TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: July 14, 2009

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

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FTS HHS HCFA

Moderator: John Albert
July 14, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants will be on a listen only mode. Today's call is being recorded. If you have any objections, you may disconnect at this time. Now, I will turn the call over to Mr. John Albert. Sir, you may begin.

John Albert: Thank you. Just for the record, today is Tuesday, July 14 and this is a non-group health plan or a Workers' Comp Liability No Fault Insurer Policy Teleconference. This is conference is geared more or mainly towards policy issues that have come up as a result of the implementation of Section 111.

And, again, we've received many continuing questions through the CMS Resource Mail Box and are trying to incorporate those into a newer version of the NGHP User Guide in the near future, so please continue to submit your questions.

I will remind everyone that we cannot necessarily provide direct replies to every question that we received, which now number in the many thousands. But, we are trying to use those questions to formulate and improve the User Guide and other materials that are on the CMS Web site for Section 111, which is mandatory insurer reporting of mandatory INS REP, as you probably all know, at www.cms.hhf.gov/mandatoryinsrep, excuse me.

I'm going to begin this, today's, teleconference with a brief presentation by Pat Ambrose. Some of the things that she'll bring up are probably a little bit more

on the technical side, but we wanted to take this time because we just had a technical call.

A couple of things have come up and wanted to try to get that message out as quickly as possible. And we will, then, of course, incorporate that into additional alerts or updates in the material on the Web page and following that will be basically a presentation by Barbara Wright, as well as going over many of the questions that we've received to date.

And to also provide additional information based on previous questions and new materials forthcoming. So, with that, I'd like to turn it over to Pat and Pat?

Pat Ambrose: Okay, thanks, John. As John said, most of these announcements that I'm going to make now are more of a technical nature, but probably do apply to those people on the phones.

The first concerns registration, which is comprised of the new registration step and the account setup step on the Section 111 COBC secure Web site. It is absolutely critical to provide information on your authorized representative during the new registration step. The first step on the Section 111 COBC secure Web site for the registration process.

During the account setup step, the second step that you perform after you've received your letter with the PIN, P-I-N, or Personal Identification Number, that second step, account setup, must be performed by your account manager.

The account manager will obtain a login ID and sign the User Agreement for the Section 111 COBC secure Web site during that time. So, again, it’s

absolutely critical that you provide information on your authorized representative during new registration.

And that your account manager performs the account setup step and provides their own personal information for the account manager during the account setup step. Remember, that authorized representatives cannot be users of the COBC secure Web site for any RRE ID.

If you've found that you have entered incorrect information, the wrong person, for the authorized representative during the new registration step, then contact the assigned EDI representative or the EDI Department at 646-458-6740 before proceeding to the account setup step with your PIN.

Please also see the User Guide and the How To's on the menu of the home page of the Section 111 COBC secure Web site for a more thorough description of registration steps and user roles.

Particularly, please read the How To Get Started and How To Invite Designees that can be found on the Section 111 COBC secure Web site homepage.

This Web site is www.section111.cms.hhs.gov. You must click on the I Accept link of the login warnings page in order for the homepage to display. You do not need a login ID to view the information on the homepage.

This information is also covered in the User Guide for liability insurance, including self-insurance, no fault insurance and Workers' Compensation, that can be found on www.cms.hhf.gov/mandatoryinsrep. On the left-hand side of the page, you'll see a menu option for a series of pages for that particular Web site.

We have staff currently working on questions that have been raised related to the X12 270271 mapping for the query input files and the corresponding companion guides that you will use or you need if you're using your own X12 translator rather than the HIPAA eligibility wrapper or queue software.

Please make sure that you have submitted your questions related to the X12 270271 mapping and the companion guide to your EDI representative for consideration if you haven't already done so.

I'd also like to note that there has been a sporadic problem with files uploaded to the COBC secure Web site using https and sometimes your secure FTP methods. The user transferring via https using the Section 111 COBC secure Web site user interface will see the file upload successful page.

But, then, may not see the file on the file listing or the test file results pages. If you do not see the fact that your file is received on the file-listing page of the COBC secure Web site the day after you have uploaded it, please contact your EDI representative to make sure the file was successfully transferred.

In most cases, the file has actually been received and will be processed. Your EDI representative will let you know if you need to upload the file again. There is a correction going into the system this weekend to resolve this issue. It is not occurring on all occasions and on all file transmissions though.

Please remember when you're uploading files to the COBC secure Web site using the user interface for Section 111 or sending to the secure FTP server that you should only be submitting text files. Text files only, not files with a dot Z-I-P or zipped files or any other binary files.

Those will not be accepted and will not pass the upload process. All filler in these files should be filled with spaces. Please review the file layout specifications for that information. There's also a minor problem on the RRE listing's page of the COBC secure Web site having to do with the sort function.

If you use the sort function, occasionally then selecting an action will fail. A correction is going in for those this weekend as well. To find the RRE ID in question, please use the search function and, then, select the appropriate action for the RRE ID. Until next week, please avoid using the sort functionality.

You may also see some response files with an incorrect response date and possibly the response, no response file link for the download. This might be occurring only for GHP RRE IDs. But, in case you see that happening, a correction is also going in for this weekend.

This occurs when the response file isn't actually ready for download, so you might see something unusual posted to the Web site in that case. The profile reports have been recently updated. A problem where the profile report was being sent missing city and zip code information has been corrected.

Also, the profile report should only, at this point, show your file transmission, assigned file transmission, timeframe for the claim input file and it also will show the month and day for when your file submissions are due. The year is not displayed.

Official notice of when files are due for claim input file processing can be found on the mandatory INS REP page of the CMS Web site. On the non-GHP page, in an alert dated May 11, 2009.

That alert provides information about when claim input files are initially due for non-GHP processing and that is the second quarter of 2010, April through June 2010, during your assigned file submission timeframe. The User Guide is being updated for this information too.

The file submission timeframe groups, the number assigned to each file submission timeframe is defined in the User Guide. If a RRE wants a new profile report in the updated format, please contact your EDI representative.

They will be able to generate a new report using the new format, which will be sent to your authorized representative. We expect to have the updated liability insurance, including self-insurance, no fault insurance and Workers' Compensation, otherwise known as non-GHP User Guide published by the end of this month, the end of July 2009.

Also, note the email address for the CMS Section 111 Resource Mail Box that we often refer to on these calls, that email address, is TL110-173FC111-comment@CMS.HHS.gov.

It can be found on the Section 111 Web site at www.cms.hhf.gov/mandatoryinsrep on the overview page in the third download at the bottom of the page. This download is entitled Revised April 10, 2009 and then MMSEA 111, opportunity to comment on CMS' plan for implementing Section 111.

Don't forget that there are computer based training modules on the Section 111 process available. Please go to the aforementioned Web site. On the left-hand side of the page, click on the link for MMSEA 111, computer based training and follow the instructions on that page.

You'll receive an email invitation to the CBT, computer based training courses shortly after you provide enrollment information. There’s no charge for the CBT courses.

You do not need a user ID or a login ID for the COBC secure Web site. In order to access the CBT courses, you do not have to be a registered RRE yet to take those courses. Once you have enrolled, you'll be automatically notified of new courses as they are rolled out.

Courses available include the process overview for non-GHP reporting, registration and account setup, the query process, file format, file transmission methods and courses on the COBC secure Web site. Further courses, based on the updated non-GHP User Guide, will be posted shortly.

The program, I already mentioned that. The RRE listing’s page on the Section 111 COBC secure Web site now shows the claim input file submission timeframe for each RRE ID.

Originally, we had a posted a phone number for the RRE ID on that page and that has been removed and replaced with the claim input file submission timeframe assigned to the RRE ID.

Please note the query test end production files will now be accepted for RRE IDs that are in a testing status. In order for your RRE ID to attain a testing status you must have your authorized representative sign your profile report and return it to the COBC EDI staff as indicated on that profile report.

Note that claim input file testing begins January 2010. Initial claim input files are due during your assigned file submission timeframe for your individual

RRE IDs in the second calendar quarter, April through June, 2010. I think, John, that's all that I have, so I will turn it back over to you. Thanks.

John Albert: Okay, this is John. I had one thing also that I wanted to go over. Again, we brought it up at the last couple of calls and that is in Section 18.2 of the User Guide, there's a contacts protocol for Section 111 data exchange operation.

We've been receiving some direct comments regarding EDI service to the CMS Resource Mail Box and I wanted to remind everyone to please utilize the contact protocol in Section 18.2.

Whereas, if you are not able to get a response from or a call back from an EDI rep, that there's an elevation clause in terms of a couple of layers of the COBC that can, basically, you can bump your call up if you're not getting responses.

I would also ask that the questions to the EDI Department be limited to more technical questions. Policy questions should still be submitted to the CMS Resource Mailbox because EDI department won't necessarily be able to answer those questions on behalf of CMS.

