TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: June 19, 2012

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
June 19, 2012
1:00 p.m. ET

Operator: Good afternoon. My name is (Stephanie) 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. John Albert, you may begin your conference.

John Albert: Thank you, operator, and good afternoon everyone. For the record today, it is Tuesday, June 19th, 2012 and this is the Section 111 NGHP town hall teleconference call. I just want to mention the disclaimer, we always do and that there are times where we may contradict the official written guidance that's out on the CMS's Web page at cms.hhs.gov/mandatoryinsrep. Where we do contradict that, I just want to remind folks that the written guidance is the official CMS instruction policy, et cetera, concerning the implementation of the Section 111 mandatory insurer reporting requirements.

Also I want to quickly apologize for the last minute cancellation of our last call. It was beyond our control. We have to cancel it because of something else that came up. So, again we apologize for any inconvenience. We will be, of course, having more of these calls in the future as well as today.

I just want to alert folks that we do have a couple of pending alerts and a revised NGHP user guidance. It's been reformatted that we are targeting for publication no later than probably July 4th, hopefully the end of June early July.

Keep your eyes off of that. We recognize that our listserv is not necessarily working the way we want it to, but we are also trying to publish information on the secure website that you used to submit your reporting data.

A couple of the things that I've mentioned in the past, I'll mention again is that we understand that, you know, there are issues that crop up from time to time related to what we refer to blanketly as denied claims issues.

It's very important that if you are somehow involved in this kind of information, the only way that we can or any of our contractors can assist is if we have a very specific information concerning who, what, where and when, we encourage folks to get a hold of the Medicare summary notice that has the reasons for the why the claims was paid or not claimed and all that. That's the piece of information that would tell you exactly what happened and why before moving forward.

Generally as the first step, if the claim is denied somebody should be going to the contractor that process that claim or one in hand, Medicare. So again have the details if you're looking for systems related to claims and denials.

In many cases they are being properly denied because the person has some other coverage that's unrelated to a particular NGHP situation. Like a very common one is they have group called Group Health Plan coverage for example.

Also I know folks out there or many are aware that CMS is in a middle of a procurement to basically reorganize and redefine the MSP contracting structure and that is in full swing right now. We've awarded an integration contractor. We have other contracts that will be awarded very shortly. The hope is to have all of the transitions done by the end of the year.

So because of that that means that our ability to implement changes and things like that of existing processes are somewhat limited. So, we still want to hear about those issues. But I just want to warn folks that when you're in the middle of a transition, it's not like we can put in systems releases while in the middle of moving a data center.

So, after the July release that we're in the process of completing right now there won't be most likely very much coming out that's in terms of, you know, improvements or new tools, et cetera related to the Section 111 process as we basically stand up the new contract strategy which will include a combined coordination of benefits and recovery operation of types center that will handle both front end Section 111 as well as recovery which we think makes sense combining it because it certainly, you know, be a lot easier to go to one entity for both COBs as well as recovery issues. And that's what we're doing here.

So anyway that, you know, with information that's publicly available, it's publicly available concerning the procurement but we really can't talk about it beyond that just because we are still in the middle of awarding contracts.

We have with us say some folks of Medicare coordination of benefit contractor, who are going to give a brief presentation regarding some more technical related issues. And then I think Barbara you're going to – yes, Barbara Wright is going to provide some additional follow up.

And then we'll move into the Q&A session that everyone is familiar with. We ask for the person's – the speaker's name and who they represent and we do ask because there are close to 400 participants on this call that if you can limit your question to one and one follow up. We looked at all the questions that came in to the resource mailbox through the end of this past week.

I'm sure the ANPRM probably generated a few more. But the – again, I encourage folks to continue to submit those questions. Sometimes we actually do directly reach out to the submitters depending on what the question is. Other times, we try to answer them through this teleconference or just through the materials that we put out there, the combined user guide.

