TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: June 29, 2011

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 29, 2011
1:00 p.m. ET

Operator: Good afternoon. My name is (Stephanie) 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 that time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Mr. John Albert from CMS, you may begin your conference.

John Albert: Thank you, operator, and good afternoon, everyone. For the record, today is Wednesday, June 29th, 2011. This is the NGHP Policy and Technical Open Door Teleconference.

Again as we state for the record, at the beginning (of these) while we try to present everything as is in our written materials, occasionally we misspeak. Where there is a conflict between anything that we say on these calls, we would refer you to the official printed guidance on the mandatory insurer reporting website as the official CMS position at this time. As we do in these calls we have some presentations and then we'll move into a question-and-answer session. And we have a lot of participants today.

So as we have asked in the past, please limit your question to one and one follow-up, so that we can get other people who are in the queue a chance to get their questions heard. So we just ask you to go back into the queue after you've had your first and follow-up question answered.

So I'll begin as always with Pat Ambrose, who will provide some information, and then Barbara Wright has a few things, and also William Decker as well.

So, with that, we can get started.

Pat Ambrose: OK, thank you, John. This is Pat Ambrose. I have some announcements of a more and information of a more technical nature. Some recent postings on the CMS mandatory insurer reporting website pages that can be found at www.cms.gov/mandatoryinsrep. On the MMSEA 111 alert page, you'll see an alert about the upgrade schedule for the query files and the HEW software, so that is the X12 270, 271, query files and the corresponding HEW or HIPAA eligibility wrapper software we are as you should know by now moving to version 5010A1.

The alert dated April 5th, 2011 the companion guides for those using their own X12 translator will be posted shortly, they're in the queue for posting right now. These companion guides are for use only by those RREs and agents that use their own X12 translator and do not use the HEW software or the ATW software. Some of the changes – and the HEW software will be available to all RREs and agents as of October 1st, 2011.

Some changes involved in the 5010 transactions. If you're using your own translator, the version is obviously moving to the 5010, specifically a 005010X279A1. Another minor change is the ISA11 segment uses a PIP instead of a capital letter 'U' in version of 5010. And there is a version number on the ISA12, I-S-A-1-2. It goes from 00401 to 00501. Segment GS08 also has a change for the version number that I mentioned earlier. And the FT03 segment is added to the FT segment for 5010. So changes should be relatively minor. Those companion guides as I said will be out there shortly. If you're using a Hughes Software you don't have to worry about those changes, just implement the software and you should be good to go.

On the NGHP alert page, we reposted the pin reference response file and address validation alert with some additional information dated May 17th, 2011. And the changes or the update corrections made to that alert are listed at bullets at the beginning of that alert, so that's out there on the NGHP alerts

page. And then, of course, on the NGHP transcript page you'll see the transcript from the May 4, 2011 call.

Version 3.2 of the NGHP user guide is still not finalized, it's still in draft form. The draft is currently under review. I hope to see it posted by August 1st. In the meantime, essentially all the information you need to comply with reporting can be found by starting with version 3.1 that's out there on the website on the NGHP page and then applying the information posted on the various alerts since July 2010.

Some changes coming up in the July release for Section 111 reporting. You will be able – there will be a new feature on the Section 111 COB secure website. The URL for that you should all know is www.section111.cms.hhs.gov. You will – there will be a new feature to allow you to download in RRE listings. So if you have multiple RRE IDs associated with your user ID, you'll be able to log – login to the COB secure website and select this function to produce a file that can be loaded into a spreadsheet software such as Excel, and it will essentially provide you with a listing of all your RRE IDs and other information that's displayed on that RRE listing page.

Also direct data entry will be available to all RREs including those that are not currently participating in the pilot for that process. We're making a minor change to the password rules. This is a security requirement that's beyond our control that we must adhere to. Again there will be minor changes. And the page where you change your password will provide you with instruction. It will – also there will be quick help available. And, of course, your EDI representative can help you with that. Now you will not have to change your password and abide by these new rules until your current password expires. So, as usual, you'll either be prompted to change your password when that time is up or you can go in and perform the changed password function yourself and then those new rules will apply.

You will also be able to download a list of valid ICD-9 off of the COB secure website login page under the "Reference Materials" menu option across the top, just on – that same menu option is where you can download a list of

excluded ICD-9. Now we're posting out the entire list of valid ICD-9 scores Section 111 reporting.

We're putting in a fix in the July release not to apply the TPOC thresholds – interim thresholds to no fault claims. The TPOC interim thresholds only apply to workers' compensation and liability TPOC.

We're also adding as I mentioned on the last call a new file threshold error, where a file will suspend if the system finds that you have submitted a no fault insurance limit or a total TPOC amount of 100 million or more on any single claim record in the file. It's our belief that that is an exceedingly large amount and should not happen essentially. So as we do find that condition on any one claim in your file, it will suspend with a threshold error and you'll follow the same procedures contacting your EDI representative who may either delete or release the file for processing as the conditions merit. That I wouldn't panic about this threshold error, it should happen very, very rarely.

We are also putting in a fix for those of you who are receiving the FP32 error when you submit a record where the ORM termination date equals the date of incident submitted on the claim. Now that fix is going in July 29th. All the other changes that I've just previously mentioned will be available as of Monday, July 11th, 2011. And then the fix for SP-32 will go in July 29th. And so if you have received SP-32 on a claim for that condition you'll be able to resubmit it after July 29th and have it processed normally.

Another note or a reminder, please remember that RREs are required to correct and resubmit records returned with disposition code SP and associated error codes unless the user guide indicates otherwise for that particular error being returned. We are seeing RREs resubmitting record without making the necessary corrections or not resubmitting these records at all. CMS and the COBC will be following up with RREs that represents the biggest offenders of this circumstance.

Remember that responsibility for accurate compliant Section 111 reporting ultimately rest with the RRE. Even if you have a reporting agent reporting for you, the RRE must still make sure that reporting is done timely and accurately

and it is the RRE that will be held accountable. There are some reporting agents who edit the records ahead of time and notify you of errors and you're expected to fix those errors prior to your file submission, your other cases where the agent system might reject a record and not transmit it to us, it really depends on your agents and their system. But ultimately it is the RRE's responsibility to make sure those errors are getting corrected.

A few notes about ICD-9 reporting. I do understand the ongoing difficulty that people have whenever possible tried to provide additional information or additional support. Remember that there are computer based training or CBT modules out there free of charge that you may register for that you might find helpful in terms of submitting ICD-9 codes. Here are some other reminders. Remember to only submit only ICD-9 to describe the injury or illness involved with the claim. Rebate session in the user guide where it explains that the ICD-9 should describe the injury or illnesses for which you have assumed ORM for or the illnesses or injuries that are alleged are claimed or released by a settlement judgment award or other payments by the TPOC amount.

Now, these codes may be selected or derived by the RRE for this purpose. Codes do not have to come from medical claims submitted by doctors and hospitals and other suppliers to the RRE. However, this may be a good source, but note that these providers don't always supply E codes, the cost codes causes injury codes. So you might have to derive that yourself. Anyway make sure that the ICD-9s that are pulled off of these claims and submitted for Section 111 actually deprives the illness or injury the RRE has ORM for or the illness or injury claimed or alleged associated to the TPOC settlement.

Sometimes providers will submit medical and hospital claims with ancillary or extra ICD-9 codes like hypertension or something of that nature that isn't actually strictly related to the illness or injury covered by the workers' compensation, no fault or liability claim. In that case, if you did not assume ORM for example for hypertension don't submit that ICD-9 code on your Section 111 to report. If you submit ICD-9 codes that do not apply to the

illness, injury to the claim you're reporting, that of course may adversely affect claims payment from Medicare beneficiary.

And someone did actually submit a good suggestion about using the workers' compensation NCCI or WCIO nature in cause of injury codes. We, in fact, considered using those codes way back when Section 111 reporting requirements were first developed and it was determined that these codes could not be used. But I certainly appreciate your feedback and input. It was a good suggest, but unfortunately that's not going to work for us.

Improvements continued to be made to the SFTP or the secure file transfer protocol process. Report any issues to your EDI representative and escalate those issues if needed. Remember that there is regularly scheduled maintenance for the both the COB secure website server and the SFTP's server. Check the bulletin board on the login page of the Section 111 COB secure website and other places where that information is supplied. And in some cases, we've had – people report problems with SFTP and it turned out they were trying to transmit during a maintenance at a regularly scheduled maintenance outage period.