So again, help us help you, you know, manage the requests for assistance by using that contact protocol for technical questions to the COB contractor. Thank you and with that, I'll turn it over to Barbara who's going to go over some of the questions and what not that have come in since our last call. Thanks.

Barbara Wright: Thanks, John. The first thing I wanted to do was look at a couple of the outstanding issues. We've had a number of questions and we've said this in

the last couple of calls that have to do with hospitals that are doing write-offs for what they state is risk management purposes.

That issue is still under discussion here so we don't have an answer for that today. The second thing I wanted to say was for product liability and mass torts we did ask people to submit if they wanted to be part of any work group.

We have received some replies on that. No, we haven't set any meetings yet for that work group so if you are interested and haven't sent anything in, send a comment to the Resource Mailbox and please list that work group in the subject line so we can sort that easily.

The next thing is periodic payments in connection with workers compensation. We have an alert as a supplement to the User Guide that is in queue to be put up on the Web site and I'm going to read what that says. We believe based on comments we've received, it should generally make the industry happy.

It says, "In situations where the applicable workers compensation law or plan requires the RRE to make regularly scheduled periodic payments to or on behalf of the claimant and the applicable workers compensation law or plan specifically precludes these periodic payments from including any direct or indirect payment for past, present or future medical expenses.

The RRE does not report these periodic payments for - parens - they are not reportable as either (t-pox) or ORM - close parens. Otherwise these payments are considered to be part of and are reported as ORM."

That means, for example, if you have a state law that specifically says that indemnity payments are for lost wages and that they cannot include medical, then you would not be reporting those payments at all.

If on the other hand you were in a state where indemnity payments might include lost wages and some medical expenses, the example given on one of the questions that came in, was their indemnity payments might include an ambulance payment, it might include lost wages, et cetera.

In that situation, you would need to be reporting those periodic payments as ORM. That alert should be up by the end of this week. Could you hang on a second? Okay, we're back.

The next thing is just a repeat of what self-insurance is for purposes of Medicare secondary to the payer provisions. We continue to see comments that indicate that what we define as self-insurance isn't how the industry thinks of self-insurance and we're aware of that.

But the Medicare secondary payer provisions, which are found at 42USC1395y(b) specifically state that if an individual or entity engages in a business trade or profession and they bear any of the risk, they are essentially self insured to the extent they bear that risk.

We have repeatedly emphasized in the User Guide that people must be familiar with the definitions that are applicable to this program. So in terms of are we going to change the definition of self-insurance and can we do anything about that, the answer is no.

We do need to stick with our definition of self-insurance and rely on you as participating in this process of reading the User Guide and understanding our definition.

The other thing in terms of questions coming in is we continue to see questions that either have limited information in terms of some essential facts, contradictory information in terms of their description of the situation or are putting in a lot of facts that aren't really relevant to the basic rules that we're looking at.

We will continue in what we're drafting to deal with the basic rules and it will be up to you to apply those rules to your particular situation. We cannot do individual advisory opinions on every single situation or we would be doing them long after this is being implemented and probably for the rest of our federal career.

So we are going to count on you to do that. What we're planning to do is Pat mentioned that the User Guide, we expect a revised one to be up by the end of this month.

We did say that we would give the industry a chance to comment on the additional language that we would be adding regarding who is or is not an RRE. So that will be out before the end of this month too.

And when we put the User Guide out, we will put some type of description out telling you exactly which pages or sections in that are the ones that are potentially being changed by the draft comments so that you'll have a way to crosswalk between the two different documents.

When we put out the new languages or revisions to the language regarding who is an RRE, it will be specifically listed as draft and will give you specific instructions about a time frame to comment if you believe what we've changed or how it's worded is wrong.

If you're making comments, you need to tell us why you believe it's wrong, why it doesn't fit with the structure we've set up or if you have a situation you truly don't believe is covered by the rules, you need to give us details on that situation and what aspect of it is in your situation that's not covered.

In terms of further conversation today, I will say at the beginning and hopefully someone here will remind me to say it at the end, we thought we'd go over where we stand on some of the draft ones right now. Again, cautioning you that this is what we, at this point, we plan to have out within the next week or two but not an absolute guarantee.

In other words, you should not take this discussion to the bank as CMSs final statement on this, particularly since you know it's going to go out in draft. The first thing is corporate structure and RREs.

At least one of the conferences we attended, we had an entity that said, I just finished registering but now based on your comments, I'm not that I registered correctly.

They essentially said that they had five companies that were under a single holding company and they had had one of the five register for its four siblings. And we did tell them that was inappropriate.

What we plan to put out right now in terms of corporate structure and RREs is the following: An entity may not register as an RRE for a sibling in its

corporate structure. An entity may register as an RRE for any direct subsidiary in its corporate structure.

Apparent entity may register as an RRE for any subsidiary in its corporate structure regardless of whether or not the parent would otherwise qualify as an RRE.

So in the example that I gave at the beginning of this, the parent, the holding company, could register as the RRE for those five corporations and then it could designate one of the five as its agent.

And last for purposes of this rule that we're setting forth, regardless of corporate structures and RREs - I'm sorry, for purposes rule regarding corporate structure and RREs, a captive is considered a subsidiary of a parent entity and a sibling of any other subsidiary.

And those are the four major points we have under the corporate structure and RRE and believe that will answer a number of the questions that have come up at recent conferences.

The second big issue and what has taken up a significant percentage of the comments that came in are deductible issues, so I'm going to go over some of the rules we've got as drafted right now for deductible issues.

First of all, deductible amounts are self-insurance for MSP purposes. Second, if the amount paid is the deductible amount or less, the insured as the RRE for purposes of that deductible amount unless payment of that deductible is made by the insurer with reimbursement by the insured to the insurer.

Third point, if the amount paid exceeds the deductible, the insurer is responsible for reporting both the deductible amount and any amount above the deductible.

The total of the deductible paid and any excess above the deductible paid is used in determining whether or not any applicable reporting threshold is met. If any insured chooses to pay directly without recourse to existing insurance, all payment regardless of whether or not the amount exceeds the deductible is self-insurance and the insured is the RRE.

Where the insurer is reporting the deductible amount or the deductible - I'm sorry, where they're reporting the deductible amount or the deductible and any amount above the deductible, we want to make it clear that that's being reported as a single payment, it's not being reported as partially self-insurance and partially a policy. And we will have specific language on that.

Where the insured themselves makes payment of both the deductible and any amount above the deductible with reimbursement from the insurer to the insured, then the insured is the RRE.

This last, I would say is arguably already covered in a bullet we had about reinsurance stop loss insurance, in other words where the insurance is making payment to the insured and they're the ones that are actually paying the injured party.

So in essence, we've set it up or plan to set it up so that there will be one RRE when you have a deductible situation unless you have a situation where the insured pays the deductible separately and the insurer pays the amount above the deductible separately.

In that case, we have not come up with any way to have a single RRE. We believe that both the insured and the insurer will have to be RREs in that situation.

We've been asked a number of times about fronting policies and again, our position is that in a fronting policy, the clear intent is for the insured to actually pay all claims and in that situation, the insured would in fact be the RRE. We've had additional questions about self-insurance pools including when a self-insurance pool serves more than one function.

A self-insurance pool may in some instances meet all of the criteria that we've set forth in the existing User Guide, in other words, a separate legal entity with full responsibility to resolve and pay the claims using pool funds and without involvement of the participating entity. But also have some clients or members who are for administrative services only.

In the extent a self-insurance pool meets the criteria we mentioned but is also providing administrative services only for other entities, the self-insurance pool is not the RRE for the entities for which it provides only ASO.

Hang on a second, I need to pull up some of the other questions. Several of them again dealt with sub companies. We believe that the language I gave you a few minutes ago covers all of the questions we got in that regard.

Essentially if you want to put it very common parlance as opposed to less technical, you can make the RRE as high as you want up the corporate structure.

What you can't do is do the reverse unless it's directly in the corporate structure. You can't make a subsidiary responsible for some separate reporting

responsibility a parent might have. You can't make a subsidiary responsible for some separate reporting a sibling might have.

We've had questions about entities that write businesses for carriers in other states and asking who is the RRE. Our pretty much standard position is that the carriers for liability insurance are the RREs between the carrier and the underwriter.

In terms again, if you're talking between the insured or the insurer, it would go under the rules that I mentioned a few minutes ago. One question that came in that Pat did not address is how to register for self-insurance.

There's again, a misunderstanding about what self-insurance is. In most instances, self-insurance is liability self-insurance. So we had one question where an entity was saying we were told if we pay an individual directly and we don't have an insurance policy, that we're self-insured.

But when we went to register, our only two options were to be a group health plan or liability, no fault or worker's compensation. We aren't either because - was their statement.