I think people are really liking that it breaks up the policy from the technical and we based it, went through a whole re-edit of the entire thing just because we've been adding to it over the years. We hope that you will like it. We'll keep the old guide out there for awhile just so you're familiar with, but it should – it's going to have links in it, so you'll be able to link right through documents without having to go search for them, et cetera. So it will be hopefully more user friendly as well.

Barbara Wright: Before we go to Jeremy's, as John mentioned the ANPRM, I'm not sure everybody on the line necessarily knows what we're referring to. Those ANPRM published last Friday that has to do with future medicals and Medicare secondary payer.

It's an advanced medicine of proposed rule making. It is not an NPRM. What it does is lay out the agency's thoughts on the subject, ask for your comments, your analysis, your ideas if you have – if you have a better idea, if you have a reason why one of the things we candidly proposed will work or won't work. In other words, it is really soliciting public input before we actually write the NPRM.

As we've said on past calls, these calls right now are limited to Section 111, but we continue to get some calls about (satisfies), et cetera. So, we wanted to bring up the NPRM. We're not going to take any questions on it. It's pretty much self-explanatory, but we did want everybody to know it's been published.

There's a site, www.ofr.gov for the Office of Federal Register and you can go there and click on the tab labeled "Public Inspection Desk" and you'll find the regulation listed there or you can go to the federal register site and simply find the documents that were published last Friday.

John Albert: OK. So, this being – just skipped around. Thanks, Barbara. And just one other thing too is that, you know, as we move forward with the new contracting strategy and as Section 111 moves into, you know, pass the implementation phase we expect that these types of calls in the future will probably evolve into something different across all of MSP.

And, you know, if you have any thoughts on that, we'd appreciate it because we know that for some folks, these calls are kind of getting old because they've already kind of been through a lot of the questions and things like that.

So, again, we want to continue even after we, you know, Section 111 is, you know, fully implemented and all that which for the most part it is. We want to hear your feedback regarding these types of calls because, again, with a new combined center we thought about expanding this to include other topics. But Barbara is right, for now, we're trying to limit this just the Section 111 implementation calls.

So with that, I will turn it over to Jeremy Farquhar, the Coordination of Benefits contractor. And he's going to go over some things and then we'll go back to Barbara for a few other points. Thank you.

Jeremy Farquhar: Thanks, John. To start, I just have a few general announcements. First on May 1st, an alert was posted in reference to the lifting of quarterly restrictions on claim file submissions. For those of you who may not already be familiar on this alert, it can be found within the additional NGHP Alert's section of the CMS Mandatory Insurer Reporting website.

Since the posting of the alert, we've received numerous questions most of which relate to the timing of claim file submissions now that multiple files are now accepted within a single quarter.

As noted within the alert, multiple files will now be accepted, but subsequent files will not be processed until the prior file submission has completed processing. RRE should refrain from submitting a new claim file until they've received a response for the prior file. Should a new file be submitted prior to that point in time, it will be placed on hold and automatically released once the prior file completes the processing.

RRE should also limit their submissions to no more than one claim file per every 14 days. The primary purpose in removing the quarterly restriction is to allow RREs to report ORM termination dates in a more timely fashion electronically.

Although multiple files may now be submitted within the single quarter, it's important to note that RREs are under no obligations to submit more than one per quarter. And it's still expected that an RRE standard quarterly file be submitted within their previously assigned quarterly submission period.

The fact that standard submissions are still required within the RRE, so the submission period tends to be what spurred most of the questions. At possible times, the claim file could take up to approximately 45 days to process. RRE's have questioned whether or no circumstances is even impossible to process subsequent files without encountering problems with late submissions for the following quarter.

There are a couple of things worth noting in this regard. First, more often than not, the quarterly claim files submission will not take the full time allotted for processing. Commonly claim files will complete processing within two or three weeks. However, even if an RRE standard quarterly submission does take up work to 45 days to process that does not mean the subsequent file will also take that long.

It's expected that RREs will still be submitting the bulk of their data within their standard file submissions during their allotted submission timeframes. As subsequent files within the same quarter are expected to be utilized primarily for updates such as ORM terminations, those files should be significantly smaller in size.

