TRANSCRIPT
TOWN HALL TELECONFERENCE

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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: John Albert
April 24, 2012
1:00 p.m. ET

Operator: Good afternoon my name is (Candice) and I will be your conference operator today. At this time I would like to welcome everyone to the NGHP Policy and Technical Support conference call.

All lines have been placed on mute to prevent any background noise. After our speakers' remarks there will be a question and answer session. If you would like to ask a question during this time simply press star and then the number one on your telephone keypad. If you would like to withdraw your question please press the pound key. We also ask that you limit your questions to two questions per queue.

Thank you. Mr. William Decker, you may begin your call.

William Decker: Thank you, Operator. Hi, everybody, my name is Bill Decker, I am with CMS in Baltimore, Maryland. I have with me other staff from CMS including Barbara Wright. And Barbara and I will be principally leading this call although we do have other staff with us in the room who may chip in on answers or responses from time to time. If they do we will identify who they are.

Today is Tuesday – let's see, what is it today? Tuesday, April the 24, 2012. This is an NGHP technical call principally although we know that policy questions will slip in, I suspect, but we would like to open it up to anyone who has a technical question on NGHP Section 111 reporting or as a policy issue that they wish to raise.

We have received a number of questions ahead of time in our Section 111 dedicated mailbox. We have reviewed the questions and we will be

answering some of them, well, hopefully, all of the ones that are pertinent to the issues that will be raised here on this call today.

Before we go further I'd like to remind everyone that this is a Town Hall call for Section 111 reporting. What we say on this call is to the best of our knowledge complete and concise and accurate. However, as we always do, I'll point out that the material on the Section 111 Web site including the user guides and the alerts are, is the official material for Section 111 reporting and if there is a conflict between what we say here and material on the Web site, it is the material on the Web site that can controls. So please keep that in mind.

We always assume there won't be any such conflicts but if there are, that the Web site material controls. There will be another call for all of you NGHP folks. It is scheduled for Thursday, May 24, and it's not a Tuesday call – it's a Thursday call. It's in May. It's on the 24th.

We have two people who are going to be presenting materials to you before the question and answer period gets started.

First we're going to have a representative from our Coordination and Benefits contractor in New York. His name is Jeremy Farquhar and I believe that Barbara Wright has a couple of general announcements to make before we open it up to questions. And so, after Jeremy speaks I'll be turning it over to Barbara.

And so, Jeremy, we're ready for you if you want to go?

Jeremy Farquhar: Thanks, Bill. I just have a few general announcements to start. First of all I'd like to note that restrictions previously limiting Section 111, non-NGHP RREs to one claim file submission per quarter have now been lifted.

NGHPREs may now submit multiple claim files within a single quarter. However, there are two limitations that currently apply.

First we only process one claim file at a time, therefore RREs should wait to receive a response file for their prior submission before submitting a new claim file for processing. If a new claim file is received while a prior file is

currently processing or in threshold status the newly submitted file will be placed on hold until processing of the prior file is completed.

Second, claim file submissions will be limited to no more than one file for every 14 days. Please note that although multiple claim file submissions will now be accepted within a quarterly timeframe, RREs are not required to send more than a single file each quarter. RRE submission timeframes will still remain the same and it is expected that standard quarterly files submissions will continue to be submitted according to this schedule.

Although other transactions will not be rejected, the primary purpose for the removal of the quarterly restrictions is to allow RREs to more expediently report things such as ORM terminations electronically.

An alert regarding these changes should be posted to the CMS Section 111 Web site very shortly. For those who may not already be aware the URL for that Web site is (www.cms.gov/mandatoryinsrep).

OK, next. As many of you are certainly there have been numerous complaints regarding the inappropriate denial of claims linked to no-fault workers' comp and liability ORM present on Medicare's database. CMS had continued in their efforts to address these matters via outreach and education in order to prevent these inappropriate denials.

Most recently an (MLN) matters article has been posted for providers containing detailed information regarding the appropriate handling of claims in situations where a beneficiary may have an open no-fault, workers' comp or liability record reflecting primary coverage for accident-related claims.

For your reference a direct link to this article has been posted to the COB Section 111 secure Web site log-in page. In addition to this a technical direction letter has been issued to all Medicare administrative contractors also regarding the proper procedures for the handling of such claims. It is expected that with increased education we should begin to see a decrease in the occurrence of these inappropriate denials. That being said it's still extremely that Section 111 RREs take care to ensure that all claim records are submitted containing ICD-9 codes that are specific as possible and only those

ICD-9 codes that are directly linked to the injuries for which the RRE is specifically responsible.

And finally, it appears that there may be still some lingering confusion regarding the delay timeline for a liability (TPOC) reporting which was referenced in the 9/30 2011 alert posted to the CMS Section 111 Web site. Confusion seems to stem from the fact that the information from this alert was not included in the December, 2011 update to the NGHP user guide.

This delay timeline is still in effect and its absence from the most recent user guide update was simply an oversight. Please note that these delays are optional. RREs are not required to submit (TPOCs) that are under the threshold dollar amounts provided during the timeframe's reference. However, if an RRE wishes to submit (TPOC) values under the current thresholds they're welcome to do so and those claims will not be rejected.

That being said, the internal reporting thresholds referenced in Section 11.4 of the current user guides are also still applicable and must also be adhered to. Unlike the thresholds outlined within the 930 alert, (TPOC) values which do not meet the minimum interim reporting thresholds will be rejected.

At the present the minimum internal reporting threshold is $5,000, therefore at the present while we will accept liability (TPOC) announced that are under the values indicated in the 9/30 alert those (TPOC) values must still exceed the current $5,000 interim reporting thresholds. Please refer directly to the aforementioned 9/30 2011 alert in Section 11.4 of the NGHP user guide for more and complete information regarding the optimal liability (TPOC) delays in the interim reporting thresholds respectively.

From here I'd just like to address a number of the questions that were received via the CMS drop-box since the last call.

The first question which I'd like to address was in relation to the model language form present on the CMS Section 111 Web site which was made available to assist RREs in their attempts to obtain specific personal information from their covered individuals who they believe maybe entitled to Medicare.

The individual who wrote into the mailbox was asking, "If the claimant refuses to complete and sign the Medicare information notice and provide their SSN, what, if anything, are we required to do?"

And in such situations the RRE should document their attempts to obtain this information and retain that documentation within their records, and they may want to be persistent and continue to attempt to obtain that information, but as long as you document your efforts well and maintain that documentation, you should be OK.

The second question was also in reference to the aforementioned model language form. This individual had encountered a situation where the claimant had filled out the form but not in its entirely so there were still missing key pieces of information. However, these missing pieces of information were successfully obtained via other means.

The question being asked was whether they should attempt to force their claimant to fill out the information or if they could simply fill out the information for them. And the answer is that neither are actually necessary. Reporting entities are not required to utilize this document and are not required to submit these forms to CMS. They simply have been provided as a tool which may utilized to obtain some of the necessary information required for Section 111 reporting.

If the information has been obtained via other means then the form may not be necessary at all. The important thing is that the appropriate information required for reporting is submitted via Section 111 process. That is all that is technically required.

The next question, the individual writing into the mailbox had asked, "In the event that data needs to be updated such as address and phone, Social Security number, beneficiary name, et cetera, can this updated at any time without having to wait for the quarterly reporting period?"

And now this is something that we'd expect most RREs to understand by now. The personal identifying information for a beneficiary is not something that an

RRE would be capable of or required to update on Medicare's database. Any changes that may occur to a beneficiary's personal information could only occur at Social Security and once those changes are made at Social Security they will be passed along directly to us.

If a record had previously been submitted and there are subsequently changes to the beneficiary's personal info the RRE is not required to take any action at the time of these changes. Occasionally there may be changes to a beneficiary's (HICN) and if something of that nature should occur the RRE may simply send a new updated (HICN) whenever the need should arise to send a claim-specific update for that record.

The new (HICN) will cross reference with the old (HICN) in our system and the previously submitted record will still update successfully. Now on the other hand if an RRE had submitted this information incorrectly initially causing them to receive an inappropriate match on the beneficiary they must re-submit their claim record with corrections to that personal identifying information.

As referenced at the start of my presentation, RREs will now have the ability to submit more than one file per quarter, and so, if necessary a follow-up file with updated information could be submitted after the prior submission has completed processing, without needing to wait for the following quarter, otherwise on the following quarterly submission that record should be re-submitted again.

Another question received was regarding scenarios where there may have been claim involving a younger individual who is not Medicare entitled at the time of the claim but where the state in which the claim occurred requires lifetime responsibility for medicals. The question was regarding the need to continue querying on such an individual even if the entity were to administratively close their claim.

The answer is that in situations where there may be lifetime medicals, the RRE would be required to report this claim should the individual become entitled for Medicare. It matters not whether or not they have administratively

closed their claim as they are responsible if there is further treatment, that information must be reported.

They will need to be able to monitor the individual status in order that they are aware of Medicare entitlement (inaudible). There is no specific requirement to send queries on an individual but the query process is a tool provided in order to help RREs determine when an individual is entitled. It would be advisable that they continue to utilize that process in order to monitor the individual's entitlement status but there's no reason to believe that the individual would have become Medicare entitled, it may not be necessary to submit them every month to verify their status but they would be wise to submit a query on occasion to ensure that nothing is changed at which they may not be already be aware.

