TRANSCRIPT
TOWN HALL TELECONFERENCE

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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
December 14, 2011
1:00 p.m. ET

Operator: Good afternoon. My name is (Melissa), and I will be your conference operator today. At this time, I would like to welcome everyone to the Section 111 NGHP Policy Technical Conference Call.

All lines have been on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star and then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

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

John Albert: Thank you, operator, and good afternoon, everyone. For the record, today is Wednesday December 14th, 2011, and this teleconference is the Section 111 NGHP, it's both a technical and policy conference. And we have some other folks here who'll be providing us some general announcements and answer some of the questions that came in to the resource mailbox.

Again, this call is for both technical as well as policy. It's the last call scheduled for this calendar year.

We do not have calls scheduled for next year at this time, but please keep an eye out on the (inaudible) reporting Web sites for announcements of future open-door teleconferences. The first off will be Bill Ford and Jeremy Farquhar from the COBC are going to provide some announcements. And

then I think that's all we have, and we're going to straight into – after that the question-and-answer session.

As we ask in the past, people to provide their name and who they represent as well as please limit your question to one primary and one follow up so that it allows other people in queue a chance to get their questions answered. The call will run until 3 o'clock sharp at which time we'll end it.

And with that, I'll turn it over to Jeremy. He's going to provide the first …

Jeremy Farquhar: Yes.

John Albert: Yes, OK. Jeremy Farquhar of the COBC, who has some general announcements and what not regarding more recent developments with Section 111.

Go ahead, Jeremy. Thanks.

Jeremy Farquhar: Thanks, John. OK, I just got a few quick announcements and then I'm going to dive in to some of the questions that we received at the resource mailbox since our last call.

To start, just a reminder, most of you are already aware of this but on the off chance to anyone listening who may not be five timelines for TPOC reporting were published as of (inaudible). The new guidelines, liability TPOC reporting is being implemented under a graduated timeline depending on the actual dollar value of the TPOC to be recorded.

For detailed information regarding the delayed threshold amounts, please see the alert within the aforementioned 9/30 day, which you will find within the additional NGHP alert section of the CMS Section 111 Web site. And that address for those who don't have it is www.cms.gov/mandatoryinsrep.

Please note that the new delayed implementation timeline is not mandatory. If RREs are prepared and wish to submit all of their TPOC data as of January 2012, then they're free to do so. However, the minimum interim reporting thresholds do still apply. I'm sure that most you are familiar with those

minimum interim reporting thresholds. But for those who require any additional clarifications, please refer to the current version of the Non-GHP User Guide as it's outlined clearly there.

Just a quick note regarding our recently introduced TIN Address Validation Process. You've been contacted by a number of RREs indicating that they have received theirs on their TIN response file or addresses which they've confirmed are in fact valid. And in such examples and you haven't done so already, then please don't hesitate to reach out and provide them to your assigned EDI representatives. We'll look in to the matter, and we'll get back to you with additional feedback as soon as possible.

Just a quick reminder and as we've noted on past calls and as outlined in the current user guides, beginning in January, RREs will be required to validate their Section 111 registration information on yearly basis. With the authorized representatives and account manager for each RRE will receive an e-mail including an attached profile report.

Profile report will include any changes that may have been made after the initial registration up to the present. All information is still accurate and all those is required is either for the authorized rep or the account manager to contact their EDI rep and confirm it's accuracy. If any changes are required, then they must contact their EDI rep and provide them with all appropriate updates. At which point, their rep will generate a new profile report as the authorized rep will be required to sign the term.

Failure to do so may result in temporary deactivation of your Section 111 RRE I.D. So, please don't neglect to follow up once the aforementioned communication is received.

That's all for my announcements and jump in to some of the mailbox questions now. If you receive the following e-mail of CMS drop box which stated the following code listed on the CMS efficient codes with CMS 29 is not a valid code for AMA and confirmed that someone is researching the code, they representing the users before they released for use.

Unfortunately, the individual sending the e-mail (inaudible) inadvertently neglected to include the code in question. However, we can assure you that CMS does carefully review these codes prior to their publication on the Web site. That being said, if the person who had written in the mailbox is listening now and want to follow up with an additional e-mail including the code-in question, we can look in to this for you.

If they prefer, they can also contact me directly and I can pass along the examples. Any pertinent parties, again, my name is Jeremy Farquhar. You can call me at 646-458-6614.

Next question, we received another note in reference to the new yearly profile report validation referenced in my prior announcements. The individual requested the situations where the e-mail sent to the authorized reps and account manager, they both come back as undeliverable then we sent a notification to the account designee at that point in time.

Unfortunately, we don't have any plans to do so at present. We need to stress it is important to note that Section 111 RRE's responsibility is to ensure that any changes to their authorized reps or account manager contact information are reported to their EDI representative in a timely fashion.

Just because you maybe working with an agent doesn't mean that you no longer have any responsibilities for these type of information. So, please if there are changes to the authorized rep or the account manager, get in touch and let us know immediately, and we'll make the appropriate updates to avoid any lapse in communication.

However, if a situation should occur where an account designee happens to be aware that both the authorized reps and account manager are no longer with the RRE's organization, then they should contact their EDI reps and inform them of the necessary changes. At this point, we require request of these changes be submitted, some within the RREs organization on company letterheads.

The next e-mail I received here in the drop box was also in reference to the annual profile reports validations that will begin in January. This was coming

from an Asian group that would typically be set up as designees for the RRE within that'd be working. If the designees would not be included within the e-mail notifications, they suggested that we add entries to the account activity train within our secured Web site indicating either a positive or negative response to the profile information query.

This is a good recommendation, and we're going to certainly take this into consideration. It might be something that we're able to implement as a future enhancement although unfortunately, it won't be possible to have this in place prior to the January when we begin the new process.

That being said, I just like to note that on the off-chance that an RRE will be discontinued as a result of this process, discontinuation is something that they can quickly and easily be reversed by contacting your EDI rep and providing them with the required verification of your profile information. Upon reaching out to them while they have you on the phone, if you give them the information required, they can do that, discontinue status right there and then, and you'd be able to login and access your account right away.

We receive the following two questions from another individual who had written into the Drop box. First, they asked, Medicare recipient is under – is reported under MIR. You need to also call into the COBC to report a claim and in order to receive a requested copy of the conditional payments while we are reporting a Medicare set-asides.

I just want to clarify, it's important to note that Medicare set aside process is not directly linked to Section 111 reporting. We continue to follow the same procedures that you always have in relation to your Medicare set-asides. Section 111 reporting does not change anything in that respect.

Second was as follows, when the claimant is reported through MIR, the rights and responsibilities letters automatically go out?

The answer to that question is yes. After a claimant has reported via the Section 111 process, the claimant's information is passed along to the MSPRC. The MSPRC will then create a lead for this claim and 60 days from

the date of that lead creation, the rights and responsibility letters should automatically go out.

Barbara Wright: This is Barbara Wright. I want to add a little bit to what Jeremy just said because the question was asking if in part would they get information while they were working on the set aside. And what's going to happen in this cases is if there's an RRE and they self report and if it's liability insurance, they have proper consent to release information, then they can get conditional payment information prior to it's settlement, prior to the Section 111 reporting.

If the only reporting that's done is the Section 111 reporting, then nothing's going to go out until after the settlement because the Section 111 reporting is after the settlement. So, if you're looking for conditional payment information as an insurer or as a worker's compensation entity, unless there is some pre-reporting, you can't be guaranteed that you're going to get any type of conditional payment information or that it will be available.

Jeremy Farquhar: OK. Thanks, Barbara. Another RRE had written into mailbox, and it's stated they are property and casualty insurance company dealing with liability claims for Med-Pay and bodily injury claims only. They question whether since they don't handle workers' comp or no fault, it was necessary for them to report claims involved in medical payments coverage.

It's important to understand that the reporting of medical payment is not exclusive to workers' comp and no fall. Reporting of claims relating to medical payments is basically what this entire process is all about and that does include liability coverage.

This individual went on to the question whether they should be reporting their medical coverages ORM or TPOC. Unfortunately, they didn't really provide us with any further specific details regarding the nature of their claims. It's a bit difficult to answer, but basically if there's a settlement which may include payments for medicals, it will generally be reported as a TPOC.

The RRE is responsible for making payments on any ongoing medical treatments. Medicare beneficiary may receive as a result of illness or injury

sustained. As a result of the claim, then this would typically be reported as ORM.

In some cases, it may be appropriate if you're reporting both ORM and TPOC on the same claim as on this particular scenario. And that's a bit of an oversimplification. I would urge the individuals, if they're listening, that had written into the mailbox that they should review the information in the user guide as there's much greater detail.

Barbara Wright: This is Barbara Wright again. I want to add a little bit more to what Jeremy had said. The question came in, in some of the language that Jeremy was reading to his phrase in terms of reporting claims involving medical payments.

Remember, it's not up to the RRE to determine whether or not they are medical payments per se. If it is no-fault insurance or liability insurance or workers' compensation as defined by CMS of the Section 111 reporting, then the reporting is required if medicals are claimed or released or effectively released. It's not whether or not the settlement or documents specifically says the payments are for medicals.

Jeremy Farquhar: OK. And we have one last question that I'd like to address. This one came in and there was in reference to the list of valid ICD-9 codes for a Section 111 reporting. We received an e-mail from an individual asking where they might locate the complied list of acceptable ICD-9 codes. They have visited our secured Web site at www.section111.cms.hhs.gov and noted they could only find the list of this excluded code within the reference material's manual.

