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 23, 2012
1:00 p.m. ET

Operator: Good afternoon. My name is (Sarah), and I will be your conference operator today. At this time, I would like to welcome everyone to the NGHP Policy and Technical Support call.

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

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

John Albert: All right. Thank you, operator, and welcome everyone. For the record, this is an NGHP Teleconference for both policy, as well as technical questions. If you look on the Section 111 website, you should have seen the schedule of the future calls. The next one being March 22nd, all of the other calls are listed as well. Also for the record, as I do every time, there are times when we may say things that contradict the written materials particularly the NGHP User Guide.

For the record, the NGHP User Guide is the official source of all instruction policies that are related to Section 111, as well as any new alerts that have not yet folded into an updated version of the user guide. We apologize if we do sometimes get a little confused sometimes in terms of all the information.

With us today, we have folks from our COBC or Coordination of Benefits Contractor, are going to do some opening remarks, and then we'll come back to CMS, and as usual, go into a question-and-answer session. We ask that

because there a lot of participants that you please limit your question to one primary question and one follow-up.

And with that, I'll turn it over to Jeremy Farquhar at the COBC.

Jeremy Farquhar: Thanks, John. To start, I just have a couple of brief announcements. Some of you may have already been aware last week the Department of Health and Human Services announced their intent to delay the implementation of ICD-10. The transition had originally been slated for 10/01/2013.

This plan time – adjusted time frame to the implementation is yet to be determined. Other information on this will be provided as it becomes available.

Next, as of late, we become aware of numerous scenarios where there appears to be some confusion regarding the reporting of multiple TPOC events. Just a reminder, multiple TPOCs are to be reported if and when an RRE negotiates separate and different settlements at different times.

TPOC should be a single payment obligation reported in total regardless of whether it is funded via a single payment, annuity or structured settlement. Your other payments are not to be reported as separate TPOC payment. Further detailed information, it's highly recommended that you refer to the designated TPOC Computer-Based Training module or CBT, as well as the Section 11.5 within the current user guide regarding also called TPOC reporting.

And next, I just like to address some of the more common questions that we received via the CMS drop box since our last call in December.

One of the topics (inaudible) that we have continued received a significant number of questions is the delay timeline, the liability TPOC reporting, reference within the alert posted on 09/30/2011.

A number of people have questioned whether the delay timeline is still applicable and the answer is yes. The delay time frame, referenced with the 9/30 alert is still in effect.

Please note, that this delays are optional. At present, only TPOCs occurring after 10/01/2011 and exceeding $100,000 are required to be reported. However, if an RRE wishes to submit TPOC values under $100,000 you're welcome to do and those claims will not be rejected.

That being said, the interim reporting threshold referenced in Section 11.4 as the current user guide are also still applicable and must adhered to. Micro-threshold outlined within the 9/30 alert, TPOC values which do not meet the minimum interim reporting threshold will be rejected.

At the present, the minimum interim reporting threshold is $5,000. Therefore, at the present while we accept liability TPOC amounts that are under the $100,000 value indicated in the 9/30 alert with TPOC values must still exceed the current $5,000 interim reporting threshold.

Please refer directly to the aforementioned 09/30/2011 alert in Section 11.4 of the user guide for more complete information regarding the optional liability of TPOC delays and the interim reporting thresholds respectively. I won't bother to go through the entire timeline, the dollar amount is changing and as the dates move forward. That information is all readily available.

Next, we've received some questions regarding the time frame when ORM should first be reported. Some of these questions have referred to scenarios where responsibility for medicals maybe in this (inaudible), important to note that ORM is not to be reported until the RRE has made a determination to assume responsibility for ORM or unless they are otherwise required to assume ORM.

Once the assumption of responsibility is made that is when the initial report via that ORM claim is to be expected regardless of whether any actual payments have made at that point in time.

So, we've encountered a number of scenarios where RREs have been reporting ORM claims in anticipation – excuse me – in the anticipation that they may, at some point, assume responsibility for medicals only to determine at a later date they would not. Subsequently, the RREs we're sending delayed

transactions to remove these invalid ORM records. I just want to make clear that this is not appropriate. It should be avoided.

Another question was in referenced to our password change requirements. The individual has indicated that there are reporting for a significant number of RREs, and they were inquiring if there is anything that they could do avoid the need to manually reset their password every 60 days. I believe they were hoping for something in the way of the permanent password.

We commonly received this type of request, but unfortunately, this is something that we cannot accommodate. This password rules are required via the Federal Information Security Management Act to or FISMA and we must adhere to those guidelines.

You can automate your processes to every other extents but every 60 days there will have some type of manual intervention to reset those passwords. We apologize for the inconvenience.

Next question from RRE. They were just about to begin reporting for liability TPOC. Their question was related to the submission of (MT) files in conjunction with the delay timeline published in the 09/30/2011 alert. Basically, they were trying to determine whether an (MT) file should be submitted. If they had no liability TPOC information to submit based on a current $100,000-delay threshold.

There are also subsequent questions further relating to if and when the (MT) files submissions are required. So the simple answer to this is the (MT) file submissions are not actually required under any current circumstances. This applies to all Section 111 reporting across the board whether it'd be liability or for workers compensation or (inaudible) as well.

The generals in RRE has no new data to report than making contact with their assigned EDI rep informing them as such is the only action necessary. We'll accept the (MT) file submissions, but we really don't need them and actually prefer the aforementioned communication with the assigned EDI rep.

(MT) files submitted they will not trigger the generation of a response file. So, if an RRE is solely reporting liability TPOC information, they had nothing to report over the current threshold value, and there's nothing to require them until they have TPOC claims to report that exceed the current threshold.

And final question was in relation claim for death benefits. Claim question included benefits for loss wages only, and they indicated that no medicals would be claimed or included. There had been a settlement with the lump sum and then RRE began paying weekly indemnity payment to their surviving spouse.

So, as long as they were nothing included within the settlement, they would have the effect of releasing medicals. It would not appear that this claim would be reportable. That was – that was a basic question as to whether this is worth reportable and so the answer would be no.

And with that, I'll turn it back over to John.

John Albert: All right. Sorry, we had our phone on mute. Thanks, Jeremy.

With that, I'll turn it over to Barbara who wants to go over some of the questions that we received in the resource mailbox as well.

Barbara Wright: Thank, John. I have a couple of points to add on to what Jeremy just said. With regard to the ICD-10, please note that we do have a pending alert. So, you will have written confirmation that the delay or suspension of implementing ICD-10 applies to Section 111, as well as to our claims processors.

The next thing, Jeremy mentioned the interim threshold then the delay in the implementation. If you're not very familiar with them, you need to go back and read those separately. The interim thresholds, they'll beyond liability TPOCs. They apply to a variety of situations, but not all situations.

The delay in the implementation in the most recent alert applies only to liability TPOCs. So, you do need to be separately familiar with the two different thresholds and what they apply to.

We received several calls relating to future medicals, liability, set-asides and recoveries, and we just want to reiterate that those are outside the scope of this call. If you want information about recoveries and any new actions that are taking place there, please go to the MSPRC's website which is www.msprc.info, I-N-F-O, there are several new processes that have been announced and are spelled out on that website including one involving liability settlements at 25,000 or less that just became active this week.

Let's see, one of the questions that came in, it was asking about when there is a settlement for future medical benefits do they report procurement cost. Then the question was a little bit confusing because when you're reporting, you're reporting the total settlement and you're not reporting based on how the party has allocated it. If they allocated it to half to pass medicals, and then half to futures, you still have the RREs, still has to report the entire TPOC amount.

So, be careful in terms of what you're looking at. You're always looking at the full settlement amount not just some particular allocations that were made by the parties.

In general, we received the disproportionate number of questions about loss of consortium or other situations for medicals do not necessarily routinely occur, and what we wanted you to know with respect to all of this is that we're looking for a way that we can potentially lessen any burden on the industry. We know that the fact that our touch-tone is what's claimed on or released causes RREs difficulties particularly with the concept of a broad general release.

So, as long as medicals are actually claimed, we're going to have a hard time coming up with the process that doesn't require a particular settlement to be reported if it's above any applicable threshold, but we're looking into what we could do about situations where the only reason for reporting the claim is the broad general release.

We're looking at whether or not we could do something similar to the type of policy we set forth for the December 5th, 1980 in terms of – if certain other criteria are met then the broad general release alone will not require reporting.

Lastly, in connection with that, that same general issue, loss of consortium. We've had some people expressed a misunderstanding. They were under the assumption that loss of consortium and claims in and of themselves would never include medicals, and we want to point out that there are situations where the person claiming loss of consortium is also claiming medicals whether it's some type of therapy, whether it's drug treatment or otherwise. We know that this does occur.

We have in fact had a major automobile manufacturer talked to us about the fact that they are routinely making sure they obtain information because they do on a fairly frequent basis see situations were whether it's officially a loss of consortium or caption to some type of other actions. It is a claim by someone other than the person who was in the automobile wrecker in the accident and part of what's being claimed is emotional distress, and they are paying for therapy or drugs or whatever other treatment that's needed.