The next e-mail that say that the RRE was electronically reporting the opening of a no-fault ORM claim with Medicare, excuse me, and they were asking if someone could tell them how they would electronically close the same case.

This is – this is very basic and it's something that is clearly outlined within the non-GHP user guide as well as within the available computer-based training modules.

For anyone with questions of this nature, it's imperative that they review the user guide and highly recommended that they also take the aforementioned computer-based training modules.

The answer to this question is that the closure of the claim would be reported via the same avenue being utilized to report the opening of that claim. If this is in ORM record, then the ORM termination date would be submitted as an update transaction via the claim input file or if the claim have been submitted via (DDE) on our Web site, the RRE should revisit the Web site. Locate the claim within their claim listing. Enter the claim in order to edit it. Provide the appropriate update and then resubmit that updated claim.

If this is a TPOC scenario, then the TPOC could similarly be supported via an update transaction on our claim input file or if the claim had been submitted

via (DDE), the TPOC information could be added revisiting that claim on our Web site and then resubmitting it.

Finally, another question received, read as follows. If RRE number one is acquired by RRE number two and RRE number one has an, open ORM claims, what's the best avenue? Can (RRE 2) add (RRE 1) as a subsidiary on (RRE 2s ID) and report the terminations of ORM under (RRE 2's ID) when effective.

To answer this initial question, reporting RRE number one is a subsidiary under RRE number two, is not actually required but the updates to RRE number one's ORM records can be made via RRE number two's subsequent file submissions if RRE number one had been absorbed by RRE number two.

As long as the records are submitted, utilizing the same key fields as had been reported via RRE number one's file. The update should successfully apply. The second question was whether RRE number one's ID should remain open until all ORM – cases are closed.

And as long as the claims are being updated appropriately via RRE number two submission and keeping RRE number one's ID open would not be necessary. In some situations, we would typically place RRE number one's ID in a discontinued status.

After having done so, should the need ever arise, or updates to be sent under that old RRE number one's ID, we can always reinstate the (ID) in order that this may be possible and your assigned (EDI) representative would be available to assist in tough situations.

And that's all for me. So I'll hand it back to you, Bill and Barbara.

William Decker: Thank you very much, Jeremy.

I'm going to now ask Barbara Wright to give us her comments.

Barbara, I'll turn it over to you.

Barbara Wright: OK. Thank you, Bill.

As with prior months, I'm afraid I have to tell you that with respect to consortium directors and officers (inaudible) the liability, et cetera, that type of insurance work, the industry has been looking for some relief in terms of how we treat what claim released or effectively released. We still have internal language that's under consideration, so I don't have anything final to give you today.

What I did want to comment on is some of the questions that we've been getting into the mailbox lately. Seems when we go back and look at the instructions that we have under who's the RRE or what should be reporting when a lot of the scenarios that are being presented to us sit right within the instructions that we've given and what people are writing in and asking are essentially, it's a hidden request for an exception to that.

And what's in the user guide with respect to this is what we are going to expect to employ as our policy. One example would have to do with bankruptcy or liquidation where the issue of having a factor was brought in.

They essentially – the questioner was saying because there was the factor and they didn't know how much the factor was paying the claimant for their award, to us that's irrelevant. The amount that's reportable is still what's going to be awarded to the liquidation or bankruptcy or et cetera.

The factor is not someone or an entity that comes into the equation. They're not a responsible reporting entity and the amount that they pay the beneficiary doesn't determine how much needs to be reportable.

So you still have whatever issues you would have in terms of arranging that you know how much will be paid out under the liquidation or bankruptcy, but it doesn't affect the basic decisions of who is the RRE or how much is reportable.

We also had a couple of questions that had to do with subrogation between one insurer or another and that is covered on page 28, I believe in the current version of the guide. And it specifically talks about when you essentially have subrogation between two insurers after the original insurer has paid a claim

that that subrogation is not reportable. So, again, we would ask that you go back and look at the user guide in terms of what we have out there and make sure we haven't already answered your questions.

I don't have anything else specific right now, Bill, if we want to open up for calls.

William Decker: OK, Barbara, thank you.

(Candice), operator, we're ready to open it up for calls. And we'll, you can go right ahead and open it up for questions.

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star and then the number one on your telephone keypad. We would also like to remind you to please limit your questions to two questions per queue. Thank you.

Your first question comes from the line of (Vicky Curtis).

Your line is open.

(Susan): This is (Susan) with (State Farm) and we had a question on reporting ORM on (stacking no-fault) policies. And if an RRE is required to report the policy separately, even if they're administered under a separate claim or a single claim.

Barbara Wright: Jeremy, do you want to address that?

Jeremy Farquhar: I'm not sure if I entirely know the answer to that, Barbara, is that, I mean, I think this is a matter of whether they need to report. I mean, I'm not sure I'd – I'm not – do you understand the scenario? I'm not entirely sure I do, so …

Barbara Wright: What I heard you say is that you have multiple policies that would cover the same accident, they're all ORM and you want to know whether you should individually report them.

I think that we've said on past calls, at minimum, you need to report the ongoing ORM to all of them or (inaudible). But I don't know if we've gotten

anymore specifics or not, that you need to ensure that there is open ORM that we are knowledgeable on until it's been completely exhausted.

Jeremy Farquhar: OK. So and if the – and if the clarification that you're looking for, if I understand correctly now, is if you have multiple policies for, essentially, the same claim, if you have to report them separately, that the answer would be, "No." You could include them all within that same claim file submission. (Inaudible).

Barbara Wright: If we're talking – if we're talking ORM?

Jeremy Farquhar: Yes.

(Susan): Right, which we are. Just to clarify. In some states where you have stacking that can occur on auto policies for no-fault/uninsured motorists, you might have an – a claim under one vehicle, but then you can also dip in to the policies that limits on other policies or cars in the household.

Are you saying, we can report that under the involved policy only? Or do we need to open claims on all policies, even though we're not going to get in to those limits in most situations?

Jeremy Farquhar: It's – technically, as far as the reporting is required, I think that you would need to report on the involved policy only. The situation here is that if you were to report separately two ORM claims with different policy numbers that the key fields that identify that record are going to be the same and they would in essence overlay one another.

So the one report for the involved policy that would remain open until all ORM has terminated would be the way to approach that.

(Susan): And then just to include the total limits for all policies and the longest ORM?

Jeremy Farquhar: Yes.

(Susan): OK. Thank you.

Operator: Your next question comes from the line of Lisa Maynard.

Your line is open.

Lisa Maynard: Thank you. The first – can you hear me, OK?

William Decker: Yes.

Lisa Maynard: OK. Good. The first question I have is if the insured is an (SIR), and the insurer – the question is can the insurer report claims for the insured with an (SIR) if the insurer pays the claim and later is reimbursed by the insured for those claims.

In researching and reading the manual, our understanding is the – the answer to that question is, no. They've got to have their own RRE number, the (SIR) – the insured with the (SIR) has to have their own RRE number. This is not a deductible situation or fronting policy situation. And I just wanted to – we wanted to know if that's correct.

Barbara Wright: It's correct. The self-insured (retention) is we've addressed it in the document. You're right. It refers to risk that the insured retains that is not included in the coverage provided by the insurer. So if, for instance, it's a $30,000 policy, with a $5,000 deducible, that's not what we consider self-insured retention.

If it's a $5,000 self-insured retention and a $30,000 policy, then the insurer is responsible up to 30, but the individual is still responsible for the $5,000 in addition to that.

If it's – I'm repeating myself, but if it's self-insured retention, as we addressed it in the instructions – yes, you're correct. You cannot report for them as the RRE. They may hire you as their agent.

Lisa Maynard: Right. So, well then, OK, so the insured can – have to have their own RRE number to report. The bottom line is they have to have their own RRE number because they have an (SIR) situation.

Barbara Wright: Yes.

Lisa Maynard: Is that right?

Barbara Wright: Yes.

Lisa Maynard: OK. And so, yes, I just wanted to – there seems to be some confusion, sometimes people are thinking maybe that whoever writes the check is the one that does the reporting. That is not our understanding from reading the manual.

Barbara Wright: More than at this point, I think, two years ago, that was under consideration as a possible way to go. But the discussions at that time got even more convoluted because there were back and forth issues in terms about well, if I didn't write the check but I actually ordered the checks you know what did that make me.

And if I had money in a bank account and gave it to someone else and they physically then wrote the check, it just was clearly unworkable if we focused solely on who did physical payment. So we went to …

Lisa Maynard: OK. Yes. So, our understanding …

Barbara Wright: OK.

Lisa Maynard: Yes. So our understanding then is the whole point is the RRE is the exactly that, the Responsible Reporting Entity, the one that's responsible for the risk.

BMale: Yes. Including having to report the deductible as the policy includes the deductible.

Lisa Maynard: OK. The second question on – we have was on write off. Our understanding from reading the manual is that write off should be reported through the billing process. If the injured party is the person who – the insured is already billing Medicare for – if the injured party is a person that is not already being billed Medicare for by the insured, the write off should be reported as a TPOC. And we wanted to know if that's correct.

