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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: Barbara Wright
March 16, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Natasha) and I will be your conference operator today. At this time I would like to welcome everyone to the Section 111 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, simple press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Barbara Wright, you may begin your conference.

Barbara Wright: Good afternoon. This is Barbara Wright. This is an NGHP liability insurance, no fault insurance, workers compensation policy call for section 111, mandatory reporting.

This afternoon I have with me Pat Ambrose, who has been on many of the other calls, and I also have (Bill Zavoyna) as well as Elizabeth Poole. Pat is going to give a short update and then I have a few comments about policy and then we'll take questions and answers.

Pat Ambrose: Hi, thanks Barbara. I have just one real quick announcement. From the last call, a technical issue was reported with the RRE DCN fields on the new query layout, the query input file and it had appeared that the system was removing any embedded spaces and the caller was asking whether they could submit the RRE DCN fields in their query records with embedded spaces and yes, you may.

We did have a system problem. We were erroneously removing those embedded spaces and returning the RRE DCN without the embedded spaces, in a sense removing them and squishing the fields together. The system should no longer be doing that. So I just wanted to make that quick announcement to let you know that you may submit the RRE DCN fields with embedded spaces and the system will now preserve those and return the field to you exactly as you submitted it on your input file.

Barbara Wright: Is that it?

Pat Ambrose: Yep.

Barbara Wright: OK, first of all I'd like to mention when we open it up for question and answer, we, as usual, will be asking folks to limit themselves to one question with one follow-up question. If we have time at the end, obviously if you had one question you can hook up and try for another question if you have further ones.

In terms of documents, since the last time we had a policy call, there are not any new documents up on the Web site specific to policy. We still have the February 24th alert that was on RRE. We still have the language that needs changed in the attachment on the definitions and reporting responsibilities to conform to the content of the actual alert itself. That still needs corrected.

The language for periodic payments for no fault and workers compensation is still in clearance and as we said on many other calls we're still waiting for clearance on the clinical trial language as well as risk management language. With respect to foreign insurers or foreign entities that are self-insured, we are working on language for that. That will be coming up separately.

Keep in mind that now foreign entities cannot even register until April 1 and we've asked that entities allow a full quarter for testing. So that means that everyone will have at least until September 30 to register. The sooner you can register, the better, but no, it's not a matter of foreign entities having to register right on April 1.

Also, when you look at the user guide or any alerts if you keep in mind that for purposes right now until we have more detail about foreign entities, foreign insurers reporting, the term foreign insurer is used in terms of the user guide when it's referencing an entity that has a foreign address or has no TIN. It's not always literally limited to someone that is foreign and not doing business in the United States. It's a little bit broader than that.

So we will be getting more detail out on that but keep that in mind when you're looking at any statements on it right now.

Additionally, for foreign insurers or foreign entities that would be self-insured, if you have specific issues that you believe need addressed, we know that there is an issue with many foreign entities, our insurers, that they're questioning whether or not they have to report at all. But if you have specific other issues tied to that, it would be helpful if you would send those into the resource mailbox.

The two basic questions we have at this point is which foreign entities or foreign insurers would have to report and potential privacy issues if they are required to report. If you can be a specific as possible about particular privacy issues, that would be helpful to us.

That is actually pretty much it for right now except for two last things. In the questions that have been coming in, two issues surfaced more than once. We've had comments about subscription policies where different insurers are responsible for a different percentage of a particular policy.

We'd like anyone who is interested in that issue to flesh it out a little in terms of a comment to the mailbox to the extent that the insurer would be the RRE, whether it's a subscription policy or any other type policy, we're not clear why the inquiries believe there's a particular issue with it being a subscription policy, so if you're interested in that issue, if you could be specific and write in.

The other one is we've received several comments about indemnification, tendering claims for indemnification, and assumption that doing that takes a particular entity off the hook, so to speak. You have to look beyond just whether or not there's an indemnification agreement. Indemnification by itself would fall within the rule where we said an RRE may not by contract or otherwise shift responsibility for their RRE status.

So you need to break it back down to is the particular entity that is being indemnified by another entity, are they an RRE to start with. If they are, then they retain that responsibility. The fact that they're indemnified by someone else doesn't change that.

If they're not an RRE and they have an indemnification agreement so that you're potentially into – if you have an entity that's being sued and their payment would have been by their insurer direct to the claimant, then they wouldn't have been the RRE – then that entity wouldn't have been the RRE to start with. But if they are the RRE, the indemnification simply doesn't matter.

Let's see. The other thing is precision and terminology when you're looking at some of the Medicare issues, when you're reading the user guide. We've had a number of questions that come in along the line of if someone's Medicare eligible and then ask various questions about what happens.

You can be eligible without – eligibility precedes entitlement basically. Once you're entitled, you're enrolled and you're getting benefits. We need reporting on people who are in fact entitled or have been entitled in the past.

In other words, they're actually enrolled in Medicare. So just keep that in mind as a general statement about our policy of what we can look at here when you use specific terms that have a different meaning for Medicare then depending on who you're talking to you will get an answer that's geared to the specific wording that you're used.

We've also had several that have asked after the RRE alert questions about whether large deductible holders, if there's a policy that has a large

deductible, can the policy, the insurer, shift responsibility to the insured with the large deductible. The alert says no. We haven't changed that position. But the insurer and the insured are certainly free to work it out if they wish to do so to make the insured the agent for purposes of reporting.

An insurer could have one RREID for all the policies where there were small deductibles and could have a second RREID or a second, third, and fourth for, say, three particular policies that had very large deductibles where they worked it out for those insured to be the agent for reporting under those three specific policies.

So the fact that the insurer is responsible for reporting even in the large deductible situation doesn't mean that they don't have to lump those with all the other reporting that they've got. They have options in terms of how many RREIDs they set up and whether or not they use the insured as an agent for a particular policy.

Pat, do you have anything to add to that?

Pat Ambrose: No.

Barbara Wright: OK, operator, I don't have anything else right now. We can open it up for questions.

Operator: At this time, I would like to remind everyone in order to ask a question, press star, then the number one on your telephone keypad. Please limit yourself to one question. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of Susan Kornblatt from New York State Insurance. Your line is open.

Susan Kornblatt: Hi, I have a question. When I read in the user guide about disposition code 03, last week we said – they said at the other teleconference they said if we resubmit it, it will be as an ad record. It's as if the case – the claim wasn't

accepted. But the language in the user guide says a disposition code of 03 means the claim was accepted but the period of coverage does not overlap.

Pat Ambrose: Yeah, I did actually agree that I need to adjust that language where we say expected.

Susan Kornblatt: OK.

Pat Ambrose: It wasn't accepted in the sense of added to our COB database and passed on to the MSPRC. I should have said – I should have phrased it differently in the user guide.

Susan Kornblatt: OK so that if we resubmit it, it's as an add record.

Pat Ambrose: Yeah.

Susan Kornblatt: OK because we didn't work it out that way but now we have to change it.

Pat Ambrose: Yeah, I apologize for that. I do have it on my list to correct it.

Susan Kornblatt: OK, so and then going along with that, it says that if there's no ORM we have to resubmit if there's a subsequent TPOC. I think that when we read this we're confused with no ORM because we're assuming that you mean ORM termination and not ORM indicator equal no.

Pat Ambrose: Yeah, I mean you could read it either way.

Susan Kornblatt: But which way – right, but we want to know which way is the right way. If we have no ORM, right, why would we resubmit a claim if there's a subsequent TPOC?

Pat Ambrose: If you have a subsequent TPOC, that individual may now – that TPOC date may now overlap their Medicare entitlement date.

Susan Kornblatt: Right, but if were' saying we have no more ongoing responsibility for medical, if ours terminated –

Barbara Wright: But you have to report TPOC.

Susan Kornblatt: Even if our responsibility terminates?

Barbara Wright: Yes.

Susan Kornblatt: Yes.

Barbara Wright: The point is, often in workers compensation, the TPOC, the money in that is part of what's terminating the ongoing responsibility for medical and in many cases that remain in dispute the only payment is the TPOC. Yes, you have to report TPOC.

Susan Kornblatt: All right because we can have a TPOC where we do – we close the comp and medical portion and we would have no ongoing responsibility for medical. We're workers comp and then subsequently a claimant has a third party action as part of that claim. When they settle that, we would have to report that TPOC?

Barbara Wright: So when you said that you would be terminating ORM and doing a settlement in connection with that.

Susan Kornblatt: Right.

Barbara Wright: And that settlement would involve some type of lump sum or payment?

Susan Kornblatt: Right.

Barbara Wright: So you would report that TPOC.

Susan Kornblatt: Right.

Barbara Wright: And then you said they would have a third party claim. Are you talking about another claim where a different insurer –

Susan Kornblatt: No, connected with the same accident because a lot of times the litigation piece extends further into the future and before it gets settled.

Pat Ambrose: If that second claim has the effect of releasing – or if the second settlement has the effect of releasing medical that's reportable –

Susan Kornblatt: No it doesn't. The first one did.

Barbara Wright: Well what is the second one? If the first one has release all medicals and that's been reported in that TPOC –

Susan Kornblatt: Right.

(Bill Zavoyna): Then if the second, if what's involved in the second one did not involve a claim for or have the effect of releasing medical, then no it's not reportable under workers compensation. If the third party action was liability action, the liability insurer may need to report it.

Susan Kornblatt: OK, OK so they would be reporting it.

Barbara Wright: Right.

(Bill Zavoyna): Right.