So, if you hadn't thought about loss of consortium in that way, at least know that is one possibility. We do expect to add some further language to the user guide to add to your information on this.

Let's see, we received several questions about risk management and the write-off or reduction in cost, and the tone of many of the questions seems to be an expectation that CMS has somewhere in its manual or otherwise billing instructions that will be labeled risk management or write-off, and that's not true.

What the alert said, and what's been incorporated into the manual is that when a provider or a supplier including physicians pass a situation where they write-off charges or they reduce charges based on a risk management situation then in that situation when Medicare is billed, they need to treat the amount that they wrote-off or reduce they charges. The same as they would treat a payment by another liability insurer.

So, what needs to be look at is the billing instructions or when there has been a liability payment prior to when Medicare is being billed.

Let's see. One of the questions that came in was talking about if an insurer denies a claim or a group of claims so that the insured then ends up paying these claims themselves so is the RRE.

The question was raised because the person who sent to inquiry and thought the company that was making payment because its insurer would not pay that they couldn't be self-insured because they purchased the insurance. But our position would be in a situation like that, they are in fact self-insured for what they are paying out. It's not an insurance company that has assumed responsibility. It's not an insurance company that's paying.

If they sue or otherwise have to pursue a claim against the insurer later, and recover those funds from the insurer, they do not need to report a second time nor the does the insurer then have to report it. That's not – at that point, that's not a payment to those individuals on behalf of the insured. It is actually a recovery by the insurer or the – recovery – I'm sorry – a recovery by the insured for the funds that the insurer originally denies.

We received questions again about individuals who aren't yet entitled at the time – entitled to Medicare at the time they have a settlement, judgment, award or other payment. If it's the TPOC settlement, judgment, award or other payment, if the person is not and has never been a Medicare beneficiary at the time of the TPOC date, you do not need to report. The RRE does need to report. However, if ongoing responsibility for medicals is involved, then the RRE does have a responsibility to monitor and report if and when the individual ever becomes entitled to Medicare benefits.

OK. We had some questions once again about joint and several, and what we'll repeat is what the point that we've been making all along. If there are multiple dependents and there is no joint and several liability in the resulting settlement, judgment, award or other payment, then each RRE does its own reporting. It's only, if there is joint and several liability, does there have to be a report that includes the total amount for the joint and several obligation.

We understand that there was some concern over the December 5, 1980 alert that some of the language in there could be read as indicating otherwise. So, we're looking at how to fix that, but we would repeat again, you know, that the statements that we've made all along and that were previously in the user guide giving a specific example with regard to this. Those are still CMS' policy. We don't plan – we don't plan to change that for any reason.

On the ORM comments that Jeremy gave earlier, if you have a situation where ORM would be the result if you get worker's compensation or no-fault believe that it was in fact responsible. If it hasn't assumed responsibility, generally, you're not going to be reporting anything.

The exception that I would add a little bit more to what Jeremy said is if under state law you're required to pay while there's an investigation or if under state law, you required to pay for a certain period under denial et cetera, then you do have to report the ORM even though you could or might wish to argue that you had accepted responsibility. There, there was an assumption of responsibility by law so you would have to report the ORM.

Last, we received a couple of questions or comments that had to do with situations where the injured individual and their attorney et cetera were all saying, "Medicare didn't pay for anything." So, did the case have to be reported? Yes. If it's – is above the threshold. It's not up to the RRE to make the determination of whether or not we have a recovery claim or whether, in fact, Medicare has paid. If the thresholds are exceeded, they have to report and then we will determine whether or not to pursue a recovery claim.

John, I think that's it. If you'd like to have the Q&A start.

John Albert: OK, all right. I'd also – just one final note before we get in the Q&A. You know, we go over the questions that were submitted via the resource mailbox and there were significantly quite a few of them that really should have been directed directly to your EDI reps.

So, in terms of technical support, please go to them first because, you know, while we do try to pick the ones out of the many hundreds of question we get that we've passed on to say you're EDI rep for a direct response.

Please, you know, when submitting stuff, remember that to get the quickest response hopefully on the more purely technical question through EDI reps should be your first stop because we don't – we're not able to review these questions on a daily basis and that we'll – you also will get quicker service on some of those more technical questions.

But anyway, with that operator, we can go straight into Q&A.

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star followed by the number one on your telephone keypad. Also, we ask that you please limit yourself to one question and one follow-up.

Your first question comes from the line of (Bonnie Mustard) from Farmers Insurance. Your line is open.

(Bonnie Mustard): Yes, thank you. My question relates to the claimant who is deceased, and so we are reporting claimant beneficiaries. If the individual has a state with a tax I.D. number, and let's say for example, we happened to know that within that state there is a wife and four kids. Do we also need all of the complete information for the wife and four kids or is reporting as the state information with the tax I.D. number sufficient?

Barbara Wright: Who did you settle with?

(Bonnie Mustard): The state.

Barbara Wright: Then I would report the information for the state.

(Bonnie Mustard): OK. All right. Thank you.

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

(Catherine Dickenson): Hi, thank you. I just had a quick question on reporting. If the injured party is not a medical beneficiary, but the spouse is and her claims are strictly limited with loss of consortium with that identified actual injury or treatment. Do you have to report the spouses or not?

Barbara Wright: Is the spouse claiming or releasing medical – I mean that's the driving line behind a lot of this. It is – our touchtone is whether medicals were claimed in or released. So, if she made a claim that included medicals and released them and has settlement that's above a reportable threshold then you need to report her. And as a I said, we are looking at ways to possibly narrow that has to be reported there because we are cognizant of the issue of a broad general release, but if there are truly no medicals then hopefully she is not claiming any either.

(Catherine Dickenson): Well, you know, like I said the release language is always for the devils and the details because usually they haven't released everything and then we're kind of in a position where we're reporting a loss of consortium of spouse where the injured party wasn't on Medicare spouse. So, any guidance that you can give right now would be really appreciated by the industry.

Barbara Wright: OK.

Operator: Your next question comes from the line of Suzan Kornbluth from New York State Insurance. Your line is open.

Suzan Kornbluth: Hi. I just wanted to report that we've been getting still a lot of reports from our district office saying that claimants are calling saying that Medicare is not paying bills for unrelated treatment. One call we also got said that the person they spoke to kept asking them for RRE I.D. So, we don't know what to tell people anymore.

This is law office still reporting that the questions and the complaints haven't really stopped about this. And Medicare keeps saying that we're primary because we have a comp case and that we should close the case, which means nothing because, you know, if it's not a 32 or TPOC, it doesn't make a difference, but we're still getting calls from the offices.

Barbara Wright: When you say calls from the offices?

Suzan Kornbluth: We have like about 12, 13 district offices around the state.

Barbara Wright: Well, again, we can use more specific information. You can give us an individual case.

Suzan Kornbluth: Well, I sent after the last conference call that the one – I think in November or December …

Barbara Wright: Right.

Suzan Kornbluth: … we did send about 10 or so cases, and we never heard anything.

Barbara Wright: And I understand that those are – that those are being looked into if you want to send another note to the mailbox then just – did you include yours in the mailbox because I've seen the ones that are …

Suzan Kornbluth: Not known because after we never heard anything. I didn't really include anymore.

Barbara Wright: So, the ones you sent, were they sent just to the mailbox?

Suzan Kornbluth: No, I think they were sent to Mr. Brady.

Barbara Wright: OK. Could you repeat your name for him right now, and we'll make sure to follow up with him on those 10. We do know that, we've gotten some other into the mailbox itself, and I'm not sure whether those individual ones have been checked out yet.

Suzan Kornbluth: I have sent something before that, and I think less, maybe three or four and then I sent him a list of – I would say at least 10.

Barbara Wright: Yes.

Jeremy Farquhar: I know that Jim Brady – Jim Brady is not on the call as of the moment, but he did receive those and have reviewed them.

Barbara Wright: Yes.

Suzan Kornbluth: I've spoken to him also on the phone.

Jeremy Farquhar: Yes.

John Albert: Is that Jeremy and I have (inaudible) a lot of those …

Suzan Kornbluth: Right, and we never heard anything though.

Jeremy Farquhar: We don't really have the ability assist directly. So, that's why you haven't heard further from us we have be followed but …

John Albert: Yes, we really can't resolve those claim issues at the COBC if the …

Jeremy Farquhar: You can pass along examples.

Suzan Kornbluth: I don't know it sounds like it's the training issue because they're not getting it. It's like reporting and when I've gotten these calls from our offices, I checked to see what was reported, and these are totally unrelated. They're just totally unrelated.

John Albert: This is John. I mean, we're aware of the issue with improperly denied claims, and unfortunately there's no one single root cause of the issue. So, we have, you know, some of the processes are with the provider, some with the Medicare contractors.

In terms of claims denial issues, I mean, our primary focus is to make sure that the record is correct, and once it is, then it has to get pushed out to whoever was that is building correctly or to the Medicare contractor, but we are aware of these issues. Now, I'm working on many fronts to try to educate everyone on this.