Another point on related – this has to do with submitting the leads on your claim input files. Do not perform the delete/add process when just the HICN or the healthcare insurance claim number also known as the HICN for an injured party changes, do not report the delete or do not perform the delete/add process when the HIC number for an injured party changes. I refer you to the note at the bottom of the event table where it says that RREs only need to correct. The HICN or the SSN in cases where an incorrect person was submitted and accepted on the input record.

HICNs can be changed by the Social Security Administration at times, but the COBC is able to crosswalk the old HICN to the new HICN. So therefore in those instances where the correct person was previously submitted and the HICN happens to change for that person at a later date, the RRE does not need to correct the record. In fact, updates may continue to be sent under the original HICN or SSN submitted, but you are encouraged to – when you do – when you are required to submit a subsequent transaction for that claim report

to submit the new HIC number we will also return the most current HICN on response record and RREs are encouraged to update their systems with that information and use it subsequently.

Delete/add is not necessary to correct the person's name either. We've got examples of people sending in a delete and then adding the record back, and the only thing that's different is the person's last or first name. If the record was already accepted you do not need to resubmit unless you have something else to report and specify in the events table. At that point just submit the record with the updated information. See the event table for instructions on when to send updates in order to perform the delete/add function. You may send an update for other information and it will be processed and accepted, but it's not required.

As always, please submit your specific technical questions to your EDI representative first. Specific technical issues related to your file submission can be addressed effectively if they are sent to CMS resource mailbox or elsewhere you will get a much faster response to your specific technical issues if you contact your EDI reps and then follow the escalation procedure in section 18.2 of the user guide if necessary.

I'm now going to cover some technical questions and answers. These were questions submitted to the CMS Section 111 resource mailbox via email. That email can found under "What's New" page of the mandatory insurer reporting website pages that I – that website URL that I gave earlier in the call.

The first question was asking whether if an individual is identified as a Medicare beneficiary or matches to a Medicare beneficiary to the query process, do we have to continue to query this person's – send this person on their query files. Is there a reason to continue an ongoing query once we have received a positive response back? Once the person is identified as a Medicare beneficiary, I see no reason to continue to query. You should always get the same result going forward. I realize that we've had some questions and issues with the query matching – beneficiary matching process compared to the claim beneficiary matching process, I think all those issues

have been addressed and you should not see those discrepancies going forward. However, so if you do get a match on a query there should be no reason to – to query that person, of course, you have to submit claims as applicable for them on your claim input file.

The next question was asking about the RRE has one settlement with a TPOC date of October 1st, 2010, but separate payments one of $1000 and one of $50,000. And they're asking whether they should report or how they should report this settlement amount or – and first I want to make sure that the person submitting this question is referring to two payments for the same claim, the same type of insurance, the same claim and policy number, same interparty, et cetera. Assuming that that is the case, then you should make one report with one TPOC amount. In this case there were two payments of a 1000 and 50,000 and so that one TPOC amount should be 51,000. Again review the user guide and I suggest that you take a look at the computer based training modules which would cover this kind of information in detail as well.

Another question submitted about Ohio workers' compensation plan particularly asking about Ohio employers in the 15k program and questions about the query and use of query and claims reporting. I can't speak to any specifics about the Ohio workers' compensation program, but I can say the – the query file is optional. But if you don't use it you need to find another way to determine whether an injured party is a Medicare beneficiary and obtain their health insurance claim number or HICN or HIC number and see the model language alert on the mandatory insurer reporting website as well. To identify claims that are reportable under Section 111 you got to visit the CMS' Section 111 MGHP user guide, particularly the section entitled "What Claims Are Reportable" that's section 11.10.2 and then review the event table. The date of birth of the injured party has no bearing on whether the claim is reportable. You can be entitled to Medicare and be a Medicare beneficiary and be under age 55. Contact your EDI representative for help with the query file and any specific help with query input files and review the information in the user guide, and you might want to make use of the beneficiary lookup feature on the Section 111 COB secure website.

Another question was asking about you know asking to confirm reporting dates. In particular, they were asking first about liability insurance. Is it correct that liability insurers have no responsibility to CMS for payment or reporting of claims for the TPOC date prior to October 1st, 2011. The delay in reporting liability TPOCs is only a delay in Section 111 reporting. This question alluded to having no responsibility to CMS repayment, no other MSP obligations for liability have been changed. So please make a note that there is an alert dated November 9th, 2010 out on the website that describes the delay in reporting liability TPOC. It also describes the extension for the interim reporting thresholds for TPOCs and for reporting workers' compensation ORM. This question went on to ask, and that is then true for claim reporting of liability TPOCs you only have to report liability TPOCs with a TPOC date of October 2011 and subsequent. Is there a look back period for liability TPOCs? No. Now ORM for liability or any insurance type has to be reported back to January 1st, 2010 and subsequent.

I think that's as much as all – this question also asked about workers' compensation. There was no extension for workers' compensation and liability reporting. And so – I mean, I'm sorry I missed that. No fault workers' compensation and no fault TPOC reporting any workers' compensation or no fault TPOC amount with a date of October 1st, 2010 and subsequent must be reported same caveat as before with the liability reporting. Later on, I'm going to review the reporting – some reporting dates which might help. Again, I suggest that this individual asking these types of questions might want to take the computer based training modules. You don't have to take all of the modules. You can look through the curriculum and just select the courses that you have particular questions on or subject that you have a particular question on.

The next question was again asking about, do they have to report all bodily injury claims – all injured parties on bodily injury claims, do they have to query these individuals and do they have to report the claims for Section 111. But they're actually referring to their agent system and made a reference to a page of their agent user guide. So first I want to state that you know, of course, it's important to review the materials that your agent supplies you for whatever system you might be using to report through them. But as the RRE

you are also obligated to read the CMS' official Section 111 NGHP user guide that's on the mandatory insurer reporting website. Read section 11.10.2. The RRE must have assumed ongoing responsibility for medicals or ORM or the claim must be resolved or partially resolved through a settlement judgment award or other payment which releases medicals or has the effect of releasing medical.

So this individual was asking if the claim was closed with no payment or closed, because the RRE had no responsibility, do they still have to query the person, do they fail to report the claims. And, you know, essentially no, because that claim you did not assume ongoing responsibility for medicals and that claim was not settled. It had – it did not release medicals or have the effect of releasing medicals. And, for Section 111, you only have to report after you have assumed ORM or after there has been a settlement judgment or other payments. You can't report a zero TPOC unless happen to be reporting ORM, but there is no point in it. And then also note that there are interim reporting thresholds for TPOC amounts as well for workers' compensation and liability that is. So hopefully I've cleared up some information there and you might want to follow-up with your agent as well as you have questions about how to utilize their system.

Another question was asking, I'm not going to get into all the policy related and who the RRE is, but this is a circumstance where there was a fronting liability policy from domestic US insurers that are a 100 percent reinsured by the system offshore captive insurance company, et cetera, et cetera. Again, I can't say who the RRE is. It sounds like the individual submitting the question is clear on who the RRE is, but they were asking about – and this other entity is actually processing the claim, but the RRE is responsible for reporting. At any rate, the question was, what TIN or Tax Identification Number, T-I-N, should be submitted in field 72 and what office code in field 73 and so on, and what claim number should be used in field 75. So what I can say is that the RRE's TIN should be submitted in field 72 and on the TIN reference file. And as far as what you use for field 73 and claim number for field 75 it really depends on your particular reporting circumstances. And I suggest that you would contact your EDI representative to talk about that in

more detail. And note that the office code does not have to be used and can be set to default values if necessary, so see the user guide on that.

Next question, someone reported a discrepancy between the description for certain causes injury description, certain E codes, eICD-9 codes between say version 27 and version 28. The version 28 that we put in the user guide for you to use does use this long description and version 27 uses the short. And apparently there was a significant difference between the short and long description and they can vary of course. In the end, the cause code that was submitted by this RRE is OK with either description, because it does imply a motor vehicle crash. I would – on a year-to-year basis, I would update and use some of current description out there on the new version going forward, but there is no need to go back and change anything for previous submission.

Note that I'm talking the cause code here field 15, the cause of illness injury code, the E as in Edward code that you put in field 15. The ICD-9 diagnosis code fields one through 19 are far more important in the end than the E codes used in field 15. So if you find a discrepancy in those, I encourage you to make the appropriate updates. At any rate as I said before, we are also supplying you now with a downloadable list of valid ICD-9 codes on the website as of July 11th and perhaps on the why use the descriptions from that file, so you can be consistent with what the COBC is using.

The next question is asking about having in the event of a diseased Medicare beneficiary who is an injured party, this RRE has more than four beneficiaries or other claimants to report and what to do about that, there are five or more children for example or something of that nature. Our instructions to you in that case is just report the first four other claimants that you have on file or use your best judgment it will get worked out during the recovery process with the MSP recovery contractor as needed.