At the present, you must first login to the secured Web site in order to access these documents. After logging in, you should see the ICD-9 diagnosis code list menu item. This is actually a compiled list, which presently contains all accepted codes from version 25 through 28.

The new codes for version 29 will be added to this list as of January and actually at that same point in time, the list will also be made available at the login screen and whether that will actually be necessary the first login in order to access it. I realized that that was an inconvenience. There wasn't really any necessary reason to withhold that for people just because they weren't

able to login to our Web site. So, actually it will be easier to access very shortly.

The individual version listings are also available via the CMS Web site. Anyone may access theirs at the present. Going to the individual yearly ICD-9 versions can be found in the current version of the non-GHP user guide.

And that was all for our questions, so I'll turn it back over to you John.

John Albert: Yes. Thanks, Jeremy. A couple of things I wanted to add to my opening remarks. I just forgot to mention the formal disclaimer that the like broadcast and that is occasionally we may say things on these calls that contradict the official written materials that are in the Sections of 111 section user guide. And where we do, the user guide always picks precedence over anything we say at this meeting, and this kind of got loosen to another – the thing I just want to mention is that very shortly, everyone should be seeing a new version of the NGHP user guide.

There are no changes to the guide except that it's fold some of the recent alerts that have been published into the user guide, but there's nothing else that has already been disclosed through the previous alerts sent out earlier this year. So, that will be coming out fairly shortly.

Other than that, I guess if we're all done here we can – I guess Barbara – OK, Barbara wants to mention some stuff.

Barbara Wright: Yes. I'd like to talk a little bit about the alert that came out about the December 5th, 1980 guidelines; specifically the current version is dated October 11th. It was one revision of the earlier one.

We had some questions raised about the parenthetical at the end of the first full paragraph on page two. It's the part that talks about when Medicare will not assert a recovery claim. And parenthetical is talking about where multiple dependents are involved the claimants must meet all of the criteria for each individual defendant in order for the settlement judge may reward a payment to the exempt as listed.

And the question has been raised whether or not that was contradictory to our policy. The statement was that in the past, we've always talked about everything being dependent specific. And so, I wanted to add a little clarification to that. We're looking at whether or not we need to add any further revision to the actual alert.

But first of all if there are multiple defendants and they have a single settlement together, then, yes, the requirements must be met for each individual dependent. What we did not mean to imply is if you have a situation, let's say the original pleading listed about seven different defendants and then you have a settlement with one of those defendants, and that defendant met the criteria. In that case, then with respect to that defendant, that's sufficient.

So, again it's the distinction between whether or not we're dealing with multiple defendants in a settlement or you're just dealing with a single defendant. And we hope that, you know – we hope that adds the clarification that you need. If there are other questions about it, please submit them to the mail box where our intent was not to take away any defendant specific language. It was to make sure you noted that when you do have multiple defendants, you may have situations where it does, in fact, need to be met for each of the defendants.

The other thing in terms of questions that came in is when got several that had to do with risk management write-offs. And the questions – it appears that some of the folks who sent them in may not be familiar with the language that is in the user guide. So, we would encourage you to go back and review that. They ask for the specific codes for example for risk management write-off.

There is no such thing. What we've said is where you have a provider position or other supplier and they're engaging in a risk management write-off that that needs to be part and partial of their billing of the claim, and they need to show the amount of the write-off as being a liability insurance payment to themselves. And they should look to the normal billing instructions from when they're billing in a secondary payer situation. And that's really all the information we have about that.

Jeremy Farquhar: And the normal billing situations are not part of the Section 111 process, correct? I asked you a question if the normal billing is not …

Barbara Wright: The normal billing processes are not changed by Section 111. The provider's position and suppliers have always had an obligation to report anything that is a risk management write-off because it is in effect a self insurance payment for themselves.

They should have always been doing this. We made that clear by putting those instructions in the Section 111, but it's not a process that requires a development of new codes of any changes in the billing process. John?

John Albert: OK. Thanks, Barbara. So, operator, we can open up the lines to questions from here on out to the end of the call.

Operator: At this time, I would like to remind everyone, in order to ask a question, press star and then the number one on your telephone keypad. As a reminder, we ask that you ask one question and one follow-up. We'll pause for a moment to compile the Q&A roster.

And your first question comes from the line of Matt Stonehouse with Gould & Lamb. Your line is now open.

Matt Stonehouse: Good afternoon, everyone. Again, my name is Matt Stonehouse with Gould & Lamb. I got a quick question for you. If an insured has a policy with the carrier for convenience or financial purposes but pays the claims itself due to the arrangement as with the carrier and it states that the carrier will only pay if the insured is unable to do so, who in fact is RRE?

In the example that we have, the claims are reported to the carrier, and the carrier is obligated to pay for those claims if the insured is unable to do so. And we couldn't find this in the user guide to have fit the examples or hit precisely into the language.

Barbara Wright: You need to fit your specific example into the explanation that's in the user guide. Unfortunately, when people come in and ask for absolute yes or no in

their situation, we haven't found one situation yet where they aren't leaving out some fact that we would need to make, you know, a clear decision.

You're saying – what I hear you saying and what was – I recognized your question as one of the ones that came in to the mailbox is that you're essentially saying you're doing something for convenience, and that convenience doesn't quite fit our definition. We'll take away the factor of convenience and look where it fits in the definition. I mean that's really all we can say, we can't …

Matt Stonehouse: I'm – could I understand that to ultimately say, who ever in fact is truly paying at that time is the RRE?

Barbara Wright: No. I don't you can understand that you need to go back and look at what we said in the definition because it's not always who is physically paying.

Matt Stonehouse: OK. Fair enough. And …

Barbara Wright: I'm sorry we can't give you anything more specific. But from the beginning, we've tried to see whether or not we could give more specific definitions. And routinely there is some facts that's not in the fact (time) which then given that changes the outcome.

So, what we try to do in the user guide was to give you all the bright line rules. And it seems like a lot of the questions do revolve around convenience, and you essentially need to take out that convenience factor and see where it exists with our definitions.

Matt Stonehouse: All right. And then one follow-up question, we actually have another situation where the injured party is claiming a birth defect. And because of this, the date of incident is essentially prior to the date of birth. How should that be reported?

John Albert: Date of birth.

Barbara Wright: Jeremy, would you be able to tell us what would be the earliest date the system would take?

Jeremy Farquhar: We can accept – you know, basically, the way this works for our reporting is we'll make a note of the date of incident whatever it may be. We don't check it on the date of birth. So, say, if they sent a record in and the date of incident is prior to the date of birth, we would post that date of incident within the record, but we wouldn't create the record and affect the date of anything prior to their Medicare entitlement date. So …

Barbara Wright: I don't know that there's essentially a default for the date of entitlement anyway, plus there's no way we would pay at any claims prior to the date of entitlement. So, even if our system shows at an earlier date, it's not going to cost any disadvantage to the beneficiary.

Jeremy Farquhar: Technically, we can accept the date of incident. It would be prior to the date of birth if you were to submit it if that's what we would be appropriate based on – but see, Matt and Barbara, I don't know if that would be an appropriate scenario. That's the only question I would ask.

Matt Stonehouse: Yes. And basically, you're saying nothing – there's nothing (inaudible) date of birth or date of incident against anything else.

Barbara Wright: Yes. But it also seems that if it's growth defect, why you would essentially pick the date of birth.

Matt Stonehouse: Yes, it actually probably doesn't really matter.

Operator: Your next question comes from the line of Emily Shields with Morgan Lewis.

Emily Shields: Hi. My question comes out as a result of the statement that was made in the October call that indicated that I want to confirm that my understanding is correct essentially. If you have a TPOC settlement payment that is made when there is both a husband and a wife as the party in a lawsuit and the injured party is, say, the husband and the wife has simply a lost of consortium claim for which in the complaint she may alleged medicals.

Is her claim reportable, one, only if she is also a Medicare beneficiary? And, two, if the payment is made as a lump sum settlement to both and there's no

individual payment that is separated out or allocated to her lawsuit claim, what amount do you report for her claim?

Barbara Wright: Could you hold on just a second, please?

Emily Shields: Sure.

Barbara Wright: (Inaudible) involving a couple and she (inaudible) and there is a settlement for $50,000.

Emily Shields: I'm sorry, Barbara, you cut off in the beginning.

Barbara Wright: OK.

Emily Shields: You're on mute I think still.

Barbara Wright: Are we on an open line now?

Emily Shields: Yes.

Barbara Wright: OK. We've got a couple who got a settlement for $50,000. And regardless of whether or not the settlement of $50,000 is, one, an unallocated sum or whether 40,000 is allocated to the injured individual and 10,000 to his wife, in either case, he must report the full 50,000 for the injured party.

Similarly, if the wife, the spouse, is a Medicare beneficiary and she has claimed or release or effectively released any medicals, you have to report the full 50,000 for her. As we've said since the beginning that there will be certain circumstances where information that's reported will have to be clarified on the backend.

In these cases, you know that the plaintiff is going to be happy to clarify for us that they didn't get to $50,000 settlements what the figures actually represent. But for reporting purposes, it's important that you report the full total for either of them as long as they're both beneficiaries.

Emily Shields: OK.

