TRANSCRIPT
TOWN HALL TELECONFERENCE

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Operator: Mr. (Albert) you may now begin.

John Albert: Thank you. Good afternoon or good morning to everyone. I wanted to welcome you to one of the continuing series of calls for the purposes of implementing the MSP reporting requirements of the Section 111 of the MMSEA. For your information, this is particularly geared toward non-group health plan reporting and this is also – this call is targeted towards policies surrounding the non-group health plan reporting.

For the record, today is Thursday, February 25, 2010 and I always mention at the beginning of these calls that while there are some things on this call – that we state on these calls that may contradict some of the materials, occasionally just because we're human, the official guidance concerning the requirements for reporting under the section 111 MMSEA is found on the Website and I'm sure in the rep Website and you should always refer to the user guides and alerts associated with the reporting.

The transcripts, well, it's been taking a while to get some of the transcripts up on the Website for posting, we just have to remind you that if there are contradictions between the transcripts and the official user guide and alerts that we publish on the section 111 Website, you should always defer to those rather than the transcripts.

We have a lot to go today. I needed to announce, first of all, that there are a number of new documents that are in the queue to be posted on the section 111 reporting Website. I'll go over those very quickly. You should be receiving e-mail alerts notifying you that those are in fact, up and available on the Web.

At this point in time, I don't think any of them have made it out there yet, they are in the queue for publications, they have been approved and basically getting through the process here and CMS unfortunately has software that was used to publish that information they have to – that process was down for a little while but again, the documents are all forthcoming. I would say that because we've had issues in the past with some of the auto-alert, auto-notifications regarding new documents on the Web, please just check the Website probably regularly over the next week to – hopefully, you'll see those documents or specifically, four documents that are going up.

One of them is the newest version of the NGHP user guide which I know a lot of people have been waiting for and then there are three alerts that are also forthcoming. The first is the version of the RRE document or what we refer to as the must report document, this was published initially as a draft for public comment last year and we have that finalized and up on – will be up on the Web page shortly. The other document has to do with – there is – basically, it's an alert to tell you that there are a couple of issues that did not make it into the final user guide this time but those issues will be addressed in future alerts as well. It's an alert for liability insurance, no-fault workers' comp, it specifically goes over a couple of the outstanding issues that we have been talking about for the past few months and concerning field 58 through 62 on the claim input file detail record and on reporting by foreign insurers –

Male: Clinical trial.

John Albert: Oh yes, the clinical trial issues around the risk management activity in clinical trial and the other alert is the document – specifically to answer questions that people had overtime regarding compliance and what CMS uses and being in compliance with the reporting requirements under the NGHP reporting for section 111.

So we're going to pass the microphone around to folks in the room, (Pat) is going to go first followed by (Bill Decker) who will talk about compliance and then (Barbara) will follow up and we will as always, open up the floor to questions.

One thing I wanted to state about the RRE or who has an RRE documents, that if there are still questions that people feel are not being addressed by that latest alert coming out that you need to resubmit those questions, you may have thought that you – even if you think that you submitted that question before, we need to have that question resubmitted if you feel this new document which again is imminently forthcoming, doesn't address your particular concern because you know, obviously, nothing is ever truly final but at the same time, we want to make sure that if we did miss something, even though we did – we don't think we did because we have received an awful lot of input – feedback on the first document to basically go into this latest version, we want to make sure that we can answer those questions so with that, I'll turn it over to (Pat).

(Pat Ambrose): Thanks (John).

This is (Pat Ambrose), I have a few announcements of a technical nature based on the extension for initial production file reporting for non-group health plan or NGHP claims input file submission. First off, as you know, the NGHP technical call scheduled for last month was canceled due to weather issues, there is a new NGHP technical call scheduled for March 11, 2010. The call on March 16 which was originally going to deal with the technical issues has been – or is being changed to deal with policy issues.

So on March 11, there will be a NGHP technical call and on March 16, there will be another NGHP policy call. As (John) mentioned, we are in the midst of updating the Website with various postings, one being version 3.0 of the NGHP section 111 NGHP user guides, in the past, in some cases, notices for updates to the Websites have not been received, you don't have to sign up again to receive those notices, we are working through issues, we're aware that the notifications were not always going out and we are working through those issues but as (John) said, you should check the Website frequently especially in the coming days to look for these updated user guide and other alerts.

All changes in information provided in previous calls and alert has been added to the guide. However, the information on the definition of a non-GHP RRE

and the other alerts that (John) was discussing that were in the queue for posting have not been included in the user guide, in particular, section 7.1 of the user guide has not been updated with that "Who is an RRE?" information so you must refer not only to the user guide but to the alert for this information. That information will be added at a later date.

Even though some of these policy changes have not been included in version 3.0 of the user guide, the date changes for reporting are included in there.

Now, I'm going to go over some of the changes to reporting dates that will affect your submission of claims input files, RREs have until they are signed, file submission time frames in the first quarter of 2011, that's January to March 2011 to submit their first production claim input file. However, RREs make mass production claim input file reporting prior to January 2011 as soon as testing is completed and their RRE ID has been moved for production status, we also ask that you wait to submit production files until after April 1, 2010.

And again, I remind you that no matter what quarter you are reporting in, whether it's before January 2011 or subsequent all-year production files, claim input files, monthly submitted during your assigned file submission timeframe for the applicable quarter.

Some other changes related to TPOC reporting. RREs are required to report TPOC amounts with TPOC dates October 1, 2010 and subsequent according to the interim reporting thresholds as specified in section 11.4 TPOCs with earlier TPOC dates will be accepted, the dates and amounts of the interim reporting thresholds have not changed.

And again, the TPOC is the Total Payment Obligation to the Claimant and is spelled TPOC just for transcript purposes. RREs are required to report claims on which ongoing responsibility for medical, also known as ORM exists as of January 1, 2010 and subsequent, regardless of the day of an initial acceptance of payment responsibility. Also, the special qualified reporting exception in section 11.9 was modified. Earlier reports that ORM will be accepted but you

are not required to report unless the ORM existed as of January 1, 2010 and subsequent.

The special reporting extension of ORM in section 11.9 was removed, this allowed more time to report old ORMs, if this extension is not needed given the new reporting dates.

The special qualified reporting exception for ORM is prior to July 1, 2009 which continues through to July 2009 that was in the former version of the user guidance section 11.1 – 9 rather, has changed. It now reads essentially the following. It concerns ORM that was assumed prior to January 1, 2010. If the claim was actively closed or removed from current claims, records prior to January 1, 2010, the RRE is not required to identify and report that ORM.

Just report ORM unclaimed that was considered open as of January 1, 2010 and subsequent regardless of when ORM was assumed. You may again report older ORM claims with – older claims with ORM if you so choose in any case, if the ORM is later reopened, the claim is later re-opened for ongoing responsibility for medical or TPOC amounts, then an RRE is required to report that.

So the TPOC dates, again, has changed to October 1, 2010 to allow then full reporting of the quarter's worth of TPOC amounts when you finally report your productions – initial production files or when you're required to report your initial production files in the first calendar quarter of 2011 and the ORM date has moved to January 1, 2010.

I also want to cover some changes related to ICD-9 requirements. We have made an attempt to make these requirements simpler, these are the changes that we're making, no V, V as I Victor, no ICD-9 codes beginning with the letter V may be supplied in the ICD-9 Diagnosis code fields one through 19. These are the fields starting in field 19 and continuing to field 55 on the record.

In addition, no E code, E as in Edward, no ICD-9 codes beginning with the letter E will be allowed in the diagnosis codes 1-19 field – the list of insufficient codes that was in appendix H has now been changed to a list of

excluded codes, it is assumed that all V codes, V as in Victor codes are excluded, they are not listed succinctly in this list anymore and the remaining fields are rather values that were listed in that appendix are now considered excluded codes both for the alleged cause fields in field 15 and for the ICD-9 diagnosis codes, fields 1-19.

We are still using the last three versions of valid codes on the CMS Website as before and you can find that information in the alert that was posted at the end of December, beginning of January. You may only use the description fields, the description of injury or illness field 57until January 1, 2011. That field will still be going away as of January 1, 2011 so if you submit productions or test files prior to January 1, 2011, you may use field 57,that field will be ignored as of January 1, 2011.

Some other notes related to ICD-9 that hopefully will help you complete and submit these fields, both the alleged cause and the ICD-9 diagnosis codes 1-19 maybe derived by the RRE. They may be pulled from medical claim that you have submitted to the RRE but they don't have to be pulled from actual medical claims. The code submitted does not have to be official diagnoses made by a doctor or a hospital or other supplier of medical services. These codes are just used to describe the cause and nature of the injuries. The codes are used by Medicare to match related claims but do not have to be an exact match.

As of January 1, 2011, the alleged cause, field 15 and at least one ICD-9 diagnosis code, one is required and again, field 57, the description of the injury illness will be ignored. The requirements for the alleged cause, field 15 have gone unchanged and they are as such. The code submitted in field 15 must begin with the letter E; they must be an E ICD-9 diagnosis code.

They also must be considered a valid code. Again, referring to those last three versions of valid ICD-9 codes that are submitted or that are available on the CMS Website. And the codes cannot be an excluded code found in appendix H.

