TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: May 27, 2010

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
May 27, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Krista) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, MMSEA 111 NGHP Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Thank you.

Mr. John Albert, you may begin the conference.

John Albert: Thank you.

And good afternoon, everyone. Just for the record, today is Thursday May 27th, 2010. This teleconference is for the purposes of implementing Section 111 of the MMSEA. This is a non-group health plan policy call. As these calls usually go, we'll have some presentations in the beginning, and then we'll open it up to a general Q&A session.

I have a cast of people here to – some of them that you're familiar with and another person who will – that's going to provide a brief statement on the registration process – (Cynthia Ginsberg).

The first thing I wanted to let everyone know on the phone is that while you have not received an automatic notification, we recently, on May 25th, posted on the Alerts page, information concerning the new direct data entry reporting option that will be available in January 2011 to smaller RREs.

I'm not going to go into specifics about – just let you read the alerts if you have not seen them. Once we actually move it to the correct section of the Web page, we will – you should receive an automatic notification that it's out there. But again, it is out there right now on the Alerts page of the Section 111 Web site – or not the Web site but the mandatory insurer reporting Web site.

So other than that we have a brief announcement concerning the registration process from (Cindy Ginsberg) and then (Barbara Wright) will follow with some presentations on some other forthcoming alerts that are in the queue to be posted imminently.

So, (Cindy),

(Cindy Ginsberg): I just want to give you two reminders. If you have inadvertently registered for more RRE IDs than you will be using, please contact your EDI rep or the EDI rep department at its general phone number, which you can find on the Web site, and ask them to delete those RRE IDs that you won't be using.

You may have inadvertently done this by going to the Web site to register and then leaving the Web site and then coming back and starting all over again. So you may have more IDs than you think you do. So please check with your EDI reps or your authorized reps and make sure that the RRE IDs that you have are – you're going to be using them. And if not, please call and get them deleted.

One other announcement about registration, if you have received your profile report and you haven't signed it, you must sign it or your progress for that RRE ID will not move forward. Even if you're – you've decided that you're going to be using an agent to report your files and your information, if your (RR) ID – if the profile report attached to your (RR) ID is not signed and returned, your status will not progress and they will not be able to submit any files for you.

So please make sure you sign your profile reports and return them. It is up to your authorized rep to sign it. Your agent has no connection to your profile report.

John Albert: Thanks. Thank you, (Cindy).

And again just as a reminder this is a call directed toward NGHP policy. We do have some technical folks here, but again, when we get to the Q&A process if we receive more technical questions, we're going to defer those to the end of the call so we can get the policy questions addressed first, which his the purpose of this call.

(Bill) did you have (inaudible)? OK. And with that I'll turn it over to (Barbara Wright) who's going to present some information and then we'll get into, I guess Q&A, unless you have anything to (add).

(Barbara Wright): No, I don't (inaudible).

John Albert: OK.

(Barbara Wright): Thanks, John.

The first thing I'd like to address is just something about our dedicated Webpage. I've seen two – or – one or two notes recently that sent something into the resource mailbox and said they'd tried to submit a question to the "submit feedback" button that's on the Web site. We want to remind everyone that that's an internal feedback button.

For you to contact us you need to just specifically send it to the e-mail address that we have in the document that lists the opportunity for public comment. Do not try and use that submit feedback button. You will not get anywhere with it.

Male: The e-mail address that Barbara is referring to can also be found on the mandatory insurer reporting, what's new page at the top of that page too.

(Barbara Wright): OK. Next I'd like to mention – people have asked about further meetings for what was previously called the (Mass Torts) work group. We expect to be sending an appointment out within the next week. So please don't bother to ask questions about that when we get to the Q&A part.

And now, we have four alerts that are policy alerts that are in the queue to be posted right now. The first one is for clinical trials. And it's a very short alert, so I will just read it. Again wait until you see it on the Web site – hopefully it will be posted tomorrow. If it's not, it should certainly be there by early next week.

What that alert says it when payments are made by sponsors of clinical trials for complications or injuries arising out of the trials, such payments are considered to be payments by liability insurance including self-insurance and must be reported. The appropriate responsible reporting entity should report the date that the injury/complication first arose as the date of incident. The situation should also be reported as one involving ongoing responsibility for medical. That is the total alert.

The next one is for periodic workers' compensation and no fault payments. And again, I'll simply read through the alert. This alert addresses periodic workers' compensation and no fault payments. In situations where the applicable workers' compensation or no fault law or plan requires the RRE to make regularly scheduled periodic payments pursuant to statute for an obligation or obligations other than medical expenses, to or on behalf of the claimant, the RRE does not report these periodic payments as long as the RRE separately assumes or continues to assume ongoing responsibility for medicals and reports this ongoing responsibility for medicals appropriately. Otherwise, such scheduled periodic payments are considered to be part of and are recorded as ORM.

And then we have an example in the alert. If an RRE is making periodic indemnity only payments to the injured party to compensate for lost wages related to the underlying workers' compensation or no fault claim, the RRE has implicitly, if not explicitly, assumed ORM. Therefore the RRE shall report the ORM. The periodic payments to compensate for lost wages are not reported as (tpoks).

We have not changed our position that if there is a (tpok) situation that includes periodic payments, that that whole amount must be reported for the (tpok).

OK. The next alert is simply a revision to the February 24th alert that was talking about who must report, who is an RRE. In the appendix, we had an error when it first came out, so this alert simply fixes that error. And the definition or information about liability insurance, the second paragraph is completely deleted and it's replaced by the following, where an entity engages in a business, trade or profession, deductible amounts are self-insurance for MSP purposes. However, where the self-insurance in questions is the deductible and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible.

This is language that is already in the alert itself. But it does serve to replace what was paragraph 2 in this appendix before.

The last alert I want to talk about is one for risk management write-offs or other actions. And as we've discussed in the past, for the purposes of Medicare secondary payer, an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk, whether by failure to obtain insurance or otherwise in whole or in part. Risk management write-offs, including a reduction in the amount due as the risk management tool, constitute liability self-insurance for the purposes of Medicare secondary provisions. So then from this point on, I'm just going to read the alert exactly.

As a risk management tool, to lessen the probability of a liability claim against it and or to facilitate or enhance customer good will, entities may reduce the amount due for items and services, (parens) write-offs or provide something of value (parens) e.g., cash, gift card et cetera. If an entity takes such actions, it may or may not constitute a reporting obligation (parens) as a (tpok) as explained below.

And the first bullet reads, in instances where a provider, physician or other supplier has reduced it charges or written off some portion of the charge to a Medicare beneficiary as a risk management tool, the provider physician or other supplier is expected to submit a claim to Medicare reflecting the

unreduced permissible (parens) e.g. limiting charges and showing the amount of the reduction provided or write-off as a payment from liability insurance (parens) including self-insurance.

Medicare's interest with respect to this particular (tpok) amount have been protected through this billing procedure. The provider, physician or other supplier shall not report the write-off or value of property provided as a (tpok).

And then the second situation for providers, physicians and other suppliers is where they provide property of value to a Medicare beneficiary as such a risk management tool. When there is evidence or reasonable expectation that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the write-off or value of the property provided as a (tpok) from liability insurance. If the value of the property provided is less than the (tpok) reporting threshold, it need not be reported under Section 111.

The difference between these two bullets are, if it is a provider, physician or other supplier and you're reducing charges or writing off charges, you must show this through the billing process. This is not something new. It's something you've been required to do.

