TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: June 10, 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: John Albert
June 10, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Michelle), and I will 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 the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Mr. Albert, you may begin your conference.

John Albert: All right. Thank you, operator. And good afternoon, everyone.

Again, as a reminder, and for the record, today is Thursday, June 10th, 2010, and today's call is a Section 111 on group health plan technical call. Again, this call is geared more toward the IT professional side of the implementation of the Section 111 reporting requirements.

Just as a note to everyone on the call, we'll follow the same procedures as we do on the rest of the calls in that we usually have presentations at the beginning, followed by an open Q&A session, but due to some scheduling conflicts, we will most likely have to end this meeting around 2:45 Eastern Time so about 15 minutes early to allow other folks to take over this room in advance of their call. So we apologize if that inconveniences anyone.

We're going to have a presentation by Pat Ambrose, and other than that, I think that's it. We're going to launch straight into Q&A.

So, Pat, you want to go ahead and then we'll go into Q&A.

Patricia Ambrose: Thanks, John.

First, some announcements. Recent postings that have been made on the CMS mandatory insurer reporting Web site that's at www.cms.gov/mandatoryinsrep. On the what's-new page or tab you'll see an alert on Worker's Compensation and no-fault periodic payments dated 5/27/2010. On the MMSEA 111 alert page you'll see an alert on risk management write-offs that is dated May 26th, 2010. Also there you'll see a revised version of the who-must-report alert with an updated Appendix G attached to that. That is dated May 26th, 2010. Again, that's on the MMSEA 111 alert page. And lastly, on the MMSEA 111 alert page you'll see an alert on the direct data entry option. That is dated May 25th, 2010.

On the NGHP transcript page there are some additional transcripts posted from prior calls, the technical and policy, in particular those recently held in May on May 13th and May 27th, 2010. On the NGHP there are two new alerts pages separate from the MMSEA alerts page due to space restrictions that we have with the Web site. So you will note that there is a new page or tab entitled NGHP alerts. On that page there is now only one alert posted there and that is related to the clinical trials. I think that would also be dated May 26th, 2010.

The mandatory insurer reporting page, which is the last tab or last in the list of menu options on the left-hand side of the mandatory INS REP page, is being used as an archive to move older documents to. If you go into that page, you'll see that there are some tools there for your use in terms of locating, searching, for and sorting the archived documents or alerts that have been posted out there. In particular, it would be helpful if you clicked on the issue date link. I would recommend that you do that to refresh the list to see the most recent posting, and that will also allow you to sort by ascending or descending order. And you'll also see a filter function to select a subset of documents if you're looking for something in particular.

CMS is still considering language for an alert related to lump sum indemnity payments and when those should be reported as TPOCs. This will also include consideration of whether ongoing responsibility for medicals, or ORM, has or has not yet been reported. This alert is – again, it's under consideration, and this is language separate and apart from the periodic payment language or alert that's already been posted. The updated non-GHP user guide for Section 111 is still slated to be posted on or about July 1st, 2010. It will include corrections and clarifications for technical issues, as well as the policy updates that have been issued via the alert since the last version.

Going back to the direct data entry option, again, please review the alert that was mentioned previously that is dated May 25th, 2010. The direct data option – entry option will be available in January 2011 in time for the required initial reporting for Section 111 non-GHP, or NGHP. Before deciding to switch to this method or choose it for a new RRE ID that you are registering, you need to consider the following limitations of this option.

It is specifically intended for those RREs that will have only an occasional claim report for Section 111. It is not intended for use as a query function. It will check the Medicare status of the injured party early in the data entry process, and if the injured party is not matched to a Medicare beneficiary, you'll receive a message to that affect and no further data entry will obviously be needed or required. You'll need to confirm the data that you have entered to make sure that it's accurate.

Now when you go through this process, that counts toward the limit of 500 claim reports per year that you're allowed to use the direct data option for. So be very cautious in that if you expect to have to check the Medicare status of more than 500 injured parties as you're considering reporting claims for Section 111, you might during the course of the year run into a problem using this method and hit that 500 claim report threshold. RREs may not use the direct data entry option for query purposes only, for example, using direct data entry just for query and then reporting claim filed under a different RRE ID. If you select to use it, you're using it by RRE ID and you must use it to submit claim reports.

The other last thing that I want to note is that since all the same data elements will be required in the direct data entry option as with the file submission process, the data entry for a claim report may take the RRE a significant amount of time. So do not select this reporting option if you will be making regular claim reports each quarter. In that case, you are advised to opt for the file submission method instead.

Now moving on to RRE IDs that you may have started the registration process for and no longer need, if these RRE IDs are in other words abandoned, if you registered for an RRE ID that you no longer need and never intend to use that RRE ID for production reporting, then please contact an EDI representative or the main COBC EDI department number at 646-458-6740 to have it deleted.

Many organizations have determined that they are not RREs for Section 111 reporting since the publication of the who-must-report alert. If you will not be reporting for Section 111, you do not need to complete the registration process or testing, and again, please call the COBC EDI department to have your RRE ID deleted.

We are making some revisions to the display of the file processing results on the Section 111 COB secure Web site to make this display easier to read. We received some feedback on the file status pages and heard you loud and clear, and are making some significant changes. The same information will be presented, but it will be presented in a more readable format, and this change is currently slated to be implemented early in July.

We've gotten some questions recently that really should be directed to the RRE's agent that is sending claim files for you. Some of these questions are related to how to use the agent system and not the actual Section 111 requirement. So please be sure to address these to your reporting agent since CMS and the COBC cannot assist you with those issues. And I would recommend that those agents out there remind their customers, their RREs to do this as well. So you might want to issue some sort of an announcement to make it clear to them when they should submit a question to CMS, and when they should be submitting the question to you as their reporting agent.

We have received a question that in part asks about Worker's Compensation Medicare set asides and how they effect Section 111 reporting. Initially, the ongoing responsibility for medicals, also known as ORM, for the Work Comp claim is reported with an open-ended ORM termination date, meaning that the ORM termination date is reported with all zeros. Once the Worker's Compensation Medicare set aside is submitted and approved – now that is not submitted by the way via Section 111 – there's a separate Worker's Compensation recovery contract, or the WCRC, to whom or to which the WCMSA is delivered.

Once, though, that Medicare set aside for Worker's Compensation is approved and the TPOC date related to the settlement is established – and I refer you to the description – the field description for the TPOC date in the user guide for that – the settlement amount is reported as a TPOC and an ORM termination date is reported to coincide with the settlement data or when ORM is terminated or when it ends when ORM responsibility and for the RRE.

Make sure this second report of your claim record includes the ORM indicator set to Y. It also will include the ORM termination date and the applicable TPOC amount and TPOC date. Technically, the TPOC is not required if it is prior to October 1, 2010, and/or under the threshold, but it will be accepted since you're reporting it on a record with the ORM indicator equal to Y, and we don't do a threshold check on TPOCs for those records.

We also received some questions related to required reporting of Worker's Compensation claims that are in dispute or being appealed. Please refer to the language near the end of Section 11.10.2 of the user guide where this is addressed. It depends on whether ORM is assumed and payments are being made while the claim is under appeal. I'm not going to read that language, but I think it's easy to locate if you look toward the end of Section 11.10.2.

Also related to ORM reporting, note that ORM is reportable if it has been assumed by the RRE even if no actual medical bills have been received by the RRE or paid or reimbursed yet by the RRE. If ORM exists and the claim is open as of 1/1/2010 and subsequent, the ORM is to be reported even if the RRE hasn't made a medical payment even for some time.

