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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FTS-HHS HCFA

Moderator: John Albert
December 15, 2009
12:00 pm CT

Coordinator: Thank you for holding. Parties will be on a listen only mode until the question and answer session of today's conference. At that time you can press star 1 to ask a question.

This call is being recorded. If you have any objections you may disconnect. I'd like to introduce your speaker, Mr. William Decker.

William Decker: Thank you very much Operator. Hi, good afternoon everybody. This is Bill Decker calling you all from CMS in Baltimore, Maryland roughly speaking. This is an NGHP policy call, Section 111 NGHP. A call dedicated to policy questions and answers to the degree that we have them for you today.

If you have NGHP technical questions, we're not taking those today. And if you are a GHP caller, this is not your issue. This is not a GHP call. This is an NGHP call. So I just want to say that ahead of time.

When we turn the microphone over to you callers we're going to be asking - I think the operator will be asking you to tell us who you're with and what your name is. But we'd like you to repeat that for us.

Remember, that these calls are all being recorded and will eventually show up on our Section 111 Web site. So you might want to keep that in mind as you're talking. And I believe that that's all I wanted to talk about this morning, or this afternoon depending upon where you are.

And I'm - I have with me here today, Barbara Wright who will be speaking with you from time to time. And I have with me today, Pat Ambrose. And Pat, are you going to start off or no? Okay.

Does - Pat doesn't want to have an opportunity to do an opening presentation which is just fine with us. Barbara do you have anything you'd like to start with?

Barbara Wright: Yeah. Before we get to the Qs and As I need to give everybody the status of various outstanding issues. Unfortunately, there haven't been any alerts posted recently for most of the outstanding issues. We are still awaiting final clearance on language for clinical trials and Section 111 issues.

We are still awaiting final clearance for language and risk management write-offs or actions. We are still awaiting clearance for language having to do with what the mass torts work group was working on.

As we've said in (unintelligible) told you about somewhat on the last call that where we're headed with that is Fields 58 through 62, the definitions or descriptions of those are being completely reworded.

We're moving away from the kinds of just calling anything (gross) product liability or mass torts. We're going to be asking instead whether or not the situation involves a Group 1 or a Group 2 claim.

And we are going - we are planning on eliminating all trauma based injuries. So basically, you'd be answering no to the first field which would be Field 58 if it's a trauma based injury.

If it's not a trauma based injury, in other words, it's absorption, inhalation, ingestion, injection, implantation or exposure then you would be answering that you were - it was either a Group 1 or a Group 2 claim.

And the biggest distinction in the two probably is the fact that we're looking to have Group 1 reflect situations where you've got an identified product or class of products or a sub class of products where you essentially intentionally use them.

You've ingested a drug that's been prescribed. You've had an implanted joint, something like that. Where Group 2 we're looking to have that involved exposure through the environment regardless of whether it's an indoor or outdoor environment.

So that's the general direction in which you've been drafting those. The requirements will apply to all NGHP to the extent a claim could fall in one of those situations.

The other thing is that we are looking at - I have to keep saying looking at because we don't have final clearance on all of the language or posture here. We're looking at most likely saying that Fields 58 through 62 will not be reported until January 1, 2011.

That's where we're aimed right now. As John Albert usually says on these calls, don't take anything completely to the bank until it's in writing on our actual Web site. These are, you know, a draft position right now that we're putting forward. So that's the mass torts product liability.

We do not yet have final clearance on the final language or RREs. So that will be included when we update the manual. We are aiming to have the updated user guide in January. There was one other main issue.

Oh, foreign RREs - we don't have a final alert out yet. We have one that's in process that systems changes need to be made to accommodate what we are for want of a better term, labeling foreign RREs.

But for purposes of that what we're really talking about is the situation where the RRE does not have a US Internal Revenue Service TIN or does not have a US address. Because if they don't have both of those items right now there would be a problem with registration.

Our plans at this point, are to have registration for RREs that fall in either of those categories start April 1 and - of 2010. And with it required registration by 6/30/10. We do not anticipate at this point any change in what they must report, just the few months delay in terms of when they will report.

And we will have an alert out about the dates very shortly. With that that's pretty much what we have to announce right now. We'll take calls. I apologize ahead of time to the extent that we are not able to provide you with specific answers because we haven't finalized some of the material. Operator?

Coordinator: If you'd like to ask a question from the phone press star 1. Please unmute your phone and record your name. To withdraw your question press star 2. Once again, it's star 1 to ask a question and you do need to record your name. Please standby for the first question.

The first question is from (Shaker Siva) from (Crum) Insurance Agency.

(Shaker Siva): Yes, sir. We are adding five RRE (unintelligible) IDs which we have report each RRE IDs (geared to a) different reporting submission window. We would like to ask is there a way that we can combine all of those things and (ID) one submission window so that our processing can be done a little easier.

Pat Ambrose: Hi, this is Pat Ambrose. At this time we are not changing the file submission timeframes by RRE ID. You're correct that as you register for an RRE ID it's essentially assigned randomly and so if you have multiple RRE IDs you will have different file submission timeframes assigned to each.

If you have specific concerns about that I would suggest that you talk to your EDI representative regarding that.

(Shaker Siva): They are not helpful to us. That's the reason I'm expressing this concern here. Because it'll be taking full time (unintelligible) for us if you are to do multiple times. So we are doing it a quarter, five times a year to do it.

So all we are asking is give us one window so that we could submit all the files in one window.

Pat Ambrose: Well we'll take that under advisement. But you have to understand that we have a, you know, it would be a manual process and we've got a large number of RRE IDs registered.

And to accommodate - we're just not able to physically accommodate a request to change the file submission timeframes for all of them. But, you know, your concern is duly noted and, you know, we'll see what we might be able to do.

But at this point in time I really can't provide any better answer to you other than that you should plan to submit the files separately. I mean of course, if you're able to roll your files together and report under one RRE ID or reduce the number you may do so.

And in a sense abandon the other RRE IDs that you might have registered by notifying your EDI representative and asking them to delete those numbers if you're not going to use them.

Barbara Wright: This...

(Shaker Siva): Okay.

Barbara Wright: This is assuming that you're entitled to roll them all into a single RRE ID. Some of the folks that we're getting requests similar to yours from, they range from situations where it's a single company or a single entity that may have multiple RRE IDs because they want to report lines in a business differently or because they have certain cases in a different system.

To situations where as an agent that may be the agent for up to 1000 RREs. And certainly they would like - or even more than 1000 and we don't have an account on that.

But certainly we have no way to simply say that simply because one entity is actually the agent or doing the physical reporting, that we can accommodate allowing that entity to submit every single RRE ID they have on a particular submission date.

(Shaker Siva): Yeah, well as a follow up question to this is one of the RRE IDs that submission (unintelligible) April 1 through April 8. First of all, we - I don't

think our system is going to be ready in place to submit those if you are (unintelligible) the date.

If we are not able to submit for that particular RRE ID on that date will we be penalized for that? Will there be a penalty for that? Whether - I'm asking what is the implication if we are - if I'm not ready and unable to submit the data on the particular date for one RRE ID?

William Decker: The first step for you to take - hi, this is Bill Decker. The first step for you to take on that - in that situation is to let your RRE - let your EDI representative know your situation.

(Shaker Siva): Okay.

William Decker: You need to stay in compliance. And if you don't talk to us you won't necessarily stay in compliance.

If you do talk to us you may very well not have any problem with compliance and it will be up to you and your RRE ID to jigger around your schedule if you're having trouble reporting on one schedule date.

(Shaker Siva): Oh, okay. So we are five companies - all of our sister companies - can you roll up that into one company, all are equal length? Can we report - can you roll up all RRE IDs to one RRE ID?

William Decker: No. You need to look at the alert that was posted dated July 31. Basically, one entity cannot assume RRE responsibility for another entity. If - and in the draft language that's out there right now it makes it clear that a sibling corporation or a sibling entity can't assume it for another sibling.

Nor can anyone - any entity assume it for an entity above it in the corporate structure. The instructions do allow for assumptions below a particular entity in a corporate structure.

So if you had a parent company that had aligned one liability, one no fault, one something else, and they could all be transmitted in the same system so that you had the ability to roll them up - if the RRE registration were at the parent company level, then you could have a single RRE ID and submit a single file.

You really need to go back and take a look at the July 31 alert.

(Shaker Siva): Okay, sir. Thank you.

Coordinator: Are you ready for the next question?

William Decker: Yes, we are. Thanks.

Coordinator: The next question is from (John Armand) from the Michigan Guarantee Forum.

(John Armand): Thank you. I've got a claimant who is 74 years old. We verified through the affidavit and a copy of all of the information. The social security number we're using is valid. The name is valid. The date of birth is valid. However, through the query process that's coming back is not a Medicare eligible.

But we received a copy of her Medicare card. On it it's Railroad Retirement Board card. Is Railroad Retirement exempt from MST reporting?

Barbara Wright: No. If she has Medicare card through Railroad it should be reflecting that she is a Medicare beneficiary. You're using the number that's on that card?

(John Armand): Well we're actually using her social security number to match because obviously the - or the benefits are through her husband.

Barbara Wright: Yeah. But in a case where you have that situation and you actually - if you have her Medicare number that is our preferred submission. And I guess in a situation where they're willing to supply their social security card I would generally expect them to be willing to supply their Medicare card.

But I think and Pat tell me if I'm wrong, we'd like to follow this up and find out why a Railroad beneficiary isn't matching based on her social security number. So if you could give Pat contact information she could have someone get back to you.

Pat Ambrose: Actually the best thing if - are you able to give me your RRE ID?

(John Armand): Yes. Hang on. We'll double-check it real quick. It's 13588.

Pat Ambrose: Okay. Make sure that you report those circumstances to your EDI representative in a secure fashion indicating what you submitted on your query record.

And, you know, the query record - what we do first would be to match that social security number and then three out of four of the remaining fields must match. I'm not sure if the circumstance is such that we, for some reason, don't have this person on our file of Medicare beneficiaries.

Or if we're not getting a match on the first name initial, the first six (bytes) of the last name, the gender or - and the date of birth, perhaps there's something, you know, three out of four of those fields are not matching. But your EDI representative will be able to help you with that.

