TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: January 28, 2010

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Bill Decker
January 28 2010
12:00 p.m. CT

Operator: Good morning. My name is (Amanda) and I'll be your conference operator today. At this time, I would like to welcome everyone to the MMSEA 111 NGHP conference 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. Thank you.

Mr. Albert, you may begin your conference.

Bill Decker: Thank you very much, operator. Hi, everybody. I am actually not John Albert; he's setting next to me. I'm Bill Decker. Welcome to the Section 111 NGHP national teleconference call scheduled for today; Thursday, January the 28, 2010. Thanks, everybody, for dialing in and for getting your questions ready.

We will be taking your questions after we've done presentations at the beginning of the call. Those of you who have been on these calls before know how this setup works. We'll talk for a while and then we'll open it up for you. You will have the opportunity to ask one question and one follow-up question. And that's – we are limiting it to that because there are so many people here on this call that we want to try to get as many of your questions as we can.

With me today are John Albert, who is sitting just directly to my left as you can plainly see. Across the table from me is Barbara Wright and Miss Pat Ambrose and there are other staff members in the room too; principally (Bill Zabonia), who I know will be checking in with us from time to time.

That's the lineup we have here in Baltimore and I'm going to turn the initial – let's see; turn it over initially to Pat Ambrose who has some general announcements for you. I do want to say one thing, though, before Pat gets started.

This call is announced in the – on the Web site as a – as a non-technical call; that is an operations call. This call; it was designed not to be – not to answer technical questions, but rather to talk about policy issues. We know from where the NGHP RREs are in their process of signing up with us that some of you do have pressing technical questions. We will entertain some, but principally we want to focus on policy issues. If we – if you have to have a technical question answered and it's important for you to get that question answered then you can ask it, but we do want to focus on policy today on this call.

And with that said, I'll turn it over to Pat Ambrose. Pat, take it away.

Pat Ambrose: Thanks, Bill. Yes, I do have some technical information to share with you, principally to help you with testing that has begun and is underway for non-GHP section111 reporting. First off, please make sure that you have reviewed the technical alerts recently posted to the Section 111 Web site at www.cms.hhs.gov/mandatoryinfrep. On the left hand side of the overview page, you will see a new link or task in that left menu called MMSEA 111 Alerts.

And under that alerts tab or on that alerts page, you will see an alert dated December 29, 2009 regarding registration guidelines for foreign entities and you will also see an alert dated December 23, 2009; a technical alert regarding the addition of the document control number, or DCN, to the query process and the HIPAA eligibility wrapper, or HEW software, and the corresponding HEW or HEW software upgrade.

And lastly, and most important in terms of testing that is taking place right now is an alert dated December 23, 2009, technical alert for claim input file field requirements. There is some additional information that has not yet

made it and been published in an updated user guide that you will no doubt find helpful in your current software implementation and testing.

Some – we – as I said, testing has begun and we're processing test files from RREs and I have some information to share with you that might help you in your testing and also some additional information that has not yet been published regarding some of the field requirements.

The first is that it's a change or a loosening of some field related to representative name and representative tax identification number or TIN. This includes the injured party's representatives and also claimant one, two, three, and four representatives. But again, it's only representative information.

So the representative name and TIN field edits will be loosened. This goes into effect on February 8, 2010 for test and production files. This includes representative field, again, for the injured party and claimants one through four. The representative TIN will become optional fields. When submitting the representative name, you will be required only to submit the representative's first and last name or the representative firm name.

So for example, if the representative that you are providing information for is a member – is an attorney and a member of a law firm and you only have the name of the law firm, you're – that will be an acceptable condition to just supply the representative firm name and leave the representative first and last name blank.

Again, that change goes into effect on February 8 with files processed as of February 8 and subsequent. An alert is pending on this to give you the exact fields that are affected and updated field descriptions. And of course this information will be added to the upcoming user guide.

I do want to note that, as with all of the data elements on – as a part of this date collection, as CMS starts using the Section 111 data that is – and it's incorporated into the Medicare systems, both related to claims payment and recovery that as that data is used there may be changes subsequently to certain field descriptions and requirements at some point in the future; however, you

will always be given plenty of notice in order to incorporate those changes into your system.

This particular change related to representative fields is in a sense loosening the requirements, so we're implementing it right away to actually get a better percentage of records accepted.

Another announcement I have related to testing is the – there is an e-mail that is sent to account managers for the RRE ID; when it's filed, hits the 20 percent error threshold. If 20 percent or more of the records on the file are found to be in error, the file is suspended with a threshold error and an e-mail goes out to your account manager.

This e-mail was recently updated to actually list the errors that were found on the file; however, there is a problem with the display of the error codes and messages on that e-mail. Actually the error codes displayed are accurate, but the descriptions are not. So please use the descriptions in the user guide for error codes. We are correcting that e-mail, obviously, to associate the proper descriptions with the error codes that are listed there.

And of course the error codes are on your response file and that's really where you should be going to address them and, again, the error code table in the user guide is accurate and that should be your primary source. Remember that the error code table from the user guide is also available in a text file and Excel file format on the COB – Section 111, COB secure Web site and can be downloaded from there if you choose to use that.

Another issue has come up regarding the field 17; the state of venue. A value of US is acceptable in field 17 state of venue; however the system was not allowing this or is not allowing this at the current, so if you submit US in field 17, the state of venue, your record will be returned with error code CI04. A fix is being implemented for this as soon as possible. I'm afraid I don't have a date, but I'm sure it will be there by February 8 at the absolute latest, but probably sooner.

Another helpful hint in terms of getting your files through the testing process related to TIN reference file errors; if a record on your TIN reference file has

an error, it will not be accepted. That particular TIN record will not be accepted. This in turn will result in all records on your claim file submitted with that TIN being rejected. Now of course when I'm talking about TIN, I am talking about the combination of TIN and office code.

So again, this in turn will result in all the records on your claim files submitted with that TIN office code combination being rejected in error for missing TIN information. You pretty much get an error for each required TIN field back on your response file; however, this can be somewhat misleading. For example, we had a tester who submitted a invalid zip plus four field. The TIN records were rejected. There errors that showed up on the response file did not include the one for the zip plus four. Instead the errors that showed up were related to the required TIN field and the zip plus four field is actually optional.

Your EDI representative can look at a TIN error report right now to see what errors actually occurred and help you correct your TIN reference file and resubmit it along with your resubmitted claim input file. Now to address this, the COBC is working on a new report that will be created for RREs to list the TIN file errors. It's not really a new response file, but in a sense will be like that so that you can more clearly identify the errors on your TIN reference files.

So stay tuned for that. In the meantime, if you get a lot of records rejected with TIN-related fields; fields that have come in on the TIN reference file, most likely you have a problem with your TIN reference file records and your EDI representative can help you with that.

Another helpful reminder is to please review the appropriate default values for field type and certain sections of the record layout. Note that unlike what is said in the current user guide, if you are not using a section like that for representative information or claimant information or claimant representative information, you may actually leave that whole section and associated fields blank. Right now the user guide states to default each to its default value, which is perfectly acceptable, but we're also in a sense kind of loosening the

requirements there so that if a – if you're not using a particular numeric field in that section, either spaces or zeros would be accepted, for example.

I also want to remind you that there is test beneficiary data that can be loaded from the Section 111 COB secure Web site. Again, the link for that is www section111.cms.hhs.gov. You don't need to log on to the Section 111 Web site in order to obtain this information. Just click in the I Accept link of the login warning page. You'll be brought to the login page of the Section 111 COB secure Web site and under the reference materials menu option, you will find options to download the test beneficiary data, also an explanation of it, and of course there also, as I mentioned earlier, is a file of the error codes and their associated descriptions, as well as the list of insufficient IPD9 codes that are found in Appendix H.