And the other question attached to that is does the insured have a choice about which way to report it, as a TPOC or through the billing process or is it

mandatory that it be reported through the billing process if that's – if it's Medicare (inaudible).

Barbara Wright: You're generally correct. You're generally correct. But keep in mind that the explanation you were just giving me appeared to be largely limited to providers, physicians and other suppliers.

Lisa Maynard: Yes.

Barbara Wright: (Now there) (inaudible) someone who would, in fact, be billing Medicare. The other thing to take into account is the billing rules existed far before section 111 was actually passed into law.

And so providers, physicians and other suppliers have a responsibility and a requirement that they bill appropriately and that includes showing any amount that would be essentially liabilities to health insurance on any bill they submit to Medicare.

If they were only trying to use section 111, they would be violating the billing rules. What we've done is said, where it's part of the billing process, you do not need to separately report it through the 111 process.

So if they are writing off something for their own facility, that's one thing. But if there are additional bills that they're paying, they're either then reporting ORM or TPOC for those other bills.

Lisa Maynard: OK. That's helpful. Thank you.

Operator: Your next question comes from the line of Wendy Rader. The line is open.

Wendy Rader: Hello. My question has to do with the interim threshold for medicals only which according to user guide 3.3 terminates December 31, 2012. And I'm wondering if you're considering any extensions or if we should expect that to be the end of this threshold.

Barbara Wright: Are you talking about the one for workers compensation specifically, the $750 one?

Wendy Rader: Yes. Right.

Barbara Wright: I don't have any answer for you today. That's under consideration right now.

Wendy Rader: Well, OK. Thank you.

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

Susan Jones: Well, hi there. I have a question about – earlier, I think it was Jeremy, you were talking about the instance where a claimant, you're unable to get, for instance like the claimant's social security number. We're finding a lot of times the claimant's attorney is refusing to give us whether it's the claimant's social security number or the estate doesn't have a (TIN). Or they don't want to give us the representative's phone number and address.

And so, were trying to report and I just want to make sure that it's OK that what we're doing since we have all the information. For example, if the plaintiff's attorney refuses to give us the representative of the estate, they refuse to give us any address or phone number so we're listing the attorney's phone number and address on the estate so we can report it. Is that OK?

Jeremy Farquhar: I don't know.

Barbara, what are – what are your thoughts on that? I mean technically, it would be able to probably (pass our edits). But I don't know that it's appropriate.

Susan Jones: Yes. I mean, I understand it's not – it's not the right data but we don't know what else to do to get it reported.

Barbara Wright: (I mean), the attorney needs to know. If that's the only address he's giving you for his client then that's where any mail or anything is going to go.

Susan Jones: OK. And then – so in this same situation if we don't get – so if – because sometimes the estates don't have a (TIN) so we don't list the estate as the claimant. We list the representative and we can get their social security number sometimes then we'll list that instead of listing the estate when there's not a (TIN). Is that OK?

Jeremy Farquhar: (Right). I don't – I don't believe it would case the (record) to reject but I, again, defer to you, Barbara as far as whether that would be an acceptable practice or not.

Barbara Wright: I think …

Susan Jones: Yes. I'm not really talking about whether it's rejected. I'm talking about being compliant basically because we're trying – and we're trying to report everything but unfortunately sometimes plaintiffs are trying to refuse to give us certain information. So we're doing the best we can and we want to make sure it's OK.

Male: Yes. Jeremy and (questioner), we're going to go offline just for a second. We're going to put you on mute. We'll be right back, OK? Don't go away now.

Jeremy Farquhar: OK.

Male: OK. I think we have an answer for you. Barbara is going to give it to you.

Barbara Wright: I believe what (Cad Ambrose) has said on prior calls was if you can't get the information for the estate that you should essentially go ahead and report it as though the beneficiary is in fact still alive, injured party is still alive and simply report that with the attorney information for purpose of the section 111 reporting.

Susan Jones: And just report the claimant's attorney information as the injured party's attorney information then?

Barbara Wright: Right.

Susan Jones: OK.

Barbara Wright: Now, before we go to any of the …

Susan Jones: (Inaudible).

Barbara Wright: Did you have a second question?

Susan Jones: Well, just kind of to clarify. So, is that in any – in any time where I don't have the necessary information to report whether it's a claimant or an estate, I should just completely ignore it all together instead of (subbing) in attorney information and just list the injured party and the attorney as the injured party rep?

Barbara Wright: I think (inaudible) saying the actual claimant is the attorney – yes.

Susan Jones: OK. OK.

Barbara Wright: Now, before we go to any other questions, we would appreciate it if everyone who's asking a question would identify themselves and where they're from before they give us their question.

Male: You've been doing a fine job of identifying yourselves. We forgot to ask the operator upfront to also try to find out who you represent or where you're calling from or what it is your – who it is you're associated with. If you could (inaudible) that information in for us it's very helpful to us here. OK. Thanks.

Operator: And your next question comes from the line of Vicky Vance from Tucker Ellis. Your line is open.

Vicky Vance: Thank you very much. I have two questions, one is to clarify some of the instructions we heard on the last town hall call with respect to the subject of rendering a defense.

And you may remember, Barbara, there were some questioning about a situation involving, let's say, a product liability case where when the complaint is filed the plaintiff may name as defendants both, let's say, a manufacturer of a product as well as a distributor of a product.

But there may be an agreement in place – longstanding agreement in place that since the distributor really didn't do anything wrong, they will tender their defense to the manufacturer and the manufacturer takes on all responsibility

from that point forward in handling the defense, directing the defense, trying the case if necessary or resolving the case if necessary.

But, let's say, the distributor's name continuous to stay on the pleadings and it stays in the case but for intents and purposes the distributor has – and their lawyers, their company ahs essentially closed the books on this case because they know the manufacturer is handling it.

If the case gets settled at some point down the road, a case that quite frankly the distributor in a way has lost track of because they have no responsibility for it. I understand from the instructions that there could be a reporting obligation still with that distributor assuming it was never dismissed out of the case.

And if that is indeed true, I'm just wondering you know and thinking about the practical challenges to those companies that perhaps years go tendered their cases over to another manufacturer or somebody, do they now have to go back and try to find out what happened, check on settlements. These are cases that that they may have lost you know they weren't following.

And what advice or instruction for reporting obligation do we give to those companies who tendered their cases and never thought that they'd have to confront any kind of responsibility at all let alone a reporting responsibility to CMS.

Male: I understand that what we've said on the last was our standard response that an RRE cannot by contract or otherwise transfer their responsibility from being an RRE. But again, they always have an option in terms of how they physically do the reporting whether or not whoever they tended their defense to.

If they have an argument or a basis for it, they may routinely wish to consider that one of those obligations is the actual physical reporting. They would technically be using that other entity as an agent.

But you're telling me they're counting on that as a team to protect their right you know always in any case. So it doesn't seem like it would necessarily be

adding anything new, extremely new or extremely different to have them do the physical reporting and it's very possible for all effects. There's at least an argument that they would have to indemnify them for any penalty anyway.

Vicky Vance: I agree with all of that and the notion of having that company that has accepted the tender – perhaps years ago accepted the center but the case you know again, is still pending or maybe it's settled a few months ago.

I guess there's two issues, one are the retrospective cases, cases where now companies are thinking that, oh, my goodness. I tendered a case you know maybe many cases to companies, a variety of companies over the years litigation-wise.

How far back do we need to go to find out that those cases have resettled? Was there ever money paid? Was the money paid in 2010? Are there TPOC you know obligations? That's one big challenge that a lot of companies are really sort of concerned about now.

On a going forward basis, I think your advice is very hopeful, that we can think going forward with tendering obligations that we try to – that we have the company accepting the tender except that – in a way, an agency obligation to do the reporting as well.

But I'm wondering if there's any retrospective guidance we give to companies and for our – in terms of how far back do they need to go to worry about cases that may have settled. And do they – are there any residual reporting obligations that they never thought about until now.

Male: Well, I guess, first all, can I assume that this is most often the worry with liability insurance versus …

Vicky Vance: Yes. From my perspective, yes.

Male: OK. So the reporting obligations are, shall we say, more late starting for liabilities and then also the others?

Vicky Vance: Correct.

Male: I don't know that we have anything specific to offer you. I guess I find it hard not saying what you're saying isn't true. I just find it hard to believe that a situation where you are technically on the hook and technically a party to something you aren't at least, doing some type of general oversight to make sure you're not being hit in the face with something that is totally contrary to your interest. And …

Vicky Vance: And I think the – yes. That's a good point. And I think different companies may have different mechanisms for being able to retroactively find those cases. But I think in the practical sense, many times just in the press of handling other more current litigation that is, in fact, clearly on their plate and clearly their responsibility, cases that they can tender off like through a vendor's endorsement, a sales company passing it back up a chain of distribution to the manufacturer, they're happy to move it along in many respects.

Male: But, I mean, in terms of them being able to locate and at least identify the cases, as you've described it, these cases – the entity that tendered the defense, that company is still a named defendant. And so they're still part of actual ongoing litigation.

And certainly in terms of risks to their company or any annual reports or anything else, it would seem like they would have to have some type of handle on that, no matter you know how limited.