The ICD-9 diagnosis code fields one through 19 must be valid codes. Again, on one of the three of the most recent versions of valid CMS ICD-9 diagnosis codes, the ICD-9 diagnosis code fields one through 19 cannot be an E code and it cannot be a V code. No E code and no V codes, E as in Edward and V as in Victor, cannot be submitted in ICD-9 diagnosis codes one through 19.

In addition, ICD-9 diagnosis code one through 19 cannot be an excluded code, you may not use any of the codes that are listed in the new appendix H and at least one of these codes is required. As always, if any ICD-9 field is invalid, the entire record is rejected even if one valid code is supplied in another field.

You're encouraged to submit as any ICD-9 diagnosis codes, codes that you can, in fields one through 19, live on as they follow those rule, and they're all valid.

One last announcement. As of Friday – so as of Monday, March 1, 2010, new files of the error codes and the excluded codes that will be in appendix H of the user guide will be posted on the – excuse me – section 111, COB secure Website. Those downloadable files that are in Excel format and text formats will be available as of Monday, March 1, 2010for download and will correspond to what is found in the appendices of the user guide version 3.0.

OK, that's all I have and I think I'm turning it over to (Barbara Wright) – to (Bill Decker), I was confused.

(Bill Decker): OK, (Pat). Hi, everybody. Thank you.

My name is (Bill Decker) and I'm also at CMS here in Baltimore. Welcome to this NGHP policy call. I'm going to describe to you one of the most (interest) going up in the Website, it's what we call the compliance alert. All of these documents that we're discussing today as (John) mentioned before, our – in the queue, could be posted on the Website.

We thought that perhaps they would be posted by now, I didn’t check the Website before I came to this meeting and they are great and if they're not ((inaudible)) they're (shortlisted) and we got that closed. This is no longer a

situation which we're working on getting these documents ready for posting and are in queue for posting and will be arriving shortly on your doorstep.

The alert I'm going to talk about is going up ((inaudible)) with the rest of documentation is what we call the compliance alert, it is an alert for liability insurers to describe for them what it needs to be in compliance with the section 111 reporting and I will read you just a piece of this alert, it's only a two-page – actually, a three page alert, it goes into some detail but the bottom line as we like to say here, is if – to be in compliance with section 111 reporting, in general, section 111 NGHP RRE will be compliant with its section 111 reporting requirements. If it registers for reporting with the CMS coordination of benefits contractor and once registered, the RRE engages in data exchange testing with the CODC and once testing is completed, the RRE begins and continues with regular section 111 production data exchanges with the COBC.

By doing this, we are able then to be participating in the section 111 process in the manner prescribed by CMS and that will keep you in compliance with the section 111 reporting requirements. This is described in some detail in the alert and in more detail in the user guide and we can certainly discuss it in a little more today if you wish to and we have – I was just passed a note, I will get to that in a second.

We'll certainly be able to discuss this in the question and answer period at the end, the note that was just given to me was that if this does predicate a course, in the exchange of data with us that the data is actually the accurate data, and if you insist on sending us inaccurate production data for example, we may choose not to keep you in compliance and thus – we do want to point out that the point here is that you register your tests, you send in production files and as long as you're doing that, you will be in compliance, you don't need to keep questioning us as to – if you make a mistake, does that make you out of compliance and if you are late or if you are early, if you – locations, how does that affect your compliance? As long as you continue to register the test and then at the end of the process, have accurate production files and that's all I have and I will now turn it over to (Barbara Wright). Thank you.

(Barbara Wright): Thank you, (Bill). My name is (Barbara Wright). I'd like to – before I talk about the alert that has to do with who must report, I have a couple of other points. The alert that's out that talks about some areas that are on hold from your perspective until we have additional directions, one of the things it doesn't mention is periodic payments for workers' comp or no fault. That has not been updated in version 3 of the NGHP guide; we do expect to have that relatively shortly.

Secondly, with respect to fields 58 to 62, there was already an alert issued about these fields saying they were not to be used until we have further instructions. We had a number of questions that concerned particularly with some of the cases where there may or may not be technically considered mass torts but situations where there may be a settlement prior to the actual identification of who will be paid or how much each person will be paid. We are working on an alert to address just those specific issues and that should be out relatively quickly too.

A third point about alerts is that we received a couple of comments and calls within the last week or two where people are saying well, it was only in an alert, it wasn't in your user guide on the Website and we want to make it clear that absent some specific statement by us that an alert is a draft as was the one for RREs for 731, alerts do contain final instructions and how we use them is to supplement any version of the user guide until we can do a new version.

Otherwise, we could be churning out a new 220 or 250 page document almost weekly and we can't do that, we don't think that's what you want to receive. The three alerts that we were talking about today, all of those, you'll notice, when you get them that they have a date subsequent to the revised version of the user guide. They do in fact, supplement that and you should, as (Pat) said, you need to read them in connection with the user guide.

Last, in terms of registration, foreign insurers – we have received some concern about, I believe that foreign insurers must register by 04/01/2010 and actually, that's the first that they can start to register since the new deadlines require production files in the first quarter of 2011, that means entities need to be registered no later than September so that they can have a full quarter of

testing before they need to do production files. They're certainly encouraged to register as soon as you can but to the extent a foreign insurer has an issue because they are waiting for some further directions that we're issuing, know that you are not required to be registered by 04/01.

With respect to the alert about who must report. We're going to go over – the general issue – the biggest issue that affects everyone in the largest number of questions and then I'm going to hit some other points in this alert.

First of all, what we got in response to the July 31 draft is the overwhelming number of questions that came in is issues that were all related to situations where there was a deductible and who had to pay – who had to report for the deductible versus any amount in excess of the deductible, et cetera.

And we made a major change in this regard and situations where at the self insurance is only a deductible, when you are talking about the deductible, the deductible, is going to be reported by the insurer. The insurer will be responsible for the deductible reporting for the deductible and any amount in excess of the deductible.

If you have self insurance that is other than that, for instance, if you have a self0insured retention then that will need to be reported by the entity that self ensured but this means that if you have a situation where your insurance is solely through a policy and your only possibility of reporting before was that you would have some responsibility for reporting a deductible, you no longer would have to register a report if that were your only situation.

So that is really the biggest change and it does affect or address pretty much the bulk of the questions we received. Some of the other areas in this is the section that we had on corporate structure and responsible reporting entries, that section is remaining basically the same, if you have a situation where you have self insurance that is other than a deductible, then you may still have situations where you want to register other than at the insurer level. You may want to register higher in a corporate entity but you are not required to do so.

We heard from several different entities and different groups there still seem to be continuing confusion over deductible versus the concept of self-insured

retention so in this alert, we state that deductible refers to the risk of the insured retains with respect to the coverage provided by the insurer, self insured retention refers to the risks the insurer retains that is not included in the coverage provided by the insurer and while for most of us, we believe this was self evident that everyone should have known it, and there were clearly those that were coming in with questions where they were mixing those two concepts up so we did put something in the document.

Also, with respect to payment, many of the comments that came in were assuming the term payments in the context of who's an RRE referred to who was funding something versus actual physical payment. Despite the fact that the documents did not define it that way, this alert will – now specifically says when referring to payment of an ORM or TPOC, in this who must report section, the references to actual physical payment rather than the who or which entity ultimately funds the payment.

Fronting policies, the same type of issues, the same type of position we took before, we believe the language is a little bit clear what it says now is the intent with fronting policies is that the insurer will not ultimately retain any risks under the insurance policy, the expectation of both the insured and the insurer is that the insured will retain the ultimate risk under the insurance policy for all claims where the insured pays the claim, the insured is the RRE, where the insurer pays the claim, the insurer is the RRE. So that is an instance where your physical payment issue comes into play.

Multiple dependants. We continue to get questions about situations and will repeat what we said before, is where there is joint and several liabilities under a settlement judgment, reward or other payment, then each entity must report and they must report the total amount.

If you have multiple dependants and they have individual settlements, then they are each responsible for reporting with respect to their own settlement. Self insurance pools. We received a number of comments in this area, there are entities that would like to be the RRE and are a self-insurance pool or JPA but did not qualify under our draft language. We have not changed the three characteristics that we had in the July 31, 2009 alert, what we did put in

though was a specific language that makes it clear that where the statute authorizing the establishment of a self insurance pool stipulates that the said self-insurance pool shall be licensed and regulated in the same manner as liability insurance or workers compensation where applicable then the self insurance pool is the RRE.

Absent meeting this exception unless all three of the characteristics specified that we had in the 7/31 draft, then the participating self insured entity is the RRE. Another point we added with respect to self insurance pool is people were concerned about what we meant by being involved in resolving claims. We've got language that says the self insured pool resolves and pays claims without review or approval authority by the participating self-insured entities.

We have defined reviewer approval authority a meaning that the self-insured entity has the ability to affect the payment or other terms the settlement, judgment, reward or other payments including ORM. So if for instance, the only power the self insured entity has is an auditing function that if they disagree with the ultimate payout, it doesn't affect the terms that the settlement that (John) acts, it may affect the reimbursement to the JPA itself in terms of how they're paid or otherwise reimbursed for the actions they've taken but it doesn't affect the individual settlements then in that case, we would not consider that review approval authority that we'd try to draw a distinction between when it affects the particular claim and when it doesn't.

