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
March 22, 2012
1:00 p.m. ET

Operator: Good afternoon. My name is (Sally) 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 the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. Mr. John Albert, you may begin your conference.

John Albert: Thank you, operator, and good afternoon everyone. For the record, today is Thursday, March 22nd, 2012 and as the operator said, this is an NGHP Section 111 call from a policy and technical question. As I've stated at the beginning of everyone of these calls, I have to put out a disclaimer that occasionally we do say things that may contradict the official written guidance of the Section 111 website, and then until the guidance is published that is the official instruction regarding Section 111 reporting.

As we do with all these conferences, we'll have some presentations in the beginning and we'll move into a Q&A session. We ask that participants please limit their question to one, and one follow-up, so that we can give everybody a chance at the microphone. It's fairly a large attendance today. So again we appreciate that. With that, I am going to turn it over to Jeremy Farquhar of Group Health Incorporated, the COB contractor to have some stuff to go over and then we'll go also into – and some of the questions that we've received through this Section 111 mailbox, again please continue to use that as your primary vehicle for getting questions for this call into CMS.

We do look at every single one of those and process them accordingly and use that information to hopefully improve the materials that we have. And with that, I'll turn it over to Jeremy.

Jeremy Farquhar: Thanks, John. I just have a number of general announcements followed by some answers to a handful of the questions we've received at the mailbox. First, for the announcements; last month the Secretary of the Department of Health and Human Services announced the date by which certain healthcare entities would need to transition to the use of ICD-10 Diagnosis and Procedure Codes would be postponed. This being the case, the transition from ICD-9 to ICD-10 for Section 111 of course has been delayed until further notice. And alert with languages affect was posted on the CMS Section 111 website on February 22nd.

For those not already aware, CMS Section 111 URL is www.cms.gov/mandatory I-N-S-R-E-P. This alert can be bound within the additional NGHP Alerts section of the aforementioned page. And keep your eye out at some point in the future, there will be additional guidance.

Next based on our recent analysis is found evident that significant numbers of RREs are misusing the NOINJ diagnosis code on their claimant put files. The NOINJ code was created for using extremely limited in specific circumstances relating to certain types of liability claims. Types of claims to which this would apply are those were a settlement judgment award or other payment may have the effect of releasing medicals for which type of incidence typically has no associated medical care. Based on what we've been finding, it would appear that many RREs are simply NOINJ as a default when they have not successfully derived a valid ICD-9 or Alleged Cause of Injury code.

We've got numerous RREs to be submitting this code on the records that reflect ORM and we've also found codes being submitted for no fault and workers' comp claims. In all of the aforementioned instances, the use of the NOINJ code is absolutely inappropriate. For RREs that have been utilizing the NOINJ code in this fashion, we would that you seize doing so immediately. For more detailed information, please refer to Section 11.2.5.1

titled Specific Default Diagnosis Code for Liability within the current version of the NGHP user guide.

Another topic worth mentioning here is the profile recertification process. As most of you are probably aware, the new profile reporter's recertification process was implemented in January. From this point onward, all Section 111 RREs will be required to recertify their profile report information on a yearly basis. When it comes to timer recertify, an e-mail notification will be sent to both the authorized reps and account manager associated with the RRE. On receipt, it is required that the authorized rep or account manager contact their assigned EDI rep via either e-mail or phone in order to let them know that either there have been no changes and all information is accurate, or that there have been changes which would require updates to their information.

If there are no changes, the EDI rep will simply recertify the IDE and that would be all that is required. If there are changes, then the RRE must provide their rep with the appropriate information at which point in time, it will make all the necessary updates. After updating the RREs information, the EDI rep will regenerate their profile report. A newly updated copy must be signed and returned by the authorized rep. Failure to recertify may result in the discontinuation of the RRE ID, and we've now reached the point where some RRE IDs have begun to be discontinued.

Please note, if your ID is discontinued, all that is required to reactivate your account is to contact your EDI rep in order to recertify your information. On recertification, your assigned EDI rep will be able to reinstate your ID. If you got questions or problems related to the recertification process then please reach out to your EDI rep directly. If you do not receive the assistance required, please follow the escalation procedure outlined in Section 18.2 of current user guide.

The next thing is something that was addressed on last month's call, but would like reiterate as we continue to see examples that would indicate that it's still source of confusion for some reporters. This is regarding our recording of multiple TPOC amounts. Please note that multiple TPOCs are to the report if and when an RRE negotiates separate and different settlements at

different points in time. The TPOC should be a single payment obligation reported in total regardless of whether it is funded via a single payment, an annuity or a structured settlement.

Periodic payments are not to be reported as separate TPOC events. For further detailed information it's highly recommended that you approach the designated TPOC computer-based training module or CBT as well as Section 11.5 within the current user guide regarding multiple TPOC reporting.

My final announcement is also something we addressed previously, but it also still seems to be a point of confusion for some. We continue to receive questions in reference to the 9/30/2011 alert regarding the liability TPOCs delay timeline. A number of people have questioned whether the delay timeline is still applicable, and the answer is yes. The delay timeframe reference within the 9/30 alert is still in effect.

Please note that these delays are optional. At present only TPOCs occurring after 10/1/2011 and exceeding $100,000 are required to be reported. However if an RRE wishes to submit TPOC values under a $100,000 they are welcome to do so and those claims will not be rejected. That being said, the interim reporting thresholds referenced in Section 11.4 of the current user guide are also still applicable, and must also be adhered to. Unlike threshold outlined within the 9/30 alert, TPOC values which do not meet the minimum interim reporting thresholds will be rejected.

At the present, the minimum interim reporting threshold is $5,000. Therefore at present which we accept liability TPOC amounts that are under the $100,000 value indicated in the 9/30 alert, those TPOC values must still exceed the current $5,000 interim reporting threshold. Please refer directly to the aforementioned 9/30/2011 alert and the Section 11.4 of the user guide for more complete information regarding the optional liability TPOC delays and the interim reporting thresholds respectively.

Barbara Wright: Jeremy, this is Barbara Wright. I'd just like to add a little on what you said. I didn't hear you mentioned it back about the alert not making it into the manual or into the user guide, had you already mentioned that or not?

Jeremy Farquhar: No, and that is actually the source of most of the confusion. Yes, we had indicated in all our prior documentation that when there were alerts, they would supersede anything that was in the user guide, if they had come out post the present user guide, but all alerts would be incorporated to the subsequent version of the guides. And there was an oversight and the 9/30 alert was not included in the December update to the non-GHP guide. And so there was confusion based on that.

Barbara Wright: OK.

Jeremy Farquhar: But rest assured that it wasn't because the TPOC delay timeline is no longer in effect, and it will be incorporated in the next version of the NGHP user guidelines.

Barbara Wright: Right, so the – just to sum yours up, the two main points we've been dealing with is our failure to include the user guide made some people think that September alert was not in effect. Also, there still seems to be continuing confusion. I just got a call again, yesterday about it is the big distinction between the alert and the threshold that's already in the user guide is the threshold is mandatory, the further delay that's in the alert is optional. Back to you, Jeremy.

Jeremy Farquhar: OK. Thanks, Barbara. Next I'd like to address ample of the questions that we received in the resource mailbox. First question, excuse me – the first question I'd like to address came from an RRE that had questions about proper reporting of ICD-9 codes. And more specifically, the question how they could simply report on ORM initially with single add transaction, to getting the ongoing responsibilities for met goals and then only once more some hidden update transaction in the claim determination of that ORM.

I think that it indicates in the user guide that when you're reporting to ORM that you may only need to send two transactions for an ORM claim and that maybe the source of confusion here. You're not limited to two transactions. There are concerns centered around situations where the beneficiary may be seeing multiple providers throughout time or there may be different or additional ICD-9 codes linked to those individual visits.

It's important to note that an RRE is required to report ICD-9 codes that indicate to the best of their ability, specific injuries or illnesses for which they have responsibility via their claim. However those ICD-9 codes do not need to come directly from an EOB and specifically codes coming directly from provider might not be available to all RREs at the time of their required for report initially. In those instances, it's the RREs responsibility to derive the most appropriate code or codes from a list of accepted ICD-9.

If after an RRE's initial report, they would received further or more specific ICD-9 codes than they may send an updated transaction on their subsequent submission detaining those updated codes. That being said, it's also important to understand that just because an ICD-9 code may be present on an EOB, it does not necessarily mean that it's directly related to the injury or illness for which the RRE may be responsible. It may often be ancillary codes on an EOB which are unrelated to an RRE's claim. Common examples may be things such as diabetes or hypertension related codes. It's the RREs responsibility to weed out any of these unrelated ICD-9 codes prior to submission and a failure to do so may cost problems with claims payment process.

The next question, another reporter had asked, are liability insurers and other reporting entities required to report settlements with individuals whose medical expenses were paid by Medicare Advantage Plan?

The answer is that an individuals' enrollment in the Medicare Advantage Plan doesn't really have any bearing on the requirement to report. If a Section 111 RRE has a no fault, workers' compensation or liability claim for a Medicare beneficiary, the claim meets the appropriate reporting requirements then the RRE must report that claim, whether the beneficiary is receiving standard Medicare coverage or if they are enrolled in Medicare Advantage Plan, the claim would be reportable either way. And Barbara, I believe you had some additional...