It's come to my attention that we did not document some error codes that we need to document in the user guide, and this will be added to the next version, version 3.1 that we're working on. The first is related to a question that was submitted to CMS and that we were unable to address on previous teleconferences, and this has to do with when an RRE sends a delete transaction for a record that does not match a previously accepted record, what will happen.

In that circumstance, if you send a delete transaction either for a record that wasn't previously accepted, so we have no record of it as a COBC, or it was – you know it was not a record for which you received an O1 or an O2 disposition code, or if you sent the delete transaction with the incorrect P field such that it does not match the original record, you will get an FP disposition code back and either an FP 48 or FP 49 error code, these error codes are not currently documented in the user guide and will be added. That was just an oversight and mistakenly left out of the prior versions of the user guide.

Another error code that needs to be added to the user guide will be FP 31. This happens only in a rather complicated situation, and hopefully will not happen often, but we do need to document it because we have actually seen this condition on a recently submitted production file. So a little bit of background information about this situation.

The COBC usually receives entitlement information for people in advance of their entitlement date. Usually, I would say 90 days in advance, but I – don't quote me – well, I'm not sure. I guess I am going to be quoted here, but I'm not really sure exactly the timeframe, but some you know significant number of days in advance. So suppose an individual is to become entitled to Medicare on July 1st, 2010, now suppose a query record is processed today on June 10th, 2010, for that individual, it will most likely return an O1 disposition code since the record will be matched to a Medicare beneficiary, albeit a future one. So if you then send a claim record for this person and it is processed prior to July 1, 2010, the system will actually reject it with an FP disposition code and a FP 31 error. This is an error that, again, is not currently documented in the user guide.

Now this issue is not with the COBC system or constrained by other systems that we need to interface with and update within the family of Medicare systems. So another one of these systems that we have such an interface with won't accept this scenario, and I'm not going to go into further detail on this call. And yes, technically this could have possibly a better resolution in the future, but this is how it's working now and how it will work for the indefinite time period. So now the good news is, though, that all you need to do is resubmit this record that received an FP 31 again on your quarterly file.

So, again, if you receive a record with an FP 31, you will only need to resubmit the same record unless there are other errors on it. Obviously, if there are other errors on the record, those should be addressed as appropriate, but this FP 31, the RRE does not need to take any action other than to resend that record the next – on the next quarterly file. And before someone asks me about it, we are looking at the compliance flag logic to make sure that that doesn't get set in this situation and you aren't flagged for a late submission of that record.

OK, next before I get into individual questions that were submitted, I'd like to address some ICD9 diagnosis code issues. We continue to receive questions and have noted the concerns. Particularly some of the questions center around a mapping from the WCIO body part nature and cause codes to ICD9. These WCIO codes are obviously commonly used in the Worker's Compensation industry. Now, we cannot provide a prescribed mapping of these codes to ICD9 so you, as the RRE, or your agent needs to create or should or may want to create a mapping of these codes to ICD9 diagnosis codes using your best judgment.

ICD9 diagnosis codes do not have to be an exact match to claims Medicare might have received and paid erroneously. The MSPRC, the MSP recovery contractor, searches all claims for a Medicare beneficiary and then uses the tool to group claims by likely incident or injury to associate them to the recovery case. This is done only in part by the ICD9 diagnosis code submitted in the alleged cause in diagnosis code fields for Section 111 reporting. Most of you may be aware that the same incident may have been

reported by the beneficiary or the beneficiary's attorney as well, and they would have provided some information to the COBC, which is also passed on to the MSPRC for recovery purposes.

Now, in some cases, you may be submitting one of the more generic ICD9 diagnosis codes since you were unable to match it, and this apparently is having more related to the E codes and the alleged cause. When that is necessary for you to submit an E code in the alleged cause field, do your best to submit more specific codes related to the injury in the diagnosis codes. Those are just as important as that alleged cause. And if you're specific with the diagnosis codes there, that should take care of you using a more generic code in the alleged cause field.

Now for – I know that there's concern out there related to if I'm having trouble with submitting diagnosis codes on my Section 111 claim report and is that going to have an ill effect on me as an RRE when it comes to the recovery process. Do note that for liability recovery cases, generally speaking, in most cases, the recovery action is usually directed toward the beneficiary rather than the insurance company involved; however, insurers or Worker's Compensation plans will be directly involved for Worker's Comp and no-fault situations quite often.

The insurer must follow the MSP regulations and take Medicare's interest into account when settling and reporting the insurer as described by the MSP regulations other than Section 111, as you all know. When you're reporting a TPOC amount, that claim report should include all the ICD9s that are related to the injury or treatments that are released or alleged and covered by that settlement judgment award related to the TPOC amount for ongoing responsibility for medicals. You are to submit diagnosis codes that the RRE has accepted or is required to accept and pay medicals related to. We are looking at some ways to provide some additional outreach and education related to ICD9, so please stay tuned for that.

John Albert: This is John. I just want to reiterate the point that Pat made about something that's (obviously) – you know the questions we've received on the codes, etcetera.

Again, you know the primary point of this is that the better – the better attempts that you make to give us complete and accurate information is so that CMS doesn't have to come back to you and can just basically pursue recovery and be done with it. So we recognize (this) you know a learning curve here. And as Pat said, you know we want to, based on questions coming in or you know as more people go into live production, you know get some feedback loops going with the MSPRC, for example, and the COBC.

We'll attempt to address you know those educational needs on a – on an ongoing basis – excuse me.
But again, you know don't get too bad out of shape if you're not 100 percent sure. You know, we're asking you to make your best effort on this, but at the same time, you know we also do expect people to make that best effort. So, again, you know continue to work with us and you'll be fine.

(So) all I want to say.

Patricia Ambrose: OK, now I'm going to launch into some of the specific questions that were submitted to the CMS Section 111 resource mailbox or e-mail for Section 111.

The first question relates to ORM, ongoing responsibility for medicals coverage, that was reported in error or reported, and then no treatment was incurred and the claim was closed by the RRE with no payment. The questioner referred to this (as) reporting zero dollar payments, but as you all should know, when you're reporting ORM, unless there is a TPOC, you're not actually reporting dollar amount. If the RRE has ORM but made no medical payments before ORM was officially ended, then an update with an ORM termination date must be submitted in the next quarterly file. It's possible that Medicare received the medical claims instead of the RRE.

On the other hand, if the ORM was reported in error – if the ORM reported was erroneous, then a delete transaction should be sent in the next quarterly file to remove that. So the answer to this question depends. Just because you didn't pay anything before ORM terminated, it didn't mean that the RRE didn't have ORM that should have been reported and then followed up by the

subsequent appropriate ORM termination date. But if you discover that you reported ORM and honestly did not have it, then you would submit the delete.

Another question came in regarding an RRE who has set up four separate RRE IDs. They now believe that they may not have anything to report for any of these RRE IDs, however, they may have something to report in the future due to their particular business circumstances. And in this case, they didn't think that they would have anything to report until after the threshold – interim thresholds have expired in January 2014.

So if you will not use – this answer really goes to anyone – if you will not use your RRE IDs for the foreseeable future, please contact your EDI representative or the EDI department and ask that they be deleted or put in an inactive status. The EDI rep will help you decide which is the appropriate action to take, whether actually deleting the RRE ID is appropriate, or whether, in a sense, suspending it in an inactive status is more the appropriate action to take.

Next question was submitted and related to submitting a record with a TPOC amount that was below the threshold, and the record was rejected with an FP disposition code and the associated error code of CJ07. For this record, it was asked what further action does the RRE need to take, do they need to send a delete record, and the answer to that is no. If your record was rejected for this circumstance, no further action is necessary. Unless there is a further TPOC amount or something else related to the claim that requires reporting, no delete is required because deletes are only needed under specific circumstances for records that received an O1 or O2 disposition code. So if your record was rejected for being below the threshold, there is no further action you need to take unless something changes. And I do refer you to the event table in the user guide and things like that.