We were asked – there is still a part in the draft where we talk about reinsurance, stop-loss insurance, excess insurance, umbrella insurance, guaranteed funds, patient compensation, et cetera and we are talking about these as being situations where that type of policy or situation has responsibility beyond a certain limit that the key is whether or not payment is to the injured claimant/representative of the injured claimant versus payment to the self insured entity to reimburse that self insured entity.

We kept that same language, but what we did add based on some comments from the industry is they asked us specifically to address subrogation lien insurer, so we've made it clear that if an insurer pays a claim of the insurer under the terms of the contract, the insurer is the RRE and they report that

payment. If that insurer then files a subrogation claim on behalf of its insurer or the injured party against another insurer and is indemnified by the second insurer, the indemnification payment is not reportable by either insurer.

State assigned, date established, assigned claims fund, what we did again in there, we kept our language consistent talking about review or approval authority in terms of what that means, otherwise in general, the language remained pretty much the same.

We did change appendix G which has definitions and reporting responsibilities. The paragraph that deals with liability insurance, the second paragraph under that, we deleted a particular sentence and similarly with respect to the paragraph dealing with the Workers' Compensation (LAR) plan, we deleted the last few sentences, these are both tied in to the decision to lump the deductible in with any amount above the deductible and make all of our language consistent, you'll see in the alert that we include a copy of the revised appendix so that you have it.

The result, a part of this is the discussion under Workers' Compensation is short somewhat and makes it clear that when you essentially have a similar compensation plan established by an employer in that situation, you're either going to follow the rules for the insurer or the self insured and if you have a situation where the (LAR) plan authorizes the employer to purchase insurance, standard rules for insurance apply. The same thing for self insurance so that what you'll really be concentrating on in the discussion under Workers' Compensation (LAR) plan is the situations where the applicable (LAR) plan specifically establishes a state or federal agency and what that means in many cases.

Those are pretty much the big changes in the alerts, (John), does anyone else have anything before we go to questions and answers?

John Albert: Just a follow up to the no discussion by compliance, again, the – one of the reasons for the delay in reporting is we want to make sure that we can get as many people in compliance before reporting, actually we can recognize that there have been some difficulties with testing, et cetera and again, the purpose

of these delays and other exceptions and things like that that we've done over the past two years is that we do want to make sure that we build an efficient data exchange process that has minimal impact as possible to all involved and we also, again, are not as interested in civil monetary penalties as we are a good clean data exchange so I will again reiterate that over and over and over again.

That is the purpose of all the material that has been published to data and the continued guidance that you will receive and as you can – you should be able to tell from reading materials when they're up on the Website over the next day or so, we do take your questions in and we do pay attention to them and we value your input and we want to make sure that it's clear to as many as possible and so ((inaudible)) I wanted to state and with that, operator, can you turn it over to the questions.

Operator: At this time, I would like to remind everyone, in order to ask a question, press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from (Werbach Adjustas) from (Disney). Your line is open.

(Werbach Adjustas): Yes, my question is actually answered with the update. But my second question is, I may have missed this but are the filter amounts changed, with TPOC and it's currently $5,000, is that going to be modified and updated in the user guide?

(Pat Ambrose): Those are remaining the same with the same dates.

(Werbach Adjustas): OK, thank you.

Operator: Your next question comes from (Nancy Riley) from (John G. Stern), your line is open.

(Nancy Riley): Thank you, I have actually a couple of questions but they're all having to do with TPOC. The first question has to do with the delayed start date, we don't really understand what that means and if we settle at a mediation but we don't

actually issue the check until maybe two months later when the judge signs the order, do we report…

(Pat Ambrose): You need to look at how the TPOC date is defined in the record layout.

(Nancy Riley): We tried and it doesn't make any– it doesn't compute in our minds.

(Pat Ambrose): Maybe if you finish giving your example, (Barbara) can answer that particular, so…

(Nancy Riley): OK.

(Pat Ambrose): An agreement has been reached but must be signed by…

(Nancy Riley): It must be signed by the judge of compensation claim. So let's say we went to a mediation on January 10. We've reached an agreement to settle the claim for $50,000, our attorney then prepared the documents and sends them to the claimant attorney for signature and then it goes to the judge and all that process takes probably 30to 60 days. Would we report the January 28 mediation as the TPOC dates and project 03/28 as the delayed start date?

(Barbara Wright): I believe we said in the definition and I'm looking for the field number right now that where…

(Nancy Riley): It's 101 I believe.

(Barbara Wright): …where a court approval is required it's the date when court approval is received.

(Nancy Riley): When would we use the delayed start date? We don't…

(Barbara Wright): You mean the delayed funding dates?

(Nancy Riley): Yes.

(Barbara Wright): That was one of the things that ties in the fields 58 through 62 and…

(Nancy Riley): OK.

(Barbara Wright): And when we're able to do an alert, hopefully no more than two weeks and as we said publicly in a work group, so this isn't new, what we're looking at with respect to – it will largely apply mainly to what technically would be amassed towards a specific situations where there may be a settlement judgment award but that settlement has the ability for the people that will actually receive money to be identified subsequent to the settlement and the amount that's to be paid is identified subsequent to the settlement.

We're looking – it's not final yet but where we said we're moving toward is doing a separate instruction that makes it clear that no one reports for NGHP or TPOC payments until you have identified who the person is that will be paid and how much they'll be paid and with that, the need to use the delayed funding field in general will probably be largely go away and in fact….

(Nancy Riley): OK.

(Barbara Wright): …it will end up rarely used and so that's what we're working on right now and I hope that…

(Nancy Riley): That helps a lot.

(Barbara Wright): The next alert should answer, I think, your questions.

(Nancy Riley): OK.

(Pat Ambrose): But generally speaking, is it true (Barbara) that you should not have occasion to use the funding delay beyond TPOC's start date field really much anymore at all.

(Barbara Wright): I think that's true but we need to make it clear in…

(Pat Ambrose): Right.

(Barbara Wright): You know, the next discussion of these fields.

(Nancy Riley): OK, and can I ask one more question in reference to TPOC?

If we have – let's say denied a body part, and then we go to a hearing and we're ordered to pay that for that body part, we're accepting other body parts, we've got an accepted claim, we're paying on it, we've got ORM, and we pay the lump sum for that back benefit, is that a TPOC or is that just part of ORM?

(Pat Ambrose): That would still be – if that lump sum still reflects the individual medical services claims, it's really a part of ORM that you should have reported. What you want to do is send an update record with an additional diagnosis code to include the new body part and I think, (Barbara), correct me if I'm wrong, the sort of catch up amount is really just additional ORM that you should have paid and it does not have to be reported as a separate TPOC.

(Barbara Wright): No, to agree with what (Pat) said, I would have to assume that it's a situation where you still got ongoing responsibility for medical. If you have a situation where you're doing a TPOC to close the record out to – at the commutation of future medicals et cetera, then you're into reporting a TPOC, but if it's one where it's connected with the ongoing responsibility for medicals and you're going to continue to pay that, then report the ongoing responsibility for medical.

(Nancy Riley): And what if we reached an agreement to wash away a body part that we are never going to pay for again, we're still going with ongoing responsibility for other parts, but this one body part is not going to be paid but we give them a lump sum to go away.

(Barbara Wright): And that is the TPOC for that body part so you would have to report the TPOC as well as the ORM.

(Pat Ambrose): Yes, and you would report that by an update record still with the ORM indicator equals Y….

(Nancy Riley): OK.

(Pat Ambrose): And then fill out the set of TPOC fields for that lump sum, so….

(Nancy Riley): OK, thank you very much.

Operator: Your next question comes from (Teresa Wilcox) from Desert Mutual. Your line is open.

(Teresa Wilcox): Thank you, we have questions around representative, if our injured party is under 18, we pay the parent, is the parent considered a representative?

(Pat Ambrose): They are a representative but if you have both like a parent representative or an attorney whose really representing the child on behalf of the parent, we need to know about that attorney and the only time you use the claimant field is when the actual injured party is deceased.

(Teresa Wilcox): Right. We do understand that, we just weren't sure if we're paying the parent, there's no attorney involved whatsoever, is the parent considered a representative.

(Pat Ambrose): The parent would be the representative, yes.

(Teresa Wilcox): It has to be reported as such.

(Pat Ambrose): Yes.

(Teresa Wilcox): OK, and then if the child was injured at age 17 and ages out before the ORM is over, they're at 18, do we have to send an update that the parent is no longer the representative, is…

(Pat Ambrose): Please check the event table to see whether that's a change in the field that would trigger an alert, I mean an update.

Also remember that you're only reporting for someone who is or at some point was – you got –they are or were a Medicare beneficiary, it is rare that someone who is under 18 is a Medicare beneficiary, it is rare that someone who is under 18 is a Medicare beneficiary typically, if they are, that's only through ESRD which tends to be a group health plan issue, not a liability no-fault or Workers' Compensation.

So that actual situation you described, I would expect to be pretty rare.

(Teresa Wilcox): We just wanted to account for it to make sure.

(Pat Ambrose): And I've gotten myself to the event table and that change in representative is – does not trigger an update requirement, you may submit an update but you don't have to.