So I'm afraid we don't really have anything specific we can recommend. But it does seem like the expectation would be that the company would have you know some ability to check.

Vicky Vance: OK.

Male: But we do need to move on. So …

Female: OK. Thank you.

Operator: Your next question comes from the line of Sean Downey with (John Eastern Company).

Sean Downey: Thank you for taking my call. We're a TPA who handles worker's compensation claims for several municipalities. And a very common occurrence is where a deputy sheriff comes in contact with the suspect's blood and is treated at a doctor's office that does the protocol testing for HIV and hepatitis.

I have been unable to or we have been unable to identify an appropriate ICD-9 or an E code to match this description. The doctors uses a V code, V 15.85. But as you know V codes are not acceptable for Section 111 reporting.

We contacted our EDI representative for this and other – and another unusual situation. And what he did was he said look at the user guide starting on page 54. But after referring to that, we really haven't found a suitable answer out to what ICD-9 code or E codes to use in these cases.

Bill Decker: This is Bill Decker. Thanks for that question. We – I actually saw that in the questions that were submitted to the mail box. My first question to you would be why are you considering reporting this? Is the deputy sheriff a Medicare beneficiary?

Male: Yes.

Bill Decker: Yes. OK. In that case, you're going to need to report something apparently if there was an injury or some such thing like that. Mere exposure would be an injury.

I would counsel you to pick an ICD-9 code that is acceptable that comes closest to describe what actually is the problem that the deputy has encountered, which is perhaps exposure to a toxic substance, or just even – you could even report something as innocuous as a visit to an emergency room or visit to a physician's office.

Male: But in terms of a diagnosis code, I guess I would ask what is it they're testing for? In other words, what diagnosis are they really trying to rule out?

Bill Decker: I believe the question that came in was – well, I don't actually remember it offhand, but I suspect it's almost always HIV. Yes.

Sean Downey: Yes, HIV and hepatitis.

Bill Decker: Right, right.

Female: OK.

Bill Decker: You can use those disease codes.

Sean Downey: But now they aren't positive for that so – in those cases so it really isn't – it wouldn't be accurate to report hepatitis in a case that is not – he doesn't have hepatitis or HIV.

Male: Just out of curiosity, have you seen the actual emergency room or doctor bills, or lab bills, or whatever to see how they're coding those particular cases?

Sean Downey: Yes. What they're doing is they're coding them with the V code, the V 15.85. And that's the only code they're using.

Male: So that's the only code you've seen so far anyway. How many of these have you actually seen?

Sean Downey: It's fairly common with you know our municipalities with (inaudible).

Female: (Inaudible).

Male: Yes, it's not common for them to be Medicare recipients, but it's common in the sense that it happens in the line of duty for firefighters and for police officers.

Bill Decker: Well, I think we had given you what we here in Baltimore think of.

Jeremy, do you have anything you want to pitch in on this?

Jeremy Farquhar: No, I mean, I would probably just reiterate what you had already stated as far as taking the closest possible ICD-9 bills (inaudible) that they use the ICD-9

for HIV or hepatitis then I suppose they could do that. But other than that, I don't have much to add.

Sean Downey: OK. Thank you.

Operator: Your next question comes from the line of Suzan Kornbluth with New York State Insurance Fund.

Your line is open.

(Frank): Yes, hi. This is actually (Frank) (inaudible) from New York State Insurance fund. We're a worker's compensation carrier. We just want to get some clarification. We've had some discussions about an issue where we sometimes deny a claim and we then settle with the claimant without actually accepting the claim. We usually settle for relatively small amounts of money.

And there will you know are instances where this person – these people may be Medicare eligible. So we're just trying to get some insight as to how we should report those claims if we're not truly accepting any actual liability.

Male: Remember that the MSP statute says a demonstration of primary payment responsibility which can essentially be done by a settlement or judgment or otherwise. And specifically in the statute, it has the words regardless of whether or not there's a finding or determination of liability.

There doesn't have to be an affirmative acceptance of liability, in fact, I would wager that at least with liability insurance there is virtually never a statement that, yes, we're responsible, that all liabilities will be denied but there's still a settlement. If there's a settlement, judgment award or other payment, all the rules apply and you have to report.

(Frank): So then, in essence, we would report – although we weren't necessarily accepting, we report the ICD-9 code or codes that were associated with the alleged (inaudible).

Male: What we've said is two things for worker's comp. Well, actually, for any situation where you're reporting ORM, we've said that for the ORM report,

you should report the diagnosis codes associated with what you're actually paying for or what you've agreed to pay for. If you're reporting a TPOC situation, you need to report the diagnosis codes associated with everything that they've alleged.

(Frank): Right. OK. Thank you very much.

Operator: Your next question comes from the line of Anne Armstrong with Intermountain Health Care.

Your line is open.

Anne Armstrong: Thank you. So this is Anne Armstrong from Intermountain Health Care. I actually called in last month and post a question and was asked to submit it to the e-mail box, which I did, and it's about hospital write-off.

So I didn't hear it addressed so I can go ahead and read the question to you again. So this concerns risk management write-off and hospital charges by a self-insured hospital who was also an RRE.

So I understand that while we do – when we decide to write off a charge for Medicare-eligible patient, we would then send it in the bill. The portion we've written off, assuming we don't write off the total charge, but some portion thereof, the portion we've written off and we identify as a liability payment.

But my question concerns subsequent activities because when we do this, the patient typically is left with the remaining co-payment. And we would like to in some instances also relieve them of the obligation to pay that co-payment. So, once Medicare processes our bill, they – you know they consider that we've already paid a part and then they part a part and then the patient gets their remaining bill.

My interpretation of the billing guidance that's on the CMS Web site is that a hospital is permitted to waive their own – their own – the (inaudible) obligation (inaudible) that would come back to the hospital. So, once we've processed the bill in accordance with the (MMSCA) guidelines and identify

that primary payment, can we then also waive the remaining co-payment obligation on the patient?

Male: I have your question in front of me. And, unfortunately, what you're asking is outside the scope of Section 111. I mean, one way for the individual not to have the responsibility for the co-insurance being deductible, et cetera, is for you essentially to write off a certain amount and give them a cash amount that's the equivalent of (inaudible) pay the co-insurance and deductible.

When you're asking questions about waiving co-insurance and deductible, that is controlled by other areas within CMS. It's not something that we can address within the scope of 111.

Anne Armstrong: Well, if we did decide to try that option – in other words, we go ahead and write off a portion – and then when the patient is left with the remaining obligation, we provide that in cash or a check and use that as TPOC.

Male: If you provide – yes.

Anne Armstrong: But then that would be reported on the claim into file as a TPOC.

Male: Yes. We're not recommending that you do that. We're just saying you know if that's something, that is one way that it would be clearly something that's within the purview or scope of what we're talking about for 111, the suggestions or things that you asked about in your e-mail – we did go through it – they just really are outside the scope of our authority or what we do.

CMS has its own rules and rationale for how it deals with the whole general area waiver of co-insurance and deductible.

Anne Armstrong: OK. I have one more related question. If we do – if we do decide that in, say, a particular case we do want to go ahead and pay the patient, are you – do you have any prohibition on us making the – making the payment or the checks from the liability fund payable to the patient and to the hospital that actually – it's intended ultimately to reach the hospital, are you aware of any prohibition in making the check payable to the patient and to the particular hospital where the patient had the services?

Male: I thought you were casting yourself as the hospital that actually provided the treatment.

Anne Armstrong: Well, we own several hospitals. So, let's say the patient is in hospital A and our self-insured fund decides to pay – pay the – relieve the patient of any out-of-pockets, but we would also like to you know rather than the patient take that check, not pay the bill that they owe the hospital and do something else with those funds in order to insure that that is what the money is used for, we're considering whether or not we could make the check payable to the patient.

We'd still report it as a TPOC, but we would also ensure that the hospital receives the funds.

Male: That is something that you would have to discuss with your lawyers. We can't really address that. I mean, you – you've got your own options in terms of how you deal with it, whether – whether or not you simply do a larger write-off of the actual charges and not do anything with co-insurance and deductible at all.

All of that would be determined between you and the beneficiary in terms of how you're settling or dealing with the claim or potential claims.

Anne Armstrong: OK. Well, thank you. I appreciate the time.

Male: You're welcome.

Operator: Your next question comes from the line of Suzanne Jordan with (inaudible).

Your line is open.

Suzanne Jordan: Hi. Good afternoon. We are a TPA. And one of the standard practices that happens in the insurance industry today is you have clients move between you know from one TPA to another TPA.

And what we're discovering is that while the business or the responsibility for reporting the claims for that RRE might have moved to another company, it

seems that either CMS or other entities such as MSPRC is still looking to that last RRE that we reported the claim.

And so our question is you know well part of our concern is just the delay in things such as demand letters or something if it ends up in the wrong – at the wrong company, but how can we notify CMS that the reporting responsibility has moved to another company?

Jeremy Farquhar: Well, they – I mean, technically, you can – you could be sending updates with the – the records that are out there that were submitted presumably under one RRE I.D. are moving up or two or different RRE I.D. entirely. And if that's the case, an update could be sent under the RRE I.D., the one that had assumed responsibility for that claim with their information provided on the (TIN) reference file.