And because that's done that way, in those two situations you don't have to do a separate Section 111 reporting. You cannot choose to do Section 111 reporting instead of proper billing. If you have a situation where you're providing something of value other than specifically a write-off or reduction of charges, then it's subject to the Section 111 reporting and the threshold.

With respect to an entity other than a provider, physician or supplier, we've said in instances where any other entity has reduced its charges or provided property of value to a Medicare beneficiary as such a risk management tool, when there is evidence or a reasonable expectation that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the write-off or value of the property provided as the (tpok) from liability insurance including self-

insurance. If the amount of the write off or value of the property provided is less than the (tpok) reporting threshold, it need not be reported under Section 111. And that's the end of that alert.

One other thing that I want to mention that's still under discussion here, and I caution that this is where we're leaning at this point, but we have not reached an absolutely final conclusion is we've had questions that have been raised about cumulative trauma and what should be used as the date of incident for that.

And right now what we're leaning toward is saying that you should provide the date of incident as – essentially the same type of language that we used in the clinical trial alert that the date of incident is when the injury or complication first arose. So that's where we're leaning on that issue.

And, John, with that, I think that's our announcements for right now. I think we can go to Q&A unless anyone has something else.

John Albert: Yes. The – just for – to add to it again the – how to submit questions, the alert was dated April 10th, 2009. It's the opportunity to comment on Section 111 of the MMSEA. So again if you need to submit questions, please use that process and the address on that document, which is right on the homepage of the Section 111…

(Barbara Wright): Oh, I have one last thing to say about the alerts I forgot, is we are running out of space again on our alert page. So I was informed when I submitted these alerts to put in the queue that it's likely that part of them will be on the alerts tab and the others will be on the actual liability no fault workers' compensation tab. But I was also told that the what's new tab should tell you exactly where they're located.

John Albert: OK. And that's all that we had this time. We'd like to now open it up to questions. And again, please limit your question to one and one follow up and also to more policy specific questions. We reserved this call for policy questions, but also ask the – to have the name and entity the person represents as well.

Operator?

Operator: At this time I'd like to remind everyone, in order to ask a question, please press star number 1 on your telephone keypad.

Our first question comes from the line of (Paul Schaffer) from (VCM).

Your line is open.

(Paul Schaffer): Hi. This relates to the State of Texas. In the State of Texas, you can opt out of workers' compensation and become a non-subscriber. And I've heard a couple of different stories but it seems like the majority of them says that the line of business that we would put in there is liability since you're – you have – since in turns into employer liability. I just want to confirm that you wouldn't put workers' compensation because, you know, you're kind of doing a lot of the (stuff) similar to workers' compensation?

And I was also told that an alert was going to come out on that (inaudible) as well.

(Barbara Wright): Actually – this is (Barbara) – I thought that we'd already addressed that in the user guide, do you remember, (Pat)?

Female: I have no – I don't. That doesn't sound familiar to me, no.

(Barbara Wright): We'll go back and look, but I think you're correct that we did say that where you've opted out of workers' compensation, it is in fact reported as liability insurance.

(Paul Schaffer): (And you thought it was in the user) (inaudible)?

(Barbara Wright): (Pat Ambrose) is saying she doesn't remember it being addressed. I have sort of a visual memory of it being addressed but I can't tell you exactly where…

Male: We'll see if…

(Barbara Wright): … right now so…

Male: … if we could – we'll see if we can find it on the – while we're on the call.

Female: Yes. I'm looking right now, and if we find it we'll announce that later in the call.

(Paul Schaffer): OK. Great. Thank you.

Operator: Your next question comes from the line of (Diane Duffy) from (ACR).

Your line is open.

(Diane Duffy): Hi. My question is related to workers' comp and deceased claimants. As we're going through and cleaning u our claims getting ready for the reporting, we're finding we do – we are in a state where there – where claims do get closed under statute after X number of years of no activity. And we're finding that there are claims that are supposedly or technically open under statutes but the claimant died well before 2010. Are those claims reportable?

Male: (Inaudible) I mean the case obviously closed when they died…

Male: Yes.

(Diane Duffy): Our ORM ended on the date that they died, yes.

Male: Yes.

(Diane Duffy): So then we can treat that then as that's when the statute ended as well and not – they're not reportable?

Male: Yes.

Male: Yes, although I'd find that hard to believe that the statute didn't contemplate that the claim would end when the person died, at least with respect to ongoing medical.

(Diane Duffy): I mean – yes, I'm not sure about that. In our system, the statute is generated sort of automatically based on the number of years, you know, projecting out

from the last date of activity. So we're just – I just want to make sure that we're reporting properly.

Male: No, if they've died, there isn't anything – if you're talking about ongoing responsibility for medical and they died before 2010…

(Diane Duffy): Yes.

Male: … there isn't any ongoing responsibility to report.

(Diane Duffy): OK. Perfect. Thank you so much.

Operator: Your next question comes from the line of (Bernce Anderson) from (Beacon Mutual).

Your line is open.

(Bernce Anderson): Thank you, my name's (Bernce Anderson) from (Beacon Mutual). My question concerns the interim reporting threshold found on page 52 of the user guide, that's the one where if it's no lost time under $750 and no more than 7 days out of work, those people don't have to report it. And my question is if it's less costly for us to report people who fall below that threshold, can we do that?

Female: I will go back and check whether or not that creates any complications in our other system as opposed to the system that would take the information in.

Male: We had (inaudible).

Female: Now, I mean we have no way of editing the ORM record as reported. So you won't get a system error but I believe (Barbara) is indicating that it is not preferable to see amounts – to have the information reported…

(Bernce Anderson): I mean, obviously there will be, you know, the Medicare beneficiaries and we will have assumed ORM so every other criteria will be met.

Female: Well, but it may also cause some convenience for you – inconvenience for you too, particularly the ones where we're talking the ORM with no days lost

from work et cetera. Because what it means is the system will reject payment for claims related to the associated diagnosis code until such time as it has proof that workers' compensation is not going to pay. So you know, I will – I will go back and check…

(Bernce Anderson): OK.

Female: … from our perspective, but it also – we were also taking into consideration hopefully some of the claims processing issues.

(Bernt Anderson): No. I understood. I – originally I thought this was really for the carrier's convenience.

Female: Well, it's both.

(Bernt Anderson): Yes. All right. Could you run that exception or concern by me again? I didn't quite follow you. What might be a consequence?

Female: Well the purpose of setting up the ORM records is so unless the provider or supplier submits information indicating showing that the workers' compensation is not – will not pay for the related care that our systems/contractors would deny payment to that claim until they had such proof.

(Bernt Anderson): In our state that would be appropriate because even though we only pay $350 initially or something, unless we took some formal court action to shut that down, which we would have to report to you, we would be on the hook for those medicals if they incurred some in the future.

Female: Yes. I understand it was – like I said it was looking at all different factors. We will check on it.

(Bernt Anderson): Oh, and how will you let us know?

Female: We will address it on the next call.

(Bernt Anderson): OK. Thanks very much.

Male: Did you submit that question to the resource mailbox?

(Bernt Anderson): I did not. But I can.

Male: Yes, we would really appreciate that and if you want to reference today's call or something in the subject line.

(Bernt Anderson): All right. Thank you.

Male: Yes. We appreciate that.