So, just the fact the we now have more MSP – so many more MSP records coming in at those – you know, therefore, you're going to have more views to these issues to come up but – I mean, I can't give you an answer on the phone to make you happy, but we are aware of these issues and looking at, you know, the best thing as I've said I know what I said is that providing the specific examples and the more of them the better because we can use that to

try to figure out if it's a particular provider directly or if it's a broad-based issue things like that. So …

Suzan Kornbluth: I know that – like in the last week, they again, said that whoever they are speaking to, Medicare is asking for our RRE I.D. which really has nothing, and we're not giving it out to our offices.

John Albert: Yes.

Suzan Kornbluth: That's reporting purposes, and we're not giving that information out to our offices.

John Albert: Besides speaking with Medicare, do you know who – like what organization or the one that had a Medicare, is it COBC, is it MSPRC …

Suzan Kornbluth: I believe it's the call center.

John Albert: The 1-800 Medicare call center?

Suzan Kornbluth: Yes.

John Albert: And we should have a whole bunch of new scripts that are in the process of being cleared right now to address some of these issues to make sure that the information is conveyed more clearly and correctly in terms of when there is an issue which should occur because that's where the bulk of Medicare calls are in 1-800 Medicare call center.

Suzan Kornbluth: OK. So, we should just tell them – you see, I've told them – I don't know if they should go on – the claimant should go on – my Medicare.gov and appeal. I don't know what to tell them.

Barbara Wright: If they have an actual claim denial, that actual claim denial includes …

John Albert: Yes.

Barbara Wright: … your rights and tells them exactly how to appeal. If they're having a situation where they're having service is refused to be provided, you know,

our providers refusing to furnish services, that's not something they have any direct right of appeal to us on.

It is an issue that we're very concerned about, and we are working on a number of fronts to make sure that, you know, providers and suppliers are better educated that the simple fact that there is an open MSP record or open MSP occurrence when its liability insurance, no-fault insurance or worker's compensation doesn't automatically mean that Medicare will be denying payments for all services.

Suzan Kornbluth: Right. I know that, you know, they're telling us that the claimants are calling back and calling back, and they were afraid that the provider is going to be denying services if they keep having these kinds of issues.

Bill Decker: What was your name again?

Suzan Kornbluth: Suzan Kornbluth from State Insurance Fund. Want our RRE I.D.?

Bill Decker: Sure.

Suzan Kornbluth: 18493.

Bill Decker: 18493. OK. We're taking that – this is Bill Decker, we're taking that here in Baltimore, sure that they're taking it down up in here (inaudible) at the COBC. So …

Suzan Kornbluth: OK.

Bill Decker: We'll be on it.

Suzan Kornbluth: All right. Thanks.

Bill Decker: Thank you.

Operator: And your next question from the line of Sean Sheehan for HeplerBroom. Your line is open.

Sean Sheehan: Hello, Barbara. I've got a question about the joint and several liability issue, can you point me to a particular alert or a section in the user guide that will give me the examples that you referred to?

Barbara Wright: In Version 3.2 on page – let's see – make sure it's here …

Jeremy Farquhar: Barbara, I think that joint and several is referenced in the current version. I believe it begins on page 26.

Male : What version? 3.3?

Jeremy Farquhar: That's right 3.3.

Barbara Wright: What page did you say Jeremy?

Jeremy Farquhar: Twenty-six, your multiple dependents.

Barbara Wright: OK, thank you very much. I appreciate it.

Operator: Your next question comes from the line of Cathy Ballard from Marathon Oil Co. Your line is open.

Cathy Ballard: Yes. Barbara, you've mentioned that plaintiff's counsel and the plaintiff say that no medicals are being charge to Medicare. I'm not sure how we can get an ICD-9 code or any other information from them if they're telling us that there has been no medicals?

Barbara Wright: The example I gave was one – they didn't say – the example that came in wasn't one that didn't say medicals exist – didn't exist, and it didn't say that medicals weren't being claimed. What it said was that the plaintiffs and the beneficiary that's there were all saying that Medicare hadn't paid for anything.

Cathy Ballard: Oh. OK. That …

Barbara Wright: Yes.

Cathy Ballard: … suffices.

Barbara Wright: OK.

Cathy Ballard: Thank you.

Barbara Wright: And if I misspoke, I apologize.

Operator: Your next question comes from the line of Tara Nielsen from Bell, Moore. Your line is open.

Tara Nielsen: Hello. My question goes back to the general release. I'm an attorney, and we do have a lot of settlement agreements that are general release. In my understanding of the language is that, the release of any medicals such as emotional damages under compensatory damages would be something that would require reporting.

I also understand that I've received a response that it does not need to be reported unless future medicals are waived in that general release. Could you point to me where in either any of the alerts or the user (manuals) where it says that I don't have to have my – the company that's paying the settlement or several agreement to file the report?

Barbara Wright: I'd like to know who told you that you don't have to report when medicals are released unless they are future medicals?

Tara Nielsen: I had gotten an e-mail back. I had sent the e-mail to the general mailbox, I believe, and got it back saying that the general release doesn't need to be reported unless I'm releasing future medicals.

Barbara Wright: Well, just so we can check it further, would you mind sending a copy of that e-mail and with the note to our mailbox because we're missing something in the translation here for this because we would – we would never simply say, you never have to report medicals unless there's future medicals.

Tara Nielsen: OK, that's what I thought. So, the general idea right now is that if there's a several agreement that releases all claims, even if there's not an injury claim, then that still needs to be reported that if it needs to threshold monetary number, correct?

Barbara Wright: Yes. And that's what we're trying to limit because we're not interested in rims of paper as we absolutely have no claim, but we also don't believe that we can simply leave it in the hands of the beneficiary or the hands of the insured and decide when we do or don't have a recovery claim.

Tara Nielsen: OK, very good. And I'll send that e-mail forward then and go forward with the idea that anything that meets the threshold amount needs to be reported until you have published something online to the extent, otherwise, correct?

Barbara Wright: Yes.

Tara Nielsen: OK. Thank you.

Operator: Your next question comes from the line of Julie Salvucci from Broadspire. Your line is open.

Julie Salvucci: Hi. I'm here. We're getting – people calling us telling us that they're applying for Medicare and they are being told that to have their claim close before they can enroll. Do you have any information on that?

Barbara Wright: They're being told by who?

Julie Salvucci: The (CMS) – we have Medicare recipients enrolling for benefits being told to close her claim before she enroll.

Barbara Wright: You said – you said …

Julie Salvucci: When she called – when she called Medicare.

Barbara Wright: Well, are you talking about applying to be enrolled in Medicare itself?

Julie Salvucci: That's what it sounds like.

Barbara Wright: Well, those are applications are taken by the Social Security administration. They're not taken by CMS or by our agency at all. So, you know, again, if we have specific information we could try and track something down, but I can't remotely imagine all those field offices for Social Security telling everybody

that or asking them whether or not they have pending liability claims and saying they have to be closed before they enroll in Medicare.

Male: Yes. Besides, this – you have no idea how that would even occur for them to ask that.

Barbara Wright: Yes. If there's something lost in translation, I have heard of at least one or two instances of attorneys telling their clients not to enroll in Medicare until their liability case is solved, and that's slightly different construct.

Julie Salvucci: OK. So, if I get all the details I should send them in to your mailbox?

Male: Yes.

Barbara Wright: Yes. We would be very interested in hearing where that came from but I – but I can't tell you I do know that there – that, you know, there are some instances where attorneys representing plaintiffs have told their clients not to enroll in Medicare until they've gotten their settlements for their – for their particular pending liability case.

Julie Salvucci: Does it have anything to do when they're doing their annual enrolment in Part D when they come back to do their annual enrollment? They have to do that every year?

Male: It shouldn't affect that.

Barbara Wright: It shouldn't affect that at all. I mean, the scenario I gave you is one that I can understand why an attorney might have decided that was good advice. The scenario you gave us – we're having a hard time figuring out how that would make sense.

Julie Salvucci: OK.

Bill Decker: Yes. This is Bill Decker. Almost everybody who comes in to the Medicare Program comes in when they apply first. At the initial application, they make for their Social Security benefit.

If the enrollment in Medicare Part A and the option to enroll on any other part of Medicare is provided to humans who are eligible for Medicare …

Julie Salvucci: Human?

Bill Decker: … at that time that they enroll in their or to begin to collect Social Security maybe that they were applying for Social Security early and aren't still eligible to enroll in Medicare until he do reach the age of 65 for Medicare Part A. But basically, that's how everyone comes in through Social Security. Nobody comes in because they apply to CMS to be enrolled.

Barbara Wright: And in fact, unless Social Security has changed its process, the way it used to work because if you came in for benefits – cash benefit before you are 65, the very last section of the application or online form or whatever they use now specifically asked about Medicare and also ask about Part B because they didn't want you to have any delay or anything when you actually turn 65.

And so, you would then simply just get a notice when you were turning 65 that your Medicare was going to start and you had signed up for Part B and you're going to get that too.

Julie Salvucci: All right. Part of the information that I just got was she's applying for Medicare and needs this in order to complete the application process, and she's asking us to provide her with the letter stating that her claim has been closed so she can complete her application.

Barbara Wright: She's applying – I'm sorry we couldn't hear you.