Barbara Wright: Yes, I want to make it clear that when someone is in a Medicare Advantage Plan, the insurer first of all doesn't necessarily know whether all claims are being paid by that Medicare Advantage Plan. There are rare situations where if something maybe paid by traditional Medicare, but additionally individuals

can go in and out of Medicare Advantage Plan. So there could be a situations where part are paid and the majority possibly is paid by someone other – is paid by traditional Medicare rather than the Medicare Advantage Plan.

And the last thing that you should be aware of, we're not going to talk about this in any detail or take questions on it, but everyone should be aware that if a beneficiary is in a Medicare Advantage Plan, and had for example part of their care paid by a Medicare Advantage Plan and part paid by a traditional Medicare, not only would Medicare have a recovery claim, potentially a recovery claim for anything is paid related to what's claimed or released but Medicare Advantage Plans have their own direct right of recovery for what they pay. So you should at least be aware of that, that those are two different situations for recoveries.

Jeremy Farquhar: OK. The next question involves a scenario which an RRE provided and did a claim for work-related accident involved injuries to two separate body parts. The example provided, the individual suffered an injury to their lower back and also an injury to their right shoulder. In this scenario the workers' comp carrier accepted ongoing responsibility for medicals for the lower back injury, but denied responsibility for medical treatment related to the right shoulder. Eventually the claim was settled and as a part of the settlement, the carrier agreed to pay for several unpaid bills linked to treatment of the right shoulder, although they have not accepted ORM injuries like to that body part. The RRE was questioning how this should be reported?

In this case, two separated records should be submitted. The first should be an ORM record reflecting the appropriate ICD-9 codes linked to the lower back injury alone. And the second record should be TPOC only and would include ICD-9 codes for both the back and the shoulder. And this individual had referenced several specific claims that they were paying for within the settlement, and so the amounts for those specific claims should be included in the TPOC amount that they are reporting.

Barbara Wright: This is Barbara Wright again. The main point, part of the question that came in is they wanted to know about as part of the settlement, the insurer agreed to pay three unpaid bills for treatment of the shoulder which was being settled

only by the TPOC settlement. Should those specific payments be reported as ORM or TPOC? And they clearly were not any part of what the insurer had accepted ORM for, so they should be reported as part of the TPOC value regardless of whether the settlement agreement says that the insurer will cut the check directly or cut the entire amount to the beneficiary either way, they are part of the total TPOC value.

Jeremy Farquhar: OK, thanks Barbara. And the last question which I personally will be addressing came from another individual who had written into the mailbox with questions regarding the CMS lists of valid ICD-9 codes or specifically the version 29 listing. It seems that the individual have been experiencing difficulty locating version 29 which is the most current list.

The version 29 listing is currently available on the same page as the prior versions 25 through 28. The link to the CMS page for versions 25 through 29 are posted can be found within Section 11.2.5 of the current NGHP user guides. In addition to this, there is a combined listing which may be downloaded from the Section 111 COB Secure website which includes all of the valid codes from versions 25 through 29 minus the excluded codes indicated within the current version of the NGHP user guides.

The link for the COB Secure website is also present within the aforementioned section of the user guide. Once add the COBSW, the list can be found within the reference materials menu located at the top of the screen. The combined list may be somewhat easier for most RREs to utilize, otherwise they would have to combine the handful of lists that are present on the CMS website and then take any consideration separately the excluded codes in the user guide. So the combined list basically does all that for you to eliminate a step.

And that's all I have. So I'll turn it back over to you, John.

John Albert: All right, thanks Jeremy. All right, next Barbara Wright has a few things.

Barbara Wright: One thing I wanted to mention is we actually received an inquiry recently that was asking why we didn't have an MMSDA Section 111 website. And this

particular person said where they were going for their information was www.cms.gov/home/medicare.asp.

For anyone who is getting their information or getting access to the user guide or some of our documents through Google or any other site, please be aware that we do have Section 111 website, it's www.cms.hhs.gov/mandatoryinsrep M-A-N-D-A-T-O-R-Y-I-N-S-R-E-P. That's where the official copy of everything can be found and all the official implementation instructions. So please be aware of that, if you've been getting your information through your reporting agents or through Google questions or things like that, the more complete source is to go directly to our website.

We've had some questions about clinical trials and whether or not all sponsors must register, all sponsors must report, et cetera.

You need to go back and look at the general clinical trial policy and the information in the user guide about clinical trials. If a clinical trial sponsor says that they are going to be responsible for all injuries or complications arising out of the clinical trial, if and when there are such injury or complications, then they have a responsibility to pay primary for those for Medicare beneficiaries. Those types of payments are what we're talking about having to report.

We have never said that all clinical trial sponsors are automatically RREs or that all clinical trials automatically involve some type of reporting responsibility under the Section 111. So if there is further confusion about that, if you can write in more specific questions, please do so. But it is limited to situations where essentially we've determined that the clinical trial sponsor is the primary payer because they have a responsibility for injuries or complications and those – they are in fact paying for those injuries or complications.

We have one question that asked about the risk management process and if an entity was doing multiple write-offs, should it add them up or should it do – and do a single TPOC or should it be essentially doing individual TPOCs?

The question seemed to miss some of the point of our alert and incorporation of material on risk management in the user guide. If you are a provider or a supplier and you're doing a write-off, the instructions tell you that you must incorporate that information through the normal billing process. It doesn't give you an option of submitting TPOC reports through 111. You are required to bill those correctly and long-term billing instructions will before Section 111 is when you have a situation where you are in essence acting as a liability insurer, self-insurer then you have to show that on the bill that you're submitting for Medicare.

We are looking into – there have been some questions about how never events tie into the risk management instructions.

So we're still looking to see whether or not that would change any instructions that we've put out, but so far we don't believe that it does.

With respect to ORM, one of the questions we had was the beneficiary dies before termination of ORM, what's the obligation to report, once they learn of the death?

And our records are going to show the death of the person.

John Albert: Yes.

Barbara Wright: So if you don't report a termination, we're going to have...

John Albert: Yes.

Barbara Wright: In essence have terminated the record anyway. For completeness of your records you may wish to submit a termination date.

John Albert: Yes, but I mean CMS receives the death termination through Social Security Administration, it's part of our update regarding entitlement information. So obviously we'll have that, so there really is I guess an effect not really a need to report anything unless you have to make changes to existing records that you've already sent. So it doesn't really matter from a reporting perspective

to tell us if the person died because again we'll have that information that would obviously affect...

Barbara Wright: Hopefully (reaching) down the center...

John Albert: Yes.

Barbara Wright: And hopefully we are not having any providers submit bills for services.

John Albert: Yes.

Barbara Wright: After the date of death.

John Albert: Yes. All right, OK.

Barbara Wright: I think that's the only ones that I have right now, John.

John Albert: OK. Operator, I guess one last thing to as Jeremy, mentioned about the ICD-10. We still do not have any kind of dates in terms of when that implementation is being delayed to, but I am sure that there will be an official announcement way beyond Section 111 notifying the published of when that new date is set. So please don't ask us because we don't know. I know there is a lot of discussion here at CMS about that but again, we have no idea and that it's really out of our hands.

So with that operator, we can go straight into Q&A session.

Operator: At this time, I would like to remind everyone in order to ask a question press star then the number one on your telephone keypad. We will pause for just a moment to compile the Q&A roster. Your first question comes from the line of (Bonnie Mustard) from Farmers Insurance. Your line is now open.

(Bonnie Mustard): Thank you very much. My question relates to a discussion during the last call, and I may have misunderstood the comments that were made, but as the discussion went on, I wrote down the following. If the insured is not eligible for Medicare at the time of the TPOC date, the RRE does not need to report, but if the payment includes future medicals, the RRE is responsible to monitor and report if or when the individual becomes Medicare beneficiary. Now I am

not sure if I misunderstood the discussion that was being posted or if you could provide additional clarification?

Barbara Wright: Well, we either misspoke or you misunderstood, because either ways that information is not correct. If you have a situation – let me find it again.

(Bonnie Mustard): The discussion and when this came up was when someone has future medicals and reporting, and I thought that the individual was saying that they did – they weren't eligible for Medicare at the time of the TPOC dates but...

Barbara Wright: OK, if you have – as we've said all along, if you have responsibility for ORM and someone is not eligible at the time that's established, you have to monitor and if they are still eligible for ORM when they become a beneficiary, report that. If someone is not, it's not a matter of whether someone is a beneficiary exactly at the time of the TPOC, it's whether or not they are or have been a Medicare beneficiary, because you could have a situation where someone no longer gets Medicare, but part of the time they were a beneficiary overlapped with what's covered in the settlement judgment award or other payments. So first of all we need to make it clear that it's are or have been a Medicare beneficiary.

And in terms of your understanding about future medicals, anytime there is a settlement judgment award or other payment essentially we consider that payment has been made for medicals but for Section 111 reporting purposes, if the person has not been and is not a Medicare beneficiary as of the TPOC date, then they have no further reporting obligation with respect to that TPOC.

(Bonnie Mustard): OK.

Barbara Wright: So it doesn't mean they might not have a responsibility with respect to future medicals with the beneficiary but it does mean that there is no Section 111 reporting responsibilities? Does that clarify us?

(Bonnie Mustard): Yes, that does. Thank you. I tried to login to ask the question during the last call. I just couldn't get through. Again, thank you.