The smaller the size of the file, the greater the likelihood it will complete processing more quickly. That being said, if a subsequent file should happen to take an extended time in the process and overlap with the following quarter submission period, the RRE should not be penalized if the next quarter's file submission is slightly delayed as a result.

Though multiple files will now be accepted within a single quarter, RRE should consider the amount of time remaining before their next standard submission is due prior to sending an off cycle file.

The window of time before the next schedule of submission timeframe is less than a few weeks even probably regress for the RRE to hold off and submit the FDA during their next quarter release submission timeframe.

Or if the number of updates are very small, they may wish to address them via call to the COBC's call center instead. Updates via phone will be limited to no more than five per call. The COBC call center's number is 800-999-118 for those of you who don't already have that.

Should you have a large volume of off cycle updates or any problems involving deletes, please contact your EDI representative as soon as you become aware of the issue and they'll instruct you guys to how best to proceed.

The next topic we'd like to address concerns no fault reporting. And specifically the reporting of the exhaust date for the dollar limit of no fault insurance versus the reporting of the ORM termination date.

We've received numerous questions regarding the distinction between the two aforementioned fields and the data analysis had noted differences between the two values within the same records.

It would appear to indicate a certain degree of confusion. Now, this is an attempt to add some clarity. It's expected that the value provided within the exhaust date for the dollar limit of no fault insurance is the date upon which no fault coverage is exhausted and subsequently at which point the insurer would no longer be responsible for medicals.

Once funds run out, no longer – there's no longer any responsibility for the no fault insurer to be paying on those claims.

That being the case, if the exhaust date for the dollar limit of no fault insurance is populated, it would expected that the ORM termination date field be populated with the same date for an ORM record of course.

The offset may not necessarily have to be the case that it maybe possible for ORM to be terminated without all available funds having been depleted. In

many cases, we've noted that RREs are populating the exhaust date without providing an ORM termination date. In other cases, we found that RREs have populated both fields with entirely different dates.

In both scenarios, they appear to be either missing or incorrect data. Again, in situations where the exhaust date for the dollar limit of no fault insurance is populated, we would expect that the ORM termination date be populated and the dates in both fields ought to be the same.

Next, just to reiterate, John touched on this briefly at the beginning topic that's come up in a number of times as in reference to new postings to the CMS Section 111 website. An occasion there had been issues with the listserv e-mailer which has prevented the notifications from going out regarding new alerts.

As John mentioned you may have noticed, but we've begun posting notifications on our COB secure website when those alerts are published as well. It's right on the log-in page of the COB secure website towards the left-hand side of the screen. So, you can watch for that. There'll typically be a brief synopsis along with the direct link of the alert.

OK, from there, I'd like to jump in to a couple of the more technical dropbox questions that we've received since the last call. The first is – first question one received was regarding the reporting of the stacking no fault policies. Between (incomplete) scenarios where an insurer may have something such as both PIP and MedPay in relation to a single date of incident, the individual that's written to the mailbox is looking for confirmation as they can report both coverages with a single claim record where the total limits for all applicable policies and the latest termination data of all policies will be reported within that single report.

But their understanding is correct. Unfortunately we do have personally the capability to maintain multiple no fault ORM records for the same date of incident. Therefore the RRE should combine their data for all applicable policies into a single report to the best of their abilities.

The no fault insurance limit should be the combined amount, the exhaust date for the dollar limit for no fault insurance should be provided only once all funds for each policy have been exhausted and the ORM termination they provided should be the latest date of all the policies.

And another received related to proper ICD-9 usage and this is in situations where the injured party had died as a result of the accident. The individual that had written in was having trouble locating appropriate death related ICD-9 codes. In such situations, we would not be looking for ICD-9 codes directly indicating the death of the beneficiary.

What RRE should be reporting are the injuries or illnesses sustained rather than an ICD-9 actually indicating death. That's what we're looking for and that's what would help us do properly identify a claim if there happened to be any claim prior to the point in time that the beneficiary passed.