Another question related to a diseased beneficiary and other claimants or in reporting of other claimants. This is a situation where the injured party was a Medicare beneficiary is now deceased. The additional claimant is a family number who actually is a foreign national, does not live in the US, does not have US citizenship and does not have a Social Security Number, and this

individual was asking how they can go about reporting this other claimant, because the TIN is or Tax Identification Number is required and they do not have one. What I suggest is that you try submitting the other claimant with a default Tax Identification Number of all nine since that's number it should get past the system or just don't submit that other claimant at all. However you should or must still report the claim. So just report the claim with the deceased beneficiary and the injured party. And again if there is any recovery necessary that should get worked out on the backhand with the MSPRC.

Next question has to do with the new TIN reference response file that's being added as of October 1st. And this RRE or agent was asking whether they would be able to test. Generally speaking you will be able to start testing your TIN reference file and the corresponding response file as of October 1st. We're not opening up general testing to RREs prior to October 1st. However, you might want to plan on sending though your TIN reference file separately prior to your fourth quarter claim input files as soon as possible after October 1st. And the idea would be to get that TIN reference file submitted cleanly in production and then send your claim input file. And those of you who are to report in that first week – first couple of weeks of October you know might be a little bit late, because of trying to cleanup your TIN reference file and I'm sure CMS will understand that and the COBC will work with you through that.

As always it's posted out there in a compliance alert on the website if you are going to be late in reporting for any reason as long as you contact your EDI representative, you're considered still in compliance with Section 111 reporting if again you've notified CMS and the COBC through your EDI rep of your particular circumstances. So again, the TIN reference file may be sent separately from your claim input file and it may be sent as many times per month as you want or per quarter rather as you want. There is no limit on to the number of times you can send it. So what I would do is prepare my TIN reference file submitted separately and you know get it processed. If it comes back with errors cleanup, those errors and resubmit it and continue that process until my TIN reference file is completely accepted and clean and then proceed with my claim input file. The TIN reference response file should take about three days to process so you should get a response file for and about

three days. I do understand that it's inconvenient not to be able to test the process prior to October 1st. And in the future when we make changes like this, we'll certainly plan for that and allow for testing as possible for RREs before requirements are implemented into production environment. So it's a goal and we will do the best job we can on that.

Some other questions were submitted related to the reporting of other claimants again in the case of deceased Medicare beneficiary. And the first one was asking about when they should use a state code for an individual name provided or code E for the claimant type versus an X for an entity name. I believe that the distinction has to do with whether a separate Tax Identification Number has been assigned to the state. Initially the state uses the Social Security Number or SSN of the deceased individual and then depending on the circumstances a separate Tax Identification Number may be assigned. So in the case at a separate Tax Identification Number has been assigned to the state use X and submit then that new TIN for the state otherwise use the code E for the claimant type and submit the beneficiary's Social Security Number.

The next question had to do with a circumstance where there is a – in this particular state a personal representative assigned to the deceased individual other than an attorney and they were asking in the representative field what they should provide, whether they should provide the attorney or the – this personal representative. In the case where there are two representatives we've asked for the attorney information and that would be true for multiple representatives for the injured party and multiple representatives for the claimant. If there is no attorney then obviously the other representatives, and in this case, this personal representative could be submitted and use the other code because there is no other representative indicator applicable.

OK, I think I've answered this question. Next question was about workers' compensation Medicare set aside account, our payments to a Medicare set aside account and a settlement on the workers' compensation claim treated as TPOCs or TTOCs. The entire settlement including the amount which is used to fund the workers' compensation Medicare set aside is reported as one TPOC amount and then no further reporting is necessary on that claim since it

has been settled, and presumably the RRE no longer has ongoing responsibility for medicals or ORM.

Lastly was a question about confirming the reporting dates. And in particular this individual asked if they are in NGHP, RRE, and will only report liability insurance TPOCs no ORM. They want to confirm that they are to start reporting as of the first calendar quarter of 2012 and will they need to report claims only with TPOC date of 10/1/2011 and subsequent, and that is correct.

So let me review the reporting dates. And again if you have any questions on this, you should contact your EDI representatives who could help you with further explanation. There is also information on this in the CBTs; I believe they have been updated for that November 9th alert where these reporting dates, certain reporting dates were extended. The reporting dates are for all insurance types, workers' compensation, no fault and liability, ongoing responsibility for medical, ORM, all ORM as of January 1, 2010 and subsequent to be reporting, and should have been reported by now.

Workers' compensation and no fault TPOC with TPOC dates of October 1st, 2010 and subsequent must be reported. And reporting for that should have started in the first quarter of 2011. Liability TPOCs with TPOC dates of 10/1/2011 and subsequent are reportable. Liability TPOCs with dates prior to 10/1/2011 are not required to be reported. But if reported, they will be accepted. You do have to adhere to the interim reporting threshold so. RREs were to start reporting as of first quarter 2011 unless they have nothing to report. For example, they have no reportable claims or they only have liability TPOCs to report. RREs with only liability TPOCs to report or to commence reporting in the first quarter 2012.

RREs that have selected the direct data entry must commence reporting if they haven't already by July 11th, 2011. Please see the DDE alerts for more information about the retroactive reporting that you might have had to do. And then, again in that November 9th, 2010 alert out on the website all the interim reporting thresholds have been extended for one year, so please make a note on that.

John, that's all I've got.

John Albert: Thank you, Pat. Bill Decker has a couple of things to bring in.

Bill Decker: Hi, good afternoon, everybody. My name is Bill Decker and I'm with CMS here in Baltimore. I'm going to talk a little bit about some legality of collecting in information, questions and Social Security Number questions and general. But first I'm going to respond to one question we got, which is about HRA reporting. And HRA reporting is not NGHP reporting. I think that whoever sent us – to this mailbox was wrong. We're not going to address that. I'm just going to move on from that. If you did ask a question about HRA reporting specifically, this is not the call for you.

The question – the first question I'm going to answer all or at least address is – came to us from an organization that claimed that some insurers were telling them that they the insurers were not legally allowed to capture and provide Social Security Numbers or HICNs to whoever was requesting and we presume the reporter, an RRE. We're not sure why – where that comes from, we do know that there are some states that have state laws that appear to be more stringent than the Federal Laws on this subject. But this is – if someone needs a Medicare ID number, a Medicare HICN, the HICN should be appropriately supplied to whoever requires it as long as it's being used to – in relation to Medicare covered services. There isn't anything in the Federal Law that will prevent an RRE from asking for or using a Medicare ID number which is a Medicare HICN from any Medicare beneficiary.

There is a specific question, where we've got a number of questions about no match situations. They – you send us information that – requiring about whether someone is a Medicare beneficiary and we'll send you back information saying we did not get a match on the information you sent us and you're assuming that the individual then is not a Medicare beneficiary even though the individual says they are. There is a number of reasons why this can happen.

First of all, you need to – and in the matching criteria we have, you need to get the matching criteria you're sending us correct. If you're sending us a

name, first initial or the first letter or the first name – it's first initial, first name, first five letters of the last name, date of birth, sex, and Social Security Number. If you have the SSN correct and you have the date of birth correct, but you don't have the other information correct, we're not going to have a match for you. It's that simple.

The other situation is that the individual could not be giving you correct information about the individual. They could be giving you, A, the wrong Social Security Number, or they could be using a name for example that isn't their social security official name. That happens sometimes. In such cases, there is nothing we can do about getting you the correct information. We can only suggest to you that you ask the individual to check with the social security to see what they have on file and get back to you on that information.

If you don't have a HICN for someone and you're asking us if they're a beneficiary, we would ask you to collect the HICN if you can. The Medicare ID number should be available to any Medicare beneficiary. There are folks who are over the age of 65 and you'll have a Social Security Number, but how may not be a Medicare beneficiary for a number of reasons. There may not be many of those people out there, but there are some, and you may occasionally someone who is not a beneficiary for one reason or another, even though they're of age to be a beneficiary and have a Social Security Number.

And, finally, let me just check my notes here – and finally I'm done. Thank you very much. I've covered the information I wanted to cover and I'm turning it over now to Barbara Wright.

Barbara Wright: Thank you, Bill. I would add one thing on what Bill was just talking about. If you have a situation where you're not sure that the information matches, I would not suggest as first step telling them to go check with social security. I would suggest as a first step being more specific with them in terms of exactly what is shown on your social security card, can you tell me...

Male: Or Medicare card.