Operator: Your next question comes from the line of (Nancy Cardinale) with Ascension Health. Your line is now open.

(Nancy Cardinale): Hi, I just wanted to clarify and make sure that I am understanding the reporting requirement correctly. My understanding is that reporting is required if it meets the threshold regardless of whether as long as the person is a Medicare beneficiary, regardless of whether the care and question or the service such as with dental, whether that's something that's covered by Medicare? My understanding is it doesn't matter, you still want reports on those things just by virtue of the person being a Medicare beneficiary, but I wanted to make sure that that's correct. Thank you.

Barbara Wright: First of all, assuming we're talking about liability insurance, no fault insurance or workers' compensation. The issue is whether or not medicals have been claimed or released or effectively released. Again I would emphasize that the insurer doesn't necessarily know all of the payments that Medicare may have made. So you're not making a – you're not making the final judgment about whether or not we have a recovery claim, you're in essence knowing of hi, we've done a settlement judgment award or other payments that's over the threshold and it's then in Medicare it's hands to determine whether or not they have a recovery claim. Does that help some or not?

(Nancy Cardinale): Yes, that helps. Thank you.

Operator: Operator: Your next question comes from the line of Anne Armstrong with Intermountain Healthcare. Your line is now open.

Anne Armstrong: Thank you. I just have a couple of questions actually, one, related to the introductory information you just provided with respect to clinical trials. We have some clinical trial sites and principal investigators that are conducting trials, and the process whereby we obtain consent from the patient is our process. And we've been contacted by representative of our pharmaceutical company for example who is sponsoring a trial. And they have asked us to provide to them the names, social security number, basically all of the basic demographic information that would be included in a claim input file on a particular individual immediately on every subject in our trial.

And I have tried to communicate with them about why they feel they need that information at the outset on every single study subject versus maybe gathering that information at the point where they are engaged in some kind of resolution, in other words, paying for us whatever complication or paying for care or paying money or doing anything on behalf of the study subject. And they insist that they – there is a lot of the reporting requirements, require them to report immediately on everyone enrolled in a study. Can you give me any clarity, I don't see it the way they see it. And doing what they ask will require – it's I can't do it, because it's an inconsistent with the consent form in the first place.

Barbara Wright: We would be interested in hearing what or having them send you or have them contact us directly with anything in our instructions that say that they have to report on everybody that's in a trial what we've emphasized, that's what I was in part talking about at the beginning that at least one entity had written in seeming to misunderstand that somehow all clinical trial sponsors might be or arguably RREs et cetera. What we're talking about is situation where the clinical trial sponsor has assumed responsibility for everything or all care that results from the clinical trial. And in essence they've said, they are responsible for any complications or injuries arising out of that trial.

Those are what we're talking about. Where there would be an actual injury cause by the clinical trial and they have responsibility under that agreement, then they are a primary for that and they do need to report that to us as ongoing responsibility for medicals. But we have never said that everybody that's in every clinical trial needs to be reported to us. So if you want to send something into the mailbox after talking to them again that they want to talk to us, please do so.

Anne Armstrong: OK. I will do that. And do I have time for a separate question?

John Albert: Sure.

Anne Armstrong: So I appreciate the additional comments on risk management write-offs, we have interpreted all of the guidance in this manner. I still do have little bit of a conflict on the cms.gov website, there is nice recently asked question section

and the question – this is the not the MMSDA website, this is Medicare and Medicaid Services but it is the official cms.gov. And there is a question on there that says what if a hospital – this probably remains to the False Claims Act, it was recently updated, but it's been there since 2006. What if a hospital wants to write-off a Medicare patients deductible on co-insurance regardless of their income level, is that permissible?

The answer is basically yes, and so my – I am thinking that the new guidance with respect to MMSDA to some degree overwrite this information, but I want to make sure I am understanding it correctly. In other words, the new guidance says if a risk manager is writing something off or purposes of avoiding litigation, avoiding claims, or as a goodwill, to facilitate or enhance goodwill just by definition under MMSDA liability payments. This language uses courtesy allowance as permitted write-offs for a hospital inpatient care. So there is a little bit of a conflict with those two pieces of guidance. And I guess I am not 100 percent sure where to go on that one.

Barbara Wright: If you want to send us more detailed information on where that is on our site and the specific wording of this, the question we'll try and track down the people who did it, but there is always a distinction between what you're allowed to do and what the effects of allowing you to do that are. And we're in essence saying when you meet the criteria for where you're write-off would be considered, liability, self insurance – self-insured liability insurance that is reportable for purposes of Section 111.

It's my limited understanding that there are other reasons why the program allows write-off of perhaps co-insurance et cetera and it's not necessarily tied to a risk management situation. So we can look into that more if you can send us more information.

Anne Armstrong: Wonderful, thank you so much.

Operator: Your next question comes from the line of (Melissa Harkins) with Indiana University. Your line is now open. Your next question comes from the line of Doug Holmes with UWC. Your line is now open.

Douglas Holmes: Hi, I have a question about the comment about the Medicare Advantage Plan. I was just wondering under what circumstances if any of the plan administrators for Medicare Advantage Plans would have access to Section 111 report information? That's my first question.

Jeremy Farquhar: They would receive that information directly from CMS.

Douglas Holmes: OK, then the second question is what priority would they have for recovery as compared to CMS for Medicare or the primary cares? What addresses that issue?

John Albert: I don't think there is anyone here in the room that has unofficial answer for you. If you want to send it in writing Doug, we can look and see if we can get you one. Our position of course is that traditional Medicare has the priority right of recovery.

Douglas Holmes: OK, I assume that but of course it gets more deep – when you get to more detailed about what's covered by whom and it gets to a little bit more.

Barbara Wright: Well you've got – a Medical Advantage Plan would only be pursuing recovery for items or services it had in fact provided. Our Medicare secondary payer recovery contractor only has information about claims paid under traditional Medicare Part A and Part B. So it only pursues recovery or conditional payments we've made under Medicare Part A or Part B.

Douglas Holmes: I understand but it gives – thanks very much. I'll get back and formulate the question so we can get something to clarify, thank you. That's it.

Operator: Your next question comes from the line of Lloyd Leroy with Brayton Purcell LLP. Your line is now open.

Lloyd Butch Leroy: Yes, my question goes back to the last town hall and concerns the language about loss of consortium settlements. You touched briefly on that with the ICD-9 codes this morning, but my question concerns cases in which no medicals are claimed or can be claimed. We practice in California and under California law, loss of consortium plan is purely non-economic damages, gets purely general damages, no special damages are claimed or awarded at any loss of consortium action. When you release a loss of

consortium action which can't by law contain any economic damages, therefore no medicals, how can you have to report or be required to report loss of consortium settlements?

Barbara Wright: What we would say again is that our touchstone is what's claimed or released or effectively released. If you're in a state where it can't be claimed and it can't be awarded then the question would be presumably you're not going to include it in the release either and then you don't have to worry about it.

Lloyd Butch Leroy: OK. So do you specifically say obviously under the law no medicals can be claimed, therefore none are released. That's good enough.

Barbara Wright: We're not concerned with how you phrase your release, if you're not including medicals, we get concerned when medicals are included.

Lloyd Butch Leroy: Obviously.

Barbara Wright: And what we said before and we're still working on is what we can do to possibly offer some release at least for medicals are not claimed in situations like directors and officers, employer liability, consortium et cetera. So we are still working on trying to give a little bit more assistance to you in that area. But in the meantime, where a particular type – where medicals cannot by law be claimed and they are not being released then no claim, no release and the law to back you up there, you should be OK.

Lloyd Butch Leroy: All right, thank you.

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

Susan Bolster: Hi. As we're getting calls regarding denials, one thing that I have noticed is sometime tracking to the folks at the COBC or Medicare, they are not aware that there are certain states where a workers' comp claim cannot be closed out. And I was just wondering if maybe there will be something that can be provided some kind of trainings for all these individuals, because they are telling people you need to close their claim out before we do anything and yet they can't and the beneficiary did really upset with us because we're tired and

we can't close it from Medicare's thought and that they need to close. And I know, Barbara, you talked about you can't listen – not listen but they shouldn't be saying what have you but may be some training to some of these folks, excuse me, and advising them that there are states out there like Texas who has lifetime medicals. And that's just a suggestion.

John Albert: And this is John. I mean we're aware of these issues and we actually have quite a number of things in the works to kind of address the overall issue of denied claims. I mean this is one of many reasons this can occur and there are some confusion out there regarding what to do in circumstances and I won't go into the dozen or so issues that are out there, but we basically can just state like what we said before. So we have a bunch of different things we're approaching in terms educational outreach materials to get out to our various stakeholders that are involved in co-ordination of benefits. So this is one of the issues. So we are aware of it, thank you.

Susan Bolster: OK, I appreciate that, and also a lot of these service providers call up, they don't know how to read those notifications, entitlement notices either. And that's another big issue that I am finding when these people are calling me. So just an FYI.

John Albert: When you say, can you explain a little bit when you say that?