Note that – speaking then of test beneficiaries and if you're having trouble getting files accepted with an 01 or 02 disposition code and getting instead a lot of disposition code 51s back; you're not able to match to a Medicare beneficiary, you may want to make use of the test beneficiary data. You may submit multiple claim records for each test beneficiary in the same test file.

Use of these test bennies will help you get some 01 and 02 disposition codes. Again, many RREs that are using only their own data are struggling and only getting 51s back. If you are using your own data, which is perfectly acceptable as well, you might want to make sure that you're submitted individuals or injured parties that over age 65 to increase your chances of getting a fit to a Medicare beneficiary. You, of course, can also use the query function prior to sending your test claim file.

Another reminder or helpful hint or situation to avoid has to do with the office code or site ID field. This field must either be left blank, if not used, or if you are using office codes site IDs, they must be nine-digit numbers; they must be nine-digit numerics. Many RREs are treating it like an alpha-numeric, which the system won't allow. Also review the cross-referencing or matching that is done between the TIN and office code on the claim record to the TIN reference file record.

Please remember that field containing dollar amounts have an assumed two decimal places, so in other words the last two digits in those field are the cents part of that dollar amount. And then some other very basic issues that are causing severe errors with files; remember that the numerics or the numbers that you are submitting on your files must have leading zeros to completely fill the field blanks.

So for example, many RREs are putting the number five followed by spaces rather than leading zeros; say suppose the field is seven digits long, they might need to put, for record count field, for example, six zeros followed by a five in the record count field on the trailer in order for that to be accepted. Also, the dates that you have on your header and trailer records must match each other.

Another common issue causing severe file errors is that each claim record submitted on the file must be 2,220 bytes and you must fill the entire record with spaces to the end of that record. The carriage return line feed goes – actually invites 2,221, if you're thinking of it that way. Many RREs are submitting files with variable length records; just ending them where they last put data and not filling the rest of the record with spaces to make it a fixed length record of 2,220.

Another common problem that we're running into is some RREs are sending files for more than the specific RRE ID to the same mailbox. If you're using the secure file transfer protocol, SFTP, make sure that when you're transferring files, you put the file in its proper mailbox by RRE ID. You cannot – if you have five different RRE IDs, you must place those files, according to their RRE ID into five different mailboxes. You can't load them all into one and ask us to sort it out later. There's actually system check to make sure that files are being sent to the proper place, so that's important to remember too.

There's a fair amount of – well before I get into this one, let me address the last – one of the last points. Regarding address formatting, this is not an error, but just a request or suggestion, as you're formatting address field, the address line one should only contain a street number and street name. Things like

apartment number, suite number, attention to, and the like should all go in address line two.

And lastly, let me talk a little bit about ICD9 diagnosis codes. You may submit ICD9 codes in filed 15 and in the 19 diagnosis code field starting in field 19 at this time; however they're not required until 2011. The basic requirement right now is that you either provide a description; a text description in field 57 of the illness-injury or – and this is at minimum; or you must supply field 15 and field 19. And you may supply more diagnosis codes in the field following field 19.

The trick here, or not trick but the – something that a lot of folks are running into is that they don't realize that if they attempt to use field 15, the alleged cause and the diagnosis code staring in field 19, that the system will edit them. Even though they're not required until 2011, if you give them to us we will edit them and if there's anything – and we will edit them according to the requirements listed in the user guide and in that alert on the alerts page that I mentioned earlier. And they'll e edited thoroughly, completely. If anyone diagnosis code submitted (not) to be valid, that will generate an hour and the entire record will be rejects.

So even if you're giving us a good description of the illness or injury in field 57, if you give us an invalid diagnosis code or you don't adhere to all the edit requirements related to the diagnosis code field the record will be rejected. So if you're not – right now, it's a good time, obviously, to be testing your submission of diagnosis codes. If you are struggling with that or not prepared to proved diagnosis codes at this time, you can leave those fields blank and just supply field 57. And I think that alert is going to be helpful.

The other point I wanted to make about ICD9 codes is that if you're only supplying one diagnosis code field, diagnosis code in field 19; that code must be valid. In other words, beyond that – the files that we provided for what CMS considers valid ICD9 codes, and then it also must meet that requirement that one of the diagnosis codes that you supply has to be not an E code, not a V code, and not an insufficient code.

Now if you supply such a code like that in field 19, in diagnosis – for diagnosis code one, then diagnosis code two, three, four, and subsequents; they must contain valid diagnosis codes, but they may be E codes and V codes and insufficient codes. You're encouraged to supply as many as you possibly can as long as they are valid.

So that is all I have. Hopefully that'll help some of you with your testing process and please stay in touch with your EDI representative, report issues, and we'll get you help and get any issues found addressed as soon as possible.

Bill Decker: Thanks a lot, Pat. We hope that information was useful to you all. Many of you have started the testing process. More of you are – know that you must start the testing process relatively soon. And so we wanted to get that information out to you on this call, even though this is in fact supposed to be a policy call; limiting it – ourselves to a policy call.

And on that note, I will now turn this discussion over to Barbara Wright, who will in fact discuss some policy-related issues, or in the non-group (kind of) reporting process. Barbara?

Barbara Wright: Thanks, Bill. The first thing is to announce status (inaudible) waiting. We still have a significant number of items that are in our clearance process. The language for clinical trials is still in clearance. The language for risk management write-offs or risk – or things including gift cards, et cetera is still in clearance.

For periodic payments for both workers' compensation and no-fault, as we've said on other calls, we're looking to change the language that was in the July 13, 2009 alert and that's now in the current version of the user guide to expand it to no-fault and also to make the limitation on reporting more helpful to the industry in general. That language is also in a clearance process.

Let me see. What was called mass torts before, the thing that we want to make clear to all of you, that the information to fields 58 through 62, which has been announced in an alert that those fields are not being used initially, Pat, if I remember (correctly).

Pat Ambrose: That is correct. We're expecting spaces to be submitted in those fields. If you're currently filling something into fields 58 through 62, it most likely will be ignored, but what you're putting in there will not be correct down the road when these requirements are finalized, so I would recommend that you just move spaces to fields 58 through 62 right now. Whatever else you might be trying to submit in there you know you are commended for attempting to fill them out, but it – they will not be correct, so there's no sense in pursuing that at this time.

Barbara Wright: The specific question we received about that that was if they've already set up their system to include something for 58 through 62 and they're attempting to put that information in, will there be anything that will reject what's there if it is filled with other than spaces? That's what they want to know; they want to know if it has to be changed to spaces.

Pat Ambrose: I don't really know, to tell you the truth. I doubt it. I believe the edits have been turned off, so I – that's all I can – I can actually say. You know you can always submit them on a test file and see what happens; most likely nothing. However, when we go to production, starting in April, these data files are being passed on to other parts of the system. I am assuming those other Medicare systems will ignore them as well too, so you probably can get away with it. Again, I would personally recommend that you move spaces to them at this time.

Barbara Wright: OK. For 58 through 62 and, as I said before, those fields were labeled more as product liability/mass torts. We've gotten a number of questions in asking how we're, quote, handling mass torts. As we've said in other calls and as we discussed in the workgroup that we have the industry participating on this, we moved away from the concept that this was specifically to handle, quote, mass situations. We're more interested in making sure we have certain additional information in labor cases involving exposures or implantation, et cetera, as opposed to your typical trauma-based injury.

So to the extent people are writing in and asking if I have, quote, a mass tort or I have an MDL, et cetera, are there special reporting requirements for that? At this point, no. We are still looking at the issue of whether or not we will

have a separate additional mailbox that will require very, very, very limited information, simply to alert the agency of the situation, such as MDLs or cases involving a certain number of beneficiaries or certain number of claimants.