Susan Kornblatt: OK, can I just ask one more question?

Barbara Wright: OK.

Susan Kornblatt: All right, what – as far as workers comp goes, what is considered a TPOC? We have – let's say we have two kinds of settlements here that we do. One closes the compensation, the compensation and the medical piece, and we have another one that only closes the compensation piece for wage

replacement benefits but the medicals continue. With that second one where we're only closing out the compensation piece and the medicals are continuing, would that be considered a TPOC?

Barbara Wright: We are trying to address that as part of the language we're doing for periodic payments to determine whether or not you would have to report that particular situation. So I don't have an answer.

Susan Kornblatt: No, no I'm talking – well the language – the periodic payments aren't really technically a lump sum.

Barbara Wright: I understand that but we are looking at whether or not we can include something to address the specific situation you raise right now where you're ending the periodic payments with a lump sum, right?

Susan Kornblatt: Right, so there's no definite answer on that yet.

Barbara Wright: There's nothing other than what's in the user guide right now. We're looking at whether we can add to that.

Susan Kornblatt: OK, thank you.

Operator: Your next question comes from the line of Norman Reese from Louisiana Guaranty. Your line is open.

Norman Reese: Hello. We sent in a production query on March 2 and on March 5 the account manager received a response back stating that they had received the file and that it could not be processed due to the following error and the error states the head of record RREID does not match file name. Now I've emailed the EDI rep and haven't – she said it'd take about a week to fix and then she writes back and I think she referred me to the manual.

But we can't – what we're trying to figure out is this something on our end that we need to fix or is this something that our EDI needs to take care of?

Pat Ambrose: Could I have your RREID please?

Norman Reese: Yes, it is 17681.

Pat Ambrose: OK, I'll take this back and have someone follow-up with you.

Norman Reese: OK.

Pat Ambrose: In general, in the future, if you're unable to get an answer that is satisfactory to you, you should follow the escalation procedure that's outlined in section 18 of the user guide and send it up the chain.

Norman Reese: OK.

Pat Ambrose: But that isn't necessary. I will have someone follow-up with you to let you know what you need to do with that situation.

Norman Reese: OK, thank you very much.

Pat Ambrose: You're welcome.

Operator: Your next question comes from the line of James Houston from State Farm Insurance. Your line is open.

James Houston: Good afternoon. This is Barb Taylor. I'm actually standing in for Houston asking these questions. Our first question comes from where we have ongoing responsibility for medical under perhaps MPC or PIP and all we are doing is actually paying for something such as glasses that were broken in the accident or perhaps dentures that kind of flew out of somebody's mouth and were cracked.

So we're paying for that or someone goes to the emergency room just to get checked out with actual no diagnosis code. We're wondering what ICD-9 code we can use for those.

Pat Ambrose: I don't have a list or the ability to tell you myself.

Barb Taylor: they seem to fall under the v codes which apparently we're not supposed to be using.

Pat Ambrose: Correct, we do not accept V codes. They're generally not specific enough or they aren't describing things that are covered by Medicare.

Barb Taylor: Right, it's difficult to assign an injury code when someone – no medical provider has found an injury. So we know we have to report these because we are assuming ongoing responsibility but it's just we're kind of in a quandary of what to put in.

Barbara Wright: If the only thing alleged and being released has to do with replacing glasses, etc., one of the things you might look at or consider are codes that would be necessary for an eye examination.

Barb Taylor: OK, thank you.

Barbara Wright: Because in connection, while we may not pay for the glasses, if someone needs an examination to get those glasses replaced, yes, we would typically end up being billed for that. Whether it was covered in a specific instance would depend on other factors.

Barb Taylor: OK, thank you for that. we've also, kind of as a follow-up question, we've run into a situation at least one state under no fault insurance that has some optional coverages which we're kind of strangely in that – I'll just pick one limit – the limit for no fault is $100,000 for the first 3 years and if after 3 years that limit then drops down to $3,000 and we're wondering under field 81 what we should put as an ORM limit and under field 82, of course that's the exhaust date which we would fill in when the benefits are exhausted.

But it's interested because we have this large limit for the first 3 years in which CMS might pay conditional payments that we might not know about

until after 3 years when we have a $3,000 limit. So we're kind of wondering how we should fill in the field 81 for ORM limit.

Barbara Wright: I have a question. When you say it drops to like $3,000 after 3 years, when you say it drops to that do you mean that if they don't get the claim in before 3 years they're limited to $3,000 even before that or do you mean there's a limit of $3,000 for any care after the third year?

Barb Taylor: It is any care furnished more than 3 years after the date of lass.

Pat Ambrose: By date of service or something.

Barb Taylor: Yeah.

Barbara Wright: So I think we probably need to discuss this some offline.

Barb Taylor: OK, I will send you a written question on that.

Barbara Wright: As a first reaction, if they haven't exhausted the $100,000 to start with, that probably – and you need to have ORM open anyway, you may just need to leave the $100,000 limit and if and when there were any claims after the 3 years, a defense against owing us anything or having to repay would be there's a new limit, etc.

But we need to talk about that because providers, physicians and other suppliers, have right now a minimum of 15 months and a maximum of 27 months to accept claims for payments, so just cutting it off right at the end of 3 years could create problems.

Barb Taylor: Right and we understand that. We don't want to underreport which is one of the reasons that we're submitting this question. Thank you. I have just one follow-up, very quick question, and this has to do with the ICD-9 codes on page 47 of the user guide.

It talks about codes must be left-justified and so if we have an ICD-9 code that only has three digits, should we fill in the remaining two in the field with zeroes or should we leave spaces?

Pat Ambrose: Spaces.

Barb Taylor: Spaces?

Pat Ambrose: Spaces. Generally speaking, what you want to do is look for that code on the text file. That section provides a reference to text files of valid ICD-9 codes on the CMS Web site and the various versions that CMS puts out each year, version 27, 26, and 25 are the most current three and the code that you enter has to match the first five positions of some code on one of those files. So it really depends on how that code shows up on those text files of valid ICD-9 codes.

I suspect it probably is three digits and two spaces. But I can't say for sure. In some cases ICD-9 codes might have numeric digits in all five positions. In other cases they're shorter and when shorter generally the rule is to space fill.

Barb Taylor: Thank you very much. That's the end of my questions.

Barbara Wright: Are there some instances Pat where there would be a leading space or leading zero?

Pat Ambrose: No, never a leading space. There may be a leading zero if that's helpful but it has to again match the first five positions on some entry on one of those text files. Okay, net question/

Operator: Your next question comes from the line of Kim Nelson from Nationwide Insurance. Your line is open.

Kim Nelson: Hi, I have a question about ICD-9 codes. As a casualty insurance carrier, we sometimes are making TPOC payments without having access to a medical bill that contains the ICD-9 codes. So for our claims associates we're trying

to find a way that they can type in a valid code by keying in a description of an injury.

We've noticed that even doing a casual search we're finding Web sites that provide this type of service but we're hesitant to use those and I wonder if CMS had any contacts with vendors or can recommend sites where this type of service is available and authorized, approved so to speak.

Pat Ambrose: Yeah, we don't actually authorize or approve or certify any of those particular vendors. We have no problem – CMS has no problem with you using one of those vendors or software of that nature. But unfortunately we can't advocate for a particular one. So we can't tell you which one might be more acceptable to another. It would have to be your decision.

Kim Nelson: OK, in your experience with getting these kind of questions from insurance carriers, are you getting this same sort of question from other carriers?

Pat Ambrose: It has come up.

Kim Nelson: OK. The other one that I have is also related to ICD-9 codes where we understand that we're encouraged to submit as many as we can but only one is required. In the user guide, in the field descriptions for fields 21 through 27, it says that ICD-9 codes are required based on number of body parts affected. So I was curious.

Pat Ambrose: The generality is that one is only required. What that field description is trying to get at is if there are multiple injuries, a broken left arm, a broken right arm, and a broken right leg, we would – what we're asking for is then three different ICD-9 codes to reflect those three different body parts.

Kim Nelson: OK.

Pat Ambrose: But the actual technical requirement is one code be submitted.

Kim Nelson: OK so if we submit –

Pat Ambrose: It will improve the whole recovery process if you provide and also the claims payment process, coordination of that if you supply all codes that are applicable to the multiple injuries to make it less complicated and more streamlined. But again, the technical requirement is just one code be supplied.

Barbara Wright: If there's ongoing responsibility for medical and it's safe to assume, then you know there's three body parts and you only tell us about one, then we're likely to make conditional payments related to the other body parts that should be made which increases the need – our potential of a recovery claim which is more paperwork, pay and chase, for both sides. We're interested in avoiding that whenever possible.

Additionally, if it's a TPOC situation and you only give us one and you know about three body parts, then there's potentially more reconciliation we have to do on the back end in determining what we have for recovery and could necessitate further contact, either additional contact with the plaintiff or beneficiary, plaintiff's representative, and/or in some instances with the RRE. We're interested in having information so that we can do both the front end and back end as accurately as possible and avoid repeated contacts when possible.

Kim Nelson: Correct, that makes sense. So we want to supply what we have but we also want to make sure we understand what the requirement is. So thank you.

Pat Ambrose: You're welcome.

Operator: Your next question comes from the line of Lauren Neal from CSL Behring. Your line is open.