The next question had to do with the ORM termination date and what is the reason why the ORM termination date must be at least 30 days after the CMS date of incident. Again, this is due to some of the constraints that the COBC has related to its interfaces with other Medicare systems. The COBC posts ORM records on another internal CMS system which has this 30-day

limitation. We are looking into getting that changed, but in the meantime, please follow the user guide instructions for the time being. We've addressed it I believe adequately in the user guide and you are asked to default that record, the ORM termination date, to 31 days after the date of incident. If it's a no-fault case, give us the appropriate no-fault policy limits and the date the expiration or the date the policy limits for no-fault were reached.

John Albert: Limitations of CMS's internal systems will not affect your compliance or lack of compliance with this process, so don't worry about that either.

Patricia Ambrose: Thanks, John.

Another question was asked whether plaintiff attorneys can query clients like RREs query injured claimants and the answer is no. Only Section 111 RREs may use the query functions offered under Section 111 reporting. Section 111 is not for use for querying by plaintiff or beneficiary's attorneys.

The next question gets into some policy issues that I'm not going to address. It has to do with asking for clarity on using the self-insured indicator field 64 on the claim input file and how and when this should be – or how this field should be set. So I'm not going to get into it on today's call, a discussion about what is the – what is the self-insured retention versus a deductible. But what I can say that when an insurer, RRE is reporting – making a report for coverage that the policyholder has under their policy, then that record should be reported with a self-insured indicator of N for no.

Now if the self-insured entity is making a separate report because they are an RRE under other circumstances for the self-insured retention and they are making that report, then they would make use of the self-insured indicator setting it to a Y. And again, I'm not qualified to discuss when it's a SIR or self-insured retention versus deductible. But I can say when the insurer is making the report as the RRE that they would naturally be using a Y – I mean an N in that self-insured indicator because they're reporting coverage under a policy or related to a policy.

The next question had to do with if you sent both the HIC number, the HICN, and the SSN, the Social Security number, on the claim input file if the HIC

number is not matched to a Medicare beneficiary does CMS then look for a match on the SSN? And, in fact, it does not. If you are submitting a HIC number on a claim record, the system will attempt to match on the HIC number to our file of Medicare beneficiaries, and if an exact match is not found – and again remember that we're able to match it to previous and current HIC numbers that may have been assigned to that Medicare beneficiary – but if a match is not found, the system will essentially make the assumption that you have incorrect information and it will not go on to check the SSN.

The next question is related to a liability settlement, I believe. This individual is stating that they have a claimant or injured party who is eligible for Medicare – so we have an injured party with Medicare beneficiary – and this individual confirmed that she did not want her medical bills to be – or reimbursed to her but rather payment go directly to the provider of those medical services. Again, I'm assuming this is not an ORM circumstance but a TPOC circumstance so that part of the settlement was paid to the injured party and part of the settlement was used to reimburse providers of medical services, doctors, hospitals, and the like.

In this circumstance, the provider of medical services, the doctor or hospital, does not need to be reported at all. They are not a claimant related to this scenario for Section 111 reported. So you're reporting the beneficiary as the injured party and the total TPOC amount reflecting the settlement. We're not interested as far as Section 111 reporting goes if you issued separate checks to the provider and the beneficiary.

Next question was related to formatting addresses, and this is something we've covered previously and will also be included in the upcoming update to the user guide. The question is related to how do I format an address that includes a suite or room number, attention to, or in care of those additional address fields or additional address information outside of just the street number and street name.

We ask that you put the street number and street name in one address line and all the other information, such as the suite – I have to back up. I think I

misspoke. We ask that you put the street number and street name in one address line and all other information, such as suite, attention to, in care of, and so on in the other address line. It doesn't actually matter which address line you put the street number and street name in as long as it's separated or segregated from the other information. Again, I'll update the user guide with that information.

OK, moving on, a interesting question was submitted related to a file that included duplicate records. So the RRE submitted a file with duplicate claim report and they received a response file back that provided a disposition code of O1 for each of those records, and they were expecting an error code but they didn't get one. In situations where duplicate add records are submitted, and in fact, duplicate update records are submitted, the system will treat the second and subsequent add or update records as updates. No error will be returned, and essentially, the last record processed is the one that will be retained and kept.

In specific cases, however, where you do not understand the response file records that are returned to you – so, for example, you got a 51 disposition code back and you really thought that that record should have matched to a Medicare beneficiary, you need to report that to your EDI representative and work through the details of that situation in order to figure out why you did not get a – get a match. The matching process in both test and production is the same and should be going against the same Medicare beneficiary database; however, there's obviously timing issues that – you know that we're continuously updating our Medicare beneficiary database. So if you've got a 51 returned on a query or a claim record, at one point you may then find it matched to a Medicare beneficiary later, as is obvious.

The next question I have on my list was related to reporting ORM that was in dispute or under appeal, and I already referred you to the Section 11.1.2 toward the end of that section about the assumption of ORM and reporting of ORM. So there's instructions there regarding whether – if the claim is under appeal whether the RRE is making payment or not making payment is what determines whether that and when that ORM is reported. Now if you previously reported ORM termination and you need to reopen it, you just need

to submit an update, obviously with the ORM indicator equal to Y, and just submit zeros in the ORM termination date. That will essentially open your ORM record back up.

Next question had to do with a case where a settlement is going to be split three ways as follows; an amount to the spouse, an amount to the children, and an amount – and an annuity at a particular bank, and the question was asking whether we need the bank's pin number for disbursement of the check. As far as Section 111 reporting is concerned, one claim report is made with the Medicare beneficiary as the injured party. The spouse and children are likely to be reported as claimants. The bank is not a claimant and does not need to be reported.

So the spouse and children are reported as applicable in claimants one through four fields and only one TPOC amount is reported if there is obviously only one settlement amount you know for the entire settlement amount regardless of how it's split. Again, I direct you toward the field description for the TPOC amount. However, if there are truly separate settlements, as we've addressed previously, you would utilize the TPOC two through five (sets of) field for that.

John Albert: As a caveat, I want, Pat, that we are, of course, assuming in this situation that the injured party is deceased.

Patricia Ambrose: Right. Exactly. Thank you.

The next question is related to the direct data entry and an RRE asking could I use direct data entry for one RRE ID but submit files for claim reports under another RRE ID. I think the circumstances behind this situation might be related to an RRE who has a specialty business, for example, where claims are processed outside their normal data processing system. So for the majority of their claim reports, they would be creating a claim input file and processing the claim reports that way. However, for this small subset of their business, those claims are not integrated, and they believe that it would be easier to opt for the direct data entry option since there might only be one or two of those claims per year and that is an acceptable situation.

And we said before that you can't use the direct data entry option only for querying, but if you are using it with the intent to report claims for a subset of your business, you can register a separate RRE ID and use direct data entry for that RRE ID and then report all your other claims on files under your other RRE ID.
You can switch to the direct data entry option if you've already registered, or you will be able to switch at a future date if you've already registered in the file submission.

And then if you are using the direct data entry option and at some point in the future your business grows, you have more claims to report, and you'd like to switch to a file submission method later, that is certainly acceptable as well. I can't speak to the exact process of how you make that switch, but certainly, information will be provided at a future date.

