TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: March 9, 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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CENTER FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
March 9, 2011
1:00 p.m. ET

Operator: Good afternoon, my name is (Simon) 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 speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. We ask that you please limit your questions to one and one follow-up. Thank you. Mr. John Albert, you may begin your conference.

John Albert: All right, thank you operator. Just for the record, today is Wednesday, March 9, 2011. This is an NGHP Policy and Technical Call meeting that we will present and also answer questions on those technical issues as well as policy issues related to the Section 111, implementation for non-group health plans. Again, to state for the record that on occasion, while we try to state what is on in the official user materials on the Mandatory Insurer Reporting Webpage, there are times we may contradict written materials that are out on the Webpage, specifically the alert and the user guide.

Where that happens, the user guide and alert are the official CMS instruction. We again often update those as the result of these calls and the questions received to the resource mailbox, and until they are updated, the official instruction from CMS is on the CMS Mandatory Insurer Reporting Webpage. The NGHP reporting has now been live for a considerable amount of time. A lot of data is coming in which we are happy to see. Again, we encourage feedback through the dedicated resource mailbox related to this process. With us today, Ms. Pat Ambrose is going to have the presentation and I think followed by Barbara Wright as well, and then we'll go into the question and answer session.

Again, please limit your questions to one and one follow-up and then let other people get on the line to get their questions answered. You can always get back in the queue. We have a lot of participants today. So with that, Pat are you ready?

Pat Ambrose: Yes, I have just a few brief announcements. Thank you, John. On the dedicated CMS Mandatory Insurer Reporting Website which is (www.cms.gov/mandatoryinsrap), there are a few alerts that have been posted since the last town hall call revisions to the direct data entry or DDE alerts are out there on the NGHP alert page. Also, an alert regarding the beneficiary lookup function on the COB secure Website that went live on March 1st. That alert is out on the NGHP alert page.

On the NGHP page itself, there is an alert for foreign insurers dated or foreign RREs dated February 7, 2011, and also the NGHP town hall transcripts through the February 9th call have been posted out there. There are some other upcoming alerts. One in particular is regarding the new TIN Reference Response File and related address editing or validation, TIN validation and TIN address validation processes that will be revised as of October 1, 2011. There will be an alert published by April 1, 2011, with information regarding that new TIN Reference Response File and the file layout and related requirements.

We are working on the update to the user guide but please note in version 3.1 of the user guide, if you start with that and then apply any updates or changes as published in the alert, you have the most current information. There is very little other information that will be modified in the next version of the user guide to all the information that's pertinent to your reporting is currently out on the Website either in version 3.1 of the user guide or in the separate alert.

I think, with that, if you, one other reminder is that you should be examining the compliance flags that are returned right now related to TIN validation and address validation and cleaning up those issues now because those compliance flags will be converted to actual error codes as of October and it will mean rejection of TIN records, TIN reference file records and rejection of corresponding claimant with file records. So the idea is now for you to

examine the compliance flags carefully and make any modifications you need to your TIN, reported TIN, and TIN is TIN, Tax Identification Number, which I didn't state earlier, and the corresponding address information on the TIN reference file.

So please examine those compliance flags and make the corrections now because again, those compliance flags will be changing to error codes as of October. If you receive an error back on your claim input file or your claim response file that is, an error that is not documented in the user guide for some reason or an error that you don't understand how to correct, please make sure that you contact your EDI representative via phone or email to report that and get the matter resolved. And remember that your EDI representative is your best source of information for answering questions related to reporting technical questions related to reporting.

So they should be your first line of defense or assistance and then of course there's an escalation process in the user guide in Section 18. Also as John noted, there is a Section 111 CMS resource mailbox. The email for that can be found on what's new page of the mandatory insurer Website. And with that, that's all I've got.

John Albert: OK, I guess we're going to turn to Barbara. Do you have some things you want to say? Go ahead Barbara.

Barbara Wright: Thanks, John. I only have a few points. It's only been two weeks since our last call because we're crunching everything into the one call this month. I want to say that with respect to the workgroup that's dealing with the 12580 issues and the implantation, ingestion, exposure issues that I expect the next workgroup call to be on April 14th. I don't have the lines confirmed yet but the expected time and date is April 14th at 1:00 to 3:00 p.m. and those of you who are in the workgroup should have an invitation within a week.

We are not any further in giving you a final answer on the lump sum indemnity alert nor do we have any further information to report on the employment liability errors and admission policies, et cetera, the ones where we've been asked to consider whether or not we can eliminate reporting for

certain types of insurance that rarely involve medical. So we're still trying to look at that and see if there's a way that we could accommodate the industry.

In terms of questions that have come in since the last call, we're going to go through a few things that came up. We had, I believe, two questions that were dealing specifically with situations where the inquiry was concerned about whether or not they had to judge reporting depending on the entitlement date of the beneficiary and basically, the queries that we have and the information we return, I don't believe that we return the entitlement date. The RRE is normally not going to know those entitlement date, so just don't worry about that. If you have a liability no-fault or worker's compensation situation and the person was there is a beneficiary, then go ahead and do the reporting.

We also have some questions pending on qualified settlement funds and we're checking to make sure that our answer is specific enough and that we're not inadvertently including settlement funds that we don't intend to that we're dealing specifically with certain types so that we give you the correct sites. In general, most qualified settlement funds are not going to be the RRE. That would involve a transfer of responsibility from the actual RRE and as CMS has pretty consistently said since we've started to implement this an RRE cannot transfer their responsibility as an RRE. So we will be giving you more on qualified settlement fund.

We've had additional questions about a delay in reporting, delay in implementation, suspending reporting, et cetera, and we published an alert that I believe the date was 11/09/2010. If Pat can check right now while I'm talking, but the alert all it did was delay the effective reporting date solely for liability insurance TPOC. It didn't change reporting where you had ORM responsibility. It didn't change no-fault reporting. It didn't change Worker's Compensation reporting but there is a separate alert. I believe it's on the NGHP alert tab and it actually has a reference to the delay in the subject line. We'll come back to that if Pat finds the actual site and we'll read it to you.

We had some questions about PIP or other no-fault that potentially includes wage loss, essential services or other items and the questions were whether or not these payments needed to be reported and how they're reported. If you

have a no-fault of any type that can include medicals, then once you have assumed any responsibility under that no-fault, you need to report that as ORM and you never for ORM report specific payments for the purpose of the Section 111. You're reporting the open ORM record and you eventually report the termination of that in any exhaust limit but you would not be reporting specific payments.