And again, if it's self-insurance for the most part, it's liability self-insurance or in some instances, it could be self-insurance for worker's compensation. So if there's any question about registration, you would pick a liability, no fault or worker's compensation.

We had some questions about bankruptcy and insolvency. And in a case study that was presented to us, they went through a number of facts that in essence they said that there was an individual TPOC amount that was for underinsured and it was paid by the insurance company.

And in that case, the insurance carrier would report that TPOC. The situation went on further to say because there was insolvency involved, that the state guaranty association subsequently made a payment of $300,000.

In that situation, we would expect the state guaranty association to be the RRE and report that TPOC of $300,000. The situation then went further and said that the liquidator had filed a proof of claim seeking a balance of approximately $500,000, of which after - I'm sorry, the claimant had filed a claim seeking a balance of $500,000.

The liquidator placed a value of $200,000 on that claim but ultimately it was paid out at some percentage. We will put this out in the draft again that we're putting out but we would expect in that type of situation, what would be reported is when there is actual payment on that liquidation.

And it would normally be reported by the company that is in liquidation. In other words, the entity on whose behalf the money is being paid. So that's what would take place when the actual payment occurs. I think those were the general ones we wanted to go over and so we'll open it up for questions right now.

John Albert: Operator, this is John, we'll take questions now. We ask that folks please announce who they represent as well as to limit their question to one primary and one follow up and then to basically get back in the queue.

We have over 500 folks on the call and we'd like to give everyone a chance to ask at least one question.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1, please record your name. Again, that is star 1, one moment please for the first question.

Woman: Yes, but we don't have to do it again?

Man: No.

Coordinator: (Suzanne Cumbold), you may ask your question and please state your company.

(Suzanne Cumbold): I don't know if that's me or not but I just wanted to know on when we do the query process and we submit a claimant who possibly remarried or changed their name, are we going to get a hit on it, an accept?

John Albert: Yes. I mean, the numbers are cross-walked if that's what you're talking about.

(Suzanne Cumbold): Yes, but if we submit, like a maiden name and the card is issued under the married, are you going to have - it's going to give us a match?

Pat Ambrose: No, the name information is as it appears or as they have updated with the Social Security Administration. So if they have changed their name with Social Security, we will get that update and match it with the new name.

If they have not yet matched or changed their name with the Social Security Administration, we won't have that information and we'll fill the operating under the old name.

(Suzanne Cumbold): So the query response will give us is a no if we don't have - if you don't have a new name update?

Pat Ambrose: It's most likely unless the first six characters of their last name. Now remember, we need to get an exact match on the HIC number of SSN.

(Suzanne Cumbold): Right.

Pat Ambrose: And then three out of four of the other fields.

(Suzanne Cumbold): Right.

Pat Ambrose: You have the date of the birth, the first initial and the gender correct, you conceivably could get a hit even given the name change.

(Suzanne Cumbold): Okay, thank you.

Coordinator: (Suzanne Jordan), you may ask your question.

(Suzanne Jordan): Hello, this is (Suzanne Jordan) with Broadspire. I have a question regarding profile reports. We've noticed several profile reports come in that have the first submission date prior to April 1, 2010.

We contacted the EDI rep and they indicated that the system that generates the profile report has not been updated with the new dates for file submissions. Do you have any further information about that?

Pat Ambrose: Yes, actually I did attempt to cover that at the beginning of the call. The profile report has been changed to show just month and day of the file submission timeframes, not the year.

And it's also shows your file submission group, so it has been updated recently with that information. It no longer indicates your first file is due during X quarter of X year. You can get an updated profile report regenerated by your EDI representatives.

The official location for information about when files are due for non-GHP Section 111 reporting is the CMS Web site at the mandatory INS REP page and on the liability, no-fault and worker's compensation page, there's an alert out there.

I think it's dated May 11 and that clearly indicates that your first claim input file submission is due in the second quarter, is required to be submitted in the second quarter of 2010.

(Suzanne Jordan): So even if it states first quarter, then we're okay because of that alert that's out there?

Pat Ambrose: Yes, absolutely, absolutely.

(Suzanne Jordan): Okay, but we can get a new report generated...

Pat Ambrose: Yes, you may.

(Suzanne Jordan): ...by the EDI rep, okay, thank you very much.

Pat Ambrose: You're welcome.

Coordinator: (Celia Winchell), you may ask your question and state your company name.

(Celia Winchell): Yes, this is (Celia Winchell) with Crawford, thank you. It's our understanding that occupational accident medical claims, which are those claims arising under the policies issued to truck drivers and are paid by those individuals are issued to the employers.

And paid for by the employer and or the employee for injuries on the jobs are not subject to the SCHIP reporting requirement, can you confirm?

John Albert: That is incorrect, we consider that to be no fault insurance.

(Celia Winchell): You do consider that to be no fault?

John Albert: Correct.

(Celia Winchell): Okay, thank you very much.

Coordinator: (Lisa Trembly), you may ask your question and state your company name.

(Leslie Trembly): This is (Leslie Trembly) and my question has been answered, thank you.

Coordinator: (Tom Kennedy), you may ask your question and state your company name.

(Tom Kennedy): Hi, it's (Tom Kennedy) with (Ace) and I apologize, I missed the first couple minutes of this call. Were you - did you discuss the RRE examples and when they would be issued or is this not the right forum?

John Albert: Yes, we did go through the RRE examples and to do it very short. Again, this is what we proposed to put out for further comment. Essentially, the only time you would have to have two RREs when there's a deductible is when the

amount under and up to the deductible is paid by the insured and the amount above it is paid by the insurer.

Otherwise, the examples we gave allows for it to be narrowed down to one RRE.

(Tom Kennedy): Are you - were you going to issue some examples or there was some...

John Albert: We're going to issue the language that I went over today and we are sticking examples in those and we hope to have that out by the end of next week.

(Tom Kennedy): Okay because the phrase paid by still means 100 different things.

John Albert: Well we essentially we're speaking about it in terms of the fact that if you're saying that the insured paid, then they're seeking reimbursement from the insurer if it's the amount above the deductible.

If you're saying that the insurer paid and it's - you're talking about the deductible amount in order for the insurer to be the RRE, it would be seeking reimbursement from the insured for that deductible amount.

(Tom Kennedy): Okay. Thanks.

Coordinator: (Kurt Williams), you may ask your question and state your company name.

(Patricia Rothbart): This is (Patricia Rothbart) from the Lion's Insurance Company and I'm going to be asking a question of behalf of (Kurt Williams). In the example that you gave in the liquidation context where we have what we call the allowed amount, you valued the claim at $200,000, which will ultimately be paid out

at some percentage because the estate does not have enough money to pay all its claims.

Reliance is making small interim payments as time goes by. Would we be required to report those interim payments or would we report the actual amount that is ultimately paid out in total at whatever reduced percentage it is?

John Albert: We will address that when we put the draft out. I would imagine that our answer will be that those interim payments will need to be reported as TPOCs with the total of them considered in terms of whether or not you've met any threshold. So we will specifically address interim payments.

(Patricia Rothbart): Thank you.

Coordinator: (Anita Bensivingo), you may ask your question and state your company name.

(Anita Bensivingo): Hi, (Eunice)'s Corporation and my question is we have a policy in which we pay in advance based on reserved amounts on an annual basis, we pay the insurer up front based on the reserved amounts and then they pay the claim. Who would be the RRE in that situation?

John Albert: And your reserve is meant to cover your deductible or?

(Anita Bensivingo): No, the claim is reserved for what they feel the claim will ultimately cost them. And they bill us on an annual basis based on that projection. So we're actually paying in advance.

John Albert: Are you self - basically self-insured using the third party?

(Anita Bensivingo): We have a deductible and so for our claims, when they reserve those claims, what the claims will ultimately cost, they bill us for that on an annual basis. So we pay in advance on those claims and then the carrier pays the claims.

Barbara Wright: Like an escrow account?

(Anita Bensivingo): Through a TPA, they pay the claims (through).

John Albert: I guess what we're trying to understand in your example is the entity you're paying actually insuring you or they're simply acting as a TPA...

(Anita Bensivingo): No.

John Albert: ...that's billing you in advance?

(Anita Bensivingo): No, we pay - we have policies with AIG, AIG - we pay AIG in advance on an annual basis based on the total reserved amount on the claim and then the TPA pays the claims for AIG.

John Albert: And you pay no separate deductible?

(Anita Bensivingo): No, I mean, no. I mean, there is a deductible and that's what we're paying AIG.

John Albert: That's what you're paying in advance?

(Anita Bensivingo): Right.

John Albert: Okay, that's what I was trying to understand, you're not really paying the whole claim in that advanced part you're talking about, you would have your premium plus you're paying your deductibles in advance, right?