And you would need to send an update for (inaudible) ('TIN) reference file with their updated – with their information and then you would have to send an update for your claim records so that your record would properly cross reference that information from your (TIN) file.

But, basically, the updating a (TIN) file owner, the information is actually – probably the same on your (TIN) file and there may not even be a change, but what needs to happen is on the claim input file under the new RRE I.D., you can submit updates to that claim and reference the (TIN) that would link to your or the new RRE's (TIN) reference file and their (TIN) records.

And that update of that claim record on your claim input file would cross reference with that new responsible entity's information and it would update that claim record with their information so it goes to the appropriate place.

So, in essence, there may not be anything that's changing on the claim input record when you're sending an update for it under the new RRE I.D. than when you would send it on a prior I.D, but it's cross referencing. The only thing that may be different is it's cross referencing a different (TIN) on that other RRE's (TIN) file and, therefore, updating the claim record with that new responsible entity's information.

Does that make sense?

Anne Armstrong: Well, I'm not sure if it did, Jeremy. I think what we're worried about – because, see, the reporting has moved from us to another place or parties, so, I guess, we'd be relying on them to send an update record.

So what we were hoping is that may be CMS might consider some type of update that would notify you, hey, we're no longer you know responsible or you know if we brought in new business that we could you know send something over just to avoid that delay and correspondence because it seems like the correspondence is going to you know again, the last person who reported it.

And I just don't know how you would send in an update if there's no update on the claim. I guess I'm confused by that.

Jeremy Farquhar: Well, I mean, the update I was referencing is – they would be updating that claim with the new – with new (TIN) information basically if that is going to the new RRE. The new RRE would actually have to send that update. And it is their responsibility to report on these claims moving forward.

It is that entity's responsibility for sending an update on that information. And we don't – I don't know whether we really have the means by which the old RRE could inform us that they're no longer responsible for the claim. We don't necessarily want you to (delete) to the pre-existing claim because it is in essence a valid claim and should remain open.

I don't know if Barbara or (Bill) would have any additional input they'd like to provide.

Barbara Wright: Our question is we thought that the person who's speaking was not talking about a change in RRE. She was talking about a situation where there was a change really in the agent who was reporting for the RRE.

Is that correct?

Anne Armstrong: Well, yes and no. There may be instances in both. Sometimes it does move to a different RRE, but other times it's actually moving to a different TPA. So it could even be with the same you know reporting agent, but then the correspondent is still routing it back to the last person you know that reported the claim.

So it's looking at that (TIN) reference and you know in this case, the temporary solution that you guys have for the (TIN) reference file would have our address on it. So you know we might get you know (lien) notifications and such that don't belong to us any further, it would belong to a new TPA.

Jeremy Farquhar: Well, that would even more simple. And if you've got – if it's the same RRE and the same reporting agent – so the RRE I.D. hasn't changed – the reporting agent is going to have to be aware of this change in TPA. That reporting agent that's sending in data for that RRE should be sending in an update to that (TIN) reference file with the care of to the new TPA as permitted for our temporary work round and then will also need to send an update on the claims on the claim input files to cross reference that data and appropriately update the claim information or the TPA information that would be linked to that particular claim record. You know if you've got the same agent, it's the same RRE that's dealing with this scenario, these people should be well aware of the change. They would just need to send an update on their TIN reference file first and then also an update on any of the impacted claims records they had submitted.

The information on the actual claim record they are submitting may actually be exactly the same in this situation. There might not be a change to the data within the actual claim input file but they would have updated the TIN reference file information and so when that update transaction goes through it's pulling and cross-referencing data from that updated TIN reference file and that will cause the TPA information to be updated. This is associated with that claim.

Anne Armstrong: So our reporting agent could just in essence send in a new TIN reference file if it moves from one party to another. And so, if we were getting a new business we, as part of that you know take over, so to speak, we would send in

an update to the TIN reference file if they had previously been reporting under another agent? Right?

Jeremy Farquhar: Yes, but then there would also have to be the corresponding update for any of the impacted claims records on the claim input file because they're not just the TIN reference file alone built-in because the claim records that they had previously posted to be updated. They need to be able to cross reference, and so, that update transaction is sent on a claim file would cause the information to be pulled from that TIN reference file and for it to cross reference properly in order to associate it with the new TPA information.

Anne Armstrong: OK. All right, we'll work on that a little bit. And then my second question is just last year it was you know quite a while ago we had sent in additional examples on you know who is the RRE that touched on an earlier question that came up today in (SAR) situations until they see the RRE.

And previously we had talked about maybe incorporating some of those examples into the user guide and we just didn't know whether that was still the intention or if we needed to re-submit those examples.

Barbara Wright: Why don't you re-submit the example because you know I think we haven't had concerns particularly expressed in that and we at least were under the impression there was now a clear understanding.

Anne Armstrong: OK, and so, I'll turn on those again. Thank you.

Jeremy Farquhar: Thank you.

Operator: Your next question comes from the line of Bonnie Mustarde with Farmers Insurance, your line is open.

Bonnie Mustarde: Thank you very much. I do have two questions. One, if the situation were a simple auto accident, well, maybe not so simple the insured perhaps had some sort of an egregious act of DUI or that type of thing and the individual has more injuries than we have policy limits. Let's say for example our policy limits are $2,5000 but the insured agrees to also pay the claimant $5,000. It's not an (SIR) situation.

The insured is you know (John Smith) who you know works at the dry cleaners down the street. He's just trying to help this person out. We secure one release for the $30,000. Do we report a (TPOC) of $30,000 or do we report a (TPOC) of $25,000?

And if we report $25,000 is that insured then expected to become an RRE for this one circumstance that is not anticipated to happen again in their lifetime?

Barbara Wright: There's a couple of things going on in your example to the extent that your report that you have policy limits and that's what you're paying out and you have no obligation for that $30,000, only for the $25,000. You can only report the $25,000 and yes, the insured would be responsible for reporting the additional $5,000 assuming it's above any mandatory thresholds that's in place at that time.

On the other hand keep in mind that it has to be someone that is in fact a responsible reporting entity where (MSP) is the consideration. And so, if it's an individual who owns the car and is in a car wreck and they end up paying in excess of the policy limits. Unless they are self-insured for purposes of (MSPs) then they aren't going to be doing any reporting.

You're self-insured if it's an individual or entity engaged in a business trade or profession to the extent that you bear the risk. So if (John Smith) is (inaudible) and someone falls at his office in the context of his business and he picks up the self-insurance for that, then he's going to have a reporting obligation assuming all thresholds and everything are met. But if it's (John Smith) who's just – he's retired, he's not engaged in any type of business, trade, or profession, he's just tooling down the road in his private car and he pays 5,000 in excess there isn't any Medicare secondary payer, probably there aren’t any Medicare secondary payer obligations attached to that additional $5,000.

The other thing that comes up in the context of what you gave an example of, your incoming e-mails said that this is not a joint in several situation but on the other hand you said that there is only one release, so you know depending on how that release and everything is worded, there may or may not be joint in

several obligations but that's not something that you know that we can really address right here.

Bonnie Mustarde: Right, OK. OK, so in other words (Joe Smith) who is just – I mean this is not his business trade, something like that, he's just – he sees the best choice to get a clear release against him for $30,000, the claimant, the Medicare beneficiary. And the $5,000 let's say it is of the reporting threshold he would not have a responsibility to report because he is not an RRE but if it's a business …

Barbara Wright: Well he would not have an obligation to report because the extra $5,000 is not insurance and it's not subject to the (MSP) rule. But you know that's why the issue would be what's the context of the accident or incident, he could be, very well be self-insured but if he's not then it's just you know if your grandfather was out driving his car he hasn't worked at anything for 30 years, no.

Male: He voluntarily kicks in the extra 5K.

Bonnie Mustarde: Yes, OK, all right. That seems to be a fairly reasonable situation when there's some egregious tax.

I do have a second question and this is with regard to due diligence in particular for undocumented workers or foreigners. Right now when we make our first contact and we are advised that someone doesn't have an SSN we follow the alert that CMS issued and we actually follow up at day 21 and day 365 and then annually if that is an ORM or an open-claim file to attempt to identify if that individual is at that point a Medicare beneficiary.

And we've been asked to review our process to see if we've taken the due diligence expectations that CMS has beyond your expectations especially in those cases of undocumented workers and foreigners.

William Decker: Thanks, Barbara. Hi, (Bonnie) this is Bill Decker.

Bonnie Mustarde: Hi, Bill.

William Decker: Let's start with the opening constructs that you have – you have an undocumented worker/foreigner, undocumented, right?

Bonnie Mustarde: Yes.

William Decker: And you're asking us to tell you what we think you should do to be sure you're not shirking your reporting responsibility for this undocumented worker?

Bonnie Mustarde: Well we've set – let me clarify that we have set what we think to be a fair and reasonable effort to make due diligence to report what CMS has set as an expectation and what we're hearing from some individuals and this is in particular with work comp is that if the individual is clearly an undocumented worker or a foreigner that's working under an approved entrance into the country that both of which are you know quote, unquote, "obviously, according to this individual would not have Social Security or Medicare." They think we are taking our effort …

William Decker: (Inaudible) spoke to has a skewed take on this. If it's a totally undocumented person, an illegal immigrant for example they won't have any documentation, there won't be a Social Security beneficiary, there would never be a Medicare on account of their undocumented – on the other hand so you would not necessarily need to know anything more about that individual.