Now, that's all that I have. So I'll pass it back to you, John.

John Albert: All right, thanks – thanks, Jeremy. Yes, the – I guess I'll reiterate just again that, you know, the issue with the – the ability to submit multiple files, again, I mean this – you know, the point of it was to allow people to provide more frequent updates to information necessarily serve as the fault second quarterly file submission.

And as with anything, we will try it out and see how it goes. And if it works, then that's great. And if we need to make, you know, changes to it, we will. But again, the point of it is to allow folks who have been asking how can we provide more timely updates through the fault process to our data rather than just submitting once every quarter. So that's why we did that.

So we encourage folks that want to be able to provide that information to use that. And again we'll take any feedback that we can get on it.

So with that I'll turn it over to Barbara who wants to go over some of the – of the more policy related questions that we've received.

Barbara Wright: Thanks, John. I have just a few general questions that came in. Once again, we have received a few questions that touch on Medicaid and they were asking when Medicaid was part of the settlement, did that part get reported to us? If part of the settlement is designated to the repay Medicaid, it's still part of the settlement.

So if you have a TPOC amount, you still have to report that total amount including the funds that you've designated for Medicaid. Another issue that's come up again as we've been asked to publish or put out more examples having to do with the self insured retention and who is actually the RRE.

In fact we haven't been receiving many or any additional questions about that lately. As far as we can tell most people do understand exactly when are the RRE or not when you have self insured, depends on our access funds, et cetera. But we did speak to the folks who work together to submit five or six examples to ask them for clarification on a couple of points. And when we get that back, we will putting up the examples either if we get them back in time before we put out the user guide, we'll put them in there or if we don't, we'll just put them out as a separate alert.

Another question we got involved a particular state who said that they had sovereign immunity so that they don't – so that they don't have either insurance or an insurance pool and they're not subject to recognizing any subrogation claims or any claims including Medicare.

And what we would tell everyone is that in that particular situation, the states, state agencies actually self-insured under the definition and the statute and our regulations to make it clear that a government entity is engaged in a business. And so the Section 111 reporting requirements and the Medicare secondary payer obligations do both apply to state entities that are self insured.

John, I think we can go ahead just with questions now.

John Albert: OK. All right, operator, we can turn it over to questions from the – from the listeners.

Operator: And at this time, I would like to remind everyone, in order to ask a question, please press star one on your telephone keypad. We'll post for just a moment to compile the Q&A roster.

And your first question comes from the line of Lisa Maynard from Hamlin and Burton Liability Management. Your line is open.

Lisa Maynard: Hi, this is Lisa Maynard with Hamlin and Burton Liability Management. We are still looking for the transcript from the April 2012 town hall conference – teleconference. And we're just wondering when that's going to be published. There were the question that I asked that was pretty valuable to one of our clients and we still don't see it there. And we're just wondering when it's going to be there.

John Albert: I'll see if we get an answer before this call is over.

Lisa Maynard: Thank you.

Operator: And your next question comes from the line of (Amber Lee) from (Claim Administrative). Your line is open.

(Amber Lee): Hi, this is (Amber Lee) from (Claim Administrative Resources) and we're just wondering about the TPA information, if we submit it on the Section 111 reporting (inaudible) alerts on, are we definitely not going to need a prefect representation because I called the MSPRC today and the representative that I got said we'll still need one on file to dispute, you know, demands and conditional payments.

Barbara Wright: I guess first of all that's a recovery claim, so it's definitely outside the scope of this. But what you submit for Section 111 has nothing to do with proving whether or not you have authority to represent someone or whether you have consent to receive information.

The recovery process is separate. What you're submitting for the reporting does not establish U.S. rep and it does not establish that you have the right to receive a consent, you know, that you've been given a consent to release.

(Amber Lee): OK, that's what we didn't understand because we thought Alert said that prefect representation then to act on behalf of the insurer wouldn't be needed.