And we can follow up. Make sure that you let them know that this is a Railroad beneficiary situation. And again, as Barbara suggested, if you do have their Medicare card that shows their ID and the Railroad (HIC) numbers are formatted differently, that that should still - you should still be able to submit that number and - or ID and get a match on it.

William Decker: We do crosswalk the Railroad - the odd formatted Railroad ID numbers...

Barbara Wright: And we...

William Decker: ...through our Medicare database.

Barbara Wright: And we do crosswalk when someone obtains benefits on their spouse's record.

William Decker: Right.

Barbara Wright: So we definitely want to follow up on this and check out why there's a problem because if you supplied accurate information for at least three out of the four fields it should not be rejecting.

(John Armand): Okay.

Man: And then on a side note, on the - and I'm sorry, this is probably more technical. On the test beneficiaries that were out there for the query process

can we also use those same tests - HICN numbers for a production test file for a claim?

Pat Ambrose: No.

(John Armand): Okay.

Pat Ambrose: I'm not sure why you would submit the test beneficiary data on a production file.

Man: No. On a - it's the test claim file. I'm sorry. So the...

Pat Ambrose: Oh. Oh. Oh. Oh. Yes.

Man: Okay.

Pat Ambrose: Yes.

Man: Sorry.

Pat Ambrose: The test beneficiary data that has been made available on the COB secure Web site may be used on test query files and on your test claim files when you start testing in January.

Man: Yes. That's what - I'm sorry. That was my question. Thank you.

Pat Ambrose: Okay, great.

Coordinator: Your next question is from (Crystal Brodsky) from PMSI Settlement Solutions.

(Brenda Smith): Hi. Can you hear me?

Pat Ambrose: Yes. Please go ahead.

(Brenda Smith): Hi. This is actually (Brenda Smith) from PMSI. And I have a question from one of our clients in regard to the model form for obtaining social security numbers.

And the model form posted on your Web site is in color so they number one wanted to know, when they send it to the beneficiary, in order to be considered compliant do they have to print it and send it in color? Is that a requirement?

William Decker: No. Hi, this is (Bill), doctor. No. You don't have to send it in color. You just need to reproduce it and give it to the beneficiary. The color is nice and it makes it look nice on our Web site but it's not necessary. It won't make you - put you out of compliance if you do use it and it's not in color.

Barbara Wright: And I believe don't we say on the form, (Bill) that they're red, white and blue Medicare cards?

William Decker: Yeah. I believe we do. The Medicare card if it's not in color should still look very much like a Medicare card.

(Brenda Smith): Okay. And they also wanted to know can they add a return address on the bottom of the form? Would altering the form in that way be okay?

William Decker: I believe we permit you to modify that form for your own use if you wish. And so certainly you can add more data to it.

(Brenda Smith): Okay. Thank you.

Coordinator: The next question is from (Stephen Marshall) from (Sonnenschein, Needham & Rosenthal).

(Stephen Marshall): Thank you. I have two questions with regard to installment payments, settlements that involve installment payments. But first I wanted to follow up on something that Barbara had raised when she indicated that consideration is being given to deferring until January 2011.

Completion I guess of Group 2 claims, exposure claims with regard to Fields 58 to 62.

Barbara Wright: Okay. Let's back up a little. I didn't say we were deferring when there's that type of TPOC. What I said is that we're looking at the idea that you would not have to report Fields 58 through 62. You would still have to submit a report for that beneficiary for their TPOC.

You would just not be putting any data in Fields 58 through 62.

(Stephen Marshall): That's why I was seeking clarification. I thought that's what was intended but wanted to be certain. My question involves, as I indicated, installment payments.

One hypothetical is there's a claim in litigation, it's settled during 2010 for the sum of $3000 with $500 being paid that year, and the balance of $2500 to be paid on an unspecified date in the future which will be determined based on the occurrence of certain events, none of which events involve medical expense or anything comparable to it.

How would you report that or when would you report it?

Barbara Wright: I think when we've said as pure installment payments (unintelligible) the total sum in the beginning. If you report the total sum, the beneficiary, if we based our demand on the full $3000 they would certainly have every opportunity to come back and say why they couldn't owe us that much yet or why.

And if it's a settlement that low (unintelligible) it's a situation where they had very few or little medical expense. So that even the amount they received might be plenty to cover any recovery claim we have.

(Stephen Marshall): Well, but this situation involves if it's a 2010 settlement it's below the TPOC threshold, the $5000, so...

Barbara Wright: Okay, well if it's below the threshold and it's not reportable then it's not reportable.

(Stephen Marshall): But would you report it? Let's say in 2012 the balance of $2500 is paid does that $2500 then get reported in 2012 because it would be in excess of the TPOC threshold for that year?

Barbara Wright: If you have a true installment where you have a settlement where you have to pay $3000 and you're paying it at - in multiple installments and it gets reported as a lump sum, if you in essence have two separate settlements or you have a situation where someone's entitled to come back for more money.

And an example would be - in (Fen-Fen) for example, many of the settlements involve a surgical guarantee. If they had a valve replacement within one year

they were entitled to come back and get another $100,000. That type of situation gets treated as two separate TPOCs.

But if you have one that's just a true installment you owe - you are paying $3000, you're just paying it out over time. Then you need to report it all at once. You described a contingent situation which sounds more like the (Fen-Fen) situation. They're not guaranteed that they're going to get that money.

(Stephen Marshall): In your true installment situation if it is in fact a lump sum that is just being paid over time, if the threshold is not exceeded in the year in which the settlement is consummated or the first installment is made, then none of it ever has to be reported?

Barbara Wright: That's true.

(Stephen Marshall): Okay.

Barbara Wright: But let's make sure we understand what that translates to. You're talking about you have a total settlement that's $4000 that you're going to pay out $1000 per year, okay, and you're saying it's under the $5000 threshold.

So even if your fourth payment takes place in a year where our threshold is zero or $2000 or whatever it would be at that point no, you wouldn't have to report it. Now if you had one that was installment and let's - the total was $10,000 and was being paid out $2000 per year.

That must be reported in year one as the entire $10,000.

(Stephen Marshall): Okay. One other question. Let's assume that the TPOC date and the first installment is in 2009 and the second installment payment is in 2010 and that payment exceeds the threshold amount, would there be a need to report that?

Barbara Wright: No. Remember, you need to look at whether it's a true installment thing so you've got one TPOC date. Or it's a situation that I described like for (Fen-Fen) where you've really got what we consider two separate TPOC dates.

That's what you're going to look at and you're going to look at the threshold that's in effect as of the applicable date.

(Stephen Marshall): So...

Pat Ambrose: And if the settlement date was prior to 1/1/10 you don't have to report it.

Barbara Wright: If the TPOC date as defined on our claims detail input is prior to 1/1/10 you don't report it.

(Stephen Marshall): Okay. And that's the case even if the second installment, and I'm assuming a true installment settlement...

Barbara Wright: Yes. That's the case.

(Stephen Marshall): So if the second installment exceeds the threshold in 2010 the client is not obligated to report any of it.

Barbara Wright: The RRE is not obligated to report it for purposes of Section 111.

(Stephen Marshall): Okay.

Barbara Wright: Any other responsibilities that they have under the MSP provisions remain in tact. For purposes of these questions we're answering Section 111 responsibilities not MSP responsibilities in general.

(Stephen Marshall): Okay, thank you.

Coordinator: Your next question is from (Susan Bradbury) from Berkley Accident and Health.

(Susan Bradbury): Hi. (Susan Bradbury), Berkley Accident and Health. During the GHP call on December 10 we received confirmation of our understanding that accident only coverage is not defined as a group health plan and therefore is exempt from the GHP reporting requirement.

However, they mentioned that the language is pending to determine whether accident only is reportable under the non group health plan. In looking at the user guide there's nothing to indicate that accident would be considered a non group health plan as the coverages are listed as liability type products only.

Furthermore, we have not seen anything under the NGHP or GHP that would have led us to believe that there were any decisions pending relating to accident only coverage which is I would say, considered health insurance.

Is there a way that we can get a clarification on this accident only or are you aware of something (unintelligible)?

Barbara Wright: I will need to talk to some of the people that aren't here today. I wasn't here for the call on the 10th. If it's a policy that is, you know, inherently - if it's either sold as liability insurance in any way or if it constitutes self insurance then it clearly...

(Susan Bradbury): Not at all.

Barbara Wright: ...is under the NGHP. But I will have to find out what information the other policy folks have on this.

(Susan Bradbury): Okay.

Barbara Wright: Can you tell us the nature of the accidents that you're proposing to cover here?

(Susan Bradbury): Well it's group accident coverage for sporting events or sports teams or I mean it can be anything like that. It's always - I mean from a...

Barbara Wright: I will check. But I believe that we have said in the past that those are liability insurance. I will have to go back and check.

I'm not making any commitment on this call but policies held essentially for liability at sporting events and everything else, sound to me based on what you've said, as though they are liability policies. But we will check.

(Susan Bradbury): Well when they're filed from a compliance perspective, when they're filed with the states it's always health insurance. Now whether you're going to look at it as liability then, you know, that's a complete redirection for us. So how will I get an answer to that?

Barbara Wright: Well we will have to address it on the Web site.

(Susan Bradbury): Okay. We also submitted the...

William Decker: Thanks for raising it again. I was on the call on Tuesday and I remember you from that call too. So...

(Susan Bradbury): Okay.

Barbara Wright: But you said these are specifically policies like for accidents at sporting events, things like that.

(Susan Bradbury): Well it would be if an individual is injured on, you know, while participating in some kind of a program.

Barbara Wright: Okay. Is it typically only for those that are actively participating or also the audience?

(Susan Bradbury): No. It's actively participating.

William Decker: How is it paid out?

Barbara Wright: And how is it paid out?

(Susan Bradbury): It would be paid to either an indemnity benefit or an expense incurred benefit to the individual.

William Decker: Okay.

Barbara Wright: Okay.

William Decker: Thank you.

Barbara Wright: Thank you. All right?

(Susan Bradbury): Thank you.