I have one last question, and again, I think we might have covered this before. It's related to ORM and a Worker's Compensation RRE. If we are paying for a body part without prejudice for a Worker's Compensation claim, do we need to include that body part mapped to an ICD9 code even though we haven't accepted it and it hasn't been established by the Work Comp board. I believe if you're paying claims on it – Barbara, correct me if I'm wrong – if you have accepted ORM, you're paying – reimbursing medical expenses or medical claims for that situation, then it should be included on your report of ORM.

Barbara Wright: Remember that for purposes of Medicare secondary payer, primary payment responsibility can be established without an acceptance of liability. Primary payment status can be determined by a settlement or a compromise or otherwise. There – it's regardless of whether or not there's a finding or determination of liability.

Patricia Ambrose: Now from a more technical standpoint, if you had reported an ICD9 code previously and the question was asked can we delete it later, so from a policy perspective if it's appropriate to delete that ICD9 code, then yes, you may send an update on without that ICD9 code, which will have in effect the – or have the effect of deleting that ICD9 code from your original report.

(Barbara): But remember, typically, if you're – if you're reporting ORM, you're (going to have) been careful to only report the codes that you've actually accepted responsibility for and that you're paying for. So the need to do any type of delete should be rare. When you're in a TPOC situation, then you have to report the codes that are related to what is claimed and/or released. So it would be unlikely that you're narrowing that group of code.

Patricia Ambrose: And, of course, you can always send an update with additional ICD9 diagnosis codes, as appropriate, and you should.

With that, John, that concludes my technical presentation.

John Albert: OK, we wanted to move next to the Q&A session. Again, this call is geared more towards the technical side of implementation. We would ask for those questions. Please defer any policy- specific questions to – for other calls.

Operator, we normally take one question and a follow-up and you may begin (inaudible) questions.

Operator: At this time, I would like to remind everyone, in order to ask a question, press star one on your telephone keypad.

And your first question comes from the line of (Susan Cornblue), New York State.

Your line is open.

(Susan Cornblue): Hi. In a prior conference call, someone had asked about the possibility of including more recipients on an e-mail from CMS, like possibly to send correspondence to an e-mail group or at east multiple recipients. Has any thought been given to that?

Patricia Ambrose: Yes it has. We're currently not working on changing the e-mail notification, but one thing that we are looking at is providing acknowledgement files (back) when a file has been received, when a file has hit a threshold, when a file has hit a severe error. So we are – you know we understand what the situation is, and that in some cases the appropriate individual or entity is not

easily notified you know. So, for example, if a file is suspended for a threshold error and an e-mail is sent to the account manager but it's really an account designee or an agent that ...

(Susan Cornblue): Right.

Patricia Ambrose): ... needs to know that, we think that we might have a – what might be a better, more automated, more you know – or a better solution whereby that notification to that other individual or entity would be done via a file rather than an e-mail. I don't know very much about the process. I do know that in the EDI world, in the X 12 world there is a 997 transaction or something like that. So it would probably function like that, I mean, and be some you know small acknowledgement file that could then be used in an automated way to notify the reporter of the problem.

(Susan Cornblue): OK, and just one other thing, basically about something you mentioned before.

In previous conference calls, you had indicated that if we provide a HICN and a (SOS) that you would check the HICN. And if you don't get a match on that, you would then go to check the (SOS).

Patricia Ambrose: You're right. I was wrong. I was corrected just today on that process.

(Susan Cornblue): OK, so then if you – if you check the HICN and it's wrong, you're not going to check the (SOS) at all?

Patricia Ambrose: That's what I have been told, yes.

(Susan Cornblue): OK, because we had workflow based on that, but I guess we have to change it now.

Patricia Ambrose: Yes, I apologize. That – it was – I was quite surprised to find that myself.

(Susan Cornblue): So were we.

Patricia Ambrose: Yes, so you know at least we got the proper information out there. I do apologize for that misinformation before. Obviously, we've got a lot of information to disseminate and at times things have gotten a little confused.

(Susan Cornblue): OK, that's all I had. Thank you.

Operator: Your next question comes from the line of (John Milano), (Gold and Lamb).

Your line is open.

(John Milano): Yes, good afternoon, everyone. Just have a question with regard to how it should be treated when as a reporting agent we're notified that an RRE has been deleted. If the RRE that has been deleted has previously provided claim records that have been accepted, do we need to submit a delete action type with regard to those records?

Patricia Ambrose: No, that – and first off, in a production reporting mode, if an – if a claim report has been made under and RRE ID in production, the RRE ID should be set to a D activated status, inactive status. I believe we're referring to it as not a deleted status. So if you have a circumstance where a production claim was reported back and you then received notification that the RRE ID was deleted, that – you need to contact the CODC and talk about that. Now in the case of deactivation since the RRE went of out business or something of that nature, you do not have to take a subsequent action to delete that record.

(John Milano): OK, I mean, I guess what the scenario I was thinking of is you know where we've had the redefinition of RRE at this point and you know we may have some clients or customers out there that have registered an RRE ID because they were self-insured for the deductible amount and they may have begun voluntary reporting prior to January 1, so they may have some records that were you know accepted, and now they've you know received a redefinition, and now the carrier is dong the reporting and has assumed the responsibility of the RRE.

Barbara Wright: I guess I would ask, Pat, I don't think we've had any reporting prior to January1 for that.

(John Milano): Well, you will.

Patricia Ambrose: No, I mean, you're talking about right now ...

Barbara Wright: Oh, OK.

Patricia Ambrose: ... not January 1, 2010, not prior to that. But you know right now, they have submitted – some folks have already submitted production files.

You know, the record reported by the insurer will match on the key field and it's all good.

(John Milano): All right. You don't have to do any kind of deleted action on the previous RRE ...

Patricia Ambrose: Absolutely not.

(John Milano): ... and just – as it's reported, it will be reported as an add under the new RRE and they'll match the key fields and everything will be copasetic.

Patricia Ambrose: Yes.

(John Milano): OK, terrific. Not so much of a question, but, well, more of a clarification. Do you have anymore details with regard to the direct data entry system that you can share with us such as other features that it may have, (and) is it going to be able to provide any type of data validation or any information that would you know give the user any assistance, like help screens or anything of that nature, any pop-ups that might help direct the user ...

Patricia Ambrose: The first ...

(John Milano): ... data ...

Patricia Ambrose: ... part of your question – well, let me see if I'm answering it. Yes, as with any Web site application that we roll out we'll have a user guide that will be accessible online and there will be associated quick help links for every page. We will also develop computer-based training modules that will be utilized, or can be utilized by users too that will take them step by step showing them the

flow and how to use the system. So those are at least three of the intended you know help mechanisms or information mechanisms that we plan to implement.

(John Milano): Wonderful. Thank you guys so much. These town hall meetings are very, very helpful. Thank you.

Patricia Ambrose: You're welcome.

Operator: Your next question comes from (Ruellen Allen) from Morgan Lewis.

Your line is open.

(Ruellen Allen): Hi. This is just sort of my standard question. Has the (toxic tort) conference call been set as yet?

Barbara Wright: No. My standard answer.

(Ruellen Allen): (Inaudible). I mean, we keep hearing it was going to be in May, and then ...

Barbara Wright: Part of what happened is the agency has adopted a completely new audio conferencing system and conferences were disappearing so there's things going on with that. So I needed to get that firmed down before I sent it out.

(Ruellen Allen): OK, any target?

Barbara Wright: Based on what you just said, I should say no.

(Ruellen Allen): OK.

Barbara Wright: As soon as possible.

(Ruellen Allen): OK.

Operator: Next question comes from (Bonnie Mustard) – your line is open – from Farmers Insurance.

(Bonnie Mustard): Yes, thank you. My question actually relates back to a question that we asked the last time, but I think it is technical enough in nature that I'd like to throw it out here.