Lauren Neal: Thank you. Last week on the technical issues call, one of you had mentioned that there's talk about setting up a modality where low volume RREs could just report every so often through a web modality. I may have one claim to report in 5 years. Is it reasonable for me to wait for this low volume web-

based modality to come onboard? Should I begin all this testing business now even though I don't have any files/

Barbara Wright: Well there's two aspects to that because we've said from the beginning that if you don't have any reasonable expectation right now of reporting, you don't have to register. Our directive or comment was that once you have a reasonable expectation of reporting a claim, you should register in time to allow yourself a full quarter for testing. So if you truly don't have anything to report right now, that's up to you.

On the other hand, I'll let Pat speak to – I don't think we have a definite date for any low volume reporting.

Pat Ambrose: We don't have a definite date but that information will be provided I believe within a month. I mean I can't – I don't have 100 percent control over it but so honestly if I were a small reporter – now we haven't defined what a small reporter is, but if you believe that you will only have a handful of claims, say five claims per year to report, it is in my opinion safe to wait to find out what the answer is in terms of that solution for direct data entry or for the small reporters.

Lauren Neal: So are you waiting for some sort of authority or the answer is yes, there's just not an IT resource to set it up?

Pat Ambrose: We're waiting for two things. One, CMS has to make a decision as to the definition of a small reporter, how many claims per year is it really.

Lauren Neal: OK.

Pat Ambrose: Is it 5, 10, 15, 20 and then we have to – the IT team needs enough information in terms of requirements in order to provide an implementation date and that hasn't been established either. As I said on the last call, we know it's a priority. We know that it's important to get this information out to save people the expense of developing their own system to submit or go and contracting with an agent to submit.

So I'm personally doing everything that I can to get an answer out there within a month.

Lauren Neal: Thank you.

Operator: Your next question comes from the line of (Jennifer Littick) from Erie Insurance. Your line is open.

(Jennifer Littick): Hi, on your prior call, the technical call, you stated, I think Pat stated that you would only accept term dates that are six months into the future from submission, the report submission.

Pat Ambrose: That's right.

(Jennifer Littick): OK because we're currently putting the statute of limitations to administratively close our files in the termination date. So you're saying if we submit it, it would be rejected?

Pat Ambrose: I'm afraid so. Essentially if you know for sure that ORM will terminate due to some statute of limitation or other state regulation in 3 years from the date of incident, you won't be able to submit that termination date until six months in advance of it and what I would recommend that you do or what you really need to do in that circumstance is to report the ORM and leave it open, leave the ORM termination date all zeroes until such time you can actually submit a definite date.

I know that's causing some difficulties systematically for folks and I actually am looking into whether we can change that requirement of the six months but it is dependent or is a requirement of a system that we interface with. So we don't have control over it. However of course we can request that change be made. I'm not really even sure what the reason for it is. So we're looking into it but right now what you need to plan on is reporting the ORM with an open-ended termination date until such time the system will accept that future date.

(Jennifer Littick): OK, thank you.

Barbara Wright: Remember though we also said as far as termination dates for ORM, you cannot report contingent ones. So even if you have a statutory provision that responsibility ends after 2 years if they don't need care within that 2 year period, you don't know on day one that they're not going to need that care. That's still a contingent situation.

So don't assume that just because there is a statutory provision that plays in that you automatically can put a termination date in advance.

(Jennifer Littick): OK, thank you.

Operator: Your next question comes from the line of (Rita Kareni) from Health Indemnities. Your line is open.

(Rita Kareni): Yes, hello, I have a question also in reference to the earlier question about dentures and such. What I think I heard was that even though there is no injury, that dentures and hearing aids and eyeglasses that are lost, if a hospital chooses to replace those, they would be reportable.

Barbara Wright: We're talking about medical items or services and associated care. If you have glasses that you are replacing and there's care associated with that such as there might need to be an eye exam or something else tied in with that, then presumably – if you've assumed responsibility, presumably you're assuming it for both, not just physically replacing the glasses.

So the question was framed more in the terms of we don't know how to code this and so I made the comment not as official CMS guidance but as more of a common sense approach that if you're replacing any appliance or item, regardless of whether or not it's something that would be covered by Medicare, if there's associated care that's typically tied into that in order to get the item, then you may have a reporting responsibility.

(Rita Kareni): So we might. You're not really saying that we do. If there is no real injury you can't pick a –

Barbara Wright: If what's being claimed or released in terms of them coming to you and complaining or what you're doing involved medicals, if it has the effect of claiming and/or releasing medicals, that's our touchstone and you're describing a situation that to us does include medical.

(Rita Kareni): OK, on the denture side, Medicare doesn't even really pay for dental care, do they? But we would still have to report that, the hospitals would.

Barbara Wright: Well first of all I think we're treading on ground where we haven't given you advice yet. I think hospitals – providers, physicians, and other suppliers as well as other types of industry have asked about risk management activities including situations where they do a write-off of certain medical care and also where they're providing it free and your specific question I believe goes into that and we haven't issued that advice on that.

That's why I said the question we were answering before was more in terms of if it's something that we don't have an actual ICD-9, how's a way to get to one. So what I was saying from a logic standpoint, if you're dealing with something that has to do with glasses, do you want to look at codes that are tied to eye exams, etc. I was not trying to give advice about risk management activities and how to report that.

(Rita Kareni): OK so you are saying that this could fall into that category.

Pat Ambrose: Of risk management.

(Rita Kareni): That's what I think I'm hearing.

Barbara Wright: Yes, I mean from the way it's been described in other calls, people have been talking about replacing glasses that are lost, etc.

(Rita Kareni): OK, all right, I have another question. We've been querying in production and there are times that we have a claimant we believe we need to report on and we have a HICN number and a confirmed Social Security Number, date of birth, and name. We've sent it up but we do not get a return HICN from you.

I mean if we have gone through the lengths of confirming that information and we don't get a HICN, then I can only assume then that we are not to report that.

Pat Ambrose: It depends on the disposition code that you're getting back. Are you getting back a 51 disposition code?

(Rita Kareni): Yes, one saying that they can't be found.

Pat Ambrose: Right, so for whatever reason, we have not matched the information you've submitted to a Medicare beneficiary on our fie and that could be because the information that you're supplying is not the same as what we have for that particular individual or it could be that they truly are not a Medicare beneficiary.

If you're fairly confident that they are, being a hospital and having that information, their Medicare card for example, then most likely what is happening is that we're not matching on those fields necessary, either the SSN or HIC number exactly, the name, date of birth, and gender.

What I would recommend in those cases is examining the individuals' Medicare insurance card if you have obtained a copy of that to see how their name is printed on that card. But if you've submitted accurate information and we're saying that they're not a Medicare beneficiary or that we haven't matched it, you cannot submit that claim.

Barbara Wright: If you've actually seen their Medicare card and submitted the name the way it's on the card, where you're more likely to have a problem is an error

obviously with date of birth or gender. Someone who's named Francis, is Francis male or female.

(Rita Kareni): We'll go back and check but I'm almost sure that we did a double check on that. We'll look.

Barbara Wright: And the same thing about date of birth, if even just the day or the month is off, particularly while you're doing testing, I guess I'll ask Pat, if you've got one where you've actually seen the card or have a photo of the card and you're sure it's still not matching, would COBC like to see a couple of those to make sure that we're not having an issue?

Pat Ambrose: Yes, actually I meant to say that as well. If you're confident that you should have gotten a match and you did not, you should supply that information, report that to your EDI representative in a secure fashion and allow them to research it. That's a very good idea.

(Rita Kareni): OK and along the same line, if we submit information in our query but a claimant indicates – say their birthday is not for six months and they claim that they don't get benefits but we query and there is a HICN number returned –

Pat Ambrose: You would want to submit that claim. Some folks don't.

(Rita Kareni): Get a HICN, we report it.

Pat Ambrose: Yeah, if you get a disposition code 01 and a current HIC number returned, yes report that claim. Some folks are not necessarily up to speed on their actual Medicare entitlement dates.

Barbara Wright: And also think about the phrasing you use when you talk to them. if you say, are you getting benefits, many of them think about have they paid for x, y, or z versus thinking about are they a Medicare beneficiary and if they happen to be dual Medicare and Medicaid, many of them simply don't distinguish. They simply have a healthcare card.

(Rita Kareni): OK, all right, thank you.

Operator: Your next question comes from the line of (Wendy Radar) from State Compensation. Your line is open.

(Wendy Radar): Hi, my question is regarding the settlement of medical liens, medical treatment liens and whether or not that's considered a TPOC and what I mean is we may have disputes with a particular provider as to whether all the money they are charging us is due and then we settle that usually at the time of resolution of the case and we're not sure whether or not those lien settlements are TPOC.

Barbara Wright: Well a couple of different things. You are separating this from ongoing responsibility for medicals. You're not talking about ongoing responsibility under no-fault.

(Wendy Radar): Well no, this is worker's comp and ORM is a separate issue.

Barbara Wright: OK, anything that you pay out as lump sum medicals is in fact reportable to us as a TPOC if you have not – if you're reporting ORM and you're paying them, fine. But if you no longer have ORM and you're making a payment to a provider, physician, or other supplier, then yes, you need to report those TPOC.

(Wendy Radar): OK so then the issue is whether or not we've reported termination of ORM and then we're making another payment after that.

Barbara Wright: Yes.

(Wendy Radar): Even though that payment doesn't open up ORM, it simply – I mean the services were all provided earlier and now we're just taking care of all the loose ends. So it's not opening up any more responsibility.

Barbara Wright: Could you hang on a minute?

(Wendy Radar): OK.

