from (Lyon Abner) with Illinois Hospital. Your line is open.

(Lyon Abner): Yes, hi. Very quickly, I think there's conflicting advice from the July conference call to (Barbara)'s earlier comments on never events. In July, it was said that since there is no right to bill Medicare following a never event, the provider need not submit a zero bill to Medicare simply to comply with MSP or any section 111 obligations. And I think (Barbara) said the complete opposite today that you should submit a zero bill, indicate yourself as primary payer so…

(Barbara): I hope that I said, if it was a situation where the provider was required to bill a zero bill but they should do so. And so, I would be the first to say and admit that I am not a billing expert. So you need to follow the billing – you need to follow the appropriate billing rules. And there are some circumstances that require zero billing.

If you're in a situation where zero billing is required, then you would be into doing what we mentioned for risk management. If it's a situation where you're

not billing us because it's a never event and those are the associated billing rules, then yes, you need to follow those. Does that help?

(Lyon Abner): I guess, it does. I'll have to learn what the billing rules are regarding that.

Real quickly, I'm concerned about ORM and the risk management write-off and whether or not when a provider writes off a bill that by definition, that is ORM. And so, while the write-off may not be reportable under section one, that will be handled through the normal billing process.

My question is, to take a conservative approach to this, should we also be reporting that write-off and assumption of those bills by the provider essentially has ORM and be safe than sorry and report the ORM?

Male: If you're taking responsibility for the associated injury, definitely, you need to report the ORM. Remember, the ORM doesn't tie you into reporting specific dollar amounts.

(Lyon Abner): Right.

Male: That doesn't change the billing requirement for a particular bill that you may have reduced, that would otherwise be billed to Medicare.

(Lyon Abner): Right. I'm just envisioning if someone falls in the property, they go to the ED and it's kind of a customer service while the hospital is investigating the (GL) claim as to whether or not they're responsible. They waive the charges or the courtesy and there's no determination at that time whether or not they are or are not liable or whether or not they'd even pay for any follow up care. But just the active writing off the bill and taking responsibility for those charges, could that be interpreted ultimately by CMS as an assumption of ORM.

Male: Is that the only thing they're doing is writing off the charges or that particular service?

(Lyon Abner): Yes. And I would comment that – let's say there's an independent ER physician or a radiologist and the hospital doesn't have control of those bills and chooses to pay those bills, I would agree that that is clearly ORM but

where a provider has the ability to control all the billing and chooses to write-off those, is that, by definition, ORM?

Male: If the purpose was – because of risk management, yes.

(Lyon Abner): OK.

Male: I mean, the real distinction seems to be situations where you got like a single bill that you're reducing or writing off as opposed to your, more or less, describing a situation where the hospital by default or otherwise, pretty much intense to pay the associated bills up until at least some point in time, so your description sounds like ORM.

But let's say someone is in there and sleeps in the waiting room or something and so they write off all or most of an x-ray. They can do that through the normal billing procedures. They aren't going beyond that. So it will be very fact-driven.

(Lyon Abner): Yeah, very slippery slope on that. I'm just trying to take a conservative approach as we advise our hospitals on it.

Thank you very much. I think the program is going pretty well.

Male: Thanks.

John Albert: Operator, we have to conclude this call. This is John Albert. I'd like to thank everyone for their participation. Please continue to pay attention to any new alerts especially again, we are to remind everyone we are forced to reschedule the September 15, 2010 policy call. We do not yet have a date for when that will be scheduled but again, keep an eye up for a fresh alert on that. We have to get back to you in enough advanced.

Please continue to submit your questions. Again, technical assistance through our EDI department, any policy or technical questions that you feel are not addressed by the written materials or CBT, etc., please send those to the resource mailbox and we will continue to answer those, you know, through the materials, as well as these calls.

And with that, thank you very much. And if operator, you can stay on the line after concluding the call and give us a count of attendees. Thank you.

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

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