Bill Decker: And this is Bill Decker. So, there's a part to that question that said if what happens if the wife is not a Medicare beneficiary. Remember that this is Section 111 reporting and if anybody is not a Medicare beneficiary (inaudible) information about that individual does not need to be reported. In this particular case, if the husband is a Medicare beneficiary or was a Medicare beneficiary, that would have to be reported as to what it is that will have to be reported.

Barbara Wright: If the husband is the injured party and the only that's beneficiary reporting the full 50,000 premium as they're both beneficiaries and the wife is essentially effectively released medicals, you're reporting the full 50,000 for both of them. If the injured party is the husband in this particular case is not a Medicare beneficiary, you're not reporting anything for him.

But if the spouse is the Medicare beneficiary even though her claim is just for consortium, if the claims are released or effectively released medicals, you would be reporting the full 50,000 for her. Does that clarify things?

Operator: Your next question comes from the line of (William Levitt) with Carl Warren & Company.

(William Levitt): Thank you. My name is (William Levitt) and with Carl Warren & Company. Several weeks ago, we submitted a question for clarification. It had been our understanding from prior town hall meetings that it was not required to report a TPOC in workers' comp that did not include or terminate the medical feature but included only the wage loss or indemnity portion of the client.

We are now seeing correspondents suggesting that the TPOC is to be reported even though the ORM remains open. Is that correct?

Barbara Wright: Could you tell us what correspondents you're referring to?

(William Levitt): I'm sorry, I'm not sure. It came from you. I just needed to get this clarified that we don't have to report it.

Barbara Wright: Well, the – the language …

(William Levitt): TPOC that does not terminate the medical.

Barbara Wright: The language that's in the user guide right now is on page a hundred …

(William Levitt): Certainly, we understand that any TPOC or event that terminates ORM is a reportable event, but do not understand why a settlement that leaves the ORM open should be reported. We just need clarification.

Barbara Wright: The language that's in the user guide right now on my copy prints out on page 114, bullet at the end of the page, and it says in situations where the applicable workers' compensation (inaudible) requires the RRE to make regularly scheduled periodic payments pursuant statute for obligation other than medical expenses to or on behalf of a claimant.

The RRE does not report this periodic payment as long as the RRE separately assumes, continues to assume ongoing responsibility for medicals and reports this ORM appropriately, and the paragraph goes on from there. If you have something else where we have put in writing that says something to the contrary, we certainly want to see it.

But what we would also caution people and we're seeing more of these in the incoming is people who send in a question and say "I was told this some place else, please tell me if it's true" instead of going to our user guide and looking at the language that's there. If you're getting language from someone else or some other group or entity and it contradicts what we've got in our official instructions, know that you should be following our instructions.

If you find anything where we contradict ourselves, please let us know as soon as possible because we do want to take care of those, and it can happen. But our instructions right now are still what's in the user guide.

(William Levitt): OK. Thank you. That clarifies for periodic payments. What if the RRE decides to lump sum settlements or settle those periodic payments and affects the TPOC or a settlement but does not include the medicals? Is that the same answer?

Barbara Wright: Again, what that paragraphs say is that the ORM continues in place and you don't separately have to report that to TPOC. Now, we have had an issue raised in some of the questions that came in to the mail box that was asking, what if under state law the ORM or medicals terminate had a date earlier to the indemnity payments and therefore that the ORM has terminated?

Under what we have right now you still have to report the indemnity at TPOC, and reporting that indemnity at TPOC does not necessarily rule out all the senses to the recovery claim. So, I mean keep that in mind, it goes along with what we've said on one of the earlier answers. There are going to be some cases were you have to report and, you know, there maybe a further defense raise when we actually pursue for recovery claims. So, for the time being, you should follow what's in the user guide.

(William Levitt): OK, as I understand what you just said, if we effected the TPOC, either this are at the time ORM termination or after ORM termination, that TPOC is then reported,

Barbara Wright: Yes.

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

Crystal Brotski: Hi this is Crystal with PMSI. How are you distinguishing whether or not claims are reported correctly when exposure continues past December 5th 1980? Does (CMS) just going to accept those claim reports to the understanding that RRE should know they're reporting requirements and determine it was affordable even though the date of incident was actually prior to 12/5/80?

Barbara Wright: Are you the one who sent us question into the mailbox?

Crystal Brotski: Yes.

Barbara Wright: OK. Keep in mind that except for exposure type situations or anything, I guess I truly don't believe we're going to see trauma-based injuries and stuff that are still affected claims almost 30 years after the fact. You know, at this

point, it should be a problem that is largely confined to the exposure and plantation and ingestion. And if they're saying that it continued that we have a claim, we would have any reason to have that.

Crystal Brotski: OK. Would there be any consideration for implementing any sort of indicator to make it easier for RREs to identify these claims or report them?

Barbara Wright: I'm not sure why would you report something that we don't want you to report. And if it's reportable, then we're already accepting. I'm not sure what your real issue is here. I understand you're trying to think outside of the box and make sure you've explored every scenario but given that 1980 is now like 31 years ago, I just don't really see it being a particular issue other than a theoretical issue.

And so, I am going to ask Jeremy right now since he and Bill Ford are on the line to think about this. If they see any reason that an indicator would have some value, we're always willing to consider suggestions. But initially, I can't really see of any real purpose on it.

Crystal Brotski: OK. And just one more question, once a case is being appealed while payments are being made and the claim is reported with ORM why, if it's found that the RRE is not liable for that claim, how would they go about updating it? Should they send a delete or update the record with either an ORM termination date the same day as they have reported it?

Barbara Wright: I guess part of my question before I refer to Jeremy and Bill on this is anything we've already paid, are they entitled to recover it or not under state law?

Crystal Brotski: Yes. Well, I guess other scenario then (inaudible).

Barbara Wright: Well, I mean I think it would have to make a difference whether or not they were entitled to recover. If they should have never paid it all and I'm entitled to get all that money back from the beneficiary that's different then as they made payment. And although they no longer have responsibility, they don't have any right to get back what they've already paid.

Jeremy Farquhar: Right. So, I mean technically as far as how you'd handle that depending on the scenario, if they were able to recoup that money and they were not liable for any of the payments that they had made previously, then you could actually send a delete transaction to remove that record in it's entirety.

If they weren't going to be able to recoup the money and during the timeframe that's been decided the money is they paid out, then they should send a termination date as of whenever appropriate decision has been made.

Barbara Wright: And if you end up having to do it with termination date, if someone later made a claim for further ORM because of the open record, you would have documentation to support refuting that further demand.

Operator: Your next question comes from the line of Tiffany Pickens with Phoenix Aviation Mangers. Your line is now open.

Tiffany Pickens: Hi, my question is in regards to conditional payment. Most of our settlements are contingent upon satisfying the Medicare requirement. And in this particular instance we have a settlement for the policy limit and the conditional payment is also pretty much at a policy limit. But the conditional payment letter says do not send payment at this time. So what would be the course to settle the claim because our procedure is to send check directly to MSPRC?

Barbara Wright: You represent who?

Tiffany Pickens: The RRE.

Barbara Wright: OK. And a conditional payment letter means that no one has notified us that the case is settled yet. So a conditional payment letter is not a bill.

In a case where someone – the payment are settlement or judgment is maxed out because of policy limits then when they notify us of that final same settlement then we have to do our official calculation of our recovery claim and it takes that policy limit into accounts. So it's not going to make a claim for anything that exceeds the settlement matter.

Yes, I'm a little bit confused about what you're actually trying to find out right now and how it relates to the Section 111.

Tiffany Pickens: Because we would pay the claimant whatever is remaining after the conditional payment. So if we are going to send CMS pretty much the entire settlement is that number going to be negotiated or reduced based on the fact that is the policy limit.

Barbara Wright: Are you (know fall) insurance, workers compensation or …

Tiffany Pickens: Liability.

Barbara Wright: You need to send something into the mail box and mark it to my attention this is Barbara Wright and spell out your issue in more detail because some of what you're saying just doesn't making any sense in our normal context in doing things. And I think we need to do is something outside of this call because what you're doing isn't really related to 111.

Tiffany Pickens: OK.

Barbara Wright: So if you would do that, I'd appreciate it.

Operator: And your next question comes from the line of (Wendy Raider) with State Compensation Insurance Fund in California. Your line is now open.

(Wendy Raider): Hi, I thought I had a question into the mailbox and it had to do with our employer's liability portion of our policy that we saw at the worker's compensation. And we wanted to know if we should be reporting those employer liability claims separately and in addition to reporting workers compensation claim.

Barbara Wright: OK. Let me find your question again. If I remember correctly, in your incoming question which I can't locate right now, you were talking about you were carrier for certain types of things that you also faces in that and I guess the point we would reiterate is we're not concern with how you name your complain or what you say you pay.

We're concerned with whether or not you're doing settlement to (entrance board) or other payments for liability insurance, no fault insurance, our worker's compensation as CMS has defined these terms. And if you have the situation were did you say your mainly paying workers compensation?

(Wendy Raider): Right, we're a workers comp carrier?

Barbara Wright: Sorry, OK. Someone just handed me your question. So you said the name of the policy you sell is worker's compensation and employers liability insurance policy.

To the extent what you're paying or what the claim is worker's compensation as defined by your states laws then you should be reporting as workers compensation to the extent it's employer's liability.