We had talked about if a medical beneficiary has died, we have his social and all of the details, and we need to report him to CMS, but the (KP) said we have to document as claimant beneficiary for reporting purposes. We have the claimant beneficiary's basic information but don't have a social. He refuses to provide it. And the last time you suggested issuing a duel payee check made payable to Medicare and the claimant beneficiary. And that makes perfect sense except it did miss one thing and I didn't realize it last time.

It misses the what do we do about reporting claimant beneficiary on the – because if we put in a claimant beneficiary we have to put a social. If we don't put have a social, we can't put a claimant beneficiary.
You know all we know to do is say if there's a claimant beneficiary who refuses to give a social but we have everything else use the dual payee check ideas you've suggested and report it as if the Medicare beneficiary has not died. But do you have any other thoughts to this?

Barbara Wright: I guess – this is Barbara Wright and I guess I don't remember, and maybe I wasn't on that part of the call, suggesting that you use the dual payee naming the beneficiary – naming the beneficiary and the claimant.

Patricia Ambrose: I think we're mixing terms here.

Barbara Wright: Yes, we have said in the past that in order for an insurer to protect itself, we can't advise you to do so, but we've seen it. This is you know in the recovery realm where the insurer will do a multi-payee check that names Medicare as well as the beneficiary. We have talked about multi-payees in that regard. I honestly do not remember ever suggesting a dual payee check that names a claimant and the deceased beneficiary.

(Bonnie Mustard): No, no, no, no, no. The suggestion you had was make payable to the – to Medicare and the deceased Medicare beneficiary's claimant – what we would normally report as the claimant beneficiary.

Barbara Wright: We're calling the claimant

(Bonnie Mustard): You're calling the – what you're calling the deceased individual spouse or child.

Patricia Ambrose: Right. Claimant one through four, the people that you put in claimant (inaudible).

(Bonnie Mustard): That's right.

Barbara Wright: I mean, I guess – I guess what I'm saying is that there's a difference between protecting yourself for recovery purposes, and your more specific question right now is ultimately what do you do about not having a Social Security number of the claimant.

(Bonnie Mustard): And that's the question – that's the question I'm coming back with is for reporting purposes do we simply report the Medicare beneficiary as just they are alive and we have no claimant beneficiary, and therefore, we can fulfill all of the reporting fields? Or is there any option for making that social on that claimant beneficiary optional, or some type of a refused to provide where we provided everything else we had on that claimant beneficiary information wise but we would not have that social. And we actually have a situation where the claim will be resolved before we have to report on it but it would be good to know.

John Albert: I mean, basically, without that SSN, the record will not process the systems that we have set up to essentially validate that person is who you say they are.

(Bonnie Mustard): So ...

John Albert): That social or ...

(Bonnie Mustard): ... we have ...

John Albert: ... or the HICN is the most critical ...

(Bonnie Mustard): ... (inaudible) ...

John Albert: ... piece of that

Patricia Ambrose: So I think what you're suggesting, John, is that the record be reported with just the injured party Medicare beneficiary and – but you as the RRE keep a record of ...

(Bonnie Mustard): Yes.

Patricia Ambrose: ... the you know other parties associated. What we're referring to as you know the people that you would normally put in claimant one through four ...

(Bonnie Mustard): Right.

Patricia Ambrose: ... certainly attempt to obtain that information but – and if you have a record of that information, at least if there's any follow-up or issues later, you can produce that. And I guess then we'll take the requirement of the claimant one through four SSN under advisement and you know let you know if there any changes. But right now, certainly we want the claim reported, and if you can't report it and you know get it through the system, then you know you have no choice but to take that option right now. But do be advised that you need to keep a record of that.

(Bonnie Mustard): Yes, I – once in our claim file it's a permanent record. Yes, absolutely. OK, that was my only question today. Thank you.

Operator: Your next question comes from (Donna Brechard).

Your line is open.

(Donna Brechard): I'd like to talk about disposition code O3 again if we could. Is there going to be change in the user guide when the new update comes out?

Patricia Ambrose: Yes, ma'am. As we've talked about before, I understand the confusion over some of the wording in the user guide related to that. (Inaudible).

(Donna Brechard): So it's not going to be accepted. I think that's what's killing me is the user guide says the disposition code means that it was accepted.

Patricia Ambrose: Yes, what it really should say is that your record did not have any errors in it and your record the injured party submitted did match a Medicare beneficiary. However, we did not retain a copy of this record and accepted as applicable to Medicare secondary payer because what you have reported does not affect or overlap that Medicare beneficiary's Medicare coverage, and so is not primary to Medicare.

(Donna Brechard): OK, so this would be where the entitlement period was in the past and the SP 31 that you talked about earlier ...

Patricia Ambrose: Well ...

(Donna Brechard): ... in the future.

Patricia Ambrose: ... it could be in the past but there's another scenario.

(Donna Brechard): (Inaudible).

Patricia Ambrose: Let's suppose you know you could be reporting something on a person who was entitled for disability. Let's say, and for whatever reason, although it's probably not likely, their entitlement for disability and they are no longer a Medicare beneficiary. Now they're still going to be on our file of Medicare beneficiaries, and let's suppose you report a Worker's Compensation claim or whatever, it may be with the date of incident subsequent to when their Medicare entitlement ended. In that scenario, you could get an O3 disposition code because they are no longer a Medicare beneficiary but they were.

Another scenario is that you report a record with ORM along with an ORM termination date – suppose it was an auto accident with no-fault and you report an ORM termination date that is prior to that individual's Medicare entitlement starting. And in – and in that case, again, the incident – the car accident and related injuries and the time period for which the RRE had ORM ended prior to Medicare kicking in and so you'll get an O3 in that case as well.

(Donna Brechard): Oh, I won't get the SP 31?

Patricia Ambrose: Gosh, I'd have to think about that.

(Donna Brechard): I know. This is so – this is just the one piece that's just so complicated.

Patricia Ambrose: You know you're kind of putting me on the spot here.

(Donna Brechard): It's my job.

Patricia Ambrose: Yes, entitlement – I really honestly have to check with the systems folks to find out which comes first. I believe the answer is, if the – if you are submitting an ORM termination date that you will get the O3 disposition code, but if you are submitting an open-ended ORM termination date that – conceivably you're telling us that ORM may overlap their Medicare entitlement, then – but you've reported it prior to the actual date of their Medicare entitlement, then you get the SP 31. And I will be sure to provide examples of these scenarios and will update the CBTs as well.

(Donna Brechard): OK, and then what about if they're deceased? That was the other thing we had talked about prior.

Patricia Ambrose: That has no bearing.

(Donna Brechard):: So if they're – if they're deceased and I send an update, am I going to get an O3?

Patricia Ambrose: No.

(Donna Brechard): OK.

Patricia Ambrose: Not necessarily, no.

(Donna Brechard): It would still be accepted?

Patricia Ambrose: Yes, I mean, you know, we're not going out and expecting termination dates for – I mean, well, you could send in a termination date for a deceased individual ...

(Donna Brechard): I'm planning on it. If we know – if we know ...

Patricia Ambrose: Yes.

(Donna Brechard): ... they that they died ...

Patricia Ambrose: I would.

(Donna Brechard): ... we terminate and that's our internal reason.

Patricia Ambrose: I would. That's fine. No harm done. That makes sense.

(Donna Brechard): OK.

Patricia Ambrose: So, yes. Now, I will make one comment about the user guide. While the wording might not be you know as stellar or perfect as it could be, the action that you need to take is still accurate. If you get an SP disposition code, then you need to look at the errors and (deal with the) ...

(Donna Brechard): Right.