The current definitions for fields 58 through 62 that are in process actually talk about reporting the information that will be in those fields for cases involving one or more beneficiaries. So the current draft is not designed to necessarily get to large universes. It's designed to get to certain types of recover claims. Now we still are working on the language for replacing, I believe it's section 7.1 in the user guide. It's the additional information about our RREs, based on the draft language that was published 7/31/09.

An additional issue that's bending that we don't have a final answer on yet; the industry has asked us if there's some way we can look at the issue of the 12/5/80 effective date for liability and no-fault and is there some way we can give the industry at least for cases where they believe all exposure, for example, clearly ended before 12/5/80, but injury, et cetera, beyond 12/5/80 is being released, since our touchstone is what's claimed and/or released. So we're still looking at that issue.

Now let's see. One of the issues that has come in over and over is we continue to get a number of recovery-based issues. Those aren't really Section 111 issues. So that everyone out there knows, in connection with recovery, we are looking at ways to do additional outreach to the industry in general, not limited to plaintiff's bar; to both plaintiffs and insurers, et cetera; that so we aren't particularly doing conferences at this point on that.

We are looking you know how to do something on a broad basis. We may in fact institute some town hall calls, specifically on recovery issues. If you have a specific recovery issue that you think is unclear that you really want to know about, we don't have an objection if you send that question in to the 111 mailbox, but it absolutely must be labeled in the section – in the subject line that it's a recover issue.

And as with the questions we have now, we're not going to be doing one-on-one answers. We would be looking at that solely for the purposes of trying to make sure we covered as many issues s possible as we move forward with any outreach for recovery.

(Bill Decker): However, just to be – just to be absolutely clear, when you say recovery issue, you're talking about recoveries that CMS isn't going to be engaged (in)?

Barbara Wright: Yes.

(Bill Decker): Right, OK.

Barbara Wright: OK. Let's see; one of the questions that came in was a two-fold one that says they had heard that CMS has a process for entities to apply to be exempted from Section 111 reporting if they're a small (enough) player. And it sounds like that individual or the one making the inquiry is misunderstanding a concept tied to group health plan reporting and liability, no-fault, or workers compensation.

For NGHP, there is no, quote, exclusion for small employers. In the GHP context, what there is is an issue of whether or not the Medicare (as) secondary payer provision actually apply in certain situations, when a company has less than 20 employees. What there – there is a concept called small employer exception and if an employer belongs to a multi – multiple employer group health plan, if any employer in that plan has 20 or more employees then the working aged MSP provisions apply.

The statute also allows CMS to grant an exclusion to a particular plan for a specific employer's situation, if that particular employer has less than 20 employees. But that is only a GHP concept about whether or not MSP applies. That has no relation to Section 111 reporting and there is no exclusion simply because an RRE is a small employer or a small entity.

We've had questions about ORM that's asking about future termination dates and situations where under state law the entity is allowed to terminate their responsibility, their coverage, if there is not required treatment within a specific timeframe, such as two years, et cetera. I believe our answer was

before, and I'll ask people here to confirm, that in that case you cannot put in a future termination date. You don't know for sure that there will be termination. You should only be putting a termination date in in advance if it is a definite termination date.

Pat Ambrose: Yes. And the system will accept future dates in the ORM termination date, so if it is a definite day, you may supply it.

Barbara Wright: So if you're in a state, for example, that for workers compensation has a particular type of settlement that the medicals are open, but by law responsibility ceases at a certain period of time if there is no further treatment, you cannot put in a termination date in advance. You must keep the record open until you've actually verified that there won't be any claims within the appropriate time period and then you can report the termination.

We had a question that talked about a situation where a claim was being reported where ORM is in and they're also reporting an ORM termination date. And they were saying this is a scenario they believe that could occur for them. And I'm not sure exactly how that would happen. Typically, if you're not reporting ORM and then you have an ORM termination date, you could have a situation where you're reporting both the establishment of the ORM and its termination in the same record, but then you would be reporting the why for the ORM.

So the question that came in along this line; we don't see how that situation could occur. If you wrote this question and you still believe there's some way you could be reporting both an N and a termination at the same time, you need to send us a further e-mail (to) clarify this.

Pat Ambrose: It – I mean we're certainly not expecting to see anything in an ORM termination date on the same record that has an N in the ORM indicator. It's – it should be Y. If that claim ever had ORM and you are reporting when it ended, you would still report that record with ORM equals Y. The ORM indicator is not an on/off switch.

It indicates that at one point in time or still currently, the RRE has responsibility for – ongoing responsibility for medical. And even after it is –

when you're reporting the termination that ORM indicator should still remain a Y. It's the termination date that turns it – turns off the ORM in a sense.

Barbara Wright: OK. We've also gotten questions about TPOC where people continue to describe a situation that sounds to us as ORM and they want to know about whether or not – what if the claim doesn't exceed $5,000. If you're making payments on medical and essentially you've assumed responsibility even though you don't have a final settlement, you need to report the ORM and potentially terminate that when you have a settlement. For ORM, you don't wait until it exceeds $5,000.

Let's see. We need to put you on hold just (one) second.

(Bill Decker) (Bill Zabonia's) going to give us a little presentation here.

(Bill Zabonia): There was a question about occupational health and accident insurance. That is no-fault insurance. It satisfies the definition of no-fault insurance in the regulation.

(Barbara Wright): And, (Bill), is that occupational accident the same as accident and health and other …

(Bill Zabonia): Yes.

(Barbara Wright): OK. So …

(Bill Zabonia): I mean (I'd) – the policies that I've seen have been no-fault; that they believe – if someone has a policy that they believe does not satisfy the definition of either no-fault or liability, they can send a question into the mailbox and attach a copy of the policy.

(Bill Decker): OK.

(Barbara Wright): OK. We've had several questions come in that are aimed at excess insurance, reinsurance, where the description in the incoming is clearly that one insurer is paying another insurer. Insurer one is paying insurer two and that it's insurer two that actually is handling the claim, the making payments to a Medicare beneficiary. We've had it phrased in terms of an adverse arbitration

agreement. We've had it phrased just in terms of we're paying the money, et cetera.

Keep in mind that we've said from the beginning, when you have excess insurance, reinsurance, stop-loss, et cetera and that insurance, the excess insurance is reimbursing the first insurer, in that case that second insurer, the excess is not the RRE. And I think we've said that pretty consistently, but we had I think at least five or six questions in the last month or so.

On foreign insurance, which is one I neglected to mention in the beginning, where language is still pending; we believe we're fairly close to issuing an alert with the policy when we're talking purely about entities that have liability insurance or that have workers compensation, et cetera. What will be a little bit longer forthcoming is CMS's position when the individual or entity is foreign and is self-insured, since that's not quite the same scenario in terms of, for example, whether or not they're doing business within the United States. So know that that is forthcoming as well.

(Bill Decker): A purely – a purely foreign employer, for example, that self-insures for liability.

(Barbara Wright): Well it could be a foreign manufacturer, for instance, who's self-insured and who is clearly selling products within the United States. We still are awaiting information from internal discussions and our counsel on how we're going to proceed in that situation.

We have had a couple of questions that have to do with attorney responsibility if someone's an attorney for an RRE. We cannot give you legal advice on what your obligations are with respect to your client. We were also asked whether such attorneys could ever by RREs.

Whether or not they're an RRE when they're acting purely in a – in an attorney responsibility to an entity that's an RRE would not eliminate the fact that they might be RREs in their own right, either because their law firm was self-insured or their law firm was involved purely from a status of being an RRE on their own. So attorney firms or individual attorneys are going to have to evaluate or not they are an RRE in a particular situation.