(Teresa Wilcox): OK.

And then at a previous meeting, we did hear that the ORM has to be a minimum of 30 days, that's correct, so even if we – if they get the whole bundle of money within the first 30 days, we still have to say they were ORM for 30 days.

(Pat Ambrose): Yes. And the new version of the user guide does address that.

(Teresa Wilcox): OK.

(Pat Ambrose): and provides you with instructions on what to do in that circumstance. Basically, we are recommending at 31 days to the date of incident, plug that into the ORM termination date and then if it's a no-fault claim, to allow the applicable no-fault related policy limit fields and when the policy limit was reached, and there is no 30 day requirement related to the no-fault policy limit.

(Teresa Wilcox): There is no 30-day requirement related to the no-fault, OK.

(Pat Ambrose): Yes, there are separate fields for…

((Teresa Wilcox): The exhaust amount.

(Pat Ambrose): Yes, the exhaust amount and when the policy limits were exhausted and you are to provide us a date for that in a field on the record and that can be the actual date that it was reached.

(Teresa Wilcox): Right, OK. That's going to be the actual date, that one doesn't have to be 30 days.

(Pat Ambrose): Right.

(Teresa Wilcox): So that actually brings up another question for us, we have planned to – when they exhausted the benefit, the ORM date, the ORM term date, is that correct or incorrect?

And we have a three-year window, you get hurt, you have three year for your bills, if they meet that $15,000 within a year, that…

(Pat Ambrose): But generally, speaking….

(Teresa Wilcox): That's the end of it.

We no longer have any obligation to that person so we plan to update the ORM term date as of the year instead of the three year.

(Pat Ambrose): Yes.

(Teresa Wilcox): That's correct? OK.

John Albert: Yes.

(Teresa Wilcox): Other than when it's within the 30 days?

(Pat Ambrose): Yes, it's just, you know, yes, we do want the actual ORM termination date and the situation you described does reflect an actual termination of your ongoing responsibility for medical.

(Teresa Wilcox): Right.

(Pat Ambrose): It's just that the exceptional case of when it's less than 30 days, and that's a – just some requirements on for a system we interface with and we just need to find a way to in a sense, get around that.

(Teresa Wilcox): OK, and so. I think we also – a slight bit of confusion around if a person dies the same day they are injured, we had planned to report that as an ORM because we have the ongoing responsibility for medical for whatever there was before they died, you know, ambulance, whatever, doctor, and I'm wondering now if that's valid. If someone – they died the same day they are injured, is there an ORM situation or is it only a TPOC situation.

Male: If you have accepted responsibility, yes, but then if you subsequently have a TPOC, you need to report that too in case we have in fact paid some claims.

(Teresa Wilcox): OK. All right, I think that answers all the questions I have. Thank you very much.

Operator: Your next question comes from (Nikki Long) from LWCC. Your line is open.

(Nikki Long): Hi, I have a question about the extract file. If an extract file, w e send a claim and it comes back to us with an SP disposition code, for the next extract file, I know that we're supposed to resend that claim but what if in the time being, we actually had to delete that record because of some reason, let's just say it's not Medicare eligible, the claimant is not Medicare eligible any longer, do you expect us to send a delete?

(Pat Ambrose): No. You only need to delete records that were originally accepted or previously accepted with a 01 or 02 disposition code.

(Nikki Long): OK.

(Pat Ambrose): If in the time being between receiving the SP and when you get to submit your next file, if you realize that you need to submit that claim record at all, just don't submit it.

(Nikki Long): OK. So you all won't be tracking that or anything like that? That was my main thing.

(Pat Ambrose): Correct. We do not save the SP.

(Nikki Long): And obviously if we didn't get an SP, if it went through it, we will send a delete on the next record as it needs to.

(Pat Ambrose): Yeah.

(Nikki Long): OK, perfect. Thank you.

Operator: Your next question comes from (Allen Wells) from Reliance Insurance Company. Your line is open.

(Ken Shestak): Actually this is (Ken Shestak) from Reliance. I had a little confusion over Barbara's description as far as large deductibles under Worker's Comp and who is responsible to report and who is not. As I understood it, you said that the under a large deductible where the claim responsibility falls with the insurer, the insurer has to report. But then you later said that the physical payment determines reporting requirements. A lot of large deductibles are funded by the insured but the actual under policy terms the responsibility of the insurer. I am a little confused as to who is supposed to report that.

(Barbara Wright): OK, two separate things. If it is deductible and we distinguish for you deductible versus self-insured retention or reinsurance, et cetera. If it is a deductible, it is the always the insurer's responsibility to report whether it is a large deductible or small deductible. It if it is reinsurance self-insured – if it is reinsurance or stop-loss insurance, excess insurance, etcetera, there it is physical payment. If the reinsurer is simply paying the insured and insured is the one that is paying the claimant then the self-insured reports. So, distinguish between whether you're talking about a deductible issue at all or you're talking about a situation that is like reinsurance.

(Ken Shestak): I see. Now, we're actually in liquidation, so the insured under deductible plans have the responsibility to pay the losses and only report them to us so we only reimburse them when that loss exceeds the deductible.

(Barbara Wright): We just said we have a change in policy. If it is the deductible, it is the insurer's responsibility. It is not the insured's responsibility for…

(Ken Shestak): We don't have to…

(Barbara Wright): That is what is in the draft.

(Ken Shestak): OK. Thank you.

Operator: Your next question comes from (John Spellman) from Nationwide Indemnity. Your line is open.

(John Spellman): Thank you. First of all, I wanted to point out that taking a first quick look at the alert, I think the definition that change in or the change in the reporting definition at the end of the alert says that where deductibles or copayments are physically being made by the insurance company rather than the self-insured entity then the liability insurance company reports everything, the deductible and everything else, but…

(Barbara Wright): Excuse me. Could you tell me which alert you're talking about? Are your talking about the one dated February 24?

(John Spellman): Yes, the one dated February 24th.

(Barbara Wright): Do we have a major typo here? What page are you talking about, please?

(John Spellman): I am on page 11, excuse me, page 12, the last page.

(Pat Ambrose): Yes, while you're getting there, the alerts have made it to the Website, not yet the user guide but it's definitely on its way.

(Barbara Wright): OK, we may need to revise further that definition. The intent was to fix it for deductibles period. The intent of this alert is where there are deductibles; they are reportable by the insurer, period.

(John Spellman): OK. Well, I actually had a…

(Barbara Wright): Yeah. I can see where it is not clear that we did not take out enough there, so we will have to get something out on that very quickly but…

Man: You want to repeat once again about the deductibles just to make sure every one's clear about it.

(Barbara Wright): The major trust of this alert is that where you are talking about a deductible versus self-insured retention. If it is deductible, both the deductible on any amount of above the deductible are reportable by the insurer.

(John Spellman): OK. Regardless of who pays it?

(Barbara Wright): Yeah. And probably, I need to think about it, go back look there's a good chance we should have just deleted that old paragraph that you're referring to.

(John Spellman): OK, well…

(Barbara Wright): I will go back and look at it.

(John Spellman): I have a, maybe a little, related question in regard to a situation that comes up especially in terms of asbestos claims. There a number of large companies that have insurers but they handle all the claims themselves. They hire the lawyers, they defend the claims, they pay the settlements, and then they send out a bill for reimbursement to their reinsurers. So, they are doing the physical payment of the settlement, let's say, and then they later get reimbursement periodically from their insurers.

(Barbara Wright): And if it under insurance, then that is going to be the insurer's responsibility to report.

They may, again, we've given – we've said that any entity can use who it wants in terms of its agent and if it is in a situation such as you described, I would guess that the insurer most likely would be using the insured as their agent for actual reporting but we certainly, we don't mandate that, we don't have any say in that whatsoever.

(John Spellman): Yeah. OK. So, that's a significant change from the way things were before this alert came out because…

(Barbara Wright): But the problem with the way it was before was it was getting financially greater in terms of examples where the slightest little new ones change who would report and there was no real way to cover all those with examples or it appeared from the questions came in get any consistent set of understanding in terms of had to be the RRE and we needed some way to make it a more bright-line rule that everybody could understand.

(John Spellman): OK. So, notwithstanding the change in the definition of payment to actual physical payment if even if the actual physical payment is being made by the insured who later gets reimbursed, it's still the insurer that has to report.

(Barbara Wright): Right. Well, what's done – if you look at the alert and you go to page 4 or it's the deductible issues versus reinsurance stop-loss, et cetera; essentially, what we've tried to make it clear is that if you've got the policy then it's always been – if it is covered under the policy, it's always the insurer. Only when you get into stop-loss, excess, umbrella, does the physical payment come in to play.

Obviously, this audience has not had a chance to read this since it has gone up, we will repeat what we've said in the beginning. If after reading this you believe that there is a point that is not clear, like the situation you just pointed in Appendix G where we apparently missed something, please submit your questions to our resource mailbox.

(John Spellman): OK. Thank you.

Operator: Your next question comes from (Victoria Vance) from Tucker Ellis & West. Your line is open.

(Victoria Vance): Good afternoon. Thank you very much for all the effort you've put in to revising and responding to everyone's concerns. I have a quick question regarding, well, two situations.