On the other hand a person on the contrary legally on certain types of working visas which can go for years can become a participant in the Social Security System and as could theoretically become a Medicare beneficiary.

An undocumented person is not the same as someone who is in the country on proper documentation. Any one here in the United States who is here although they are a foreign national but here under color of law could conceivably, at some point, become part of the Social Security System and thus could conceivably at some point become a Medicare beneficiary. So those are two very different situations you're discussing now.

Bonnie Mustarde: Right. I think that one of the issues that this individual has said is once they say to us this is an undocumented worker in the United States illegally we should not ever ask them another question, again. And our point has been is

that an easy answer and excuse and we're just going to do our due diligence on anyone and everyone that we have a claim – that has a claim with us to protect from any concern that you might have.

Male: Well, I think we just expressed what our thinking is on undocumented work, on undocumented, anybody. Simply put, anybody who is actually undocumented and is in the country without proper documentation or authority will not be participating in the Social Security system or the Medicare system.

Female: OK, very good. Thank you so much.

Operator: Your next question comes from the line of Suzanne Vick with Malaby and Bradley. Your line is open.

Suzanne Vick: Thank you. I have a question about the e-codes used in asbestos matters. Back in October 2010, I specifically asked a question about which e-codes to use because the e-codes listed for asbestos really fell under poisoning, really fell under poisoning.

And then at the May 4, 2011 teleconference, I guess I got – I received an answer. If I could kind of read this to you, this is on page 15. A default or an e-code that you could use in the case of or the even of exposure might be E-0008, E-0009. And I guess my question is I really wanted to confirm if I could use these e-codes for asbestos exposure. The E-0008, the definition is "other external cause status", and the E-0009 is "unspecified external cause status".

So, basically, my question is are these two codes acceptable to use for asbestos exposure on the Medicare Form B?

Male: We're pondering, hang out a second.

Jeremy, do you have anything to add?

Jeremy Farquhar: The e-code is something – I mean, to us, and this is my opinion and you may feel otherwise, the e-code is not something that is important, is not as

important as the ICD-9. It's OK if there is not an e-code that precisely fits your situation, it's OK to use a somewhat vague e-code such as have been referenced.

But the ICD-9 that you're using is what you need to be very careful about. The ICD-9 has to be specific as possible, but the e-code is somewhat vague, that shouldn't cause any problems. The e-code is not used for anything too terribly important on our end. They will not cause the claims to be denied because there is inappropriate e-code. If the ICD-9s are good, that is what is going to be the most important thing.

Suzanne Vick: OK, thank you. That was my main concern. The diagnosis codes that we use has been appropriate and specific to the diagnosis.

Male: (Inaudible) are you OK with that answer?

Female: Uh-hmm.

John Albert: This is John Albert, I've joined the call. The – I mean the ICD-9 codes, from my understanding, are what are used in actual claims processing for (inaudible).

Male: Correct. And the e-code were used more as supplemental information when we're looking at recoveries, et cetera. But – so I think we'd agree with what Jeremy said.

Suzanne Vick: Great. Thank you very much.

Operator: Your next question comes from the line of Toni Ellington, from (inaudible) LLC. Your line is open.

Toni Ellington: Yes, hello. We are a law firm and we represent some clients or defendants who are self-insured in the context of liability settlements. My question is in some instances, our clients enter into group settlements for which the release is done in such a way as the individual amounts per defendant are not disclosed. In that instance, the way we understand the guide is that we would

report the entire amount of the settlement, and I just want to confirm that that's correct.

Male: No, we have never said that. You have an obligation to find out how much each claimants is obtaining.

Toni Ellington: No, I'm sorry. I think you misunderstand. There's one plaintiff but multiple defendants.

Male: OK. And it's all from the same insurer, so it falls on the same – it's all being reported in the same claim or what?

Toni Ellington: Well, I mean for our particular client you know they may – they would be paying a portion but the release, as we understand the guide you know the CMS looks to what is being released. The release simply gives the total amount being paid to that particular beneficiary.

Male: What is – what you're saying is that the defendants don't want the amounts disclosed?

Toni Ellington: That's correct.

Male: OK, that's not binding on us at all. And you can't – our regulations require beneficiaries to cooperate in coordination to benefit activities. And if you look at 42 CFR 411.24, I believe, essentially by a beneficiary having claims filed on their behalf to Medicare, they've granted authority to any entity they're dealing with to provide us with the information we need for coordination of benefits. They can't, through a settlement agreement, circumvent those regulations and say, one, I'm going to enter into a settlement and keep that secret from you.

So if there's joint several responsibilities, then yes. If there's four of you involved and you all have joint and several responsibilities, then all four of you report the total amount. But if you don't have joint and several responsibilities, then you each need to report the amount you're responsible for even if there's a single settlement.

Toni Ellington: OK. All right, thank you.

Male: OK.

Operator: Your next question comes from the line of Sean Devore with Physician Professional Indemnity Association. Your line is open.

Sean Devore: Yes, good afternoon. As a medical malpractice – I work for a medical malpractice insurance company and as part of settlement negotiations, potential settlement negotiations, we – I mean a huge part of that is making sure all liens are satisfied either prior to a settlement or a guarantee that they will be satisfied shortly thereafter, basically qualifying the Section 111 reporting for our purposes a little late and we'd like to get – we like to be in discussions with Medicare Part 2.

Is this something that we could use Section 114 in the event that we believe we can settle the claim should – can we file prior to actually settling the claim and get to Medicare that way?

Male: Let me ask you a question first, I didn't hear in the beginning. Did you say you represent claimants or defendants?

Male: Defendants.

Male: OK. No, you can't use Section 111 reporting ahead of a settlement judgment award of other payments. In the first place, it wouldn't be accurate. You don't have a (inaudible) then. If you assumed all around, you're going to report that in a different manner anyway. Also, in terms of us – in terms of CMS developing and arriving at its recovery claim, it takes into account what they paid up through the date of settlement.

That's why although the beneficiary can receive an interim conditional payment amount, they can't receive a final conditional payment amount until there's been a settlement judgment award. I will direct everyone to the MSPR – Medicare Secondary Payer Recovery Contractor, MSPRC, to its Web site, which is www.msprc.info.

And there are several new – three new options I think of there in terms of certain situations where a beneficiary can agree to a fixed percentage for particular types of settlements or can do a self-calculation for a particular type of settlements, depending on certain factual circumstances that's outside the scope of this call. But those of you that are familiar with that should probably check out that Web site.

Male: Thank you.

Operator: Your next question comes from the line of Jennifer Souza, with Westfield Insurance. Your line is open.

Jennifer Souza: Hi. Thanks for taking my call today. And this is a follow-up to a question, I think two questions ago. We think we understand mostly the issue of joint and federal liability for settlement judgments, payments or other awards. But we think it would be helpful for perhaps you to elaborate a little bit more on what you mean by joint and federal liability for those payments.

As a little bit of a twist to the scenario that the caller two questions ago painted, in a situation we have multiple defendants involved in a global settlement let's say for $350,000. But in this case, the release itself specifically allocates each defendants responsibility for that $350,000. Is that a situation where each of those defendants then need to report the total amount of that settlement or the $350,000 or do they, in that case, report only their respective share?

Male: I can't give you an absolute answer on that because I don't know what the state law, et cetera would be in that particular jurisdiction. If under state law, you have joint and several liability regardless of what's written in the document, then you have to act according to state law. If you have completely separate settlements and you have (inaudible) several liabilities, then report separately.

We're not in a position to give you legal advice about every single jurisdiction and what the rules would be. What I can say is that in terms of some of the – we said before that we're revising the NGHP user guide and expect the revised guide to be out shortly.

There is one example, on joint several, but I believe – or one paragraph on joint several that a couple of events (inaudible) of assets to change or clarify, that was during the 12580 policy guidance and we have agreed to do that. So, these entities have told us to change would be helpful to the type of question you're asking.

So, we should see something shortly on that, I believe. We expect to revise that, to be out within at least a month.

Male: Right. And we expected the reviser guide to be out by now, in fact. But we are pretty – we're all certain now that we have, Barbara, major stumbling blocks reversed that we should have – we should have the guide out by the third week or so in May is what we're shooting for right now.

Sean Devore: OK. I do think those examples will be very helpful for us as we move forward with many of settlements and judgments, et cetera. Thank you.

Operator: Your next question comes from the line of Marcia Nigro with Sedgwick. Your line is open.

Marcia Nigro: Good afternoon. I have two questions; one should be quick addressed to Jeremy. You noted that we were able to send multiple files in a course of a reporting quarter. And that they may very well be on hold pending the completion of the initial file that was sent and that could be up to 45 days, correct? I believe that's how (inaudible).

Jeremy Farquhar: That is true.

Marcia Nigro: But you all – but I know you guys are doing it faster on most of the cases. When they're on hold, is it incumbent upon us to contact our (EDI) rep and tell them to release the file or is this automatic?