We had one question that had to do with the case where there was a lawsuit where based on a breach of no-fault contract and the question was whether it should be reported as no-fault or liability. From the information we had in the incoming, what you were talking about is a situation where the lawsuit itself involved liability insurance. The fact that it's based on a breach of no-fault contract is not controlling. It's what the actual settlement judgment reward or payment is which from the description we got was a liability insurance situation. In which case it would be reported as liability.

We had some additional questions on a subject I believe we addressed in other call situation where there is essentially more than one ORM that's open, whether it's because there is a settlement that left a certain amount of money open for future medical in addition to ongoing ORM or some other situation within either case, if it's the same policy, the same type of insurance, essentially what you do is you need to leave the ORM open until both are exhausted.

An additional question about the delayed reporting date. Someone (tied) their question asking it in terms of direct data entry. The delay in the reporting applies regardless whether or not you're using electronic file transfers or you're using direct data entry. We've had a few questions from entities who assumed they weren't doing any reporting but did acknowledge that they actually have a self-insured reserve, not a deductible but a self-insured reserve and they would be the RRE at least for that self-insured reserve. So whether or not they wish to register to do electronic file transmissions or want to participate with DDE, either way, they need to register to report if they have cases or files which should be reported at this time.

And as we said in the past, if you're going to do the electronic file transfer, then you need to register in time to be able to do any proper testing before you would have any report to do. We had some questions about credit and Worker's Compensation cases and liability cases and in general, when Worker's Compensation has a credit by virtue of a liability settlement judgment award or other payment, that doesn't eliminate their obligation. It simply defers their obligation. So in general, that credit is not going to change their reporting instructions. They may have a defense for paying a particular claim. They may have an ORM record where they're actually denying payment for some cases or some claims filed against them, but in general, it's not going to change their reporting requirement. John, I think we can go ahead with the questions.

John Albert: OK. I guess operator, we can open it up now to questions from the participants. Again, I ask folks to please limit your question to one and one follow-up so we can get as many people on the line as possible. Also, I wanted to note that the next NGHP call, which again is out on the…

Pat Ambrose: We have the title for the alert, delayed reporting. It is November 9, 2010 and the title is Revised Implementation Timeline for TPOC Liability Insurance Including Self-Insurance Settlement Judgment Awards or Other Payment and it also covered an extension of current dollar threshold for liability insurance including self insurance and Worker's Compensation. So again, that was the alert dated November 9, 2010, that talks about the reporting on delay for liability TPOC and is on the NGHP alert page of the mandatory insurer reporting Website.

John Albert: OK, thanks. Yes, I just wanted to, before we go to the questions, (I would) also to remind people that the next call, which is a policy only call is on Wednesday, April 6th, followed by May 4th as an NGHP technical call. Again, the schedule is out on the Mandatory Insurer Reporting Webpage. With that operator, we can go straight to questions.

Operator: Ladies and gentlemen, at this time, I would like to remind everyone that in order to ask a question, please press star, then the number one on your telephone keypad. Again we ask that you please limit your questions to one

and one follow-up. Thank you. Will pause for just a moment to compile the Q and A roster. Your first question comes from the line of (John Hiyano) with (Gold and Lamb). You're line is open.

(John Hiyano): Good afternoon everyone. Just a quick question. I received a few questions from some of our customers that state that they are self insured for no-fault insurance. Now, the situation is that their self-insured indicator field 64 states that since self insurance rules are applicable to liability and Worker's Compensation only, they don't apply to no-fault, therefore the plan insurance type is D, then you have to fill the self-insured indicator with the value of no. So how do we recommend that our clients report the claims where they allege that they are self-insured for no-fault?

Barbara Wright: We're going to have to inquire to hang on just a minute

(John Hiyano): OK, thank you.

Barbara Wright: We're back. This is Barbara Wright again. The specific cases that we've encountered and we have no reason to believe this wouldn't be the general rule is we have had situations where entities have said that they are self-insured for no-fault and after looking at the facts, the insurance is not really no-fault as we define it. It is still self-insurance as defined in the statute for MSP purposes but it's being administered as though it's no-fault.

One example we had was a state where they were in a JPA or Joint Powers Authority for self-insured pool for most things and they handled and, I think that was their large claims as liability insurance and under the criteria we had, they could not have the pool, the RRE, but they also had a category of claims which they processed as being no-fault even though they were actually self insurance payments.

(John Hiyano): These cases are where the client is self-insured.

Barbara Wright: When the client is self-insured then they pretty much by definition don't hold a no-fault policy but it still has to be reported. It is self insurance.

(John Hiyano): OK, so the recommendation then in this case would be that they reported it as a liability self insurance. Now, in this case where they are treating it as if it is no-fault insurance…

Barbara Wright: If they're self-insured, it is still technically under our rule liability insurance and should be reported as such, but if they have assumed the ongoing responsibility for medical, just as they would with no-fault, those are the limited number of cases where we actually expect to see ORM reported for liability.

(John Hiyano): So in other words, when the policy limits are met or exhausted rather than filling out of a no-fault exhaust date or dollar limit as they would if it were truly no-fault, they would simply populate an ORM term date?

Barbara Wright: Yes.

(John Hiyano): OK, great. That's all I need to know, thank you.

Operator: Your next question comes from the line of (John Arment) with Michigan Guaranteed. Your line is open.

(John Arment): Thank you. We submitted a query to receive disposition code 01 with an HICN number. Subsequently, in September, we sent our claim detail record and again got disposition code 01 that the claim was accepted. In January 2011, we did another query and the disposition code came back as a 51, claimant doesn't have coverage. We contacted our EDI rep and she indicated that the member record was updated in January to where the member no longer has coverage. Do we have some of the delete record on some point there?

Pat Ambrose: You do not have to send the delete for that. I'm somewhat curious about why you would get a 51 though because they should be on record as having been a Medicare beneficiary and so the query submitted after their entitlement ends should have, a query should still come back with an 01. A brand new claim could be returned with an 03 depending on the circumstances.

(John Arment): I know some changes made late December 6th that piece of it. Maybe it (inaudible) but it isn't always the case to 51's, correct? When coverage is terminated?

Pat Ambrose: Yes, again, when Medicare entitlement ends, you should not necessarily receive a 51 though. So I guess, without…could I have your RRE ID?

(John Arment): Actually, it's not my particular, (inaudible) guarantee funds we work with and I'm working with their EDI rep for not getting a satisfactory answer on how to resolve it.

Pat Ambrose: OK, I guess without knowing all the circumstances about the particular beneficiary and the beneficiary's entitlement dates and the claim itself, I have a hard time knowing how to answer you. So what I would recommend is that you ask the (EDI) representative to actually contact me, Pat Ambrose, and I'll look into it further in follow-up. You could also follow the escalation process in the user guide in Section 18, I believe it is but if you let your EDI rep know that I'm curious about the circumstances, I'd be happy to take a look at it offline.