Patricia Ambrose: ... resubmit the record. And so if you get an SP 31 that I talked about earlier today in this call, you're getting an SP disposition code.

(Donna Brechard): I'm going to resubmit the record.

Patricia Ambrose: You are.

(Donna Brechard): OK, now when I get the disposition code O3 if it's just for TPOC, I'm not going to do anything else.

Patricia Ambrose: You're right.

(Donna Brechard): However, if I after – that I get my – I send an add, I got a O3, you didn't take the add, so then if later on I have another TPOC, I have to send that as an add again.

Patricia Ambrose: That's right.

(Donna Brechard): OK, I can handle that. Now ...

Patricia Ambrose: Now also – I mean, ORM also – you know there's instructions in there about ORM ...

(Donna Brechard): (Inaudible)

Patricia Ambrose: ... and that continues and whether you need to continue to monitor this person or continue to actually submit the claim.

(Donna Brechard): I think the only thing that I will know to do is just to keep sending the add.

Patricia Ambrose: I believe that that – if I'm understanding your scenario that is accurate.

(Donna Brechard): Now if I send an add, it's accepted, I send an update, it's accepted, I send another update, I could get an O3 if there're entitlement ...

Patricia Ambrose: No.

(Donna Brechard): ... (inaudible) ...

Patricia Ambrose: ... no, no, you won't.

(Donna Brechard): I will only get an O3 on an add?

Patricia Ambrose: Yes, I mean, you know you could erroneously send an update record you know instead of an add, and you know really the system is going to treat that as an add. But you know if you're sending adds and updates as appropriate, you should only get an O3 on an add.

(Donna Brechard): Well, what if – what if I'm on – I'm on Medicare, I send the add, life is good, and then for some reason I'm miraculously healed so my entitlement ends. We get some additional information on our claim so we're going to send you an update. At that point, they're not entitled anymore and that update is going to do what?

Patricia Ambrose: You know it really depends on the dates, but if the record was previously accepted with an O1 or an O2, you're not going to get that – you know for that related incident and date of incident you're not going to get an O3.

(Donna Brechard): OK, all right. OK, I have one more question. I just wondered. On the archive section that you were talking about on the Web site ...

Patricia Ambrose: Yes.

(Donna Brechard): ... is that going to – that searching, is that all going to include the current postings or is it only going to show the things that have archived?

Patricia Ambrose: I believe it only shows (what) the archives. I'll ...

(Donna Brechard): (Inaudible).

Patricia Ambrose: ... have to (inaudible) ...

(Donna Brechard): Well, right now it goes to 3/18/10 ...

Patricia Ambrose: OK.

(Donna Brechard): ... so I would assume everything else is not out there. But (I'd) be nice to throw them all in one place.

Patricia Ambrose: OK, hear you. I understand.

(Donna Brechard): Thank you so much. You guys have a great day.

John Albert: As we've said before, we have certain limitations on how we can arrange and build our Web pages, and unfortunately that means that we have to push out a lot of materials and such, things like transcripts and whatnot. We run out of room. So the Web site is always ever-evolving, but I hear you loud and clear regarding one place for all.

Operator: Your next question comes from (inaudible) from Mutual Insurance.

Your line is open.

Female: Hello. Thank you. This is kind of like the previous call, but that one it really confused me.

We only have TPOC. We don't have ORM. So when Pat said earlier when we get an SP 31 we should resubmit. But we didn't think we were receiving entitlement dates, so if our TPOC is actually outside of the entitlement date, how would we know that we know that we should not resubmit?

Patricia Ambrose: I can answer you very specifically. If you get the SP 31, you should resubmit that record in your next quarterly file and for reconsideration. And you know then we'll come back and provide you with the appropriate disposition code. And you might get an O3, but please resubmit it. So ...

Female: OK.

Patricia Ambrose: ... OK?

Female: OK, we'll do that (inaudible). Thank you.

Operator: Your next question comes from (Jason Pates) from Publix Supermarkets.

Your line is open.

(Jason Pates): Yes, my question is about the key fields. The only key fields that is likely to potentially separate two claims for the same individual is the date of incident. So if we have an individual who has two different claims with the same date of incident there's nothing to differentiate those from one another. So if we send one and then we send another you're either going to reject the second one or you're going to update the first with the information from the second.

Barbara Wright: Can we ask a question on that?

(Jason Pates): Sure.

Barbara Wright: Are you talking Worker's Comp or are you talking no-fault or liability because certainly for no-fault or liability, presumably you'd have at least a different policy number or you'd have a different type of insurance. You wouldn't have two claims for the same date of incident for the same beneficiary.

Patricia Ambrose: Same policy.

Barbara Wright: Yes.

(Jason Pates): We're talking about predominately Worker's Comp. I'm not if our GL could run into that or not but – and I also – I assume that your key fields are within a given RRE ID. That's not stated, but I would hope that would be the case. But yes, our Worker's Comp can have potentially situations where one individual has two claims with the same date of incidents.

Barbara Wright: Just for our information, can you give us a couple of examples (inaudible)?

(Jason Pates): Well, I guess, if someone was run over by a forklift and had the fortitude to make it back to work that same day and then sliced themselves on a meat slicer, I mean, that would be two different incidents.

Patricia Ambrose: Well, you know, I'm here to tell you that from a technical perspective you know that would – you're right. The two reports would be associated with the same case. Now we post information on internal files you know, there would be the Worker's Compensation you know record of you know primary's Medicare, and then both records do go separately and independently to the recovery contractor to the MSPRC.

So you know they're kept separate on their way over to the MSPRC, but you know there are some limitations in that circumstance, and I don't know quite how to get around that right now given the systems that we have to interface with. It's unlikely in many cases but – and it's – and those key fields are not by RRE ID. In other words, you know they're – another RRE ID can update subsequently like in the case we were talking about earlier with one RRE ID being deactivated and the claim being reported by another or an update being reported by the other.

(Jason Pates): So then if two different entities are making this update – OK, so then if – but the policy number and/or claim number are not key fields and if the RRE ID is not factored in, then if this individual goes out and gets into a car wreck the same day that they get hurt at work ...

Patricia Ambrose: Well, again, the insurance (play) I'm thinking might be different you know.

(Jason Pates): OK, or so they have two jobs, they get hurt at both of them on the same day. So now ...

Patricia Ambrose: Well ...

(Jason Pates): ... (inaudible) Worker's Comp ...

Patricia Ambrose: ... I mean, I hear you. You're making a point. You know, yes, we have some limitations here. Now, like I said, the separate records do go to the recovery contractor with policy and claim numbers – unique policy and claim numbers.

Some of the internal systems that Medicare maintains do not include that information and you know you could – you could look at it as sort of a shortfall. However, we have been operating under you know that scenario for many years, and you know I'm not saying it's as good as it could be, but it's not as bad as you're making it out to sound just because it's highly unlikely – those circumstances. So you know it is what it is and I do understand what you're saying.

(Jason Pates): You know what do I do if I find this issue – if we find a situation where we would potentially be reporting ...

Patricia Ambrose: You make those – you make those reports – submit those reports. So if you have two Worker's Compensation claims you know submit those reports, and you know we'll handle it on the back-end.

John Albert: I mean, in some of these situations that are more exceptions to the – to the normal processes, I mean, that kind of stuff does have to get worked out manually you know after we receive the data. But, again, we're working with certain limitations on CMS's internal systems that you know through this process we collect additional information and our normal systems have not been able to store and pass that data on directly to the end-user so that they can efficiently you know perform the process that they're charged with doing. And the whole goal of this is to essentially you know make sure benefits are recorded correctly as well as to streamline and reduce efforts for all involved related to recovery processes.