Susan Bolster: OK, so service providers, hospitals, doctors offices, they have like a third-party that don't go to and then they get these eligibility notification, eligibility forms which tells them (inaudible) primary, Zurich Medicare secondary to workers' comp. Lot of these services providers, doctors office, office managers don't understand that if the claimant, if the beneficiary who is getting services from them as long as it's not met that let's say workers' comp related that Medicare will be primary. And some of them had been very assisting. The service providers say no Zurich, you have to pay it, or like no, you need to understand how this form reads. I find it many, many times when people will call me provider or (Qual) and I have explained them on that, if it's not workers' comp related we are not primary. And they just don't know how to read that form. And I've seen the form and I could see where it can be misunderstood, but they just don't understand how to translate that

information and we tell them to go to I guess you have a Medicare service provider line that these people can go to (Qual) to verify Medicare eligibility and that's the step I am taking now is saying look, you can call your medical provider number, I don't have it, you have it. They can clarify that. Medicare will cover this.

Barbara Wright: Also I am not sure that all of us here in the room are familiar with the specific form you're talking about. If you wouldn't mind redirecting one and at least for the beneficiaries name or HIC number and sending it to us.

Susan Bolster: I'd be happy to... How do you want me to send it, Barbara?

Barbara Wright: Well if you can just send it to the mailbox if you don't mind.

Susan Bolster: The general mailbox, OK.

Barbara Wright: Yes.

Susan Bolster: I will. Thank you.

John Albert: Thanks.

Operator: Your next question comes from the line of Sandra Roman with GAINSCO. Your line is now open.

Sandra Roman: Good afternoon. My question is regarding the reporting and ongoing responsibilities for medical statements. Hello?

John Albert: Yes, we're here.

Sandra Roman: Sorry. I couldn't here. And I got a response because I've submitted question and still a little – (inaudible) but pretty much the example that you gave me in the response what came from William Decker. He said for example your date of finish for acceptance for payment responsibility was 8/14/2009 for that claim you still have ongoing responsibility for medical payments on January 1st. So we have to report that. And I understanding that we're still paying claims as of that point or treatment as of that point but they have statute

limitations. So my question is the injury in the loss occurred on August 14th, 2009. The person gets three months of cryo treatment.

The claim gets closed down. So far we know we're not treating any more, it will (deferred on treating), technically that person could still come back within the next four years from that date because of statute limitations in certain states. And we could potentially owe more medical treatment or will have more responsibility for medical. So as of January 1st 2010 we don't know, if they are going back to see for example now an orthopedic. Would on January 1st we would be responsible for appointing that person, which I know even the workloads and we're no longer working on that file. Does that make sense?

Barbara Wright: This is one that administratively you closed prior to the 1/1/2010 date, right?

Sandra Roman: Correct, because they are done treating. It was three months. The doctor gave them a clearance and said they are OK, but they can come back a year later and said my back is still hurting, I'm going to go see another doctor. So now we've reopened file.

Barbara Wright: Right, and when you reopen the file you have report the ORM at that time.

Sandra Roman: Correct, at that point would, but I am saying in the cases that we didn't reopen and because they didn't come back after a year later, would we technically still have had to appoint that person on January 1st because we technically would still owe responsibility for medical and the future is something that comes up because of that loss.

Barbara Wright: Right, but I can't find – I don't have the entire user guide in front of me now but there is a page that says of specific exceptions for reporting if you have – if it's inactive on your books prior to the 1/1/2010.

Sandra Roman: OK.

Barbara Wright: Hold on just a second.

John Albert: And we're looking at it up right now, hold on.

Sandra Roman: No, I appreciate your help. Thank you, because it's just one of those like little gray areas.

John Albert: Got it. It's 11.9 on page 102.

Sandra Roman: OK.

John Albert: Most recent user guide and that's actually pretty detailed.

Sandra Roman: OK.

John Albert: Exception.

Sandra Roman: OK, perfect. Well thank you so much.

Barbara Wright: Thank you.

Operator: Your next question comes from the line of Emily Shields with Morgan Lewis. Your line is now open.

Emily Shields: Hi, I just wanted to follow-up on a question that I had on the last call. It involved whether CMS had made any further decision on how to handle the claims that I consider to be over reported where the only basis for reporting is a claim that was from an old complaint from a long time ago, even though the evidence shakes out to be something different when it comes to mass tort claims for the pre/post '80 analysis. And I believe the response at that time was that there was further guidance that was under consideration and y'all are waiting on final approvals. I know it still hasn't come out as of today and I didn't know if that was still in the works?

Barbara Wright: So you said ones that are over – are you again talking about ones where you don't think medicals actually exists, but they were claimed and released?

Emily Shields: No, I am talking about there are medicals, they are claims, they are released but we believe it to be a pre-1980 exposure and mass tort claims and the only basis for reporting otherwise is that there is a claim and an old complaint probably on file 20 years ago that indicates that overly broad number of work years as to all defendants which is in evidence there is out of more limited

time range for each individual to send in overtime but out of the benefit caution there are definite RREs and there is those areas of litigation that are reporting the claims out of concern, if there is one complaint from a long time ago that had someone's entire 60 year work history, alleged, even though later on evidence turned out to show otherwise. And it was my understanding based on the last discussion that we had that that was a concern that was understood and that there had been some guidance that was being considered, and that y'all were running it through legal and hope to publish it soon and that's all I was asking about.

Barbara Wright: I'm not sure what to say. Can you send us an updated note to the mailbox, because our policy is out there was put out in the alerts that the last version of the alert was I think October 11th of last year.

Emily Shields: Right, (I have seen that). This was a little bit different because there has been discussion in the past about amended complaints being used in whether those amendments which you proceed as they do.

Barbara Wright: OK, now your question is getting familiar.

Emily Shields: OK. I am sorry, I wasn't expecting to get asked so quickly, so I probably (I'll turn my) question.

Barbara Wright: No, we haven't put out language about amended complaint specifically yet.

Emily Shields: OK. So it is that one that you all are still considering I guess is my question.

Barbara Wright: It is one that we've gotten a couple of questions about, yes.

Emily Shields: OK. That's all that I have then. I just – I was under the impression that whatever new guidance may come out with respect to that was going to come out fairly quickly based on my last question on it and so I just trying to confirm.

Barbara Wright: OK. I am sorry, I didn't get the gist here.

Emily Shields: Sorry, I assembled that way through my question that time. I apologize for being less than articulate.

Barbara Wright: OK, thanks.

Operator: Your next question comes from the line of (David Hyatt from Hyatt Consulting). Your line is now open.

(David Hyatt): Hi Barbara, I'm (David Hyatt). Hi, I want to follow-up on that question that Anne Armstrong asked from Intermountain Healthcare about the clinical trials. We are requesting the clinical trial site to provide us information in order to determine whether or not they are beneficiaries. And then that information is held pending a decision on the clinical trial sponsor on what injuries they feel that they are under obligation to a payment board. So rather than that clinical trial site to make decisions about on behalf of the sponsor, what injuries are attributable to that clinical trials. It's actually the trail sponsors' responsibility and so they get to asses that. So it's not we are definitely not asking, clearly not asking always clinical trial sites to provide and pulling information across all of the test subjects, OK.

And on the other payment question, I know this is coming up over and over again. And whether the payment is made I think and you originally wrote the alert is to indicate that a payment is made then it is formal liability insurance. And so therefore calls under statute but the fact that the clinical trial sponsor accepted responsibility report whether or not they made the payment let's say that it was a trial conducted by university (internal) and if they use their own doctors if that a payment made blah, blah, it's really that my understanding is statute said or your – what's your guidance is if they expect responsibility, whether or not the physical payment cash has been paid to a particular provider or not...

Barbara Wright: A physical cash payment is not required to accept ORM in general. What we've tried to say is where ORMs has been accepted for all injuries or complications by virtue of the sponsors' initial agreement and an injury or complication occurs, that should then be reported as ORM.

(David Hyatt): OK, that's my understanding. I appreciate that clarification. Thank you.

Barbara Wright: OK.

Operator: Your next question comes from the line of (Linda McCalla) with Fleming & Hall. Your line is now open.

Barbara Wright: Hold on please.

(Linda McCalla): Hi, can everyone hear me?

John Albert: Yes.

(Linda McCalla): OK. I want to make sure I have some very quick question, just to make sure that I am clear on everything. As far as the reporting piece goes, we have a $5,000 cap, right? That's what I thought I heart. At any claim $5,000 or more we need to do the reporting. I am in the liability unit and basically – so when this whole thing went down we made sure that pretty much everyone that made a claim soft tissue had no medicals, we did no, if they were going to seek treatment, but we went ahead and captured in the very beginning those pieces of information that we needed. And then it was up to the battle of the bodily injury adjuster at the time of settlement of that claim to go ahead and do the remaining piece. But I am thinking now for every single claim coming in the door, do we need to continue doing that or do we wait and make sure that this person's medical or their injury is going to reach that $5,000 cap?

Barbara Wright: It's not whether or not their injury reaches that cap, it's the size of the settlement judgment award or other payments.

(Linda McCalla): OK.

Barbara Wright: I mean if you have a $1 million settlement and you think that there is only been ($0.50) in medical bill, that doesn't mean you don't have to report. You're reporting based on the size of the settlement judgment award or other payments.

(Linda McCalla): OK, all right. So then in essence then basically we have to continue getting all that information for every single injured party or potential injured party coming through the door, correct?

Barbara Wright: You have to have a time to report timely.

(Linda McCalla): OK, all right. OK, thank you.