Julie Salvucci: I'm sorry. She's applying for Medicare and needs this in order to complete to complete the application process, and she's asking us to provide her with letter that states her claimed has been closed so she can complete the Medicare application process.

Barbara Wright: Wow. We'd love to see the correspondence on that.

Male: (Inaudible).

Barbara Wright: Because it doesn't make sense. To closest I can come although she's actually applying for worker's comp – if she's actually applying for Social Security disability not retirement and not Medicare although it would eventually result to Medicare.

When you apply for Social Security disability, they do or they used to ask questions about any pending worker's compensation because Social Security had a monetary offset of the Social Security payments based on what you were getting for worker's compensation, but …

Julie Salvucci: OK.

Barbara Wright: … really, really we're just guessing here.

Male: Yes.

Barbara Wright: We really don't need to see whatever it is you got.

Male: You can see how far down our (inaudible) will peak and go on this one. So …

Julie Salvucci: All right.

Male: We will correspond.

Julie Salvucci: All right. Thank you so much.

Male: Sure.

Operator: Your next question comes from the line of (John Meano) from Golden Land. Your line is open.

(John Meano): Yes, good afternoon. (John Meano) with Golden Land. Thank you so much for taking my question.

The first question I have is in regard to the write-off issue. Now, we'd had a few facilities contact us and the question that they're asking is if there is a situation tied to a single incident where there are multiple reductions or write-offs being used as a risk management tool, whether each of these risk

management write-offs should be considered individual TPOC or whether it might be considered ongoing responsibility for medical.

For instance, one example was that we had an injured party who was a patient from a hospital that had a slip and fall incident within the hospital and was brought to this facility with a broken hip. They had surgery in that facility and another slip and fall reinjuring himself requiring a subsequent surgery and anesthesia in accepted facility.

So, what we have here is one incident with multiple medical bills tied in the same incident from the same facility that occurred over a period in time with each one of the write-offs or reductions to those bills be considered to be an individual TPOC or could that actually be considered the ongoing responsibility for medical considering that they are making an acceptance of ongoing medical care treatment.

Barbara Wright: If they – if they have affirmatively accepted ongoing particular responsibility, it sounds like they still have two incidents to report, not one.

(John Meano): Yes.

Barbara Wright: But the point is, when it's done – when it's done just as a risk management thing, they're basically exposed to be incorporating those write-offs or reductions in their billing to Medicare. They cannot bill …

(John Meano): Yes.

Barbara Wright: … Medicare for the full amount, and say, "Oh, reported ORM, so I get to bill you for the full amount."

(John Meano): Oh, I understood, but I guess the question I have is where there is multiple bills from the same facility regarding the same incident, are each one of those treated individually as a TPOC?

Barbara Wright: Yes, if they were each reduced, they …

(John Meano): OK.

Barbara Wright: … when their bill, you know …

(John Meano): And so …

Barbara Wright: … in relation with that bill, they have to report it. Now, the situation …

(John Meano): OK.

Barbara Wright: … you described, if they are actually assuming ORM then they would have to report that in addition to doing their risk management write-off on the actual Medicare bills because if they're assuming responsibility – if they are asked that all I'm sure that the care that's involved also requires doctors who bill us separately et cetera.

Barbara Wright: So, if they truly assumed the ORM, then they need to report that separately.

(John Meano): All right. I guess, what I'm trying to do is to kind of turn this issue around and say that is the act of, you know, issuing reductions or write-offs as a risk management tool on multiple bills considered to be ongoing responsibility for medical. It's tied to the same incident.

Barbara Wright: That …

(John Meano): In other words, if they found a patient within a facility …

Barbara Wright: I understand what you're saying but I'm not …

(John Meano): Yes.

Barbara Wright: … in a position to give anyone some type of bright-line rule if someone has a (particular) …

Barbara Wright: … whether it's financial or other who has – so that there is – they're assuming something as a risk management action. That's not necessarily the same thing as assuming ongoing responsibility for (inaudible).

(John Meano): OK.

Barbara Wright: (Inaudible).

(John Meano): All right. That's what I needed right there. That's what I needed to go through right there. Thank you.

And just kind of a housekeeping question, in regard to the TPOC date and the funding delayed beyond the TPOC start date. I understand that by definition that the funding delayed beyond the TPOC start date should be a date subsequent to the TPOC date, but maybe this is more of a question for Jeremy or the COBC crew. Is there any validation or area code that would be thrown if the TPOC date and funding delayed beyond the TPOC date were the same?

Jeremy Farquhar: I would have to look into that for (John), but I'll do so …

(John Meano): OK.

Jeremy Farquhar: … and can get back to you probably after the call or if I can answer before the end of the call. I'll chime in, but I would most likely I'll get back to you.

(John Meano): OK.

Barbara Wright: Also …

(John Meano): All right, and Barbara just – OK.

Barbara Wright: On your ongoing responsibility for medicals, I want to emphasize again that it's not – it does not necessarily demonstrate (ORM), but I'm not going to say that in some cases it could.

(John Meano): Yes. It's a case by case basis. It's more or less the intent. I understand.

Barbara Wright: I know, but people like to quote this as having given a bright-line rule.

(John Meano): Yes.

Barbara Wright: If …

(John Meano): No.

Barbara Wright: … the hospital has not assumed – if for instance they've decided for risk management purposes, they're going to do a reduction or write-off for all the services they provided, but they are flat out not willing to pay for any other doctors or anything else. They don't consider that they – that they have actually assumed responsibility then I don't see how they …

(John Meano): Got you.

Barbara Wright: … afforded this ORM.

(John Meano): Got you.

Barbara Wright: Based on the (inaudible).

(John Meano): Very good.

Barbara Wright: If they wanted to go away, and they wanted to do …

(John Meano): Yes.

Barbara Wright: … ORM, that's fine too.

(John Meano): All right. That was a perfect response to that scenario. One last thing and it's an observation. You know, we utilize professional and social media here, and I belonged to a group (unlinked) in which is the Medicare, Medicaid Group and I can tell you over the course of the last week there have been more than 15 entries in response to an individual insurance company representative that stated that there have been multiple situations where injured party benefits or either being denied or they're being refused treatment in clinical environments due tot eh fact that they have an open claim.

Now, the danger here especially on the worker's compensation side is that there's a lot of pressure being exerted on this claim handlers because, you know, in one circumstance, one scenario we had where there was an injured party that was receiving cancer treatment and once their claim had been reported to CMS for an unrelated worker's comp injury. He was refused medical treatment and went back to the claim handler and told the claim

handler that if they didn't close his claim, that he wasn't going to be able to get his cancer treatment.

So, you know, it puts these claim handlers, the RRE et cetera in a very difficult position and, you know, we've been providing examples. I know that everybody that, you know, we've been speaking to have been trying to provide examples. It's very difficult when you have an upset injured party on the phone to find out, you know, who exactly it is, that they spoke into this responsible for the denial of their benefits or the refusal of their medical treatment.

What the situation is here is that it's very provocative. I can tell you that it is bringing the attention of the plaintiffs (bar) and, you know, it's not going to be long before they start to get involved here and it's just – it's not going to be good for anybody in the industry if that occurs.

You know, so, it is very, very important that we zero in exactly on whether this is training issue – where that training issue needs to occur because some – from some of the claims, there are customers who've provided us as an example. The ICD-9 codes with regard to the conditions reported on those accepted claims are not broad or nonspecific. They are actually quite specific in most cases, and we can understand why these nonrelated conditions are not being provided benefits or treatment is being denied.

So, you know, we have our customers at Golden Land. We have several RREs that come to us, and asked us for advices to what they should do, and the only thing that we tell them that they can do is just to, you know, refer the injured party back to the normal (inaudible) procedure through COBC, and in some cases (inaudible).

Male: That is the COBC (John). It's true – there is the (appeal) process, but it doesn't through the COBC, sorry.

(John Meano): OK, all right. I'm sorry. But, you know, the situation is …

Barbara Wright: (John)?

(John Meano): … that we're telling these (TPAs) and RREs are providing letters in some cases saying these are the conditions we accepted. These are the conditions that were accepted and that seems to be the only way that some of these situations are getting resolved but it is extremely administratively burdensome.

Barbara Wright: OK, could you hold on a second?

(John Meano): Sure.

Male: While you're waiting on Barbara (John), I did take a look and to the best of my knowledge the edit for the (coming) to page beyond TPOC date – I believe they were only editing to see that it is a valid date. So, it is the same as the TPOC date, I don't believe it would currently kick out although that's something that you may want to take a look at. So, I mean, technically it really should later than the actual TPOC date.

(John Meano): You would think the term delayed would be enough, but I just want to make sure we get our validations perfect.

John Albert: Hey, this is CMS. Yes, again, thanks (John) for your comments because we are very aware of all of these issues, in fact, we did just release a change – request out to our Medicare contractors also giving further instruction on this issue.

I can always say that, you know, there is no one particular cost to all of this. It's kind of across the board, and again, we are taking this very seriously. We recognize that with all the new data coming in just kind of stop – just kind of (crop up) more frequently than it is.