(John Arment): OK, So I'm assuming we start to monitor in case they become eligible again.

Pat Ambrose: Yes, that would be correct.

(John Arment): That's all, thank you, Pat.

Pat Ambrose: OK.

Operator: Your next question comes from the line of (Boni Mustard) with Farmers Insurance. Your line is open. (Boni Mustard) with Farmers Insurance, your line is open.

(Boni Mustard): I apologize, I was on mute. Yes, thank you. I have a question. In a case where the court has already settled the case and there's really only at this point in time an appeal of that but the settlement is already there. It's not been paid out because of the appeal and there's likely no additional opportunity to get adverse account to cooperate with information we need. Do we…then we…if

the appeal finds that we have to make the payment under the settlement, do we go ahead and (inaudible) the adverse account for the model language form asking that each person to sign that form or provide the appropriate information?

Barbara Wright: What we've said all along is that that model language should not be your first recourse. You sounded like you're assuming they won't cooperate. You need to request the information and document your attempts to get that information. If they won't cooperate, then you should attempt to use the model language. But we have said from the beginning that that model language should not be your first approach.

(Boni Mustard): I guess, we realize that and we are not doing that on any normal basis at all. I think what we're looking at is we are the ones that have been on the question about the class action lawsuit. It has already been decided by a judgment. It's on appeal and we're trying to look at if we lose that appeal and therefore the judgment remains, there's really no negotiation opportunity for securing information. If we lose on appeal, we are going to have to immediately be prepared to provide payment and yet our problem will become that we don't know the information to appropriately report. We mentioned earlier answering based on the question we submitted that this would be a liability and not a no-fault situation. So if it occurs prior to 10/01/2011, I understand we don't have to report but at this point in time, we really don't have an opportunity because the settlement is already out there or the judgment is already out there and we are at this point, simply waiting on the appeal.

John Albert: We're not sure what the outstanding question is right now from you.

(Boni Mustard): The outstanding question is if we cannot get any information, we have no negotiation ability to get any information from adverse account. In this situation, how do we address that?

Barbara Wright: It was said all along, you should document your attempts to get the information, then the model language is an approach to use when you're unsuccessful with your initial attempts. If you can't get the model language, (even) completed again, you need to document your attempts to get that.

(Boni Mustard): OK. All right, thank you very much.

Operator: Your next question comes from the line of (Liza Riley) with (CCMI). Your line is open.

(Liza Riley): Hi. I have a question about when you get a 03 as a disposition code. We've had a couple of instances where we sent the claimant profile. We did receive a response of 03 and I do understand that we're under an obligation then to keep checking for the Medicare status of that person. So we're continuing to do that but when we have information to update on that file such as an (OR termination) day and we're sending another claim input file for that, do we send that as an add or an update?

Pat Ambrose: As it turns out, either will work. The appropriate submission would be an add, since when you receive an 03, we're not saving that, we're not actually storing that record. That's just to let you know that the date on the claim don't overlap the Medicare entitlement. So the appropriate resubmission would be an add but if you submitted it as an update that would work as well too as it turns out. And then if ORM is terminated and there's nothing else to report, you should not need to then send another record again.

(Liza Riley): Right, the end of our obligation at that point?

Pat Ambrose: Exactly.

(Liza Riley): OK. Thank you.

Operator: Your next question comes from the line of (Peter Dunn) with Applied Underwriters. Your line is open.

(Peter Dunn): Hi. Our question actually pertains to the claimant query file. You guys indicated sort that the claimant cannot be matched to a Medicare beneficiary. The response file should contain exactly what was submitted on the query file for the claimant fields. We've noticed in the response files that if the claimant is not matched to a Medicare beneficiary or we don't have a date of birth, the response (inaudible) give us back some random date and then a gender of male. So we've asked our EDI rep about this. She indicates that if we are, the

records that you guys have don't have a date of birth, the system has insufficient information to make a match but she has no idea what information we are getting back but it's not the data that we sent.

So we're trying to get the information when possible but when we sent those records without the date of birth, we should still be able to get a match if all the other fields are correct but we would like to know what's happening to the records we sent when they don't have a date of birth and also how could we be sure that these records are still being checked to see if they are beneficiary and is there any way you could tell us what we're getting back?

Pat Ambrose: Well, first up, as to the best of my knowledge, the system should not be messing with date of birth that you've sent. If you sent a blank, so I'm going to have to research that further to see if you sent a blank or all zeros for date of birth to see if the system is for some reason plugging something in there so that we don't have a problem on our end, I don't know. I will say if you do not send a gender and we've said this before on the calls that we will default to male for matching purposes. So I'm going to have to take a look at…first and foremost, when you receive a 51 response back on your query or a no match on your query, you should not have been using any of the other data returned to you since it would be meaningless.

It's only when we return a match or disposition 01 that that information would have any bearing. So again, I'm going to have to look at the circumstances of the date of birth to the best of my knowledge. We're not messing with that field but you've seem to have an example where that is the case.

(Peter Dunn): Yes and even when we sent the gender, sometimes it will return, right? Was that happening? No. OK. I thought it was sending back the wrong gender but I guess not.

Pat Ambrose: OK. So you know, I guess it sounds like you've already provided examples to your EDI representative?

(Peter Dunn): Yes.

Pat Ambrose: And again, it would be helpful if you ask your EDI representative to follow up with me and I'll make sure somebody takes a look at it.

(Peter Dunn): Is there anybody else we could contact?

Pat Ambrose: Yes. You may follow the escalation procedures in Section, I think it's 18 of the user guide. The EDI supervisor is (Jeremy Farquar) and his contact information is in there as well as the EDI manager, (Bill Ford) and then, subsequent to that is (Jim Brady), the project director.

(Peter Dunn): Find out what's in the data but it's just kind of confusing why we get random dates back.

Pat Ambrose: Yes. So why don't you do that. As part of the escalation procedures and send it to (Jeremy) and he will follow up on that and I'll talk to him about it as well.

(Peter Dunn): OK. Thank you.

Operator: Your next question comes from the line of (Carol Dumby) with (Benner Health). Your line is open.

(Carol Dumby): Thank you. I have been having trouble. I submitted a test-file claim and put test file on February 8, which was a month ago, and it was stopped, putting suspension for a threshold error and then my EDI rep released it and she emailed me that a response file had been generated on the 10th and I then got the automatic email saying that it had processed, but I could not see it when I went to the Website and looked for my RRE ID under test file results.