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

Suzan Kornbluth: Hi, I have a question. I believe a few months ago, there was a comment made that a lot of cases were claimed back in the queries as 51s, and I think you guys have mentioned that if a claimant is a Medicare Part B only might be – it might come back as a 51. Is that still the case?

Jeremy Farquhar: Actually we've just recently addressed that matter and now the query processes be it the – whether it be the file submission query process or the beneficiary lookup online and the claim submission process should all be in sync. We no longer be returning 51s when an individual is entitled only based on Part B. We do currently have an issue I believe where some claims are not posting when they come in. You may receive an error. It's something that's being addressed at the present. If you send a claim on your claimant put file for somebody that has Part B only.

There are certain instances, limited certain instances mainly I believe when the date of incident is prior to the Medicare entitlement date which is not information that you referred me to but if the date of fixing happens to be prior to the entitlement date, there is a system problem where the record on the claimed file may kick out at you that is currently being addressed and should be an issue much longer in the future, but everything is in sync again. For the most part, all of your claims that are Part B only should post.

Suzan Kornbluth: As an 01.

John Albert: Yes, with an 01 accepted disposition code.

Suzan Kornbluth: Do you have any idea when this was fixed, because we just got a query file back yesterday. Does that mean it should be correct?

Jeremy Farquhar: When did you submit it?

Suzan Kornbluth: I believe a few days ago.

Jeremy Farquhar: Yes, then it should be correct. I believe that it was the fix was implemented at some point last week I believe or may be the week prior but if it was only a few days ago, that you had submitted, it should...

Suzan Kornbluth: I believe it was like the 16th we've submitted it. Last Friday.

Jeremy Farquhar: You should be safe.

Suzan Kornbluth: OK, thank you very much.

Operator: Your next question comes from the line of Karen Bert with King County. Your line is now open.

Karen Bert: Hi. I am from Washington State and we have permanent impairment payments that we make that we're reporting in TPOC. But from time to time, that payment actually gets paid to the Department of Labor and Industries and not directly to the worker because the department – the workers being put on a second injury pension. If the payment is not being made to the worker, does it still need to be reported as a TPOC?

Barbara Wright: It's being paid on their behalf?

Karen Bert: On their behalf to the Department of Labor and Industries. They don't have any – they have no access to that money.

Barbara Wright: That's something that we'd have to address on the back-end.

Karen Bert: OK.

Barbara Wright: I mean it's being paying on their behalf. So you do need to report it.

Karen Bert: OK. Then I have a second question. In workers' comp sometimes we've got a third-party that's responsible for the injuries. So we get third-party recoveries. Is the liability insurer responsible for reporting that payment or is the workers' comp insurer responsible for reporting that payment?

Barbara Wright: You're talking about a situation where the liability insurer is primary to U.S. workers' compensation, and so you want to know who has to report the liability insurers' payment?

Karen Bert: Right.

Barbara Wright: It would be the liability insurer.

Karen Bert: That would be my – OK.

Barbara Wright: The liability insurance RRE whoever happen to be.

Karen Bert: Would be responsible for reporting the payment. OK, perfect. Thank you very much.

Operator: Your next question comes from the line of Peter Foley with AIA. Your line is now open.

Peter Foley: Hi all. I just wanted to follow-up on Doug's comment about Medicare Advantage Plan. The priority of payment is an important issue but I'll talk about recent memo in December supporting Medicare Advantage Plan as being secondary, acknowledged in the memo that the courts disagree with the position CMS has taken. And so as you think about this, consider the fact that courts have not agreed with what you articulated earlier in this call, our second call, pardon me, Barbara.

Barbara Wright: They didn't agree with which point, they said that the Medicare Advantage Plan has priority recovery rights over...

Peter Foley: No, they actually commented in one case I read that the Humana is not in United States federal government and doesn't have the right as a secondary plan.

Barbara Wright: OK, that's when someone asks about priority, what I said is that our expectation is that traditional Medicare assuming they both have recovery rights that our expectation is that traditional Medicare would have the priority right of recovery, whether or not courts are agreeing that Medicare Advantage Plans have recovery rights, the Social Security Act I believe is Section 1854 –

1852 A4 approximately that has a specific provision that says that essentially the Medicare and secondary care provisions apply. Now how the courts are interpreting that, I am not going to get into that one way or the other. I was just letting everybody know that our position is that Medicare Advantage Plans do have recovery rights.

Peter Foley: Well they ask (inaudible) companies subsidized by the federal government. So we should take that into consideration as well. The other point I'd like to make is that we continue to hear about beneficiaries losing their benefits, you acknowledged that on the call already and I am not – I just would say to you that what I am hearing to is that it could be an education process at the COBC, it could be a technology issue, different members of our coalition had called in and shared with me examples but unfortunately I don't have anything to give you today.

Barbara Wright: As John said, we're trying to address it on all fronts.

Peter Foley: As we are as well as the insurers were taking for – for the allegedly turning off the benefits. Thank you. Hope you have a good day.

Barbara Wright: Thank you.

John Albert: Thank you.

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

(Bonnie Mustard): Thank you for taking my next question. And I've submitted this to quite a while back and submitted again yesterday. This is talking about ORM, and we're making periodic payments and the termination via the correct ORM termination date in a work comp situation. There are cases where it's based on the law, you can actually have a separate statute limitation for medical and separate statute limitation for indemnity, and so the question is if in the states where we have the two different statutes which one do we use? We are thinking we would use the statute of limitations relative to medicals because once that date passes which usually it is a date in advance of an indemnity

statute limitation. Once that date passes, if we were to get a medical bill after that date, we are going to decline payment of it. Do you agree?

Barbara Wright: We again look at your question. We didn't have a final answer on it yet. So we're not prepared to give you one today. I would ask in terms of what you said just at the end out of curiosity, when you say, if let's say the medical statute of limitations ended December 31st 2011, and you got a bill on January 2nd, you just said you wouldn't pay that bill, you wouldn't pay it even if it was for services prior to?

(Bonnie Mustard): No, we would pay it for services prior to, but if they went to the doctor on January 1st then we received the bill on January the 5th, we would not.

Barbara Wright: OK.

(Bonnie Mustard): And actually this question has been out there since (November the 8th), so I did just resend it but it has been out there for a long.

Barbara Wright: We have – I have it front of it me right now.

(Bonnie Mustard): Thank you. I do have several other questions if we get to the point there is no one else to question.

Operator: Your next question comes from the line of Barbara Bossie with Houlton Regional Hospital. Your line is now open.

Barbara Bossie: Yes, thank you. I am a hospital risk manager. And my question is if a hospital makes a decision to write-off a Medicare beneficiary entire admission, and we don't submit any bill at all, are we still required to report it if the monetary amount meets the threshold?

Barbara Wright: First of all my understanding – again what takes the first step of this or provider supplier is what are the billing requirements? It's our understanding that if the hospitals are required to submit no pay bill which means you would be submitting a bill showing essentially that the entire amount was covered by your self-insurance.

Barbara Bossie: OK. And am I correct in understanding that the threshold was recently reduced from $5,000 to $2,000?

Barbara Wright: There hasn't been any change in the published threshold. Remember that there are different thresholds for liability insurance, workers' comp, no fault, etcetera, so we've been talking generally about the liability ones when people have asked that these thresholds again are separate from your billing requirements. So if you do a write-off that's under $5,000 you're still bound by our billing rule. And you need to bill appropriately which includes showing that that write-off in a risk management situation as one where you've essentially received – where you've recently the liability payments through yourself insurance.

So don't mistake the idea that we have a threshold from reporting that that somehow changes your billing requirements for one that are under $5,000.

John Albert: To entirely separate operation.

Barbara Wright: Does that help or hinder?

Barbara Bossie: No, that helped. OK, thank you.

Operator: Your next question comes from the line of Karen Malone with Hanover. Your line is now open.

Karen Malone: Thank you. In a professional liability claim, for example a claim that involves financial laws due to may be a Ponzi scheme type investment. If there is a one line allegation of emotional distress that's embedded within this claim, is this claim deemed in your eyes reportable under Section 111? And in this case, we'll assume a settlement is paid and that's the liability thresholds have reached?

Barbara Wright: Assuming that, yes. At this point it is, it's the one that we're working to give you some language that will give you a little bit more freedom but you're going to – you're most likely going to have an ongoing concern as long as claimants – at least claims and medicals, we may be able to do something

about broad general releases but if medicals they are also claimed, that presents an additional problem.

Karen Malone: Yes, and so if medicals aren't claims but there is just an allegation of emotional distress, would your opinion change?

Barbara Wright: Emotional distress means medicals potentially. And as I think I mentioned on the last call, we've talked to at least one major manufacturer who has acknowledged that they routinely have situations where they may be paying for counseling or medications or other care in connection with complaints with emotional distress.

Karen Malone: Thank you.

Operator: Again if you would like to ask a question, please press star then the number one on your telephone keypad. Your next question comes from the line of Su-Lyn with Tucker Ellis. Your line is now open.

Su-Lyn Combs: Hi my question is, is a distributor and a manufacturer both need a defendants in a product liability litigation and the distributor immediately tenders it's defend to the manufacturer where upon the manufacturer accepts the tender of defense and proceeds to hire the attorneys and (bill this patient). And the distributor no longer is in filed in the actual prosecution of the – of the lawsuit. And the manufacturers during discovery finds out that the Medicare beneficiary that that he sit with the Medicare beneficiary. Is it sufficient that the manufacturer, once they settle with the plaintiff, does the Section 111 reporting and then provides assurance to the distributor that everything has been resolved and the reporting was done?