You know, there are lots of different things to play. We're going (inaudible) in 20-day conditional payment rule. We're hearing that provider are not following those rules in they are billing Medicare first for payment, and we are denying because we have not seen proof that they have attempted to bill the primary payer first, you know, under 120-day rule, they have to actually – they can't just submit it to Medicare for primary payment. They have to submit it …

(John Meano): Yes.

John Albert: … and have it rejected by the, you know, liability, no-fault insurance et cetera and then Medicare will make its payment. That's one of the issues.

Now, the other issue is, again, unrelated claims, you know, because of diagnosis codes are not being examined as they should be across the board (blank) denials were occurring.

You know, there's a lot of different things going on, but again, we have our – we start of putting instruction now to hopefully take care of some of these at least now and to continue to work on other enhancements which include I mentioned earlier the scripts the 1-800 Medicare (issue) for example because they are kind of the first line of communications for the bulk of our Medicare beneficiaries.

Now, if there is ever a question regarding the accuracy of the record on CMS' system, that's when you need to go to COBC to modify that record. We know that some of the root cause is also assisting correctly reported records we have. You know, beneficiary is calling saying, "No, this is – this isn't related," or whatever that we have to go out and modify the record. That occurs as well, but again, we hear what's going on, and we are definitely making an attempt to address it across all fronts of CMS.

Barbara Wright: And the beneficiaries can also contact the appropriate regional office staff there.

John Albert: Yes.

Barbara Wright: And sometimes help them with these issues.

(John Meano): I just don't want to see a situation where we have adjusters or anyone that's, you know, calling up, you know, calling the phone line to terminate ORM. Actually, it's not appropriate just so that, you know, because they are being told that they need to close (plan).

Barbara Wright: No. I mean, that's why we're trying to do outreach not just on bill claims but for situations where nothing has been billed. Where there is potentially a refusal of service. Those are the ones that we don't necessarily know about because if the beneficiary doesn't come in complain or tell us if the claim is actually denied. As I said, they will get Medicare summary notice or a Medicare (inaudible) that tells them the claim has been denied and gives them full appeal rights.

(John Meano): Wonderful. OK. Well, thank you very much for that.

Barbara Wright: Operator?

Operator: Your next question comes from the line of (Carol Dundee) from Banner Health. Your line is open.

(Carol Dundee): Hello. We are – have a question about reporting others releasing medicals that's the main claimant and if they are only claiming lot of consortium and no injury, and we're putting the code no (in) in both the cause code and the first ICD-9 Diagnosis Code.

If they are claiming injuries, then we're putting all of those diagnosis codes into their claim – I mean into their report, but the question is what to put for their cause of injury because theoretically it was caused by whatever happened to their (spouse), and so just wondering if that's a problem to put in what happened to their spouse and use the same cause code for the original injured person as we are for the – for the spouse.

Barbara Wright: I don't know if Bill Decker is more familiar with the codes or not but to the extent that you have a choice between one that would be like shock versus falling down stairs because they're – if you know they were in shock because their spouse's accident I would choose the shock over the falling down stairs if they weren't (wounded) actually. In other words, a code that most describes what caused their injury.

Bill Decker: Barbara mentioned my name here because (I've announced) to many people here in the CMS back in another life I was actually a medical records coder. So, I'm very familiar with the coding system, and I see (inaudible) right now

when people have questions about whether it's possible to actually do something in the coding system or not.

In my experience, and this again, this is my experience, ICD-9 coding is not difficult. It's not tricky. It's not mysterious. It's pretty straightforward and I'm somewhat surprise when I hear people suggesting that it's hard. It was – for the all thousands of people out there who knew this, our medical records techs and record techs, extractors and every – all of the folks who've used this closely on a daily basis. This has not been a major problem over the course of the 30 or 40 years who saw that these codes have been used in this country. Now …

(Carol Dundee): I'm not saying that the coding of what happened to the claimant is a problem. The cause for that is usually fairly clear. The question …

Bill Decker: Right.

(Carol Dundee): … becomes what do we use as a cause for the spouse because they're upset over whatever happened to their spouse, but I'm not (inaudible) code for that.

Bill Decker: Barbara's examples, they were right. The code – what is the – what is causing the injury to the spouse.

Barbara Wright: So, there's some code for emotional trauma, you want that if that's what's really going on as opposed to saying, hit by a car when they weren't the ones who were hit by the car.

Bill Decker: Right.

(Carol Dundee): All right. Well, thank you. (Inaudible) codes …

Bill Decker: That is actually what causing the injury.

(Carol Dundee): … that are clearer for things like emotional trauma, but we'll go back and look at it.

Bill Decker: OK. There is code for that. Yes.

(Carol Dundee): OK.

Operator: Your next question comes from the line of Lisa Maynard from Hamlin & Burton. Your line is open.

Lisa Maynard: Hi, I'm Lisa Maynard of Hamlin & Burton. We have a question – two quick questions.

For the TPOC amount and I have this question just because of what you said earlier Barbara, involving the global settlement that does not involve joint and several – joint and several liability exposure and separate releases. Do we report the entire amount of the settlement?

Barbara Wright: I wasn't sure exactly what you're referring to a moment ago when you said global settlement.

Lisa Maynard: OK. With the RRE settle in conjunction with the other dependents, and we all know what the total amount was.

Barbara Wright: So, OK.

Lisa Maynard: We've got separate releases. Are RRE have a separate release?

Barbara Wright: If there's no joint and several liability, again, then you're going to report only what you as an RRE are responsible for, and you're going to report it on a beneficiary by beneficiary basis because that's the way Section 111 reporting is done.

That make sense or I'm missing something in your question?

Lisa Maynard: Well, just – I'm just wondering what do you mean by joint and several because that, you know, some states have it and some states don't. So, we would not (inaudible) if we're working in a state that does not have joint and several liability, we would never be reporting a global settlement in that state based on what you're saying there with the – with the manual though. Am I understanding that correctly?

Barbara Wright: That's should be true.

Lisa Maynard: OK. So, and then our second question was on the TPOC dates, court – there's many different court approval. What type of court approval would trigger a TPOC date? Would it be one that …

Barbara Wright: (Inaudible), yes, I have some – wasn't you that sent that question into the mailbox.

Lisa Maynard: Yes, yes.

Barbara Wright: I did see their question and so not that long before this call, and I didn't get to go back and look at the record layout. My memory of the record layout is that only comes into play with court approval is required. If you have nothing for which court approval is required, then you don't have to worry about it. If you got a situation where court approval is required in order that – to have the settlement, then you need to factor that into the definition that's there.

We're not trying to make things harder for you. The court approval actually gives you a slightly potentially longer time to report. If court – part of what we're doing is if you have a TPOC – if you signed it in June but it requires court approval and it takes two months to go through that process we wanted the TPOC date to be when it did actually gets through that process, when it's truly final. When that – and that makes sense for what you would use to report.

Lisa Maynard: OK. Yes, so, it doesn't matter what they're calling it is not – it just matters whether or not it's required.

Barbara Wright: Yes. I'd say that's the keyword in the court approval is whether it's required or not.

Lisa Maynard: OK. Very helpful. Thank you.

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

Victoria Vance: Good afternoon. Thank you for taking my call. While we're on the call Barbara, I did look at the MSPRC website about the new program that you

mentioned with respect to individuals being able to self-calculate their conditional payment amount and just to quickly review those rules – so appreciate the tip that that was there.

I noticed that this program like some other type of programs is limited to just liability insurance and it specifically excludes settlements that are not – it would exclude settlement related to ingestion, exposure or medical implant.

And I had a question then when – if you know with the physiology of ingestion, would that ,therefore, exclude settlements that arise out of – let's say an ingestion or eating of a food products that causes a problem or taking a medication because it's administered orally and that may give rise to a claim?

Barbara Wright: Yes.

Victoria Vance: Is that what is contemplated by excluding ingestions?

Barbara Wright: I would have to go back and look or (Suzanne Kola) who's here might be able to join in. My memory of the new procedures generally we used the word that we're dealing with situations that are physically trauma (based). In other words, whether or not you were in a car wreck, whether or not you fell down the stairs et cetera and exposure, ingestion of any kind are generally excluded.

(Suzanne Kola): Part of our – in contemplating that, this is (Suzanne) by the way, part of our contemplation in that is really revolves around the fact that we're trying out from these new processes, and we recognize that the majority of the cases that we deal with on a day-to-day basis are the trauma-based injuries and that's really where these new processes are focused. Once we get into them and see how they work, we may reevaluate whether to extend those or not.

Victoria Vance: OK, and I can understand that the trauma cases are more discrete events that are easy to identify. I can understand why that would be a good starting point. So, I'm correct in my understanding that when you're using the phrase "ingestion," ingestion would contemplate almost as the name implies …

(Suzanne Kola): (Inaudible).

Victoria Vance: … eating something, taking it orally a medication for example. Those are types of claims at least for now are being excluded from some of these new programs …

(Suzanne Kola): That's correct.

Victoria Vance: … to the (finding).

(Suzanne Kola): Yes.