Barbara Wright: Let's go back and look at what you said to us again. Let's take scenario A, you've reported ORM and you reported it as of, I don't know, you reported it as of January 1, 2011 and we're now in December of that year and you're reporting in your fourth quarter and you're reporting ORM is terminated, OK?

(Wendy Radar): OK.

Barbara Wright: And then you had – you either get it submitted after you've done the termination or it was still disputed at the time you did the termination but you're paying for an additional service that was during the ORM period of time.

(Wendy Radar): Right.

Barbara Wright: You're paying it directly to the provider supplier.

(Wendy Radar): Right.

Barbara Wright: No, you don't need to report that separately.

(Wendy Radar): OK, great.

Barbara Wright: If you have a situation where you're paying for something outside the ORM period and you're paying it either direct to a provider supplier or direct to the injured beneficiary, then you're in to describing a TPOC situation. You've reached some settlement of some particular issue beyond what was covered under ORM.

(Wendy Radar): OK, that makes sense.

Barbara Wright: Does that help?

(Wendy Radar): Yep, it does, and then I have a follow-up question on diagnostic codes because in general we are understanding that if we are denying ORM, we don't report it. So let's say we have some accepted body parts but others are alleged and we are denying those.

Would you recommend that we report or don't report that ones that are denied?

(Bill Zavoyna): So you're accepting ORM for certain diagnosis codes?

Barbara Wright: Right.

Pat Ambrose: For certain body parts.

(Bill Zavoyna): Or for certain body parts, that's what you're going to report. The fact is if you deny a claim for a different body part you don't need to report specifically that you denied a claim.

(Wendy Radar): OK but these are all part of the same claim, the same date of injury.

Barbara Wright: Inputting ICD-9 codes, if you're reporting ORM, report the ICD-9 codes that are related to what you've accepted ORM for.

(Wendy Radar): OK and then also when we're preparing a patient for surgery, sometimes we will temporarily cover comorbidity factors that, say for instance, diabetes needs to be controlled. So during that period of time we will be paying bills for those things but generally speaking they're not part of the case. Do you recommend reporting or not reporting those?

Barbara Wright: If it's for any period of time, it would be helpful to have it reported. What helps is if you are paying those claims directly to the supplier or provider then hopefully they're not going to show up for us to make any mistake or erroneous payment or conditional payment.

(Wendy Radar): But then let's say the surgery is completed and we're not going to pay anything else on that. Would we have to send an update to remove those?

Pat Ambrose: Well you're either sending an ORM termination date or a TPOC amount. No?

(Wendy Radar): But this is just for certain body parts is what I'm saying or certain conditions.

(Bill Zavoyna): For a period of time they accepted a certain diagnosis code for ongoing responsibility. After a point in time they no longer accepted that. I think it would be an update record.

Barbara Wright: If you don't – we don't require you to do an update record. The risk you run if you don't do an update record is that providers or suppliers could continue to bill you for that related comorbidity issue.

(Wendy Radar): OK, OK, thanks.

Operator: Your next question comes from the line of (Sunnie Li) from Wilson Elser. Your line is open.

(Sunnie Li): Hi, thanks for taking my call. Regarding worker's comp TPOCs where the Medicare beneficiary has died and it's just a matter of the widow receiving death benefits, that's not considered a TPOC, correct?

Male: What's included in the death benefits?

Male: Could you hear that?

Female: What's included in the death benefit payment?

Female: Well, it's her – it's her – would be essentially the lost wages, I guess.

Female: I mean, if it's limited under the workers' comp provisions to lost wages or some indemnity along that type, then no, it wouldn't need to be reported. But if there's any way it can cover medical or past medical expenses, then it does have to be reported.

Female: Thank you.

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

Your line is open.

(Susan Jordan): Thank you.

My question is in regards to the 8.3 section on the changes to the RRE registration. On page 33, there's a sentence that states that a delete request should be made only for an RRE ID that has not been used for production file submission.

And my question is this. If the RRE ID is still in test mode, and not in production status, but we have, in fact, submitted Medicare beneficiary queries, would we still follow the delete request if the RRE is changing to another party?

Female: Yes. I need to update the user guide to indicate that the delete request should be submitted if the RRE ID has not been used for production claim reporting.

I realize that some folks have used their RRE ID for production query processing, and now have realized that they are not an RRE, based on the new definitions that have been issued. And, so they should submit that delete request to their EDI representative.

(Susan Jordan): OK, so long as they haven't reported a production file.

Female: Yes. And, either way, if you are no longer going to use an RRE ID going forward, that needs to be reported to an EDI representative, and the COBC, or the EDI representative – the EDI department can make a determination as to whether they delete that code – put it into a delete status, or whether they put it into a discontinued or deactivated status.

Female: As I think we said on the last call, if you're in a situation where you thought that you would an RRE because of deductible issues and under the alert we issued, you know that you are no longer an RRE, because your only time you would have been paying was – or would have been reporting, was in

connection with the deductible, then you may not simply keep that open to do queries. If you're not an RRE, you may not maintain and RRE ID simply for a query process.

(Susan Jordan): OK, thank you.

And, just in follow-up to that, just as a point of confirmation, when we are requesting either an abandon RRE ID, or even the (CC-ing) and transitioning, does that request always need to come in from the authorized representative? Or can it come from the account manager?

Female: I don't have an answer to that. I'm sorry. I'm going to have to look that up myself. There's not someone from the operational staff in the room that can help me.

(Susan Jordan): OK, and just a real quick follow-up. You had mentioned that there would be a clarification alert coming out on the RRE definitions. Is that expected to come out soon?

Female: Yes, as I said at the beginning of the call, it hasn't been released yet. It's – but I reiterated that that change will be to bring the definition in line with the content of the alert itself.

(Susan Jordan): OK, thank you.

Operator: Your next question comes from the line of Susan Bradbury from Berkley Accident.

Your line is open.

Susan Bradbury? Your line is open.

Susan Bradbury: Yes, this is Susan Bradbury. Thank you.

Our product is a blanket accident product coverage participants for accidental bodily injury arising out of participation in a defined activity, such as Little League baseball players. It never covers venues or spectators, and it pays regardless of liability or negligence.

This product has been deemed exempt under GHP, but then we've heard that there's some question whether it must be reported under NGHP as no fault.

Male: It is no fault.

Susan Bradbury: And if understood you correctly on the last call, you said that we should refer to the applicable specific no-fault state laws to determine the products for reporting requirements.

Male: You need to look at the definition of no-fault in CMS's regulations.

Susan Bradbury: CMS's regulation. Not the state.

Male: Right. Federal supersedes state.

Susan Bradbury: OK. OK, because it would not be no-fault under any state law, so I will look to the CMS definition then. OK, thank you.

Operator: Your next question comes from the line of (Carol Dawndee) from (Donner Health).

Your line is open.

(Carol Dawndee): Thank you.

We have a question about what to use for ICD-9 codes in many instances. One is when a spouse signs a medical release for future medicals, and there have been no medicals indicated. Or when parents of a minor do the same thing, and they are Medicare beneficiaries.

When a spouse gets – signs the TPOC settlement for loss of consortium, which doesn't really translate to an ICD-9 code. Or when we have an employment issue, where they – part of the settlement is to sign a release of future medicals, but no medicals of any kind have been indicated. What are we supposed to use for an ICD-9 code?

Female: In loss of consortium claims, we have said, if it's – it doesn't claim and/or release medical consortium by itself, isn't reportable. If there's no medical component. Either claim nor release.

We have, on the list of issues to look at further, we've been asked by more than one part of the industry to look at the whole issue of errors and omissions. And is there any way that we can exclude reporting for errors and omissions. Policies and claims resulting from that. So, we don't have an answer for that part of, you know, your question right now.

(Carol Dawndee): But typically, releases, when they're signed, include future medicals, whether there's anything indicated or not.

Female: I understand that. And that's one of the reasons that the industry has asked to look at error and omission policy.

(Carol Dawndee): Well, it's not just errors and omissions, though. It's also for parents who might be Medicare beneficiaries, signing for their minor, who was the injured party. And also ...

Female: Well, is the minor a Medicare beneficiary?

(Carol Dawndee): No, but the parents might be.

Female: Well, if they're getting – if they're getting a TPOC settlement, and they're a minor, and they're not a beneficiary, you don't have any reporting responsibilities.

(Carol Dawndee): I thought that if the parents were also signing, or the spouse was also signing, and the parents or spouse were Medicare beneficiaries, we still ...

Female: No. Who is actually being – who is the injured individual? And if the claimant – I don't want to use the word "claimant," because in the record input file, that refers to situations where the beneficiary is deceased.

(Carol Dawndee): Right.

Female: Where the injured party, the only one claiming injury or releasing injury, is a child, and they're a minor, and they're not a beneficiary, you don't report it. If they're an adult, and it's being signed by their – if the alleged injured party is the husband, and for whatever reason, the wife is signing the release with respect to her husband's injuries, if the – if the injured party is not a beneficiary, and it's a TPOC situation, you're not reporting.

Similarly, if the wife is – had made an allegation, and she is not a beneficiary, if it's a TPOC situation, even if she's releasing medicals – remember, for TPOC, it's really whether or not they are or were a beneficiary by the date of the settlement, or you're not reporting it. If it's ongoing responsibility for medicals, and those continue on, then you potentially get into the issue of monitoring to look for future Medicare entitlement.

But if it's TPOC, you don't reach that point. You're dealing with whether they are or ever have been a beneficiary by the time of the TPOC date ...