Operator: Your next question comes from the line of (Carol Inaudible).

Your line is open.

(Carol Inaudible): Hi. I wanted to know, last time you mentioned that if you had an employee claim and they signed off on medicals but there were no specific medicals that had been talked about at that time that you did not have to report. I wanted to know if that might also be true for the co-signers of a medical claim for say, a spouse or a child where we also always have the parent or spouse sign off on medicals. Sometimes there are medicals already specified and of course we could report those, but sometimes there are no medicals specified or only loss of consortium, do those need to be reported?

Female: We're looking at each other here, and we don't remember saying exactly what you just reported.

(Carol Inaudible): You don't remember that if it was – I thought that it came up in the last policy meeting that if it was an employee situation and they were just signing off on medicals, even though no…

Female: Now, if you're talking – I think we may have said that in connection with a severance package. But that's different than, you know, a claim other than, you know, a situation that involves other than severance…

(Carol Inaudible): OK.

Female: … that was a severance package with a general release…

(Carol Inaudible): OK.

Female: … that was in reference before.

(Carol Inaudible): OK. But so…

Female: Well, with respect to severance package, that's fine. But if it's some other type of claim, it's not fine.

(Carol Inaudible): OK. So we're still having to report, but what in the world are we going to use for and ICD-9 code when there have been no medicals specified yet – at the time of the release?

Female: A translation from the description – the alleged injury that's claimed.

(Carol Inaudible): Well, I'm talking about a co-signer. So yes, of course I have something for the person – the main person who has the injury, but many times we have a spouse or a parent also sign a general release of medicals and…

Female: Can I – can I – can I ask you a question?

(Carol Inaudible): Yes.

Female: When they sign a general release of medicals, are they signing a general release of medicals with – for themselves?

(Carol Inaudible): For themselves, for themselves…

Female: Even thought they're not a party to the whole matter?

(Carol Inaudible): Even though they're not because there are many illnesses that are stress related or exacerbated by the stress of maybe caring for their spouse or child who did – is the one who has the injury, that could come up. And so of course, if anything's come up already then we have something to report.

But many times we ask them to sign the medical release when we're doing a settlement and there is no medical issue at that time, but we don't want them coming back, you know, 2 years from now and saying oh my gosh, you know,

I'm having these terrible migraines because of this – of having to take care of the person who was injured. And – but we don't have anything to report. We don't have an ICD-9 code.

Female: (That) co-signer an injured party?

(Carol Inaudible): The co-signer – yes, we always have the spouse and, if it's minor, the parents have to sign off on these (general release) (inaudible).

Female: (Inaudible). My question – my question is – is you know, would they be considered an injured party – these other – at that point in time that they're signing that release?

(Carol Inaudible): If there's – if they have claimed nothing specific then, you know, at that time, no (they're not an injured party).

Female: Have they – have they claimed anything at all? Are they – are they any entity that's going to receive payment, are they, you know…

(Carol Inaudible): Well, of course the parents usually – you know, receive the payment when it's a minor…

Female: But do they receive payment on behalf of themselves or are they receiving it solely on behalf of the child?

(Carol Inaudible): I'm not sure about that. I know if they are claiming loss of consortium, then I believe it's understood that the payment is partially for the spouse.

Female: We're going to have to take it off line. We just don't have a definitive answer here.

(Carol Inaudible): All (righty). Thank you.

Female: So yes, you know, as usual, please resubmit that question and – specifically and we'll just have to reevaluate it.

(Carol Inaudible): Thank you.

Operator: Your next question comes from the line of (Yvette Griffith) from (Brown and Brown Insurance).

Your line is open.

(Yvette Griffith): Hi. I'm with (Brown and Brown Insurance) and our question is we'll use the (NCCI) code and we were discussing the (E) codes in a meeting yesterday and we were wondering is there any – because some (inaudible) are so specific and the others are not, is there any kind of crosswalks between the (NCCI) codes and the (E) codes?

Female: Not that I'm aware of, and I don't think anyone here – no I'm sorry we're not aware of any crosswalk.

(Yvette Griffith): OK. So those two – those two – there – there's no – there's no communication between (NCCI) and what would – what would be the (cause) code?

Male: I don't think so.

(Yvette Griffith): OK. All right. So…

Female: Again, if you have not submitted that question, please do so, and we can research it further and perhaps provide something on the next technical call.

Male: Yes, we're – I mean in recognizing the need for outreach related to the (ICD) codes, we're trying to prepare as much material as possible for that, so…

(Yvette Griffith): OK. Yes and we're just trying to – it seemed – it seemed to us that there – that there would be some kind of – some kind of crosswalks with those two. We can submit that question with our further details.

Male: We appreciate it.

(Yvette Griffith): OK. Thank you.

Operator: Your next question comes from the line of (Joel Casey) from the Office of the Special Deputy.

Your line is open.

(Joel Casey): Hi. I have two questions that are related to insurance companies that are currently in liquidation. I am handling the payment of claims for those companies. And the first one has to do – I'm paying a hospital claim on behalf of a Medicare beneficiary, and I believe I do have to report that, correct?

Male: Hospital claim – who filed the claim?

(Joel Casey): The claim was filed by the hospital and we do note that the claimant is of age and they do have Medicare coverage listed, you know, on the medical bills.

Male: So it's a payment on behalf of…

(Joel Casey): Yes, it'd be on behalf of the Medicare – of the Medicare beneficiary.

Male: I would think it would need to be reported.

(Joel Casey): OK. And I have a separate question, kind of – it's related to liquidation where we won't make a payment immediately though because the company's in liquidation, it could be you know, 6 months, 9 months before we actually pay the claim and sometimes we get reassignments of benefits where a third party will come in and buy out the claim.

You know, where someone will come in and say oh, a third party administrator will come in a buy out that hospital claim. You know, they'll give them 50 cents on the dollar and then suddenly I'm paying a different third party person, would that still be reportable under that condition?

Male: (Inaudible), you'd report it as – yes because you're paying for the medical items and services.

(Joel Casey): Yes. OK. I understand that. And what – we don't need though – I noticed we don't identify the payee. It's – we're just identifying the injured party and the (tpok) amount and we're not going to worry that the payment was made on behalf of them. There's no way to identify that (in) reporting, correct?

Female: Correct.

(Joel Casey): OK. Thank you very much.

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

Your line is open.

(Bonnie Muscard): Yes. Thank you very much. I have a question relative to the reporting of ORM termination within 6 months. I missed the last call. I don't know if it was discussed. You know, originally we were to be able to forecast ORM termination, and then we were advised that we would have – we could only report it within 6 months, has there been any further review of that?

Female: No, that still is a system requirement that we will accept future dates in the ORM termination date, but we cannot accept a date that is more than 6 months in the future compared to the date that the file is submitted – or really (it's) the date that we are processing that file.

We pass information onto other systems and one of the systems that we must post this information to currently does not allow us to post a termination date more than 6 months in advance. So we have it on the list of concerns. And we are looking at some changes related to that and to the requirement that the T – I mean the termination date cannot be less than 30 days from the date of incident.

We're looking at both of those to see what changes that we could make, but currently no change is scheduled. So you know, it's on the list to see what we can do about that. But for right now, you should plan your system development such that you do not send ORM termination dates more than 6 months in advance. So essentially, you have to hold that report until you're within that time period and then make the report when that termination date will be accepted.