Barbara Wright: Which one did you say kept the case, the manufacturer?

Su-Lyn Combs: The manufacturer did. So the distributor once they convict their defense no longer was involved in...

Barbara Wright: Was the manufacturer dismissed from the case or does the manufacturer end up signing a settlement, I mean you'll have to look at each case on a case by case basis. If the distributor actually signs a settlement and they have any

joint – any responsibility for at all, joint, several or otherwise then they are going to have to report.

If they were dismissed from this case or if they signed a settlement and the amount that they owe period is zero and they have no joint and several responsibility for what the manufacturer does, then it's essentially the manufacturer reporting its settlement but the simple fact that someone has tendered a defense, we've said over and over again that an RRE cannot by contract or otherwise eliminate or transfer their reporting responsibility. So you're going to have to look at each case and what really went on there.

Su-Lyn Combs: OK, so if the manufacturer pays for the entire settlement and is completely responsible for indemnifying the distributor, in that scenario given that the distributor is not paying for anything and is not responsible for anything.

Barbara Wright: I didn't say that they had to pay for it and I didn't say that they couldn't have – couldn't be indemnified, the point is if you don't need to be indemnified, if you have no responsibility. So you're back again. So what is the legal responsibility of the distributor to start with? If they have responsibility which someone else's indemnifying them or then they most likely are going to have a reporting responsibility.

Su-Lyn Combs: OK, thank you.

Barbara Wright: I really can't give you a bright line rule there that's going to exempt them but you name the situation where the distributor starts out as being a defendant and to the extent that they are not dismissed from that that they are part of the ultimate settlement, and they have any responsibility even if they have a claim to have it indemnified by someone else, then they are going to continue to have their RRE responsibilities. It doesn't mean they can't have that the manufacturers as part of their indemnification if it's part of their contract or their agreement, they could be using the manufacturer to be there agent for their own RRE responsibility to the extent they have any.

But there is no way that with the situation that you gave me that I can say that they are off the hook.

Su-Lyn Combs: OK, that's a good point though. The fact that the distributor could potentially gets tract the manufacturer to also be their RRE agent, once they have...

Barbara Wright: If they are agent, I mean what we're saying is they cannot eliminate or transfer the ultimate RRE responsibilities. They are free like anyone else to use whoever they wish to use as an agent, but it doesn't mean that their responsibility goes away unless like, I said if they were to – if all parties dismissed them from the case or if the settlement by itself made it clear that they had no joint and several responsibilities that they are responsibility was absolutely zero, but what under what you're describing I doubt that the plaintiffs would agree to that.

The plaintiff doesn't care if the manufacturer indemnifies the distributor, but it would probably want to be keep both entities in there as possibilities.

Su-Lyn Combs: Right. OK, great. Thank you so much. That helps us.

Operator: Your next question comes from the line of Shannon Nessier with Hanson Bridgett. Your line is now open.

Shannon Nessier: Hi good afternoon. This question is kind of a combination of two earlier because I think there is some conflicts there. So in talking about severe mental and emotional distress allegations, most recently we just said that that implicates medicals. But then much earlier council was discussing loss of consortium and had kind of said that in a state where maybe the parties believe that such claims are not allowed under the laws and are not released in the complaint that there would not be obviously an obligation then to report that. But I would ask the leading that your touchstone is always what is claims or relief. Is that same matter has a compliant which includes boilerplate allegations, severe mental and emotional stress, even if that same party believes the law doesn't allow those, wouldn't that necessarily implicate medical claims that would require reporting?

Barbara Wright: I am sure I'll have to go back and look at the transcript to find out exactly what I said earlier, but I thought the gist of what I was saying is if you had a situation where the law – first of all, I didn't mean to imply that everybody got

to make their own interpretation, I thought the person with the inquiries specifically said the law prohibited recovery of medicals.

Shannon Nessier: I think so.

Barbara Wright: That means the law has to be very specific that it prohibits the recovery of medicals, and I also said if they are prohibited by law and they can't be recovered, then I was in essence asking why are they being claimed or released, and if they are not I said you don’t have any problem.

Shannon Nessier: Absolutely. I’m sorry, I am saying what if they appear in a complaint because then they would in fact be in claim regardless of the state of the law.

Barbara Wright: OK, in that case the way our instructions stand right now and are likely to stand in terms of the complaint, it’s going to have to be reported.

Shannon Nessier: Absolutely.

Barbara Wright: The problem – part of the problem is for someone just say well I can't recover for that by law, that’s almost the same thing of saying I couldn’t prove X or I couldn’t prove Y and that’s why I am doing a settlement.

Shannon Nessier: Absolutely.

Barbara Wright: And that’s why our touchstone is what’s claimed or released. We don’t need to re-litigate or renegotiate what the parties did. If it’s claimed or released then if we paid for medical care best related to that we’re entitled to recover.

Shannon Nessier: That’s exactly what I thought and that's what I wanted to clarify because if it’s being put in the compliant it doesn’t matter what arguments people want to make afterwards, it’s in that compliant that’s your guys’ touchstone.

Barbara Wright: Correct.

Shannon Nessier: Absolutely, awesome. Thank you so much.

Operator: Your next question comes from the line of (Ray Dabben) with PRI. Your line is now open.

(Ray Dabben): Hi, good afternoon. I am working with a software vendor and the question has come up regarding query files. And that question is if we submit a query file and in the response file somebody comes back with a HICN and we note that in our system, in call hearing previously or read in a guide, in the user guide that it's not often but it is possible for somebody's Medicare eligibility to (UCs) or the lose their eligibility. So when we submit a subsequent query file if they are no longer Medicare eligible, is there HICN removed, is it not included in the response file to us?

Jeremy Farquhar: It will still be there. When you query beneficiary on your query file, it will tell you whether that beneficiary is, was, or will soon be a Medicare beneficiary. So response of an 01 disposition code on your query file or your query response file does indicate that they were a beneficiary at some point in time but their Medicare entitlement could have and in fact terminated prior to the point in time that you sent the query.

And the way that you would need to follow through with that is to submit that individual on your claim input file, and in circumstances where perhaps their entitlement had terminated in the past and does not overlap the timeframe which you're reporting for your claim, you might receive an 03 disposition back on your claim response file and that 03 just indicates that thank you, you've submitted everything that you need to send us, you're clear but your covers that you've submitted for your claim doesn't have an overlap with their Medicare entitlements, no further action necessary, unless the individual might become.

I mean one caveat to that, if you have ORM that is open and continues, you will want to continue to monitor that individual's entitlement throughout the period of time that you have ORM because if they're having to regain entitlement then you might have to resend that claim on your claimant put file if it isn't ORM related.

(Ray Dabben): So with the first time we get the response file back, if they are a beneficiary it will, be an 01, later on when we query them again to get some subsequent

over the life of the claim if they come back with the beneficiary indicated or equaling no a 51.

Jeremy Farquhar: Actually, that's – yes, let me clarify and I think I may have just confused you. You're always going to get the 01 for this individual. If the query process works – if they are presently if they have been or if they may in the near future become an beneficiary, you will get an 01. You're going to get an 01, if you can continue to query the individual you will continue to get an 01 straight through but you continue with ORM if you have an ORM claim it continues and to your claim, you still have responsibility then you'll want to continue to send them on your claimant put file at least periodically because if they do regain Medicare entitlement, you'll need to post that claim record.

And it is a little tricky. You don't really know, there is not an easy way for you to tell but you can just resubmit them on your claim file. You could if you like, you could just resent them on each time you send your claim file and they'll continue to get an 03 disposition and it's fine, if that's the case. And if ever they regain their entitlement during the (called in) time you have responsibility for medicals then, we will at that point in time give you an 01 and post that record.

(Ray Dabben): OK, I think in short to sum it up. I think what you're saying is once an individual gets an 01, they are always going to get an 01?

Jeremy Farquhar: On the query response file, yes, that's true.

(Ray Dabben): Once 01 always 01. OK, thank you very much.

Operator: Your next question comes from the line of (Eileen Reece) with Hudson Health Care Insurance. Your line is now open.

(Eileen Reece): Thank you. When the beneficiary is deceived, the NGHP user guide does not currently provide for more than four claimants. When there are more than four claimants, how do you recommend that the RRE counter for putting through the additional claimants?

Jeremy Farquhar: We do not currently have a technical process to accept more than four claimants, but it is something that we are discussing internally in order to determine an avenue for which to collect that information in the future. At the present via the Section 111 process that you can only really report the four claimants. Unfortunately, if you were to try and give your EDI repetition claimants, there is no process via which they can relay that...

(Eileen Reece): Right.

Jeremy Farquhar: Update our system. Other than that, there is a not a lot I can tell you other than, I don't know if CMS would like to add any additional information but...

(Eileen Reece): OK.

Barbara Wright: I would have one additional comment and Jeremy, tell me if this makes sense because if the claimants are for instance all the children, they essentially all have equal weights. So I am not sure we would care which board children got reported, but if the estate is one of the claimants, then for sure you'd want to make sure the estate was listed as well as one or two of the children if that's who the other claimants were.

Jeremy Farquhar: Yes, I would certainly agree with that, Barbara. If you have claimants of different priority basically you can prioritize what you include on your claimant put file.