Barbara Wright:...or Medicare card if they actually are a beneficiary, because one example is women who are married and they've never changed their name with social

security, that could be a field that's causing us to reject and they aren't even thinking about that fact.

Male: Right, they don't think about that and they give you their married name rather than their social security name and that's...

Male: Right.

Male: ...you know but that may not be what social security on file.

Barbara Wright: And also individuals who have common nick names all the time. Most people know that Bill is usually short for William, but Betty isn't necessarily a substitute for Elizabeth or even if it is some names like those had been used by the person their entire life, they don't view them as a nick name. So you know the first choice is to get them to check what's actually on their social security card.

Male: Actually the first choice is to get them to give you their Medicare ID number. Yes, that all settles properly.

Barbara Wright: So other issues I wanted to go over before we got to questions, we're getting a number of questions that appear to tie into recovery efforts, they aren't really within the scope of this call. I'm going to touch on a couple of them very high level, we're not going to take questions on them, but just to clear the way since we've got a lot of questions.

First of all, there has been – there are some discussion about the fact that the recovery contractor has suspended. Write some recovery letters and demand letters. Those letters are both then resumed. So any issues you had with that should be taken care of.

Additionally there were some questions that were asking about reporting somehow in the context of situations where people were having a concern with the combination no faulty in my ability case with the MSPRC. Again there was an issue there where the MSPRC was not issuing – was giving people information that they had to exhaust the no fault before they would get

their liability demand letter. That has been corrected. That's no longer a situation, so if you're one of the people that wrote about that.

Third one that's not – again basically my answer is going to be that it's not related. We got a question about the set aside protocol that the AUSA and the Western District of New York has put out for his area and they asked how that would affect the MMSEA Section 111 reporting. It doesn't have any affect. It's completely separate and it's not a CMS process as it says on the protocol itself. So it doesn't change any obligations you've got with respect to reporting.

OK. One of the – and either one or two of the questions that came in had to do with risk management situations and provider physician or supplier billing. And the question was essentially whether or not provider, physician or other supplier had a choice when they had a choice where they did a risk management write-off. Could they take care of it on their billing or could they choose to do a Section 111 report? And you cannot ignore. Providers, physicians and other suppliers can't ignore their billing obligation. They have been required to bill correctly even before the Section 111 reporting. Situations that constitutes self-insurance, liability insurance have billing requirements and those would exist even if we no longer have the Section 111 reporting. So there is no choice. You must bill properly in those situations.

Pat spoke some about different coding issues, and one of the questions that came in that I don't believe she touched on is one of the inquiries was talking about their use of unspecified codes and how this was causing problems with beneficiaries not getting their claims paid and made the suggestion that CMS should simply do a batch process that would stop denial of claims where there was an unspecified code. And this system was what Pat was talking about. Our – codes are given to us in part, so that we can pay properly on the frontend.

And when there is ongoing responsibility for medicals, the more specific the code is, the better we'll be able to process claims. If you have ongoing responsibility from medicals and you've put in a very generic unspecified code that increases the risk that a claim that a beneficiary submits which is not

in fact related is going to be rejected until those further approved that the workers' compensation or no fault will not pay it. So you should not simply be choosing unspecified codes, because for example, you don't have a doctor's bill that has a particular code. As Pat specified, you are not required to use a doctor's bill as your only source of code. You should be doing whatever analysis you need to do to submit as specific a code as you can.

Male: That applies for TPOC. That applies for any report, because again those – the reasons for those code sets is to allow CMS to properly identify those claims that are related and those that are not related to that particular incident.

Barbara Wright: The one distinction we would make is we did say that for ORM you should only report codes associated with what you have assumed responsibilities for. If you're reporting for a TPOC you are obligated to report codes related to whatever has been claimed or what is claimed released or have the effect of being released.

So slightly on a different topic of one of the questions, for clinical trials, someone asked the question whether if a sponsor makes a payment direct to a provider/supplier as opposed to a beneficiary, do they still have to report that? Yes. It's not who is receiving the liability payment, it's basically on whose behalf it was made. If you're making payment and it has to do with a beneficiary situation then yes it needs to be reported.

We also had a question that had to do with the thresholds for 2013, and I'm going to ask John for confirmation on this. We have already given you the thresholds for 2012. We extended the existing ones from 2011. What we could say about 2013 right now is simply I think we've promised that we would always give at least six months advance notice of any changes in thresholds. And at this point it is really all we can say about 2013.

Pat Ambrose: Are you just referring to the workers' compensation ORM?

Barbara Wright: I'm talking about all the thresholds that are listed, the dollar thresholds.

Pat Ambrose: Well, we do go past 2013 for the workers' compensation and liability TPOC threshold.

John Albert: We already go past.

Pat Ambrose: Yes, I mean the 5,000.

Barbara Wright: No, but the issue is what changes – I understood the question to be what changes are going to be made for 2013 or will we extend what we have for 2012...

Pat Ambrose: OK, OK.

Barbara Wright: ...once again. And we will always give at least six months advance notice of what the thresholds are going to be, but that's all we can say at this point.

Pat Ambrose: OK.

Barbara Wright: We had some questions come in about what we're doing about December 5th, 1980 issues and what is still being called mass reports in general. We had expected to have a call set no later than the beginning of June. We've had various objections that came up on some issues. Those are still under review by CMS. So no, we have not set another call yet. Yes, we will set one as soon as possible. No, we have not released another draft at this point. And we will issue it as soon as possible, but I don't have a date that I can give you at this time.

John Albert: We're still here. Checking some notes. I guess when Barbara is still checking, I'll tag on – also there is some stuff Bill Decker talked about earlier with SSN and things like that. You know we have received a lot of questions about you know supposed in consistencies and some of the match found, not found, things like that. And again we stress to go to your EDI rep for ones that you've basically run out of you possible reasons in terms of any inconsistencies to assist. And if you're again not getting what you need, please elevate those questions using the escalation process that's in the user guide. We do have technical reps from COBC on the call as well. So if there are questions that come up, he can assist. You're done? OK.

All right, I guess, we're ready for question and answer. Again, I'd ask folks to please limit their question to one primary and one follow-up, and then allow others a chance at the microphone since we – as with these calls we normally have a fairly large audience participating. So operator you can open it up to Q&A.

Operator: Certainly. At this time, I would like to remind everyone in order to ask a question please press star then the number one on your telephone keypad. We ask that you limit your questions to one primary question and one follow-up question. Thank you. We will now pause just a moment to compile the Q&A roster. Your first question comes from the line of (Lisa Riley from CCMI). Your line is open.

(Lisa Riley): Hello. I have a couple of questions. The first one has to do with Medicare and the rights against in a state. One of our clients called and said they've been to a seminar on Medicare saying that Medicare had no right against in a state. But my understanding was if you have an injured party that is deceased and there are the claim being made from their estate, then any type of settlement would be – we could have to report that to Medicare. Is that correct?

Barbara Wright: Yes. First of all it would be incorrect to say that Medicare never has rights against a state.

(Lisa Riley): OK.

Barbara Wright: There are certain states in which the wrongful death that you combine with the way a particular suit is pursued may or may not mean that we have a recovery claim, but that's not a legal determination for the RRE to make. You need to go ahead and report. And if the wrongful death laws in a particular state prevent us from having a recovery claim then if we make one that would be something for the state to as a defense if they in fact with who we were pursuing recovery from.

(Lisa Riley): OK. Got it. And then my next question was from the same client. They have quite a few ancestors' claims and they just had a quick question. If say there was 10 parties and the settlement is a $100,000 and their part of it is $10,000

to pay, did I report the whole $100,000 or just the $10,000 that they're required to pay?

Barbara Wright: What we've said is if they have a separate settlement for $10,000 that's all they report.

(Lisa Riley): OK.

Barbara Wright: If Stan and John have a settlement for $20,000 and they believe their portion is each $10,000 but they are each equally liable under that settlement, then you have to report the whole amount.

(Lisa Riley): OK. Got it. Thank you.

Barbara Wright: OK.

Operator: Your next question comes from the line of Katie Fox from Franco Signor. Your line is open.

John Albert: Katie?

Katie Fox: Sorry, I'm talking and I'm on mute here. I apologize. Hi guys. My name is Katie Fox. We have a question from one of our clients who had previously submitted it to the mailbox, they then reached out to an EDI rep for some direction, and the EDI rep was very helpful but wasn't able to give us some answers that we should bring it to this forum. So I'm going to explain it and then if we have any details in the question I can try to fill those pieces in. In essence the – there is not one legal entity, it is a group of 500 sibling companies where there is no legal hand corporation. And the question is do this 500 sibling companies that may own one, two, three percent, small percentages of another company each need to register as RREs or will there be a way to register one sibling company do the reporting for the entire group?