Female: Also please remember that you're not to report contingent termination dates. So if there's anything that could occur that would keep – meaning that the record stayed open, you should not be submitting that termination date ahead of time.

(Bonnie Muscard): Right. Let me ask you one other question related to this. On the ORM termination, where we aren't able to file that termination date until within 6 months of it, looking at the laws and requirements across the country there are varying laws where, you know, an ORM could stay open for anywhere from 3 years to 10 years or of course, you know, almost literally never close. But let's use the example of an ORM termination date is estimated to be 3 years or 10 years down the road due to the statute and we have an exhausted limit.

So in that time span, one of the things we're looking at with our system and trying to identify how we're going to deal with it in the case that CMS adds additional fields, deletes fields, changes field requirements, any of those types of issues, we're trying to figure out what are we going to do 3 years or worse yet, 10 years down the road when that additional field in particular, would require contacting and identifying that individual to secure that information.

Female: Well, we'll take that under…

(Bonnie Muscard): (Inaudible).

Female: … you know, we'll take that under consideration if changes are made to the reporting going forward. You know, I understand what your concern is, that you would have to – it would be a difficult task possibly to get that additional information if you – for the (inaudible) in terms of the – any changed reporting that comes up not requiring it on such a record, perhaps down in the future.

Now, right now, we have indicated though that the ICD-9 codes that we're using and then when we switch to ICD-10, you know, that will be you know, we're – we'll be each year updating our list of acceptable ICD-9 codes, you'd still have to take that update record and run it through, you know, an edit process to make sure that it will pass those basic requirements and you know,

perhaps have to modify some of the codes on it. But any new fields or new requirements, we'll most certainly have to take that into consideration.

And as I said we are trying to make a change to these other systems such that we could accept a future date farther out. So I mean, I don't know what else to tell you at this point other than, you know, I hear you loud and clear.

(Bonnie Muscard): I guess – and I appreciate that. I guess the thing is that I don't know if I – I just can't believe other companies have found a simple solution to this, but I'll look at it – we are looking at it very actively. And you know, even for example, you made the comment ICD-9 codes have to pass the edit when submitted – when submitting the ORM termination data.

I have to say for all of the time we've spent on that that's not an issue that we had identified. And you know, these are – these are very complex and difficult issues because you're talking about people handling something, in many cases manually here that have – are so long past our handling times that it – you know, it – just additional time, hands on (inaudible)…

Female: Right. Right and again I could see we understand the point that you've made. We can't give you some satisfaction today. But we've definitely made a note of it, and we'll see what we could do in the future to you know, alleviate this concern.

(Bonnie Muscard): I appreciate that. Thank you so much.

Operator: Your next questions comes from the line of (Rulan Alen) from (Morgan Lewis).

Your line is open.

(Rulan Alen): Hi. I joined a few minutes late, so if you've already covered this I apologize. But I was checking to see if the (inaudible) (torts) conference call or (town hall) meeting's been set yet?

Female: No. One of the things I said at the beginning was we hope to have something out within the next week.

(Rulan Alen): OK. I signed on a few minutes late so I probably missed that, my apology. Thank you.

Male: Operator?

Operator: Your next question comes from the line of (Emily Schultz) from (Morgan Lewis).

Your line is open.

(Emily Schultz): Hi. I have a question involving the proper registration of the correct RRE. I had a new situation come up – actually two scenarios. One, a parent company has a subsidiary that they now own or acquired but another company actually accepts tender and payments for the claims. Based on your alert from February 24th, am I correct in thinking that the – that other company actually pays the subsidiary's – since they actually pay the subsidiary's Medicare claim, then is it responsible for reporting or is my parent company responsible because they now own it?

Male: Well, the subsidiary itself could be the RRE or its parent company could be. But just because there's an agreement, essentially for indemnification by a third party, doesn't make that third party the RRE.

(Emily Schultz): Well, I guess what I was trying to understand is that if – based on page 3 of your other alert – it tried to clarify that it is the party that ultimately funds the payment and the company that ultimately funds the payment is not the subsidiary.

Male: (But the party) that signs the payment is acting as an agent, are they not?

(Emily Schultz): I think it's the company who used to own.

Male: But they're acting as an agent now of the other company?

(Emily Schultz): I guess. They've retained the liability in whatever agreement that was made in the corporate transfer.

Male: If they're acting as the agent, the agent is not an RRE.

(Emily Schultz): OK.

Female: If you want to send this in and point out where you think in the alert we're contradicting ourselves or not making ourselves clear, please feel free to do so.

(Emily Schultz): OK. And I guess sort of as a follow up the other situation is that a parent company has a former subsidiary that it no longer owns but it does maintain the liability and pay those claims. So in that situation how do they register that subsidiary as an RRE?

Male: I'm not sure what you mean by maintain the liability.

(Emily Schultz): OK. The parent company sold the subsidiary…

Male: OK.

(Emily Schultz): …but the parent company in that corporate transfer kept the liability for litigation claims and paid them. But they no longer own the subsidiary that would technically be the RRE. But because they're paying them…

Male: (An) asset sale.

(Emily Schultz): I'm sorry?

Male: It was essentially an asset sale?

(Emily Schultz): I think so.

Male: (It) seems to me that the parent company is the RRE with respect to those claims (inaudible) did retained liability.

(Emily Sshultz): OK. Because I saw that on page 4 of the February 24th alert. It says the acquiring company – I believe – just a second – it says that the acquiring entity is the RRE with respect to acquired claims so…

Male: It makes (inaudible)…

Male: (Inaudible) acquired the claims…

(Emily Schultz): But they didn't require the claims so that would make it then…

Male: (The parent company).

(Emily Schultz): … the parent company. Because they actually pay them.

Male: Well, they kept the legal responsibility for them…

(Emily Schultz): OK.

Male: … it's not about physical payment. It's that the company that was sold didn't…

(Emily Schultz): OK. So in that situation, does the parent company simply – do they simply become the RRE or do they have to register that former subsidiary separately since that is technically the entity who it is being paid from – like under their policies and that sort of thing? I guess I'm trying to make sure that…

Male: (Inaudible) RRE, that I would not think we would want two RREs that way for the same company, some reporting some claims and some others…

Male: If the parent company is already registered, it can simply report. If it wants a separate RRE, just for all those – I'll call them hanging (on) claims or something, then it could register just to have an RRE ID just for that group of claims that it has retained in connection with that sale…

(Emily Schultz): OK.

Male: … but it's really up to them.

(Emily Schultz): But it wouldn't be necessary to have any sort of a tax ID number or other documentation because they no longer own the former subsidiary? It would just be under the parent company's information?

Male: Yes.

Male: Yes.

Male: Yes.

(Emily Schultz): OK. Thank you. That's all I have.

Operator: Your next question comes from the line of (Susan Cornpla) from New York (Inaudible) IMS Fund.

Your line is open.

(Susan Cornpla): Hi. I have a couple of questions. First one is with the disposition code of O3, you've indicated that you're not – that means that you're not accepting the record. Even though you're not accepting the record, you're still giving us information back, right? Because that's what it says in the user guide.

Female: Those fields in the user guide that are listed there, we are giving you some information back on your response record. It's a matter of the – the 03 means that the information that you have supplied does not affect Medicare claims or Medicare payment…

(Sharon Cornpla): OK.