Jeremy Farquhar: No. Actually, if a file goes on hold because of – if the claim file goes on hold because of a prior claim file that is still processing, as soon as the prior file completes processing, our system will automatically release the new file.

But it – really, we would suggest that you not send the subsequent claim file until you've received the response file from the prior file in case that there's anything – I'm not sure what you'd be sending on your subsequent file (inaudible).

Marcia Nigro: Well, it'll be (ORM) termination – right.

Jeremy Farquhar: There might be things you want to address if you see in your response file from that first file that that would be helpful to have before sending that second file. So, typically, we wouldn't advice in sending that subsequent file until you received that first response.

But if you were to do so and we received it, once the other file completes processing, we'll automatically release the other.

Marcia Nigro: OK. And then the other – my other question is directed to Barbara. I sent in a question and I'm a little bit confused so forgive me – on the delayed funding of TPOC, if we had a scenario, could you kind of outline exactly how it would be reported and taking the scenario we have $10 million fund that was satisfied for various claimants.

And it was – the funding was as of (1/1/2012). The claimant really will not know the next six to seven months exactly what amount they're going to get. But I'm going to anticipate maybe July 1 that they'll get the funding. We're not sure what it is but the TPOC is. So then, how would we report that, just give me the – if you can give me the sequence.

Barbara Wright: Hang on a second; let me find your e-mail.

Marcia Nigro: You can make one up – I mean, it's just …

Barbara Wright: No. I've got it here. I just need to get to the – what you were talking about was the scenario where there was a settlement which occurred – which I assume means that you have criteria which meets one of the definitions for the TPOC (date), if it's court approval and that's what's going to do it, if it's the signature of all the parties, that's what's going to do it.

I mean, if you've got a fixed TPOC date then that TPOC date is the date period no matter when you report. If the TPOC date is going to be dependent on something else you know individual releases by beneficiaries, et cetera, then that's going to fix your TPOC date which is why I can't give you an exact answer to your question. It would really be fact-specific. But you would establish …

Marcia Nigro: Go ahead.

Barbara Wright: OK. You would establish your TPOC date and if the TPOC date is, let's say, January of a particular year and then you said – it was determined – you said – you said there was a settlement date of December 1, 2012.

Marcia Nigro: Well say, for example, asbestos. We have an asbestos settlement amongst many (defendants) and it's $10 million fund.

Barbara Wright: Right.

Marcia Nigro: OK. But the claimants that are party to this action you know there are varying degrees on who gets it whether it's (inaudible), whether it's asbestosis.

Barbara Wright: Right. Right.

Marcia Nigro: Yes. It's varying degrees and it has to be calculated. They may not get if for – they may not get their (quote) TPOC.

Barbara Wright: Right. Well, we said …

Marcia Nigro: (Inaudible).

Barbara Wright: We said in the guide and I can't give you a (site) right this minute.

Marcia Nigro: I don't think that (inaudible).

Barbara Wright: Well then you (inaudible).

Marcia Nigro: I've been trying to read it for a few – I confuse myself so I figured (inaudible).

Barbara Wright: Well, we did say you don't report until you know you have indentified who gets the money and how much. So, if you had a – if for whatever reason the TPOC date was December 1 of 2012 and the funds weren't available until July of the next year but you didn't identify that (Sam Smith) was going to get $100,000 in September of that year then there wouldn't be any reporting obligation until you've actually identified (Sam Smith) as getting the $100,000.

And if the funding is already available at that point then you don't have to worry about the funding delayed (block) because you're really talking about funding for (Sam). If on the other hand you identified (Sam) in July but the funds weren't going to be available until September, then you would have to use the delay sending (block).

Marcia Nigro: (That) …

Barbara Wright: Does that make sense?

Marcia Nigro: Absolutely. Yes. I got it. Thank you.

Barbara Wright: Operator?

Operator: Your next question comes from the line of Richard Joppich with The Kitch Firm. Your line is open.

Richard Joppich: (Yes). Thank you very much. I appreciate you taking my question here. This is in follow-up to question from back in February town hall and also it kind of ties in what you've already said today about write offs and reporting of write offs where there is a subsequent (inaudible) earlier question that was a copayment.

The question that I have is the last time we had the town hall, in this scenario where there was a health care facility that wrote off its own bill and submitted its billing to Medicare identifying that it was writing it off under liabilities self insurance. But subsequently, there were risks management continuation of some medical billing payments for providers outside the health care system that that may not constitute ORM.

And I went back and I looked at the rulings – rules on the write offs and it all refers to reporting any subsequent giving that property a value in a write off situation is a TPOC. And I'm just wondering if we have to write off medical bills that are paid subsequent to a write off as TPOCs as they come up or do we report that as ORM.

Barbara Wright: Well, I mean, part of it depends on whether you're saying as a certainty that this is something that's going to be a write off by the hospital.

Richard Joppich: Correct.

Barbara Wright: (Inaudible) hospital.

Richard Joppich: It is a risk management decision and payment.

Barbara Wright: But is it a risk – would I anticipate in most cases whether or not there could be some ORM in that situation, I think there could be.

Richard Joppich: Yes. I was thinking the same that you know if I – if in the risk management (department) and I apologize I'm an attorney for our firm here in Detroit here in Michigan. And we have a number of health care clients that are concerned about how to report this.

And my thought was that if they're paying individual medical bills are they are coming in for a Medicare beneficiary for whom they've already written off their own bill that that may constitute ORM or acceptance of ORM and should maybe reported that way under Section 111.

Barbara Wright: Well, I mean, part of this depends – the section that's in the user guide right now and it starts on page 115, I think.

Richard Joppich: Right. Yes, I get that.

Barbara Wright: Only page 115. It's written in terms of taking a write off type action. It's not – and this conversation right now seems to be crossing the line a little bit into actual cash payments you know that aren't being done as a write off action by the hospital.

Richard Joppich: All right. I understand that. So, that's – it – the write off is separate from any payments that might be made subsequent to the …

Barbara Wright: Yes. The first two bullets on page 115 were really talking about where you've got a provider or physician or other supplier that reduces charges or does a write off.

And the next two bullets were really talking about whether either a provider or physician or other supplier or any other entity – or other entities they included write off but for a provider, physician or supplier it was talking about if you provide property of value other than the reduction in charges or write off that you can report the value of the property provided it can be reported as a TPOC.

But that doesn't mean – we didn't address it specifically but I don't think we ever intended to say that in a lot of self insured liability situation that you never have ORM. If you clearly have a situation where the provider, physician or other supplier is assuming on an ongoing basis the obligation to take care – directly take care of future medical or take care of those future medicals then, yes, you should report the ORM for that.

Richard Joppich: OK. That makes sense to me and my reading of the guide as well. But let me ask just one follow-up question for the other side of the coin here. If we reach an agreement with that beneficiary whom we've written off our own bill through the appropriate billing (inaudible) and codes, but we've reached a subsequent agreement with that individual that hey, we'll give you X amount of dollars, lump sum that would cover any future care that you might need, that would be a TPOC reporting situation.

Jeremy Farquhar: Yes.

Male: OK. All right, great.

Barbara Wright: Thank you.

Richard Joppich: Thank you very much. I appreciate the clarification.

Barbara Wright: You would still do – for anything where you were right off or reducing charges for yourself, for the hospital or provider, supplier themselves, you still need to take care of that through the billing process. But you could have an additional TPOC for other expenses.

Male: Very good. Thank you very much, everyone.

Barbara Wright: OK.

Operator: Your next question comes from the line of Susan Cline, with the City of Portland.

Your line is open.

Susan Cline: Hi, there. Just a clarification way back to the first part of this program where we talked about administrative closures, Barbara, I think a while back, we had – it was determined that or it was stated in one of these meetings that CMS would defer to state statute on whether somebody – on how the state considers when medical – when ORM termination stops. Is that correct?

Barbara Wright: Yes. We simply would (look to) state law, our use of the term administratively closed, the way it was used in the conversations that I remember in the way, I think it's been addressed of anything we've talked about.

And if, for example, works comp, (inaudible) as an internal policy or otherwise that if they haven't received a claim in two years, they administratively close it and take it off their books because that's just easy for them, for an operational business standpoint, but let's say that that workers compensation is in, whatever state that has lifetime medical, whether it's Michigan, or Texas, or somewhere else.

If they're in a state with lifetime medicals, their legal obligation is that they could receive claims and would still have to pay. So in the case like that, we say, if you administratively close this that doesn't mean you get to close ORM or CMS for Medicare.

Susan Cline: Right. I guess, I you know we're again, we're sometimes referred to as a quote and quote, "Lifetime medical state," but when you look at the rules were really not.

Barbara Wright: (Inaudible).

Susan Cline: The only thing that's considered lifetime would be for prescriptions and like hearing aids and things like that. And we keep the claims open for that, but there is limited on additional medicals, like you know we have aggravation rights and then the doctor would have to request palliative care, and in those cases when we reopen a claim or we accept palliative care, we will reopen it and monitor it and report that, yes, ORM is continuing (inaudible) …

Barbara Wright: But the issue there is that you have ongoing legal responsibility at all and you should have a closed record and we get a claim for palliative care. We're not going to know that that person has lifetime medicals and that we should reject the claim until we have proof about whether or not workers' compensation would pay.