(Anita Bensivingo): Right.

John Albert: Okay, in that case, it would be the insurer that is the RRE.

(Anita Bensivingo): Okay because they're funding the claim directly versus us.

John Albert: It's the example I gave of where the insurer is paying the amount both below and above the deductible and seeking reimbursement from the insured. So the RRE would be the insurer.

(Anita Bensivingo): Okay, all right, thank you.

Coordinator: (Jake Reison) you may ask you question and state you company name.

(Jake Reison): Hello, this is (Jake Reison) with (Compartments). My question is on a claim where lifetime medical benefit has been awarded, however, under the labor code the claim has been closed administratively. Does that need to be - does that closure need to be reported?

John Albert: This is one where you have ongoing responsibility under the law, the applicable law and you're saying that you have administratively closed it for whatever reason.

(Jake Reison): Correct, under the labor code. (Unintelligible).

John Albert: And it’s what we've said and we have in the User Guide right now is if you haven't closed it under the criteria we specify, that we’re specifying, it must remain open.

If you, for example, have a statement from the treating physician that no further care is required then we allow you to submit a termination for reporting purposes of the ORM, but also specify that if there were additional claims you paid in the future, then you would have to...

(Jake Reison): It would be reopened up.

John Albert: ...resubmit it on that person.

(Jake Reison): It would be reopened at that point, correct?

John Albert: Right.

(Jake Reison): Okay, all right. Thank you very much.

Coordinator: (Keith Bateman) you may ask your question and state your company name.

(Keith Bateman): (Keith Bateman), (TCI). Barbara, regarding you’re worker’s comp alert, you’re only talking about worker’s comp. But doesn't the same logic apply to no fault wage payments? Does it involve no payment of medical?

John Albert: We will look at including that but we - you’re right we did specifically just address worker’s comp in the alert right now. That is all we had a concern expressed by the industry on.

(Keith Bateman): You had the other, I'm not sure you quite understood it. But, yes, you are - have situations where you're making periodic payments for wage loss under no fault.

John Albert: Are you - does the state law preclude you from including medicals in those payments?

(Keith Bateman): You're - those are separate payments. It's just like worker's comp. The work comp statute doesn't - none of the work comp statute says - it doesn't include medical.

It says you'll pay this amount as a cash benefit for the type of benefit. No it's - but that's the thing. You're paying a statutory required benefit that doesn't include medical.

John Albert: You're - but does - basically is that a function of state law that says...

(Keith Bateman): Yes.

John Albert: That's just - put this in writing and give us a couple of examples of the applicable state laws.

(Keith Bateman): I will and I will have an email to Barbara asking for a conference call on this issue.

John Albert: When you send it in make sure it comes to the Resource Mailbox also.

(Keith Bateman): Yes.

John Albert: Before we go to the next - I want to answer the rest of any question you have (Keith) before we go to the next person.

Man: We have something that we want to add regarding the last question.

(Keith Bateman): Sure.

John Albert: Do you have anything else on this?

(Keith Bateman): No.

John Albert: Okay, on the last question where the person was asking about having to report if something had been administratively closed and reporting that closure. Again, the question was asked in the context - as we understood it - of having an open ORM record and could they close it for purposes of (unintelligible).

If they closed administratively did they have to report it for the Section 111 reporting? And again, you need to go by the rules we set forth in the User Guide for when you'd report closure.

The comment that we made had nothing to do with administrative closures and what that means in terms of the look back period that’s in the User Guide. We are still - we are considering comments where people have asked us to eliminate even more of the look back period. The User Guide currently has a look back period just to January 1, 2009. Operator, next question?

Coordinator: Yes, sure, one moment. (Don Spellman) you may ask your question and please state your company.

(Don Spellman): Thank you. My company is Nationwide Indemnity Company. My question is with - asbestos (mastord) context. Typically an individual claim - an individual plaintiff represented by council suing a defendant.

The defendant then settles the case, the defendants being defended by several insurers. They pay different shares of the settlement but they're not party to the case.

Only the policyholder is a party to the case and they pay their - each pays their share of the settlement. My question is do all of them have to report the total amount of the settlement or does each report only what it paid?

John Albert: Well what we have in the guide right now, I believe it says - let me find it - I believe it says when there are multiple parties to a suit that they each are required to report.

Man: Talking about a case with several liabilities.

John Albert: Yes.

Man: As opposed to joint severally?

(Don Spellman): Well, I'm talking about a case where one plaintiff may sue 20 different defendant companies.

John Albert: And what we have in the User Guide right now is where there a multiple defendants involved in the settlement an agreement to have one of the defendants insurers issue any payment in obligation of a settlement judgment award or other payment does not shift our RRE responsibility to the entity

issuing the payment. All RREs involved in the settlement remain responsible for their own reporting.

(Don Spellman): Right. But the question is each of them is not going to pay the whole amount. Each of the insurers is going to pay a certain percentage of the amount.

John Albert: And...

(Don Spellman): And they're not parties to the case. So the only parties to the case would be the policyholder. The policyholder is being defended and indemnified by the insurers. The insurers hire defense council, the pay defense council, time comes to settle the case they each contribute a portion of the settlement.

John Albert: Okay. Could you hang on a minute? Hi, we're back. And we were looking at our documents internally and we're going to make sure they reconcile directly right now.

There is also language I believe on Page 55 that doesn't say exactly what I quoted. What we will need to distinguish between is a situation. In the situation you just talked about are the defendants joint and severally liable or are they severally liable?

(Don Spellman): Severally.

John Albert: If they're severally liable I expect our language will say that they are responsible for reporting only their amount. If they're joint and severally liable it's likely to say that each must report the total amount and we will have to sort it out in the back end.

(Don Spellman): Okay, when you say they who are you referring to?

John Albert: The insurers.

(Don Spellman): Okay, well the insurers wouldn't be liable to the claimant because they're not parties to the case. The only party that would be liable to the claimant is their common insured, their common policyholder.

So they are not directly - they would not be directly liable or have a direct legal connection to the claimant. Their paying on behalf of their common insured. One might pay 10%, one might pay 50%, 30% because they had different portions of the coverage.

John Albert: We understand that they aren't directly liable to the entity suing the insured. However, for MSP purposes they are the RRE because they are the insurer.

(Don Spellman): Right. They're the RRE but are they the RRE for their 10% or they the RRE for 100%?

John Albert: They are responsible for what - if they are again legally severally liable. If one is legally liable for 10%, one's liable for 20%, then that's all they need to report.

(Don Spellman): Okay.

John Albert: But if they're technically jointly and severally liable then they are each technically liable up to the full amount and would need to report that amount.

(Don Spellman): All right. But if they are only - if they are only paying a pro rata share then they only report that share?

John Albert: No, if - we're talking about what they're liable for. If they are jointly and severally liable even if each is paying 20%, they must report the full 100% amount. If they are only severally liable then they report their individual amount.

(Don Spellman): Okay, jointly and severally liable to whom?

John Albert: To the insured.

(Don Spellman): Okay, well that's going to - that may vary from state to state.

Woman: We can revise this in the...

John Albert: Well, if you would like to submit more specific information of why and again I need to caution everybody over and over on this call that we're talking purposed language for this draft that's coming out. No one should be taking the comments made in the context of this call as CMSs final word and distributing them as CMSs final word.

If you can send us in and email why you believe our language about - if you have several responsibilities that in that case you would report the individual amount.

And if you're jointly and severally liable that you would report the total amount. If you have some reason why you believe that cannot work then we need to know that. But we do realize that for many of these rules the actual application will depend on state law.

(Don Spellman): Okay, all right. Well I will write something up and present it.

John Albert: Okay, thank you.

(Don Spellman): You're welcome.

Coordinator: Thank you. (Bessie Bundy) you may ask your question and state your company name.

(Bessie Bundy): Yes, I'm calling (Freehill, Hogan and Mahar). We're a maritime law firm in New York City. I've submitted my question by email a couple of times and I tried to call last time and was not able to get an answer.

So I'm trying again and the subject of my question has to do with what's called Protection and Indemnity Clubs referred to as P&I Clubs. Before I get into the details of my question do you guys remember this question? Is this something that has been addressed yet?

Woman: (Unintelligible).

John Albert: We're aware that it was sent in. Do all of us here right now recall all of the facts, no. As we said we are reviewing thousands of these so we apologize that we can't remember.

(Bessie Bundy): No, it's fine. I just mean can I go ahead and ask it now?

John Albert: Sure.

(Bessie Bundy): Okay, so a P&I Club is basically a, you know, an insurance group that's made up of members which are predominantly vessel owners, ship owners. Typically, the - sorry, typically the club requires that the member pay first. And so we're assuming that the member is the RRE.