(Carol Dawndee): OK, but if ...

Female: ... as defined in our (record) layout.

(Carol Dawndee): But if the spouse is a Medicare beneficiary, and they sign the release, along with their spouse ...

Female: Are they released ...

(Carol Dawndee): ... who is the injured party, saying they are releasing future medicals, then ...

Female: Are they releasing future medicals for themselves ...

(Carol Dawndee): Yes.

Female: ... or are they signing on behalf – if they're releasing ...

(Carol Dawndee): Yes. No, they're releasing them for themselves. That's typically the way our settlement papers are worded. And the same for parents. Because we don't want the parent coming back and saying, this trauma was so terrible with my

child that it caused me all of these medical problems. And yet, we don't have any medical problems at the time, so can't figure out an ICD-9 code.

Female: I guess we'll have to take it under advisement. We've heard this question several times today.

(Carol Dawndee): Yes. That would be really helpful. Because we have a large number of these, and it's going to become quite an issue since we are being required to do ICD-9 codes.

Female: Yes, I mean, we have no suggestion as to what ICD-9 code you could make up, if there is no injury. So, you know, we'll have to take it back and come up with some advice accordingly, subsequent to this call.

(Carol Dawndee): Thank you.

Female: Are – just as a point of curiosity, are you saying that typically what the insurer is afraid of, and is trying to obtain a release against, is essentially a mental distress claim, and care associated with that?

(Carol Dawndee): It could be mental distress. Or it could be, you know, they got headaches or, you know, they had, you know, intestinal problems because they were worried. I mean, it could be all kinds of different things. It's not strictly mental.

Male: You're saying the parent or the spouse never filed a claim in the first instance.

(Carol Dawndee): No. Now, sometimes we do. Sometimes they're releasing, and they have made allegations already that there were medical problems, and that's not a problem for us, because then we can do an ICD-9 code.

But, routinely, they put in there that the spouse or the parent also is releasing their own medicals that are a result of this – of this injury situation for their child or spouse.

Female: OK, thank you.

Operator: Your next question comes from the line of Stacy Tromble from Ropes & Gray, LLP.

Your line is open.

Stacy Tromble: Good afternoon. I know you had mentioned at the beginning of the call that the clinical trial language is still in clearance. I was just wondering, is there any ETA? Any sense of when that might be released?

Female: Those of us in the room are working to have it out as soon as possible. I honestly don't have a date, because we originally thought it would be out by now.

Stacy Tromble: OK. Very good. Thank you.

Operator: Your next question comes from the line of Richard Schultz from Fireman's Fund (inaudible).

Your line is optimization.

Richard Schultz: Thank you for taking my call. On occasion, in workers' compensation, we have no periodic indemnity payments, but only a single permanent disability settlement. If medical is being left open, is a single indemnity payment a TPOC event?

Male: Is the indemnity payment (supposedly) closed?

Richard Schultz: I'm sorry, I couldn't hear you?

Male: What is the indemnity payment?

Richard Schultz: It could be for disfigurement. It could be for permanent disability where there was no temporary periodic disability payments. So, their indemnity payment, they may not be at the end of periodic payments. They may be the only payment that – the only indemnity payments, but ORM is not being settled and continues.

So, ORM continues and indemnity payment is being once. Not at the end of a long string of periodic payments. Is that indemnity settlement reportable as a TPOC event?

Female: We'll add that to one of the things for the alert dealing with periodic payments.

Richard Schultz: Because sometimes people can have permanent disability, but not miss time from work.

Female: Yes, I understand that. So ...

Richard Schultz: All right. So, the answer is to be determined?

Female: Well, we have – you said we have an alert that will deal with periodic payments, particularly indemnity payments. So, essentially I think we should fold that into the same one, to specifically address when ORM is left open – the effect of the permanent disability settlement.

Richard Schultz: All right. I look forward to it.

Operator: Your next question comes from the line of Bill Thompson from the Hartford Group.

Your line is open.

Bill Thompson: Thank you, this is Bill Thompson.

I have a question about the collection of Social Security numbers. We're starting to see some responses from plaintiffs' counsel who are reluctant to provide a Social Security number. And I was hoping that you might be able to put some guidance out. I know there's an older alert with respect to – that the collection of Social Security numbers is appropriate.

But we've seen some numerous letters that are similar, stating that we have no right to collect it until such time as a person – we've already determined that the person is a beneficiary. And it just seems to me that we're going to get a lot of these types of pushbacks.

Female: Well, we have the model language for you to use as a resort, when someone won't provide information about being a beneficiary. And if you, in effect, get the same language in a letter – a document, your process for how you made that determination, but you can, of course, as we've said – and if you're asking – tell me when I'm done here.

If you're asking whether we would consider an additional alert to reemphasize the fact that, for anyone who is a Medicare beneficiary, that they have an obligation to cooperate with coordination of benefit activities, then we can take that under advisement.

Bill Thompson: That's what I'm asking. But it goes a little farther than that, though. Because we need to be able to query. And so, like, I think the issue is, we need the Social Security number. And at the time, we don't know whether the person's a beneficiary. So, even if they're not a beneficiary, we still need their Social so that we can do the query.

Female: That's, in part, why we provided the model language for situations where you were not able to obtain a Social Security number or a HICN.

Bill Thompson: OK. Well, I guess I would like to take you up on your offer about an additional alert, that we could point plaintiffs' counsel to, that explains that we're just trying to comply with the new federal law, and that's why we need it.

Female: And right now, just to make sure that everyone is aware of the alerts that are published on this topic, they're on the "what's new" page of the Web site. And they're dated August 24, 2009. One is an alert entitled "Compliance Guidance Regarding Obtaining Individual HIC Numbers and/or SSNs for NGHP Reporting." And the other is also dated August 24, 2009, "HICN and SSN Collection, NGHP Model Language."

Again, they're on the "what's new" page of the section 111 mandatory (INS REP) page.

Female: But I will take your request back to the other folks working on this and see whether or not they'll consider an additional alert of some type.

Bill Thompson: Thank you.

Operator: Your next question comes from the line of Louise Hensleigh from the Medical Protective.

Your line is open.

Louise Hensleigh: Yes, thanks for taking my question. Essentially, what – the problem we're encountering comes from the fact that we are getting query responses that have yes. And in some states, in particular Florida, once we get that query response yes, we're trying to work with the plaintiffs, obviously, to protect the lien.

And we're getting tremendous pushback, and essentially encountering the situation where, in Florida, where, if you make a condition upon a settlement, that it can be construed as an impermissible condition, or an unreasonable condition of settlement, that allows the plaintiffs to claim bad faith.

So, what we're encountering is plaintiffs' attorneys refusing to accept offers that are contingent upon protecting the liens. And we don't quite know how to handle that, because in those situations, we generally have a small policy limit and a huge claim. And the only way we can protect our insureds is to tender the full limit. And we have plaintiffs' attorneys using our condition of protecting the Medicare lien as grounds for rejecting the settlement offers.

Do you have any comment on that? Or anything that we can do. We try to educate the plaintiffs' attorneys. It's not working.

Female: No, I don't have any particular comment right now, I mean, I will take your concern back and see whether anyone else has any additional thoughts.

Louise Hensleigh: Do you think that you'll be able to issue an update? Or anything regarding this for us to have guidance on how to handle this situations?

Female: I don't know that we will. Remember that we cannot give you legal advice.

Louise Hensleigh: When is there going to be a process where we can report plaintiffs' attorneys for preventing us from protecting Medicare's liens? Or anything?

Female: Anything you'd like to suggest, feel free to send in to the mailbox.

Louise Hensleigh: OK, well, I'll suggest a process. Because I think we should be able to have some sort of safe harbor with respect to our efforts to protect the lien and being thwarted by plaintiffs' attorneys who refuse to let us do that.

Female: OK.

Louise Hensleigh: So, I will suggest a process.

Thank you.

Female: You're welcome.

Operator: Your next question comes from the line of Claire Bello from Vertical Claims Management.

Your line is open.

Claire Bello: Good afternoon. I have a question with regard to patient compensation fund and reporting. The patient compensation fund that – well, we have – there are several, but they tend to, no matter when settlement agreements are entered into, they actually issue payments twice a year.

And so, my thought process in terms of reporting for them is to report the settlement date – the settlement agreement date as the TPOC date. And the TPOC amount is the settlement agreement amount. And use the funding – the later funding date as the date when the indemnity check would be cut. Is that correct?

Female: Let me ask you a question. You said that they issue payments twice a year. You simply mean that they issue them on all their settlements twice a year. You're not talking about a particular beneficiary getting two payments within a year.

Claire Bello: Correct. Actually, yes. They get court approval of the settlement agreement, and then, two times per year, they issue indemnity checks on all of the settlements settled prior to that particular payment date.

Female: OK, I guess what I want to distinguish for sure is the – George Jones got a settlement, you're talking about – he got it in January, so it'll be reported in June. You're not saying that George Jones is regularly going to be paid twice a year.

Claire Bello: Correct. The – yes, the (fast) pattern that we were looking at is, George Jones gets – settles a case. The court is – the court approval is received in February, which is your TPOC date. Which means it would be reported in that quarter, at the end of that quarter.

Female: Yes, what we're ...

Claire Bello: But the – but the indemnity check would be cut on July 15.