William Decker: This is Bill Decker. There's one other thing you can do, of course, in any unusual situation is to call COBC – call your EDI rep and tell them what is about to happen so that we're alerted to the fact that you're doing something that is a little bit unusual.

(Jason Pates): OK, so it sounds like if we run into one of these, then I guess we just need to send them both and then see what comes back, and I guess we'll sort it out after the fact.

John Albert: Yes, believe me, we'd like to code our way out of every unique situation, but it's never really been possible on our end. So MSP is complex.

(Jason Pates): OK. All right. Thanks.

Patricia Ambrose: Thank you for your input.

Operator: Next question comes from Berndt Anderson from Beacon Mutual.

Your line is open.

Berndt Anderson: Thank you. A follow-up on a question you had earlier. You said that someone submitted a question that said he had submitted a record. It was below the threshold, and therefore, it was rejected (inaudible) his question, what do I do then.

Earlier also today, I thought you said you don't reject records if the threshold for the TPOC is lower than the threshold, and I thought you said on the last conference call that if it's below threshold for the no lost time, 750, you don't identify those. And assuming I understood that correctly, I was just curious. What threshold was this record rejected for because it was below?

Patricia Ambrose: I believe that they were referring to a TPOC – a Worker's Compensation or a liability TPOC and you know not referencing the section on the Worker's Compensation's ORM reporting thresholds. We don't check the TPOC thresholds if the record is submitted with an ORM indicator of Y. So you know if you're ...

Berndt Anderson: OK, but do you – do you check it if it's just a TPOC and there's no ORM? Is that what you're saying?

Patricia Ambrose: Yes.

Berndt Anderson: I see, OK.

Female: (Inaudible)

Berndt Anderson: Thank you. (Just) ...

Patricia Ambrose: Yes, and, I mean, I need to be clear that you know there's not really an ORM threshold there, but – and refer everyone to the interim reporting thresholds for a thorough description of the reporting threshold. There is a section stating that for no-fault insurance there are no applicable ORM in TPOC amount thresholds. There is a – is none for liability insurance ORM either.

There's a discussion about claims not – claims that have ORM Worker's Compensation only. Certain claims are exempt from reporting, that's listed there. And then as far as that previous question, we were really referring to a situation where the claim fell into the section entitled liability insurance and Worker's Compensation TPOC amounts, and you'll see in those requirements that it only applies to where the ORM indicator equals N. And so when you're submitting ORM indicator equal Y and you know for a claim that has ORM related to it and you're also submitting TPOC amounts, we don't do a threshold check.

OK, Operator, next question.

Operator: Next question comes from Mike Stinson from Physicians Insurance.

Your line is open.

Mike Stinson: Thank you. I was just wondering (inaudible) reference to the direct data entry – excuse me – is it going to be possible for RREs to switch between DDE and the regular files reporting system if they try one and decide it's not (meeting their needs) and want to try the other one instead?

-

Patricia Ambrose: Yes, there is the opportunity to switch. Now it can't – you can't switch back and forth every quarter or midstream or – I'm not quite sure what the limitations will be, but if you start out with direct data entry and find that it does not work well for you, you can switch back or switch to a file transmission method, yes.

Mike Stinson: OK, great. Thank you.

Operator: Your next question comes from Norman Reese from Louisiana Insurance.

Your line is open.

Norman Reese: OK, thank you. We have a person – Medicare beneficiary and he's killed in an automobile accident, we would owe the estate the medical expense and the funeral expense which would be a TPOC. The wife and children would have claims for loss of love and affection. It would sizable payments. Would those be counted as TPOCs?

Barbara Wright: It's really going to depend how your whole settlement is structured and was the claim been released to – I mean, to the extent – we are not bound by the allocations of the parties, is what this goes back to, and if there's no hearing on the merits by a court of competent jurisdiction, if there is settlements total $100,000, then we need that $100,000 reported because we have a priority right of recovery.

Norman Reese: Even though these are individual claims (to) these people and has nothing to do with medical expenses?

Barbara Wright: They're based on an injury to the deceased party.

Norman Reese: Well, actually, the death of the deceased party, which we would pay the estate the funeral expense and any medical expense. That'd be payable to the estate, but their claims are separate.

Male: I would – it depends on whether these are separate, independent claims by separate parties and the wording of the releases that this one claim and the

parties agree that X dollars goes for this and Y dollars goes for that, D dollars go for something else, we are not bound to recognize that.

Patricia Ambrose: But if they are separate claims ...

Male: Separate claims – if there's separate claim for loss of consortium, love and affection or something, and then all that is claimed and that is all that is released, then arguably that particular TPOC would not need to be reported.

Norman Reese: OK, that answers my question. Thanks.

Operator: Your next question comes from (Samantha Rowland) from First Insurance.

Your line is open.

(Samantha Rowland): Hi. I just wanted to clarify what you were speaking about earlier. Our company has – we're going to be transitioning to a new reporting system and in order to do so I wanted to make sure that our new system was registered for its RRE and every claims are transferred. I would not need to delete record for the existing RRE?

Patricia Ambrose: You know it depends on your circumstances. Some of this is addressed in the user guide in the registration section, but you may if you're reporting under a new RRE ID in a sense pick up where you left off. And so say a record you reported under your old RRE ID was an ORM record and is open-ended and then you transitioned to this new RRE ID and you need to report an ORM termination date, you can send that ORM termination date under the new RRE ID. And as long as the key fields match, it'll match up and terminate that record. Does that answer your question?

(Samantha Rowland): OK, I was thinking maybe I had to go delete record (and everything) but ...

Patricia Ambrose: No.

(Samantha Rowland): ... you're saying I can just pick up.

Patricia Ambrose: Right, and again, I refer you to, I think it's in Section 8.3 of the user guide, changes to RRE registration and reporting, and I also encourage you to talk about the scenario with your EDI representative.

(Samantha Rowland): (OK).

Patricia Ambrose: You know we don't want to get into all the details today, but if there's anything specific to your circumstances that might affect it. But that's generally the approach that you need to take.

(Samantha Rowland): OK, OK, and one last question. You said there are times (inaudible) are no longer (inaudible) beneficiary status?

Patricia Ambrose: I'm sorry, could you speak up?

(Samantha Rowland): (Inaudible) when people are no longer beneficiaries?

Patricia Ambrose: It is possible.

(Samantha Rowland): (Is that) only when they pass away?

Patricia Ambrose: They're still considered a Medicare beneficiary on – you know when they pass away, really talking about – when I was talking about people no longer beneficiaries, I was really referring to a circumstance where the person was entitled for some reason and that entitlement ended, and then later on – and they're you know still alive and later on they could become entitled again for Medicare at some point in the future.

(Samantha Rowland): OK, so there is and incident where you can (have a period) (inaudible).

Patricia Ambrose: Yes, there could be gaps in Medicare entitlements ...

(Samantha Rowland): OK, OK.

Patricia Ambrose: OK? Thank you.

(Samantha Rowland): Thank you.

Operator: Your next question comes from (Peter Dunn) from (Applied Underwriter).

Your line is open.

(Melanie): Hi. This is actually (Melanie) but I'm with Worker's Comp and I have a question about the recent alerts about periodic Worker's Compensation payment. For fatality benefits, the payments would actually fall under this alert because they are periodic payments made to the spouse or other qualified dependent. But since the claimant is deceased, ORM shouldn't be open, but this alert would make me think that it'd be reported under ORM? Can you clarify that at all or ...

Male: (Inaudible) ...

(Melanie): What's that?

Patricia Ambrose: What's (inaudible) ...

Male: ... included in the payment.

Patricia Ambrose: ... what's concluded in the payment?

(Melanie): It's a payment for lost wages usually – some sort of indemnity benefit.