Barbara Wright: I will check on that further if you're talking specifically to act as the agent of the TPA. I'm sorry, if you're talking the TPA, is the – is the agent for purposes or reporting and can then you – can you then receive things on behalf of the insurer. That's not typically the context for our proof of rep questions.

(Amber Lee): OK, that makes sense. We were just afraid our clients would, you know, question why we need that after they've provided all the necessary steps, but that answers it.

Barbara Wright: I mean you're actually – if you're the reporting agent then you would, in essence be submitting your own proof that you can receive things. So, I will check further and see if I can find where anybody said anything about that, but I would expect you to still essentially need proof.

(Amber Lee): OK, thank you.

Operator: And your next question comes from the line of Suzan Kornbluth from New York State Insurance Fund. Your line is open.

Suzan Kornbluth: Hi. I have a couple of questions. First one is when we were going through our response file that we just got back a week or so ago, there was a case that we had reported in April 2011. It was returned within the 01. We reported the case again as an update with an ORM termination date in January of this year.

We're not sure why and ITs working trying to find out we submitted again in April. But this time, it was returned with a compliance flag and we weren't sure why.

Jeremy Farquhar: If it was resubmitted as an add transaction.

Suzan Kornbluth: Resubmitted as an update, but the thing is the ORM term date was sent already in January. And for some reason it was sent again in April. I think

there's a few cases like that in our files and we – we're trying to determine why.

But it was sent with the same information yet it was returned with a compliance flag.

Jeremy Farquhar: Yes, that could occur. If the ORM termination is being sent and typically when we receive an ORM termination, that's the last we receive on a record.

Suzan Kornbluth: Right.

Jeremy Farquhar: And so – and if you sent it again, the way our system works is looking if there's an ORM termination date there and it's looking at the dates and determining whether, you know, it was late or not and it doesn't …

Suzan Kornbluth: Right, but the date was the same.

Jeremy Farquhar: I know, but what I'm saying is that our system isn't sophisticated enough to say, "Oh, we received this termination date previously." It looks at the transaction type and it analyzes the dates.

And so, since you sent it again, it's generating the compliance flag. But please note that when you receive a compliance flag, it doesn't mean that you're going to be penalized. It's just an indicator. It's not automatic penalty. There's no reason for concern.

If you sent that termination date previously, it's easy to prove that. We have that on file still. You probably have that on file. So, there's no danger of your being penalized or being conserved non-compliance too.

Suzan Kornbluth: All right. We've created reports and one of ours has complained that they hadn't had this before and now they're getting them.

Another thing we found in this last response file is we submitted about 3,900 cases and about 667 of them were returned with an 03. We thought that was a pretty high percentage. And it's just unclear as to, you know, when we're not overlapping.

Jeremy Farquhar: Yes, yes. Unfortunately, at the present given that we do not provide entitlement dates, it's less than clear for you. But if you're receiving an 03, it's not unusual. There are going to be commonly cases where you'll be reporting on a coverage period that does not overlap with the Medicare beneficiary.

Suzan Kornbluth: And it was not overlapped though. Like in what kind of situations because we were – that's what we were having trouble understanding.

Jeremy Farquhar: Well, it could be a situation where the beneficiary was entitled based on either disability or ESRD and their entitlement had terminated at some point in time and they were no longer entitled to Medicare.

And so maybe your claim that you had submitted came after that point in time. Or it could also be a situation where you're sending, say an ORM record and there's a term date on that ORM record. And the ORM actually terminated prior to the point in time that they became entitled.

Those are going to be the common scenarios.

Suzan Kornbluth: OK. Can I just ask just one quick thing? We have a case and our office is sending them me because I'm the account manager. And they don't understand. There's a claimant that's 65 years old, still working. Well, her data as far as what they compared again, you know, in our system is correct and the case was returned with a 51.

That's usual if they're eligible or do they have to officially apply or what's the story because this person turned 65 last November?