Female: … it's not – Medicare is not secondary. In other words the other insurance that you're reporting doesn't overlap Medicare coverage (inaudible)…

(Sharon Cornpla): Right.

Female: … OK?

(Sharon Cornpla): Right. I think you've indicated it was like you're not accepting the claim but you're still giving us information back.

Female: Yes. I mean…

(Sharon Cornpla): OK…

Female: … we're – it's, yes.

(Sharon Cornpla): OK. All right. Now also in a – in prior calls you indicated that you were giving us additional dummy information, but we didn't see it posted. So that…

Female: Well, if you see a discrepancy on your response record from what is listed in the user guide that you should or should not get back, you need to report that specific circumstance to your EDI representative…

(Sharon Cornpla): OK.

Female: … and we'll take a look at it. Maybe there's a system issue or maybe I need to correct the user guide…

(Sharon Cornpla): OK.

Female: … but yes, that would be the thing to do there.

(Sharon Cornpla): OK. With – but you were saying that with the CMS dummy claim information that you guys posted, that you were…

Female: (Inaudible) by that do you mean the test beneficiary…

(Sharon Cornpla): Right, the test beneficiary. But when we checked yesterday, there was no additional information posted.

Female: I was told that the new (inaudible) beneficiary information is out there, and it should have the dates of entitlement associated with each of those fake or test beneficiaries – and that would allow you to test that 03 disposition code. So you're telling me that you don't see…

(Sharon Cornpla): I don't know. We looked – we had – the original information was posted for the test beneficiaries and it wasn't there.

Female: OK. I don't know why that is. I'll have to check into that. Just for everyone's benefit, it is supposed to be posted on www.section111.cms.hhs.gov . I don't know why it wouldn't be there. So that's news to me. That would also be a good thing to report to your EDI representatives so we can get that investigated right away.

(Sharon Cornpla: OK. And another question, I just want to confirm this. Based on what you said before, if we're doing a section 32 settlement that closes out only the indemnity portion but we're continuing medical, we don't have to report the (tpok) information on that, right?

Female: We did not say that. We said that you don't have to repot periodic indemnity payment…

(Sharon Cornpla): Right, but you said this before that if the (tpok) does not include any period or any liability for medical payments, then we don't need to report it because we're reporting ORM. In those instances…

Female: No if your ORM…

(Sharon Cornpla): Continues…

Female: We will need – I think we need to probably add to the alert we've just put out. So I'm hesitant to give you exact wording right now. But you want us to specifically address when…

(Sharon Cornplus): That when only the indemnity – this is workers' comp – settling only the indemnity portion but continuing the medical. You know, ORM would be ongoing in those situations.

Female: OK. We'll look at that.

Female: Before I let you go, I just went out to the Section 111 Web site and under reference materials, there is – the test beneficiary data is out there…

(Sharon Cornpla): The new one? Yes?

Female: Yes. And it's dated 3/15, 2010 and you need to look at – you know, page over to the right and you'll see Medicare start date and Medicare end date.

(Sharon Cornpla): Oh, OK. You just added it to the same…

Female: Yes.

(Sharon Cornpla): OK.

Female: It's on the same Excel spreadsheet or (text) file…

(Sharon Cornplus): OK.

Female: … (and they're) just fields added on over to the right.

(Sharon Cornpla): OK. Thank you.

Female: (Inaudible).

(Sharon Cornpla): I just have one more quick question. I know we posted this to the Web site, but we haven't gotten an answer on it. The formatting of the address fields, I don't see it in the user guide. It doesn't mention it. But from what we've seen, I think on the (CBT)s is the street name and number are the only things allowed on that one line, right?

Female: We do ask that you put the street name and number or street number and name on one of the address lines and any other extraneous information like in care of, or suite number, or the like, attention to, on a separate – on the other address line.

(Sharon Cornpla): OK. Because that's not in the – in the user guide so…

Female: Yes, I've got to make some updates to the address formatting, so…

(Sharon Cornpla): OK.

Female: … for right now the direction is to – you have address line 1 and address line 2…

(Sharon Cornpla): OK.

Female: … just make sure that the street number and name are on their own address line and any of the other address information is put on the other. And I'm not going to say that it has to be the street name and number – have to be in address line 1…

(Sharon Cornpla): Right. Right.

Female: … they just have to be exclusive by themselves, yes.

(Sharon Cornpla): Right. OK. That's all. Thank you very much.

Female: Before we go to another question, I just want to repeat with respect to what we went over on periodic no fault and workers' compensation.

We were talking solely about periodic payments, not a situation where you're doing a final settlement of indemnity. And we will look at further language for that.

Male: (Inaudible).

Male: Also we appreciate all the questions people are giving us, but again I want to remind folks that we're deviating into more technical questions and we'd like to save those for other calls or please work with your EDI rep on that. Again, we want to reiterate this call is for more policy specific questions. So if you could please limit your questions to policy specific questions, we'd appreciate it and so would the other people waiting in queue.

Thank you

Male: Operator?

Operator: Your next question comes from the line of (Laurie Shelco) from (McGuire Woods).

Your line is open.

(Laurie Shelco): (Inaudible). Thanks for taking my call. I was hoping that you could just please re-read alert number three about the deductibles?

Male: OK – about the deductibles.

(Laurie Shelco): Sorry.

Female: The, who must report alert and the change to appendix G are you referring to?

(Laurie Shelco): Yes.

Female: OK. That – the change to the February 24th alert about who must report, what it does is it removes the existing second paragraph under liability. And what it inserts is the first two sentences of part of what's already in the main part of the alert. So it doesn't add any new language that you've never seen…

Male: And we will always accept additional if it's very helpful, so…

(Laurie Shelco): I'm going to ask another question and then I'll get off and punch back in for the last couple I have in case there are – there is time. But we have a situation where a Medicare beneficiary is a claimant in our – and has died. We have his social security number and everything we need to report him to CMS, but because he's deceased we have to identify his claimant beneficiaries for reporting purposes.

And we have basic information on the only claimant beneficiary associated with this individual. We do not have a social security number for the claimant beneficiary and he absolutely adamantly refuses to provide it to us. Now this particular situation will likely be – not be an issue for the initial reporting on the particular claim that brought this to our attention because we anticipate having it settled before the (timeline) date, but we do want to know what to do in the future since social security number for the claimant beneficiary is a required field.

Male: By beneficiary you mean, the beneficiary of the insurance policy, not a Medicare beneficiary?

(Laurie Shelco): Right. This is – this is when the – when the Medicare beneficiary is deceased…

Male: Right.

(Laurie Shelco): … and we have to have a beneficiary so you (inaudible) find…

Male: (So you're) talking about when the claimant – when the claimant field must be filled in on the auxiliary records?

Female: Well, it's actually – claimant 1 is on the regular…

Male: I'm sorry…

Female: … (inaudible) record. Yes.

Male: But the…

Female: And the social security number for that claimant or (inaudible) is required.

Female: And we have no social and the guy said go take a hike.

Female: So should they report the claim without the claimant information and just the deceased beneficiary?

Male: I think we need to take another look at it because, you know, if you're going to be cutting the check to someone else, we need that information because they are the potential debtor…

Female: And we want…

Male: I mean that's protection for the insurer as well, that we know who's actually getting the settlement.

Male: And also protection from misidentifying who that debtor is.

Female: (Inaudible).