First, in the situation of the mass torts, are you going to be clarifying the definitions of exposure and exposure dates? I know this is something we talked about during our mass tort working group calls, I know it's something that has been worked on…

(Barbara Wright): That issue is still on the list. Yes.

(Victoria Vance): And in the second question I have regards of switching gears completely, I have a client who engages in helping ((inaudible)) patients in a hospital setting or in a healthcare setting by offering and agreeing to provide upon request payment of these individuals out-of-pocket expenses, perhaps for medical care or offering to provide such services as helping somebody out with maybe, gardening services because they're laid up due to an injury or having somebody come in and do housecleaning because of some inability. There

offers are provided not in exchange for release. There is no formal claim. There is no litigation. Often, no attorneys are involved; really they do this as gestures to maintain that the spirit of good patient relations if you will. Is that kind of a transaction or exchange something that you view as a reportable event?

(Barbara Wright): As John said at the beginning of this call, we are going to be addressing risk management write offset and issues separately.

(Victoria Vance): And I think the point that I just want to up bring up about this situation is unlike other write offset, I've seen and I've experienced where in change for the payment, you're asking the injured party or family to concede that they won't sue or to release something. The situation I'm describing is there is no quit pro quo. Nothing is being asked in return. These folks, still as they are, remain dissatisfied could bring a lawsuit. So this isn't a situation of a release, and I know that that is one of the terms that is a term of ((inaudible)) Section 111 reporting. No releases are being utilized here. This is just really gestures and offers.

(Barbara Wright): Let me reiterate a couple of points we've made over last number of months. First of all, there doesn't need to be any admission or determination of liability in order for there to be an MSP situation. The statutes specifically say where there is a demonstration of primary payment responsibility by comprises release, et cetera, or otherwise, it does not require a release for there to be an MSP situation.

For example, one of the things we've put in the TPOC date is that the TPOC date can be the date of the check where there is no separate release, et cetera. So, we clearly understand that whether it is risk management or something else, there are instances where it is an MSP situation without their having to be a form of claim or a formal release. Having said all that, we're back to the point that one of the alerts that was in the queue and may be up is the one on RREs is a statement that with respect to risk management activities that we will be issuing further instructions and the alert states that the RREs do not need to report information related to these activities until the forthcoming guidance is published.

(Victoria Vance): Very good. Thank you Barbara, I appreciate it.

Operator: Your next question comes from (Joanne Rosendin) from Sack Rosendin. Your line is open.

(Joanne Rosendin): Thank you. I have a question regarding the February 16 alert delaying the implementation of the mandatory reporting requirement. Does that also mean that the monetary threshold to match for the TPOCs aren't being triggered until 2011 as well as opposed to 2010?

(Pat Ambrose): Perhaps you missed what I announced at the beginning of the call. This is (Pat Ambrose). Your initial claim input file is not required until January or the first quarter during your assigned-file submission timeframe of first quarter 2011, January to March. However, TPOC announced dated October 1, 2010 and subsequent must be reported and ORM must be retroactively reported back to January 1, 2010. So, the dates related to ORM and TPOC have changed, that will be in the updated user guide that is in the process of being loaded to the Website right now.

(Barbara Wright): But additionally, thresholds remain the same.

(Pat Ambrose): They do. The dates related to the threshold and the logic behind there is a correction made to the threshold because it is that less than instead of less than or equal to, but other than that the thresholds are exactly the same.

(Joanne Rosendin): OK, thanks for clarifying. I also have a question I wanted to ask Barbara. Barbara, is there going to be another mass tort community meeting scheduled at anytime in the future?

(Barbara Wright): We may have further meeting particularly on the (12-5-80 day) issue, but we don't have any scheduled yet.

(Joanne Rosendin): OK, because I'm on that community and I know there were a number of what we thought were pretty important issues that is still needed to be worked through, so we were kind of hoping there would be more meetings.

(Barbara Wright): At this point, some of the alerts that have to do with as I said that the basic points about identifying people and ((inaudible)) et cetera so that people can proceed with reporting generally and then, you know, we are working through any other issues that are there and if we would determine for some reason not to have any meetings, I will notify the list of people that I have. And if we are going to have a meeting, of course, I will send out an invitation.

(Joanne Rosendin): Thank you very much.

Operator: Your next question comes from (Katie Fox) from ((inaudible)). Your line is open.

(Katie Fox): Hello, this is (Katie Fox). I did have a one question with respect to the deductable scenario if it is redeductible, I just want to confirm what we've heard and what we're looking at here in the document. If the deductible is funded by the insured and the TPOC amount does not pierce that deductible amount but that still in that scenario be reported as the carrier, even though the carrier may not have knowledge of the claim yet because it hasn't pierced their reporting requirements.

(Barbara Wright): If it's deductible, as part of the policy, whether it exceeds or does not exceed the deductible, it is the insurer's responsibility to report. What we do make it clear is if there is a situation where an insured chooses to settle something without recourse to their insurance, then they are self-insured and they are the RRE. And it's also our understanding to the industry in general that as a part of ongoing relationships for insurance any amounts as well as deductibles, there is generally a requirement that the insurer be notified of them.

(Katie Fox): OK, thank you so much. You guys have good day.

Operator: Your next question comes from (Anne Russell) from Forman Perry. Your line is open.

(Anne Russell): Hi! Just to clarify, you all have not yet addressed the claims released on or after December 5, 1980 issue for, you know, in simple asbestos cases, correct?

(Barbara Wright): We have not addressed any further changes to what is in the user guide. You're correct. And so, right now, there is no guidance that you can give us on whether or not you will implement the uncontroverted evidence exception that have been discussed in some the mass tort calls?

(Barbara Wright): No there is nothing to give you right now.

(Anne Russell): OK, thank you.

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

(Keith Bateman): Hi, this is (Keith Bateman). A couple of questions, one, if someone has been granted production status and wants to report prior to the production date, do they have to report all their claims or can they, say, report their Worker's Comp claims but not their liability claims?

(Pat Ambrose): Yes, they could report only one line of business or certain set of claims. There is no requirement to report until January 2011. There is retroactive recording that we discussed earlier related to that, but if in the meantime you only want to report a certain set of claims on you production files, we don't have a problem with that.

Man: We strongly encourage folks to report prior to January if they are ready because as, you know, we found – I mean, a first production file can ((inaudible)) the uncover issue and the sooner that those are identified and resolved, the smoother the actual required production file, which is after January.

(Keith Bateman): Right, and that's why they might want to report just some of their claims to make sure the ones they are most confident with don't have problems.

Man: Yep. You said it better than we could.

(Keith Bateman): By the way, can you give us some rough idea how many RREs have been granted production status?

Man: 800 or something. Yeah, over 800.

(Keith Bateman): Quick one other question, on the low volume option which you said wouldn't be ready before April, is that likely to be ready before 01/01/11?

(Pat Ambrose): I'm sorry. Could you ask that question again?

(Keith Bateman): You were talking about possibly developing an option, reporting option where RREs that have a very low volume of claims, what you said from the call that wasn't going to be ready by April 1st?

(Pat Ambrose): Well, we are working on a direct data entry option.

Man: Right. It won't be ready for this April.

(Keith Bateman): Will it be – do you think, expect it to be ready by 01/01/11?

Man: We can't say for now. It is still at the very beginnings of development.

(Pat Ambrose): But we note that that is important for some of those RREs to know that as soon as possible so I'll make a commitment to try and get that available of that direct data entry in lieu of an actual file and again, it's only for very low volumes that we're going to have to put some strict requirements around it.

(Keith Bateman): Yes. I understand.

(Pat Ambrose): Yeah, and I'm pretty much the same and for the benefit of others that are thinking they don't have to develop a system, but we just aren't prepared to say absolutely when that will be available.

Man: It is a very high priority though for us to make it available.

(Keith Bateman): OK, thank you.

Operator: Your next question comes from (Devin Maddox) from Tressler LLP. Your line is open.

(Devin Maddox): Hi, sorry to do this to you. I have another question regarding the whole reinsurance excess umbrella issue. The confusion, I think, comes from when you say the key in determining whether a reinsurer or an excess carrier would

have to report as when is the payment is made directly to the claimant versus the self-insured entity and that self-insured entity is what confusing me a bit and if I could just give you a quick example that might help.

Let's say a manufacturer is, you know, found liable to pay a Medicare beneficiary or claim, that manufacturer is not self-insured. It has complete coverage through primary and excess insurance. So, it submits its claim to the primary carrier, the primary carrier pays directly to the claimant but the judgment was an excess of the primary's limits. So the manufacturer also submits a claim to the excess carrier now since the primary policies have been exhausted. Now, onto the excess policy, the manufacturer would have to pay it first and then the excess carrier would reimburse the manufacturer.

(Barbara Wright): And in that example, what you said, is that the excess insurance is reimbursing the self-insured entity and it's going to be that be manufacturer that's going to report with respect to that excess insurance.

(Devin Maddox): OK. So that term, self-insured, I think you're using it a little differently in this case that typically, we understand in the insurance industry and that's what I think was throwing me off because technically the manufacturer has complete insurance who is not self-insured but I see what you're saying because it is required to pay first, it's considered self-insured. Is that right?