Male: I'll try to make it up, Barbara. Barbara's got a bit of bronchial issues going on. Its cause lots of cough but everyone sure can relate.

Barbara Wright: Yes. Anyway to the extent that what you're paying is under the employer's liability insurance policy part then that needs to be reported as liability insurance.

I think we state at least once or twice in our user guide that there maybe cases or claims where there are multiple reports for that single claim because part of it's being paid under no fault and part under liability. Or there maybe a company that does both in workers compensation and liability. And they have to honor claims under both of that.

So, yes, I would expect that you're going to have something to report under both. From your description probably a lot fewer to report under the liability insurance, but definitely stomp. Does that help?

(Wendy Raider): Yes, thank you.

Operator: And your next question comes from the line of Dianne Phillips with ConocoPhillips. Your line is now open.

Dianne Phillips: Hi. I had submitted a question to the mailbox regarding the no entry code, when you've got a spouse who's claiming the lost of consortium numbers, submitting the no injury code. The claimants and defendants in our case for general liability are asking what CMS state of incident is used for her record?

Barbara Wright: For her records what you're essentially going to use is in it's all likelihood the same date of incident as the injured party. If you don't believe, you have a separate one.

If for instance John was hit by a car on January 1st and that his wife has her severe emotional reaction on January 10th and you've got a distinct date of incident then fine, give a different date of incident for her claim but if you don't then just use his date of incident.

Dianne Phillips: OK, because these are mostly the topic toward exposure claims so.

Barbara Wright: And generally, your exposure is going to be the same because unless let's you have a case were John was exposed to the 1978 and continued to be exposed through 1982 and even merrier until 1981 then obvious, you know, the (inaudible) till 1981 and obviously her date of exposure is going to be same as his.

Dianne Phillips: Right, but if they were married the entire time, then we just use …

Male: Generally, it should be the same.

Dianne Phillips: His date. OK, great, thank you.

Operator: And your next question comes from the line of (Daniel Delentio), University of Florida. Your line is now open.

(Daniel Delentio): Well, thank you very much. In my – I estimated about five questions to the mailbox. I'll just ask one and a follow-up if I may, it involves some timing of the – the timing of the settlement with exchange of money and what will in fact trigger the TPOC reporting date.

An example, the parties are at mediation, they agree to an amount. They sign a mediator statement saying that they have agreed to an amount on certain

conditions. There is a later settlement release that's signed by the parties and then the check follows.

When I read the user manual, they talk about payments in some portion of the manual and others seems to indicate when the meeting of the minds occurs is when the date – your trigger date for your reporting period.

So my question is in that scenario where you have a mediation – a mediation agreement then a formal settlement is released and then the check, which one of those three be the earliest to trigger the TPOC reporting.

Barbara Wright: How does your scenario fit with, and I'm kind of looking for the field member TPOC-D as it's defined in the record layout because that's where you should be looking. TPOC date is defined in field Number 96.

(Daniel Delentio): Yes, OK.

Barbara Wright: Wait just a second.

(Daniel Delentio): I appreciate the help I was looking and not only that but also the explanations and they go on Page 93 to 98 thereabout.

Barbara Wright: I'm sorry, Jeremy, are you any quicker in finding the …

(Daniel Delentio): OK.

Jeremy Farquhar: I can find it for you. Just give me – give me just a moment.

(Daniel Delentio): I appreciate. Thank you.

Jeremy Farquhar: OK, it's fields 101 on Page 194, Barbara.

Barbara Wright: OK. Actually mine just field 100.

Jeremy Farquhar: I'm sorry. Yes, that's 50 back to (back), field 100.

Barbara Wright: OK. And what is says is the date of payment obligation is established that says, this is the date the obligation is signed, if there's a written agreement

unless court approval is required. If court approval is required, it's the later of the date the obligation is signed or the date of court approval.

If there's no written agreement, the date of payment – the date of payment our first payment, if there's multiple payments is issued. Then what you've said, you had mediation (inaudible) signed agreement and then you had a check, it sounds like it would be the signed agreement based on what's here.

(Daniel Delentio): Or I guess normally, the mediation will say it'll be reduced to writing, you know, to an agreement that we prepared and agreed to by the parties. That answers my question.

And the second follow up on all the minor – occasions with minors in Florida, they go through the court, probably the court for approval. And as I understood it's the later – the later date.

Barbara Wright: It's the later, the court approval or if it's signed which ever, you know, is later.

(Daniel Delentio): Right. Well that answers my question. I really appreciate, thank you.

Barbara Wright: Yes, when you have – for everybody, when you have something that you are looking – particularly if you're seeing it more than one place from the user guide, always go back and check the actual record layout as well because we try to put definitive definitions in the description on the record layout so that those would be handy for those people as well. And in this case, you know, the definition that's here does give you the priorities.

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

Stacey Baker: Thank you. This question is regarding the Medicare query process. I just wanted to make a request regarding the query process. At times, we'll make a settlement and then our claim remained open. I make additional legal payments or what have you following that settlement.

We may possibly get a positive Medicare hit on the Medicare query after our settlement, we've been told in that past that Medicare sending out a positive Medicare hit on claimants who will be Medicare eligible within the next six months that are not currently Medicare eligible.

So what it's causes us to do at times and we think we've made a settlement with a non-Medicare beneficiary. We still have to go back in and investigate if that person was Medicare eligible at the time of settlement again.

So our request is to have the Medicare query process, if we get a positive hit, not only will it send the Medicare number, the HCN number but also be able to send the date of entitlement along with that. That way we know if our settlement was made prior to the person becoming Medicare eligible.

Male: OK. I mean, you know, we don't have a response for you at this time but you know I always take that as a (inaudible).

Stacey Baker: Thank you. You know, I mean obviously we'll keep us from reporting claims unnecessarily to Medicare when someone was not Medicare eligible at the date of settlements.

Male: Yes, I guess one of the concerns about providing entitlement dates is especially for people that are younger than 65 because that they can start and stop periods of entitlement. And you know, we may send an entitlement date but it's going to be the most current entitlement date and may not necessarily select the previous period entitlement.

Stacey Baker: Correct. It would at least gives us a place to start because anyone who work in an insurance business knows that actually you've made that settlement and the documents are signed trying to get a injured party to work with you regarding their Medicare benefits is pretty much impossible. So we have a place to start that would be very helpful. Thank you.

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

(Bonnie Mustard): I sent a question.

Male: Hello?

(Bonnie Mustard): Yes, I sent a question to the e-mail box on the 8th of December regarding ORM expectant. And this in reference to Page 114 as the user guide with our addressing periodic indemnity payment like lost wages, death benefit, et cetera.

And there is some confusion because the way we define in the user guide indemnity payment equal to ORM doesn't match some of the norms that they were comp industry follows.

So, what we're trying to be is make sure that the termination date that we set for these follows what your looking for as an example for prepay indemnity to your desk benefits during March 1st of 2013. And then the medical statue limitation and on 1/15/2013 but the indemnity statue limitation ends on 3/1/2015, which date are you looking for us to use as the ORM term date.

Male: You have an incoming to a mailbox it was the first time someone had mentioned that a particular state could have different legal termination dates for ORM and for it's indemnity for the same case for the same entry. So we really haven't had a chance to look at it further. I mean at this point, what we've said as we said earlier on this call is what's on Page 114 controls so if there's any issue on the back in someone can certainly raise any issue as a defense.

But, you know, as I said this was the first we've seen that. If you have more detail on something at that particularly if that's common in other states that would be helpful for us to know that.

(Bonnie Mustard): OK, I'll see how many examples of that I can call and then forward into you.

Male: Email or text like injury specific or in that particular state what everyone you're referring to does responsibility and for medicals always end before responsibility for indemnity.

(Bonnie Mustard): I don't know if it's in every state. I think it's in more than one state though I can't – I'm not the expert on that particular subject, so I can't speak to that (inaudible).

Male: (Inaudible) also I'm asking you is that difference case specific or is it the difference in a lot general and other words for that state does indemnity always run like a year more six months more than it does for medicals or was that something that was tied to the specific facts and the case and if so, what types facts we make them and on different dates?

(Bonnie Mustard): OK, I will get that additional detail and I'll send it back to you for review.

Male: OK, thank you.

Operator: And your next question comes from the line of Doug Holmes with UWC. Your line is now open.

Douglas Holmes: Hi, thank you. My questions has to do with the implementation of the proposed rule making I noticed that in you alert from September 30th 2011 there's a line that says after full implementation of the before the requirements seamlessly used to normal notice at those for making process for establishing any penalties.

I am, just wanted if you had sense that I love the timeframe would be in, I would make that transition on which is still issue with learns about rule making is pending what would be the status of the user guide basically what for you on anticipate is the timeframe and how that would work.

John Albert: We can't – this is John we can't talk about timeframes per se but obviously we, you know, from the lost of materials that we hope that people think that we're trying to communicate new information as CMS can release it, you know, on timely basis to the alert process and subsequent inclusion in the user guys.

But I mean we don't have any kind of set timeframes or with not for this. It's just that (tittler) was put out there to let people know that this was the process that we were following, I know people are anxious to see further development

on this but we can't make a commitment on a phone call at this point time to when any of this was kind of actually happen we just try to layout for, you know, folks what the expectations are, long term regarding this process.

So again we will like continue to provide information as we can relate that but other than that, we really can't say much about it so.