So I emailed back my EDI rep who said, well, she checked it out and several days went by then I escalated to (Jeremy) and he said they would check it out because I sent the screen print of what it looks like when I look at my test file result which I did and then I didn't hear anything from him for several days and emailed him again. I escalated to (William Ford) on the 22nd, and then last week, I escalated to (Jim Brady) and each of them, except for (Jim Brady) who I have never heard back from had said well, we're trying it but it's been a month now and the problem is I cannot continue testing because I don't know

what got accepted, what got rejected and so now if I turn around and just send them all at them again, I'm going to get a whole bunch more errors and get it suspended and (inaudible) I was in before. So do you have any other suggestions?

Pat Ambrose: We did have some file, well this is a test file could have affected that. We did have some issues with the file upload. I believe the dates were February 16th, 17th and 18th. However, could you give me your RRE ID?

(Carol Dumby): Yes. It's 16131.

Pat Ambrose: OK, 16131. I'll make sure someone follows up with you. I can't help you on the spot right here but I will make sure that someone follows up on this and that we get you some information back.

(Carol Dumby): Thank you very much.

Operator: Your next question comes from the line of (Rita Terini) with Healthcare Indemnity. Your line is open.

(Rita Terini): Yes, good afternoon. I missed the February 9th town hall conference call but it's my understanding that my EDI rep stated that per that conference call, there was some mention that the (inaudible) software that is available to us now is not 5010 compliant and that you are working on it. Can you tell me any kind of estimate as to when that compliant (inaudible) version will be available?

Pat Ambrose: I don't have a date for you right now and I know in other places on the CMS Website, it indicates that the conversion to 5010 must be done by January 2012. We're not adhering to that deadline for Section 111, so we will continue to accept the 4010 version of the (X12 270/271) until further notice. We will be upgrading to 5010. It really will be a very minor upgrade and the (inaudible) software will be upgraded to handle that as well. So regardless of whether you're using the (inaudible) software or not, you will be impacted by this. I don't have a date. You will be given plenty of advance notice though and most likely will be accepting the 4010 and 5010 versions for some period of time, so that's about all I can and tell you right now.

I actually, someone is now just in, I'm sorry, I'm just back from vacation so someone's telling me that we do have an upgrade for the (inaudible) for October 2011 when the 5010 version, I assume, would be incorporated into that. Now that is not necessarily saying that you must submit all (X12 270/271) in the 5010 format by then but our (inaudible) software will be updated by then. So we'll get more information and possibly publish an alert or update in the user guide on that.

(Rita Terini): So you're telling me that come January 1, 2012, via Section 111, we will not necessarily be required to submit in 5010 format at that time?

Pat Ambrose: Not to the best of my knowledge right now, that is my understanding that that deadline for 2012 is mainly out there for providers and suppliers who are submitting claim files to Medicare in the other x12 format and possibly query files as well, but it's not applicable to Section 111, but I'll work on getting a date as to when that upgrade to 5010 is required. Like I said, it sounds like we will start accessing it come October but more on that later when I can confirm that for sure.

(Rita Terini): I have one more question. We were lucky enough to get a seven-day window (inaudible) of month three, week two, which we are very glad about. I have a question about a claim that may have ORM, as well as TPOC. What is the ORM, is an assumed let's just say January 2011 and we actually turned that right at the end of March. So the ORM assumption in term would be reported to you by us in March. Let's say we actually made a settlement also at that time at the end of March but the settlement papers were not signed and executed until the second quarter of 2011 because we have such a late reporting window, can we also report that TPOC, well, say early, because we know about it to avoid a second update record?

Pat Ambrose: Yes, you could. If you have an established TPOC date, you absolutely may report that…

Barbara Wright: Even if it's a future date?

Pat Ambrose: Well, no. You report after the date, yeah.

Barbara Wright: You need to take a look at how the TPOC date is defined in the record layout. If the TPOC date itself is passed, you can report it but if it's a future date, you're not going to be able to report it until that date has occurred.

Pat Ambrose: I think your question, I think I saw this question submitted. You were saying that the TPOC date is April 4th and can you report it in the file that you're submitting in the last week of June?

(Rita Terini): Yes.

Pat Ambrose: And so, yeah, you could. So you're actually asking can you report, in June, can you report the ORM termination date as well as the TPOC information and again in this example the TPOC information was in April and you have established a TPOC date and you're making the report in June subsequent to the TPOC date? Yes you may report all of that at once.

(Rita Terini): As long as it's not a future day based on the day I report to you?

Barbara Wright: Right.

(Rita Terini): OK and are there also, I think there's no edit on the front side because we will be submitting correction records at a time. Like right now, if you chose to early report in this first quarter or 2011, it's my understanding, based on what I've read, we can only report TPOC that occurs on or after 10/01 through 12/31?

Pat Ambrose: No, that's not correct. You can report a TPOC, if the TPOC date is the day before you submit your file, you could include that TPOC on your file, if you're able to do that. I think that the 45-day grace period is just that a grace period. You don't have to adhere to that. So any TPOC you know about prior to your file submission date, you may report. It doesn't have to be in a certain time period. As long as that TPOC date has been established, you could report it the very next day if that's how the timing workout. Does that…

(Rita Terini): That's good but we should not be reporting, at this time, TPOCs that occurred prior to 10/01/2010?

Pat Ambrose: Well you can, you're not required to.

(Rita Terini): OK. All right, OK. Thanks a lot.

Operator: Your next question comes from the line of Joey Ward with Empire Pacific. Your line is open.

Joey Ward: Thank you. I have a question regarding some conversation that took place on the last call with ORM termination and the special exception with the physician thing that medical service as items are no longer needed and the question came up in the last call regarding when the physician says that the injured individual is completely healed. Is that enough and CMS's response that (inaudible) could be multiple physicians involved in the claim. Specifically for Organ Worker's Comp and probably for other states as well, the injured individual elects one attending physician to direct their care. (Inaudible) physicians state that they are done treating or in a state of medically stationary, is that sufficient for applying that exception?

Barbara Wright: You said they're done treating or medically stationary. Medically stationary isn't the same thing as necessarily done treating where that they require no more medical.

Joey Ward: Yes, that's the term that we use and organ statute says that it means no further medical improvement would reasonably be expected from medical treatment or passage at time.

Barbara Wright: OK. Again, I would say, I'm not trying to give you a hard time but the fact that someone stable and has reached maximum medical improvement is not necessarily the same thing as saying they don't require any further treatment associated with the injury.

Joey Ward: OK. That's all, thank you.

Operator: Your next question comes from the line of Nancy Riley with Johns Eastern. Your line is open.