Victoria Vance: OK. That helps. I appreciate, and I appreciate the explanation. (Next time). Thank you.

Operator: Your next question comes from the line of (Eric Constein) from (Park and District). Your line is open.

(Eric Constein): Thank you. My question has to do with reporting record only work complaints. I've had discussion with my EDI representative about this. We have many work – workplace accidents that are reported to us for record only as the employee is not treated at that time the report was completed but on occasion the employees may go for treatment at a later time.

Assuming that the claim meets the criteria that it's a compensable claim if they treat it at a later time would simply open up the file convert it to a medical only and handle medical bills and because there's a possibility that we could pay medical bills. We've been reporting record only claims as part of a query report and if there is a (hit) on the query response we've been indicating "yes" for ORM, and my question should be – we be reporting this record only claims.

And before you answer that part of the reason that we included this is that we have that situations in which their – by compensable claim was reported to us for record only and then (inaudible) a lot. The employee have been treated and submitted their bills most commonly to their health insurance, but we did have one instance where that those were actually sent to Medicare, and so we've been reporting this record only claims are part of our query report.

Our EDI representative was indicating that that's probably incorrect, and he recommended that I (pay) a question on this call.

Barbara Wright: Could you hold on just for a second?

(Eric Constein): Sure.

Barbara Wright: We believe that you should in fact continue to report those. They're essentially saying that you're presumption is these are cases that if they submitted medical bills to you, you would be paying them, and you know, sounds like an assumption of ORM to us. If at a later point, you have information that says that you would stop paying them, are there some reason not to pay them then obviously those records could be terminated or deleted if you had information to show it should never have occurred. But, yours is establishing those records should in fact be accomplishing exactly what ORM records are supposed to, to stop us paying when there is another payer.

(Eric Constein): OK, yes. You're assumption is correct as far as the – most of these are claims in which we would be – we would pay the bills if they are submitted if the person does go for treatment and that's why we assumed that they should be reported then and that we should report those as a ORM.

So, you've answered my question. I appreciate it.

Barbara Wright: OK.

Operator: Your next question comes from the line of Trevor Meyer from Hamlin & Burton. Your line is open.

Trevor Meyer: Good afternoon everyone. I have a question about (used) software. I know there's the Windows, software available and software remain (friend) version. Our company – I'm sure not the only one, used Linux servers for our claims application. So, we're having to do actual work to transfer to a Window system to use this (few) software. Is there any talk about any Linux (few) development or are you aware of any third party product, we have commercial software that's other thing that does the same job as the software that would run on a Linux system.

Jeremy Farquhar: This is Jeremy Farquhar – at COBC, we don't have any plans for development than (inaudible) this that we'd be providing for the RREs, but there are many different translator programs available on markets as far as which make the compatible with Linux.

I apologize, but I couldn't really point you towards anything specific but I would have to assume that there's something available if you were to do a little bit of research where you could find a translator that would work with Linux.

Trevor Meyer: OK, do you have any (inaudible) for.

Jeremy Farquhar: (Inaudible) for a – I'm sorry – go ahead.

Trevor Meyer: Do you know if any of – any recommendations of place (inaudible) a kit to find out what software, you know, that works well with the, you know, with the COBC system?

Jeremy Farquhar: Well, I mean, here it's not – it's not really a matter of working well with the COBC system …

Trevor Meyer: Right.

Jeremy Farquhar: … specifically except for that …

Male: (Inaudible) people translating those two transactions.

Jeremy Farquhar: Yes, EDI X12-270 and 271 transactions. That's all the …

Male: I believe the X12 website will be, you know, organization that supports those standards has information on the various programs that are available. (Inaudible). Well, I can (inaudible) to Google search or (NC, NSI), X12 to be able (inaudible).

Jeremy Farquhar: (Inaudible).

Trevor Meyer: OK, that's great help. That's what I want to know. Thank you very much.

Jeremy Farquhar: OK.

Operator: And your next question comes from the line of (Elizabeth Nunez) from Federated National. Your line is open.

(Elizabeth Nunez), your line is open.

Your next question comes from the line of (Tammy Evans) from State of Oregon. Your line is open.

(Tammy Evans): Hello, I just have – I hope was an easy question. We get few (inaudible) injured claims at the state. What I'd like to clarify is if we settle with the claimant and/or their attorney, and we've already put them through the query process which shows us they are a beneficiary, but for instance, it's a car accident so the auto insurance pays for all their medicals. We still reporting those when we settle them, but we've been told by different parties that if Medicare in fact paid nothing that we will not get a response and that kind of leads us hanging out there, waiting to finalize settlement of the claim trying to find out if Medicare has a (lane). Can you clarify that?

Barbara Wright: Well, then I get a response to your query or to what?

(Tammy Evans): When we submit the TPOC amount, and it goes through the systems that we are waiting to find out if in fact is there is a Medicare (lane). Do we need to be submitting the payment to Medicare? Because our process is if we do, we prefer to pay Medicare directly.

Barbara Wright: You are not going to get a response to your record submission each time as to whether or not Medicare has (made) Section 111 reporting is physically separate from the recovery process, and it's handled by different people right now too.

Male: If the contractors …

Barbara Wright: You're responsible for doing reporting and our recovery contractor takes from their. No, you're never going to get a response directly to your submission.

(Tammy Evans): Well, then I would ask as far as we submit everything electronically but we also go through the process of physically submitting the settlement documents to MSPRC or we have the attorney do it, but we've been told even though the person is a beneficiary, if Medicare paid nothing, we won't get a response.

Barbara Wright: If …

(Tammy Evans): So, we're submitting it saying, do we owe you money and if we don't, then we're getting nothing.

Barbara Wright: If, (Suzanne) was just saying (inaudible) here you're not even get any type of letter telling me the case is closed.

(Tammy Evans): That's kind of hit and miss. We have actually had representatives from MSPRC tells us we won't get a response if there is no amount owed, but it seems like we should be getting the response no matter what because our file sits open and, you know, then administratively, we are spending a lot of time on that. We need their reply which may or may not come.

Barbara Wright: This recovery quest is really a kind of added scope of this call if want send us an e-mail that – of what we were talking about a bit, you know, on this call. We can see whether we can talk this separately because …

(Tammy Evans): But that sounds out of the ordinary?

Barbara Wright: Yes, you're – what you're saying doesn't quite make sense with our knowledge of the procedures that the MSPRC is supposed to be following.

John Albert: Yes, in this call (inaudible).

(Tammy Evans): OK.

John Albert: Just a Section 111 call not a – which is not directly related to MSPRC activity.

(Tammy Evans): OK.

John Albert: Operator?

Operator: Your next question comes from the line of (Duran Orson) from (Bayer). Your line is open.

(Duran Orson): Yes, and thank you. As a pharmaceutical company, we are currently establishing our process for reporting injuries sustained by subjects involved in our clinical trial. To our knowledge, there's only one other company who has started to do this. And I have a question which is probably technical referring to the claim input file.

From what I can see, this template allows for reporting of only up to 19 injuries for a subject during the given quarter. My question is what could – should we do if for one given quarter there are more than 19 injuries to be reported. Is there any way to submit two claim files during that quarter …

Barbara Wright: Our …

(Duran Orson): … or if not – I'm sorry – was the answer yes?

Barbara Wright: Are you talking 19 injuries to the same person?

(Duran Orson): Yes.

Jeremy Farquhar: Do you mean 19 (inaudible). Yes.

(Duran Orson): Correct.

Jeremy Farquhar: We can only accept to 19 different diagnoses, and it's not just a quarterly limitation, that's for each individual claim that you're reporting on. So, I mean you put in either – you could even in and say, "Oh, next quarter, we're going to give you some more of these ICD-9," because you'll just be replacing the ICD-9 that you had given us previously on that claim.

Unfortunately, we only have the ability to house 19 ICD-9 for any one individual claim at this point in time, but the best thing to do, and what we would advise, and I don't know how we (see) this for you, but we would ask that you try and choose the 19 most important or applicable ICD-9 that you can or say if there were numerous ICD-9s that referred to very similar diagnosis, and there were others they were slightly different try and give us

the (inaudible) of the different ICD-9, so that you are covering all of the different aspects of the claim.

Barbara Wright: Are this ICD-9 that two or three or four are within the same range of ICD-9. Those are these complete – can you give us some idea of what would be included in those 19 that would pretty much (exhausting).

(Duran Orson): Yes. Some of this clinical trials one for many months then some of them involved to oncologic patient. They can be very sick. So, yes there could be both scenarios applicable here that they have over 19 distinct entities to be reported or – yes and that would be the most frequent case.

Barbara Wright: Remember that you would be reporting the ICD-9 codes related to the injury or complications that arose during the trial not necessarily every disease or aspect of the patient that needs treated. You're specifically only reporting with respect to the injuries or complications for – that have a reason out of the trial.

(Duran Orson): Yes, so that's great. There's actually a separate question, and that would if we need to pay any with regard the study of drug relationship here. So, what we get reported during a clinical trial is adverse events, and so from the beginning to the end of the trial, the – an unlimited number of adverse events that can reported for a patient.