Douglas Holmes: Yes, well just as a follow-up would you anticipate that you would during the – whenever is that the process begins for rule making, would you impose penalties even before the rule making was done on determining how they would be imposed or what's being would you – would you expect on that and if you'd …

John Albert: Doug again, I can't answer that. All I can say is that let the alert speak for itself at this time.

Douglas Holmes: OK.

John Albert: This is all in, you know, in development and we can't discuss, you know, policy – pending policy on, you know.

Male: And then what I would say keep in mind as what John said over and over on this call …

John Albert: Yes.

Male: … is our prime interest is in getting correct at it. It's not in making a practice of imposing silver money penalties. We want the data, so at this point everybody's best interest are served by complying as closely as you can to the requirements you put on the Web site and to our user guide, et cetera. And when we do any regulation there will of course we expect at this point that it will be done to the NPRM process.

Male: And so there's a whole process for comments and feedbacks and all that built into that process so.

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

(Keith Bateman): Hi, this (Keith). Barbara in light of what you're talking about earlier regarding the indemnity and work settlement and workers, am I to assume that the alert that had been talking about for a long time will not be forth coming.

Barbara Wright: I don't – I don't think we can say forth coming or not forth coming but I think we're back in a position were we know we can't finalize anything until we here more about this particular type of issue. It was raised today in …

Male: Hello, we're having a coughing break.

(Keith Bateman): All right, Barbara, you don't have to go in any further.

Barbara Wright: Thank you.

Male: It's the season.

Operator: And your next question comes from the line of (Elizabeth Seymour) with Techno-Risk. Your line is now open.

(Elizabeth Seymour): Yes, hi, thank for taking my call. My name is (Liz Seymour), I'm with Techno-Risk and I am the reporting agent system maritime company is one of which is their cruise line. Frequently instead of us doing monetary settlement the cruise lines will offer what's called cruise credit as a full and final second on to the third party claim.

How should that be reported to CMS?

Male: I believe that user guide covers this and right now unless you're getting in to a decently expensive through this you're below any minimum reporting threshold because I don't know many reason this wouldn't tend to be reported as (tip) box because they're a single settlement type thing as long they are under the threshold I don't think you have to worry about it.

But in the part of the user guides it talks about what can report and how. I know in the section through a risk management, it is specifically addresses one part addresses providers decisions and suppliers and how they do write ups they have to do it and of course some Medical billing and then anyone

else has to do it through the normal reporting process leases if amount is sufficient.

Male: Now that was in the Section 11.2, I think (inaudible) …

Male: I believe the (days) were this is actually reference or where it begin is Page 117 of for guides.

(Elizabeth Seymour): One seventeen, OK, thank you very much. I will have to look at that, thank you.

Male: My pleasure, thanks, Jeremy.

Operator: And your next question comes from the line of (Susan Vanilla) from (Riley Genesis). Your line is now open.

(Susan Vanilla): Thank you. My question was already addressed. Thanks.

Operator: And your next question comes from the line of (Tammy Porter) with Bay Area Medical Center. Your line is now open.

(Tammy Porter): I think you may have addressed this but just for clarity on risk management right off. My understand that if there is a write up for charges are reflected through the billing process and if that is separate from Section 111. But if we also have a thin area where there is a Medicare never event and the charges reported appropriately through the claim.

If they are over $5,000 and that is our goodwill not only are we dealing what's appropriate to the billing process but that would ends with the patient with their injury, there's no law suites. Do we also report those charges or write ups as a TPOC?

Barbara Wright: If it's the never event and I admit that we don't know enough in this room about the never events, if you again could do an update to if you've already submit to the mail box, if you haven't, you could do one and specifically directed to my attention and explain to me a little bit more about how the never events are reported on the billing and then we could possibly give a more specific answer.

(Tammy Porter): OK.

Barbara Wright: To the extent that Medicare has not paid for something then we don't have a recovery claim. If there are no – what there could be in a never event is associated care by other providers or suppliers but yes we do have a right to recover particularly if you do any further settlement.

(Tammy Porter): OK.

Barbara Wright: I think we need a little bit more information that never events here including if you happen to have a mandate, if you know where sites are in our own manuals on something to billing having to do with, you know, never events that wouldn't hurt you. Because we're not (dowing) people here and it will help us in making contacts within the agency so.

(Tammy Porter): OK and what was your last name, Barbara?

Barbara Wright: Wright, like the Wright Brothers, W-R-I-G-H-T.

(Tammy Porter): OK, thank you very much.

Operator: And your next question comes from the line of Louani Bascara with Sidley Austin LLP. Your line is now open.

Louani Bascara: Thank you. My name is Louani Bascara, I'm at Sidley Austin. Have a quick question about using dates of incident and exposure cases. Let's say you have to report an exposure case because it's alleged that was exposures on and after 12/5/80. At a certain point you learn that the actual date of exposure are different than the alleged date, would you report the actual dates of the first and last dates of exposure or the date alleged in the complaint?

Barbara Wright: As we've said and if you look at the alert that came out recently which the date under Revise 1 is October 11. And we're looking at what's claim the release or effectively release. So it's not a matter if you get to routinely explains something and then say "Oh, I decide to do discovery later and it's not really that." If what's still going to be time released or effectively release and we still potentially got to claim.

If you look at that alert and look at what you have to do did not have how this recovery plan I think it should be a little bit clearer. And if you already look that and are still confused and we apologize.

Louani Bascara: I guess my question is not whether or not it's the reportable event but what date is this incident would be using. Would you be using what's of the date that alleged by the plaintiff or it's throughout discovery you found out that it was a different date, would that be the date you report when you're reporting?

Barbara Wright: Essentially you need to report the one that, I hate to say this but in effect it favorable to the beneficiary. If they – if they're – if they're claiming that were exposed before and after and we need to know about that. If they're claiming they were exposed before or after but if they are claiming that they were only exposed before but you have clear indication that they were exposed after and you're releasing that as well. Then, you know, we're going to need to know both of those suits.

But your date of incident or what's report it for purposes of 111 as I think precaution you on the alert because it's essentially in the early state of exposure no matter what.

Louani Bascara: OK.

Barbara Wright: There's a, I believe on the alert there is actually apparent medical or reminder. I'm looking for a copy to the alert right here right now. OK, I've got the alert in front of me.

The very end there's a reporting reminder at the end of the alert at this where information on 111 can be found and it says from reporting is potential settlement judgment of order, other payment related to exposure ingestions and implantation the date of first exposure slash date of first ingestions slash date of implantation is a day that must be reported as DOI.

This is true for self identification as well as (MMSDA). We routinely get questions were they say "OK, I was exposed back here but I don't think I had any injuries until my second exposure just to add everything." And again, it's

that date of first exposure. It's not when you were diagnosed or when you decided to go to the doctor. It's when the exposure itself started.

Operator: Your next – your next question comes from the line of Armand Volta with the Law offices of Peter Angelos. Your line is now open.

Armand Volta: Thank you, Barbara. Thank you for clarifying and for responding to my question I think I have a follow-up to that however there I hope we'll further clarify and that I'll recover people on the phone today that I am trying to resolve language in the releases within. The particular question that I ask is if you have multiple dependants which you related, say seven dependants but you only have one exposure period and a complaint of 1950 to 1985.

And you resolved with the dependent whose exposure ended in 1969. My reading because it's dependent specific is that that is not a reportable event. Am I correct?

Barbara Wright: Do they meet all three criterias that are listed in the alert.

Armand Volta: Well again.

Barbara Wright: Her ingestion ended the exposure adjustment has not been claimed or specifically are the released.

Armand Volta: Well again that's why I sent the question Barbara, if there are seven dependence and in the complaint these complaints were gone done 20 years ago, in the complaint or 15 years ago, in the complaint you have an overall exposure period for the plaintiff and there are multiple dependents all of which has different timeframes and you settle with eight dependents who is clearly ending in 1969 well before 1980.

Even though the original complaint goes well – goes beyond 1980 because there are multiple dependents and many or some of them go beyond 1980 but not all of them is that a reportable event where you have a settlement with a dependent whose exposure clearly ends in 1969.

Barbara Wright: If that's a – if that's – if that exposure ended in 1969, then I assumed the release for that is going to make it clear that it only covers through 1969.

Armand Volta: Well I think the alerts further goes on and say that if it's a general release but that doesn't spring the 1980 into account.

Barbara Wright: So I need you to send me an e-mail to the mail box OK?

Armand Volta: OK.

Barbara Wright: It seems to me that what you're postulating or posing right now is you're saying that we haven't specifically addressed a general pleading that is subsequently counter indicated by the actual discovery.

I would argue, I know there are people here that would argue that we have and if you've got the claim for it and that what you describe to me doesn't meet these three but I'm willing for you to send in whatever you want to send in to narrow this down a little bit if you have more and we'll at it.

Armand Volta: OK. Well …

Barbara Wright: And I think in general most people that claim this – they aren't going to meet all three of the criteria. It's going to be the problem. If you want to explain why the situation you have that you believe it needs all three, we'll be happy to look at it.

Armand Volta: OK.

Operator: And your next …

Barbara Wright: OK.

Operator: And your next question comes from the line of (Theresa Felino) with AAA Auto Club Group. Your line is now open.

(Theresa Felino): Hi, there. Thanks for taking my call and before I forget Happy Holidays to everyone. My question is on the compliance codes. I see that, you know, you started putting the compliance codes on for like reporting past the 135 days.