Female: What we have in process that we discussed in the (mat towards) workgroup, and it hasn't been issued yet, we haven't gotten any denial of the request, but it's not all the way through the clearance process yet is we are trying to get the directions changed so that it says as far as when to report. No reporting will be done until first of all who's being paid, you know the amount being paid and the funds are actually available. Which would virtually eliminate the use of the delayed funding block.

Female: So if they issue – so then their reporting requirement Section 111 wouldn't trigger until the quarter in which the funds were available?

Female: Yes. (inaudible) …

Female: OK.

Male: (Inaudible) …

Female: So then they would – what …

Male: … (inaudible) …

Female: … would they do …

Male: … (Inaudible) …

Female: … for the other quarterly reports? Just issue – just send up the empty reports?

(Inaudible)

Female: I'm sorry. For the other quarters?

Male: It – I think we lost you on that last …

Female: Sorry.

We know that there will be two quarters in which they're issuing payments because they make payments twice a year …

Male: Oh, OK …

Female: … once in July …

Male: … Oh, OK …

Female: … once in December. And so for those other two quarters they would just send either the e-mail saying there's nothing to report, or send up an empty report? Is that correct?

Female: Yes, it's an empty file, or inaction on the Web site. Indicating that you have nothing to report.

I actually have an update on that. We were to add the action on the Web site, the COB secure Web site to state that you have nothing to report. That was originally scheduled for the April release. It is not now. But so right – but, by the time you are required to report in January, we'll either have that action, or possibly remove that requirement related to submitting an empty file, anyway.

Female: OK.

Female: But, yes, that would generally be what you would do if you have nothing to report in that quarter.

Female: Terrific. Thank you. Oh …

Operator: Your next question comes from the line of (Victoria Vance) from (Tucker Ellis). Your line is open.

(Victoria Vance): Thank you, very much. I appreciate your taking the call.

I have a follow-up question. I just wanted to hear the sort of the status, I think I know, but just to be sure. Will we be expecting some guidance and some refined language on the definition of exposure as it relates to that 12-5-80 sort of threshold date. That becomes so important to companies and clients that are involved with settling these mass tort asbestos …

Male: Yes …

(Victoria Vance): type of claims.

Female: … it is one of the issues we're not done with. Any one who wants to suggest language to help us – the specific problem, as we've said more than once, is situations where allegedly there was no exposure on or after 12-5-80, but the releases that are being signed are routinely including a release for exposure on or after 12 you know 5-80. Liability is – medical services are being claimed and/or released for on or after 12-5-80.

One of the things in the mass torts work group which I will clarify for everybody, no, we haven't had any meeting in at least a couple of months. We are not necessarily done. We do expect to be looking at the 12-5-80 issue some more. But the suggestion at some of those meetings is there's some way to come up with clear enough language so that when there clearly was no exposure, the term or phrase that people were using is if there's uncontroverted evidence that there was no exposure on or after 12-5-80, can those be eliminated from reporting.

I know – I've talked to at least one individual recently who said that he had some thoughts of potentially how to write that up. I said send it into the mailbox so that it could be considered. So, if you have an approach, or anything that you think would help us get around that problem, please send to the mailbox.

(Victoria Vance): And thank you for that.

One quick follow-up. We sometimes hear discussion in the course of settling cases and claims about whether on the liability side, not worker's comp, but on the liability side, there is now, or is expected to be in the future, any vehicle such a what they refer to as a Medicare set aside, or starting to get into that sort of practice. Do you have any thoughts or any expectation that doing Medicare set asides is ever going to be something that enters the world of the liability and casualty payers?

Barbara Wright: It has already entered. As we've said on many calls, CMS has formalized process to review proposals for workers' compensation, Medicare set aside amounts. It does not have the same formalized process for liability Medicare set aside arrangements. The process for worker's compensation is voluntary.

We have a process for an informal process on the liability side that if a plaintiff's attorney or insurer, et cetera, wishes to approach the appropriate CMS regional office and the regional office has the ability to do so workload or otherwise, that they can choose to review a proposed set aside amount if they believe there is significant dollars at issue.

Again, it's not the same extensive process that we have for worker's compensation. But regardless of whether CMS has a formalized process, or regardless of whether or not you're participating in the formalized process for worker's compensation Medicare set aside, the statute has the same language in either situation. It's not parallel language. It's not similar language. It's literally the same physical sentence that we're not to make payment where payment has already been made.

So where future medicals are a consideration in arriving at the settlement, et cetera, then appropriate arrangements should be made for appropriate exhaustion of the settlement before Medicare is billed for related services.

(Victoria Vance): Thank you.

You've indicated that there may be times at some point in the future, some education may be put on by CMS that specifically addresses these MSP …

Barbara Wright: (inaudible) …

(Victoria Vance): … practices.

Barbara Wright: … more recovery issues, yes.

(Victoria Vance): Right. Is that expected to happen?

Barbara Wright: It's on the list of things that are being looked at and worked on.

(Victoria Vance): OK.

Barbara Wright: In the meantime I guess what I should say, if we haven't referenced it before, there isn't anything – there wouldn't be anything on – the MSPRC, the Medicare Secondary Payer Recovery Contractor is our contractor for recoveries related to liability insurance, no fault insurance, worker's compensation insurance, or even group health plan insurance.

They are not the ones responsible for reviewing the establishment, or proposed amounts, for set asides. So you aren't going to find information on their site about set asides. What you will find on their Web site is information about their recovery process and general steps, everything like that.

So if you're not familiar with that, you can go to their Web site, which is www.msprc.info, I-N-F-O, and they do have some PowerPoint presentations about the recovery process for GHP, the recovery process for non-GHP, they have information about proof of representative, consent to release, and other documents available on that site. So if you're not familiar with the process

and you want to start familiarizing yourself, I would recommend you check out their Web site.

(Victoria Vance): Yes, I've looked at it. I think it's very, very good.

Barbara Wright: They have also recently, I understand, I haven't had a chance to go look, but they are doing some reorganizing and beefing up the Web site in terms of trying to more categorize some of the information. I think they have a page for attorney tools. And they have some pages for other things. So if you haven't been there recently, you may want to recheck it.

(Victoria Vance): Thank you very much, Barbara. I appreciate it.

Operator: Your next question comes from the line of (Nancy Bircher) from Chevron. Your line is open.

(Nancy Bircher): Thank you, very much. This is a quick question.

In regards to the conversation that was earlier in for the DCN and the system problem that occurred, we're still in test mode and we did get error messages and we were trying to figure out on our end, should we resubmit our test now that it is been corrected in your system?

Female: Are you talking about query files?

(Nancy Bircher): Yes. It was the query file. It was all the blanks embedded fields.

Female: Yes. I would resubmit it so that you have – you get a response filed that has DCN said we're exactly matching what you submitted, and it will make your process a little bit simpler.

(Nancy Bircher): OK, fine. Because you're not going to reprocess those files, so we just need to resubmit it?

Female: Correct.

(Nancy Bircher): OK, great. Thank you very much. Bye.

Operator: Your next question comes from the line of (Cindy Hall) from Aon Solutions.

(Cindy Hall): Hello. Thank you for taking my call. I have two quick questions.

The first is in relationship to the disposition code of F50. While I know that that is expected to be a rare situation, you're user doc indicates that if we get a disposition code of a F50 on a transaction, that we are resubmit that the following quarter. When we resubmit that, we assume that that would still be – if it was the first time it was being sent in, it was an add transaction, and we assumed that it would still carry that status with it even if, perhaps, there had been additional information added to it, like dependent information, et cetera, that would have meant the second time we sent it, it would have been an update.

So I just need to clarify that. That when we resubmit it, it's still the original status that was submitted that we got the 50 on. Is that correct?

Female: Yes. The original action type, send the add again.

Actually, if you sent it as an add, or an update, in that particular case it will be treated the same. Because the original record will process to completion, and we might have some (inaudible) added, subsequent to returning the 52. When you submit the add the next quarter, it will treat that record as an update.

If on the other hand, it was a delete transaction you happened to be sending. That, again, will processed to completion. And if it was a successful delete, when you send the delete again the next quarter, it's possible that you'll get an error code back that will indicate we couldn't find the record to delete. Which is you know pretty much the same as you know letting you know that the prior delete transaction was successful. Does that make sense.

(Cindy Hall): OK. Yes. I think – so I guess I just want make sure. If I sent a transaction in Q1 of the year and it got a 50. And in between Q1 and Q2, a dependent information was added, and I send you the latest information, what I'm sending – or resubmitting in the second quarter is not exactly the same data as what was sent in the first quarter where I got the 50, is that OK? Because I'm sending …

Female: Yes.

(Cindy Hall): … you the latest …

Female: Yes. As long as the key fields match, we'll treat it as an update and take that new information and apply it.

(Cindy Hall): OK. Perfect.

Now my second question is related to ICD9 codes. I know the hot topic of today. And I have more of a basic scenario of it. And while only one is required, you will accept multiples. And let's say I have five ICD9 codes on a claim that I'm going to be submitting. And in our system's validation process we determine number one is valid, number two is not, number three, four and five are valid. When I populate those on your file, can I just populate them one, three, four and five, and leave ICU9 code, number two code blank?

Female: Yes …

(Cindy Hall): To correspond with our files?

Female: … yes. Yes, you can.

(Cindy Hall): OK. And the next – and real quick follow-up on that. Once I've sent you those four ICD9 codes, do I always have to send them in the same quarter? Next time?

Female: No. Not to my knowledge, no.

(Cindy Hall): (inaudible).