(Barbara Wright): Generally speaking, I think if you go to the alert, that's one of the reasons we specifically use terms such as excess insurance, re-insurance, et cetera, and hide that to the example. So, you know, the example you gave is exactly what's there. It's excess insurance which is actually being paid to the injured party by the manufacturer and therefore the manufacturer is required to report.

(Devin Maddox): OK, great, and then I just have one more question regarding the date. I know you said the TPOC period for submitting is going to begin in the first quarter of 2011. Now, when does the testing, the mandatory testing, period begin?

(Barbara Wright): As soon as you complete your registration, you can start testing now.

(Devin Maddox): So, registration is available now if you want?

(Pat Ambrose): Absolutely, it has been available since April 2009.

(Devin Maddox): OK. But when, I guess, so when is the last date the insurer can register?

(Pat Ambrose): I would recommend that you do it now because testing can take a significant amount of time. It is said in the user guide that you should register, complete registration in time to allow for a full quarter of testing. I personally would register now and start testing ASAP because it could take you longer than 3 months to complete testing.

(Devin Maddox): OK. Even though when we are required to start submitting files in the first quarter of 2011, we would only be submitting files on TPOC that were made on or after October 1, 2010.

(Barbara Wright): Yeah.

(Devin Maddox): OK… what are the dates now again for the ROM?

(Pat Ambrose): The ORM is January 1st, 2010.

(Barbara Wright): And these dates are still that in the revised user guide which if they haven't made it up there, should be up within the next 24 or 48 hours. As we said, these documents are in cue and as someone said, the RRE alert has obviously gone up since we last checked.

(Devin Maddox): Right. But these file submission are not due for the ORM until the first quarter of 2011 as well?

(Pat Ambrose): That's correct but you have to retroactively report any ORM that was open, active, as of January 1, 2010.

Man: And let me say this too, the production file submission is January 1, 2011. We're testing these to be completed by then.

(Barbara Wright): It's to your advantage as soon that you know that you're going to be an RRE and that you will have something to report. It's to your advantage to register as soon as possible and start taking steps for testing. Completing testing early does not hurt you. Completing testing late is problematic.

(Pat Ambrose): And you can submit earlier dates of ORM and TPOC on test files as well as production for that matter. OK? Next question.

Operator: Yes. Your next question comes from (Sarah Christianson) from (TBC). Your line is open.

(Sarah Christianson): HI, we were just wondering on the last call, you described that if somebody is injured and there is never a settlement, it never goes very far, maybe there's a couple of medical bills and that's it that if your state allows it, you have to report ORM if down the line they become a Medicare beneficiary is the way I understood it.

Now, in Illinois, they don't have a cut off, saying you know, your ORM ended this amount or this date but they do only have three years in their last date of treatment to officially file a claim or they (borrow) from filing it, so that cut off our responsibility?

(Barbara Wright): Yeah…

(Sarah Christianson): OK.

(Pat Ambrose): …and so if that individual is not a Medicare beneficiary at the date of incidence or at the date that you assumed ORM and you would need to monitor that individual for that three-year period and then you could take them off of that and we would certainly want you to stop monitoring them.

(Sarah Christianson): Perfect. That's much better than 20 years. Thank you so much.

(Barbara Wright): Basically, what we've said as you need to look at your state law for when – if you're generally talking Worker's Compensation, you need to look at your state law for when your responsibility ends by statute and we suggested statement, essentially, the individuals position that they would require no assist, further associated treatment if you didn't have a state law that would allow you to terminate it in a relatively short time and it was, you know, minor injury so that you could have at least one other option to not have to do monitoring for 20 or 30 years for very young injured individual.

(Sarah Christianson): Right. Thank you.

Operator: Your next question comes from (Sandra Aisen) from FedEx. Your line is open.

(Sandra Aisen): Thank you. I have a question regarding what I'm envisioning as a potential problem with reporting claims that in all general releases of all potential claims but either no claims were made or the claims brought did not allow recovery from medical expenses. So for example, on page 76 of the user guide, it says if the claim from medical expenses was made or released it is reportable but the examples we have would be like a severance-type agreement with employees where they didn't even bring a claim but they might be facing discipline and we want to terminate the relationship and there's going to be a general release in the special severance payment or they might be like an EEO-type complaint pending and we're severing the relationship but they simply, they might be a Medicare beneficiary but simply have no medical claims.

The other example is wage and hour claims or age discrimination claims where you cannot even get recovery for medical expenses for those types of claims but when we settle, we don't want the employee coming back and suing us for anything so we have a general releases going to release everything that might include claims from medical and psych care even though they have such claims and did not bring such claims. Do we have to report those types of settlements and if so, what is the proper ICD-9 code because there's no injury.

(Barbara Wright): On the list is some of the questions that we're still in the queue on our list to address is to look further at severance and EEO issues, so we are still further looking at that.

(Sandra Aisen): And if I could just comment on that, I think the problem you're potentially going to have is that whoever the contractor is reviewing the data of the reported cases are going be bombarded with, you know, I don't know how many thousands of settlements that are simply a waste of their time because there's just no connection and is it going to expose to us a thousand-dollar-a-

day penalty for settlement that the government would otherwise never know about because it just has no connection and, you know, why would we be penalized for failing to report a settlement that doesn't implicate Medicare benefits at all? Those are just a couple of thoughts maybe to consider and determine.

(Barbara Wright): Well, we're looking at the severance and the EEO type complaints to see what if there's anything that we should issue as specific instructions on those. Again, the reason our touchdown is what's claimed or release is because we do not have to independently establish causation. If there's been medical claim or release and if we have in fact paid for associated medicals, we are entitled to recover for them.

(Sandra Aisen): Right, but if there's no – if they were not claimed, we still have people signing releases that release claims they'd never thought of…

(Barbara Wright): I understand but we can't live it up to the insurers to determine whether or not the person ever had associated medical. If they were always taking cared by insurers, we would never have any recovery claims.

(Sandra Aisen): OK, so I guess then, just the other thing that have to looked at is coming up with some code for us to enter because an ICD-9 code isn't going to work because there is no injury claimed.

(Pat Ambrose): OK, thank you.

(Sandra Aisen): Thank you.

(Pat Ambrose): We will take that under consideration.

(Sandra Aisen): Thank you.

Operator: Your next question comes from (Robin Hope) from Medical Center Hospital. Your line is open.

(Robin Hope): Thank you. I believe my question's already been answered. Thank you very much.

Operator: Your next question comes from (Catherine Wilkerson) from Caterpillar. Your line is open.

(Catherine Wilkerson): This is regarding TPOC payments. If we are in compliance with all of our reporting, we've done everything that we're supposed to do and Medicare then goes, you know, after to claim that payment back from the claimant and you're unable to do so, what happens then?

(Barbara Wright): Well, first of all, as we've said in a number of calls, our standard expectation is that we will be pursuing recoveries against settlements received by individual beneficiaries and if that's the route we take, there is a normal process first of all that gives beneficiaries administrative appeals right if they want to challenge the existence or the amount of the overpayments. There are also statutory and regulatory provisions that have to do with waiver recovery with respect to beneficiaries. There are also instances where the agency entertains compromise requests.

So, there's a whole host of things that goes on when we can't collect and we have no reason to waive or it's not disposed of in an appeal. The Debt Collection Improvement Act of 1996 requires federal agencies to refer debts to Treasury for further collection activities. There are limited instances where CMS has gone back to an insurer or to an attorney particularly if, for instance, an attorney for a beneficiary who ignores CMS's demand, technically, there are some risks under the regulation. Is it any type of standard practice for us to routinely go back to an insurer or attorney or other entity when we've issued the demand to the beneficiary? No.

(Catherine Wilkerson): OK. Thank you. I just have one more question. If we are paying a representative, for instance, if we're paying the attorney which happens a lot in our business, are we responsible to report that?

(Barbara Wright): Who is we? Complainant?

(Catherine Wilkerson): Caterpillar.

(Barbara Wright): Sorry, we can't hear you.

(Catherine Wilkerson): If we have paid, if Caterpillar has paid a TPOC to an attorney of a Medicare beneficiary, are we responsible to report that?

(Barbara Wright): In terms of Section 111 reporting? Absolutely. Again, going back to the issue of whether you're self-insured or you're insured, your insurer – if it's under your policy, the insurers ((inaudible)) self-insured is going to be through you.

(Catherine Wilkerson): Yeah, we are self-insured, so I just wanted to clarify that.

(Barbara Wright): We'll repeat again that this Section 111 provision about reporting does not change or eliminate any other pre-existing obligations or requirements for purposes of Medicare secondary payer to the extent of beneficiaries filing a claim and their attorney wants to know what we've paid in conditional payments to date or something, they need to go through our standard process with our coordination of benefits contractor so that we're already looking information up on claim while it's pending. Additionally, the statute and regulations require our repayment within 60 days.

So, this reporting requirement does not say, hey beneficiary, hey beneficiary's plaintiff attorney, you no longer have any MSP obligations. Section 111 is simply an additional requirement.

(Catherine Wilkerson): OK. Thank you. On ((inaudible)) 58 through 62, earlier I heard you say that they're not to be used until we receive further notice to do so?