Female: And we want to help you out and unfortunately in this situation, you know, that claimant beneficiary has no weight on their shoulders from Medicare (inaudible) paying any more of the claims as a Medicare beneficiary because, you know, I mean at least – I mean the guy's pretty much told us to go take a hike. So you know, we want to help.

Male: OK.

Female: But…

Male: We'll take a look at it from the reporting angle, but as we've said before, we don't control whether you do or don't and we can't give you legal advice. But we do know there are some insurers out there that routinely, particularly in a situation like that, cut their check to Medicare as well as that party. And you know, that does provide protection to the insurer because that party can't cash it without coming to Medicare.

Male: And they also have to note on the check who the Medicare beneficiary was.

(Laurie Shelco): OK. (Inaudible).

Male: (Inaudible).

(Laurie Shelco): OK. Thank you very much. I'm sure there's other questions by now.

Male: Operator?

Operator: Again, if you would like to ask a question, please press star and the number 1 on your telephone keypad.

Your next question comes from the line of (Bonnie Muscard) from (Farmer's Insurance).

Your line is open.

(Bonnie Muscard): Wow, (inaudible).

Male: Welcome back.

Female: Well we guess this means that everyone just finally understands everything. So that's great from our perspective.

(Bonnie Muscard): Oh, we understand it. We just have had some questions.

During the January 5th call, a caller asked about payments for vocational rehabilitation, i.e. the retraining of workers needed to be submitted to CMS, and that was not something that had been discussed before. And your response had said (inaudible)…

Male: I think we believe that's covered in the statement where we talked about any periodic payments for workers' comp or no fault, unless you're somehow saying that's occurring under a liability situation because we were talking about payments pursuant to a statute for an obligation other than medical expenses.

So if you take a look at (the) alert and see if you still have a concern or whether what you're talking about (fits), and as we said, if it's not up tomorrow, the alert should certainly be up no later than next Tuesday or Wednesday, since Monday is a holiday.

Male: (Inaudible) on the alert page, it's (up) around the NGHP page, right?

Male: Yes.

Male: Yes.

(Bonnie Muscard): I was going to ask if that was (inaudible) – it was covered in that. I couldn't get everything written down you had said. Two other quick questions, one is joint and several responsibilities. There's (inaudible) question on page 84 of version 3 of the user guide, there is a reference to – it states however where the defendants have joint and several responsibility, each RRE must report the total amount of the settlement, judgment or award…

Male: Yes. Go ahead.

(Bonnie Muscard): And the question that came up was that they asked that it be clarified (because there's) many cases where, let's say there's a three car accident and two cars share liability for the accident and each pay out their own amount and have separate settlements…

Male: Actually where you should be looking right now is not in the user guide. There is on, I believe, it's page 6 of the alert of who's the RRE et cetera. There is – one of the subheadings is multiple defendants. And I'll read the two bullets that are there. Where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurers issue any

payment and obligation of a settlement, judgment, award or other – and just saw there's a word missing – or other payment, does not shift RRE responsibility to the entity issuing the payment. All RREs involved in the settlement remain responsible for their own reporting.

And then the second bullet is, where the settlement, judgment, award or other payment with joint and several liability, each insurer must report the total settlement. You – I thought I just heard you say that yes, there was more than one insurance company that had to pay out but they each had their own settlements. If they have individual settlements, they just do their own reporting. But if there's a single settlement that they each have responsibility for and it's technically joint and several, then they each need to report the total amount. So…

(Bonnie Muscard): OK. All right. Very good.

Male: (Inaudible) your issues?

(Bonnie Muscard): That's what we want to hear…

Male: OK. Do take a look at – it will be the reissued February 24th alert, now dated May 26th. But that language is already in the February 24th alert about who must report, if you want to look at it.

Female: And we'll update the next version of the user guide, accordingly. And to that point, we still plan an updated non GHP – NGHP user guide by – published by July 1 – on or about July 1, 2010.

Male: Yes, we're trying to get all the missing alerts out there so that you can absorb them individually and then put them in the user guide where it won't – you'll already be familiar and it won't be quite as hard to see what's new.

(Bonnie Muscard): OK. I'm going to just give you my last question because it's not long. The fields 58 to 62 where we've now been told that they should be filled with spaces until we get revised requirements, one of the questions I've been asked is if we've got a taste – we've still got our fields out there sitting waiting for the revised requirements to be published. We want to make sure that, you

know, if there happen to be some data in those fields (that they) – any submission would not be rejected?

Female: It won't be rejected, but I would hate to see there be a problem down the road when those fields are used and then you resubmit claims and erroneously pick up some old data that you submitted before.

As I've said before on these calls, I think that RREs need to follow the instructions in the user guide and at this point in time, default those fields as indicated and not put any data that you may have in there. Anything that you may have in there is not going to match to the new requirements and – unless it's just coincidence and I highly, highly recommend that you know – I don't believe that the system will reject your record, but you may cause problems down the road when you submit an update, perhaps and you've got something old left in there and that gets erroneously reported later.

So in other words, please have your programmers make that change. I used to be a programmer myself and it's not that difficult to change their code. And I apologize for this but – and as we've said we'll give you 6 months advance notice of the new requirements as best we can. So you know, at this point in time, please have them default those fields to their either spaces or zeros, whatever is appropriate. I think it said spaces in the user guide.

(Bonnie Muscard): Spaces, yes. OK. Very good. Thank you.

Operator: Your next question comes from the line of (Del Thompson) from the (Hartford INS Company).

Your line is open.

(Del Thompson): Hi. Thank you. Yes I just wanted to pick up on your point about the potential of using a dual payee check. And I think one of our concerns is that obviously we want to try to protect Medicare's interest when we're settling these cases, but we also would like to the extent that's possible add some sort of safe harbor if we use the dual payee check concept.

And you know hopefully we're not going to have to have a lot of litigation over the years on some of these issues when we're just trying to protect Medicare's interest but just as a suggestion, is there any way you could put out an alert with a suggestion that you endorse that methodology? (I mean) I think from the insurers side, it would be helpful to have something to point to that shows that CMS endorses that methodology?

Male: (Inaudible) the problem is that would be giving you legal advice. We can't say you should do it that way. We can say anecdotally, we're aware that certain insurers do that. I've also heard of at least one state where it's not infrequent, I've been told, for the insurer to issue a jointly payable check. And when the beneficiary gets their demand, the attorney returns that check to the insurer and the insurer then cuts two checks to replace it, one directly to Medicare and on the other.

Or in one case, I was told, they issued two checks one to the beneficiary and the second one was made to Medicare and the beneficiary. We've heard all types of combinations, and what we're saying is if the check has (us) as the payee then certainly, we – it's up to us to take responsibility and make sure we get our recovery claim out of that. Our procedures require that the parties endorse it and give it to us and we do a refund. But we are not in the position to tell insurers how to do it or tell beneficiaries that that's the way it's going to be done.

(Del Thompson): (All right, no) I understand your position. It's just, I think, from the insurer point of view sometimes you might be dealing with a plaintiff or plaintiff's counsel who is not willing to make any representations whatsoever that they're willing to protect Medicare's interest.

And then – then you're in a tough spot and, you know, even if you suggest the usage of a dual payee check, they might say we refuse to accept a dual payee check. So you know, it's just one of these situations where there's – sometimes there's going to be a lot of roadblocks (drawn up) to – when we're attempting to protect Medicare's interests.