Nancy Riley: Hello. I got a question that I had (inaudible) and then I haven't gotten response to that I wanted to know is the death occurred prior to January 01, 2010, and the only benefit we're paying are death benefits to the spouse. So there's no ORM as of 01/01/2010. Do we report that claim?

Barbara Wright: We've said if, again, the reporting of ORM had to deal with whether or not you would close the record before that particular date, to the extent you had responsibility and you still have the record open, I believe it should be reported with its appropriate term date. We could have other claims that we should not have paid. If you're looking for a technical answer and a way to escape payment responsibility, that's quite different. I mean we gave essentially a pass or grace in terms of making you go back and look for everybody who had ongoing responsibility for medicals on or after the effective date of this provision and so if you had the record administratively open…

Nancy Riley: But it's ORM terminated prior to January 1, 2010. The person has passed away. Is that reportable?

Barbara Wright: You're not required to report that now. So

Nancy Riley: No. If the ORM was termed prior to 01/01/2010, even though our claim is open with paying debt benefits, we do not need to report that?

Pat Ambrose: I don't think so. I mean, I have to look to Barbara to that but I don't think so.

Barbara Wright: No, you're not required to report that.

Nancy Riley: OK. That was my thought by I just wanted to confirm it. That's the only question I had, thank you.

Operator: Your next question comes from the line of (Lisa Mono) with (TICA). Your line is open.

(Lisa Mono): Good afternoon. My first question is this, Guarantee Association states that to allow us to bill insurers for reimbursement of our claims but what if an insurer

takes it upon themselves to settle the claimant, the insurer paid the TPOC, who reports the TPOC and since it was settled, can we close it?

John Albert: We're not quite sure. Can you rephrase your question because we're all kind of sick in our heads, we're not quite sure.

(Lisa Mono): All right, let me read the whole thing here. I got it right now. Guarantee Funds have a state statute stating that the insurer or the employer must reimburse the fund a 100 percent of all payments paid which would include settlement. So if we pay settlement on an insurer or on a claimant, we can bill the employer to reimburse us. In this particular case, the employer settled the claim with the claimant without the fund approval or without our knowledge. So we're trying to figure out what our reporting responsibility is since they settled the claim with the claimant.

John Albert: We're going to put you on hold for a second. OK. If the self-insured employer is the ones who made the actual payment, then the self-insured employer is the RRE. Now, however, if you made the payment that are reimbursed by the employer, you are the RRE.

(Lisa Mono): OK. Regarding the settlement, the employer paid the settlement. We paid medical bills for this claimant for a time but the employer settled and paid the settlement.

John Albert: Then it sounds like the employer would be reporting a TPOC, then you would be closing out ORM.

(Lisa Mono): That's what I needed to know. Thank you.

Operator: Your next question comes from the line of (Tom Renwick) with Discovery. Your line is open.

(Tom Renwick): Yes, thank you. We need to add several new underwriting companies to our RRE profile report and I was wondering how we do that is there a special form, just write to our representatives, what would be the correct way?

Pat Ambrose: You could provide that information to your EDI representative. They can update that information internally.

(Tom Renwick): Do we have to have another profile report signed?

Pat Ambrose: Well, are you going to report under that? You're going to report those companies under the same RRE ID?

(Tom Renwick): Correct. We have an existing profile report. We need to add several companies to that profile report. So can I just do it through the EDI rep then or do I have to sign and file a new form?

Pat Ambrose: Well, depending on the change where the update that they make it may end up generating a new profile report and if it does, that needs to be signed and returned but meanwhile, you can continue with reporting.

(Tom Renwick): OK. I'll just contact our EDI rep and send him an email telling him we need to add these new companies.

Pat Ambrose: Yes.

(Tom Renwick): And let's see what he does from there?

Pat Ambrose: Yes.

(Tom Renwick): OK.

(Bill): Are these new companies related to the companies that you're currently reporting?

(Tom Renwick): No, they're all related. No. It's part of travelers and we're going to add a couple of new companies the traveler has.

(Bill): OK. So these are subsidiaries of a (parent) and it's the (parent's) RRE that you're reporting under?

(Tom Renwick): No, we have our own RRE ID. We're a business unit. We have an RRE ID under which we're reporting several companies.

(Bill): Are these other companies then siblings of yours?

(Tom Renwick): No, they are affiliates, travelers who will also be reporting these companies under another RRE number but the old process would be dictated by the RRE ID. Some of it will be under ours, some of it will be under travelers.

(Bill): Are these other companies beneath you in the organizational chart?

(Tom Renwick): No.

Barbara Wright: The simple way where we're headed on this is in putting them under your RRE ID that's pre-existing, does it comply with the rules that we set forth about corporate structure in RREs in the user guide? If it does, fine. If it doesn't, not fine.

John Albert: What page is that?

Barbara Wright: It starts on page 21 on the current version in the user guide.

(Tom Renwick): OK. I'll take a look at that. I think it's going to comply but I'll take a look.

Pat Ambrose: OK, thank you.

(Tom Renwick): Thanks.

Operator: Your next question comes from the line of Marta Herrera with Ocean Properties. Your line is open.

Marta Herrera: Hi, thank you. Good afternoon. My question is we have a self-insurer policy. The first 25 is covered by us and then, after the 25, we've exhausted the 25,000, we sent it off to the insurance company to proceed with settlement once we've reached settlement. My question is do we have to report the 25, we have our old RRE number or do they do the reporting?

Barbara Wright: You need to look at whether it complies with our definition of self insurance versus the deductible. If it's a deductible, the insurance report said as well as anything above the deductible if you meet our definition of self-insured

reserve, then you're responsible for reporting that. So you need to refer back to the manual.

Marta Herrera: OK. Where in the user guide can I find that? I know, sorry.

(Bill): We know the guide is large.

Pat Ambrose: There is a section on who must report, so Section 7.1, you need to review and then in an appendix on Appendix G as in (George), has Section 111 definitions and reporting responsibilities. So Section 7.1 and Appendix G would have that information related to deductible versus self insurance.

Barbara Wright: And specifically on page 22, I found what I was looking. Deductible versus self-insured retention and there's two bullet points. Deductible refers to the (risk) of the insured retains with respect to the coverage provided by the insurer. Self- insured retention refers to the (risk) of the insured retains that's not included in the coverage provided by the insurer. If you had a $100,000 policy and you were responsible for 25 and the insurer will only ever pay 75, that's the deductible situation. If you had a situation where there was $100,000 policy and you had a self-insured retention for 25 and then the policy would kick in for a full 100,000, really a total of a 125,000 between the two that's an example of a self-insured retention.