(Eileen Reece): OK, all right. And then we'll stay tuned. Alrighty, thank you very much.

Operator: Your next question comes from the line of (Tony Greene with BWI Risk Services). Your line is now open.

(Tony Greene): Hi, I am not sure – thanks for taking my question. I am not sure, this is more of a technical question when I reported my claim, and I received a HICN number, when I go back into the list and – to get a list of the claims there is no claims. – I only have a few claims. So I am doing the edit entry or (EDC) whichever one it's called, but anyway I am just curious why are they showing up as being reported?

Jeremy Farquhar: Are you talking about reporting via DDE where you're coming back to the (DDE) application online and you're not seeing claims that you had previously reported?

(Tony Greene): Yes.

Jeremy Farquhar: They should still reflect as reported, if you had in fact sent them. However there is one circumstance that where you might not see something. If you submit a claim and it's partial and safe, but not submitted and you wait longer than 30 days, you go ahead and update that claim. You only save a partial un-submitted claim or up to 30 days. So I don't know if that could explain things, but they would still disappear.

(Tony Greene): I do have a confirmation saying the claim was submitted.

Jeremy Farquhar: OK.

(Tony Greene): I went to my EDI rep and she wasn't sure and she suggested that I sit on one of the town hall conference call just and pose that question and I'm just...

Jeremy Farquhar: They should not have directed you to pose that question on the town hall conference call and I apologize. That is something that we should have been able to handle for you directly. And if you have – this is Jeremy Farquhar speaking. My contact information is in the escalation procedure in the user guide.

(Tony Greene): OK.

Jeremy Farquhar: If you could send that example to me, I believe it's 8.2 is the section of the user guide where the escalation procedure is at rather than read off everything in phone but send that example to me and I will follow-up for you and try to determine what may have occurred. That should not happen. Once you submit a claim, it's accepted, it should remain in (DDE) because you may need to update that claim at a later date. So if it's missing that's a problem. So I guess you hear of circumstances of that nature.

(Tony Greene): Perfect. I think your name is Jerry?

Jeremy Farquhar: Jeremy Farquhar.

(Tony Greene): OK, Jeremy, thank you so much. I will see that.

John Albert: Thank you, Jeremy.

Operator: Your next question comes from the line of Karen Still with MAG Mutual. Your line is now open.

Karen Still: Good afternoon. I work for a professional liability company. And I think that my question has been answered generally this afternoon, but I needed to ask it specifically to make sure that my understanding is correct. It's my understanding that medicals are not recoverable in Alabama wrongful death cases in accordance with Alabama Tort Law. If compensation is paid to survivors and medicals are not a part of the claim or the release, do we need to report these payments to CMS?

Barbara Wright: I am not familiar with all the specifics of state laws. So I can't guarantee you whether what you said is true or not. If there were no medicals and they weren't claimed or released, certainly there is nothing to report and if state law prohibits, specifically prohibits medicals being claimed as part of wrongful death suit and they weren't claimed or released then we would agree you don't need to report it.

Karen Still: Excellent, thank you very much.

Operator: Your next question comes from the line of (Andrew Hellie) with North Star Mutual. Your line is now open.

(Andrew Hellie): Thanks for taking my call. My question is with regard to ORMs, with a Medicare beneficiary when they have non-related treatment. It's come to our attention that a number of beneficiaries that we have ORMs on are having their non-auto accident related treatments denied by Medicare. So our providers are contacting us for guidance on this. And I've been advised by (NAMEC) that the best option is to have the individual beneficiaries contact their member of congress. Can you guys give us the insight as far as what CMS would like to see going forward?

John Albert: Well I mean the beneficiary should be appealing a claim of – a denied claim but they really, their first line is 1-800-Medicare which should help them sort through the issues and then find the information out to the right people, I mean as I mentioned before and we've said on the call there are lots of reasons that claims are denied and whether it's through bad records or inappropriate action on the part of either provider or a Medicare contractor, et cetera. But I mean the best thing as beneficiaries you is to call the 1-800-MEDICARE toll free number to ask what to do in their particular situation.

There is no one answer for a quote denied claims. And the customer service reps can hopefully assist that beneficiary to get them to where they need to get their claims paid. So this was an issue as I mentioned earlier, that we're aware of and trying to attack it on multiple fronts to make sure that everybody is doing what they are supposed to be doing and if it's not happening and depending on the situation, who they should contact.

(Andrew Hellie): Do you have – as far as with providers go, have the providers contact the beneficiary who contact Medicare and jump through those loops? Does that kind of the position that we're taking on this or is there – put it back into the beneficiary's end?

Barbara Wright: I am not sure what you mean by having the provider contact the beneficiary. First of all, the provider has direct appeal rights of their own.

(Andrew Hellie): Yes.

Barbara Wright: They don't have to go to the beneficiary to get it appealed but...

(Andrew Hellie): OK, so we should be advising the provider to issue an appeal to Medicare?

John Albert: If the claim was inappropriately denied by the Medicare claims payment contractor, yes.

(Andrew Hellie): OK. Sounds good, that's all I needed. Thank you.

Barbara Wright: But we have to caution as we've done on other calls that when we've investigated specific claims for specific beneficiaries, a significant portion of

them, the claims were in fact appropriately denied. The fact that they happened also to have some type of open NGHP record wasn't what caused the denial.

John Albert: Yes, they may have had someone saying it's denied and it's like they are saying it's not related to my actually then it will turns out they have group health plan coverage and the group health plan coverage is the primary payer. So there is a lot of things, there is no one answer for all of these. There is a lot of things that go into COB.

Operator: Your next question comes from the line of Sandra Roman with GAINSCO. Your line is now open.

Sandra Roman: Hello, my question – my phone dropped so someone might have asked this earlier and I think I came into the tail end was about security information to find out if the person is a Medicare beneficiary. We are securing everybody's social security and all that to submit in the query file. But if someone refuses to give us a social security and they sign the safe harbor letter saying that they are not a Medicare beneficiary, but later on we just determines on how they are after the consortium being closed and for whatever reason you guys come back and see that they were, what penalties are there for us and we took every measure to secure that information?

Jeremy Farquhar: Well we can't provide an answer in terms of what penalties. I mean the main thing is because that you using that due diligence in terms of using that form that the person signed stating that they were not a Medicare beneficiary, you need to keep that on record.

Sandra Roman: Correct. OK. So what in the cases where we have a – we have something set in process where we have some – we send the letter three times requesting the information. There have been cases where they refuse to just send the letter back and we have to settle the claim. So we pay it. I mean we do consider that due diligence that whereas we've done it, taking every measure to try to get that information?

Jeremy Farquhar: I mean all I can say is again to document the process you have in place and obviously if someone doesn't cooperate with your request (inaudible).

Sandra Roman: OK, all right. Well that answered my question. Thank you.

John Albert: The one thing we say all the time in cases like this is document, document, document. We will come to you if we need to at some point in the future, you just need to be able to show us that you took all the steps that you could in order to establish your reporting responsibilities.

Sandra Roman: Awesome. Thank you very much.

Operator: Your next question comes from the line of (Suzie Bielinis with Genetic and Meditech). Your line is now open.

(Suzie Bielinis): Good afternoon, I have a question following up on (Butch) and Shannon's earlier question regarding loss of consortium claims. Am I correct in understanding that whatever the state law is, if a release releases both a husband's injury claim, and a wife losses consortium claim, it serves as release medical?

Barbara Wright: I either missed some words in your question, or I don't understand the distinction you're trying to make.

(Suzie Bielinis): Sure. A lot of consortium claims doesn't occur and a document has to have a (inaudible) Medical claim for the spouse. So if there is a release that includes a husband's injury claim and a wife loss of consortium claim, wouldn't that release include the husband's medical expenses?

Barbara Wright: Well, remember that we're talking about you reporting on someone who is or has been a beneficiary. So let's say the husband in your scenario is the beneficiary but the wife isn't and never has been. Then her consortium claim isn't going to be reported. But if she is a beneficiary and if the wording of the claim and the release releases claims and or releases medicals for her, then that needs to be reported. Similarly it does and was the one that was one that driving and hurt most severely but he is only 40 years old, and he is not severely hurt enough so that he is becoming our – or has been a beneficiary but for whatever reason he marries someone 25 years of senior and his wife is

a beneficiary, then if her loss of consortium claims, and claims or leases medicals then you're back to – then her consortium claims need reported.

(Suzie Bielinis): And you're looking to both the original complaints as well as the release language itself?

Barbara Wright: Yes.

(Suzie Bielinis): Thank you.

Operator: Your next question comes from the line of (Fatima Navor with John Mullen). Your line is now open.

(Fatima Navor): Hi, I have a question regarding the beneficiary lookup. The claimant it sense that it was a beneficiary because there is a HICN number, but when we included the query, it was returned as not a beneficiary?

Jeremy Farquhar: This would probably relate to issues that we touched upon a little earlier in the call, but we were having issues with the query lookup process and the claim files as far as properly indicating when individuals that have Part B benefits under Medicare only. Basically before we would tell that – there was a discrepancy between the beneficiary lookup and the query files got processed for a stretch. And when you got to hit on the beneficiary lookup, it would have been most likely somebody that has Part B benefits only, but the query file process was returning a 51, and telling you that they weren't a beneficiary. And for a significant period of time, we were unable to actually post claim records for an individual to have Part B only.