The point of the open record is so that we don't inappropriately pay and have to do pay and chase. So if someone administratively closes their records that – and says that that somehow translates the closing ORM, that's not appropriate from our perspective because it defeats the whole purpose. We don't have an open record, exactly when we need one.

Susan Cline: OK. I misunderstood then because you know we do have a statute that says the claim maybe closed when a person is medically stationary which means no more medical treatment is indicated.

But we close it, but that doesn't mean that they can't have an aggravation four years from now when we reopen it.

Barbara Wright: Well, we can't get into every state law, but I mean, the point or the purpose of our ongoing responsibility for medicals records is so that we will deny or at least reject until there is proof that something is not covered by workers' compensation claims that are related to the code that are furnished to us with that ORM record.

Susan Cline: Right. So if legally, we close a claim under the state law, we're OK? Once the person is under the statute, medically, quote unquote, "Stationary."

Barbara Wright: If you have (inaudible). If you don't have legal responsibility for any medical, yes.

Susan Cline: Right. Then we can close it. OK. All right. Thank you.

Operator: Your next question comes from the line of Barbara Schatzer with University of San Diego.

Your line is open.

Barbara Schatzer: Thank you. My question is on employment liability cases where the final settlement just says, this releases the university from any and all further claims, but there is no stated medical issues. It just – is an any and all statement. And we're not sure how to report those because there is no diagnosis. There is no medical claim at the moment that it's settled.

Barbara Wright: That's one of the types of claims that right now, I said at the beginning of the call that we're still having some internal discussion to try and provide responsible reporting entities with some relief. For the bulk of those cases is what the industry has been telling the (truth) that medicals are not being claimed, et cetera.

Right now, the touchstone is was (to claim the release), they're effectively released. Now that's what we're trying to work our way around without circumventing the law or diminishing Medicare's rights.

Barbara Schatzer: Right. So at this point, we're just in a holding pattern?

Male: The consensus of the group here is that at this point, there's a reporting obligation that we – that you might have if there is someone – there may be some unclarity, I don't know if that's an (inaudible) word.

Barbara Schatzer: Lack of clarity.

Male: Lack of clarity, that's even better, yes, which we are attempting to make clear for you as soon as we can.

(Barbara Schatzer: And, Jeremy, I guess – wasn't there an alert or inclusion in the user guide at one point about a no injury code?

Jeremy Farquhar: Yes, there is. The no-injury code for those very specific situations is the no (INJ), is the actual code. The situations for which that would apply are outlined within the user guide if you do a search for that.

Barbara Schatzer: You don't have an approximate site (inaudible)?

Jeremy Farquhar: I can get it for you, if you can give me just a moment.

Barbara Schatzer: Thank you.

William Decker: Questioner, do you have a follow up on that? Or can we move on? Jeremy will come back and give you the site when he has it.

Barbara Schatzer: No, that's fine. You can move on. Thank you very much.

Jeremy Farquhar: Actually, I just found it. So it's on – it's Section 1122.5.1 within the current user guide. It begins on page 59.

Female: Thank you very much.

Operator: Your next question comes from the line of Kathy Engel with Health East.

Your line is open.

Kathy Engel: Hi. I'm surprised to hear the discussion on the employment liability cases that have to be reported. Do the – do the guidelines for general and professional liability TPOC apply to these employment liability cases?

William Decker: I'm not sure I understand your question.

Kathy Engel: Well, the TPOC amounts for a liability insurance …

William Decker: Oh, you mean (inaudible).

Kathy Engel: Is the timeline the same for the employment liability cases?

William Decker: Yes.

Kathy Engel: OK.

William Decker: I mean, if it's liability insurance, all the liability insurance rules apply.

Kathy Engel: OK. My second question is – we have a case where there are multiple defendants, there is a settlement agreement being drawn up that includes an annuity payment and it involves a child who currently is not a Medicare beneficiary, but may, down the line, become one – do we have an obligation to – because there's an annuity involved – to continue to check to see if the beneficiary becomes eligible at some point?

William Decker: Jeremy, what's the field number for the definition of the TPOC amount? I think reading that would answer her question.

Jeremy Farquhar: Bear with me just a moment.

William Decker: I think it might be around 111, but I don't remember.

Jeremy Farquhar: OK. The TPOC amount is field 101 and it's down on page 192 of the current guides.

William Decker: And could you read what it says?

Jeremy Farquhar: Sure. Total payment obligation to the claimant, TPOC amount, dollar amount of the total payment obligation to the claimant, if there's a structured settlement, the amount is the total payout amount. The settlement provides for the purchase of an annuity, it is the total payout form the annuity.

For annuities, base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount if there is a minimum payout, whichever calculation results in the larger amount.

Barbara Wright: So, basically, annuities would be classified as TPOC. And if at the time of the TPOC, if this is a settlement with or on behalf of a minor child, if at the time of the settlement they are not and haven't ever been a Medicare beneficiary, then you have no ongoing obligation to monitor them for purposes of Section 111.

Kathy Engel: OK. In the case of multiple defendants you know contributing various dollar amounts you know different insurance, so were all different RREs, how would we go about determining our portion of the annuity?

William Decker: Well, (inaudible).

Kathy Engel: We clearly have – I'm sorry?

Barbara Wright: I mean, you're going to have to calculate what the value of the annuity is based on the guidelines that would give you a deal, the 101, and then you're back to where you're normally are. You certainly must know how much you're contributing to get that dollars sum. And you either have joint or several liability or you don't. We're back to the same discussion sort of over again.

Kathy Engel: OK. OK. Thanks for the clarification.

Barbara Wright: OK.

Operator: Your next question comes from the line of Sean Sheehan with HelperBroom.

Your line is open.

Sean Sheehan: Thanks for taking my call. I'd like to, if you guys could talk just a couple of minutes – I know we're almost over here – about how joint and several liability among different defendants impacts the analysis of the 12/5/1980 day in terms of exposure and report-ability.

I represent asbestos defendants. And some of our defendants, all of their exposure that's claimed, released and effectively released pre-date the 12/5/1980 date, but there is joint and several liability in some of the states we represent the defendants for. So, in those states, what do we have to do about

other co-defendants that we don't represent there, completely unrelated to our clients?

Barbara Wright: I don't have any answer I can give you right now. I – we'll have to go back. Have you sent a question into the mailbox or not?

Sean Sheehan: No, I have not. I can though. I can do that. I can put it in an e-mail form.

Barbara Wright: (Inaudible) very, very specific to what you just said.

Sean Sheehan: OK. Thank you very much, Barbara.

Operator: Your next question comes from the line of Louani Bascara with Sidley Austin LLP.

Your line is open.

Louani Bascara: Good afternoon. This is about the loss of consortium question similar to the one that was asked (inaudible), but if a loss of consortium plaintiff doesn't claim medical and the state law doesn't allow recovery of medical for loss of consortium and the general release is used.

Does the RRE have to report those type of situations that's being contemplated by the language you're discussing internally?

Barbara Wright: It's the type of language that we're looking at right now. What I would remind people, those we said in the earlier calls that if – let's say the husband is the one who actually was in a car (accident) and his wife is filing a consortium claim. I believe we didn't say more than once that when you report a TPOC amount for the husband, if there is a consortium amount, you need to report the total of those, (too), for the husband.

What we can't permit is a situation where the parties are trying to simply allocate the funds to the – to the individual for whom there is no reporting responsibility.

Louani Bascara: All right, thank you very much. Barbara.

William Decker: Operator, this is (Bill Decker). Operator?

Operator: Yes? Yes?

William Decker: We can take one more question and then we're going to have to cut it off. I'm sorry, it's too close to our cutoff time.

Operator: OK. Your last question comes from the line of Suzanne Jordan with (inaudible).

Your line is open.

Suzanne Jordan: A follow up to question that was asked a few callers ago on the ORM and in states that may have like a lifetime medical – if they were administratively closed prior to 1/1/ 2010 and no further activity, we don't have to report those, right?

Barbara Wright: Jeremy, does she have the date correct if it was? We have a special exception. And if it sits within that as far as a look back, no, you don't have to report unless you know there's new activity on the case.

Jeremy Farquhar: That date sounds correct, but I would have to (inaudible).

Barbara Wright: I think it's on page 102, 11.9.

Jeremy Farquhar: OK. Bear with me just a moment.

Barbara Wright: If the ORM was assumed prior to January 1, 2010, if the claim was actively closed or removed from current claims records prior to January 1, 2010, the RRE is not required to identify and report that ORM under the requirement for reporting assumed prior to January 1, 2010.

If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original date of incident as defined by CMS. And it goes on from there, but that's page 102 section 11.9.

Suzanne Jordan: OK, great. Thank you.

William Decker: Thank you.

OK, operator, thank you very much for guiding us on this call.

And thank you all the callers who asked questions. And we're sorry we didn't get around to answering all of them. However, as I said, we do have another call next month. Once again, the call next month will be May 24, that's a Thursday, and it will be the usual 1:00 PM East Coast start time.

So if you didn't get your question asked today, you have another shot at us next month.

Operator, we'd like to close off the call now and ask you to stay on with us in the private office after the call is over and have Jeremy stay in there, too. Thanks.

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

END