Coordinator: The next question is from (Joyce Newmeyer) from Wisconsin Motors Mutual Insurance Company.

(Joyce Newmeyer): Hi. Can you hear me?

Barbara Wright: Yes, we can.

(Joyce Newmeyer): I'm from (Wisconsin) Mutual Insurance Company. And we are a single state mutual legal malpractice insurance company. So we respond to the loss of the legal rights. We don't make any medical costs or pay any medical costs. Are we in an RRE?

Barbara Wright: You may be. Legal malpractice is liability insurance to the extent there's ever any medicals that form part of what's claimed or released then yes, MS - there would be a Medicare secondary payer recovery claim.

I agree that in most instances we don't see medicals attached but we have specifically seen cases where there are medicals that are forming part of the complaint once released.

(Joyce Newmeyer): And just as a follow up question to that - I mean if we do a global settlement where, you know, nothing is really written down as to medicals or future medicals or, you know, lost wages or anything like that and it's just global, do we have a third party requirement with that situation?

Barbara Wright: The touchstone in the user guide as it looks at whether or not medicals were claimed and/or released or the settlement has the effect of releasing medicals.

We've said certainly there are certain types of insurance that don't involve medicals.

If you have a claim that's purely a fender bender and you're getting reimbursed for that dentist vendor, we don't want to hear about it. But can I give you an absolute escape clause? No.

If your situation is unlikely to have any medicals attached to it then as we've said, you do not have to register until you have some reasonable expectation of having something to report.

In that situation we are asking or saying that an RRE should register in time that they would have a full quarter in which to test before they actually had to report.

(Joyce Newmeyer): Right. And I guess one more quick follow up would be we are - I mean we're insuring lawyers that committed malpractice for one of their clients. So we probably might have one claim a year to report.

Is there any consideration for companies who maybe have like five or less than five claims that would, you know, make us report or not report? The expense is huge.

Barbara Wright: No. There isn't a threshold in terms of number that you have to report. We are looking into whether or not we can accommodate those who are small reporters with some other process for reporting in the future other than what we have available right now to start with.

(Joyce Newmeyer): Okay.

William Decker: Bottom line will be that if you have a claim that should be reported you have to report it. If you have one claim a year or one claim forever it still has to be reported. Is there a way to get around the process that we have in place now? No. Will there be in the future?

Quite probably - quite likely is what we would say at this point. Will it be available for you when you have to report? Perhaps. We're not sure.

(Joyce Newmeyer): Okay. Great. Thank you.

Coordinator: Your next question comes from (Donna Bouchard) from the Michigan Farm Bureau Insurance.

(Donna Bouchard): Good afternoon. I have two questions. Good morning. The first question we're curious on when a new user's guide and they've asked me again about the penalty guidelines, any idea when those will be out?

Barbara Wright: The user's guide we are trying to have it out sometime in January. Since we haven't got some of the - since we haven't been able to issue some of the other items as alerts we may be able to simply issue them all at once in the user guide.

Anything that we issue any time before the user guide is revised, will be incorporated in the revised user guide.

And for those of you who are not familiar with it, when the user guide is updated in the front it's either right before the table of contents or right after the table of contents. We publish a list of the changes that have been made since the last time the guide was issued, so that you don't have to read every single page to find out, you know, what was changed.

William Decker: What's been changed, right.

(Donna Bouchard): And what about penalty guidelines?

Barbara Wright: The penalty guidelines - it said - and John Albert I think has said just on virtually every call he's been on, that our aim - CMS's aim right now is to have accurate and complete data.

We're not focused on trying to impose penalties. That's not our purpose. So in the beginning the way to save clients is to be in accord with the instructions that we're putting out.

If you're having delay or you have something that would cause you to have a delay you need to be in contact with your EDI rep so that we can be in contact with you and move the process along.

We will eventually, you know, it's on our list in terms of yes, there will be specific instructions out with regard to anything for the penalty process. But can we give you a date at this time? No.

(Donna Bouchard): Okay. I'll pass it on again. Okay, now my next question, another unusual situation.

We - I found out a couple of weeks ago that we at times on - we have a liability policy where the beneficiary is not pursuing liability and as a good faith measure we agree to pay medicals for them that are not paid by other insurance. I'd like to know how - if...

Barbara Wright: Wait. You're paying for that under the policy or you're paying for it under some other method?

(Donna Bouchard): Okay. You should know by now I'm an IT person so the way it was explained to me is we just agreed to pay their medical. There's no contractual obligation for us to pay their medical but we agree, you know, to pay, you know, they slipped and fell and broke their arm in the church.

They don't want to sue the church but they don't have medical insurance to cover their broken arm and so we pay for their medical.

Barbara Wright: Okay. So that's going to be reportable one way or the other...

(Donna Bouchard): I would think so.

Barbara Wright: ...(unintelligible) thresholds. But the issue you've got to determine there is if there is a formal policy of insurance - liability insurance and that's what's paying the medical it's going to have to be reported as liability insurance.

(Donna Bouchard): Okay.

Barbara Wright: If it's a situation where nothing is being pursued under the policy and the church decides to pay it on their own then they are by definition, under CMS's statutory definition, they are self insured for that, for liability purposes and it gets reported as self insurance.

If you want to look at the most current language about who's the RRE win you need to look at the July...

(Donna Bouchard): Right.

Barbara Wright: ...31 draft language which is actually posted on the What's New page on our dedicated Web site.

(Donna Bouchard): Okay. So if I assume for a moment that this would be reportable under the liability insurance this would be TPOC and...

Barbara Wright: Well it could be either, the way you described it. If they are simply saying we'll pay for all of your associated medical bills and in other words, assuming an ongoing responsibility then it would get reported ORM. You know, if they are saying hey, we're going to give you $1000 to cover your medical bills, that's a TPOC.

And, you know, this has got to be very fact specific about what's going on. If the policy they have is a no fault policy which is what often covers slip and fall, if something's being paid under that then you've got the obligations that are tied to no fault such as reporting the exhaustion limit when it's reached or termination of coverage if that's otherwise reached.

(Donna Bouchard): These are liability policies with no...

Barbara Wright: Okay.

(Donna Bouchard): ...without no fault and without med pay.

Barbara Wright: Okay.

(Donna Bouchard): So here's what - the question that came up as - if we agree, you know, we're going to have this money set - take this money and we're going to pay

for your medical costs that you incurred as a result of this and you're not going to pursue liability, I'm thinking it's a TPOC.

But let's say there's, you know, we said there might be ten medical bills that come in, do I group them together as a single settlement or am I going to have - be in the over five TPOC situation?

Barbara Wright: That is going to be dependent upon the specific arrangement. If you've said we'll assume responsibility on an ongoing basis. Submit your bills and we'll pay them as it's done, then you need to report for ORM.

If on the other hand, you've said if and when you get some medical bills submit them and we'll give you a lump sum payment then you're going to be reporting it as a TPOC.

(Donna Bouchard): Okay.

Barbara Wright: We really can't give you a definitive answer.

(Donna Bouchard): No. I understand Barbara. So I just - what I don't want to get into is where we are frequently having more than five TPOCs and have to contact the EDI. I don't think you want that anymore than I want that.

Barbara Wright: No.

(Donna Bouchard): Right. Okay. I have stuff to go back to my claims people with. Thank you so much.

Barbara Wright: Okay.

Coordinator: The next question is from (Keith Bateman) from PCI.

(Keith Bateman): Hi. Barbara in your list of items that you're waiting final sign-off on...

Barbara Wright: Yes. We don't have your item either, the periodic payments, right?

(Keith Bateman): Right.

Barbara Wright: Okay. That's waiting clearance as well. For those who didn't understand my shorthand reference, there was language about periodic indemnity payments for workers' compensation and that's being expanded to look at both no fault and workers' compensation.

And to address the industry's concern that the way it was phrased originally did not help the industry at all. So that - there is further language on that that's in clearance.

Pat Ambrose: And that's the July 13...

Barbara Wright: Yes.

Pat Ambrose: ...alert?

Barbara Wright: Yes.

Pat Ambrose: Okay.

(Keith Bateman): One other question. I know you've been requested by some entities to consider delaying the effective date. Is that under any consideration?

Barbara Wright: As of right now the dates we have out there are the dates we plan to keep. As we've said with respect to Fields 58 through 62 the fact that those fields would not be used would simply be a delay in using those fields, not a delay in when the specific TPOCs or ORMs had to be reported and not a delay in the data which needed to be reported.

(Keith Bateman): What about those entities that are waiting - not the foreign RREs but the other ones that are waiting for definitive word on what constitutes an RRE?

Barbara Wright: For the most - as we said, we expect to have something out shortly. For the most part, entities should register to the extent they are able.

If they have a true concern about whether or not they are an RRE that's one thing for them to delay. But the basis for that delay should not be that they happen to disagree with our current guidance.

There are issues out there in terms of for instance, joint power authority, where we've given language and at this point we don't expect to have any major change in that. We know there are entities that disagree with the idea that the JPA itself can only be the RRE under limited circumstances.

But we haven't indicated that we'll be changing that. So those entities who are members of the JPA should, if they don't meet the currently posted criteria, they need to go ahead and register as RREs.

I mean the draft language we have out there in terms of who's the RRE when you're talking about the deductible versus amounts above the deductible, most entities can tell right now whether or not they're going to be an RRE in at least some limited circumstances so they can at least get their registration out of the way.

If someone registers erroneously and based on our final guidance they don't need to have registered, then we can take care of eliminating that registration.

In the long run it will be more problematic if they haven't registered and they should than if they've registered and they can later get information that allows them to have their RRE number deleted.

(Keith Bateman): Okay, thank you.

Coordinator: Your next question is from (Paul Schaeffer) from DCM.

(Paul Schaeffer): Hi. My name is (Paul Schaeffer) and this goes back to - well you pretty much answered my question at the very beginning. But I just want to get some clarification. And it's regarding the RREs, the foreign addresses.

So it's my understanding that you guys are going to issue an alert sometime soon or will just be within the next couple of weeks do you expect?

Barbara Wright: Probably within the next couple of weeks, certainly within the first week our (backs) of two in January.

(Paul Schaeffer): Okay.