However, there are circumstances where the pay-to-be-paid rule is waived and the club will pay directly. And we want to know if that changes and makes the club the RRE or if the member would still be the RRE? Does that make sense?

John Albert: Yes, hang on a second. We need a side bar here and the immediate thought that we all had here is your situations where the club would pay seems to be the equivalent of what we listed as self insurance full or a JPA.

So to the extent they were making payment and met the rules that we have in the User Guide for the self-insurance pool then the pool would be the RRE in those situations.

(Bessie Bundy): And that's the case even if the member still has to approve and is involved in the decision to...

John Albert: Well then it doesn't meet the criteria that we have listed in the User Guide.

(Bessie Bundy): Okay so in our...

John Albert: So in which case the member would still be the RRE.

(Bessie Bundy): Member - okay so if the member's still involved even if the club pays 100% up front then the member would remain the RRE because of that involvement in the decision making.

John Albert: Right.

(Bessie Bundy): And then if there was a circumstance where the member was the RRE but failed to pay is there a circumstance where then the club could be held

responsible for the nonpayment? I'm sorry, I'm sorry. Could the club be held responsible for the failure to report if the member doesn't report?

John Albert: No, the RRE is who we're going to hold responsible. So if the club is not the RRE we're not going to hold them responsible.

(Bessie Bundy): Okay. Now do you anticipate having anything in the new RRE examples regarding P&I clubs in particular or will we have to refer to the pool situation?

John Albert: I - if you can give us a site or anything, or a document that specifically refers to a Protection & Indemnity clubs and how they typically work we would be happy to, you know, adjust some language to mention them as the type of thing that may fall under a JPA situation.

(Bessie Bundy): When you say a site or a document, I mean we can send you, you know, a written description of how it works.

John Albert: If that's an official term that's basically used in the maritime industry or anywhere else, then certainly, you know...

(Bessie Bundy): Is that something that you would like to have submitted again via email, maybe a proposed sort of RRE example?

John Albert: Sure.

(Bessie Bundy): Okay. Sounds great, thank you.

Coordinator: (April Johnson), you may ask your question and state your company name.

(April Johnson): Hi, this (April Johnson) from BETA Healthcare Group. Barbara, I had issued another question asking for clarification of the self-insurance pool/JPA rule not too long ago, because it seems to me that there have been different statements being made in different audio conferences.

And, now, it's very unclear as to what the word quote involvement of the member or the insured means.

Barbara Wright: Our understanding is that the word involvement means that member had to somehow or other approve or concur with the decision made. That the power to execute the settlement judgment or award did not rest solely and exclusively with the JPA.

(April Johnson): And that's - so even though a commercial insurer might have a similar consent provision in their insurance policy, with their insured, as our self-insurance pool has with our members, why is it then that the commercial insurer can be an RRE in that scenario, but not in our scenario?

Barbara Wright: The insurer is the one whose funds are being used in the payment, correct?

(April Johnson): Yes.

Barbara Wright: Okay. And whose funds are being used in the JPA example?

(April Johnson): The pool funds.

Barbara Wright: Okay. But the key is - and I'd never heard about - let me back track. I'd never seen a liability policy where the insured did not need to concur somehow in the decision, when there's a commercially written liability insurance policy.

(April Johnson): In the medical malpractice industry, which is what we're involved in, that's very standard, because the physicians and other healthcare providers that are involved in the cases often have to be reported to their various licensing agencies, so the liability policies often contain consent provisions allowing the insured to consent to the settlement or not consent.

Barbara Wright: But if they don't consent, can the insurance go ahead and make the settlement?

(April Johnson): I think that might vary from state-to-state. In California, there is a business and professions code that specifically prohibits that from happening.

Barbara Wright: We'll take another look at it.

(April Johnson): Great, thank you so much.

Coordinator: (Ron Evans), you may ask your question and state your company name.

(Ron Evans): Yes, Farmer's Union Insurance. In the download area on the What's New, there are two documents pertaining to - I'm sorry, I'm fumbling here a little bit - the model language for obtaining social security numbers and HICNs, is it anticipated that that language is going to be extended to the NGHP?

Barbara Wright: We do have similar language in process for the NGHP.

(Ron Evans): Excellent, thank you.

Barbara Wright: Operator, next question.

Coordinator: One moment, sir. (James Maxim), you may ask your question and state your company name.

(James Maxim): Hi, this is (James Maxim) from Foremost Insurance, University of Farmer's Claims. I'm curious about whether or not there is a dollar amount threshold for reporting on ORMs?

Barbara Wright: There is currently a threshold for ORMs for workers' compensation, not for liability insurance or no fault and I believe the current threshold is listed as $600. It's still under consideration to increase that somewhat.

(James Maxim): That's only workmen's comp, not liability?

Barbara Wright: Yes.

(James Maxim): But there is TPOC of 5K for liability?

Barbara Wright: Yes.

(James Maxim): And that's from July 1 through December 31, 2010?

Barbara Wright: Yes, currently, it is.

(James Maxim): So no reporting required there, but still satisfaction must take place?

Barbara Wright: I would repeat again that any of the rules that we're setting up for this Section 111 reporting are only with respect to the reporting. They don't change any other individual or entity's responsibility under the MSP provisions.

(James Maxim): Okay, so no $1000 fine, if we don't report the ones that are $5000 or less from July 1 through December 31, 2010 on TPOCs?

Barbara Wright: Hang on a second.

(James Maxim): Sure.

Barbara Wright: I'm sorry, we were just checking something. You're correct, the threshold is to $5000 for TPOCs.

(James Maxim): And that's going to lessen after 2010?

Barbara Wright: Yes, that is our plan at this time.

(James Maxim): Okay, thank you.

Coordinator: (Mary Shear), you may ask your question and please state your company name.

(Liz Kemper): Hi, I'm Liz Kemper a Unitrin business. My first question is about a situation where, under the same claim, we have one injured individual looking for benefits under both no fault and liability. And I'm wondering do we need to report two records for that injured party?

Barbara Wright: Yes, I believe - I'll ask Pat to confirm - but if you're submitting a TPOC for no fault, you need to submit that on one record. If you're submitting a TPOC for liability, you need to submit that on another.

Pat Ambrose: Yes, absolutely, they're for difference insurance PUDs.

(Liz Kemper): Okay, great, that's why I asked. The second question I have is kind of related to the last question that was asked. Do we have to apply the threshold for

reporting or can we report under the threshold, if it's easier for us not to have to calculate?

Pat Ambrose: For claims that reflect no ongoing responsibility for medicals, no ORM. In other words, if the ORM indicator is equal to an N, you must adhere to the threshold. We will actually reject a claim report under the threshold with an FP disposition code and a corresponding error.

(Liz Kemper): Okay.

Pat Ambrose: If the claim, on the other hand, does reflect ongoing responsibility for medicals and you're also reporting TPOC amounts, the TPOC threshold is not going to be applied in that case.

(Liz Kemper): Okay, great. That's all I needed to know, than you.

Pat Ambrose: I'd like to add a couple of more things, so the thresholds - you're only required to report TPOC 2000 January 1, 2010 and subsequent, however, you may include TPOCs prior to that. And the threshold check only applies to add records, the initial report of a claim.

Obviously, you may end up sending an update to remove a TPOC amount or reduce it, which otherwise might have - which, you know, change might put you under the threshold, so the threshold check will not apply to updates or if it's a lead transaction. Okay.

(Liz Kemper): Thank you.

Coordinator: Thank you. David Piatt, you may ask your question and state your company name.

David Piatt: High, it’s David Piatt, Piatt Consulting. Hey, Barb, I just wanted to make one comment and then one question.

On the captive, I think there’s a lot of different forms of captive out there, almost like there are pools, like group captives where there might be multiple companies and associations joined together to form one trust from which all the claims are paid.

And then there’s rent captives where somebody might come in and share some of that trust and disperse the risk again and then there’s little cells that can be formed within that.

So I think, you know, the captive business is the more complex in the pool business, so I'll try to send you some information in an email about what we know about that, so you can add it to any User Guides you want.

Barbara Wright: That’s fine. We would ask if you believe that language we've given does not work that you tell us why it doesn't work.

David Piatt: Okay. Well, I was just struck by you'd said the captives can report as their parents and I assume that that’s an option, but the captive, you know, I have understood that the pool language would apply to the captive language as well, one, two, three.

Barbara Wright: Well, what we said in terms of captives being able to report under their parent, obviously, if there’s - you’re talking about multiple captives banded together, you have to look at that multi-captives and what rule apply to that.

David Piatt: Well, there are multiple businesses involved in one captive.

Barbara Wright: You need to look at whether any of them are in our RRE or if that captive has any RRE responsibility and go from there.

David Piatt: Okay. That's what I've been doing using the pool criteria. Okay. My other question is have you given any thought to how you're going to use the policyholder fields, when you're representing these deductibles that are paid by the self-insured or are we going to be using those or are you going to issue new direction on the policyholder fields?