Barbara Wright: Under the current direction, each sibling companies would technically be the ones that is RRE. The part of the issue would be that no one is required to register until they have a reasonable expectation of reporting. So if they don't expect to be able to report on a regular basis they may even opt to do the

direct data entry if and when that particular one would have something to report. But there is currently no mechanism to say that, "Hey, they can simply pick a sibling and make that one the RRE for everyone." They can pick a sibling to be the agents for everyone.

Katie Fox: Now that – can I ask a one follow-up question? The way it's structured is the developer entity is responsible for overseeing all of the claim handling, construction and management functions of over 800 plazas, but the legal owners of the plazas are the variety of these different sibling entities. So I just want to repeat what I'm hearing back is that, because there is not a sole legal entity that would be one RRE. If it is anticipated that there will be something to report under any of those 800 plazas and variety of ownership, each ownership would need to register separately as their own RRE.

John Albert: Yes, yes, no that's correct. I mean it's – again as Barbara mentioned, it sounds like based on the setup that there wouldn't be a whole lot you know to ever report of anything, but again the direct data entry option is probably the best course of action for this particular situation.

Katie Fox: OK.

John Albert: Again a lot of times we have situations like this where again they may utilize the agent to do the reporting as well as Barbara mentioned so. But in terms of – it too has ultimate liability for the payments.

Barbara Wright: And this is, of course, assuming the company as the RRE...

John Albert: Yes.

Barbara Wright: ...if they don't have a separate insurer than the RRE.

Katie Fox: There – their self-insurance is over 35 million square feet of leasable space, so there is a lot of potential. But, OK, thank you so much for taking the time to take my call, and you have a great day guys.

John Albert: All right, thank you.

Operator: Your next question comes from the line of (Tom Michalski from the Autocorp Group). Your line is open.

John Albert: If you're speaking you must be on mute. We're not hearing anything.

Operator: (Tom Michalski), your line is open.

John Albert: We'll take the next question.

Operator: Your next question comes from the line of (Bonnie Lazard) from Farmers Insurance. Your line is open.

(Bonnie Lazard): And, yes, thank you. I was just wondering if you could talk for a minute about then the difference between the disposition code 51 and the SP-31 and now SP-32 errors. I don't think the SP-32 is documented anywhere in any publication, but it has been referenced by our EDI rep. I just want to clarify that we have a full understanding of the difference between these.

Pat Ambrose: SP-32 is not documented, because you should not be getting that error. And as I mentioned earlier in the call, you might have missed it, we're putting in a correction in the system as of July 29th. Right now, the only condition that I know of that and RRE has receiving SP-32 is when they submit a record where the date of incident – the CMS date of incident is equal to the ORM termination date. That is an allowable condition. And, however, we erroneously are returning SP-32 right now. But you will be allowed to submit that condition after July 29th.

SP-31 is an issue where the individual – you probably won't be getting many of those going forward. Either that was happening when the individual was entitled to Medicare in the future and is not yet that date – first date of Medicare entitlement has not been breached. And we've made some changes to the system to the matching process to not send back a positive match until that entitlement date has actually been breached. But in the past you could have gotten out. And then – and the user guide does document it and tell you what to do and that would be to just resubmit the claim. And once that that entitlement date is reached, it should – you shouldn't have to resubmit it, but more, but once, but maybe twice in order to reach that entitlement date and

then the claim process normally. Again we've put in some changes that should prevent that going forward.

And then, the other – you were asking about the O3 disposition code?

(Bonnie Lazard): No, I was talking about in comparison to the 51. Let me ask a question and this is what brought to that is that the SP-31 and 32 codes count against us in terms of threshold whereas the 51, it's my understand it does not. Is that correct?

Pat Ambrose: Well, right now, it does, and it should not. Unfortunately, that is another issue that we're working quickly to correct. (Jeremy) you're on the line. (Jeremy Folkard). Do you have a date by any chance for that correction to remove the 51?

(Jeremy Folkard): I – it's – I believe it should be in the July timeframe. The ticket is open. There has been recent discussion and I believe it should be something that's resolved very shortly. But I don't know have an exact date for you at this point in time.

Pat Ambrose: OK. But anyway we are working toward on – towards fixing that. Disposition 51 should not be included in the 20 percent error threshold. Unfortunately right now it is. So I apologize for that. But you know your EDI rep can release the file if that is the reason that you're getting the 20 percent error threshold and get it processed. But that – you know we're applying that fix as quickly as possible.

John Albert: Hey (Jeremy) can you try to find out a date specific before the end of the call if possible, send out an email or whatever?

(Jeremy Folkard): Yes, I'll see what I can do. I'm not sure if they have a specific date at present, but I'll look if I can get one.

John Albert: OK, thanks.

Barbara Wright: OK, thank you.

Pat Ambrose: (Bonnie) thank you.

(Bonnie Lazard): Thank you.

Operator: Your next question comes from the line of Crystal Brotski from PMSI. Your line is open.

Crystal Brotski: Hi, thank you. My question is regarding the TIN Reference File Detail Record. The user guide states that the data in those fields is used for any recovery demand notifications that may be associated with the claim report. And most TPAs for the RREs are really heavily involved in the reporting process. And besides reporting, would normally have full responsibility to process and handle claims including the Medicare recovery issues. And we've seen TPAs put their own information in those files so that they receive that correspondence from MSPRC.

And now we're running into some issues with the conditional payment verification, with MSPRC because they are associating the TPA name as the actual RRE or insurer, but a claims that – they're receiving data on Section 111 reporting process and proof of representation forms that are signed by the RREs they're not being acknowledged because the MSPRC is stating that the TPA is the RRE for the data they received. Can you provide any guidance on how we might be able to resolve that?

Pat Ambrose: Can we go offline just for a minute, John, please? OK. CMS has indicated that it is the RRE's address that must go on that TIN reference file. So my understanding Crystal is that the circumstance they were putting the RRE's Tax Identification Number on the TIN reference file, but instead of the RRE's name and address and the address where the demand can be sent, they were putting the TPA's because that's where they wanted to route this information. And CMS is saying that that's incorrect and you cannot do that. I think I might have provided you some incorrect information previously on this.

So what you need to do is actually submit the TIN reference file with not only with the RRE's TIN but also the RRE's name and the RRE's address and the RRE is going to have to be responsible for routing that you know any demand information to the appropriate resource. And if it's their TPA they'll have to

do that behind the scenes. And note that the address for the RRE that was supplied at registration is not the one that is passed on to the MSPRC for recovery purposes, but it is the RRE's address on the TIN reference file keyed by TIN and office code that is passed to the MSPRC. So does that answer your question?

Crystal Brotski: It does. Do you think there will be any future consideration where the reporting process might be adjusted to allow TPA information to be used?

John Albert: Yes.

Crystal Brotski: OK.

John Albert: Yes. I mean we've seen this question before so. Again, you know, we want to be flexible and you know as we evaluate, you know this goes forward, you know we will of course you know offer improvements enhancements based on the different situations that we weren't necessary aware of prior to this going live. So yes.

Crystal Brotski: Will you be able to maybe put that sort of recommendation in writing in form of an alert or is there any way to squeeze into that user guide that's under (inaudible).

Pat Ambrose: Yes, we will certainly do one or the other on this.

Crystal Brotski: OK.

Pat Ambrose: Yes.

Crystal Brotski: Perfect. Thank you so much.

Barbara Wright: You're saying will we explain what we explained today. Again, the user guide yes. Will we put the change in the revised user guide? No, we're not that far along yet.

Crystal Brotski: No, that's fine. Yes, later.

Operator: Your next question comes from the line of (Amelle Dimo from PEMCO). Your line is open.

(Amelle Dimo): Hi, this is (Amelle at PEMCO). And I had a question about something that's on page 86 of the user's guide. And it relates to ORM – future ORM termination dates where it says future dated ORM termination dates can't be dated no more than six months after the file submission date i.e. ORM termination dates cannot be more than six months greater than the file submission date. I have a question about whether you guys are contemplating changing that six months to something a little bit longer.

And the reason I'm asking that is because most of my – our ORMs are related to PIP auto accidents and about 99 percent of them run for three years, and that is really – that really only constitutes – the only active closure we're going to see on those claims is about – it's – it would say some double entry as far as my folks are concerned. In effect what I'm saying is the ORM termination date which is three years from the date of the accident could be given to you folks right at the frontend and that would be an accurate representation of our ongoing responsibility for the medical where the diagnosis codes are on that claim?

John Albert: Is there a dollar cap on your liability?