If we prioritize, should we then use the criteria for (business)? Does that sound reasonable?

Jeremy Farquhar: Yes.

(Duran Orson): Or how should we …

John Albert: We'd like to discuss this offline just for a second, (we cut) please.

(Duran Orson): OK.

Operator: And your next question comes from the line of Ralf Guetersloh …

Jeremy Farquhar: Wait operator, we wanted to finish with the prior question yet.

Operator: Well, I apologize.

Jeremy Farquhar: It's OK, hang on; we'll be back to the session.

Bill Decker: Hi, this is Bill Decker. We would you sir if you would send your contact information to us via the Section 111 resource mailbox. When you do that, we'll contact you. We'll get back to you, and offline that is not on this call speak to you directly you and members of your team there at the – or your office there at Bayer and go over the situation you have.

We think that it would be useful for us to talk directly one on one for a period of time rather than try to address all questions on this call. So, would you send us your contact information to the resource mailbox?

(Duran Orson): Absolutely. I appreciate very much this – I'm happy to see this is possible. Now, I'm not familiar with that mailbox and that I see here an address. Is this the one that's starts with PL110 and the long number – comment …

Barbara Wright: Yes.

(Duran Orson): Yes?

Male: Yes.

(Duran Orson): OK. I have that. So, I'll send you my contact info. Thank you very much.

Bill Decker: Thank you.

Barbara Wright: Operator?

Operator: Your next question comes from the line of Ralf Guetersloh from the German Insurance Association. Your line is open.

Ralf Guetersloh: Yes, good evening from Berlin. Thank you for taking our questions.

We have a question regarding the treatment of foreign insurance companies that is non-U.S. domestic. Does CMS intend to revise the definition of doing business in the U.S.? At the background, the American Insurance Association

and our European Umbrella Organization, the European Insurance Federal (C8) had suggested some alternative language. Does CMS intend to address these issues?

Male: At this time, I mean, CMS has nothing further on that. I mean that is under consideration, but we don't have a response for you or a time frame in terms of when that response would be available. This goes way higher than the folks in this room in terms of those questions.

Barbara Wright: Do you have …

Male: You can (inaudible) we have received the information from a number of firms based in Europe. CMS the organization is not the focus in this room necessarily but the organization is reviewing our relation to check our possible relationship with foreign insurers as this is a general matter. That is probably as much as we can comment on that at this point.

Barbara Wright: And believe we did receive within the last week I think three separate communications from one from (EEA), and I'm not sure who else that we're specifically …

Male: (Inaudible).

Barbara Wright: … you know, asking about these question indicating that you might be on this call. I believe we sent an e-mail back to at least one of them indicating that we didn't have a way to respond today to this. I'm sorry if we didn't get the message to all of the people who contacted us recently.

Ralf Guetersloh: Do you have any device for how we should consult our member companies who are very eager and interested how to address these issues. Do you have an advice for us what we should recommend to them?

Male: We can't, you know, offer that kind of opinion. I mean the instructions are as they are at this time. In terms of advice, I mean, I'm not sure what's you're looking for. I mean we can't go beyond the, you know, in interpreting what's the requirements are in terms of like a legal opinion or anything like that. So …

Bill Decker: Have you laid out your position to CMS directly before this call?

Ralf Guetersloh: Yes, indeed we did. We had provided via our sister association the American Insurance Association in our European Umbrella Association with (EEA) alternative language.

Barbara Wright: So, we – we have that document and in fact I will attach to – we already had it, but it was also included with one of the e-mails that came to the resource mailbox within the last I believe it's within the last week. So, we have all these, I guess Bill's question was more in terms of if your party did the ones that have already submitted documentation then we have that documentation.

If you were going to submit something separately, then you would need t make sure that we saw, the mailbox or some way that we were having access to that because I know that some of your documents, not yours personally, but some of these documents made referenced to contacting other agencies or entities within the United States government, and we don't necessarily see those.

Ralf Guetersloh: Right. I – it's my understanding that our position would be to first await your response to our suggestions regarding revised language.

Barbara Wright: OK. Well, you – we do have the documents. They are under considerations. Do we have any way to give you any type of response today? No, we don't unfortunately.

Ralf Guetersloh: So, we will be waiting for your consideration and your response in the near future.

Barbara Wright: Yes. We hope to give you a response as soon as possible. Can I give you that time frame? No.

Ralf Guetersloh: OK, thank you. We appreciate that.

Operator: Your next question comes from the line of (Rosella Miceli) from CEA. Your line is open.

(Rosella Miceli): Yes, hello. Good afternoon. Well, basically my answer was the same one already asked by (GDV). So, well, I may ask certain questions that's answered, so thank you.

Operator: Your next question comes from the line of Susan Jones from Pendulum. Your line is open.

Susan Jones: Hi. There was a question earlier about the claimant (10) at the beginning of the call. Hoping to just get a little bit more clarification on what to report on the claim information, for example, if you have the release and it states John Smith, the administrative of the state of Jane Doe, I'm afraid we might be reporting the wrong information. We were selecting the relationship state individual name and providing, for example, John Smith name and Social Security number, but should we be providing the state information and just selecting the state entity providing the state information and the state (10)?

Barbara Wright: OK, that is going to be reliable. I would not go back and change anything you have already reported.

Susan Jones: OK. But on (inaudible).

Barbara Wright: If you have a case where the state is really the claimant and that's he's going to get any settlement check et cetera and you have a (10) for the state, then yes, I would report that (10).

Susan Jones: Because my second question is, you know, we're having a hard time getting the claimant Social Security number, but it seems like the (plaintiffs) would be more willing to give these state (10). So, if we can get that and I mean there's – so there's – there is a claimant but that claimant is the administrator of the state. So, it's OK if we just provide the state information as the claimant then.

Barbara Wright: Well, what you've described sounds like he is the administrator not making a claim for himself. He's not John Smith the administrator making a claim for John Smith. He's John Smith making a claim on behalf of the state of (Jim Bowie) or whoever. So it's really that state that is the claimant.

Susan Jones: OK. OK, great. That really answers my question. So in the event, you know, when we have trouble getting information, I know there was a conversation on a call long time ago. But I don't remember if you ever released any documentation or anything about, I know you guys always just say keep all your records so that everything you try to collect the information, but is there anything in the guidelines or in alert that talks about when you don't you're not able to collect the appropriate information that has to be reported about waiting to get it, waiting to report until you get that information?

Barbara Wright: I don't (inaudible) anything specifically about when you can't get claimant information, but I believe …

Susan Jones: Yes. It was never specific to that. I just inform you that saying something, I think it was related like the (inaudible) date or amount or something then you guys will just say obviously you wait until you get the information. If you don't have it, you can't report. But make sure you keep track of your information. I was just wondering if there's anything …

Barbara Wright: You mean (inaudible) you don't have any you can't get any further claimant information then the minimum your reporting is just on the beneficiary themselves.

Susan Jones: And there's no alert.

Barbara Wright: But there isn't any specific alert that address this in anymore detailed information for that.

Susan Jones: OK. And so if – would you guys think that it's OK if there was no (inaudible) so we just had a claimant but the plaintiff's attorney refuses to give us that social security number, would it be OK for us to report the inter-party information and put the claimant's attorney information and was the injured party and reported that way?

Barbara Wright: I'm trying to make sure I'm visualizing with writing.

Susan Jones: OK.

Barbara Wright: If the individual to see and they were the ones that were in the (inaudible) whatever and then you have an attorney who is pursuing it on behalf of the state or in behalf of the beneficiary or one of the two, if we won't give you this (inaudible) you got to get the beneficiary's social security number and the (inaudible) not social security number, Medicare number in order to be able to submit anything to it at all. So, you know, worse case scenario there you're reporting it as though the beneficiary is arguably still alive.

Susan Jones: OK. OK. Thank you.

Operator: You're next question comes from the line of (Marcia Negro) from (Inaudible). Your line is open.

(Marcia Negro): All right. Excuse me. I'd like to go back to the question with regard to the Medicare beneficiaries and the problems they had getting continued benefits when there is an open claim. This is somewhat different. We've had an instance where the claimant was in a state where we had ongoing responsibility such that a denial was confirmed (inaudible) denied the claims. However, it was going to take 90 days for our next supporting period before we could put the denial in. He would have a process in place that we could escalate that timeframe because what's happening is and this is particular instance …

Barbara Wright: You're talking about where you'd like to terminate or …

(Marcia Negro): Correct.

Barbara Wright: …do an actual reporting period.

(Marcia Negro): Correct.

Barbara Wright: And I think John can give you the specifics. But I believe you are able to contact the COBC directly.

(Marcia Negro): And with that process, anywhere in writing that we could pass under our folks?

John Albert: I don't have – well, the idea – I don't know if there's writing anywhere Marcia but, you know, you can contact our call center and they will manually place a termination date if necessary but something that I intended to reference at the beginning of this call now is making announcements and neglected to for everybody that's listening. We've actually recently removed the quarterly reporting restrictions.