Barbara Wright: I believe, Pat, correct me if I'm wrong that right now the policyholder field only gets reported for self-insurers.

Pat Ambrose: Yes, I need to check that. I'm looking at that right now, but we could move on and check it at a later time during the call.

David Piatt: Okay, thank you. That's all I have.

Coordinator: (Brenda Brooker), you may ask your question and state your company name.

(Brenda Brooker): I'm from New York Central Mutual. We have a question on Field 15 for the alleged cause of injury, incident, or illness with the ICD9. Is CMS going to be looking how specific and which ICD9 code we use in that?

Pat Ambrose: Yes, the User Guide is being updated to provide specific instructions that will reflect requirements as of January 1, 2011. And the Field 15, the alleged cause, must contain what we refer to as an e-code. In other words, it must be an ICD9 diagnosis code that begins with the letter E.

We'll be providing a reference to a file that can be downloaded, from the CMS Web site that has each record is five positions, the first five positions is the diagnosis code, the ICD9 diagnosis code followed by a description and your cause code must match one of the e-codes that's on that list.

We're also providing, in the appendix, a list of ICD9 codes that CMS does not consider sufficient for Section 111 reporting. In other words, they're not quite complete enough.

I'm not sure, off the top of my head, if any of the e-codes are on that list, but you'll have to report an e-code that is not found on that list. So it'll have to be on the list of what CMS considers valid ICD9 diagnosis codes, start with an E and not be on the list of insufficient codes.

(Brenda Brooker): Okay, thank you.

Pat Ambrose: You're welcome.

Coordinator: (John Butterer), you may ask your question and state your company name.

(John Butterer): My company's name is Global Aerospace. We're a joint underwriters' association that is made up of a pool of five or six different insurers. We, as a company, are solely responsible for managing and handling and paying the claims for our pool members. And I just want to confirm that we, in fact, would be the RRE in this case. Hello?

Barbara Wright: If you meet all the requirements that are listed in the guide for self-insurance pools, yes.

(John Butterer): I'm sorry, could you say that again?

Barbara Wright: If you meet the requirements that are set forth in the User Guide for self-insurance pools. Are we...

(John Butterer): And my second question is sort of related. We do aerospace insurance, so the policy risks are quite large and we are required, by law, to split those among a group of unrelated co-insurers.

One company is then designated as the market leader and they pay the claims and collect the money from the rest of the following market. In that case, would the market leader be the RRE for all of the co-insurers?

John Albert: It sounds as though even in that situation your coinsurer's might be the equivalent of a self-insurance pull. But absent that, it would be the coinsurer's would have individual responsibilities.

(John Butterer): And this is specified in what section of the User Guide?

John Albert: The section of a - describing RREs, which is in Section 7 I believe.

(John Butterer): Thank you.

Coordinator: Thank you. One moment. (Cory Lebranch) you may ask your question and please state your company name.

(Cory Lebranch): Yes, I'm with LWCC. Going back to the TPOC threshold questions one more time. You guys were saying that only on ads do we have to apply the TPOC thresholds. Is that correct?

Barbara Wright: Yes, because you may submit a claim at some point that meets the threshold, but then need to update that TPOC amount since possibly an incorrect amount was submitted or you submitted a TPOC amount that wasn't accepted and so does not apply or something of that nature.

And so on a subsequent update, you might be reducing the TPOC amount and it's certainly information that we want you to report but that change in the TPOC amount on the update record might put the claim underneath - or below the threshold and we don't want to penalize you for reporting that important information.

(Cory Lebranch): Okay, so the second part of my question is dealing with the - when a threshold changes. So for 2010 it's $5000 and for 2011 it's $3000. So if we have a claim with one or more TPOCs within the year 2010, when the threshold changes to $3000 if the claim now meets the threshold, do we need to report that as some sort of an update record?

Barbara Wright: It depends on the latest TPOC date related to the claim. And so, basically it's for TPOC dated subsequent to that date. So TPOC that are dated 2010, then TPOC that are dated 2011.

And so if you pay or a TPOC or a TPOC occurs in 2011, then you would use the threshold that applies to the time period that that most current TPOC date falls into.

(Cory Lebranch): Do we need to go back and add up all the TPOCs from '10 and '11?

Barbara Wright: If you have a new TPOC in 2011 then yes, you need to look at all of them together to see whether or not you meet the threshold for 2011. But if you

never have another TPOC after the ones in 2010, you owe no further reporting on those simply because the threshold changed.

(Cory Lebranch): Okay, great. Thank you very much.

Coordinator: (Mark Flanery) you may ask your question and please state your company name.

(Mark Flanery): Yes, Caterpillar Inc. And my question is a follow-up from Barbara's description of the periodic payments, earlier. I'm administering workers compensation.

And most of the state laws that I'm familiar with will say that payments for temporary total disability, which are indemnity payments, wage replacement are for lost time, or for days lost, or for lost wages.

And that's all they say. They don't go on to say that medical is precluded from inclusion in those payments. If that's what the state law says, then is that considered to be TPOC since the state law does not specifically preclude the inclusion of medical along with your wage payment?

John Albert: Does the state law specifically say that the only thing to be included in the payment is wages?

(Mark Flanery): Yes, I mean it will say for lost time or it'll say for lost wages or it will say for days missed because of injury, that sort of formulation. It varies by state according to what the law says.

Barbara Wright: But perhaps what would cut to the chase is if you would be reporting ORM for that person anyway - it's already covered.

(Mark Flanery): True, true. I mean, in other words though, do we have to report that as TPOC even though we're reporting those people as ORM as well?

Barbara Wright: No, what we said was, when they prohibit it then they don't have to report the periodic payments at all. Otherwise, these payments are considered to be part of and are reported as ORM.

(Mark Flanery): Okay, all right. So if the claim has been reported as ORM already because of payment of medical bills, then you don't have to go ahead and report those periodic payments as TPOC summarizing them by reporting period?

Barbara Wright: No, there wouldn't be anything separate to report. It would just be the continuing ORM.

(Mark Flanery): Okay, all right. And you said - my one follow-up, you said previously that for ORM reporting, you're reporting your point at which you're responsibility begins and your point at which your responsibility terminates. You're not reporting the individual payments and that kind of thing, correct?

Barbara Wright: Correct.

(Mark Flanery): Okay, great. Thank you so much.

Coordinator: (Susan Freeman) you may ask your question and please state your company name.

(Susan Freeman): Hi, my name is (Susan). I'm with LPC Alliance. I just had a question about - when (Seamus) is doing their recovery efforts, are they going after the RRE or are they going to ask for the claim to put that money back?

Barbara Wright: Well, what we said our standard process is, is what we will continue with. Typically, when there's a liability, no-fault, worker's compensation settlement, judgment or award, we typically recover from the beneficiary against any settlement, judgment or award that is received.

The time that we sometimes recover from the insurer or worker's compensation is when there's just ongoing medical involved.

(Susan Freeman): Okay.

Barbara Wright: Did that do it for you?

(Susan Freeman): Yes, it sure did. Thanks.

Barbara Wright: Okay.

Coordinator: Thank you. (Mila Tabias) you may ask your question and state your company name.

(Mila Tabias): Hi, Grace Management Services. I seem like the one that's behind here. First off, in the very beginning, Barbara, you gave a Web address for the computerized training - the computer based training. Can I get that address from you and how to get to it?

Barbara Wright: Yes, go to www.cms.hhf.gov/mandatoryinsrep and then on the left hand side of that, that'll bring you to the overview page and that's what we refer to as the Section 111 Web site or the mandatory reporting Web site of the CMS Web site.

But on left hand side, there is a link for the CBTs and it says MMFDA111 Computer Based Training.

(Mila Tabias): Okay.

Barbara Wright: And that will take you to another page that provides instruction to what you do to enroll or sign up for those courses. Just requires email to be sent and providing your information.

(Mila Tabias): Okay and I can do this without actually registering our company I've got to set everybody up. Yes, go ahead.

Barbara Wright: Absolutely, you do not have to have a login ID. You do not have to have registered yet; there is in fact courses that go over the registration process.

(Mila Tabias): Okay, good. Because I'll actually - I'm the workers comp administrator for our company and we're self-insured. And I'll be the authorized rep. We have a claims manager in-house and that person will become the account manager. I just want to make sure I get everybody trained the way we have to be.

Barbara Wright: They can all individually take the training. And on the Web site general - if there's anyone out there that doesn't know - what Pat was describing is when you go to the overview page, we have tabs for different subjects.

There is one for the GHP reporting. There's one for the liability no-fault worker's compensation. There's a separate one for CBT. There is one about what not to do when you're reporting that they're adding tips of things that have happened in the GHP reporting. There is a tab for transcripts.