Marta Herrera: OK.

Barbara Wright: Did that help?

Marta Herrera: Yes. Now with the user guide, is it a new user guide or would I find this on the first user guide?

Barbara Wright: This is in version 3.1, the one that's currently posted on the Webpage. It is in Section 7.1 and if you look through the items that are in 7.1, when I printed it out, it's on page 22 but it's under the first section in 7.1. There's a number of bullets under the sub-topic general and deductible versus self-insured retention is on that page.

Marta Herrera: OK. Second question, sorry. I know we're limited jut to one but now, since I have the chance, direct data entry, is that already, can I go ahead and start testing on that or should I just wait until July 11th?

Pat Ambrose: Direct data entry is not available to the general (NGP RRE) population until July and there's no testing required, however, you should closely review the user guide and be prepared to submit further requirements in the user guide and obviously, if you're registered, you could download a copy of the (COB) secure Website to see information about direct data entry. I believe that user guide should be posted out there by this time, and there's DDE alert as well. Oh and most helpful would be the computer-based training module, the CBTs that provide information on direct data entry.

Marta Herrera: Yes, I did see that. OK, thank you.

John Albert: We do have some pilot testers right now doing DDE but that said, it won't be open to the majority of our general public, July 11.

Marta Herrera: Because we have settled already two claims. This is within the 25,000.

Barbara Wright: We're not sure what you're referring to.

Pat Ambrose: Are these liability?

Marta Herrera: Within the SIR, the self-insurer retention.

Barbara Wright: OK. If their TPOC, remember again that that's not required reporting until you have a settlement judgment reward or other payment (10/01/2011).

Marta Herrera: Liability TPOC.

Barbara Wright: Right.

Pat Ambrose: I guess this is an opportunity, since you seemed interested in this to, if you're interested in participating in the DDE pilot, it sounds like you're ready to go, if you want to contact EDI rep or (Bill Ford) about that because we're looking for some new pilot testers.

Marta Herrera: OK. The only thing that worries me…OK. We have two claims that we settled, however, the way we are doing it right now, we contacted (MSPRC), the attorneys does, we get the consent release from the claimant, having signed that and then we sent it off to (MSPRC) and then we report the claim to them and then we just wait to get a condition payment, letting us know if any medical claims have been paid.

Barbara Wright: You're talking about the recovery process which is separate and distinct from the reporting process. If you've got a settlement judgment reward or other payment, then you can go ahead and participate in the testing as John said.

(Bill): You have to do both. In Section 111 reporting as well as comply with the (MSPRC's) recovery effort.

Marta Herrera: OK. Just because I haven't reported because we went from uploading to the new implementation, d direct data entry because we're going to have less than 500 claims to report a year.

(Bill): Yes, that's fine. Like I've said, in terms of starting in reporting, if you want to participate in the pilot test, you sound like some an entity that we want to have to do that because you…

John Albert: The pilot testing will help you to report under Section 111. It has nothing to do with any reports you make to the (MSPRC) and vice versa.

Marta Herrera: OK.

Barbara Wright: And we would also note that the initial contact for a recovery claim is actually normally with the (COBC). If once the case is set up, contacts are then with the (MSPRC). We did note in the guide that self reporting to the (COBC) for purposes of the recovery claim does not eliminate any Section 111 requirement nor does reporting under Section 111 eliminate any of the ongoing obligation for the Medicare secondary payer requirement. They are separate and distinct.

Marta Herrera: OK, I understand. OK. Yes, if you don't mind sending me some information on the pilot testing, I could look that over and see if I could practice doing that.

John Albert: We're asking you to contact your (EDI) rep.

Marta Herrera: Oh, OK. I'll contact him.

John Albert: OK, thank you.

Marta Herrera: Thank you.

Operator: Your next question comes from the line of (Debra Daniels) with Alpha Insurance. Your line is open.

(Debra Daniels): Thank you very much. Hi to everyone today.

John Albert: Are you all right?

(Debra Daniels): Great. We, our corporate office is at Montgomery, Alabama. We have what we call branch office where we have agents (inaudible) and so forth. Our RRE ID is setup so that any communication that we will receive from (MSPRC) will come to our corporate office but we have to get an enormous amount of mail to one of our branch office and we have spent hours and days, and they are trying to figure it out who these people are. We aren't able to do so.

Barbara Wright: I hate to interrupt you but the mail you're getting, is it coming from (COBC)? Does it have anything to do with Section 111?

(Debra Daniels): Yes ma'am. In Section 111, it's coming from (MSPRC). It's like the conditional letters and so forth.

Barbara Wright: Stop a second please. The (MSPRC) stands for Medicare Secondary Payer Recovery Contractor. It has nothing to do with Section 111 reporting. If you're getting mail from the Medicare Secondary Payer Recovery Contractor and it's for a non-GHP situation liability, no-fault or Worker's Compensation, they only send correspondents to whatever address they have been given of

record for the insurer. So if they're sending it to a branch office, that's either because the insurer or the claimant or the claimant's representative has that address for your company.

(Debra Daniels): I understand that.

Barbara Wright: And if you have a concern with that, you need to speak either to the (MSPRC) or actually on a specific case, you need to speak to those attorneys and find out why they're giving out that address for you. The (MSPRC) can only use an address that it's given.

(Debra Daniels): Right, I will call the (MSPRC) and I will speak to them. I give them the (inaudible) number, the case number, all these stuff that's on this letter to try to figure out who these people are. They won't even give me any information so we can get this corrected. In one letter, I finally figured out it went to an attorney in (Louisiana), so I Googled that attorneys name and called them and they said it didn't belong to us at all or them. So how do I try to figure out?

Barbara Wright: Do you represent liability insurance, no-fault insurance, Worker's Compensation?

(Debra Daniels): Yes ma'am. Liability, no-fault.

Barbara Wright: Send an email to our resource mailbox and specify what you're problem is here and I'll see if I can find out someone who's going to help you but it's basically I can tell anytime, it's basically going to rest on your company. If it's getting information at an address it's because that's the address it's giving to someone who is involved in a claim.

(Debra Daniels): Right and we can't figure it out whether the person are ours or not.

John Albert: OK, I'm sorry. I don't mean to cut you off but this is really outside the scope for the section 111 call.

(Debra Daniels): OK, so you can't tell me who basically I need to contact, that's my main question.

Pat Ambrose: I'm telling you right now, if you would, please, to write to our resource mailbox and outline this problem and then we'll see what we can do.

(Debra Daniels): OK, I'll do that.

Pat Ambrose: For purposes of this call, it really is outside the scope.

(Debra Daniels): OK. Thank you very much.