Barbara Wright: But the alert at this point is expected to be limited to specifics on when those who have - who do not have both a United States IRS TIN and a US address.

(Paul Schaeffer): What if they don't have a US address but they have a federal ID number?

Barbara Wright: They have to have both to be able to complete the current registration process.

(Paul Schaeffer): Correct.

Barbara Wright: So if they don't have either one of them then they aren't going to be able to register...

((Crosstalk))

Pat Ambrose: We're making system changes to allow those RREs that are in that situation to register. Either you don't have a TIN, a US TIN or address and/or address.

(Paul Schaeffer): Right.

Pat Ambrose: So that'll be available in April 2010 for those RREs to actually register. We also have to make updates to the TIN reference file that corresponds to or goes along with the claim input file.

(Paul Schaeffer): So will there be a period where they'll have - they'll be able to submit test data after that?

Pat Ambrose: Yeah. We'll have to allow for a testing period for that too. I mean I don't believe the CMS is comfortable giving specific dates at this point but from a system perspective we're not going to be able to accept the registration information on the COV secure Website, nor will we be able to accept TIN reference files with foreign addresses until April 2010.

Barbara Wright: Yeah. I'll repeat what, you know, John Albert has said in the past that, again wait until we put it out in writing.

But the point is what we've done in all other situations pretty much is if you have to register by the end of a particular quarter then you're expected to have completed testing by the end of the next quarter.

(Paul Schaeffer): Okay. Very good. Thank you.

Coordinator: Your next question is from (Mike Gardner) from (Corville) Corporation.

(Mike Gardner): Hello. Just one quick question about our RRE status or setup basically. We've got a situation where a customer - the parent company is essentially two individual people with social security numbers and they own a number of subsidiary corporations.

And those corporations right now are considering that they have to register independently of one another and couldn't say, have two or three under one RRE for, you know, if they were able to contract that way.

Is it possible to set that up where a dually owned set of corporations that are owned by two individuals could be the parent RRE?

Barbara Wright: Is there no single holding company or single parent company or anything?

(Mike Gardner): There is not.

Barbara Wright: I think we'd have to look at that further. But keep in mind that let's say (John) and (Sue) own ten companies and they owned all of them jointly. Well they might have to register ten times.

Certainly they could pick any one of the ten or a completely separate entity to actually do the agent and do the physical reporting for each of the RRE IDs.

(Mike Gardner): Sure. We're just trying to consolidate down into one RRE if possible.

Barbara Wright: Okay.

(Mike Gardner): All right. Thank you.

Coordinator: The next question is from (Mike Brown) from the Ohio Bureau of Workers' Compensation.

Barbara Wright: Please go ahead.

Coordinator: (Mike Brown) from the Ohio Bureau of Workers' Compensation, your line is open if you'd like to ask a question.

(Mike Brown): Hi there. We have a question regarding ICD 9 diagnosis codes. I guess you could say internally here we have disagreement on the initial reporting requirements for 2010.

We do capture ICD 9 diagnosis codes here at the Ohio Bureau of Workers' Comp but the ICD 9E codes, the cause of injury, we do not currently have those. Are those codes going to be required for the initial reporting if you have them?

In other words, could we just submit the diagnosis codes without the E codes?

Pat Ambrose: Yes. But you will - you will need to also supply the description of illness injury if you're not supplying both - the Field 15 and a diagnosis code.

So there's a requirement beyond just submitting valid codes in those particular fields, there's a requirement in 2010 that you either provide a description of illness injury or you provide at minimum, Field 15, the E code and a diagnosis code starting in Field 19.

(Mike Brown): So if we have a diagnosis code in Field 19 and we have a textual description of the cause of the injury...

Pat Ambrose: You're good to go.

(Mike Brown): Okay.

Pat Ambrose: Now, all the editing on say Field 19, diagnosis code 1, will be done as per the user guide. So if you submit only one diagnosis code in Field 19 it has to be a numeric code that is on those list of valid ICD 9 codes and it may not be on the list of insufficient codes in Appendix H.

You know, so all of those rules that are in the user guide concerning the diagnosis codes, if you supply any of them, will be applied. So if you're not comfortable with those I would suggest that you hold off until you are.

Now you can submit multiple diagnosis codes and, you know, I'm not talking about Field 15 but rather the field starting in 19. And we will accept codes in the diagnosis codes, ICD 9 codes, diagnosis codes that begin with E and begin with V.

And we will accept codes that are on that list of so-called insufficient codes in Appendix H as long as at least one of the diagnosis codes in the 19 available fields is not E - does not start with E, does not start with V and is not an insufficient code.

Barbara Wright: If you're looking for where the basic rule for what you asked about is described go and look at Field 57, which is description of illness or injury where it talks about that field as required through December 31, 2010 if no alleged cause of injury or no ICD 9 is provided.

In other words, if you can't provide both Fields 15 and 19 then you have to provide this. So that's the field you want to look at where sort of a summary of...

Pat Ambrose: Yeah. And I think in Section 11.2.5 of the user guide we try to cover those. So let me ask you does that - have we answered your question or is there still confusion?

(Mike Brown): No. I think you did answer that question. I do have one follow up question if that's okay.

Pat Ambrose: Sure.

(Mike Brown): Let's say that we are not capable of providing the ICD 9 codes and maybe there are other companies who cannot do that until January 1, 2011. I think if I'm understanding correctly, we'll be reporting a couple of files. I think we're going to be reporting one in June and probably another one before the end of the year.

How would we do subsequent allowances? Let's say we have an injury that's described textually and then there's an additional condition that gets accepted on our end.

What are you expectations regarding how do we let CMS know okay, we have an additional injury that's been added to this claim prior to ICD 9 diagnosis codes being sent?

Pat Ambrose: You could send an update record with an updated description in field, is it 57, the description of illness injury and we would accept that update, you know, and pass that onto the recovery contractor as needed related to a change in that information.

(Mike Brown): Okay. So your expectation would be to update the text and send it in as an update?

Barbara Wright: And I assume that we're talking about a situation where you - you may have already said this but where you have ongoing responsibility for medicals because typically you aren't going to have a second report if there's a TPOC.

(Mike Brown): Yes. This would be an ongoing responsibility for medical. We've accepted one injury and then for whatever reason, another injury has been added to the same claim. So now, you know, you've got an elbow and a shoulder instead of just an elbow.

Barbara Wright: Well it - are you saying that you have a new injury, so from our perspective you have two new claims? Or are you saying that someone has amended their original claim? I mean I think there's a difference if...

(Mike Brown): I know what you mean. It would be an amendment. It would be the same claim but an amendment to the claim.

Barbara Wright: Okay. Yeah, well then do the update. But if you had a situation since we've been told that the industry sometime is in essence combining what we would

call different complaints - complaint claims. If you had ones that are distinct then you could have distinct reporting obligations.

But if you have in essence additional information to add then do the update.

(Mike Brown): Okay. I think we got it. Thank you.

Barbara Wright: Operator?

Coordinator: The next question is from (Mike Testone) from The Hartford.

(Mike Testone): Hello everyone. I just wondered if CMS is looking at a particular date for the next (NASTOR) product liability conference call.

Barbara Wright: What we're looking at right now as I said, we have language in clearance from the Group 1 and Group 2 type issues. And it's basically we're pretty much following along what was discussed at the conference calls in which I gave some highlights today.

It won't at least be until after the beginning of the year in terms of looking further at the issue of language for December 5, 1980 to see whether we can give any relief to the industry there.

(Mike Testone): Okay. And if any of those language changes are made Barbara, is it CMS's goal to get that done prior to issuance of the final version of the user's guide sometime in January? Or would...

Barbara Wright: We're aiming to crash as much as we can and to crunch as much as we can in before the user guide. Remember that we've always said that there is no

absolute final user guide as things could change including, for instance, for thresholds.

We've put thresholds out there and we've said what this is planned right now. But before we would institute the next level of thresholds below $5000 we will give actual notice that we do intend to go forward with that change in threshold and we will give adequate notice.

So in that sense the user guide is a living document to reflect any ongoing changes that need to be made.

(Mike Testone): Okay, thank you.

Coordinator: The next question is from (Susie Sebakall) from (Call) Hastings.

(Susie Sebakall): Hi. My question was a reporting question. We have a client that wants to know basically that if as an employer, you know, they layoff 50 employees and offer them severance in exchange for a general release of claims which within that general release might cover medical claims, does the employer have a reporting obligation?

Barbara Wright: As I said, some of the policy people aren't here this afternoon. Have you sent that one to the resource mailbox?

(Susie Sebakall): I sent that one to the mailbox that is a receipt only mailbox.

Barbara Wright: Yeah. That's the mailbox I'm talking about.

(Susie Sebakall): Yeah. I sent that about two months ago and I still haven't - I don't know, which way - how to access the answer.

Barbara Wright: Well the access the answer should come through these calls and eventually through the user guide. But I will list this to make sure that it's on our list that we're looking for further answers on. That you've said you've got a severance situation with a general release.

(Susie Sebakall): Right. Because we basically want to know if they have to report that or if CMS takes the position that settlement payments only have to be reported if there's an actual pending medical claim.

Barbara Wright: And can you tell us in this type of situation, does it specifically release future workers' compensation and things like this or is it just a more general broad based release?

(Susie Sebakall): I think it's a more general broad based release.

Barbara Wright: Okay.

(Susie Sebakall): Okay? So the question will just perhaps be answered on another call or in another user guide?

Barbara Wright: Yes.

(Susie Sebakall): Okay.

Barbara Wright: I can't - I'm not in a position to give you an answer today. Sorry.

(Susie Sebakall): Okay. Thank you.

Coordinator: The next question is from (Aaron Larson) from (Deseret) Mutual.

(Aaron Larson): Hi. I have a - I'm here on Page 132 of the user guide looking at the - excuse me, the representative TIN or SSN. I'm wondering if CMS has any suggestion or guidance on what the expectations are as far as obtaining bills or how to obtain those.

We're just kind of in a quandary because we never had had to or thought to obtain those in the past.

Barbara Wright: Can you repeat what page again?