We have continued to say with respect to set-asides or liability situations that set-asides are not required in terms of CMS being involved in any type of determination of how much the set-aside should be. We have also said that our regional offices have the ability to evaluate proposed set-aside amounts for liability if their workload permits them to do so.

This is not the same thing as a blanket statement that liability set asides are simply not required or not appropriate. Regardless of the mechanism, Medicare's interests need to be protected. The statute says that we don't make payment where payment has already been made. Whether or not this is protected through setting up a formal set-aside, setting up a formal trust, simply keeping the money and ensuring that it's being – that it's paying prior – in a priority manner to Medicare until the appropriate funds are exhausted; those are all choices, but we need to make it clear that's not the same thing as saying – and that we are not in fact saying that liability set-asides aren't appropriate. So that's our general response on that.

In terms of reporting requirements, again, with respect to recovery; various entities seem to be confusing the Section 111 process with the preexisting and ongoing recovery process for conditional payments once there's been a settlement judgment payment award or other payment.

If a case is self-identified, either by the plaintiff's attorney or the plaintiff himself or the insurance company or workers compensation to the COBC on an individual basis, where it – while it's still pending, we have a multistep process that establishes a potential recovery case allows us to start collecting conditional payment information.

This process is not the same as the Section 111 process and does not eliminate any Section 111 requirements. We received two or three questions that said if the plaintiff's attorney has reported this as a pending case or if the plaintiff's attorney promises me or certifies that they will report this, do I still have to report it as an RRE and the answer is yes. If you have an obligation of an – as an RRE that is separate and apart from any other reporting responsibilities and repayment responsibilities.

We had a general record retention requirement. As we've said before, there are no specific record retention requirements tied to Section 111; however, there are a number of different other statutes out there that tie into MSP in general. So we have no specific advice for you in terms of record retention, to the extent that you are potentially subject to penalties or subject to issues in terms of other recoveries. Laws and regulations that govern those recoveries have to be taken into account.

We asked – we were asked whether or not there's any reason why an RRE could not purchase insurance for Section 111 penalties and fines if it becomes available in the marketplace. Several surplus line carriers appear to be interested in that. Again, we can't give you any legal advice on this. Know that if there's a situation where CMPs are ultimately ever imposed, we would be imposing that penalty against the RRE. It would not be our obligation to pursue directly from the insurer.

In terms of who is an RRE, where there's both a deductible and an amount paid above the deductible, there's at least one situation where an entity has asked for further clarification on situations that throw one or more TPAs into this mix and has a question about what happens if the TPA belongs to – the only contract with the TPA is the actual – is the contract with the insurer, but the bank account is funded by the insured. And that's one of the issues that we will be more specific on in our – in our final language.

I can't remember if I've hit this on one of the other questions before, but again, the issue of entities coming in and repeating that well, when we pay medicals and we continue to pay medicals, how do we report all these TPOCs, all these additional payments? And as I said, all the descriptions we've seen so far of the people sending the questions in are reporting situations that to us appear to be ongoing responsibility for medical situations, in which place – case, you would be reporting that ongoing responsibility and wouldn't be reporting the underlying separate payment.

Where we're leaning in terms of the periodic payments for workers comp and no-fault is to – and this – I will say leaning. I will repeat again, this is not a final position. We're trying to determine whether there are any loopholes or

unintended consequences if we move to this position. But the idea is that if there is a benefit that under state law is not expected or is specifically for something, for instance, indemnity payments for lost wages; if ORM is already being reported for that case or ORM continues as long as the periodic payments continue, then our expectation is that we'll be able to say the separate payments do not need reported, only the ORMs.

But we haven't come up with any situation where we believe that there should be such periodic payments without some type of continuation of ORM. So if there's allegedly a situation where there are indemnity payments, but no ORM, the likelihood is that we will require TPOC reporting in those situations. So that's where we are tentatively on that. Again, I say tentatively; that's not final direction.

There was a question about a judgment award of punitive and exemplary damages and whether that's included in the amount reported. There is an obligation to report the complete settlement judgment award or other payment. It would be a defense from the – when we're pursuing recovery from the beneficiary if there was actually a hearing on the merits that said a certain amount was medicals, et cetera. If it's by a court of competent jurisdiction, we would typically defer to that, but it's not up to the RRE to make that type of call.

Male (It's good), but there's got to be a finding.

Male: There's got to be a finding, not just a hearing.

Barbara Wright: OK. We had a question about whether or not the 60-day window for reimbursement is triggered from the date of the settlement; check. Basically, the actual obligation for repayment, which is in the statute and in the regulations, is 60 days from receipt of funds. Remember that, except for limited workers compensation and no-fault, CMS is – where we already pursue recovery directly from workers compensation and no-fault, we expect, particularly in the liability insurance arena that we will routinely be doing any recovery action with respect to the beneficiary settlement by pursuing a recovery demand against that settlement.

We had what actually appeared to be more of a complaint. It was an entity writing in and essentially saying we're going to be using an agent, but bottom line we can't completely control them, so we don't believe we should be responsible for compliance. We don't see how we can be held responsible for penalty. It's our RRE's choice whether or not they use an agent or whether they report to us directly, but under the statute they are the ones that are ultimately responsible if there would be any type of CMP.

We're going to put you on hold just a second again.

(Bill Decker): There was a question that referred to blanket accident coverage and it kept referring to the fact that such coverage is neither workers compensation nor liability. They neglected to consider whether or not such coverage could be no-fault coverage. And generally speaking, if the coverage is going to pay without regard to fault, it's no-fault coverage.

Barbara Wright: OK. The next issue is we continue to receive a number of cases where the situation seems to involve joint and several settlements versus separate settlements. I believe we've said on more than one call that if you have a situation that has multiple defendants and they enter into a joint settlement agreement, where they each technically have responsibility for the whole settlement if one or more defaults on it; in that situation each entity must report the entire settlement judgment award or other payment.

If on the other hand, you have a situation where there are multiple defendants and they each enter into a separate settlement, then they are each responsible with reporting with respect to that separate settlement judgment award or other payment.

Let me see if there's any other. We had one other one that has to do with things, slightly with the recovery contractor, but also in terms of what's going on here in collecting information. It was a question about consent to release versus proof of representation when we have TPAs that are working for an insurer and they want conditional payment information.

What happens in that situation is if the – if it's workers compensation or no-fault and that entity already has the right to receive conditional payment

information without any type of release from the beneficiary, what we need is a letter of authorization from the workers comp or no-fault insurance saying that TPA X is working for them with respect to a particular beneficiary's pending claim. However, if we have a situation involving liability insurance, we cannot provide information about pending conditional payment, et cetera, without a specific release from the beneficiary.

So in that situation, what we would need is a consent to release, signed by the beneficiary, saying that it's proper to release information to the insurer and there would need to be the letter of authorization from the insurer covering the TPA and saying they are representing that insurer with respect to matters involving beneficiary Y or whatever the beneficiary's name is.

The point is a consent to release doesn't give the person the information is released to the right to re-release it to another party. So in a situation where you have a TPA working for an insurer, the consent really needs to run to the insurer and then they have an agent acting on their behalf. If the – if there's a consent to release directly to the TPA, the TPA has no right to give that information to anyone further.

So I hope that clarifies it a little bit further. We will also be looking, in terms of the user guide; there's at least one place in the user guide where we talk about a settlement judgment award or other TPOC payment on or after January 1st, 2010 versus TPOC date. In all likelihood that should say date. We haven't had a chance to go back and check in the actually user guide. We will look at that and correct that as appropriate.

Pat Ambrose: And the point is that if it's a TPOC, it doesn't have to be reported unless the TPOC date is 1/1/2010 and subsequent. I think that's the phrase that originally said something like other payment and we wanted to distinguish what other payment meant in that particular sentence; distinguish it from ORM payments for individual medical services stuff.