The issue on that is originally if the cloud is administratively closed, January 1, 2010 or prior – or prior to January 1 2010, it was not reportable.

Now in the end term you do have files that reopen for one reason or another for ORM. When they reopen then of course they're reported at their Medicare recipient. So based on the date of lawsuit appears as though our reporting is terribly late though it isn't. What kind of ramifications is that going to held to have a number of compliance code for late reporting?

Male: None, I mean that that's something that I just need to keep records of on your end I guess when CMS ever had any questions. But again I mean those compliance codes are, you know, indicate about you are potentially not in compliance and that, you know, we still have enough release down to our own CRM process et cetera.

But again just keep that documentation, you know, with you. I mean there are no ramifications but if you did everything right, you're fine. And that's, you know, nothing in this compliance codes are not – they're not meant to be, you know, a definitive you are not in compliance or you are in compliance because they're addressed to help you keep check of what you're send and obviously, you know, it sounds like you did everything right.

And for those that maybe don't understand – or having problem, it's just a good way for them to basically know that based on the number and types of code that you may ask them some at, you know, actions on your part that you need to take to basically eliminate those compliance code. But they are not a definitive as, I mean, you know, if you come back to ask them before, they are there to help you improve your data report in which is our primary goal on all of these.

So it's not (inaudible), it's getting good data timely because good data timely helps us, help beneficiaries and helps everybody involved in this process as well. But through coordination and benefits as well, then it recover in issues so.

(Theresa Felino): OK. All right, I just wanted to be sure on that and then my other question is the 50 disposition code and user guide I said that there should be rarely used

in the last reporting on my response file, over 10 percent of my record were a 50 disposition code and I guess I don't find that rare and wonder if I should be concerned about anything.

Jeremy Farquhar: This is Jeremy Farquhar work to COBC that it means you have that high volume of 50 codes and you like to recap to your EDI reps and provide them with examples you can take a look at that and see if there's anything unusual about the reason for those that these being generated.

Sometimes there, you know, sometimes there are more than others in you've actually been looking at some of these recently that are we're not aware of any problem across the board that these causing 50 codes to be generated for some reason but it seem to be a variety of reasons when we're seeing them. So it may not be anything out of the ordinary.

There are occasions when you might get a 50 code where our system, we actually have records that will occasionally be locked with they particular locking contract or I.D. If there has been some type of confusions surround in the case we'll put a locking contract or I.D. on a record and sometimes you might receive 50 dispositions as result to that.

But if you give us some specific examples, we can take a look at them and see if we can decide for what might be. Sometimes we're able to provide this specific feedback and sometimes where we're not able to say it's precisely – there's an element of uncertainty sometimes because when we're hosting ORM records, we hosting them to an external database and what we're waiting on when we're processing these files is to receive a response from that external database where we post to this data.

And if we don't then receive a response back from that external database within the allotted timeframe for the processing of your file, then we end up passing back of 50. And sometimes it's difficult for us to tell why that external database specifically has not given us response in that timeframe.

But just because you receive the 50 also if you could mind doesn't mean that we won't necessarily end up hosting your record after the point in time that

your responses cut. It means that your file is still in process at the point in time that you cut your response file.

So although you won't know whether hosting is successfully or not, we may actually post that record. But that's the reason why we ask you to keep sending it on your sub screen files. I mean our chance that we did post it, you don't really know we might not have but if you did – if we did post it and you resend it again on your subsequent file, we'll just overlay the data that you previously submit. But please contact your EDI reps for examples and we'll take a look for you.

Operator: Your next question comes from the line of Eileen Atkinson with GENEX Service Incorporated. Your line is now open.

Eileen Atkinson, your line is now open.

Eileen Atkinson: OK, can you hear me now?

Male: Yes.

Eileen Atkinson: OK. This is a follow up to (Carl's) question regarding settling indemnity separate from the Medicals on an ORM file worker comp. What would happen if you did go ahead and send in the settlement if it was settling only the indemnity and the medicals were continuing to be open? Would that information go to the Medicare secondary payer or would that or would that – would it appear the a whole file is settled?

Barbara Wright: If you did not do a termination for the ORM, that would still stay open but yes our recovery contractor would get the information about the settlement and might pursue the settlement and then might re-pursue it's recovery claim in a different manner that would otherwise do against the ORM record. And I can't really give you anything definitive on that.

But we also don't want people over reporting. So if it's something we've asked you not report, we would prefer you that you not report it.

Eileen Atkinson: OK, very good. So and in ORM where you're keeping medical scope and don't report if you're only settling the indemnity portion of that file.

Barbara Wright: Yes.

Eileen Atkinson: Thank you.

Operator: And your next question comes from the line of (Nicole Rosbach) with Mercury Insurance. Your line is now open.

(Nicole Rosbach): Hi, thank you for taking my call. I sent this message into Jeremy. We are routinely receiving a considerable amount of being not Medicare eligible heir? And from the reporting perspective we know we need to then mark the card is not Medicare eligible but the question that I'm receiving are from handling perspective. And you know, adjustors are asking should they not list Medicare as payee on the payments.

And then I have been referring them to confirm the eligibility dates that do have a recommendation on how to handle those.

Barbara Wright: Of whether or not to put Medicare on the check.

(Nicole Rosbach): I guess of confirming eligibility dates. I just – I didn't what them to use that error port as this total source of, you know, whether or not they would Medicare on the payment.

Male: At this point in time, it's the – what you're queering via Section 111 process, you can use the query to determine whether or not you need to report via Section 111 but it probably isn't safe to use that as the sole means of determining their entitlements as far as payments that they may use.

Male: You know, I mean – again the information is only as good as you send it to us because I mean we have a matching criteria that if you don't have good information to begin with, we're definitely not going to find them because, you know, we require the name and data birth and gender and you know, if that stuff is not entered correctly, you know, you'll get a no hit anyway.

So, I you know, we can't really tell you how to do things outside of the coordination of benefits with Medicare but again the query process is tool that you can use to help you but it's not necessarily a definitive, you know, yes or no. Because again it depends on the information submitted so – but we can give you an advise on how to deal your outside of CMS practices, you know.

(Nicole Rosbach): OK. I think …

Male: There is – there is confusion as to whether if you think that somebody may actually – if you have reason to believe that somebody is a Medicare of beneficiary and you are not getting a hit on your query response file in no situations which we refers on prior calls where we maybe patching back at 51 with the individual ask only part the entitlement.

You could always call our call center in order to get appropriate clarification and that then number is 800-999-1118. You have to be in our RRE if you're going to be calling our call center and they'll ask you for your RRE I.D. and you organization name. But if you have that, they will – they will answer your questions of that nature.

(Nicole Rosbach): OK. Great.

Operator: And your next question comes from the line of (John Feldman) with Nation One Indemnity. Your line is now open.

(John Feldman): Thank you. Up until about last April of this 2011, there were some work going on the mass towards working group with regarded to this – to how exposure period prior to December 5, 1980 might be established in litigation? Has that effort been is it – does it still exist or hasn't been terminated.

Barbara Wright: Yes and no. The original – the original point of the work group that was called (mass to works) but we did go away from that name because we decided what we're really dealing with this exposure in just the new plantation is the 12580 policy was sort of someone of this side issue. In the original record layout what there was four fields that ask for further detail than there was mass to work.

And so – although it some what on the back burner right now, that is still on the list to revived and potentially move forward with work group in terms of working on that if we want those additional four points of data, what types of cases those would apply to? As far as 12580 policy you have that in the alert. A decision was made by management here to go ahead and put the alert out with.

(John Feldman): OK, well but the alert still doesn't answer the question of the – that was raised by an earlier caller concerning complaints that don't make a claim about an exposure date. They just sue a hundred dependence and say that they were exposed at some time.

So there still is a need – I mean that the – when that effort was still going on within the (mass to work) working group, there was – there were draft circulated that describe the kinds of – would call indisputable evidence. One deposition and other kinds of documents that would serve to show that the claim was regarding exposure that occurred all before December 5, 1980. So I think that the need is still there to as the earlier caller indicated.

Rebecca Wright: I did invite (Mr. Walt) to explain in more specificity what your remaining issue is you would like to see addressed and we will take that up with people here when we receive has note, more than that I can't promise to this point.

Operator: And your next question comes from the line of (Jennifer Sufa) with Westfield Insurance. Your line is now open.

(Jennifer Sufa): Hi, yes. Thank you for taking my call. We have a question regarding a liability settlement in particular on how we need to report this. Hypothetically we have $100,000 liability claim that is settled not for the policy limit. The plan is for attorneys for purposes of resolving the claim different disputed liability over future medicals sets up an escrow account for $10,000.

And we want to know basically how to report that. Our question is do we – do we report it as a TPOC of $100,000, as a TPOC of $90,000 and an ORM of 10 or multiple TPOC payments.

Barbara Wright: OK, let me try and repeat what we think we heard you said.

(Jennifer Sufa): OK.

Barbara Wright: The policy is a 100,000.

(Jennifer Sufa): No, the payment is – the settlement is 100,000 and is not the policy limit.

Barbara Wright: And the policy limit – let's call it a 200,000 for sake of argument.

(Jennifer Sufa): Yes.

Barbara Wright: Policy is 200,000, your settlements for a 100,000 and that entire 100,000 is going to beneficiaries/his (attorney), correct?