(Amelle Dimo): For PIP there is and it too very rarely is exceeded. But in those instances that would constitute in fact a different active closure that we would deal with. But I guess what I'm saying is that 99 percent of them – it's three years and we never really reach the dollar amount of the coverage, particularly if the dollar amount is let's say $35,000, that is rare if that's ever met. And my question is are you all giving me any consideration to changing that six months or could you give some consideration to it?

Barbara Wright: We can take it under advisement.

(Amelle Dimo): OK, thank you very much.

John Albert: Thank you.

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

Susan Jones: Hi, I have two scenarios that I'd like to get to determine if they are reportable and if it will be as ORM or TPOC. If I have a resident that has a claim against say a nursing home and in the claim it settles for say a $100,000 and the insurer agrees in that release in the settlement that time everybody, the insurer agrees to pay the medical bills or that – or maybe the Medicare liens in the settlement and say that it's $10,000. I understand and I would believe that I definitely would put that as a TPOC as that TPOC date is October 1, 2011 and forward. But would also I report ORM if they're there assuming like if they're going to be pay those medical bills from the hospital, is that assuming responsibilities for medical?

Barbara Wright: Are you saying – I mean I could interpret what you just said a couple of different ways.

Susan Jones: OK.

Barbara Wright: One way is, I settled for a $100,000 plus I will separately pay whatever Medicare lien is in a lump sum or I could interpret it as the total amount I'm going to pay is a $100,000 but I will pay Medicare's lien directly, and I can go on with different variations. I guess what we need you is for you to be a little bit more specific.

Susan Jones: OK. So it is – it actually could happen either way that you said. So that $100,000 could include that Medicare lien or it could actually be separated out and we would pay the bill completely separate then the settlement check of a $100,000. So I could have two scenarios.

Barbara Wright: If the settlement is a $100,000 and it includes any recovery claim Medicare has then you're simply reporting a TPOC of a $100,000. It sounds like what you're really doing is controlling the funding and you'll need to make the check directly. But if you have a situation where you said you beneficiary are getting a settlement of a $100,000 and we won't separately in addition to that be responsible directly for whatever Medicare lien is then what you need –

what you would need to do is when the beneficiary gets any type you would still report the TPOC of a $100,000.

And if you're going to have continuing responsibility you would need to report ORM, but if you're not, you would need to report to us that you have settled and have responsibility for that or when we send the beneficiary a demand I would expect the beneficiary to come back and say, "No, here is a copy of my settlement. Yes, I settled for a $100,000. But one of the conditions of this is that the insurer is separately responsible for Medicare's lien at which point our recovery contractor would send a demand to you for the Medicare conditional payment amount."

Susan Jones: And so is that – is that a – when I wouldn't have to report that as ORM?

Barbara Wright: You would just – the settlement that you would have with the beneficiary you would be reporting the TPOC amount when we would do the demand essentially that's when that would be cleared up on the backend. When we would issue a demand to the beneficiary, the beneficiary would produce a copy of the settlement saying, "Yes, I got a $100,000, but that doesn't include Medicare recovery." And you need to go directly to the insurer and we would use that settlement and redirect any demand we did for you as the insurer for the full amount of our Medicare recovery claim.

Susan Jones: OK. But – so if we just get the bill, I mean – I mean say it's just the bill from the hospital. They send – they send the bill to the insurer and they write that check and that's all within like a month with the settlement. So we've sent the settlement check out for $100,000, we've paid the hospital bill of $10,000. Because we've written that check to the hospital for $10,000, did we assume ORM and do I have report that to you?

Barbara Wright: In terms to your settlement (inaudible) control, I mean I can't – I could make up 10 different variations on what you just told me. If you're agreeing – if your settlement says, "We're going to pay your hospital pay or any other bills that are submitted to us," and that's probably going to work under this scenario, I just prescribed. The fact that you would pay a hospital bill would tell me, "That's not going to be the only medical bill out there. Anytime

someone's in the hospital you've got additional doctor bills at minimum, if they had surgery, you've got the surgeon's bills, you've got the anesthesiologist bills, you may have rehab bills, you may have all these others."

So you know what is it you really agree to and that's what's going to be determinative. If they have a settlement and you paid X hospital bills that you didn't assume anything on an ongoing basis then you're going to report the settlement to us of a $100,000 and we're going to send the demand to the beneficiary. But if you said, "Hey, I'm going to pay the bills and you paid to the hospital $10,000 or whatever," again you're going to report the $100,000 settlement, and when the beneficiary shows us that settlement we're going to redirect the demand to you for Medicare's claim.

Susan Jones: OK. But – OK.

Barbara Wright: All of these things are very highly fact driven.

Susan Jones: And dependent on how it's awarded in the settlement.

Barbara Wright: Yes.

Susan Jones: So what if there is no settlement at all? This is my second scenario. So what if there is no settlement at all? I'm saying there is just a visitor and maybe they slip and they fall and they need five stitches, they go to the hospital, it's one bill and that is it. And will you agree just to claims adjust or just working it out with that one individual there is no actual settlement. They just say we're going to pay this bill for you, send us the bill, we'll confirm that the medical record say, "This is what it is for and we're going to pay it and that's it." Is that assuming ORM?

Barbara Wright: Unless you're telling me we're saying, "Hey, even if there is two bills, we're not going to pay the second one." It basically your posture of the insurer is you're paying the associated bills and yes it's ORM.

Susan Jones: But if we're stating it's just this bill, this is it, this is all we're doing, that's not ORM. But if there is continual you know how old is this clinically or smaller, physical therapy anything like that, then that's ORM?

Barbara Wright: I don't mean to be rude, but on one hand you're saying there is no settlement and then you're describing a very detailed scenario which sounds very much like a settlement even if it's verbal. So if you have a follow-up – I think you've actually already had your follow-up questions, I think we need to move on. You're going to have to work it out on a case-by-case basis.

Susan Jones: OK, I'm sorry. I didn't mean to take up too much time. Thanks.

John Albert: That's OK.

Barbara Wright: I mean we're happy to answer but we could go on with permutations for a long, long, long time.

Susan Jones: OK.

Barbara Wright: Operator.

Operator: Your next question comes from the line of (Susan Jordan) from Broadspire. Your line is open.

(Susan Jordan): Good afternoon. We have a situation with an injured party that we wanted to ask about. You were talking earlier in the call about ICD-9 codes and how critical those are and this person in particular received a denial of benefits letter from Medicare and it was for an unrelated illness. And they had you know stated that it was a result of a workers' compensation claim that they had received to report from. When we went back and reviewed the ICD-9 codes, all of the codes appeared to be related to the workers'' comp injury and very specific to that injury and did not appear to be at all related to the other illness that was being submitted. Are they always looking at the ICD-9 codes or is there some other factor that they're taking into consideration such as the injured party I'm going to the same medical provider for both their workers' comp injury as well their illness that might be covered by Medicare otherwise.

Barbara Wright: CMS is looking at this issue to the extent we get any complaints that don't seem to fit the guidelines. Our claims processing contractors are instructed that they should process conditional payments when there is a liability no fault or workers' compensation that's in dispute and they should not be denying claims on the basis of an open MSP, occurrence for liability no fault or workers' compensation if it's not related to that. So I mean that's what our rule is. Are there situations or occasionally that's not met? And beneficiaries if it's clearly not related beneficiaries of course always have a pure right. They always have the ability to request a reopening, et cetera. Occasionally we find situations where it was denied inappropriately. There are also situations where the beneficiary comes in and says, "Oh! I was told it was denied, because the liability record in that wasn't actually the reason for the denial at all."

(Susan Jordan): Well, how can we get to the bottom of the reason for the denial, because when we were calling, trying to – and work with them on this one just to get it straightened out, because we couldn't find any reason on our side that the claim they had opened for workers' comp at all related to the illness. And I asked what was used or you know I was trying to figure out what could it event one of the ICD-9 codes that was a more general code that could have pointed them in that direction and could it be a true statement or is it a true statement that they might receive a denial if the medical provider didn't specifically specified that. I'm sorry, what?

Barbara Wright: I'm sorry. If it's – it a claim is properly coded and there is no hold up because of the prompt payment rules then it should be paid, if it's otherwise reimbursable and it's not related. And if a beneficiary it has the case where it's clearly not related and he or she believes that they're being given information that it's being denied, because of that open MSP occurrence then they need to appeal or otherwise object to the claims processing contractor.

(Susan Jordan): OK. Could it ever be that you know does it matter that they go to the same medical provider? Does the medical – in other words the information that we received was the medical provider needs to specify that it's unrelated to their open workers' comp claim in their dispute back? Does that – is that normally

how that would work, is that something we should be sharing with our other claimants that have similar...