And again, the reporting date for ORM is 7/1/2009 and TPOC is 1/1/2010, so I actually understand why it was phrased that way. I also understand why it's confusing.

Barbara Wright: OK, two last quick ones. We continue to get questions about what about Medicaid guidance for Section 111. Section 111 is part of the MMSEA, which is Medicare, Medicaid, and SCHIP Extension Act of 2007. But Section 111 is solely a Medicare provision, so there are no Section 111 requirements with respect to Medicaid.

The other real quick one is we've been asked again whether or not there is an exclusion for local governmental entities or any other entity – governmental agencies. There's been a statement made that such entities are not engaged in a business, trade or profession. CMS has always considered governmental agencies essentially to be engaging in business.

An example of where we use language along that line is in 42CFR 411.50, where we are talking about a self-insurance plan. And we talk about a plan under which an individual or a private or governmental agency carries its own risk. So yes; governmental agencies are required to report.

Since it's now two o'clock and we have a limited amount of time for questions.

(John Albert): This is – this is (John Albert). We're going to, in a second, turn it over for questions from the participants in the call, but there was one thing I wanted to also touch base on and that is that CMS is receiving copies or replies to requests for SSNs using the model language that we suggested and it's out there as a download on the Mandatory Insurer Reporting Web site.

And we would ask people that – to make sure they include their own return addresses, because having them come back to CMS doesn't do anything for the process and for you in particular. So please make sure that you include your own return mail address. Do not send copies of them to CMS. Nothing happens with them except going into a shredder, essentially, because we do not store those.

That's the kind of information you need to keep in your records to determine that you know to document that you are in fact attempting to collect the necessary information for compliance purposes under Section 11. So again,

please make sure that your documentation going out includes your you know appropriate return address and not a CMS address or no address.

So other than that, operator, we'd like to open up the floor to questions and we also ask that the people on the phone please state your name, as well as the company you're with.

Operator: As a reminder, if you would like to ask a question, simply press star and then the number one on your telephone keypad. You first question comes from Mike Stinson from ConocoPhillips. Your line is open.

Mike Stinson: The question that we have relates to indemnity. And I'll give you an example, like if we owned a convenience store and we were selling a – selling a bottle of water and someone's suing us because of something that they said got sick out of the bottle of water. And then the manufacturer of the – of the bottle of water said to us, the owner of the convenience store, we're going to indemnify you in this matter.

And so we – they settled – so they accepted in the lawsuit you know full responsibility for resolving it and they – it wasn't an insurance company; it was just another company. So they settled with this individual. So the question; we initially understood that both the water company and the convenience store would have to report the settlement, but in one of the prior telephone conferences, we got some confusion there as to actually, maybe just the bottled water company would have to report and not the convenience store. So on these tendered matters, indemnifications; we just need some clarification on how to proceed on those.

(Barbara Wright): Is the store in this case; did it actually settle with the beneficiary and did it provide any payment to the beneficiary? If it did, then it's still going to have responsible reporting entity status if that was self-insurance for them. The fact that they then went to you and you gave them the $10,000 they paid out, that's – you're following more into the line of reinsurance, self-insurer – I mean reinsurance, excess insurance, et cetera.

If there was a settlement agreement and payment directly by the bottle manufacturer then yes; they're probably in the RRE status unless they actually

had an insurer who was the one that had the RRE status. So I don't think we can give you a definite answer or rule. It really depends on who actually got involved or was involved in the actual settlement, judgment award, and other payments.

Mike Stinson: By involved, do you mean who was – who paid or who …

(Barbara Wright): Well also who settled. If the store owner settled for a sum of zero the store owner, even if it's self-insured, isn't going to have anything to report. But if you have a situation where the store owner settled for $5,000 and then the bottle company reimbursed them that $5,000, from the limited information we have on this call, the store owner would be the RRE.

Male: it is not (necessarily there's) not the ultimate source of funds; it is the entity that made the payment. In your – if the bottle company reimbursed the store, which gave the money to the beneficiary, the bottle company may well have been the ultimate source of funds, but they did not make the payment to the beneficiary; the convenience store did.

Mike Stinson: But if the – if the bottle company paid it; just paid it all, the $5,000, then …

(Barbara Wright): Did the bottle – did the bottle company have any type of settlement agreement? We will have to look at whether our – it sounds like our language may have a hole in it in terms of situations involving self-insurance, where you have the equivalent of excess insurance. And we'll look at the language, but I can't say from what you've given us so far that the store owner would never have a situation where they were an RRE. I can think of another – a number of situations where both might end up with some responsible reporting entity status.

Mike Stinson: Any clarification you can give us would help, because we have a lot of those situations in different you know in different types in that same level, so you know we're looking for whatever guidance we can get on that.

(Barbara Wright): OK.

Mike Stinson: OK, thank you.

Operator: Your next question comes from (Bill Donlon) from Standex International. Your line is open.

(Bill Donlon): Yes. My question is this. We want to know who is the responsible reporting entity in the following situation, when there's an insurer, a third-party administrator, and an – and an insured arrangement. The circumstances of this; there is a contract between the insurer and a TPA that's not owned or affiliated with the insurer and there is no contract between the insured and the TPA.

Also the TPA is handling claims on behalf of the insurer as an agent of the insurer and thirdly, the amount paid within the deductible originate – the amounts paid within the deductible originates from the insured bank account are transferred to the TPA's bank account and the TPA's bank account then funds the claim payments made directly to the claimants or medical providers involved who are treating the claimant.

(Barbara Wright): I think I said, Mr. (Donlon), earlier in this hour that that's precisely one of the specific situations we are going to make sure the language we're working on right now addresses. So when that language is released, you will have your final answer.

(Bill Donlon): Do you know what the answer will be?

(Barbara Wright): I really can't give you a final answer right now. Based on the way the draft language was crafted, I would say it's most likely that the insurer will be the RRE in the situation you described and I understand that you've said that you and a particular insurer are of different mindsets on this, so we are making sure that this type of situation will be addressed.

(Bill Donlon): Yes. And I'll just say this. You know we're – I don't think we're the only company in this situation and I don't think the insurance carrier is the only insurer in that same situation.

(Barbara Wright): OK.

(Bill Donlon): OK, thank you.

Operator: Your next question comes from (Bridget Grady) from Benderson Development. Your line is open.

(Bridget Grady): Thank you. (Bridget Grady) with Benderson Development; a question on SSDI. Trying to verify what are the reporting requirements relating to an otherwise non-Medicare eligible individual who has applied for SSDI, but has received – or has not received a decision prior to settlement of their claim.

There's a couple different scenarios here you know if they were denied and they might reapply. This is one that we did e-mail over to you with like four different scenarios.

(Barbara Wright): Yes. Two things, so that everybody in the audience is on the same wavelength; SSDI, Social security disability income, is different from SSI, which is supplement security income, which is a welfare-based program and I believe you questions were talking about social security disability, wherein individuals who qualify for that are entitled to Medicare after a certain waiting period.

If you have a situation that is a TPOC only, if they are not a Medicare beneficiary as of the reportable TPOC date, you do not have to report. If you have a situation that involves ORM, then you have the monitoring issue we've talked about on other calls, where you will need to continue to monitor and when the person becomes eligible, if they become eligible, for instance, because they qualify for Social security disability, then you will need to report the ORM.

(Bridget Grady): So anything prior to them being eligible or if it's settled before they're eligible is not reportable.

(Barbara Wright): Again, it depends on whether it's a TPOC or ORM.

(Bridget Grady): OK.

(Barbara Wright): OK?

Male: You know if you're still paying claims you know once they become you know entitled to Medicare and they have Medicare then that's a situation that would be reportable.

(Barbara Wright): Could you hang on one second?

(Bridget Grady): Yes.