(Jennifer Sufa): Correct.

Barbara Wright: And reported TPOC of 100,000.

(Jennifer Sufa): Reported TPOC of 100,000. I'm sorry I didn't catch your answer Barbara.

Barbara Wright: Yes I mean …

(Jennifer Sufa): Yes.

Barbara Wright: … either we missed it or why did you think you would report anything else.

(Jennifer Sufa): The escrow of $100,000 setup for potential future medicals that the way to resolve a portion of the claim was our one question.

Male: And that's 10,000 you mean.

(Jennifer Sufa): Ten thousand yes, I'm sorry, 10,000.

Barbara Wright: OK. That escrow is just something the attorney is doing right.

(Jennifer Sufa): Correct.

Barbara Wright: You settled with the beneficiary for the 1$00,000. I'm sorry. I can't – I can't think of anything or say anything in what you told me that we did take anything other than reporting simple the $100,000.

(Jennifer Sufa): OK.

Barbara Wright: When some settles with the beneficiary, whether he says here's a $100,000 go away or he says here's a $100,000 I specifically think that 50,000 is for past medicals and 50,000 is for future. You know, either of those scenarios you would be reporting the 100,000.

(Jennifer Sufa): As the TPOC.

Barbara Wright: Right.

(Jennifer Sufa): OK, wonderful. Thank you, Barbara.

Operator: And your next question comes from the line of Matt Stonehouse with Gould & Lamb. Your line is now open.

Matt Stonehouse: Hi, Barbara. I wanted to chime back in and follow up on this RRE scenario that I had with a little bit more clarity for you on the – and a different example. In the example that I have, you have insurance Carrier A, who was not able to write an insurance policy in a specific state. So they write or they have an agreement with the insurance Carrier B, and B is writing that policy.

Now, insurance Carrier A is completely funding the payments that Carrier B will be making under that policy. So it's a form of fronting policy but fronting policy isn't covered in the user guide, so in this scenario because insurance Carrier A technically can't write business in that state but they're funding the pool that the payments are being made out of. With that scenario make Carrier B RRE because they're making the payments for Carrier A the RRE because they're in fact funding the pool of money.

Barbara Wright: As I say, I certainly would never give an answer on that verbally without seeing that whole thing in writing. But second, I'm pretty sure that our user guide does in fact don't say and make the statement about fronting policy.

Matt Stonehouse: No, the user guide definitely covers fronting policies but not to this definition.

Barbara Wright: If it's not a fronting policy under our user guide then we're not considering them a fronting policy. I'm not – I'm not trying to be (fictitious) at all but I think I'm going to have to say back to you the same thing that you can't simply change this scenario and say because we've change one tiny facet of this, you CMS have to completely re-evaluate and come up with a definition we've come up …

Matt Stonehouse: It's not that at all. I'm just looking for clarity when it comes the RRE because within the industry as are well aware of the definitions betweens CMS and the insurance industry as a whole are quite different. So when they can't see it an insurance industry definition into this CMS definition, we try to come up with the best answer for our client.

So this is a scenario that's come up and I want to make sure that we relate to the client and make sure that the correct RRE in fact is reporting the claims. And that's why we're in (innovated) to argue the definition it.

So if it doesn't meet the definition of CMS, then next fund won't call it a fronting policy and then the example is Carrier A can't legally write business and XYZ states of Carrier B does it. But Carrier A is paying for all the payments that are going to be made.

Rebecca Wright: But does Carrier B is that to definition in our RRE.

Matt Stonehouse: Well if you follow the money trail, Carrier A is funding everything.

Rebecca Wright: This is Carrier B fits the definition of the RRE under what we have in the user guide.

Matt Stonehouse: I would in – in my opinion from reading through the user guidebook, carrier A and B could both fall into the definition of an RRE.

Barbara Wright: If I'm hearing you correctly, what I hear you is giving me a definition and B definite falls and that A maybe does and you want me to choose between the two.

Matt Stonehouse: I just want to make sure that A has a responsibility to report that they, in fact, are made aware that they should be reporting and not expecting B to take responsibility all own her own.

Barbara Wright: Is it – if it's the same policy, is that going to be reported by both of them? And if B clearly fits our definition of RRE, then I'm not sure why there is an effort to pull A into it. I mean we maybe missing something here, it's much harder for me to hear this verbally.

Matt Stonehouse: No, I understand. No, that's fine. I think that it provides a little bit clarity for me because it's not putting words in your mouth of course but it sounds like that if carrier B definitely be the definition of RRE then we leave well enough alone and don't drag A into it if they don't need to be there.

Barbara Wright: That would be my impression.

Matt Stonehouse: Thank you. Fair enough. I appreciate it.

Operator: And your next question comes from the line of (Catherine Dickenson) with (Hush Brockwell). Your line is now open.

(Catherine Dickenson): Hi and I apologize, this has already been address but if I have a clients that reporting via DDE and I have (inaudible) with in excess of four claimants, how do they report these to additional two claimants?

Barbara Wright: You have a wrongful of – you have a wrongful death, where's there just – there's simply multiple claimants, right?

(Catherine Dickenson): Yes and the reporting on DDAD only allows for four additional claimants.

Barbara Wright: Jeremy?

Jeremy Farquhar: Well that's the same in the (Vile) submission as well so we only allow for the reporting of the four additional claimants, so it's not specific to DDE. As far as reporting additional claimants, I have not, you know I haven't, honestly, Barbara I'm not sure what to say if there some claimants that should take

precedence or how that would work. They only do have the ability to report the four throughout the entire process.

Barbara Wright: I though – I thought the answer that had been given before and I maybe mistaken was that if we had a situation that exceeded four contacts or EDI reps.

(Catherine Dickenson): OK. We can do that.

Barbara Wright: Yes.

(Catherine Dickenson): Yes. It's a situation where there's six kids and they're all taking an equal share, so I couldn't even really prioritize them.

Barbara Wright: OK. But you know the EDI rep maybe able to work something out where we take that information about who's the lead or something else. Did you know – we would expect, hopefully it's not going happen that often.

Male: (Inaudible) made it.

(Catherine Dickenson): If I may add, it actually comes up a few times with most of my clients that maybe something you guys want to look into.

Male: OK. Thank you.

(Catherine Dickenson): Thank you.

Operator: And your next question comes from the line of Tiffany Pickens with Phoenix Aviation Managers. Your line is now open.

Tiffany Pickens: My question was answered, sorry.

Operator: And your next question comes from the line of (Susan Jordan) with (Brought Fire). Your line is now open.

(Susan Jordan): Hi, thank you. I was just looking to clarify something that we have claimants and we've been sending them a couple of examples where they've receive a

beneficiary, they're not – or I'm sorry, claim denials from Medicare as a result of worker's compensation claim that was reported.

And one thing that continues to come up – that's come up several times that the claimants are telling us they've been told from the COBC is that the reasons for these denials is because we reported the claim as being "open." And there is nowhere on the input claim input files to indicate whether the claim has been open or close or what the status is and they're asking the claimants to go back to the claim handlers to get a letter showing or reflecting that the claim has been closed.

Is that the – is that what COBC has been instructed to you know tell the claimants that they need to get a letter showing that the claims are closed? This seems to continually come up.

Jeremy Farquhar: No. That's not correct and you know we've heard this before but I'm not sure as to whether this is actually coming directly from the COBC or not. That are not the proper procedure.

First of all, let me – let me note that there is a way for you to indicate that a claim is closed. If you're reporting to ORM, then there is an ORM termination date that you would submit to us on your file's commission or VDE depending on your submission methods. So the ORM termination date is what will reflect the claim as close and it will reflect those as of that date.

That being said, you should not be instructed that you need to close an ORM record just because somebody's claim is being denied. If in fact, you still have ongoing responsibility to medical that's absolutely inappropriate and I apologize if you have been mis-instructed.

But if, you know it – to help us to get to the bottom of this and solve this type of misinformation, you know if this is to occur and you can contact us and let us know what number you called and perhaps who you spoken with, it would be very helpful as far as our properly educating people if you're getting bad information. And if you have any information of that sort, you can contact me directly, if you like. This is Jeremy Farquhar, I'm at 646-458-6614, and I can follow up on that for you.

Barbara Wright: Can you tell me whether or not this was worker's com or was it no fault or …

(Susan Jordan): They are worker's terms and actually in the examples that I'm putting together and I have once spoken before to Jeremy regarding a similar situation but this time I did get the name of the person the COBC and it seems that the claimants are just absolutely adamant that they want a letter. They keep instructing them to get a letter from the claim handlers, saying that the claim is closed.

And they're absolutely right because a lot of this, you know the claim itself maybe administratively closed, but we still have ORM for the claim, especially if it's a lifetime medical C. And you know the claimant is obviously upset because got an unrelated illness or injury but they're just trying to get claim case, so they are kind of coming back and directing these at the claim handlers saying, you know the problem is you've reported open, they keep saying open or closed claims to CMS.

John Albert: This is John, I mean if it's not related claim that's being denied, that's a whole another issue, that's a claims processing issue. I mean obviously not every claim that comes in, you know, every diagnosis code or procedural code is necessarily related to that particular incident. So that, you know, that's a case of going back to their claims processing contractor and that they are, you know not processing the claim correctly.