(Barbara Wright): Yeah, there was an alert issued in December that specifically states that and version three of the user guide which is what was in queue today makes it clear that those fields aren't used right now.

(Catherine Wilkerson): OK, and then you'll let us know, you said earlier if the mass tort groups again, you'll let us know?

(Barbara Wright): Yes.

(Catherine Wilkerson): If we're originally on the list, correct?

(Barbara Wright): Yes.

(Catherine Wilkerson): OK. Thank you.

Operator: Your next question comes from (Michael Berger) from Risk Management Planning. Your line is open.

(Michael Berger): Yes, I just wanted to point out, I know that the – you just put the February 24th alerts on the alert page, there's three alerts there but the first two links are the same. The first two links on the MMSEA 111 alert page for required reporting and for and GHP RRE compliance, they both refer to the same document. One of those alerts is not there. You have two links to the same document and the first one is not there.

(Pat Ambrose): OK, thank you. We'll check that.

(Michael Berger): OK. Thank you.

Operator: Your next question comes from (Cathy Williamson) from CNH Incorporated. Your line is open.

Again, that's (Cathy Williamson). Your line is open.

(Cathy Williamson): Yes, sorry about that. I had you on mute. I am the account designee for an RRE that would be considered a low volume RRE and I heard the comments made a few minutes ago regarding direct data entry and that CMS was working on the issue and that it was a high priority; however, I'm kind of concern about the testing process and that we are in the testing mode but we haven't began testing.
Can you give me any advices as far as whether we should hold off testing until the direct data entry process is complete?

(Pat Ambrose): Just because you might consider yourself low volume, if you are planning on submitting a file, you should start testing as soon as possible. You know, regardless of your, you know, even if you are considered small or low volume, you may still submit a file in lieu of using this direct data entry option and if you started honestly, your system development for that, you should proceed because we have yet to announce when the direct data entry options will actually be available and you'd want to be ready as soon as possible. But, you

know, we took it as an action item to announce a live date for when the direct data would be available and we'll get back to you as soon as possible.

(Barbara Wright): And as Pat said before, we haven't set thresholds for what's low volume yet.

(Cathy Williamson): Correct. Is that still being currently determined as far as what qualifies as a low volume.

(Pat Ambrose): It absolutely is.

(Cathy Williamson): OK. Do you have any, I mean, do you have kind of rough ides as far what your low volume would considered? Under 10, under 5?

John Albert: This is John. I just need to let everyone know that none of this is final and we cannot even begin to provide leads that may change regarding what those requirements are. We're at the very beginning of attempting to develop this and there is no guarantee whatsoever that this will be even materialize in the end or not. We just want to let everyone know that this is an option consideration just as a courtesy, but again until we release this whole information, we are not providing any additional information at this time on this process because we don't even know what it's going to look like yet.

(Cathy Williamson): And the process you're referring is the direct data entry?

John Albert: Yes.

(Cathy Williamson): OK. Thank you.

John Albert: We appreciate the question, but again nothing is certain until we release official information because there are so many contingencies, you know, that are preventing us from doing this sooner that, you know, there is no point even wasting time. The fact of the matter is that the process that we design is being implemented and we're expecting folks to follow that process until it changes.

Operator: Your next question comes from (Mark Seal) from ISpace Incorporated. Your line is open.

(Mark Seal): Hi, Thank you so much. I have a follow-up question to the scenario of the manufacturer being reimbursed by the excess insurer.

(Barbara Wright): OK.

(Mark Seal): If the payment for the excess amount were made directly to the injured claimant, is the excess insurer then the RRE?

(Barbara Wright): Yes.

(Mark Seal): OK. Is it assumed that because the self-insurer which in this scenario was the manufacturer had made the initial payment for under the excess limit threshold, is it assumed that they have been approved the payment of the claim and by further assumption, do they then have involvement on the excess amount that is paid by the excess carrier and therefore they do not comply with all three characteristics?

(Barbara Wright): I'm not sure where you're getting into three characteristics right now. The three characteristics was something dealing with self insurance pools that wasn't a distinction between someone who has a policy and then has excess insurance or is self-insured and has excess insurance so I'm having a little bit of trouble…

(Mark Seal): Sorry about that. I extended my scenario through that the excess carries without saying it first, is in fact a JPA pool, they are the excess carrier and that JPA pool will make a payment for the excess amount direct to the injured claimant but what I'm wondering is if the amount that the self-insured paid to the injured claimant is that assuming that they've already approved the payment of the excess amount and therefore the JPA does not meet characteristic three, or two rather, two and three.

(Barbara Wright): I'm still having a little bit of a problem connecting them because if they have, let me just add to you hypothesis or hypothetical or whatever, if a member of the JPA paid something directly and it was the JPA only kicked in for excess insurance, in order for the JPA the RRE, it would still have to meet the criteria that are listed, yes. Otherwise, it would, the responsibility would remain with

the self-insured entity. Just because it's excess insurance does not eliminate and JPA rule. If that's what I really hear you asking.

(Mark Seal): Yes and that does answer part of the question but the final part, is it meeting the third characteristic that the self-insurance pool can resolve or pay the claim without review or approval authority of the self-insured? If the self-insured paid the amount under the excess, is that automatically assumed that they also have given approval for the JPA pool to pay for the excess also and therefore the pool does not meet ((inaudible))?

(Barbara Wright): That would seem to be an issue for how the JPA is set up. I mean…

(Mark Seal): OK. Got it. I understand. Thank you.

Operator: Your next question comes from (Julie Sackentein) from Oakland County. Your line is open.

(Julie Sackentein):I'm calling on behalf of (Julie Sackentein), my name is Terry. Can you please advise us as to whether there is or shall be mandatory Medicaid reporting as well as Medicare and if so, what the procedures would be. Also, I would like to ask we reimbursed our insurer for deductibles; therefore they are the RRE, correct?

(Barbara Wright): Two separate things, this Section 111 and MMSEA is strictly Medicare. That's what Section 111 is. It's limited to Medicare. Any Medicaid reporting responsibilities are not within the purview of the people that are on this call whether they're set by regulation of statute or otherwise, we're not involve and don't have any knowledge of those reporting requirements.

Your second one, you said a situation where the deductible is paid by the insurer and reimbursed by the insurer or – could you repeat that?

(Terry): Yes. It's paid by the insurer and then we reimbursed them for that amount.

(Barbara Wright): And that's no longer an issue in terms of determining who is the RRE. We've said that if it is a deductible and not a self-insured retention, the insurer is responsible for reporting it, period.

(Terry): That's what I believe. OK. Thank you.

Operator: Your next question comes from (Joe Mesina) from Mendes and Mount. Your line is open.

(Joe Mesina): Yes, hello. In a situation where there is a subscription policy with, let's say over 30 plus insurer all paying out on a claim in different percentages, would each then be an RRE for reporting purposes?

(Barbara Wright): Question, please. Are you still there?

(Joe Mesina): Yes, hello?

Man: Could you please repeat your question?

(Joe Mesina): Yes, I'm sorry. In subscription policy, when you have a number of different insurers subscribing the same policy in different percentages, would each be an RRE if they pay out on a client?

(Barbara Wright): Could you hold on a second please?

(Joe Mesina): Sure.

(Barbara Wright): We're back and we're having some internal discussion about the term subscription. Could you please send your question to the resource mailbox.

(Joe Mesina): Sure, I actually did that this morning so it should be there.

(Barbara Wright): And if you didn't add on to it and define what you mean by subscription?

(Joe Mesina): OK. I will. Thanks.

Operator: Your next question comes from (Catherine Dickenson) from Husch Blackwell Sanders. Your line is open.

(Catherine Dickenson): Hi, Thank you. Pat, I'm sorry to do this to you, but could you go through what you're talking with the ICD-9 codes the distinction between V and E codes for diagnosis versus cost codes? I just kind of got lost to the V's and E's.

(Pat Ambrose): Well, the most important thing or the easiest thing to remember is that V as in victor codes are not accepted at all. So, don't send codes beginning with the letter V as in victor. And then, for the E codes, E as in Edward, those are only accepted in Field 15, the alleged cost.

(Catherine Dickenson): Thank you so much.

(Pat Ambrose): And we do not allow any longer E codes, E as in Edward, or V codes in the ICD-9 diagnosis codes 1-19. OK?

Operator: Your next question comes from (Barbara Sales) from (Wilkenson McHill). Your line is open.

(Barbara Sales): Thank you. We're are a plaintiff's firm and given are the nature of our practice which is nursing home litigation, most of our cases are reportable by RREs and of course we've been doing our part of this in reporting it to MSP but there seems to be some confusion at least on our part or on the defense firm or the RRE's part as to have to report this. Most of our clients are estates and are represented by personal representatives and on your, I believe it's in your Fields 104 the claimant relationship, there is an X for an estate. I'm wondering if this how these need to be reported because we're getting a lot of requests from defense attorneys for social security numbers for the personal representatives and in some cases, we're getting requests for SSNs for all of the state beneficiaries. Can you clarify that for me?

(Barbara Wright): Well the representative TIN is no longer required. That's a change that is coming in the updated user guide. The claimant TIN is actually required but the claimant 1-4 are only reported in the case of the beneficiary's death.