(Barbara Wright) (She knows that we're going to handle) (inaudible).

Female (Handling the TPOC).

(Barbara Wright): If you have a – internally here, someone was just mentioning situations where there's retroactive Medicare entitlement. In terms of TPOC you're still off the hook. You don't have to report that if they're not a beneficiary as of the TPOC-reportable date.

When you report ORM, even if you're reporting it one or two years down the line, because they didn't become a – they weren't a beneficiary at the time you actually assumed ORM, you still report the proper date of incident and that takes care of it as far as our records go, to make sure we reflect the ORM for the proper time period.

(Bridget Grady): OK. All right, thank you.

(Barbara Wright) (Operator)?

Operator: Your next – your next question comes from (John Miyano) from Golden Lamb. Your line is open.

(John Miyano): Good afternoon, everyone. This is (John Miyano) with Gold Lamb. I have a question with regard to an RRE client. Essentially the entity or organization has become bankrupt. The matter is in court. The court has not ruled as yet with regard to the bankruptcy. The currently only a court – a court appointed trustee with regard to this case and until the court rules the claims themselves can't go to a state guarantee fund.

So I guess the question is is you know who is to report these claims, when do they become reportable, who should be considered the RRE, how does the RRE get registered if the entity themselves is not bankrupt?

Male: We talked about bankruptcy with respect to group health plans (I believe). We'll have to look at that language and make appropriate modifications for the non-group health plan context. I do not think that this is a major issue. I thought it was already addressed somewhere.

(John Miyano): Well I mean you know bankruptcy has been you know handled in terms of when it – when a state guarantee fund now has possession with regard to the claims in terms of their responsibility or possible responsibility to report these claims.

(Barbara Wright) (But) …

(John Miyano): However, where these claims have not yet been, or rather where the responsibility has not yet been assigned to a state guarantee fund, where the bankruptcy court has not yet made a ruling you know we have third-party claims administrator clients of ours that would like to know what their responsibilities with regard to reporting these claims.

Because obviously you know the bankrupt or insolvent entity can't register as an RRE. There's no one there to register. So you know they have these claims and they can't report them cause there's no RRE ID to report them under.

(Barbara Wright): OK. You may have already sent this in and you may not have, but could you please take a look at your specific questions and look at the limited amount of information that it has about bankruptcy in the 7/31/09 alert and phrase your question with that? Tell us what you think is missing from that language. Could you do that?

(John Miyano): Will do.

(Barbara Wright): Thank you.

Operator: Your next question comes from (Timothy Polari) from (France Ward). Your line is open.

(Timothy Polari): Hi. This is somewhat a follow-up question, also involving the bankruptcy context and this may be something that's going to be resolved more in the new Section 7.1 when that gets finalized. But one of my clients is – has filed for Chapter 11 bankruptcy and in order to pay personal injury claims the proposed plan provides for the formation of a trust in which all the entities existing in future personal injury claims would be channeled. And then that trust as a standalone entity would be assuming responsibility for the liabilities.

And my understanding from the – from language that's been given is that, in that Section 7.1 that that trust would be the RRE, but it wasn't entirely clear because there were some previous transcripts that discussed trusts just generally as not being able to be categorized as an applicable plan.

Male: So look at the language we got with respect to liquidation at bankruptcy and if necessary make appropriate clarifications.

(Timothy Polari): OK, thank you.

Operator: Your next question comes from Richard Schultz from Fund Insurance. Your line is (open).

Richard Schultz: Yes. I heard you say earlier that the applicant attorney tax identification number was not going to be a mandatory field now. Do you have an idea when it might be a mandatory field?

(Barbara Wright): Part of what we'll be doing as reporting first starts is determining how many times we – when we don't have that information it's forcing us to make additional contacts and take additional steps; have additional work. If we change back to requiring it, just as if we would decide to require both the firm name and the attorney on an ongoing basis, we will give substantial advance notice.

Male: I mean the reason for doing that is, again, in recognizing that you know as people work to develop the complete information to satisfy the reporting

requirements you know we're hearing what you know people are having trouble with as I've said on many a call that we're much more interested in building a good comprehensive data exchange than penalizing anyone for noncompliance.

And while we do not have a date out in the future when that information would be required, the thing that we want to stress is that information can save a lot of time on the other side, which would be the recovery side. So again, we strongly encourage people to begin developing for and providing as much of that information as possible because, again, it may make it easier to report you know spaces in a field because you don't have that information, but the chances are more likely that outreach will be taking place to those particular entities to develop for that information anyway.

(Barbara Wright): And a good example of that is the attorney firm name versus the attorney's name. Remember that our recovery contractor has to be matching up situations where they may have already had a case or a pending case self-identified. And if all they have is the attorney name, because there are various ways that information comes in, and don't have the firm name and what you report is the firm name, you've actually increased your chances that we're going to have to recontact you and may have to ask you further questions, whereas if you were able to supply us with both the firm name and the attorney name then we've got that right in front of us and it makes any matching we do much easier, so.

Male: Historically you know having duplicative information that is not 100 percent duplicative on the space can result in a lot of follow-up activity that you know affects all involved. And the goal of this, again, is to get one clean record and be able to take it and run with it and not have to bother people anymore with requests for information, so.

(Barbara Wright): Yes. I mean, as we've said, our intent is not to change our standard recovery process where we're typically recovering against an individual beneficiary settlement and the more information you give us that allows us to proceed in that way and not have to come back to you, ultimately it'll save you time, as well as us.

Richard Schultz: And I understand that more information is better, especially for recovery purposes, but what I'm also hearing is that that field, which is not mandatory, will become optional.

(Barbara Wright): Yes.

Richard Schultz: Then my follow-up question on a different subject, relative to workers compensation, where we have mostly injuries to people that are in their 20s and 30s and I think you touched on this a little bit in another part of the call; in workers compensation, the majority of injuries are minor. You know they're 2, $300, $500, $1,000 injuries to people that are in their 20s and 30s.

What would you consider to be a reasonable length of time before we would put in an ORM termination date if a person is cured and not treating, even in a state that has lifetime medical benefits?

Male: My recollection is that we discussed at one point that if you have documentation from the treating physician that additional treatment will not be needed for the underlying injury or illness that you could put in the term date.

(Barbara Wright): That's correct. That's in the user guide.

Richard Schultz: Yes. It's not always easy to get doctors to do that, so I was wondering …

Male (Inaudible) …

Richard Schultz … if a person doesn't treat …

Male … state law and if state law says it's open for ever.

Male: Can you hold on just a second?

Richard Schultz: OK.

Male: OK, we're back. I mean I guess you know we just – we just want to talk internally real quick because you know we've issued a lot of you know

different guidance regarding this particular subject, but I mean unfortunately you know we can't necessarily prescribe what you know a blank you know statement that you know it it's X amount of dollars and the person's X age then you can terminate within you know X number of months, days, years or whatever.

But I mean the fact of the matter is, if it is considered you know if you have ongoing responsibility for payment of those claims then that record basically needs to be kept open. Now if the person is not a beneficiary that's a different story, because that you know that's just a question of monitoring out into the future. But for – in terms of you know the record itself that would have to be report so; if they are a beneficiary.

(Barbara Wright): So in short, if you've reported them and they're in a state with lifetime medical, so it's technically open, you need to have it open unless you have like a physician's – the treating physician's statement, et cetera. But if it's a situation where it's simply monitoring because they're not a beneficiary at the time and you have no real expectation that they're going to become one shortly and it's, for example, minor injury, then what we've said in the past is we are trying to think if we can come up with some method that would allow you to stop monitoring after a certain period of time or at least to only query on you know sort of a broad base manner, but we don't have any definitive answer on that second part.