Operator: Your next question comes from the line of (David Piot) with (Piot Consultants). Your line is open.

(David Piot): Hi Pat, it's David. Hi (Bill). I recalled that we we're going to be allowed to open and close (inaudible) less than 30 days. Did that go into production yet?

Pat Ambrose: Yes.

(David Piot): I got an (SP26) last week so it looks like it may not be working exactly right yet?

Pat Ambrose: OK. So you have a situation where you've reported ORM and the ORM termination date is within 30 days of the date of incident…

(David Piot): It returned an (SP26) which isn't in the end user's guide but it's in the claim manager's guide.

Pat Ambrose: Yes, that's a different issue. My recollection and like I said I'm just back from vacation but my recollection was that that problem was related to a future entitlement date.

(David Piot): We looked at the record, it was short. I mean I got the error for a future for termination. Oh, I'm sorry. It was an ORM termination was less than 30. It wasn't more than six months. So it looks like that what it triggers. If you read the error message in the manual it says that's one of the triggers. Pretty sure, I can send you the record if you want.

Pat Ambrose: Actually, what I need you to do is have it reported to an EDI representative with the circumstances surrounding it and we'll take a look at it. I am not

exactly sure off the top of my head what might be happening but that is an example of a, just for everyone's benefit, this is an example of receiving an error code that is not documented in the user guide and in some cases, we are tweaking our own internal system to handle that.

So far, you should not have to do anything with that. It really is something that we needed to take care of internally. So report it to us and we'll look into it. In the meantime, what I would suggest is just since the claim was not accepted, if you could just report it again on the next quarterly file to make sure that and hopefully by that time, it'll have been resolved.

(David Piot): OK. The gentleman earlier from Guarantee, he was talking about having submitted a query that got back 01 and then subsequently cleared again and got back a 51. We had that happen too one of our clients and when we did a little bit of research, it turns out the person with (ESRG) and you know how they come and go, and I understand you don't think they ever go but I'll just give you that bit of information for you to consider while you're researching. OK, so that was a comment. I have one question for Barb just to make sure I got something right.

Barb, on the no-fault bad faith claim, a lot of times these attorneys wind up suing the no-fault insurer because they won't pay. I (shoot) your comment from earlier to say that that should be reported as a liability. So is that correct? I mean you'd say the no-fault policy is 20K, the no-fault insurer doesn't want to pay, it gets in a lot to winds up being…

Barbara Wright: The specific question we got one where they clearly were not going to be receiving payment from the no-fault policy. It was a liability insurance issue, whether it was self-insured or covered under another policy or not, I don't know. What we said is that the type of insurance that's involved in that lawsuit is what controls the reporting not the underlying basis for the lawsuit.

(David Piot): OK, so let's say there was 20K limit, right and you settled for 10K, so you would report it as no-fault policy limit exhausted, 20k maximum, 10K payment and you call it finished, right?

(Bill): No. I don't think so (David).

(David Piot): OK, (Bill), sometimes these no-fault insurer, they consider that closed, right, I mean, you had to assume because it was a bad faith claim.

(Bill): If the suit was to collect benefits under the no-fault policy, that maybe one thing because then you going against the no-fault policy. In case we had, we interpreted it as to mean that they were still in the company for breach of contract or something and they were seeking punitive as well as compensatory damages. The way the case was described to us, it was clearly a liability case.

(David Piot): OK.

Barbara Wright: So (Bill) just said the same thing I did in a slightly different way. Are you really proceeding against the no-fault policy in getting no-fault fund, are you suing essentially for a breach of no-fault contract and getting liability insurance?

(Bill): In which case, the first instance we're suing other than no-fault policy, it would be maxed out when you have thought it a no-fault policy limit. As it was indeed a liability case, the no-fault policy limits were irrelevant to the settlement reached under the liability case.

(David Piot): OK. I need to do some more research to find out. I was talking to an attorney and it was my impression that he was suing because it was like a bad faith claim, right? The policy wouldn't pay out so they settled. They said our limit is 20K but we're just going to give you 10 and call it done. And so I assumed they were suing the policy. I see your point if it's a breach of contract to the policy being the contract and that would be a different plan. So I'll just do more research and find out, if I summarized that correctly.

(Bill): OK (David).

(David Piot): OK. Thanks, (Bill).

Operator: Your next question comes from the line of (Susan Bolster) with (Zurich). Your line is open.

(Susan Bolster): Hi. I just want to let you know, a couple of people have mentioned about getting the disposition code of 51 on their queries, so we just returned disposition code of 51 on our claim file, which in my understanding was we were not going to get that. I did talk to our EDI rep and it sounds like the same thing that I might have to do with the disability now over or they have their (inaudible). Pat, would you like me to send those claim numbers to you and our RRE ID as well so you can take a look at those because this is going to cost us now like a system change because now, we're going to have to show those claimants who is no longer (inaudible) no longer Medicare eligible. So now the query is going to start over again, correct?

Pat Ambrose: Well, first off, you can receive a 51 on a claim.

(Susan Bolster): Even if we did our queries and got back an old one on our queries?

Pat Ambrose: Well, no. You should not get that.

(Susan Bolster): OK, because we are getting that. So can I go ahead and forward to our EDI rep so she could forward it to you?

Pat Ambrose: Yes, that's fine. Please make sure when you're sharing any of this information that you do so in a secure fashion. Sharing us (inaudible) numbers and protected (inaudible) and protected information, private information…

(Susan Bolster): Right. I was just going to give you the claim number and RRE ID. I wasn't going to give any other information.

Pat Ambrose: Yes, OK.

(Susan Bolster): OK.

Pat Ambrose: I was really saying that for everyone's benefit because I have seen some emails where private information has been shared that way and we should just all need to make sure that we're (inaudible) that. So yeah, we can add this to the list. I mean, some of it may depend on (back before) in 2010. So before January 2011, we made a change to the query process when for future

Medicare entitlement to return a 51 when someone is not yet entitled but we have them on record as becoming entitled in the future. So if you have submitted the query prior to that change, you could have gotten an 01 and then submit it either the claim, actually when you submit the claim then you should get an 03 back.

(Susan Bolster): Right, that's what we thought. That's what we are expecting and that's why I'm just bringing this up now because it has now happened.

Pat Ambrose: Yes, I don't know. There might be something up, I don't know. So yeah, you may forward this to your EDI rep to add it to our list for investigation.

(Susan Bolster): OK, thank you very much.

Operator: your next question comes from the line of (Tim Allen) with city of Juneau, Alaska. Your line is now open.