Female: I – you know – no, they do not necessarily have to be in the same order that you submitted them previously.

(Cindy Hall): Thank you.

Operator: Your next question comes from the line of Susan Cline from the City of Portland. Your line is open.

Susan Cline: Hi there. I have just two quick questions.

On page 85 of the user manual it says that one time payments for defense are not reportable. Does that mean you know one time payment for defense evaluation, a payment made specifically for this purpose directly to a provider or other physician does not trigger the requirement to report.

Well, in the worker's comp arena we sometimes have to do follow-up reports with – for defense. Are you saying all defense, or just the very first time like an independent medical exam?

Female: You're talking about if you had to have follow-up exams, or what?

Susan Cline: Yes. Like if – we're allowed in the State to have three different independent medical exams during the life …

Female: OK.

Susan Cline: … of a claim, while it's open.

Female: And would these always be paid directly to a provider, physician, or other supplier?

Susan Cline: It would be paid to an independent medical examiner. So it's more of an expense, rather than a medical.

You know in order to determine compensability of a condition.

Female: But I guess our point is when you say a medical evaluator, that's a medical professional?

Susan Cline: It's a medical professional. However, there's like – for independent medical exams, there's groups. So one independent medical group called like OME, has 100 different doctors. And when we request an independent medical exam for compensability determination, we go through OME. And the check is paid to OME as the IME company, but it is a medical provider who is doing

the evaluation and gets their compensation directly from the independent medical company.

Male: Is the independent medical company examining the patient?

Susan Cline: I'm sorry, it's hard to hear you.

Male: Huh?

Susan Cline: It was hard to hear you. I'm sorry.

Male: Is the independent medical company examining the patient? Or it's strictly medical records?

Susan Cline: They are seeing the patient, but not to develop a relationship with the payment. Just a one time visit and reviewing medical records.

From prior physicians.

Female: But they're not passing your payment to yet another physician?

Susan Cline: No.

Female: (inaudible) payment to them.

Susan Cline: Right.

Female: Our initial reaction is that we can probably lump it in with what's there, but we need to take it back to make sure no one else raises any other concerns.

Susan Cline: OK. All right.

And then one other quick question on ORM termination.

We are a lifetime medical state …

Female: Before you go on …

Susan Cline: OK.

Female: … can you write that up and send it in to the resource mailbox? …

Susan Cline: I will.

Female: … (inaudible) there that we said that we would look at expanding that language in the user guide …

Susan Cline: OK.

Female: … so we (inaudible) …

Susan Cline: I'll do that.

Female: … we don't (inaudible)?

Susan Cline: All right. And then the second quick question on ORM termination. Like I said, we're a lifetime medical State. We have two ways to close claims. One, is when the doctor sends a closing report and says the person is medically stationary which means they're not expected to get better with the passage of time, or additional medical treatment. And at that point we close the claim. Ninety-nine percent of the time the claim remains closed, there's not any ongoing responsibility for medical. They do have the option of reopening on an aggravation. And in that case we would reopen it and notify CMS.

So I think we're OK from that perspective. It says here – just let me read the rule, it says, to address the situation RRE's may submit a termination date for ORM if they have a signed statement from the physician that he/she will require no further medical items or services, regardless of the fact the claim may be subject, or otherwise subject, for further payment.

Female: Yes. No, in your phrasing of the description of what you got, I heard you say that they're stable and they've reached maximum medical improvement, or they won't require associated care. Just because someone's stable doesn't mean that they won't require ongoing associated care. So I guess we would have a little bit of concern about how you phrase that.

Susan Cline: OK.

Female: If it said that they're stable and they won't require further associated treatment. But phrase that strictly as an alternative for – particularly for catastrophic situations, or ongoing chronic conditions, the fact that they're stable or have – are they you know won't get any better, per se, is no indicator of whether or not they'll need care.

Susan Cline: OK. So I guess just changing our language and getting the information from the doctor would be helpful.

The other way that we close claims is administratively. Which is called like a bug letter, a 14 day letter. Do you know claimant injures his finger – scratches his finger, goes to the hospital, gets a tetanus shot, may get a stitch or two, and never goes back to the doctor. There's no time off. One hospital bill. We send a 14 day letter to the worker and the physician saying you know if you don't reply within 14 days – and this is 30 days after their treatment. So we give them you know a total …

Female: (inaudible)

Susan Cline: of 44 days to respond saying that they're you know they're fine, they don't need any more medical treatment. Is that going to be sufficient to …

Female: Well, if this is worker's compensation you said?

Susan Cline: Yes.

Female: Did you look at the criteria – I can't remember the page it's on.

Female: It's in Section 11.4 of the user guide. The interim reporting threshold. There's a threshold for reporting worker's compensation ORM that might …

Susan Cline: Yes.

Female: … might preclude you having to report that, at least until December 31st, 2011.

Susan Cline: OK.

Female: Claim is medical's only. There's no lost time. Or the lost time is no more than the number of days permitted. Or the …

Susan Cline: Right, right. Yes, I did see that. OK.

But let's say for instance it was somebody that you know went to the doctor and then disappeared off the face of the earth. And there's no – or moved to West Virginia or whatever. And we send a 14 day warning letter and they never follow-up. And the doctor never follows up. And we don't have a current address. And we don't have the you know no further medical treatment, dah, dah, dah, dah, dah. Then we have to leave ORM open?

Female: Techincally …

Susan Cline: (inaudible) accepted.

Female: … Technically, yes. So you'd …

Susan Cline: OK.

Female: … report it with an open ended ORM term date. And if the you know State worker's compensation law is such that you know you aren't able to terminate ORM, just leave it sit with a open ended termination date.

Susan Cline: OK. All right. Thank you very much.

Operator: Your next question comes from the line of (Michael Anderson) from Medical Insurance. Your line is open.

(Michael Anderson): Yes. Thank you for taking my question.

I have a case actually in Hawaii that creates two reporting issues, one of which was addressed by the gentleman from The Hartford, regarding confidentiality. And plaintiff attorneys citing confidentiality restrictions in responding to our information requests. What I'm getting from defense counsel is that they're actually claiming that State law prohibits them from even asking for the Social Security number so that we can query.

My first question is whether the model language would cover that?

(Audio gap).

(Michael Anderson): Hello?

Female: You're saying – the model language is clearly premised on the idea of going out and if the person refuses to give their Social Security number, or their Medicare claim numbers, stating that. I can't interpret for you whether or not your State law allows you to even send that model letter.

(Michael Anderson): No. I mean, obviously, our concern is remaining in compliance in the setting of State law that prohibits us from say serving interrogatory responses that request information that is prohibited under State law. I mean if there is – if we can simply send the model form and have them cite that State confidentially provision, in the eyes of CMS would that be sufficient?

Female: We can go back and discuss it with the folks who developed the model language.

(Michael Anderson): OK.

And this is on a particular case in Hawaii. But the second issue that's been raised is this – and I'll premise this with I'm a medical malpractice insurer, so it is completely fault based. And often we will get either a loss of consortium, or a wrongful death claim, that where the you know the patient is not the plaintiff for the purposes of the loss of consortium or the wrongful death claim. However, at the front end they are claiming – they are making a personal injury claim based on basically mental distress – emotional distress and needing some psychiatric care.

If later it bears out in the case that that claim is completely groundless and we end up settling the underlying matter, and specifically do not release medicals for this particular plaintiff. And what we're talking about is not the patient at issue, but say the spouse of the patient. If that claim is overall settled, but specifically medical special damages are not part of the release language, does that still fall under reporting based on it having been claimed at some point?

Female: But there is – the release, presumably, that you're talking about is then not signed by that spouse, and their claim is not – doesn't have a settlement, judgment, award or other payment, right?

(Michael Anderson): Well, what we'd be doing is building that into the release language. That we are specifically not releasing any claim being – that may have been made for medical special damages.

The problem is they're typically sort of piggy backed on to, say, a wrongful death claim. Where they're claiming that they needed to get, let's say, 6 months of psychological counseling. If, for whatever reason, that is not born out in litigation to be a merit – a worthy claim, but yet it has been claimed at some point, we end up settling the underlying wrongful death action for completely unrelated reasons. However, because it has been claimed and/or released at some point, and that spouse is found to be a Medicare beneficiary, what we're looking for is if we are not paying for those – that groundless claim for medical special damages, but are paying for other aspects of the case …

Female: (inaudible)

(Michael Anderson): … will the release language, if it is crafted in such a way that it does not release medicals.

Female: Typically, no is the answer. Because the point is we're not bound by allocations of the parties. We can't simply say well, you claimed it, but you crafted your release well enough so that it technically doesn't release medicals despite the fact that we gave you $5 million so you don't have to report.

I realize I'm hugely exaggerating there, but …

(Michael Anderson): Sure.

Female: … but our you know our standard is that we're not bound by the parties allocations in terms of allocations and settlements. And that includes crafting releases so that it doesn't appear that anything was allocated to medicals.

Now if there is a hearing on the merits, and a determination on that, that's a different matter. Can you hold on for just a second?

(Michael Anderson): Sure can.

(Audio gap)

Female: I'm back. The – what we put you on hold for, the person was going the same place that I just took you in terms of …

(Michael Anderson): OK.

Female: … if there is a hearing on the merits by a court of competent jurisdiction, then we – our standard is that we routinely defer to that.

(Michael Anderson): OK.