Male: I can tell you that we understand. And as we said, you know, we can tell you what we've seen but beyond that, I don't believe…

(Del Thompson): OK. Thank you. Appreciate it.

Male: (Inaudible).

Operator?

Operator: Your next question comes from the line of (John Butterer) from (Global Aerospace).

Your line is open.

(John Butterer): Hi. I'd just like to – if you could you had mentioned self-insured retention several times, I just reread the alert regarding who must report. Is there another alert that discusses self-insured retentions specifically at a more detailed level?

Male: (No). It's – the language I was reading from was – I think it's on page 3 and it's the subheading that just says deductible versus…

(John Butterer): Right. I saw that. Is there – is there – is there something in the user guide that also discusses that?

Male: To…

(John Butterer): I remember that several months ago, we had submitted a number of questions regarding self-insured retention and this is…

Male: Well the other place that it talks about self-insured retentions to a certain extent is when you get over to the next page where it's deductible issues versus reinsurance stop loss, excess, umbrella. But a lot of what was in the user guide, as we've said, this whole alert replaces the whole section 7.1 of the user guide. So you shouldn't be counting on anything that's in section 7.1 of the current user guide.

(John Butterer): And the date of that alert is?

Male: It's February 24th. It's headed Alert Reliability Insurance Including Self-Insurance, No Fault Insurance and Workers' Compensation, Who Must Report. And it's the exact same alert that's being reissued with the May 26th date. The only difference is that this re-issuance contains the corrections to the attached appendix G.

(John Butterer): OK. Thank you very much.

Operator: Your next question comes from the line of (Kate Hurt) from (Inaudible).

Your line is open.

(Kate Hurt): Thank you. I understand that you are planning to have the (Mass Torts committee meeting) in the next week or so, and I just wanted to see if you were going to address the (E) code for alleged cause of the injury to make sure that we have specific codes?

Male: I don't think that that is part of that work group at all. I mean we've been discussing the information that will ultimately go in fields 58 to 62. We're also looking at some issues tied to the December 5th, 1980 date, but we have not been discussing ICD-9 codes.

(Kate Hurt): OK. Because we have several that we are considering, but they're – it does not seem to be one that is really case specific, you know, to the (Mass Torts) or exposure to asbestos.

Male: I thought and (Pat), correct me if I'm wrong, I thought there are several codes that are specific to asbestos.

(Kate Hurt): (E) codes.

Female: An (E) code.

Female: I saw a question submitted to the mailbox related to this.

(Kate Hurt): I just – I just submitted one.

Female: OK. (Well), I guess, obviously we don't have an answer for you today.

(Kate Hurt): OK. Thank you.

Operator: Your next question comes from the line of (Joel Casey) from Office of the Special Deputy.

Your line is open.

(Joel Casey): Yes, thank you. I have a situation that has come up where because we are liquidators, sometimes monies that we pay to a claimant or this could be a Medicare beneficiary, go uncashed. And sometime down the road we would have to turn that over to the state unclaimed property fund. If I have a check that – or a payment that I reported initially as paid to a Medicare beneficiary and then say a year later, it may be uncashed and I have to turn it over to the State of Illinois, do I have to report that again or is the initial filing enough?

Female: Your initial report is sufficient.

(Joel Casey): OK. Thank you very much. I appreciate it.

Female: Because you're not retracting the payment.

(Joel Casey): No that is correct. Yes, I would pay the person if they had cashed it or perhaps they didn't even receive it, but no (I won't do any of this turning it over) to the state as unclaimed.

Operator: Your next question comes from the line of (Scott Ault) from (Fenmar Credit).

Your line is open.

(Scott Ault): Thanks very much. I'm not sure how soon the new alerts are likely to hit the Webpage, but I was wondering if you might be able to go back through, I think it was the fourth one that you described, the risk management write-off alert. I was taking notes as best that I could but I want to make sure that I didn't miss anything.

Male: Well, I think what I'll do instead of reading the whole thing again is just go over it conceptually. There's three points. The first point is that if it's a provider, physician or other supplier, if you're taking an action, which is a write off or reduction in charges as a risk management tool, then you must include that information in the billing. That's something that should have always been there. You need to show that information as a primary payment to Medicare.

And so that's providers, physicians and other suppliers. If reduction in charges or write-off, then they have to do it through their billing. It's not a choice of whether they use the Section 111 threshold or do the billing. They must do the billing.

If they, as a risk management tool, provide something else of value, whether it's a gift card or free parking for life or whatever you want to name, that is technically reportable but it is subject to the threshold. Any entity that's not a provider, physician or other supplier that as a risk management tool provides property of value, then that needs to be reported but there's the threshold that applies.

And again when we're talking a risk management tool, we're talking when there's evidence or reasonable expectation that the individual has sought or may seek medical treatment. So that's the general concept and…

(Scott Ault): Is the language that you just described, the reasonable expectation that the claimant has sought or may seek further care, is that language within the alert?

Male: Yes.

(Scott Ault): OK. And just to clarify, that first of the three categories where you described that this information would need to be included in the billing, in any event, therefore in that scenario, you do not need to make a Section 111 report…

Male: Yes.

(Scott Ault): … correct?

Male: I'm sorry – I'm sorry I failed to repeat that. But yes.

(Scott Ault): OK.

Male: If it's a provider, physician or a supplier and if the reduction in charges are write-offs as the risk management tool, then it is in their billing and they don't need to separately report it.

(Scott Ault): Perfect. Thank you very much.

Male: OK.

Operator: Your next question comes from the line of (Matt Inaudible) from (Cinco Holdings).

Your line is open.

(Matt Inaudible): Good morning – or good afternoon, everybody. On the – on the risk management alert, you just mentioned something on gift cards and cash or whatever that value may be, is that something that the meter would start running on October 1st, 2010?

Male: Yes, it being a (tpok), yes.

(Matt Inaudible): Yes. So they are considered (tpoks) and a provider would not need to go back in time to try to collect those records, it would only be for those things given after October 1st 2010?

Male: Right.

Female: And remember that the reporting thresholds apply as well.

Male: The reporting thresholds apply unless it's a provider, physician or a supplier and they do write off a reduction in charges. And then they're tied into how they should be billing properly and don't need to do it separately.

(Matt Inaudible): OK.

Male: And as far as billing, I can't emphasize enough that that's not a new requirement. That has always existed, as far as showing – it's existed as long as the liability of provisions have existed.

(Matt Inaudible): I understand. Thanks a lot.

Operator: Your next question comes from the line of (Cathy Inaudible) from (Inaudible) Underwriting Alliance.

Your line is now open.

(Cathy Inaudible): Hello, thank you for taking this call. We have one question – a couple of people ago, they asked about the auxiliary record and the claimant information. So we are questioning, if the work comp settlement is for the indemnity benefit only with no medical payout or ORM, are we required to report the claimant info?

Male: First of all, as of right now, we've said there isn't any language that addresses a single indemnity payment. The second thing is we are hard pressed to understand how there would be a situation where you had responsibility for indemnity but you had no responsibility for any medicals. I mean if you had responsibility for the claim, how would you have responsibility for only indemnity and not associated medicals?

(Cathy Inaudible): Well, the medical would go to the specific providers or entities that provide the service. There would be no medical settlement payout to an individual…

Male: (But) that is ORM. ORM doesn't mean that you're necessarily cutting a check to the beneficiary. It means that you are – that you have a continuing responsibility where you're paying those medicals. Those need to be reported as ORM.