Male: I guess you know from just looking at it from the CMS perspective and that is you know our task is to essentially enforce the MSP statute and we're looking you know we're looking for assistance. We're not out to make people report you know things that would never result in MSP or whatever, but at the same time, we do have to be able to provide justification and I recognize the statement that you know a statement from a treating physician is not exactly the easiest thing to get in all cases, but we are looking for suggestions in terms of how to address that.

And I know we, like I said, we understand the issue, but at the same time you know we have to do what we have to do here and we're just trying to basically

build a process that is you know as beneficial, but at the same time not so onerous that it you know.

(Barbara Wright): And keep in mind it's particularly problematic for the states where there is …

Male: Yes.

(Barbara Wright) … lifetime medicals. For instance, if someone has a knee replacement when they're fairly young, because they had a severe injury, but it's not enough to make them disabled for Social security purposes so that they end up with Medicare.

In most cases with a knee replacement where someone is relatively young, they are going to need at least one more knee replacement down the line and perhaps more than that, particularly as they age. So what we don't want a situation where we never hear about those people so that we're routinely paying for those expensive procedures down the line, when in fact the workers comp, in the situation I just discussed, clearly would have the legal responsibility to do so.

So that's our dilemma. It's not that we don't want to work with you and figure out a way to do it, but we haven't come up with any way to protect our interests in those situations, except to require the monitoring so that it can ultimately be recorded.

Operator?

Operator: You next question comes from (Bob Russell) from Sedgwick CMS. Your line is open.

(Bob Russell): Thank you very much. Just a second; I got to get my question back opened here. Here's my question. If we settle a liability claim for a total of $100,000 and obtain a signed release for the full $100,000; settlement documents agree that a portion of the settlement is allocated for payment of the Medicare lien.

So for example, 70,000 is paid to the claimant and 30,000 is held back to pay the Medicare lien, based on the most current conditional payment statement;

however, we cannot make the payment to MSPRC until we receive the final – MSPRC's final demand. How do we report TPOC? We have a settlement for 100,000. Do we use the date the settlement agreement was signed, even though we'll be making two different payments on two different dates.

(Barbara Wright): Use the TPOC date as defined in the user guide, which essentially says normally it's going to be when you have the releases, if it requires court approval when that occurs. The only time you'd be using payments is when you have no release or no other documents, so I would hope that that would occur fairly rarely. And you'd be reporting the full $100,000.

The fact that the most recent conditional payment statement has X amount is not a guarantee that that will end up as the full – as the final conditional payment amount. Further, in the majority of the times, if there is no change in the conditional payment amount, our actual recovery demand ends up to be less than the conditional payment amount, because if there are attorney fees and costs borne by the beneficiary in conjunction with that recovery, when we do our conditional payment recovery, we do a pro rata reduction to take those into account.

(Richard Schultz): OK, thank you very much.

Male (And they have) said that the Medicare recovery demand would exceed this $30,000 you mentioned, Medicare is not bound by the private agreement between you and the injured party.

(Richard Schultz): Right. And then we would just have to do a revised TPOC, correct? In that case, where the MSRC amount was more than 30,000?

Male: Yes. You would have to change the amount of your responsibility, yes.

(Richard Schultz): OK.

(Barbara Wright): No. If you're reporting the full $100,000 then you've reported the full amount.

Male: No, no. He's saying because they now have to pay more than $30,000, here's another 10,000.

(Richard Schultz): Right.

(Barbara Wright): If your settlement agreement is for $100,000 and it's liability insurance then that is the bounds that governs how we calculate our recovery claim. The fact that the amount cut to CMS might need to be more than the amount you allocated for purposes of that doesn't change what the bounds are for our recovery if it's a liability situation.

And as I said, in most instances, we will be issuing the recovery demand to the beneficiary. So whether you end up cutting us a check for part of that in full or doing it as a joint payment and the attorney ends – the attorney/beneficiary ends up making up the difference that's not really an issue. If you're liability settlement is for 100,000 that's what you're going to be reporting.

Male: OK.

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

(Susan Convose): Hi. First thing, I just want to make the statement; we can hardly hear Barbara Wright. It's extremely hard on this end. I don't know if anybody else is experiencing that, but.

My first question is, with TPOCs, are we only supposed to report them if they include medical payments?

(Barbara Wright): We have said in the past that you're reporting when a settlement judgment award or other payment releases or has the effect of releasing medicals. It's not up to the RRE to determine how to allocate the settlement judgment award or other payment. As we've said, we're not bound by the parties' allocations.

And so in a liability situation, if you have a total of $100,000, that's the settlement; that's what you need to report, even if you – even if the parties

want to say 95 percent of it's for pain and suffering and five percent is for medicals, no; you need to report the 100,000 and CMS will make the determination regarding what its claim is.

(Susan Convose): OK, so if we – sometimes we settle only the indemnity portion; we continue the liability for the medical. So does that mean we do not report that?

(Barbara Wright): If you have ongoing responsibility for medicals, you'll be reporting that separately as ORM.

(Susan Convose): OK. So we wouldn't report just the indemnity only, all right. My second question is, when we were looking at the claim response file, we were wondering, how is CMS going to notify us that they have a different date of incident, because the error codes are basically formatting? How …

(Barbara Wright) (Yes), there is – there is no systematic check, comparing the date of incident to anything that we might already have on file. The information that you – so if your date of incident is accurate or is a properly formatted date and so on, passes the edit, we take that at the COBC. It does get passed to other systems and particularly, say the MSP recovery contractor, the MSPRC and they may have a report of that same incident. It's up to their system to determine you know if the dates are off. They handle that on the backend.

(Susan Convose): OK. And can I just add one more quick question? I was looking at some of the CBTs and on one of them it says that if we provide a social security number and a HICN; if the HICN is wrong, they would then validate the Soc. Is that accurate?

(Barbara Wright): That is the routine that is in place for the matching (of the) injured party, both in the query and with the claim input file.

(Susan Convose): OK. Cause I thought that originally we were told that if we supply a HICN and a Soc they'll only look at the HICN.

(Barbara Wright): Well it starts out looking at the HIC number and if it cannot get a match on the HIC number, if the social security number is present it will try that next.

(Susan Convose): Oh OK, all right.

(Barbara Wright): And then if a match is found on the social security number and three out of four of the other fields match, your record will be returned to you with what we do have as the current HIC number.

(Susan Convose): Oh OK, all right. Thank you.

(Barbara Wright): Where you may have gotten confused and, Pat, correct me if I'm wrong, is if you supply both the HICN and the social security number …

Pat Ambrose: Right. It'll only look at the HICN.

(Barbara Wright): If the HICN is correct …

Female: Right.

(Barbara Wright) … it does not go on and validate the social security number, so even if it's wrong, you won't know (that the) …

(Susan Convose): Oh, OK.

(Barbara Wright) … social security number is wrong.

Pat Ambrose: We – yes. That is accurate. The – whatever social security number you send to us, we always send back, whether we matched it or not.

(Susan Convose): OK.

Pat Ambrose: We don't ever provide, in a sense, social security numbers back in that field.

(Susan Convose): OK, all right. Thank you very much.

Female: Good.

Operator: Your next question comes from (Carol Sheehan) from Highpoint Insurance. Your line is open.

(Carol Sheehan): Yes, I had question – two questions, if you can allow them; the first about social security numbers. When we are asking potential claimants for their social security number and they're telling us they don't have one. They fill out the certification; we've used the model certification that you've provided.

What they then sometimes come back at us with is they fill out the certification; they provide a number, a social security number. But they say it's not as social security number; it's a tax ID number. So I'm trying to understand how that could possibly be. And it starts with a nine. Is there any differentiation on social security numbers when they start with – the first number starts …

Male (Inaudible) social security number; it is a TIN. There are circumstances where an individual does not have a social security number and somehow or other the IRS assigns the TIN. I would – you'd need to give me more detail on that for me to research that.