Now, sort of a follow-up and related question to that is if there is no claim for medical specials, but we're still in the situation where there is a wrongful death plaintiff, or a loss of consortium, which is the loss of care, comfort and society, not a medically based claim. If the release language is general that it will you know in the bucket of anything else, any other potential future claims, also includes medical, but does not specifically include medical. Is it sufficient to draft a general release, or is that going to trigger reporting as well?

And again, this is with medicals not being claimed on the front end.

M: What – why (inaudible) is the language in the release.

(Michael Anderson): I'm sorry, what was that (Bill).

(Bill): I – it's – I can't really react without seeing the language in the release.

(Michael Anderson): I see. But …

(Bill): The language is (inaudible) …

(Michael Anderson): … basically if CMS sees any reference to potential future medical claims and the nature of the claim itself, for instance a wrongful death action, does not typically include a claim for medical special damages on the part of the plaintiffs.

If in the general relief language though, CMS see a reference to potential future – any claims for potential future medical care, does that trigger reporting.

(Bill): My gut would tell me yes, because the medicals have been (inaudible) release.

(Michael Anderson): OK.

So basically – just to recap so I'm clear. If any amount of medical special damages are claimed by a plaintiff on the front end, and that plaintiff is a Medicare beneficiary, there is no way that that person can receive any money for any sort of claim regardless of the release language without having to be reported to CMS.

(Bill): Unless there's a finding on the merits before a court of competent jurisdiction.

(Michael Anderson): OK. OK, thank you very much for the time. Appreciate it.

Operator: Your next question comes from the line of (Michael Testone) from Hartford Insurance. Your line is open.

(Michael Testone): Hello. Thank you.

I was just wondering if you could give us a status – that status update as to when the mass tort revisions might be released?

Female: We are working as hard as we can to get as many updates or changes released within this calendar month. But as far as specific dates, I really don't have them to give you.

(Michael Testone): OK. And I just have a follow-up question as to …

Female: (inaudible)

(Michael Testone): … a comment that was made earlier on regarding the Group 1 and Group 2 claims. Where the payment doesn't have to be reported until the beneficiary is known, that the identity of the beneficiary is known, the amount is known, and the fact that it's funded. But there's also a discussion about sending in a notice to it – to CMS, an open file notice for I think the comment was maybe doing away with that …

Female: Well, there's …

(Michael Testone): … all together.

Female: … a couple of different things in what you just said. First of all, when we were talking about the concept of the injured party has been – is a beneficiary, they've – you've determined how much they specifically are being paid, not necessarily everybody in a class or group. But you've determined how much that beneficiary's being paid, and the funding is available. When we're looking at language for that, we're not limiting – looking at limiting that to Class 1 and Class 2. We are looking – our idea is, and this what needs to go through the clearance process, is the idea that we would extend that to all NGHPs. So to the extent that there is currently a delayed funding block, that would essentially become obsolete. So that's the first thing. And now I've lost track of what you said the second was.

(Michael Testone): Yes, I know. That is helpful, Barbara, thank you. The second part of that was – I remember we were talking about some (notice).

Barbara Wright: Oh OK.

Male: A settlement was executed without having that information and how that process would work.

Barbara Wright: So what I think you were referring to is we talked about we have a separate mailbox to essentially report class actions or very large groups beyond a certain (size). Just preliminary notification. And we don't have anything final on that, obviously. Or maybe not as obvious to the public. So we won't impose that without giving sufficient notice.

And we have had a request on this call that if we wanted to do anything like that, that there would be some way to report that under a (Sudo 10) so something else. So I guess if people don't like the idea of a separate mailbox, and they see some way to put that information into our record layout, certainly wouldn't mind seeing their suggestion.

Male: And (we've got) the reference earlier by the (empty) file or action on the web site, COBC web site was – that was kind of referring to what you just described.

Barbara Wright: There was one question during this call that I took to be a reference to that mailbox. Did they mention an (empty) file, I don't remember.

Female: I think the empty file issue was different. They might have been talking about – they were talking about the funding delayed the situation where they would only have something to report in two quarters out of a year.

Barbara Wright: Oh yes. That one.

Female: But this notification process really is separate from the (empty) file concept, or having nothing to report. But you know we certainly can accommodate you know whether it is a different record type in the file, or originally Barbara had talked with the (Master Oric) group about a – and you know sending an e-mail to a specially designated e-mail address at (CMS).

But it has not been worked out yet as to what you know would be a preferable approach.

Barbara Wright: The empty files, (Pat) right, an individual asked a question about a patient compensation fund that only cuts the checks twice a year for all individuals that it's making payment to, and asked what it needed to do in the two quarters in which it did not cut checks. And under the scenario that we just described you know they would only be sending in the reports when the funding was available, which would be the quarters when payment was actually made, when the fund actually had it available.

Male: That is helpful. That is very helpful. Do you plan to reconvene the (mastorite) working group before you issue the revisions?

Barbara Wright: We haven't made a final determination yet. We've got about a three or four page draft of some of the concepts there. And I am also – I want to be specific about those compensation funds only cutting checks twice a year. I am going to specifically take that back and make sure that people agree that that would constitute quote, funding being available.

Male: OK. All right well thank you very much.

Operator: Your next question comes from the line of (Tracy Nedorf) from (Frezno County Risk). Your line is open.

(Tracy Nedorf): Yes, I had previously asked a question about – we can receive – in California we can get claims directly from hospitals. And we don't know – they're on behalf of patients that they have treated. But they haven't necessarily been paid. They can – if it's a liability situation, say a car accident they can make a claim directly to us and we have to pay them back directly. Do we have to report that type of a claim? You had said you were going to check on it, and that was like in December. I have never heard anything.

Male: (inaudible) in the mailbox (inaudible) specific example. I'm a little bit lost. You are going to see a claim to a hospital without knowing you know who is being provided treatment or for what reason.

(Tracy Nedorf): Oh no. We would know why and we would know who. But our claimant in that situation is the hospital, not the patient.

Male: So the claimant (inaudible) the hospital. But my view would be if you didn't pay – so let's assume it wasn't a Medicare beneficiary, the hospital would look to the injured party for payment.

(Tracy Nedorf): Right.

Male: So in essence, you are making a payment to the hospital, not (behalf) of the injured party. (Inaudible)?

(Tracy Nedorf): Right.

Male: So in essence you are making payments to the hospital on behalf of the injured party.

Female: But let's back up a little. First of all, is this Workers Compensation? Is it no-fault, or is it liability?

(Tracy Nedorf): Liability.

Female: OK.

(Tracy Nedorf): In California.

Female: So if it – is this a matter that is still in dispute, that you have a claim from a beneficiary, or you have never heard from the beneficiary?

(Tracy Nedorf): Sometimes I may get a claim just from the hospital. Since we're a public entity, they have six months to file a claim. We don't solicit claims, so they have to come to us. So I may never get a claim from the patient. Normally I do. But sometimes I don't.

Female: Are you a liability insurer, or are you a self-insured entity?

(Tracy Nedorf): We're self-insured.

Female: OK. Then that is a – in that case, remember you have to be careful about how the word claim is used. In the record layout, claimant is (appealed), but it's only used when the beneficiary is deceased. What you've got is a situation where the injured party is the beneficiary, and you are making a (Tpock) payment.

(Tracy Nedorf): But I have – I am not going to have any way of knowing if they're a beneficiary. Because a hospital is not going to release their social to me of their patient.

Male: Are you going to be able to get a copy of the (2B92) and the (associated) (1,500)?

(Tracy Nedorf): I don't know what that is. It's a medical bill, you mean?

Male: (inaudible) standard uniform bill.

(Tracy Nedorf): OK. Yes I – they will give me their medical bill.

Male: OK. And the standard medical bill is not a standard industry-wide form. On the standard industry-wide form, they identify the individual and indicate whether or not they are a Medicare beneficiary.

(Tracy Nedorf): I don't normally see that. Sometimes they do. Sometimes they don't. So if it doesn't indicate on the bill that they're a Medicare beneficiary, then I can assume that they're not?

Male: If – no. I would say that if you get something other than the standard industry-wide bill from a provider, I would ask them for the standard industry-wide bill. That's what I would do personally.

(Tracy Nedorf): OK.

Female: And then – and I would remind everybody, because we're going to have to wrap this up. We all have other meetings (inaudible) time is, we consider most of the calls except for the issues we have identified that are still pending, we consider most of the issues that have come in through the mailbox as being addressed in the user guide et cetera.

If you have outstanding issues, then it's fine to cut and paste and send the same one in. If you believe we have an issue. But particularly for (RRE), if you have a question and you believe you don't know who the (RRE) is or there is something that is unclear then you need to submit a new question to the mailbox and tell us what it is you believe is unclear.

If there's an issue that was several months ago, like this particular one you don't believe we've answered, then feel free to submit it again. We have thousands upon thousands of questions that have come in. And we're doing our best to keep current and make sure they're all addressed. But obviously in some instances we may drop the ball. OK.

Female: So is your advice to this caller to resubmit that question, or?

Female: From what you've given us, it is a (Tpock) payment. So it does need to be reported. It sounds like you have got an outstanding issue in terms of exactly how you'll collect the information to report it. But if they are a Medicare beneficiary, and they're the injured party, and you're self-insured with liability insurance, then yes it is your obligation to report.

Operator could – you come back to us after we wrap up the call. But for everybody who has participated, we want to thank you. We do – we are going forward with two calls a month for the next few months. All of those should be posted on the web site.

And again, we thank you for your participation.

Operator: This concludes today's conference. Callers, you may now disconnect.

END