(Cathy Inaudible): Thanks.

Male: So if there's some confusion about that we really need to straighten that out because that's basic to the whole concept of ORM. The point is that when ORM is reported we post it on our records and if, for whatever reason, the

doctor's (clerk) – he has a substitute some day and somehow she doesn't remember to bill it to workers' comp, and mistakenly bills it to Medicare, then by us having that in our records, we should, hopefully, be able to deny it and deflect it back to the workers' compensation.

So absolutely, when you're paying the doctors, hospitals, et cetera you need to be reporting that ORM.

(Cathy Inaudible): Right. But on a death claim, if you're – if you're final settlement payment is only going to be for the indemnity portion, do you need the auxiliary claimant information if you're not paying any portion of the – any medical portion to an individual?

Male: And my question still remains, how would you not have had responsibility for medicals prior to death if you're assuming responsibility at all? Again, how could you have only an indemnity payment? And as we said, it has to be a situation where by statute, you know, you have this separate provision. You – it's not simply a matter of the parties allocating it and saying, oh this is all indemnity. It doesn't include any medicals. And we have not been able to find anything that in any way would indicate that indemnity payments should be payable without responsibility for associated medicals.

So if you have further information you'd like to submit on this issue, we'd be happy to listen to it. But the assumption underlying in its – I think it's stated in the language I read, the assumption underlying our alert is that you would not have these separate indemnity payments if you didn't have responsibility for medicals.

(Cathy Inaudible): OK. Thank you.

Operator: Inaudible.

Male: Operator? Before you take any more questions, just to let everybody know, we are going to have to wrap up by about 10 of today because there are other people coming into this media center. So with that, if there's any more questions.

Operator: Your next question comes from the line of (Joseph Coppola) from the (Inaudible).

Your line is open.

(Joseph Coppola): Good afternoon. Thanks for taking the question. I manage a claims unit that handles employment practices liability claims and I seem to recall from a prior policy conference call that CMS was going to reconsider application of the reporting requirements for EPL claims where all it's alleged is what I'll call garden variety emotional distress that comes with a job loss, headaches, nausea, things like that. And then of course the release in the settlement is a general release for anything associated with those conditions. Is CMS reconsidering that portion on EPL claims?

Female: It's on our list to look at errors and omissions. If you have a more specific situation like only job loss or something, if you haven't submitted something to the mailbox, if you'd like to send it, or if you have resend it.

(Joseph Coppola): Well, each – I mean each case differs slightly as to what they allege. Some are treating with let's say a psychologist for the job loss or the harassment that they feel they've…

Female: And that's part of our problem because in some instances people do treat and if the standard thing is to release medical…

(Joseph Coppola): But I guess what I'm saying is that in many of the cases where they settle earlier or resolve early, there – we may never see evidence of any medicals…

Female: And I understand that, but you might also never see it because it's been being billed to Medicare.

(Joseph Coppola): So if there are any where the plaintiff tells us there are no medicals to – I'm not treating, I just have the garden variety sleeplessness, headaches, nausea, that still has to be reported or queried?

Female: If you're having them released from medicals, if you're comfortable that there isn't really any medical problem and you're not releasing them then there

might be – if they're not – if they're not claiming or releasing (them), if the settlement doesn't have the effect of releasing medicals, then we don't have an issue with it but…

(Joseph Coppola): Well, I think all defense counsel that are hired want as broad a release as possible so they do ask for that in an ordinary EPL claim…

Female: I understand that. That's why we said we would look at it. And if you'd like to write up your particular issues and send them in that's fine. But what I'm trying to explain from our perspective is that there are cases where people do treat and do have medical things and to the extent we've been paying for those, if we simply say these don't need to be reported then we won't necessarily know about them.

(Joseph Coppola): (Right). I guess – I guess the bigger overriding factor that's out there is that in the employment arena, since most people employed are not Medicare beneficiaries. They're generally in the workforce under 65. They're not disabled. They're in the workforce, then we're going to have very few positive matches to Medicare beneficiaries…

Female: And for that I would recommend the direct data entry alert that will be out shortly.

(Joseph Coppola): The – I'm sorry the what?

Female: If you were – weren't on the beginning of the call – I'm sorry it actually is out – on the Web site. There has been an alert posted about the direct data entry option instead of the transmission by electronic files. And so if you would like to take a look at that, that might solve some of your concerns about having to test or do other things if you really expect to have absolutely minimal reporting.

(Joseph Coppola): OK. Thank you.

Operator: Your next question comes from the line of (Jim McMarlon) from (PG&E).

Your line is open.

(Jim McMarlon): Yes, hi. Thank you for the information about the cumulative trauma. I just had some input on that issue you've addressed several times today in the call when you have a death case.

In some jurisdictions you're – if you have an injury and then you later die from the injury, those are two separate claims so the first claim for the injury, you might pay for medical and then you never settle, so you never agree to ongoing medical. Or you may and so you might report that. And then the person dies, that becomes the subject of a new claim with a new statute of limitations, et cetera. And so that death case, all you're settling is the burial benefits and the death benefits. So there are no medical payments.

Occasionally there might be an emergency room bill or something, which is the sort of the last medical, but oftentimes, that becomes the – that's paid on the other claim, which wasn't the death claim. So that was my input.

Male: Are you – just out of curiosity are you talking workers' compensation or are you talking…

(Jim McMarlon): Yes, workers' compensation.

Male: OK.

(Jim McMarlon): Because you're talking about you couldn't envision a situation where you wouldn't have ongoing responsibility for medical yet you would pay indemnity benefits. And that would be the case. You have a death claim for which there is no ongoing medical (inaudible)…

Male: (Inaudible)…

(Jim McMarlon): … medical, it's just the death claim and so you're paying the spouse or minor dependents, whoever…

Female: And if under the state law there is a provision for a death claim and the death claim is specifically limited to indemnity et cetera, that it can't include medical so you're not releasing medicals and they won't (inaudible) have been claimed or released and, no you wouldn't have to report it.

(Jim McMarlon): Right. But you would be probably reporting it on the other claim, assuming the person qualifies – otherwise would qualify as a beneficiary…

Female: Yes.

(Jim McMarlon): Under those rules…

Female: (Inaudible). As we've said in the past, we can't possibly cover every single nuance with a separate rule. We are doing our best to give you broad rules that you will need to apply to the specific facts of the case.

(Jim McMarlon): I agree – I understand, I mean. That's all I had.

Female: Operator, we can take maybe one last call.

Operator: Your next question comes from the line of (Amy Makin) from (KNL Gates).

Your line is open.

(Amy Makin): I'm just wondering if there's anything new coming for foreign insurers.

Male: It's still on our list that we – I don't expect anything within the next week or so.

(Amy Makin): OK. Thanks.

Male: Operator, we have to end the call because again as I mentioned, there's a – as (Barbara) mentioned there's another group that's coming in and they need to set up for their next meeting.

I would like to thank everyone for their participation and please ask folks to continue to submit their questions to the resource mailbox and for those seeking more technical support, please work through your EDI representative.

With that, stay tuned for future calls on the Web site. Again, as we mentioned earlier, a number of new alerts are coming out. They might actually come out before you receive an unsolicited notice that the alerts are there. But again, a

bunch of them should be out by no later than probably early next week. They're in the queue right now for posting.

And if, operator, you could stay on after closing the call.

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

END