Barbara Wright: If the codes we've been given are for example or injuries to the right arm or to the arm since we don't have ICD10 that tells you whether it's right or left yet. But if it's injuries to the arm and they're getting claims denied that have to do with diabetes that should not be happening.

(Susan Jordan): OK. And that's happened in this situation. So we were – that's exactly what happened except that it was a back rather than an arm.

Barbara Wright: Well, they need to object to their claims processing contractor.

(Susan Jordan): OK.

Bill Decker: The contractor that's actually is not paying the claim.

John Albert: This has always been an issue since long before Section 111 resulted in more records on our system. And, you know, we do reach out to the folks at CMS who have authority over the Medicare contractors try to work with them and do outreach. But this does occasionally occur. What the critical thing as Barbara mentioned is the appeal rights that exist when claims are denied and those should be followed and that should be followed up with that claims payment contractor.

(Susan Jordan): OK.

John Albert: But we really can't answer any more questions on that, because that's kind of outside of the scope of this call.

(Susan Jordan): OK. All right, well thank you. I appreciate it.

Operator: Your next question comes from the line of Sarita Shipe from Texas Association of School Board. Your line is open.

Sarita Shipe: Thank you. This follows somewhat relative to the question that just preceded us, but we're in Texas and we provide workers' comp, and we're a lifetime medical state and we have no claims of them in here. So what we do is we

leave the ORM field open even though the claim has been administratively closed and the treatment has ended. But because the ORM field is left open indefinitely we are finding more and more that Medicare beneficiaries are being denied healthcare and are coming to us for some type of assistance. And we've been given previous directive that in order to close the ORM field we need a letter from the treating physicians stating that no further treatment is necessary and we're finding that doctors aren't responding to those request and probably are not going to provide that stating that no future treatment will be necessary, so the beneficiary is left hanging. So we were wondering what kind of directive you can provide to us as to what type of information we can send to the beneficiary that would assist them in getting whatever treatment they need PIP or through Medicare.

Barbara Wright: Again, if it's a claim that's not related they should be complaining to the claims processing contractor. If it's related presumably you would have responsibility under what you said and it should be appropriately you know denied. So...

Sarita Shipe: Can I provide a possible example? The worker's comp claim was for a knee injury that resulted in surgery. Treatment ended and the claim was closed. Couple of years down the road, the beneficiary has arthritic changes or an arthritic problem that we deem is no longer related or is not related.

Barbara Wright: If you have a specific claim that the beneficiary says was denied because of the workers' compensation, if they have documentation from you that that claim has not covered under their workers' compensation case, they again can present that to the claims processing contractor and the contractor will then pay the claim if it's otherwise reimbursable.

Sarita Shipe: OK. So we can provide the specific cum principle condition...

Barbara Wright: You can provide a specific denial of workers' compensation coverage for a particular claim, so that the claims processing contractor knows that that particular claim is not covered.

Sarita Shipe: So that would be say an explanation of benefit sent back when once the bill has been submitted.

Barbara Wright: Whichever way the workers' compensation entity wished to document it.

Sarita Shipe: OK. We can provide our own method of documentation.

Barbara Wright: As far as we in this room here, no. We are not claims processing people. Certainly an EOB is the easiest way for claims processing contractors to document something. But as far as we know if there is other written documentation of a particular claims is not covered by the workers' compensation case that they would accept that as well.

Sarita Shipe: OK. Thank you.

Operator: Your next question comes from the line of Doug Savage from State Farm. Your line is open.

Doug Savage: Thank you very much. Just got a question to go back to this ORM termination date and trying to input that date into the MMSCA electronic report. In situations where we have not exhausted our benefits and/or we're not within that six months window to put our ORM termination date, there is a special note on page 86 that says, if we obtain this letter from a physician saying that the person no longer is treating for injuries related to the accident that we can use that date in the report as the termination date. Is that correct?

Barbara Wright: I don't think we said no longer treating. I think we said they no longer require treatment for the injury. But yes, I defer to you on this, Pat.

Pat Ambrose: Yes, absolutely. You know whatever day, you know if you're abiding by that exception and that is the day that ORM terminates I would use the date on that letter from the treating physician.

John Albert: That is all treatment, not just the treatment from their physician.

Doug Savage: OK. So if they have – if their – say treating with an orthopedic and their primary care physician where they need a letter from each of those entities in order to close that off.

Barbara Wright: They don't need a letter from each of those entities. What they need is medical documentation that they don't require further treatment for that injury. What we're trying to avoid or the distinction is, if someone's going to a primary care physician and an orthopedist the need for the specialized orthopedic treatment might end relatively soon, but there might still be follow-up care that's being managed by the primary care physician. We don't really care which one signs that document in general. What we require is documentation that the person doesn't require any ongoing or future treatment for that injury.

Doug Savage: And just maintain that in our claim file, the documentation?

Bill Decker: Yes.

John Albert: Yes.

Barbara Wright: But you do need to be – you need to be careful that it's not just that someone stopped treating, because just because they stopped going to the doctor doesn't necessarily mean they don't – there isn't anticipated treatment needed.

Doug Savage: OK. And a follow-up on the question before in regards to the situation with the regional contractors. It's my understanding that with the situation with the unspecified codes and the ORM term dates and denials of benefits, that when these bills are submitted to CMS and they've stripped out the information out of our electronic reports and put them all in this national common working file that the regional contractors should be communicating with the providers prior to submitting any type of denial to the beneficiary. And if we're finding instances that's not occurring is there anybody that we should be communicating with in regards to that.

Barbara Wright: I guess I'm not sure what you mean by they should be communicating separately or earlier with the provider.

Doug Savage: Well, it's our understanding and talking to the COBC that they have indicated the way this system should work is if they run into a situation in the common working file where they find something that maybe questionable, that may cause a denial of benefits per se an unspecified code that they should contact

the providers, the claims contractor should contact the provider to determine whether or not that was something that was accident related or employment related or whether this is something other type of injury that is unrelated to either are already issuing these denials.

Barbara Wright: The claims processing contractors process over a billion claims a year. They do not routines. A lot of the processing is done through an automated fashion based on what's coded on the claims. They are – claims denials don't all pile up for phone calls to the providers.

Doug Savage: OK. So when we spoke with COB then, if they were to tell us and they have, so that they use a batch edit system on their computers, so as soon as they see these unspecified codes that they're batched out and that automatically process the denials. So that's what we're being told by COBC by their supervisors.

Barbara Wright: Could you hang on just second?

John Albert: We're going to go offline just for a second.

Pat Ambrose: I think there is some confusion about – this is Patty Ambrose, I'm going to just try to give out a high level overview of how it's working and see if that helps. And I think there is some confusion about the discussion that you had with the COBC. I really think that that individual is probably talking about the recovery process. So let me start from the beginning.

You send in a claim with ORM and certain – say it's workers' compensation, ORMs and certain ICD-9 codes. That information is posted on the common working file to be used by claims processor as long and you know as long as it's accepted and so on, and let's suppose that your ORM is open ended. And so the claim processor then – they get a claim from a doctor's office submitted to Medicare and they look at the data service on that claim and they are to compare it then to this information on the common working file that we refer to as Medicare Secondary Payer Occurrences or MSP Occurrences. And this workers' compensation claim is out there as an MSP occurrence. So there is – in theory to look at the diagnosis on the claim and determine whether the diagnosis and services on the claim relate to that workers' compensation

injury that is documented on the workers' comp claim that you submitted and was stored on the common working file as a workers' comp MSP occurrence.

Now the diagnosis doesn't have to be an exact match, but if the diagnosis on the workers' compensation MSP occurrence on the common working file on CWS is very big, it could be misinterpreted. And so the MAC or the Medicare Administrative Contractor that's paying the claim is you know makes a determination about whether you know and this is systematically, it's not really a human being who is looking at it, the claim is submitted by the provider electronically 99.9 percent of the time and the MAC is processing it electronically as is the common working file.

So at any rate, if they determine or believe or you know the system determines that the claims are submitted by those physician or the doctor to the MAC is related to the workers' comp injury it will deny and these physician billed the claim for primary payment, that's also an important factor to Medicare. The Medicare claims contractor will deny the claim back to the provider with codes on that claim response saying we're denying this claims for payment, because we believe that there is an MSP situation and you've submitted this as for primary payment and we think it has to go to essentially the workers' comp for consideration first.