(Aaron Larson): Page 132. And I'll give you the field number here in a second, as soon as I get there. Field 88, representative TIN.

Pat Ambrose: It's the attorneys' TIN.

Barbara Wright: The reason we ask for that in case people had been wondering, is technically there's a provision that's in 42 CFR 411.24 I believe, that talked about the situation that if we don't recover from the beneficiary - let's say we sent the demand to the beneficiary. We are technically entitled to pursue recovery from any individual or entity whose hands the money passes through.

So we - although it's not a regular practice to do so we do have the right to go back against -- if the check by the insurer, etc. was made out to the attorney and the beneficiary jointly and put in the attorney's escrow account which is what happens typically -- we do have the right to pursue recovery in that situation against the attorney.

There have been limited circumstances where we've done so. And the Debt Collection Improvement Act of 1996 also says that CMS should be collecting

TINs for any entity where we have a business relationship which includes potential debtors.

And so that's sort of some background on that field. And we understand in some states attorneys are required to supply their TINs because of the fact that their fees - there is like a global 1099 is not quite the right word, but there's global reporting their fees for tax purposes, etc.

Do we have any specifics on exactly how to obtain it? No, we don't.

(Aaron Larson): Okay. So I guess your message is just get it.

Barbara Wright: More or less.

(Aaron Larson): Okay, all right. Well I have a second question also related to TINs or EINs. This is on Page 138 and 139 of the user guide, Fields 104 starting with the claimant information areas.

Field 104 - if we were to put in a value of X in Field 104 - and in the description a value of X is an estate or entity name provided and the example is the Estate of John Doe.

If we put in an estate meaning a value of X, in Field 105, what TIN or EIN or SSN are we expected to use? We're not quite clear on that.

Barbara Wright: It would be the estate's TIN.

(Aaron Larson): The estate's TIN. Okay, so you're implying that every estate - any entity set up as an estate should have an associated TIN.

Barbara Wright: If you're actually filing a formal estate it's our understanding that yes, you do routinely get a TIN through the IRS.

(Aaron Larson): If it's an SSN can it be the deceased's SSN?

Barbara Wright: If there's no formal estate and the only thing there is the decedent's SSN then yes, that's what I would supply.

(Aaron Larson): Okay.

((Crosstalk))

Barbara Wright: Well we're going to have that for the injured party anyway.

William Decker: Okay, good.

(Aaron Larson): Okay. Well those are my questions. Thank you.

Barbara Wright: Okay, thanks.

Coordinator: The next question is from (Rhonda Brucker) from New York Central Mutual.

(Rhonda Brucker): Hi. This is (Rhonda Brucker). We're New York Central Mutual. We had been looking at some of our files and we're coming across issues that we're not sure how to proceed. We have a Medicare beneficiary and they are involved in an auto accident.

They only went to the hospital to get checked out and were only given a V code for observation. The hospital has only supplied us with two different

ICD 9 codes which are for preexisting condition and hypertension - preexisting conditions, hypertension and diabetes.

They gave us no ICD 9 code for what they were observing. How would we report that?

William Decker: Hang on a second please. We're going to put you on mute here and...

Barbara Wright: In talking over here we believe we need to consult further with some other folks here. But in many situations like that if they don't have a specific injury like broken leg, broken arm, etc. and they're observing them they are often observing them in connection with their preexisting condition.

So those codes could, you know, be most likely the most appropriate codes. If - a lot of conditions have co-morbidity factors that with that condition stress or other things like that can exacerbate that condition. So we can't give you any final answer now.

But normally they're going to be billing codes used for that observation and those diagnosis codes would most likely be the same ones you would use then.

(Rhonda Brucker): Okay. Now what about another scenario - someone involved in an auto accident, they're taken to the hospital, that's what was given to us on the last notice. We've never received any medical bills and we don't know possibly paid by Medicare.

No information as to what may have been the injuries. All we know is that they were taken to a hospital.

Barbara Wright: Well you - presumably you're obtaining some type of allegation in order to pay their claim. You would - they would certainly expect more money if they went to the hospital and ended up staying there for ten days than if they went to the hospital and they said fine, you're just shaken up.

We don't even need an x-ray. So it's a little bit hard to understand that you would require no information whatsoever.

William Decker: We assume that our - we're assuming that you're actually paying a claim on that mysterious visit to the hospital.

(Rhonda Brucker): No. We haven't received anything. In New York State we send out what we call personal injury protection application form and they're sent out and sometimes we never receive any of them back. We never receive a medical bill. But...

Barbara Wright: And if you don't in that situation do you believe that you haven't in fact assumed any responsibility for ongoing medical? I assumed you were talking about reporting an ORM situation based on part of what you're saying.

If you don't actually have any request or information to substantiate a decision that you are in fact assuming responsibility for ongoing medicals then I believe we would say that you have nothing to report at that point.

But if you, you know, if there are any medicals alleged or you make a determination that yes, you're going to pay medicals associated with this then you do need to report.

(Rhonda Brucker): But what if we have no ICD 9 code to report?

William Decker: Well again, if you have a claim that you're going to be paying on probably - it would probably be your obligation to get some sort of an ICD 9 code to report on that claim.

It's hard - I mean this is a situation like thousands of other situations where we - that we have run across in this exercise that we're going through here, where the requirement is the requirement.

And if you're going to pay on a claim and you need to report certain items with that to us, as a consequence of that payment then you need to do that somehow. We can't tell you what happens if you don't have something or what happens if you can't get something.

There's just, you know, we...

((Crosstalk))

Barbara Wright: ...that you're going to pay presumably you've made some type of determination about the parameters. You wouldn't simply pay whatever medical bill waltzed in through the door. So, you know, what are you basing your decision on?

How - for what you've said it sounds like more an issue of have you or have you not made a determination that you will pay associated medical bills. If you haven't assumed ongoing responsibility then I guess we believe that you wouldn't be reporting at that point.

(Rhonda Brucker): But we have assumed responsibility because in New York State, New York State no fault we would pay for injuries sustained in that accident.

But as far as reporting this Medicare beneficiary to CMS how could we do that if we cannot comply with inputting the ICD 9 codes that we do not know what they treated? Because possibly the hospitals...

Barbara Wright: Well it's not what they treated, because remember everything on the - our input document talks about alleged injury, what's claimed, etc. when the - when you're getting information from the beneficiary including information for you to establish that they're a beneficiary.

You certainly at that point, could ask them in what way they were injured or in what way they alleged they were injured and use that as the basis for doing your ICD 9 codes.

(Rhonda Brucker): So we would have to pretty much guess at an ICD 9 code if they said I hurt my arm in the accident and I'm getting treated but we never receive any bills? So we would have to look up and...

Barbara Wright: Yes. You'd be making a reasoned judgment as to what should be the reportable ICD 9 code. You - in many situations that we've heard described to us the insurer or RRE will not necessarily have an ICD 9 code furnished to them.

They are going to have to teach or educate their staff to be able to use ICD 9 terminology in connection with any allegations that are made to them. And that's one of the reasons we were careful in the record layout to make clear we always said alleged, etc.

We're not saying that you - by you reporting this that you agree that this was in fact the injury or that this in fact happened. What you're reporting on is essentially the alleged injury.

(Rhonda Brucker): Okay. Going back to a question we heard previously regarding the Railroad employees, we had called our local social security office because we also had come across an 83 year old individual who had postal worker.

And we got back our query saying they were not a Medicare beneficiary. And we checked and everything was absolutely correct.

So we called our local social security office and they were telling us that in prior - that pre-1983 federal employees did not contribute to social security and the government had their own coverage and that that is probably why this individual would not be a Medicare beneficiary.

Barbara Wright: That may be possible for United States postal workers which I believe were in fact government employees and now it's a quasi governmental agency. But Railroad beneficiaries were not government employees, they were Railroad employees.

And our understanding here is that all Railroad employees were entitled essentially to social security if they - that the Railroad industry was covered. There is in fact a Railroad board that administers the Medicare claims for Railroad beneficiaries.

So that is going to - through the EDI rep, check out the Railroad situation. But I believe the postal situation would be different. You've opened our eyes on that. We will, you know, check on that. But yes, I agree. I do know that federal employees at one point did not pay in.

So it would be possible to have some fairly elderly prior federal employees that might not be covered under Medicare.

William Decker: I remember a couple of months ago I was looking on the Social Security Administration Web site for something else entirely but did come across information about that.

I didn't pay much attention to it because I wasn't looking for it but I do believe there is information on the SSA Web site about - specifically about folks who were covered by US or federal government in lieu of social security payments back in the old days.

(Rhonda Brucker): Okay, I - one other question I have. Back in - months ago, in May there was a teleconference and someone had asked a question regarding subrogated medical. And in New York State what we have is actually it's a loss transfer claim issue where one carrier will pay for the individual's injuries.

And then they have a right to recover that money from the at fault party. It involves vehicles over 6500 pounds or vehicles for hire. And the answer was both would report. But we don't feel that this is - would be correct because the individual that's paying the first party benefits would be the one reporting.

And the transfer is only between the two carriers. Could we get that clarified?

William Decker: Are you saying that we said that both would have to report?

(Rhonda Brucker): Yes.

William Decker: Do you know if this is - is this in a particular transcript that you know of or this is just your memory?

(Rhonda Brucker): No. May 14, 2009 teleconference. It was on Page 64 of the transcript.

William Decker: Okay. We'll go back and look at that. The way you're phrasing it right now sounds similar to what we were saying about situations with reinsurance that when it's one insurer reimbursing another that that second one does not have to report. So...

(Rhonda Brucker): Well that's what we thought. And that's when we got confused when we were going back to the transcripts and saw this and it was telling us something different.

William Decker: That would be confusing. That's true. Well we'll reiterate our standard proviso about the transcripts. They're transcripts of conversations that we've had and may not necessarily be - reflect accurately what we now say in the documentation we have on the Web site.

Barbara Wright: And obviously things have been changing to a certain degree...

William Decker: Right.

Barbara Wright: ...since last May. You're probably going to tell me you've already written about this to mailbox too. But...

(Rhonda Brucker): Yes, I did.

Barbara Wright: And do you mind giving us your name again? And do you know about when you wrote into the mailbox so we can go check it?