What I would caution you with, with regard to transcripts for the NGHP calls the last time I looked some of the transcripts are actually on the liability no fault worker's compensation page and some of the are actually on the NGHP transcripts page. So check both those pages. .

We are doing some reorganization but one of our problems here is, the whole system used by the agency limits the number of documents we can have attached to each tab. And so we have to continually accommodate for that. Operator?

(Mila Tabias): Okay, thank you.

Coordinator: (Susan Montoya) you may ask your question and state your company name.

(Susan Montoya): Hi, this is (Susan Montoya) with Traveler's Insurance. The question that we have is in regards to Field number 105 and these are related to the claimant information data.

We were kind of wondering, when it come to the claimant one where it's the state, the family or other on that Field 105, it's asking for either a TIN or a social. What would you use that for because we are not certain we can always get this information?

Barbara Wright: Once again, if there's someone else that is the claimant because the beneficiary is deceased, they will be the ones receiving the settlement. And so that would be who we would normally pursue the recovery from. So, yes, we do need their TIN or social security number.

(Susan Montoya): Okay, thank you.

Coordinator: (Tamara O'Brien) you may ask your question and state your company name.

(Tamara O'Brien): (Whitehurst) (unintelligible). I'm calling about a situation where an insured settles with several of its' liability insurer's - essentially, policy buyouts. And the policy proceeds are paid into an escrow account that is used solely to pay product liability claims.

And when a claim is settled, the insured requests payment from the escrow and they give notice to the insurers. But it's really not bearing the risk because the funds to pay the settlement are coming from the escrow, which is funded with the policy proceeds. In that circumstance, who is the RRE?

Barbara Wright: Your situation is precisely why we still have mass torts et cetera to discuss.

(Tamara O'Brien): Okay. Should we be doing anything in the interim?

Barbara Wright: We hope to have the work group within the next few weeks started. So if you're interested in participating, again, send something to the Resource Mailbox.

(Tamara O'Brien): Okay, thank you.

Coordinator: (Lorain Seagull) you may ask your question and state your company name.

(Lorain Seagull): (Lorain Seagull) with (Chubinsun). And we just wanted to confirm - I think it was in the last call, about whether or not, do we report the claim to you after an initial payment is made on a medical or we get a claim in and we know we will be paying medical but we haven't paid it yet?

Barbara Wright: If it’s a situation where you’re talking about ongoing responsibility for medical, you should report it when you assume that responsibility, even if you haven't made payments yet. Obviously, the only exception to that is if you have reason to believe that it’s going to fit within the ORM threshold for worker’s comp.

(Lorain Seagull): Okay, so...

Barbara Wright: But our limited understanding from the industry on that, is normally they get everything at once. It’s a pretty much one shot bill for that type of situation or it’s not going to fit within the ORM.

((Crosstalk))

(Lorain Seagull): So we have a work comp claim and we’re going to be paying medical - for I don't know how long on it and they’re Medicare eligible, you want the report to come after we've made our first medical payment or?

Barbara Wright: We want it to come after you've assumed the responsibility. You will generally know if it’s going to - or have an idea whether it’s going to fit within the ORM threshold because, first of all it will absolutely be a claim for medical only and secondly, there will be essentially no lost time.

We’re still looking at tweaking language there. So report it right away, once you know you have ORM unless you suspect it will not reach the worker’s compensation ORM threshold.

(Lorain Seagull): Threshold, okay. Okay, thank you very much.

Coordinator: Thank you, (John King), you may ask your question and state your company name.

(John King): Thank you, Liberty Mutual, and we're seeking clarification on what communication correspondence CMS through their contractors will send to the TIN reference file address? And then secondly, to the claim input file where you have the planned contact information, Fields 76 through 80.

Barbara Wright: Hang on a second, well the TIN - on the TIN reference file, the name and address there are used for the associated with the TIN for the RRE if further follow up is needed regarding coordination of benefits issues and recovery issues related to the claim.

(John King): Okay, so that's strictly going to be from MSPRC recovery efforts or is there going to be any other communication or letter sent?

Barbara Wright: That's the primary contractor for recovery purposes. Yes, the COBC passes information onto other Medicare contractors including the MSPRC.

John Albert: It's possible you could receive additional coordination of benefit related questions from the COB contractor at that address but in terms of any recovery activity, that would be from the Medicare secondary payer recovery contractor.

(John King): Okay, if we were acting as a TPA, what we don't want to have happen is to receive some correspondence that should have been directed to the RRE.

Barbara Wright: Well I guess you mean you said if we're acting as a TPA, are you saying that in that field that the RRE would simply be reporting their TPA contact and you don't want to receive information other than for recovery?

(John King): Correct.

Barbara Wright: For the most part as John just said, our intent is largely to use that for recoveries but obviously we can't rule out every single situation.

John Albert: I mean there might be a situation for example where that, you know, that Section 111 record came in but some other source came to the dispute that or whatever and there are, you know, depending on the source and what the information is, the COB contractor may reach out to, you know, clarify or attempt to clarify, you know, discrepancies from multiple sources.

But as Barbara said, the primary focus of that is recovery operations, especially in the NGHP area.

(John King): Okay, was there any issues with - I think I made the last call back on 7/1 regarding foreign address?

Barbara Wright: We do have language forthcoming in the revised User Guide that should be out within the next couple weeks that will address foreign addresses.

Pat Ambrose: Essentially if you do not have a domestic U.S. address for an RRE, you're going to have to work with CMS to determine what to put in that field, those fields on the TIN reference file.

We are providing a work around, so to speak, for other addresses on the claim records related to the claimant and representative but when it comes to registration and the TIN reference file, we are going to require a U.S. based address.

And we do understand that there are circumstances under which there might not be one and that is going to need some interaction with CMS to determine what entity to provide there.

(John King): Okay.

Pat Ambrose: Now you also referred to the planned contact information in Field 76, 77 and so on, that is mainly to identify a particular individual whom Medicare contractor could follow up whether it be the COBC or the MSPRC, could follow up directly with a person.

So all of those fields are optional. Any formal communication would be mailed to the contacted - or the name and address provided on the TIN reference file. But this information might be used in those fields starting around Field 76 for a more informal follow up.

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

(John King): Yes.

Barbara Wright: We're back. Was that the end of your question or do you have a follow-up?

(John King): No, that's it. So the correspondence can be limited to notification, search and demand letters?

John Albert: Yes, I mean essentially yes. That's the primary.

(John King): Okay, I appreciate the time. Thank you.

Coordinator: Thank you, (Michael Kimkoff), you may ask your question and state your company name.

(Michael Kimkoff): Yes, this is (Mike Kimkoff) of (Eckert Siemens). We have a question concerning documentation of exposures prior to December 5, 1980. Particularly in asbestos cases, the complaints we received rarely specified the date of exposure to a particular product.

And it's also common to settle claims before a discovery occurs and it's also common that witnesses that are still alive, don't have a clear recollection of the precise dates of their exposure.

And under those circumstances, if the plaintiff or the estate specifies in their settlement agreement that they are not making claims for exposure occurring after the 5 of December of 1980, is that adequate to confirm that we need not report that claim?

Barbara Wright: First of all, are you talking workers compensation situation or liability insurance?

(Michael Kimkoff): Liability insurance situation involving, you know, for example mass tort or asbestos claims. Basically we're trying to determine if we don't have a documentation of the time of injury, you know, what sort of documentation is good enough that we can rest assure that there will not be a, you know, an outstanding claim against us?

Barbara Wright: At minimum, if you're talking about putting something in the release and please don't count this as legal advice.

(Michael Kimkoff): Okay.

Barbara Wright: We would be talking about you should at least - they should at least be asserting that they're not alleging exposure or claiming anything more because the issue is, you know, when the exposure took place.

Not whether well gee I had exposure before 12/5/80 but I'm only making claim for exposure or gee I had exposure, you know, both times but I'm only making claims for the exposure before 12/5/80 so...

(Michael Kimkoff): Sure, sure. So what you're saying is if they put in the release they're not alleging exposure or claiming any exposure prior, you know, or I'm sorry after December 5, 1980, that would probably be sufficient?

Barbara Wright: That would probably be sufficient but it should be consistent with your other records too. It shouldn't be a matter of they came in with a claim and it clearly involves something after 12/5/80 and then whey signed the release, gee whiz, all of a sudden it didn't involve that.

(Michael Kimkoff): Okay, thank you very much.

Coordinator: (Andy Boyle), you may ask your question and state your company name.

(Sandy Formisko): Hi, this is (Sandy Formisko). I think that we potentially could be an RRE because we are self-insured up to our deductible of a $1 million, however, we don't currently have any claims or beneficiaries to report. So do we go ahead and register as an RRE now?