We're aware of a lot of issues related to inappropriately denied claims and there's a lot of different of pieces of the puzzle, there is issues at per higher level in terms of how they're billing. There are issues – they come up with our Medicare claims processing contractors and there are other issues related to whether or not the actual Section 111 submission was accurate and also when it was – and it just needs to be updated or terminated.

But if claims are being denied there not related to the Section 111 ORM record, that's not a COBC or RRE Section 111 record issue, that's more of a claims processing issue.

Male: It is possible someone could have responded because they believe it was done because of the open record …

John Albert: Yes.

Male: But that doesn't mean that that was a legitimate basis or denial.

Male: Yes and we are – we are trying to provide more information to all of our many partners and COB to facilitate at that process, works the way that it should work. And we just have to release through instruction to our Medicare fee for service contractors regarding this particular topic.

But that's why if people have issues, I mean the more detail they can gather up front, that will help us help you because a lot of times we would just make an assumption, it's one thing or another and a lot of times it's something totally different and unrelated so.

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

(Bonnie McCarthy): Thank you very much. Actually my issue is exactly the same as the prior caller's. I actually spoke with (inaudible) based during the last call and I have – had a couple of discussion with (Mr. Brady) about this. I have a whole file of examples and these changes anything from COBC telling the individual, "We need a letter saying, that your claim is closed."

Where or we actually have people who have talked to COBC representative and have been told that, our adjusters to people billing as we kind of – they indicate that new records show that we are the primary representative and these are cases where these are what we paid under our or accident or claims have absolutely have nothing to do with the bills that are coming in now and it's really – there's a lot of medical beneficiaries who are very upset, and we really don't know where to direct them.

These are ORM claims and we can't turn in a termination because the doctor won't provide us with that letter and statute of limitations has not run on these and so we're obligated to – we may administratively close the claim. We can

send them a letter and say, you know we've close our claim at this point in time but you know we have actually have some cases we terminate, we were – ORM is actually terminated long before Medicare or secondary reporting became required.

So, I would welcome a way to address more of this with you.

Male: Thank you. Than again it sounds like from what you're saying is not that you needed to term a record, you're talking about unrelated claims being denied which is a whole another issue. What was your name again?

(Bonnie McCarthy): My name is (Bonnie McCarthy), I'm with Farmers Insurance and I'd be happy to give you a call after this. I've got a whole files set of examples and I – the last time I spoke to (Mr. Brady) I gave him three examples of how document (inaudible).

Bill Ford: Jim Brady was just sitting here – in here during this meeting nut has to step out. But he has your examples and he's looking into them.

As Jeremy has indicated earlier, if this information or some of this misinformation is coming from the COBC, we would really appreciate to know who was people are speaking with. Well …

(Bonnie McCarthy): I can look and see if I have specific names, I don't know in some of these I have indicated to them. So you know we have individuals who's extremely upset and their directing – I mean they're directing their frustration at us as an instrument carrier but yet I think I understand that we're not at the heart of this but they don't understand (inaudible) to you.

And you know I haven't yet taken the approach that (ARA) has directed and mandate in, started sending them to their senators but it seems like perhaps that's what it's going to take to get this issue resolve, how we – how do we deal with it. These are people's, you know either people's grandparents, in a lot of cases either people's grandparents so they really don't know what to do.

Jim Brady: Hey, (Bonnie), is that you?

(Bonnie McCarthy): Yes.

Jim Brady: Hi, it's Jim Brady.

(Bonnie McCarthy): Hi, Jim.

Jim Brady: Hi. So thank you for the examples, we have been researching on them and actually one of my folks is working with somebody at CMS to try to get back to the center administrative contractors that denied those claims. I mean, you know I think everything you said is spot on.

The diagnosis that you gave us is fairly specific and those things don't look like they should have been denied, so we are trying to get to the bottom of that.

(Bonnie McCarthy): Great. I'm happy to give you more examples, I have – I have medical beneficiaries who just really are begging for help, literally begging for help.

Jim Brady: (Bonnie), if you want to pass the other ones of to me, we'll do the same with those and you get …

(Bonnie McCarthy): I promise. I'd left you a couple of messages; I know you've been busy …

Jim Brady: That's right.

(Bonnie McCarthy): So I'll give you a call after this and maybe we can connect them.

Jim Brady: Great.

Male: We appreciate that, I mean the specific examples are the first thing that if anyone are having , you know they're having issues that come up, we really need the specific examples for us to be able to do something with them because we often times just get blanket statements that "Oh my claims are being denied," and that there is to it and it doesn't really – the thing that we need at the specific examples of the beneficiaries and we can go back and that's good ammunition for us to help, you know, (Alicia) is on her Medicare people service contractors and get them to work correctly and I'm glad to hear that again.

The fact that you provided very specific diagnosis code, that's the first thing, is that when people are reporting the data to us that they provide us much specificity as possible.

I mean you can put a whole lot of ICD code on that input form and we encourage people to provide as much detail as possible not just the bare minimum one because that's what cause problems, some either they little be more generic ICD code with something that's more specific or additional codes that would warrant, please make sure to include those because that's the first thing and then after that we can trace it down so whether or not our records just simply needs to terminated or in the cases of these inappropriate denial which what we're seeing more of now that we have a lot more reporting of this information.

We can use that to go back to the center which the CMS that oversees the Medicare contractor and make sure that their procedures are well documented and enforce as well. So because – I mean I – ultimately, we all are trying to assist the Medicare beneficiary whether it's on coronation of benefit claims payment and/or handle a recovery.

Male: For anyone else, who has this type of situation, make sure that you are getting at least the beneficiary name, their Medicare number and when we said ICD-9 because we need information on what claims.

Male: Yes.

Male: Because anyone could have add a claims process for a 100 different services, so what service is being denied …

Male: Yes.

Male: … whether it's data service or whatever.

Male: So …

Jim Brady: Right. And (Bonnie) did a great job with that one because she not only gave us the detail on the claims but also on people themselves where we could reach out, so that was good help.

Male: Again, CMS wants to say thank you because this is the kind of information we're really wanting to get so that we can try to get some of these resolved.

Operator: Your next question comes from the line of Louani Bascara with Sidley Austin LLP. Your line is now open.

Louani Bascara: Thank you. I just had a follow-up question, my earlier question about date of incident for exposure. Presuming you're going to report. If for example you had a first exposure that was alleged in a complaint as say July 1976, but you learn that the actual exposure started in say July 1970. Would you be reporting as the date of incident, the actual exposure in 1970 or the alleged exposure in 1976?

Male: As I said before it's really in many ways what happens to the most visit and today just to be beneficial. The earlier – if you know that it was earlier, you should report that.

Louani Bascara: OK. So the distinction of actual or alleged doesn't really matter, it's really what was earlier. What is …

Male: It matters in terms of whether you want us to not pursue a claim, you know – if you look at the 12580 alert, we have to take into account what claims are release or effective release because we don't have to prove causation.

So under MSP, the statutes specifically says, we look get what's the – claims are released that we're looking for demonstration and primary payment responsibility and that can be made regardless of whether or not there's an admission or determination of liability.

So, you know I can't say that the allegations are unimportant and not relevant but you really need to go back to that alert. And if you can meet the exceptions and you don't have to report it, if you can't, you, you do have to report it.

Louani Bascara: And presuming you are going to report it, if the actual date is before the alleged date, would you report the actual date that …

Male: Report the actual date in that case.

Louani Bascara: OK and that's the alleged date is before the actual date?

Male: I will report the alleged date.

Louani Bascara: OK and then with regards to past expose would you – how would that work out? Would you …

Male: I would report it which ever is the most recent of the two in other words, if one of them is 1982 and ones 1983, report the '83.

Louani Bascara: OK. So the later – for last exposed, the later of the last exposed.

Male: Yes.

Louani Bascara: OK. Thank you very much.

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

Stacey Baker. Your line is now open.

Stacey Baker: Yes, thank you. I wanted to ask a follow-up question to the indemnity only settlement for work comps. You said previously that we do not report the TPOC of the indemnity only settlements if ORM is less open. If later on in the file, we settled medical and closed the ORM, we terminate that. Do we include that previous indemnity settlements in the total TPOC amount or do we only report the medical amounts that was settled?

Male: You report the – just the TPOC that's associated with that final settlement.

Stacey Baker: OK …

Male: So that can (inaudible) …

Stacey Baker: In work comp claims, we are never reporting indemnity only settlements.

Male: Not true. If you had an indemnity only settlement where you were terminating ORM but for whatever reason you believe that was not part of the settlement agreements and I would say, you'll still reporting that indemnity one in that case.

Stacey Baker: OK.

Male: I realize it sounds like semantic into a certain extent it is.

Stacey Baker: Yes, I understand. Thank you for clarifying that.

Male: OK.

John Albert: Operator, it's 3 o'clock and we have to end the call, so that's another meetings to attend.

Again, we'd like to thank everyone for their participation and excellent questions. Again, for those that have examples of claims denial issues, please get that specific information to you EDI reps, so that we can hopefully you know keep that process moving to make sure that this problem start to go away.

Anyway, I'd like to thank everyone. Stay tuned again to the Web site for notices, I mean future calls, we don't have any scheduled at this time but we will surely have calls next year.

And with that, happy holidays to everyone, and Happy New Year. Thank you.

Operator: Thank you.

John Albert: Operator, you can stay on the line after you have released everyone.

Operator: Thank you. Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

END