(Rhonda Brucker): (Rhonda Brucker) from New York Central Mutual. And I sent my email on November 6.

William Decker: (Unintelligible).

Barbara Wright: Okay.

(Rhonda Brucker): All right. Thank you.

Coordinator: The next question is from (Katrina Valencia) from (Schaeffer Lax).

(Katrina Valencia): Hi. Thanks for taking my question. My question is essentially what is CMS doing to handle situations in where there is a divided percentage of liability, specifically with comparative or contributory fault?

William Decker: Do you mean - by divided do you mean between the plaintiff and defendant?

(Katrina Valencia): Yes. Or among descendants. For instance, if a, you know, if someone is injured and their, you know, their medical bills are $300,000 that have been paid by Medicare but the plaintiff themselves is, you know, 95% at fault for the accident.

We're unable at this point at least, you know, (positionally) to settle cases for a nuisance value without the entire settlement being subject to collection by Medicare. And I'm wondering what CMS is doing, you know, if anything, on this issue.

Barbara Wright: I suppose from the industry's perspective the answer would be that we're not doing anything. The agency's perspective is that we have priority right of recovery as well as a subrogation right. We do not do a pro rata reduction based on comparative negligence.

Nor do we do a reduction based on allocation of fault or any allocation of the parties. The sole exception to this is when there has been like a determination - where there has been a determination on the merits by a court of competent jurisdiction.

Let's say there's a jury award of $100,000 and there's a specific factual jury finding that only $10,000 of that is for medical. In that case we normally defer to the court judgment.

But other than that any allocation the parties were not bound by if there are multiple parties that are responsible, if they're joint and (similarly) liable we could pursue the full amount from each and every one of them until we have full recovery.

If there are - as we've said before, if there are separate settlements we could pursue each one for the amount of that settlement. Does that answer your question in general or are you looking for more? I mean...

(Katrina Valencia): No. That generally answers my question. And I'm assuming this is the plan. You guys don't have any plan for altering that approach in the future?

Barbara Wright: Well remember again, this call and what we're trying to implement new instructions for is specifically for a reporting process. The Section 111 doesn't change the preexisting statutory, regulatory or other guidance issues in terms of Medicare secondary payer responsibilities and agency rights or policy.

So no, we don't have any plans at this point to change any other policy with respect to recoveries. Do keep in mind that when you have a beneficiary and let's say you have a situation where there is a nuisance value settlement.

If it is a liability situation we are - we consider our recovery rights bound by the parameters of that settlement. If you settle for a nuisance value of $10,000 then we have recovery rights up to that amount. But if our conditional payment is more than that we don't against the settlement, have any additional rights.

And further, if we pursue recovery from a beneficiary, beneficiaries have certain rights including the right to request a waiver of recovery in certain situations which takes into account both determinations of what's called without fault as well as whether it's against equity and good conscience would defeat the purpose of the Medicare program in order to recover.

And they have full administrative appeal rights and potentially judicial review rights on that issue. And our contractors - our recovery contractors are first tin line for those. But they make the initial determination and waiver determination can be a full denial of waiver.

They may be - partially grant a waiver or they might grant a full waiver. And in limited circumstances the agency does engage in compromise discussions with, you know, plaintiff's attorney about whether or not we're willing to compromise our claim.

So there are other avenues available to address this issue but it's not really a Section 111 issue at all.

(Katrina Valencia): Okay. Your answer is certainly helpful. And I have just one other question. In situations where a business entity may have - and this is again more of a toxic question, a toxic exposure question.

If they have - if an entity has a claim against them where there are several policies involved in exposure over an extended period of time they may become a reporting entity in and of themselves if they're paying part of the settlement.

How is it handled with regards to different policies over the course of years?

Barbara Wright: To the extent that a settlement is from a particular policy the way the record layout is set up I think we would say they need to report on what's paid under that policy for that claim. That's the way the structure is set up.

(Katrina Valencia): So for each separate policy that is paying out it would be reported?

Barbara Wright: Yes.

(Katrina Valencia): So if each policy is paying under the reporting cap, for instance, if there's 20 policies and each policy is paying under the $5000 would they not have to report even though the aggregate is over the reporting requirement?

Barbara Wright: I mean that tends to sound like there's some manipulation going on there if you're somehow just paying that little amount out of each policy. You know, I'm not really prepared to answer that particular question.

(Katrina Valencia): Okay. All right. Thank you.

Coordinator: The next question is from Sue Cline from the City of Portland.

Sue Cline: Hello. My question has to do with obtaining conditional payment reporting. We're using a third party for - to do our query and we got our first query back

and we have about 15 hits. Most of these hits on the workers' compensation are for permanently, totally disabled individuals who are in their 70s and 80s.

If - what I'm doing is I'm going through and I'm picking out the correct ICD 9 codes and the descriptions that need to be filled out in the fields that you mentioned. But for the obtaining the conditional payment information I do have the blip on your Web site to either call or write to them.

How far back do we need to go for the conditional payment in order to say reimburse CMS for payments that Medicare has made when we should have been making them but we weren't presented with any bills?

Barbara Wright: Well again, that's not really a subject for this call. What I'd rather do is take your name and number and get back to you separately. I mean if we have a case that's reported they will look for associated conditional payments back to the date of incident.

And if you assumed responsibility all the way back then we have the right to recover for those.

Sue Cline: From all the way back. So it could be, you know, 20-30 years.

Barbara Wright: Theoretically it could be.

Sue Cline: Okay.

Barbara Wright: But were they a beneficiary for 20 or 30 years?

Sue Cline: Well there's one in particular that I know of. He moved out of state and I think that's what happened. He was quite young when he was injured. He was about 40. And...

Barbara Wright: But if he's...

Sue Cline: ...he applied and we do the social security disability offset for him. So I do know that he has, you know, he is a Medicare beneficiary and has been for quite some time. But we never got any bills when he moved for follow up treatment to Montana.

Barbara Wright: Again, do you mind giving me your name and number?

Sue Cline: No. Not at all. It's Sue Cline, C-L-I-N-E, City of Portland, Oregon, (503) 823-5257.

Barbara Wright: (503) 823...

Sue Cline: 5257.

Barbara Wright: And your first name again? I'm sorry.

Sue Cline: Sue.

Barbara Wright: And this was because we're not going to get into privacy stuff. A 78 year old workers' comp (bene), right?

Sue Cline: Right.

Barbara Wright: Okay.

Sue Cline: Okay. Thank you.

Coordinator: Your next question is from (Linda Sparrow) from Amica.

(Linda Sparrow): Hi. I sent an email over a couple of months ago regarding the ongoing responsibility for medicals when you can send an end date if you haven't reached the exhaust - like if you haven't exhausted your benefit.

Okay, so my question is, is that in there it states that you have to have something signed by a doctor stating that the person has reached maximum medical improvement before you can actually send the termination date for the ORM.

So my question is, is a signed discharge report from a specialty doctor like a chiropractor, is that good enough? Or do we need something from like a regular physician?

Barbara Wright: Well we need some type of statement. It's not just a discharge because you can be discharged from Dr. A to Dr. B, Facility A to Facility B. It's a statement that the individual does not require any further treatment for that condition or for that accident. That's what we're looking for.

I mean there are many people that are discharged from a specialist because the level of care they require no longer requires that specialist. But they clearly require some ongoing associated care.

(Linda Sparrow): So if the only place they ever treat at is a chiropractor and the chiropractor says that they've reached maximum medical improvement and they're at pre-accident status that's not sufficient enough to pass a termination date?

Barbara Wright: I think you're going to have to assess some of them yourself. I mean if you've got a situation where, you know, all of the medical evidence shows the person basically doesn't require further treatment I'm not going to tell you, you can't terminate the record.

But what we are saying is things like routine statements such as discharge and maximum medical improvement don't necessarily equate to no further treatment being required. Someone who's at maximum medical improvement, that's not the same as saying in all cases.

It's not the same as saying pre-accident condition. So, you know, we have to be very careful in terms of trying to give you a statement that you can take a couple of buzz words and assume they always mean that you can terminate the record.

And I'm sorry that that's not as bright line as I'm sure you would like. But...

William Decker: I don't - in my experience there isn't any real bright line here. I have a - I may have a medical condition that - for which I'm not requiring - I don't need any medical help right now. It may flare up again in six months.

The issue is not am I cured. I don't know if there's any doctor in the world who would say that you're absolutely - one is absolutely cured of anything. The question is beyond that and we can't answer it frankly.

(Linda Sparrow): All right. So basically unless we've reached our - like our maximum policy benefit then we shouldn't ever pass because you're never going to get a doctor to say that - like I have a bad back. I've had a bad back for years.

So if I get in an accident and I have a flare up and I treat and it goes back to where it was before but no doctor's ever going to say I'm not going to need treatment again.

Barbara Wright: Well interestingly enough one of my physicians I asked him this question last time I saw him, how often he signs this type of thing. He said he ends up signing it on a fairly routine basis.

(Linda Sparrow): Really? Oh, because we can't ever - well we have...

Barbara Wright: But nonetheless, I think what we're saying is you have to look at as a whole, who describes something very specific to us in terms of saying the person only treats with the chiropractor.

The chiropractor said they were at pre-accident status and didn't require - that's way different than saying I'm discharging this person or this person has maximum medical improvement. Your analysis went a step further.

(Linda Sparrow): Okay.

Barbara Wright: It said the person was - so you're going to have to assess them on a case by case.

(Linda Sparrow): Okay.

Barbara Wright: So we're trying to make it clear is you can't simply use certain words as a buzz word to say oh, this equates to I can terminate.

(Linda Sparrow): Okay. That makes sense. Thank you very much for your time. I appreciate it.

Coordinator: The next question is from (Rhonda Morris) from the (Sheriff)'s Health Insurance Fund.

(Rhonda Morris): I'm actually going to withdraw my question.

Barbara Wright: Okay, thank you.

(Rhonda Morris): Okay.

Coordinator: The next question is from (William Levitt) from (NovaPro) Risk Solutions.

(William Levitt): Yes, thank you. We - I have a question regarding the TPOC date. We understand from prior calls that you're looking for the date that a settlement is approved or finalized. The issue is the definition of finalized.