Barbara Wright: What we said in the guide is that if you don't have any reasonable expectation of having something to report, you do not need to register now, however, you should keep an eye on your claims workload et cetera.

And if at some point you have a claim or you have a reasonable expectation of having to make payment to a beneficiary, then you should register in time to allow a full quarter for testing purposes.

(Sandy Formisko): Okay, thank you very much.

Coordinator: Thank you, (John Shotink), you may ask your question and state your company name. Sir, your line is open, you may ask your question. I'll go to the next person. (Rita Falen), you may ask your question and state your company name.

(Rita Falen): This is (Rita Falen) and I'm from CCC in New York. Where medical malpractice coverage is for the hospital and its voluntary affiliated physicians come from an off-shore group captive that is owned by the voluntary hospitals, the U.S. program administrator that is also owned by the hospital, is intended to be the partner and RRE. Is that okay?

Barbara Wright: I think we lost you a little.

(Rita Falen): Okay.

Barbara Wright: It's your language. I mean, basically you've got to look at the rule we've set forth. And if the RRE you're setting is higher in the corporate structure than the captive, that's fine. If it's a parallel, like a sibling, or if it's lower, that's not fine.

(Rita Falen): Well, it's the program administrator is owned essentially by the insured hospitals.

John Albert: The insured hospital is the RRE. The program administrator isn't the RRE. They can be - what do we call it?

Barbara Wright: Agency.

John Albert: Agent representative.

Barbara Wright: Reporting (unintelligible) of the name.

John Albert: Right.

(Rita Falen): And that would apply also to the voluntary physicians who insured themselves through the program?

John Albert: Are you talking about the voluntary physicians are insuring or voluntary physicians are self-insurers?

Barbara Wright: Remember, that there's a general rule that no one is an RRE for non-GHP simply for being a TPA. So is someone who's self-insured but hire someone else to payout the money, that TPA is not going to be the RRE.

They need to look at who, really is the insurer who's bearing the risk, in your particular case, and look at where that entity fits in relation - in the corporate structure in terms of who you're suggesting should be the RRE.

(Rita Falen): Yes and if I might clarify. I'm not really speaking about a TPA. I'm really talking about a program administrator on behalf of the insureds.

John Albert: And I guess.

(Rita Falen): Owned by the insured.

Barbara Wright: Corporate structure wise, I guess, where does that fit? You're saying there's another entity, another company that's owned by the insured. So if it's a captive and it's actually the insured, than it's the RRE. But if it's not a captive, again, where does it fall in the corporate structure in relation to the entity that you're talking about?

(Rita Falen): I think we would sit in the shoes of those honors.

John Albert: Why don't you put together a few examples and send it in to the Resource Mailbox (unintelligible).

(Rita Falen): Okay, thank you.

Coordinator: (Frank Sourland) you may ask your question and please state your company name.

(Frank Sourland): (Frank Sourland), New York State Insurance Fund. I had a question regarding in New York State we have situations - we have cases where we have ongoing medical responsibility.

The claimant settles a third party action. And at the point where the claimant settles a third party action, we go into a credit-taking mode. And at that point, we don't have ongoing medical responsibility.

However, further on down the road, the claimant can basically apply to have their payments reinstated if the, what's called the net third parties recovery exhausted and we're trying to figure out how we're going to report the fact that we have an ORM termination and then ultimately we may pick up ORM

again but as of a certain date, there would be a gap in-between us not having ORM.

Barbara Wright: Could you hang on a moment please.

Woman: (Unintelligible).

John Albert: Could you put that in writing?

(Frank Sourland): Excuse me?

John Albert: Put your question in writing with an example and give it to citation through the annotated code of New York.

(Frank Sourland): Okay. Yes, I mean, yes I know in New York. I would assume it occurs in other states too. One other very quick question, just on federal cases, we just weren't sure and hadn't see anything whether or not we had to report - we cover worker's compensation in New York State but we do have some federal cases.

I just wanted to know if a decision has been made whether or not we have to include those when we report?

Barbara Wright: When you say federal cases

(Frank Sourland): Once on the Long Shore Harbor Workers Act

Barbara Wright: Long Shore Harbor Workers cases are reportable. We're stilling looking at, I mean, if the government is not the actual insurer, if it's not a government

situation, then the rules apply like they would to any other liability or workers compensation.

(Frank Sourland): Okay yes we are the - we would be the insurers on these cases yes.

Barbara Wright: Then if you are just follow the regular rules.

(Frank Sourland): Okay, great.

Coordinator: Does that answer your question?

(Frank Sourland): Thank you.

Coordinator: Lou Drapeau you may ask your question and state your company name.

Lou Drapeau: Yes. This is Lou Drapeau from the University of Kentucky. Our question is, are self-insured medical payments for athletic injuries reportable?

John Albert: You're talking about things that are generally handled by so-called insurance and they would be reportable.

Lou Drapeau: Okay. Does the same thing apply to clinical trials?

Barbara Wright: We will have language about clinical trials forthcoming. The language in that is a little bit different than exactly what you were talking about for the sports injury.

Lou Drapeau: Okay. And then when you post the ultimate rules is that going to sort of be like a frequently asked questions type of thing or are you going to do that

separately from some of the questions that have come out of these phone calls?

Barbara Wright: No, that when we post a particular policy rule, it will be in the User Guide. And when the User Guide - if we need to because we are not putting out a revised User Guide immediately, we will post it as an alert, if we put it in a revised guide.

Any time there is a revised guide, there are pages at the beginning that state exactly what's been updated.

Lou Drapo: Great. Okay. Thank you very much.

John Albert: Operator.

Coordinator: Sure. One moment while the party comes up.

Barbara Wright: Operator? Operator can you tell us how many people we have in queue for questions?

Coordinator: Sure, 17. (Catherine Dickens), you may ask your question and state your company name.

(Catherine Dickens): Hi, It's (Catherine Dickens)from Husch Blackwell Sanders. I was wondering when we could expect the similar Safe Harbor language for non-group health plans.

And have you guys considered in a lot of states we can't require someone to provide that information or sign something before paying them workers comp

or even in some of our jurisdictions we litigate in a lot of the judges wouldn't condition a settlement on someone signing that.

John Albert: Can you hold on just a second?

Barbara Wright: We were just regrouping here on your question. In terms of referencing of Safe Harbor, we want to reiterate what's been said a couple of times during this call, that anything that has to do with reporting or protecting you in terms of insuring that your quote in compliance is not a Safe Harbor or any type of protection with respect to any other responsibilities you may have under the Medicare Secondary care provisions.

If we provide language that we consider that if used makes you in compliance, it would be solely for purposes of Section 111.

(Catherine Dickens): Okay, that is probably how I should have phrased it then. Something in kin to what you guys have done for the (unintelligible)

Barbara Wright: And as, as we did say earlier in this call, we are working on similar language to what was put out for the GHP.

(Catherine Dickens): But, like as far as like I said we can't condition a workers comp claimant to sign anything before we have to pay him under most state laws.

Barbara Wright: No but to the extent of workers comp, we've been told to, I don't think any state has told us they don't have social security numbers for workers comps so you would clearly have the ability to query and find out whether those people are beneficiaries.

(Catherine Dickens): Yes, but I mean as far as getting something, I mean and again, you guys have said the query, just doing the query alone wouldn't say we were in compliance per se.

Barbara Wright: If you, if you have correct information and it's reliable information, then the query is going to give you an accurate response. So if you have assurance that you've got the correct social security number and name for the individual, you know, for workers compensation we generally been told the query function shouldn't present a real problem.

(Catherine Dickens): That's definitely has not been our experience with a lot of our clients only because the information is only as good as the day you get and sometimes obviously, I'm guessing you guys deal more with GPAs then you do with actual companies.

But, you know, sometimes the information gathering done by administrators isn't necessarily going to bring back results from the query that would make us feel comfortable relying on that completely, you know what I'm saying?

Barbara Wright: We hear your comment.

(Catherine Dickens): Not to insult any of the GPAs that are on the call right now but, that has been a concern from a lot of our clients that often times we'll have, you know, 0000000 and the social security number when we go back in some of the files.

John Albert: Okay, with, with that final segment it's now 3 pm Eastern time and we need to end the call. Please stayed tuned to the Section 111 Web site. Sign up for the LISTSERV if you haven't to receive notification of updates to the Web site itself.

There's also a complete schedule to the end of this calendar year for future Tele, Open Door Tele-Conferences. With that I would like to say thank you on behalf of CMS and please continue to submit your comments. And I guess finally, operator, I just want to know how many people were on the call?

Coordinator: Yes, total sir, you had about 814.

John Albert: Wow, a lot of people coming in late. Okay, all right, thank you.

Coordinator: This concludes today's conference. Thank you for your participation. At this time you may disconnect your lines. Thank you.

END