(Barbara Sales): Correct. Like I said, most of our clients are actually estates.

(Barbara Wright): OK. So, you would be reporting the TIN for the estate.

(Barbara Sales): Correct and it would be reported as an X, right? And I would not need those social security numbers of all those other individuals?

(Pat Ambrose): Yeah. I think that applies if there is a TIN associated with state, Barbara?

(Barbara Wright): Yeah. I mean, we still ask for the claimant TIN but the representative of the estate now.

(Barbara Sales): OK, because there are times when we have banks or trust or so forth that are representatives of a estate and clearly, they don't have any kind of a number to give us for a bank, so then going forward, they should be reported I guess as estates. Thank you for your help with that.

(Barbara Wright): Well, a bank would have a TIN EIN or a tax identification…you know.

(Barbara Sales): But by enlarge, they would be reported as an X as an estate. OK. Thank you.

(Pat Ambrose): Claimant number one, yeah.

(Barbara Sales): OK.

(Barbara Wright): However, I want to state that you said you've normally been going to the (CBOC), you don't want to drop that practice.

(Barbara Sales): Of course not. No, no, no, no. We're not doing that at all.

(Barbara Wright): OK.

(Barbara Sales): OK. Thank you.

Operator: Your next question comes from (Linda Wardlow) from Kit Carson County. Your line is open.

Again, that's (Linda Wardlow).

OK. Your next question comes from (Raymond Mariani) from Nixon Peabody. Your line is open.

(Raymond Mariani): Hi, thanks for taking the question. I have two questions unrelated topics. The first one was with respect to the settlements you referenced where there's, you said, where there is joint and several liability and those instances, the RRE must report the total amount of the settlement. I wasn't clear. Do you mean that the settlement itself makes clear that if one of the parties does not

pay, its fair share of the settlement that then the other party to the settlement agreement must then step in to make up portion of the settlement.

(Barbara Wright): We're saying if there is legally joint several liability, we can't give you legal advice on how the settlement would be awarded. If an entity, if there's five defendants and each of them enters into a separate settlement with the beneficiary, then they're going to be reporting their own amount. If it's a single settlement where under the law they are joined in severally liable, then they each need to report the total amount.

(Raymond Mariani): Well in some settlements what we find or practices, you'll have a settlement where there will be three parties and the settlement itself will call out the amounts that each party must contribute which are often not equal amounts and in those instance because the settlement is a contract, then each of the parties including the plaintiff is bound by that and the parties are only obligated to pay what is called out in the settlement. That could occur even in a estate which otherwise would have joint and several liability if the parties were perceived to trial and judgment. So…

(Barbara Wright): Again, I'm not trying to give you a hard time but we need to avoid giving or appearing to give legal advice. If under the settlement there is no joined several liability they would each report their own amount. But if there is joined several liability, then they need to report the total amount.

(Raymond Mariani): Understood then. Thank you. The other question is with regard to the foreign insurers. Can you explain what the status presently is with respect facilitating those entities registering as RREs particularly those that do not have the tax ID numbers?

(Pat Ambrose): We are implementing changes in the April release. I think it's April 5, 2010 where entities not based in the US and therefore not having an IRS assigned tax identification number and/or a US-based address may register on the COB secure Website and we're also implementing changes to the TIN reference file such that and international address can be submitted for the RRE there are well on the files submission and basically, the RRE will make up a fake or what we refer to as a pseudo-TIN for the foreign entity in order to get through

the registration screens and they are setting process that will take place at the COBC and these instructions are in the user guide and should explain that.

(Raymond Mariani): So, just to be clear, you mentioned the date of April 5 but now you've just mentioned the user guide. So the user guide, the new user guides that's about to be published any day now is going to give an explanation of the process that you have just described?

(Pat Ambrose): Absolutely.

(Raymond Mariani): And then the April 5 date, I'm sorry, tell me again what that date means?

(Pat Ambrose): That's when it is possible for a so-called foreign RRE to come to the Section 111 COB secure Website and begin the registration process.

(Raymond Mariani): OK. Understood. One final quick question if I could please, with respect to the new TPOC date, just to be clear, that if we settle a case on behalf of our client as an RRE and settles a case anytime before October 1, 2010, that is not a reportable event?

(Pat Ambrose): You need to look at how TPOC date is defined in the record layout.

(Raymond Mariani): OK. Sorry. I should have been clear. If we actually completely settled pay, everything is signed and done before October 1 in satisfaction of the definition, that would not be a reportable event under the new timeline?

(Barbara Wright): Yes.

(Pat Ambrose): You are not required to report it. You may if you want but you are not required.

(Raymond Mariani): If on those instance when you say "you may if you want", is there any, I'm speaking as a lawyer for client, is there any advantage to our client to do a reporting of that event.

(Pat Ambrose): Not necessarily. To me, from a technical perspective, if you've already designed your system to collect on amount prior to that and it's easier and, you know, you may do so. And then certainly if you are going to start you

production reporting prior to January 2011, that's pretty much all you would have to report, you know…

Man: Other than ORM.

(Pat Ambrose): Yeah. So, you know, there's no other particular advantage other that that it's easier for you and so that you have to make fewer changes as a result of this extension.

Man: Do it early and do it often.

(Raymond Mariani): OK. Understood. Thank you very much for the responses, appreciate it.

Operator: Sorry. Your next question comes from (Sally McKinney) from the Republic Group. Your line is open.

(Sally McKinney): Yes. Good afternoon. Thank you for taking the calls and the question. My question has to do with the scenario where an injured party who is a Medicare beneficiary, we verified that and Medicare shows up on the bill but the provider makes the decision not to submit the bill to Medicare and at the time of settlement Medicare is not paid. Are we required to report such claim to CMS?

(Barbara Wright): Yes. Among other things, you would not necessarily know if every provider made that same decision. I mean, what we do is when it is reported, as we check for any bills that we have in fact paid and you may or not be approving to all those. So…

(Sally McKinney): Well, if we've actually called the providers to check with them?

(Barbara Wright): No, but what I'm saying, and this is hypothetical again, maybe the beneficiary went to six providers and he only told you about five, it's not your decision to determine whether or not Medicare has been billed for associated services. It is our determination whether or not we have the recovery claim. So, when there is a settlement judgment award or other payment and it involves a medical beneficiary unless anytime it has the actual result or effect of claiming and/or releasing medical claims, it must be reported.

(Sally McKinney): OK. A question then from legal liability and I know you cannot give out legal advice but how does the carrier protect themselves, you know, we're not aware of a provider that filed with Medicare that bill was not submitted, that medical was not submitted or record, and we didn't include Medicare as a payee. How do we protect ourselves from those scenarios?

(Barbara Wright): We do not encourage, we don't discourage whatever, but there are some insurance that make Medicare a joint payee on checks when they know it's a Medicare beneficiary. There are also insurers where aware of where they have an arrangement for the beneficiary ((inaudible)) by them. We can't tell you exactly how to handle it.

(Sally McKinney): What if Medicare pays after a settlement? Again, provider – and I've been told more than once such as a hospital will not file with Medicare because they know they can give more money from that auto-insurance carrier, so a settlement is made, Medicare has not paid but then the provider goes and files after a settlement. Would the carrier be liable for that?

(Barbara Wright): Let's limit this to talking about liability insurance because that's the easiest to do it here. When CMS has a recovery claim, it makes its recovery claim with respect to the settlement judgment award or other payment that took place. So, if you settled with the beneficiary, let's say policy limits were $50,000 and the associated medical bills were a $150,000, the most recovery claim is going to deal with is the $50,000 unless we would, you know, we're essentially bound by the parameters. This is a general statement of the liability settlement judge were awarded.

If policy limits are $100,000 but the beneficiary actually did a settlement with you for $50,000, if we're making a recovery claim with respect to that settlement, then we're dealing with that $50,000 amount. Does that help?

(Sally McKinney): Yes. I appreciate that. On one additional topic, future medical, when documentation is submitted that this injured party may need future medical treatment, how do we handle that as a liability carrier?

(Barbara Wright): As we've said before this call is not really the forum to talk about future medicals associated with settlements. That's a whole separate discussion, it's not Section 111 reporting.

(Sally McKinney): Where do go for help on that subject?

(Barbara Wright): If you have a question about future medicals you need, you can submit it through the mailbox and I'll refer it to that correct person but you need specific questions not just a generic statement about future medicals. What we've said is in connection with the Section 111, we are further looking into additional outreach about the recovery process in general and we are working on that, we are looking at it. When we have something available, we will make that known to the public. We don't have a product to offer you right now.

(Sally McKinney): OK. Thank you very much.

(Bill Decker): Operator, this is (Bill Decker). I am substituting for John Albert at this point. We're going to have to stop this call now and to terminate because we have reached our call limit time, and I want to thank everybody who did call in and I'm sorry that we – if you are in cue waiting to have your questions asked, I'm sorry, we could not get you this time but as you heard we are scheduling another policy call, I think on the 16th of March and you can call on then because by then it'll have you better questions. So, operator, we done with this call and you want it have included from your end, that's fine. We do want to check with you again after the call instructions.

Operator: OK. This concludes the today's conference call, you may now disconnect.

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