And we just recently resolved that issue, so that we can be hosting those claim records properly. And so that the query processes if any lookup online as well as the final query process and the claim input file process are in the sync.

John Albert: Hi Jeremy.

Jeremy Farquhar: Yes.

John Albert: I just wanted to get clarification because from the caller that this was the issue because from our perspective it sounded like she was talking about she had a

HIC or an SSN and that she thought was valid that turned out that they got – they didn't get to know one and I was wondering from the matching criteria issue like someone may provide you with a HICN or an SSN, but if you submit that and the name, date of birth and gender, doesn't meet enough for the matching criteria, that will also result in a 51.

(Fatima Navor): OK. Because the first name, it looks like the first name is incomplete, but the last name, the gender and the date of birth is the same.

Jeremy Farquhar: Yes, because and yes, then you may only need the first initial to match, you had indicated that you had gotten to match when you plugged it into the website, in the beneficiary lookup screen but then when you sent it on your file that you had gotten a 51, correct?

(Fatima Navor): Yes.

John Albert: OK.

Jeremy Farquhar: And that is the situation I was referencing.

John Albert: But that should be the thing of the past so...

Jeremy Farquhar: Yes, hopefully now if you were to submit them, since you did get that positive response on the website, on the beneficiary lookup, now if you sent them again on your file, it was just as of last week that this was corrected. So if you send them again on your file, they should no longer receive that 51 onto the in sync. And if you find anything that seems odd, if there are discrepancies still then please reach out to your EDI rep directly to provide them with the examples that we've be looking to it but I don't believe you should see any of those discrepancies any longer.

(Fatima Navor): OK, thank you. Can I have another question? Just one of our RREs filed bankruptcy and so when they received annual profile reports for the certification, they sent an e-mail to the EDI rep that under the process of closing. And then I just saw on the COBC website that this RRE, the status is discontinued. So is that correct?

Jeremy Farquhar: It maybe if we have not actually recertified your RRE ID. They have had recertification and provided to the EDI, I mean had you information via – I mean even though the entity is filing for bankruptcy you could still confirm whether the information on your profile report is accurate or not. Had that went on or where there updates need to be made or was it kind of left. If it was left hanging then it's possible that it had not been recertified and that you've been discontinued. Please note that discontinued does not mean that you're shutdown permanently. All that we need from you is to touch base with us again for you to give us the appropriate information that we need to recertify the RRE ID. And we'll reactivate you right away, update any information as appropriate or the information was all accurate, and we just recertify and there is nothing further that needs to be done.

And then we can proceed from there as far as the bankruptcy goes. I mean I don't know if you may have anything that you need to report in the short-term still for this RRE that's kind of another story, but the recertification could have caused you to be discontinued, but we can fix that for you.

Barbara Wright: Particularly entities that are self-insured if they are going into bankruptcy, they often have a quite a bit to report in connection with the bankruptcy because they are resolving outstanding self-insured liability insurance claims.

(Fatima Navor): OK, if on the e-mail that was sent to the EDI representative, it says that the account manager said that we will not be completing the annual profile report until our bankruptcy (CSI provide direction).

Jeremy Farquhar: Well I believe it's a kind of a non-response.

(Fatima Navor): Yes. So we really need to get in touch with the RREs, so they still need to submit that?

Jeremy Farquhar: Yes.

John Albert: Yes. In order to stay registered.

(Fatima Navor): OK, thank you.

Operator: Your next question comes from the line of (Mia Whitney with Medical and Mutual Insurance). Your line is now open.

(Mia Whitney): Hi, thank you. I believe my question was just answered, it was on loss of consortium for a beneficiary who is alive and the wife was paid and they are represented by an attorney. The attorney showed up on our input file as along with the beneficiary but the wife did not and we were expecting her too. And I think what I've understood that is if the release releases medicals for her, she gets reported.

Barbara Wright: As long as she is a beneficiary. Hers would be...

(Mia Whitney): She is a beneficiary.

Barbara Wright: Yes, if she is a beneficiary but remember each beneficiary has a separate report. So it's not that she is going to show up on the...

(Mia Whitney): On his, so we have to do one for her.

Barbara Wright: Right.

(Mia Whitney): OK.

Barbara Wright: If you've got a family that's in a car wreck and they are all beneficiaries, you're going to have separate reports for each one of them.

(Mia Whitney): OK, all right, thank you.

Operator: Your next question comes from the line of (Beth De Guise) with LEMIC Insurance. Your line is now open.

(Beth De Guise): Hi, I just wanted to make sure you all are aware. We have talked a lot about the people getting denied claims because of previous claims like from an MVA. We had an incident happen yesterday and the person has been trying to contact Medicare but they tend to be on hold for over an hour at a time, so that it it's adding to their frustration level.

Barbara Wright: Well first of all, we don't know exactly who they are contacting at Medicare, but if they've got an issue with denied claims as John said, their first line if it's a beneficiary is 1-800-MEDICARE. They can also contact their applicable CMS regional office for assistance, but if they are calling for instance our recovery contractor that's not who they should be contacting.

(Beth De Guise): I'll pass the message along. Thank you.

Barbara Wright: Thank you.

John Albert: There definitely are not one hour hold times at 1-800-MEDICARE.

Jeremy Farquhar: Or COBC.

John Albert: Yes.

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

Louani Bascara: Hi good afternoon. I just wanted to clarify two points that were made earlier today. One is that RREs need to report TPOCs for claimants who are beneficiaries at the time of settlement or who were beneficiaries before, but may no longer be beneficiaries at the time of settlement, is that correct?

Barbara Wright: If they ever have been or are currently then you report.

Louani Bascara: OK, thank you. And the other question I had just to clarify on this loss of consortium issue, if the state doesn't allow recovery of medicals for loss of consortium but a plaintiff claims medicals for loss of consortium nonetheless in the complaint that should be reported.

Barbara Wright: Yes.

Louani Bascara: OK, thank you.

Operator: Your next question comes from the line of (Carol Dondi) with Banner Health. Your line is now open.

(Carol Dondi): Hello, I just wanted to add one thing to the person who was getting a hit on the query, but then they were getting a rejection when they tried to claim report. The query only looks at the first six characters of the last name and the first character of the first name. And that was my – they might have this correct, but it may be that their first name or last name is not exactly right and when they send the whole thing in from the claim report, it might get rejected. So they need to see what gets sent back in the query first, and then if they have to check with the person and get the exact spelling and all of that because it could be a difference there.

Jeremy Farquhar: Well that actually let me just correct you there, although we require that you send the full name on the claim input files, the matching process does actually work the same. We're only looking when we actually match on that beneficiary or when we attempt to match as beneficiary. We only do look at the first initial of the first name and the first six characters of last name. We ask that you report the whole thing to us but as far as the matching purposes go, it works the same in all the processes.

(Carol Dondi): OK, but she should still check what gets sent back in the query and make sure that that fits because they could be off on one.

Jeremy Farquhar: Yes, that's correct. They way the query process works, there are – you have to have a valid HICN or SSN plus three out of four of that first initial, first six characters of the last name, date of birth or gender in it. One of the or the later happen to be incorrect, but the other three match and there is a valid HICN or SSN. And we will get a match in one of those fields, the one that had been incorrect will be returned as we have it on our Medicare database. The only thing that will not be corrected in a query response of that nature would be the SSN. We would not return the corrected SSNs but the other personal matching criteria could be corrected.

Carol Dondi): Thank you.

John Albert: Remember that historically where a lot of the mismatches begin is with the names themselves. Frequently names are changed after Social Security Numbers have been issued and remember that the Social Security

Administration supplies us with the names of the people who are becoming Medicare beneficiaries. Their Social Security Administration provides us with the Medicare health insurance claim number, the Medicare HICNs based on the person's SSN. If you're sending us information that is not what is on the Social Security Administration database exactly, you could have an issue.

(Carol Dondi): I think we have also gotten errors and in fact I know we have when we have sent in an incorrect middle name. So we send it an M, which was the first character their first initial got a hit, but then when we send in the whole claim, we put in their middle name and then a space and the initial for their – we put in their first name and the space and the initial for their middle name and it got rejected. So I believe that it is looking at more than just that first character.

John Albert: That would not be a reason you'd receive an error on your response.

(Carol Dondi): OK, well I will go back and look at what had happened and if I do have it, I will send it to you.

John Albert: Or in the middle initial, the first initial, the middle name on the same line is the first and last name for example.

Jeremy Farquhar: Yes, but I think we should still only be looking at the first character of the first name, when we try to match. I don't believe that should give you 51 response.

John Albert: (I'm not sure if you've appended) it to the last name, exact through.

(Carol Dondi): I will look at what I have and send it to you.

Jeremy Farquhar: OK, we can look into it for you. Thanks.

John Albert: Operator, it's now three o'clock and we need to end the call. I'd like to thank everybody for their participation. Keep an eye on the Section 111 website for future town hall teleconference, I'm not able to recall the next one on top of my head but I don't think...

Jeremy Farquhar: Next month.

John Albert: Next, yes next month. Again please continue to submit your questions to the resource mailbox and stay tuned for other announcements et cetera as they come. And with that, thank you everyone and we'll talk you in a month. And if operator you could stay on the line. Thanks.

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

END