Obviously if you have a court approval settlement that would be the date the settlement is finalized. But the vast majority of settlements in liability claims do not require court approval or never receive court approval. And there are multiple dates that potentially could apply.

Most of those claims may be settled over the telephone so that's one date. The release has to be signed. That's another date. It has to be returned and received by the carrier. That's a fourth date - third date. And the check is issued and that's a fourth date.

And we want to train our people to know what date to use, and as I was preparing the training program, I didn't know. Can you give some clarification on what you're looking for, for the TPOC date?

Barbara Wright: Did you go back and look at Field 100 and the description that's there? Is it that field or somewhere else?

Pat Ambrose: Yeah. The TPOC Date 1 - date of associated total payment obligation to the claimant without regard to ongoing responsibility to medicals. Date payment obligation was established. This is the date the obligation is signed if there is a written agreement unless court approval is required.

If court approval is required it is the later of the date the obligation is signed or the date of court approval.

Barbara Wright: Yeah.

Pat Ambrose: And then it goes on just one last - if there is no written agreement it is the date the payment or first payment if there will be multiple payments, is issued.

Barbara Wright: And this is in Field 100 on the claim input file detail record. It starts on Page 135 on our copy.

(William Levitt): Okay. I did search through the manual to - or the user's guide to try and find that information. But I guess I overlooked it. You say it's on Page 135?

Barbara Wright: It starts on one - Page 135 on my version. It's Field 100 in the claim input file detail record. If you look for TPOC date when you're looking in the auxiliary record it doesn't repeat all of the definitions.

I guess what we would say to everyone listening in terms of a caveat, is you should never be looking just at the file at the record layout or just at the text in the user guides. You really need to look at both. There are many things where there is some description in the verbiage of the text.

But then there is additional description in the actual file record layout. And there are a limited number of things where the description is pretty much entirely in the record layout itself. So you do need to look at, you know, both parts of these documents.

(William Levitt): Okay, thank you.

Coordinator: The next question is from Melissa Payne from the Health Systems International. Melissa Payne, your line is open. Please check your mute button.

Melissa Payne: Hey, this is Melissa - I'm sorry. I can't figure out the phone. This is Melissa Payne with HSI. I got a really odd question a couple of days ago. Well actually last week I submitted it to the mailbox and the EDI reps are unable to help me.

I have a client that strictly has a contract with the union to provide medical care for an injury specific to the job, it's a teacher's union. They're not responsible for lifetime medical needs or for injury needs after the claimant terminates employer or reaches MMI.

They're exempt from all workers' comp rules and regulations and - by the State of Tennessee and any federal rules or regulations. They're not an insurance company. There's no mention of insurance in the contract. Are they supposed to be reporting?

Barbara Wright: Why don't you give us your name and number and if you remember the date you sent the email in.

Melissa Payne: Sure. I have it. My name is Melissa Payne, P-A-Y-N-E. My direct phone number is (334) 290-4752. And I sent the email to the box on December 8, 2009.

Barbara Wright: And this is - the company is responsible for...

Melissa Payne: It's a contract with a union. It's not an insurance company. They just have a contract with the union to provide medical services. But once the claimant terminates employment or they reach MMI they don't have to pay any - they're not responsible for any medical.

They don't have future medical. They don't - they're not responsible for anything but when the claimant breaks their arm they go to the doctor, you know, all the way up until it's fixed. So it's not - they don't have lifetime medical.

They don't pay anything except for a doctor's bill here and there. And they're completely exempt from workers' comp rules and regulations by the State of Tennessee.

Barbara Wright: I'm not saying it is but part of this sounds like it maybe some type of GHP policy technically, whether it's through a multi employer or otherwise, you know, that's sponsored by the union. So, you know, which would cast it into the GHP world as opposed to the non GHP world.

So I think we need to look at what you sent in and we may need to get back to you separately.

Melissa Payne: Okay. That'll be perfect.

Barbara Wright: If that makes sense why...

Melissa Payne: Sure.

Barbara Wright: ...we're looking at it that way.

Melissa Payne: No. No, I appreciate any help I can get.

Barbara Wright: But I - anybody that tells you that they're exempt - it's one thing to say, have a state say that they're exempt from state workers' compensation rules but any company that tells you they're exempt from all federal rules and regulations is blowing smoke somewhere.

Melissa Payne: Yeah, I - they may have just been doing that to see what I said. But I told her I had to have some sort of proof from somebody at CMS that they didn't have to report before I tell her that.

Barbara Wright: Okay.

Melissa Payne: Okay? Thank you very much.

Coordinator: The next question is from (Rita Carini) from Healthcare Indemnity.

(Rita Carini): Yes. Hi. My name is (Rita Carini). I'm with Healthcare Indemnity, a medical malpractice insurance company. We are preparing our files for testing come 1/1/10.

And on that quarterly input what I'd like to know is there are edits in place to insure that during this test phase the TPOC dates have to be within a certain period?

Pat Ambrose: Not particularly. They - we can't accept future dates in the TPOC field or, you know, future dated TPOCs. So the only...

William Decker: (Unintelligible).

Pat Ambrose: We cannot. Yeah, the system cannot accept future dates.

(Rita Carini): So if we are following our new changed procedures to be reviewing TPOC dates and we're looking at fourth quarter 2009 claims at that time for submission for 1/1, after 1/1/10 we'd be okay?

Pat Ambrose: Yes. I mean exactly right. And you may submit TPOC dates with 2009 on your test files or in 2009 on your test files. The threshold that we might apply will pertain to that first threshold of $5000 on the liability and worker comp TPOC field. And that is exactly what you should do.

Barbara Wright: Can you clarify - Pat, you said she could submit 2009 dates? If she's testing in 2010 she's free to submit any 2009 date, right?

Pat Ambrose: Yes.

Barbara Wright: Okay.

(Rita Carini): I just wanted to make sure that those edits would not be in place.

Barbara Wright: For someone who is not testing - let's say they're testing in February, they would not be able to submit. No one can ever submit a TPOC date that is later than the date of submission.

Pat Ambrose: Correct. But if you're - if you sent in a test file in February you could send in TPOC dates in January of 2010.

Barbara Wright: Or even any date up - in February up until the date of your...

Pat Ambrose: Right.

Barbara Wright: ...submission.

Pat Ambrose: And in fact the requirement for the TPOC reporting is such that you are required to report TPOCs that fall, you know, within the, you know, or over the threshold of 1/1/10 and subsequent.

However, you may if you choose, report TPOCs that are prior and they will be included in the threshold check for that initial threshold.

(Rita Carini): I just wanted to make sure that when we submit a file that if - that the edits in your program would not edit it and say that the TPOC date had to be from 1/1 to 3/31 as if in production mode.

Pat Ambrose: Yeah. It won't do that. And in fact it never will do that.

Barbara Wright: Even in production mode it won't do that. Remember, you have a 45 day grace period...

(Rita Carini): Okay, right.

Barbara Wright: ...so that you will routinely be - may routinely be reporting some items that technically don't fall within the last 90 days preceding your submission.

Pat Ambrose: Yeah. And what you described about reviewing TPOCs on the prior quarter and reporting them in your test file in January, that sounds like a very reasonable approach to take.

(Rita Carini): Okay. I've got another question.

Pat Ambrose: Sure.

(Rita Carini): If we have a Medicare beneficiary who is deceased and through our negotiations we've talked with, you know, there is no plaintiff attorney involved. There may be several children. In the end the check, the settlement check is cut to only one child.

Would you consider that then one claimant even though there may be some negotiators or discussions previously with more than one child?

Barbara Wright: If you've got one claimant to which you're making payment that's who we're interested in having reported in that claimant field when the beneficiary is deceased.

(Rita Carini): Okay, so you're talking about who is the check being cut to.

Barbara Wright: Basically.

(Rita Carini): Okay. I guess that's my two questions. All right, thank you.

Coordinator: Next question is from (Kathy Ballard) from Marathon Oil Company.

Barbara Wright: If the operator or anyone is speaking we can't hear them.

(Kathy Ballard): Hello? If we're named as a defendant in a personal injury lawsuit and we are fully indemnified by another company and that company is the one that pays the settlement and then we are named in the settlement release it's my understanding that we have no obligation to report that. Is that correct?

Barbara Wright: As you've described it I would agree. You're essentially being sued and you have no financial obligation. But if in the settlement you have a financial obligation for which someone else is indemnifying you then I have to think that through in terms of who we're naming as the RRE.

I mean if there's more than one insurer involved, typically the one who's paying is the only one we need to talk about. I guess I have a question in terms of indemnification versus reinsurance, etc.

If you have an informal agreement that someone is indemnifying you yes, in most instances they would be the RRE. But...

(Kathy Ballard): Okay. All right. Thank you.

Coordinator: The next question is from (Tara Kelly) from King and Spalding.

(Tara Kelly): Hello. I am following up on an issue that we discussed in the mass torts working group and that was that there's going to be situations in the mass torts context where we're not going to have all of the information to report and I'm just not talking about Field 58 through 62.

What we had talked about is perhaps having a different trigger date that would instead trigger off the date when funding was made and when information available to report was made available. Barbara, do you see that new guidance coming out in the user guide?

Barbara Wright: We - as I said, we have language and clearance. And if - unless it's only going to be a difference of a few days, if we have an alert ready and cleared before we have the user manual, you know, finalized, then we will go ahead and issue it as an alert.

(Tara Kelly): And Barbara you do anticipate that issue being addressed in either the alert or in the user's guide?

Barbara Wright: Because we were talking about the idea that it's not just who you have to pay and how much they're entitled to but it's also the issue of when funding is available.

But we're also trying to concentrate on how we would define that phrase when funding is available. Because there's a difference between a situation where X amount - let's say a class action or some X amount is paid into the class action.

And no funding is available until 95% of the people sign off or until X analysis has been performed and the idea that someone just says well, I'm not going to cut the check. I mean, you know, we're really talking about funding availability versus someone having bothered to cut the check. So...

(Tara Kelly): Okay. I guess what we're just concerned about is in terms of obviously the TPOC date, when the settlement is executed or when the court signs off on it. We may not of course, have the information for reporting at that time.