(Barbara Wright): But if they supply a number that they're saying is not a social security number is a – but is a TIN, you can always include it in the query.

(Carol Sheehan): Right. And that's what we figured we would do, but and then as a follow-up, because other – our claims adjusters are questioning the situations where people say they don't have a social security number, but they are working for you know a major corporation. They pay taxes you know they fill out W-2s and all that. How can that be? How can you work for a company legally and yet not have a social security number? Can people come into this country and do all that and not technically have a social security number?

Bill Decker: Well the general – hi, this is Bill Decker. The general rule is – on SSNs is that you have to be assigned an SSN by the Social Security Administration and generally you're assigned an – and they only assign SSNs to citizens or people who are legally entitled to have a social security number. In the case o tax ID numbers, there are people in the country legally or here on, say legal visas, who are working legally and who don't have an American issued – they're not a U.S. citizen.

They don't qualify for social security, but they need to have their income reported because they may be in fact paying taxes. And besides, the employer has an obligation to report that sort of thing. And so they can obtain from the IRS a number that looks like a social security number, but is not a social security number. It is in fact just a tax ID number, so used only for reporting for IRS purposes, not for social security system.

I believe – I believe that if you go to the Social Security Web – the SSA Web site, you will find that no legal event is – no real social security number start with a nine.

Female: Correct.

Bill Decker: And so any social security number you see that begins with a nine is not a social security number in the way that we ordinarily think of them. They could be tax ID numbers; they could be anything else that might be legally issued.

(Barbara Wright): And therefore that person is not a Medicare beneficiary.

Bill Decker: Right. And that person – right. Anybody who has – comes to you with a tax ID number that looks like a social security number that – but that is not – is not going to be a Medicare beneficiary.

(Carol Sheehan): OK. And can I …

(Pat Ambrose): I just wanted to chime in and state that I believe that CMS's preferred identifier is the HIC number and you know you should be encouraged or your claims examiners, whomever is collecting this information should be encouraged to get the Medicare beneficiary's HIC number if at all possible, since really what you're trying to do is report only on Medicare beneficiaries and obtain that number first, instead of a social security number.

(Carol Sheehan): OK. OK and another quick question about ICD9 codes. We're really struggling as to how we could possibly report that, when our claims adjusters, who are casualty-liability adjusters, have very little knowledge and understanding about ICD9 codes.

So if when they are being presented with an injury to, let's say you're you know you've herniated a disk at C34; there's probably 50 ICD9 codes that match up against that. So are we really ever going to give you the correct code? Is it OK to then make assumptions, maybe do some mapping that just generally provides general ICD9 codes, as opposed to really getting a specific code out to you?

Male: Number one, in the short term you can use a verbal description.

(Carol Sheehan): Right, but I'm worrying about next year.

Male: And number two, generally I would assume the claims adjuster has gotten copies of bill, say from a hospital or other institutional provider. They generally will have diagnosis codes on them. Those will generally be ICD9 codes.

(Carol Sheehan): Well quite often we don't get the bills and we don't want to hold up settlements for that and so you know we're presented with medical records, MRI reports, narratives, and never get an ICD9 code.

Male: Well I mean all I can – I mean we don't really have a response for that, except that you know the move toward using those code sets is becoming you know more and more common and we would encourage you to you know invest in trying to get that information, because as all healthcare information goes more and more electronic, that code set is becoming more commonly used across the board and that also, again, as I mentioned earlier, that information will assist in quickly resolving any backend issues in terms of recovery, so I you know we recognize that you know this is a change in a – in a process that exists now, but unfortunately those are the requirements, so.

We will you know of course we're aware of you know that you know this is a new issue for a lot of people and you know we plan on providing additional information and maybe some other guidance, training, et cetera, to the public over time to basically help get everybody in compliance with the requirements. But I realize the requirement starts you know a little sooner

than it used to, but that is the requirement we expect everyone to move toward.

(Carol Sheehan): All right, well I just hope could take into consideration the amount of extra work that would involve and possibly delaying litigation because we're going to hold up you know resolution of claims, because we're waiting for doctors' bills that sometimes the attorneys can't even get. I mean it's not as you know we're not health carriers. We are liability carriers and we are not paying the bills, so we don't have access to a lot of that.

Barbara Wright: But we're not – we're not saying that you have to have the bills and remember the record layout says alleged injury. So to the extent you invest in training within your company or entity in terms of recognizing appropriate codes for certain types of injuries, et cetera, you are – you are free to do the coding yourself.

(Pat Ambrose): And so, Barbara, it would be an acceptable situation that if their claims adjusters, someone working the claim had a verbal description of the injury that the IT people could write a conversion process to pick out key words and map that to a ICD9 diagnosis code?

Male: Yes.

(Carol Sheehan): Are you saying that's acceptable to kind of make a more generalization about an injury and match what appears to be an appropriate ICD code?

(Barbara Wright): Yes, that is – that was …

(Carol Sheehan): OK.

(Barbara Wright) … what was said.

(Carol Sheehan): OK, thank you.

Operator: Your next question comes from (Debbie Lee) from Orlando Health. Your line is open.

(Debbie Lee): Hi. We are a self-insured healthcare facility group and occasionally have a TPOC to report or will have a TPCO to report. And I'm wondering, when would an entity like us ever have multiple TPOCs on a claimant or is that something that you would normally just see like on a work comp or another kind of …

(Barbara Wright): We would expect, whether it's no-fault, workers compensation liability that in most instances there won't be multiple TPOCs. You will typically either have ORM or you will have a single settlement judgment award or other payment. But we do – we are aware that in at least limited circumstances there are a minimum of two TPOCs, particularly in situations – I'll give you an example.

At least some of the Fen-Phen cases had a surgical guarantee, where they settled for a relatively low amount, but if valve surgery occurred within, I don't remember whether it was one year or some other timeframe, the individual got another $100,000.

(Debbie Lee): OK.

(Barbara Wright): That's a clear situation where they would have a reporting of two separate TPOCs. But does that happen in every case; no. And certainly a lot of trauma-based injuries; it would be most likely that you would have a single TPOC.

(Debbie Lee): Thanks so very much.

(Bill Decker): Operator, we actually have to end the call a little early today due to another group that's going to be coming here, but before you did I wanted to have – Nathan Crawford wants to provide a brief announcement, as we have in the past, regarding Medicare secondary payer recovery contractor activities. Nathan?

Nathan Crawford: I just wanted to let everybody on the phone know that in the next couple weeks we're going to be updating the recovery contractor's Web site to make it a little bit more user friendly and apply some documents to the Web site that you can use to help facilitate the recover process.

So always stay tuned to that Web site, cause in the next couple months we'll be updating it periodically to just make it more useful and help everybody through the recovery process.

Male: Could you give them the site?

Nathan Crawford: The site is the mprc.info site.

(John Albert): Thanks, Nathan. And this is (John). I wanted to go back to the previous question again, regarding the ICD codes. I just wanted to also state that you know while, again, we you know there are processes that can be developed for accurate reporting; the reporting does have to be accurate. Simply loading random ICD9 codes will not suffice and would you know be considered noncompliant with the reporting requirements.

The point we were trying to make is that there are products and services out there available to help people convert that information into valid and accurate ICD9 and future ICD10 codes.

And with that, operator, we're going to have to wrap it up for now. Again, like I said, we have another group coming in here in a few minutes and they need time to set up. I'd like to thank everyone for their participation. Please continue to submit your questions to the resource mailbox. They are very valuable. As you hear, we try to answer some of these directly on the call or through improvements to the materials.

And with that, I'd like to say thank you and, operator, if you could hang on for just a minute.

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

(John Albert): Operator?

Male (She has).

END