Male: Well, we got to be careful of what you're paying. Usually it's not always. If the payment is strictly for lost wages of the deceased party and is not in any way compensating for anything other than lost wages, then arguably, it would not need to be reported. However, if you were lumping together the entire resolution of the claim, then they could arguably include some medical expenses and you're just prorating it out over a period of time, then I believe that would need to be reported.

Barbara Wright: Remember, we've got a general underlying rule that when no medicals or claims are released in the settlement judgment award or other payment does not have the affect of released medical, basically that's not something that's reportable. So you can't look at every one of these rules completely in isolation. You need to keep the broader rules in mind when you're looking at some of the specifics.

(Melanie): OK, I just didn't – it seemed like the alert precluded that, but I guess that makes sense.

Barbara Wright: We're were just talking about what happens in a specific situation that would otherwise be reportable. It doesn't eliminate or invalidate the general rule that when there's no medical claim to release it doesn't have the effect of claiming a releasing medical and is not reportable to start with.
Does that help at all?

(Melanie): Yes. OK, thanks.

Operator: Your next question comes (Cindy Fennell) from (Great Northwest).

Your line is open.

(Cindy Fennell): Thank you. I was calling about direct entry questions. Do we have to (inaudible) (them) at any time, or do they have (inaudible) like payments (inaudible) at the same time like (quarter) when we do – if we were to do the (fit and) file?

Patricia Ambrose: Are – you do not – if you're doing direct data entry you won't have an assigned file submission period. You will go to the Web site and report on a claim-by-claim basis one at a time essentially. That claim still will be held to timeliness standards. You know, we need to write up – I think the alert covers that to some degree, and then you know in the user guide when we're rolling this out, we need to address that as well. Does that answer your question?

(Cindy Fennell): Yes, that does. A follow-up question. Could we also – to do direct entry could we use the query test file to test for Medicare beneficiaries and not use up our 500?

Patricia Ambrose: No, unfortunately not. You know, if you're going direct data entry – your direct data entry all the way, no query files you know and – yes.

Barbara Wright: And as Pat said earlier, when you submit – if you submit something for John Smith, if it turns out he's not a beneficiary that uses up one of your 500 ...

Male: (Inaudible) direct data entry.

Barbara Wright: ... if you're using direct data entry.

John Albert: I mean, DDE essentially is combined of query and then report for each record that ...

Patricia Ambrose: Right, and again, it's intended for you know those that have a small number of claims in the first place and then a small number of reportable claims.

Barbara Wright: I mean, if you have any significant number of claims and you're going to have any dependency on the concept of querying, then DDE probably isn't for you because you could use up your 500 simply by getting 500 rejects.

(Cindy Fennell): Right, so (we're still) trying to figure that out. So – all right. Thank you.

Operator: Your next question comes from (Satama Yaver) from (John Mullin).

Your line is open.

(Satama Yaver): Hi. I have a question regarding the DDE offense, a follow up to the previous one. If we enter the claim for the first time and then we found out that only a few were Medicare beneficiaries, so next time we're going to input again those claims and then will that count to that 500 those claims that were rejected for the first time?

Barbara Wright: You're going to count twice. Once when you enter the first time and again when you enter the second time.

(Satama Yaver): (Inaudible).

John Albert: Well, I mean, I guess if you entered them the first time and they were Medicare beneficiaries, I mean, again, you should complete that record and be done unless you're doing some like (inaudible) query.

Patricia Ambrose: You know, we might need to think through, they're not a Medicare beneficiary yet but the ORM continues, how do they go about monitoring that going forward. And I – you know we're still working on finalizing the requirements, quite frankly, so you know we'll make sure that you're not penalized, so to

speak, for adhering to the rules. But there – stay tuned is all we can say. We can't really tell you exactly how it's going to function. Obviously, you're going to need to be able to come back and update previously accepted records, maybe even request a delete, but we're just not prepared to give you all the specifics in this meeting.

Barbara Wright: The big point right now is to understand and remember that there is no separate query function, and you're using up your limited 500 number to the extent that you haven't already ascertained that the person is a beneficiary because any reject will count as one of your 500.

(Satama Yaver): OK, thank you. That's all.

Operator: Your next ...

John Albert: Operator ...

Operator: Yes?

John Albert: ... we have – OK, we got a few more minutes. Go ahead, operator.

Operator: We have two questions left.

John Albert: OK.

Operator: Next question comes from (Cynthia Stacos) from Union Pacific.

Your line is open.

(Cynthia Stacos): Good afternoon and thank you so much for taking my call. I was listening to a previous call about the beneficiary being dead and the reporting requirements and I guess this has always been a question that we've always kind of got confused on when it does come from to the reporting.

If a beneficiary – Medicare beneficiary is pronounced dead and had a railroad accident and there are no medical bills related, but yet his family is pursuing the railroad for pain and suffering and settlement and that type of thing, so we would pay like a funeral expense or something to that affect and pain and

suffering is later on paid, does that require a Section 111 report if there's no medical bills involved, but it was a Medicare beneficiary?

Barbara Wright: In the first place, in many cases where there's an accident and a death on a scene there are still limited medical expenses in the term – in terms of ambulance, et cetera.

(Cynthia Stacos): Right.

Barbara Wright: So you know – but in a disaster, someone submitted a similar question like you know 9/11 circumstances you know ...

(Cynthia Stacos): Where there's just a coronary, that comes up and there's no fee – there's no ambulance fee.

Barbara Wright: (Inaudible)

Male: (Inaudible) (medical) claims (inaudible) ...

Barbara Wright: Again, in that case, I would hope that both parties would have the sense to not claim or release medical.

(Cynthia Stacos): So then if both parties are (in odd), you mean in the settlement wording?

Barbara Wright: Well, in the actual claim when they come in and make a claim or any pleading, if it goes to court or anything. Our touchstone is whether or not it's claimed or released.

Male: In other words, if it wasn't claimed, but yet you wanted a general release that included release of any medicals, it would need to be reported.

Barbara Wright: So you know think about it in terms of even if framing your release. If you're absolutely sure there's no medicals, then it shouldn't cause you concern not to have medicals included in your release.

(Cynthia Stacos): OK, that clears it up. Thank you so much. I appreciate that. Thank you so much for taking my call.

John Albert: You're welcome. We have time for one more.

Operator: Your final question comes from (Krista Moses) from Positive Physicians.

Your line is open.

Christina Moses: Hi. My name is Christina. I just have a question regarding the direct data entry again. I just wanted to clarify some information.

If you choose to go the route of the direct data, it's my understanding that you have to use that for query and for claim because it is as one. You can't use like one system or one mode of transmission for doing query – you know querying the system and then use the direct data just for submitting the claim. Is that correct?

Patricia Ambrose: That's currently the requirement, yes.

Christina Moses: OK. All right. That's what I needed to know. Thank you very much.

John Albert: OK, operator, we have to – as we mentioned at the beginning of the call, have to end the call a little early.

One thing I wanted to mention that I failed to mention at the beginning of the call is a disclaimer that while we try to speak accurately of all the existing written requirements of the mandatory insured reporting Web site, there are times where we contradict the official written materials on the Web page, and if we do, the Web page always takes priority over what we say on these calls. So, again, I just want to set disclaimer on there and that's the same disclaimer we put – when we load that up for the Web site.

Other than that, I'd like to thank everyone for their participation today. Some really good questions. We'll take those back with us and hopefully provide additional information and continue to improve the quality of the materials that we have out there.

Barbara Wright: And, operator, could you stay on and come back and tell us how many ended up on the call?

Operator: Yes, I can.

Male: Thank you.

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

END