So now you can actually submit a file more than once a quarter for these exact types of scenarios. And I imagined we'll be placing wording in the newer version of the user guides to indicate as such so you'll see that. But basically you have claims that you need to need to close out in the interim between your (inaudible) submissions moving forward, you can send another claim file submission with that appropriate termination date and that can handle it.

If you need it done even more expeditiously then you only have one or two, but it's isolated incident you can go ahead and call our call center at 1-800-999-1118 and they can update the claim for you right away.

(Marcia Negro): OK. Well, this should let you know. We did try that number because we had spoken, I got that information earlier to somewhat and they told us to resubmit the file so then we had called back and tell them no this is what we we're told this way. It was a fairly serious case in a woman with congestive heart failure. So they did fixed it, but they're really, you know, and they said do we have any kind of – do we have guidelines to the teacher and how better to do this?

Male: We will have it in the user guide.

(Marcia Negro): OK.

Jeremy Farquhar: (Inaudible) more distinctly or discretely, however, whichever you want to consider it. There will be guidelines on it.

(Bill Decker): Yes. I mean, again, I mean Jeremy is right (inaudible) you can submit more than one file. But again the other options, default option is always to call the COBC call center directly which is 1-800-999-1118.

(Marcia Negro): One other question. If we do submit a file, do we have to – can we submit the whole file again with the changes that we submitted previously?

John Albert: You can just give us that one record.

(Marcia Negro): That may be a challenge an (inaudible) challenge to do but – OK.

Jeremy Farquhar: You shouldn't be resubmitting things that you had sent to us previously again. That's something that you should be avoiding. If you have, you know, technically the reason why we're allowing the multiple submissions is for scenarios where you need to close out the record of this nature or you will need to delete the record for a similar purpose.

We don't reject the subsequent claim file submissions if they have transactions or anything of that nature on there. We won't necessarily turn your submission away. But it doesn't have to be just that update necessarily. You had something new to came and say, if your system works in a fashion where you have a new ad, they get broke into that file transmission as well as the update for closing out or around. It's OK, we'll process that for you. I don't know if that helps at all.

(Marcia Negro) : And one other suggestion, as you design this process is that it might be helpful to have a hotline for these beneficiaries, when they have these issues such as shoulder injury still open, but the diabetes medication has been suspended because the doctor won't see them again because Medicare won't accept it but there should some sort of a hotline rather than – these are elderly people that are having some challenges if they will try to go to an appeal process.

Anyways, that's my suggestion. Thank you.

Operator: Your next question, onto the line of (Rhonda Brooklyn) from New York Central. Your line is open.

(Rhonda Brooklyn): Good afternoon. I just want to reemphasize that – I've been listening to all the other calls and we are also getting many calls from beneficiaries that are being told that their benefits will not be covered by Medicare because we have

an open claim and we're explaining to these individuals that we will need a letter from their treating physicians stating they no longer treatment due to a motor vehicle accident.

And now we're running across some doctors that will not provide a letter stating that and when I had called, I was told that well, you don't need to get a letter anymore and you can just put in a date when you thought you need the person needed treatment due to the MVA. So I had submitted this to the mailbox and it hasn't been addressed.

Barbara Wright: Whoever told you that you can just arbitrarily close it if you have an information on that call, we would certainly like to see it since that's not an appropriate response.

As we discussed at length earlier on this call, we're trying to attack this issue on several different fronts including educating those providers and/or suppliers who seem to think that an open record automatically immediately won't pay any claims.

(Rhonda Brooklyn): OK and we've also had calls from individuals applying for their Social Security and Medicare and have been told, "We see you have an open claim with New York Central. You better get that closed or when you go to the doctor, your medical benefits will be denied." I do wanted to let you know that we are also hearing that from people.

Barbara Wright: We'd like more information on who they're hearing it from because it's really hard to imagine someone at the Social Security Administration sitting around and telling them that.

Male: And more importantly, we won't be able to post that record by entitlement anyway. So it couldn't really block their signing up with Medicare.

Male: Yes. (Inaudible) Medicare beneficiary, yes.

Barbara Wright: OK.

(Rhonda Brooklyn): I understand but this is what we're hearing and we don't know where it's coming from either. Before, people are just calling us up saying, "Well, I just told you, you just got to close your file." You know, we have to follow certain – you know, we have to say, "Well, either the policy is exhaust to the person's disease or we need this letter from a treating physician" and of course, it's usually the letter and now, these doctors are absolutely refusing to do that.

Also along those same lines, we're also getting a lot of letters from Medicare asking to complete the (inaudible) case closure and the final settlement detail and when the alert came out on January 10th, we were wondering if these meds that we no longer have to complete those forms in between our quarterly submission.

Barbara Wright: I'm sorry, you said you were getting the requests specifically for that form?

(Rhonda Brooklyn): Yes. They were sending them in all the time in our claims, asking us if our files has been closed, then we have to complete the form and return it back to …

Barbara Wright: You said they?

(Rhonda Brooklyn): It's MSPRC.

Barbara Wright: Could you send a couple of examples of those?

(Rhonda Brooklyn): Oh, yes. We can send you quite a few. You want them to come through your email line?

Barbara Wright: If you can scan them and password protect them, yes.

(Rhonda Brooklyn): Yes, we can do that.

Barbara Wright: So if you'd send them to the mailbox because we need to check that out.

(Rhonda Brooklyn): So we don't have to complete these forms and send them in every time that we're settling a claim? As long as we're going through the online reporting?

Male: Are you talking about (inaudible) MSPRC?

(Rhonda Brooklyn): Yes.

Male: I think they still need that document in order to process that case but I think if you just send that off to Barbara she'll be able to get a follow-up.

(Rhonda Brooklyn): OK. All right. Thank you.

Barbara Wright: Thank you.

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

Emily Shields: Hi. I am following up on (mass tort) question that came up a couple of times I think on both the October and the December 2011 calls where the CMS indicated they would think about whether or not they would consider amended complaints to revise dates of exposure pre and post 1980 after discovery has taken place. Because in many instances, I think we've talked about how a lot of complaints, broadly alleged allegations as to all dependents and over a long period of time, might have been filed 10, 15 or 20 years ago and once discovery takes place, it's clear what the allegations are per dependent.

So a lot of dependents were in a position of having to owe report claims on simply based on a very old complaint and I know that that issue has been raised a couple of times and you all talked about considering whether or not an amended complaint would be considered so that defendants could rely on that and that there wasn't anything new on it.

(Suzanne Kola): Actually, this is (Suzanne). We had a conversation with our senior management about declaration this morning. We intend to consult with counsel this week and then through next week and we're hoping to have an answer, a formal answer, in the very near future. So it is definitely under consideration and definitely in the forefront and we do recognize the types of concerns that it raises especially with respect the 12580 (assistance) arena. So hopefully, a lot of news are coming very shortly.

Emily Shields: OK. Thank you very much.

Operator: Your next question comes from the line of (Keith Stateman) from PCI. Your line is open.

(Keith Stateman): Hi. It's really not a question but looking at the questions that you've been receiving on the call, I had made a suggestion a long time ago that there needed to be some dialogue on the recovery process. I really think that you can seriously, even if it's only a town hall format, you ought to be considering that because we took up about half of this call on recovery issues. Not Section 111 issues.

Barbara Wright: All right. I appreciate your concern. We did our best recovery limited from this call. We have raised the issue of a town hall. We don't have a final answer on that here. What you or may not have seen is that the agency is in the midst of concerning a lot of things – the recoveries and there had been several new processes again, posted on that website and you know …

(Keith Stateman): And you have had no dialogue as to whether how they're working from the point of view of the users.

Barbara Wright: I understand that and I can say that we'll pass on your concern but I'm not in the position to make a determination whether or not that call will or will not get pushed.

(Keith Stateman): OK. One other thing, you have somebody had early on said that they'd been requested to provide RRE numbers and you asked who was asking for it, I don't know in their case but I can tell you, I had sent an example to you, probably somewhere between nine months and a year ago, that it was coming from the MSPRC folks. Our member were being asked for RRE numbers, their claims desks and they don't have it.

Barbara Wright: Are they still being asked for that?

(Keith Stateman): I don't know because nobody responded to my raising the issue the first time so I haven't asked.

Female: This is a point of interest. Do you know if the RRE I.D. is being requested by MSPRC as a result of the insurers seeking conditional payment information? I mean is it being requested in part as some sort of authorization type tool or mechanism, do you know?

(Keith Stateman): It's been so long, I can't remember the exact circumstances but it was being asked of claims department and they do not have that information as the person on the call explained earlier.

Female: Right. OK. We'll look into it.

John Albert: Operator, this is John. It's now 3 o'clock and we have to end this call because we have some other meetings to attend at 3 o'clock.

I wanted to thank everyone for their participation again concerning the denied claims issue, we are very aware of the issue and continue to gather specific examples that are most helpful for us in terms of identifying issues that which we know that are again many across, many fronts with this. But again I would thank everyone for their participation and the next call is scheduled for March 22nd and we have other calls scheduled as well. Please refer to the Section 111 webpage and we also would like to ask if after sounding everyone off, operator, if you and the CBOC folks can stay on the line.

Thank you.

Operator: And this concludes today's conference call. You may now disconnect.

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