Barbara Wright: Right. That - well that's why we talked in the mass torts group about trying to set, you know, at minimum it's not going to be until a decision has been made as to who gets paid and how much.

(Tara Kelly): Okay.

Barbara Wright: And we're trying to fold in some language if it doesn't alter what happens in a lot of other fields that would tie it to the funding being available as well.

(Tara Kelly): Right. And then a follow up question or actually a different question is as the confidentiality we are still concerned about what might happen if somebody submits a FOIA request for the information, particularly the information as to how much was paid in a settlement.

Are RREs going to be notified when a FOIA request and is there anything we could do to further protect the information to keep it confidential?

Barbara Wright: Well remember first of all that when you have a FOIA request we don't simply release privacy protected information or information about a specific beneficiary. It has to be something that's subject to an exception for FOIA purposes or the information is redacted.

So - and in FOIA generally, we're basically talking about something specific that exists. We're not a FOIA expert. But my memory is that in general we don't create reports in response to the FOIA requests.

So, you know, I'm not saying that you don't have any concerns at all but when you add all the factors I just named together, we aren't in the habit of getting FOIA requests - if we got a request that said how much did you pay out for XYZ drug we don't even necessarily track that.

For the most part we have figures of how much we've recovered on an annual basis for liability insurance, for no fault insurance, for workers' comp. We don't keep it by condition or by case.

And if someone asked about what we recovered for (Jimmy Smith) it would have to be something - information that we could actually release about (Jimmy Smith). And in most instances if it was simply a FOIA we wouldn't be able to release it.

(Tara Kelly): So your take on this is if for instance, somebody was asking for what the amount was paid to a specific claimant, that that information would not necessarily be subject to a FOIA request because of privacy concerns.

Barbara Wright: Right. If they're asking for beneficiary specific information it's generally protected.

(Tara Kelly): Would the RRE be notified of a request like that?

Barbara Wright: I don't believe that they would because, you know, if it's not - first of all if it's something we're not going to release there'd be no reason to notify.

And secondly, what you said would imply that anytime we get a request we have to go into our records and figure out where every piece of information came from and if the particular piece of information requested, if we tied it to entity X we'd have to go out and tell entity X.

And if - you heard what it sounds like when I described that. That would be pretty impossible.

(Tara Kelly): And just as a last point, is there anything else we could do then to protect this information, the settlement amount, as we are sending it into you?

Barbara Wright: Well keep in mind again we keep stuff on a beneficiary specific basis. We don't do reports that would tie specific amounts to specific (benes) unless it's something that's in an individual beneficiary's record. And the point is we're supposed to have been paying secondary to that all along.

It's supposed to have been being notified to us. In many cases it's been notified by the insurer in something other than 111 or we've been told about it through their beneficiary, their representative or some other format. And we have that type of information on the individual recoveries we do now.

And we do not to the best of my knowledge and most of us - at least (Bill) and I hear or see FOIA requests that come in, in the MSP area. It's not like - we don't - we simply don't see the type of request that you're asking about.

(Tara Kelly): Okay. Okay, well I appreciate your time. Thank you.

Coordinator: Are you ready for the next question?

Barbara Wright: Yes.

Coordinator: (Murray Seligman) from the Ohio Bureau of Workmans' Compensation.

(Murray Seligman): Good afternoon. We have two questions once again dealing with ICD 9 Series E causation codes. The first question is for claims that we will report to you for of course Medicare eligible beneficiaries in 2010.

And we will not have reported to you any Series E codes and probably not - no ICD 9 diagnosis codes. In 2011 - we're now past 1/1/11, if we have an additional condition allowed and it truly is the same claim but another condition allowed in that claim, do we now have to report to you a Series E causation code?

Pat Ambrose: Yeah. The Field 15 and at least one diagnosis code starting in Field 19 will be required on as an update. So if you were to submit an update record, perhaps I'm not actually getting at the gist of your question.

But from a system perspective, when you submit an update record, after January 1, 2011 we will require both valid codes in Field 15 and at least starting in Field 19.

(Murray Seligman): All right, let - and this is an offshoot of that because I just thought of it so I don't want to give up my other follow up question.

Pat Ambrose: That's all right.

(Murray Seligman): All right. If that update is a TPOC, in other words, we have not given you up to that point an ICD 9 code or a Series E code at all, but and starting after 1/1/11 we have a settlement on this claim do we still have to give you a Series E code?

Pat Ambrose: Yeah. If it's - if you're sending us an update record with an additional TPOC there's no distinction made on the Field 15 and the alleged cause and the diagnosis code field. They're required fields for both ORM reporting and TPOC reporting.

(Murray Seligman): Then I think I know the answer to this final question. For a legacy claim that we've had on our system for quite a while but prior to 1/1/11, this would not be a Medicare eligible individual. Now after 1/1/11 becomes a Medicare eligible individual and we have to report it to you will we be required to report Series E codes as well as ICD 9 diagnosis codes?

Pat Ambrose: Yes.

(Murray Seligman): That's what we thought. Thank you very much.

Pat Ambrose: You're welcome.

(Murray Seligman): Thank you.

Barbara Wright: Okay, Operator I think we're right about at 3:00. Could you tell us do we have very many people in queue for questions or if it's just like one we may be able to take it.

Coordinator: There are still 19 parties in queue for a question.

Barbara Wright: All right. We'll take one more.

Coordinator: Okay. The last question is from (Tracy) Meador from the company (unintelligible).

(Tracy) Meador: Yes. In California we have a law that says hospitals can make claims directly themselves. Normally healthcare providers have to file a lien so hospitals can make their own claims. Would we have to report - we're just - we would just be paying their hospital bill.

Now their patient might be a Medicare recipient but they're not our claimant. The hospital is our claimant.

Barbara Wright: This reporting is relevant to where the injured party is a Medicare beneficiary. So yes, if you, you know, if you've got a situation.

(Tracy) Meador: But I'm not going to have any - I may not have any information on that injured party besides their name.

Barbara Wright: Then why are you paying their bill? We're missing something here.

(Tracy) Meador: Well I may have information but I'm more - I'm not going to have their social security number or their healthcare number. I'm not going to have enough to report it based on their information.

Barbara Wright: So I guess...

(Tracy) Meador: In a claim from a hospital.

Barbara Wright: If - are you assuming any ongoing responsibility for medicals or is this what you would call a TPOC?

(Tracy) Meador: That would be a TPOC to the hospital.

Barbara Wright: We'll need to get back to you on that.

William Decker: (AID)?

(Tracy) Meador: Okay. I have one other question.

Barbara Wright: Can I get your name and number first?

(Tracy) Meador: It's (Tracy) Meador, M-E-A-D-O-R, County of Fresno. Do you want my phone number?

Barbara Wright: Yeah. In case we need further information.

(Tracy) Meador: (559) 488-3360.

Barbara Wright: Okay.

(Tracy) Meador: And my other question is if I have a claimant that I settled with and he was - they were not Medicare recipients. Say they're, you know, 40 or whatever. And they end up treating for that same injury late - like 20 years later when they are a Medicare recipient and I would not have reported that settlement.

If they go in and they say okay, I'm treating based on this old injury could you come back after us 20 years later or whatever?

Barbara Wright: Well first of all if they're not a Medicare beneficiary originally then Medicare wouldn't have paid any claims so it wouldn't be reportable for that first settlement if it was a TPOC.

(Tracy) Meador: Right.

Barbara Wright: And if it's someone that you assumed ongoing responsibility for medicals for and you had no basis to terminate the record then you have an obligation to monitor it and determine when they become a Medicare beneficiary, report the ORM at that time.

If you simply have a situation where this person was injured, they got a TPOC. At the time they got it they weren't a Medicare beneficiary. Then 15 years later for whatever reason, because the statute of limitations and everything obviously could come into this.

Or, you know, if there is a new claim based on that same injury that you're making payment on and they are a beneficiary then you are going to have to report it. So...

(Tracy) Meador: But what if there is no new claim? They just go in and they start treating. They tell their doctor it's based on this old injury. And you guys, are you going to ask them for information based on that even if it was never reported?

Barbara Wright: Okay, are we talking workers' compensation?

(Tracy) Meador: No. We're talking liability and there's no ongoing responsibility for medical.

Barbara Wright: If there - if it's liability insurance and you had a TPOC before they were beneficiaries and that ends your reporting obligation for that individual for that claim.

If at some point in the future they tell their doctor they're treating and it's related to that other injury the type of questions they ask is in part whether or not there's any pending liability claim. And in that instance presumably, the beneficiary would say no.

And so the doctor wouldn't be telling us anything about it. And, you know, you haven't described the situation. For liability insurance unless and until there is a settlement, judgment, reward or other payment we don't have any type of recovery claim.

(Tracy) Meador: Okay. And is there any - do you have any type of statute of limitations? I was told in a seminar that there's a six year statute of limitations. Is that correct? I hadn't heard that before.

Barbara Wright: This could be another one of those instances where the answer is maybe yes, maybe no depending on what you want to tie to it. Generally, there is a statute of limitations in terms of how long you have to bring a litigation action. But there's different rules in terms of when it runs from.

And generally, anything we have doesn't start to run until we have knowledge of the claim. And certainly in a liability situation it's not the date of accident that controls. What we're looking at is when there was any settlement, judgment, award or other payment.

So we would have at least six years from that date.

(Tracy) Meador: And after six years then you would no longer pursue recovery?

Barbara Wright: That's not necessarily true. What I said is the six year statute of limitations is generally tied to when we can pursue action in court. But there are other recovery actions that we have that we can take as well.

(Tracy) Meador: Okay. Thank you.

William Decker: Okay Operator, I'm sorry but we're going to have to close this call off now. Thank you everybody who was on it. We appreciate your questions. And for those who didn't - we didn't get your questions we're sorry. We'll be doing this call again - a call like this next month.

And thank you and good afternoon or good morning still. And Operator can you - before you go away can you tell us how many people we had on the call and how many people were still in queue? Thank you.

Coordinator: Sure. Just a moment. That concludes today's conference. You may disconnect at this time.

END