(Tim Allen): Thank you. I recently was sued for a bodily injury case in the city of Juneau as a self-insured entity. I did report the claim and it did come back that the claimant was Medicare eligible, and throughout some legal proceedings and some advice the claimant got from legal counsel, he ended up dropping the case against me but in the meantime, I had filed a question on what (lean) would I be obligated to pay if I were found responsible for this but now that the case has been dismissed, could I expect to receive any further information or correspondents from Medicare stating that I am still obligated to pay any lean?

Barbara Wright: If you have a situation that was reported through the coordination of benefits contractors that the Medicare Secondary Payer Recovery Contractor setup a potential recovery claim and that claim is officially dismissed or abandoned with no settlement judgment award or other payment, then you should report that dismissal or abandonment to them so that they can close to the Medicare Secondary Payer Recovery Contractor so they can close out their case. If it's dismissed because you have a settlement judgment award or because you have a settlement or other payment, then you need to report the settlement or amount but if it's specifically abandonment or dismissal without any resolution, then that needs to be reported so the records can be closed.

(Bill) You do have one little tweak on that potentially. You said you reported it, if you had reported it to Section 111, I'm assuming that was because you had accepted ongoing responsibility for medical. So even though the case was further dismissed, I think you would still have been responsible for the time created which you had had the ongoing responsibility for medicals which would have been filing of the claim until the dismissal of the claim.

(Tim Allen): Well, that's an interesting question because I denied any responsibility for the claim from the onset which I know that has maybe not here nor there but I reported it thinking that possibly, at some point in time that there is a possibility that maybe a legal judgment could be found against me. I didn't know that but I was prepared.

Barbara Wright: You took the appropriate action. What we're saying is there are two things going on here and you also said you were self-insured, so we're talking liability insurance and normally, we don't see those as one where ORM is assumed, although earlier in the call, we did discuss one situation where it happened. For your specific situation and the whole recovery process, my statement about if there is dismissal or abandonment with no resolution, in other words, no settlement judgment award or other payment, then that needs to be reported to the MSPRC if there has been a case setup. What (Bill Inaudible) was raising is in limited circumstances where ORM is an issue and has been reported through Section 111. The fact that you have a formal claim that has been abandoned doesn't necessarily change the fact that you assumed responsibility for ongoing medicals and that that should proceed along its own track.

(Bill): (Can) you report this liability claim right through the Section 111 process or can you reported it to the (COBC)?

Barbara Wright: Because there is no settlement judgment reward, you had not reported your claim through the Section 111 process, correct?

(Tim Allen): I don't know how to answer that because I was working through my contractor (Gold and Lamb) and trying to follow their suggestions, so I don't know how to answer that.

Barbara Wright: They are the ones that can tell you but I would have a hard time believing that they reported it through the Section 111 because they wouldn't have any settlement judgment reward date to provide nor any (inaudible) to provide.

(Tim Allen): Exactly. OK. The other question, how do I find out who my EDI rep is for Alaska?

Pat Ambrose: You should have received a profile report. Have you registered on the Section 111 Website on the Section 111 (COB) secure Website?

(Tim Allen): I believe so.

Pat Ambrose: So if you've gone to www.section111.cms.hhs.gov and gone through the registration process and received an RRE ID.?

(Tim Allen): Yes, we have that.

Pat Ambrose: Then you do have an EDI representative assigned. Hold on just a minute please.

(Tim Allen): Yes, much appreciate it.

Pat Ambrose: I'm pretty sure that you can see the EDI representative information displayed on the Website when you log in but you should have received a profile report and signed that and returned it and on that profile report, it came via an email to your authorized representative as an attachment to that email and your EDI representative information is on there as well.

(Tim Allen): OK. Thank you.

Pat Ambrose: Do you happen to know your RRE ID off the top of your head?

(Tim Allen): You know, I don't ma'am. I'm sorry.

Pat Ambrose: OK. Now, if all else fails, out on the Website is also a general number for the EDI department and that might be a good way to…you can call that general number for the EDI department as well. So again, the Website is

section111.cms.hhs.gov and there's a contact us let's accept the log in warning and then there's a contact us menu items. I should note also that your EDI representative is assigned based on RRE ID and not geography so it doesn't matter where you're located.

(Tim Allen): Very good, OK.

Operator: Again, if you would like to ask a question, please press star then the number one on your telephone keypad. As a reminder, we ask that you please limit your questions to one and one follow-up. Your next question comes from the line of (Boni Mustard) with Farmers Insurance. Your line is open.

(Boni Mustard): My question is actually not related to the reporting and I know that's not correct but (inaudible) I wanted to ask if you have a suggestion on how I could follow up with MSPRC. They have indicated they would not provide our claim number when they sent information to our office and we have one document printer that secures all of the documents for all of our claim files and this is going to be very problematic for us. I can't find a way to reach someone at MSPRC that will discuss this with me.

(Bill): Will you hold on just a second.

(Boni Mustard): Thank you so much.

Pat Ambrose: (Boni), we'll contact you offline.

Boni Mustard: Thank you so much.

John Albert: This is John. I would like to add please no more MSPRC questions. We have four hundred and some people on this call to ask about Section 111. This is what the call is for. We're not going to take any more questions related to any recovery related issues. Thank you.

Operator: Your next question comes from the line of (Nancy Riley) with John Eastern. Your line is open.

(Nancy Riley): Thank you. One question I forgot to ask when I was on before is when someone goes from being a Medicare recipient to a Medicare Advantage Plan, do we continue to report that?

John Albert: Absolutely.

(Nancy Riley): Will the reporting change from an 01 to a 51?

Pat Ambrose: No, it should not.

(Nancy Riley): OK. So if it changes from 01 to 51, it has nothing to do with Medicare Advantage?

Pat Ambrose: No. There is still a Medicare beneficiary regardless of whether this elected to go with the Medicare Advantage plan versus the regular (P4) service plan. That should have no bearing on the return for the query.

(Nancy Riley): So if we have some of those, we'll just email you as you said before on another call. All right, thank you.

Operator: There are no further questions at this time. I turn the call back over our presenters.

John Albert: OK. Well, with that, we'd like to thank everyone for…actually, we have one more thing.

Pat Ambrose: I have one thing. A caller earlier was not able to provide the number for the COB contractor EDI department. If you're not able to find your EDI representative contact information, you could call area code 646-458-6740.

John Albert: OK. With that, we'd like to thank everyone for their participation. Please stay in touch with the schedule. Again, the next NGHP is on April 6 and that's a policy call followed by NGHP technical problem report. Thank you, everyone, keep your questions and comments coming, and operator, after turning off the call, could you please stay on the line. We have a few questions for you. Thanks.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect. End

END