And so in theory, the physician you know would take that electronic claim, attempt to submit it for payment to the workers' compensation carrier on get payment or not get payments and then the results of that they resubmit the claims from Medicare for secondary payment indicating that they did submit it to the primary workers' compensation and workers' comp paid this much or denied it, and then the claim is reconsidered and paid. And this is done on a claim-by-claim basis as claims are submitted by hospitals and doctors to Medicare bumping up against these MSP occurrences on the common working file.

And, you know, sometimes as Barbara said, there are mistakes made in terms of saying that the claims submitted to Medicare is related to the workers' comp injury or not. Obviously there are cases where Medicare pays primary when it should and then of course there is the ability for an instruction that a

MAC is supposed to pay conditionally if there is a delay in payment from you know if the workers' comp or other claim that is in dispute. And so Medicare can pay conditionally and then recover its money later.

I think when you spoke to the COB and they were talking about batching up claims and the like, they were probably talking about the recovery process. So the recovery contractor on the other hand is looking at the same MSP information although not all of what they get goes to the common working file. If you submit a claim that just as a TPOC we at the COB just transfer it directly to the MSPRC. But we also transfer on those claims with ORM to the MSPRC. They are looking at those claims determining if Medicare is the secondary payer and then they are looking at Medicare claim's history and trying to decide if any claims were paid for that injury or illness incorrectly you know if Medicare paid primary when it should have paid secondary or the like.

Now when they do their claims history search they will look at the dates on the workers' compensation no faults or a liability claim and search Medicare's claims history looking for dates of service that relates that fall within the same time period and batch those up. But this is not the Medicare claims contractor is paying claims, this is the recovery contractor. And then they sort them, they group them by you know related injury.

You know there might be a serious of claims that are obviously related to a heart transplant, and most series of claims that are you know regular doctor's visit, so a series claims that are related to apparently a broken arm or something like that and then they are determining out of those groups of claims which ones would relate to the workers' comp the no faults or the liability and then producing a recovery demand, and that sort of high level – and you know that – in that process as the recovery contractor is making those determinations about what claims relate to the NGHP claim that you have submitted for recovery purposes they are making use of the ICD-9 codes that are submitted to determine whether they apply or not. Again it's not an exact science and not an exact matching process, but the better you are at submitting your ICD-9s the closer both the Medicare claims pairs and the recovery contractor will get in their process.

Barbara Wright: But we did receive at least one incoming inquiry that at least implied that they're potentially using unspecified or undetermined codes on thousands of their report. And as we've said earlier during this call, if that's what you're putting in as your diagnosis code particularly for ORM, because that does affect incoming new claims. If that's what you're putting in for ORM, the chances of the claims being denied because of the open MSP occurrence go way, way, way up. And then it would be a matter of whether or not workers' comp did in fact cover that particular service or that particular claims, we would have to have information on that before Medicare could pay the claim. So using an unspecified or undetermined code because you haven't received an exact code from a physician or something, can in the long run cause you more trouble or time then if you make the effort to a sign a more specific code upfront.

Doug Savage: Pat and Barbara, State Farm appreciates that very good in-depth explanation. We really do.

Pat Ambrose: You're welcome.

Operator: Your next question...

John Albert: Next question.

Operator: Sorry, your next question comes from the line of Wendy Gottorff from OneBeacon Insurance. Your line is open.

Wendy Gottorff: Yes, my question relates to the TPOC claims. Now we have a large group of professional liability policies that contain SIRs as defined by CMS. However, as the insurer we do setup and handle each one of these claims from dollar one and then the insurer just pays them as it happens to fall within their SIR. So we understand that CMS' position is that the insured and the RRE in these cases because these are technically what you would call SIR arrangements. However since we have all the data necessary to report and actually have the claims in our system, it would be very easy for us to report it under RRE and assume the responsibility and whereas all of our individual insured are not

setup to report or you know really know very much about this. Is that acceptable for us to report those?

Barbara Wright: At minimum – if it's one that truly is the responsibility of the insured then they are the RRE and they have ultimate responsibility. Technically you can report as their agent. This is in some ways similar to the sibling question that was asked way back in the beginning. Our instructions right now, OK, if you're not the RRE you're not the one that should be reporting it under your ID that that we need a separate ID for the RRE. Certainly direct data entry is one way to go. Other than that I don't think we have a separate answer for you. What I hear you asking is can we change our rules and if you have that type of situation may you assume the responsibility, can we assume – you'd also want to assume the risk of any penalty.

Wendy Gottorff: That's a good question.

Barbara Wright: You know I'm not saying that you shouldn't work something out with them. But I mean we tried to be as even handed as we could in drawing bright lines for them.

Wendy Gottorff: Right, right. I understand. I understand. And just from my follow-up question, I only wanted to a comment just to reiterate that the two prior callers that we are seeing exactly the same problems for totally unrelated diagnosis codes and Medicare the contractor denying payments for current injuries. I just wanted to add that. Thank you.

Barbara Wright: Thank you.

Operator: Your next question comes from the line of Robin Kendall from Hamlin & Burton Liability Management. Your line is open.

Robin Kendall: Hi, I'm wondering about the write-off, it's on page 98, I believe of the manual. And I'm trying to get some clear direction for some of our clients as far as when they would use the billing process and when they would not. And when I'm looking at the language and I'm looking at the difference, the first instance says the provider physician or other supplier, the second one uses that same language, and then the third one says any other entity. Really the

bottom-line is what I'm trying to find out is, if they are billing Medicare for if it's a service that they could bill Medicare for, they would report it as liability insurance. But if they would – if they are not billing Medicare, then they would report it as TPOC. Is that kind of the bottom-line of it?

John Albert: They had the ability to bill Medicare.

Robin Kendall: Right. If they have the ability and it's something that they would build Medicare for if Medicare were paying it, then they would report to the billing process?

John Albert: No, if they had the ability to bill Medicare, because your provider, physician or other supplier that they must choose the billing process that they are not an entity that can bill Medicare. In other words, they are not a provider, physician or other supplier and then reported as a TPOC.

Robin Kendall: But what if it is something – you know what if it's some kind of a service or benefit, a property, a value that isn't something they typically would bill Medicare for, would they still will use the billing...

Barbara Wright: Well, you're saying they're doing a write-off with reach back to a medical service. Yes or no.

Robin Kendall: Well, that's one scenario. One scenario would be write-off, but the other would be some kind of a value like giving them some free rent or providing some services that they wouldn't typically need. So those would be TPOC.

Barbara Wright: You're saying hospitals are going to give free rent to someone.

Robin Kendall: Well, I never say no, but I'll say we're talking about a nursing house.

Barbara Wright: OK. And you're saying they're going to give free rent, they're giving them money or they're doing – are they reaching some type of settlement, or they writing off services? I mean...

Robin Kendall: These are – these are where in the second paragraph it takes about this property of value. So I'm clear on if they're able to bill Medicare and they're writing off something that's a part of a bill then that would go through the

billing process where I'm trying to get some clarity on is say for example it's a claim against the hospital and they are doing some things for these people like they will send them to a nursing home for the rehab period and pay for all of that on their – if they'll pay for that because they want to avoid a claim. It's not writing off their own bill, they're paying some other bill.

Barbara Wright: Right. A provider, physician or a supplier you're going to have to analyze whether it's really a TPOC situation or an ORM situation. Part of what you've described sounds ORM, a couple of the instances you've described sound like TPOC. I realized the second para – hold on I'm not sure whether it's second or third, but the paragraph you are referring to on page 98 of the thing was giving a TPOC example. But you certainly could have a situation where a provider, physician or a supplier is engaging in ORM. But if it's not something that they could bill Medicare it is to be reported at Section 111 liability insurance and as most likely as a TPOC or as you said possibly ORM.

John Albert: If they can fill for the 'I' number of services that they've billed. They can't bill for the 'I' number of service, that is the TPOC.

Robin Kendall: That's what I was looking for. Thank you.

John Albert: All right. Operator we have to end the call, it's a little bit after 3 o'clock. We'd like to thank everyone for their participation. Again look out for the transcripts at a future date and keep your eyes on the Section 111 website for future calls as well. Again thank you. Continue to submit your questions.

Just as an FYI some of the questions that came up repeatedly regarding you know billing type of questions which again are really a little bit outside the scope of this particular group. We are aware of those issues and continue to work as we always have even before Section 111 to try to address some of those inconsistencies, because again providers as well as Medicare contractors have an obligation to do this correctly and there is oversight of them obviously with their being a lot more data coming in through Section 111, there is you know the chance of this occurring of course would increase. But again we are aware of those issues and working with our partners across CMS to address those.

Thank you every one. And if operator you could let everyone go and stay on the line to give us the stats that we asked for, appreciate it. Thank you.

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

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