Jeremy Farquhar: Well, it depends on a number of factors, I believe. You know, it's possible – you have to – well, OK, you have to – you have to have enough hours worked in order to qualify for social security benefits in order to become entitled to Medicare.

So depending on the number of hours this person has worked, they maybe working now, but who knows what their past history maybe.

Suzan Kornbluth: No, I think she was here a long time as a state worker.

Jeremy Farquhar: OK. That's – it's strange. I mean what most likely is the case is that piece of the person identifying information is off, does not match what Medicare has on file for the individual if you're receiving a 51 at that point in time.

If you know they have worked enough hours to qualify for social security benefits and you're – and they're over 65, you're positive of that – positive of that and you still receive the 51, one of the – more than one of the identifying pieces of information could be off.

You know, when we match, we're looking at the social security number or any number.

Suzan Kornbluth: Right, I know.

Jeremy Farquhar: We need one of the two and then three out of the four and the first initial, last name, date of birth and gender. So, if you – if you're an HICN or SSN or if neither of those are good, then you're going to give a 51 automatically. And if you have two out of four, the remaining fields thereof, sometimes, you know, people, the date of birth is a common one that will be off by a day or two.

Suzan Kornbluth: Would it definitely be a data element then in this case, it wouldn't be the fact that she hasn't really officially applied maybe?

Jeremy Farquhar: Well, when once you turn to 65 …

Suzan Kornbluth: She's working full time.

Jeremy Farquhar: Yes. My assumption is that it's a data element in this case. But in order to know for sure, we would have to look at this more closely. If you'd like to contact us offline after the call, we can look at this and …

Suzan Kornbluth: All right. I'm just wondering if it happened, you know, that's a possibility then we can, you know, justify that in another cases where, you know, they're swearing that the information they had is correct.

So, we're not – so it has to be that even if they work and they could still – they would still come back automatically to be an 01, we weren't sure.

Barbara Wright: Jeremy?

Jeremy Farquhar: Yes.

Barbara Wright: The other possibility, I'm not sure about this anymore, but I think at one point under some of the at least their older pension systems or retirement systems that some states or state agencies, et cetera did not necessarily contribute to Medicare.

And if the person is not entitled to premium free Medicare, then there's a good chance they might not have purchased it particularly if they're still working.

Jeremy Farquhar: OK, thank you.

Suzan Kornbluth: All right. Yes, so I guess, you know, we'll go back and we'll probably send our EDI rep the information because they're swearing up on them that it's got to be that, you know.

All right, so as long as they're eligible that it should come back as an 01 if everything is correct and everything …

Jeremy Farquhar: Yes, yes.

Suzan Kornbluth: OK, all right, thanks.

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

Emily Shields: Hi. I have a question involving the number of RRE I.D. that one RRE can have, is it possible if an RRE wants to be able to internally track the different types of liability claims that have for it to have more than RRE I.D. to do so?

Jeremy Farquhar: Absolutely. You can have as many RRE IDs as you wish. We have no limit. So, I mean, we have some insurers who are quite large who might have 25, 30 IDs, maybe even more for a single insurer. And it's just the type of stuff that you're referencing.

So if you would to set up multiple IDs, then please feel free to do so. You just follow the same process for your following or your subsequent IDs as you had when you registered initially.

Emily Shields: OK. And does it – does it require you to have the same contact information for each of those or can you vary that as well?

Jeremy Farquhar: That can be varied. There is nothing to force you to maintain the same, say, authorized rep for account manager for them all. Usually the authorize rep stayed the same, but if you want to have different account managers, that's not a problem at all. You can have different designee assignments for different groups. That's absolutely fine.

Emily Shields: OK.

Jeremy Farquhar: Were you trying to say something, Barbara?

Barbara Wright: Yes. Can you comment on whether or not if they choose to have multiple RRE IDs, you can or cannot guarantee them that they will have the same submission window.

Emily Shields: Oh, that's fine.

Jeremy Farquhar: That's correct.

Emily Shields: Yes, that's OK.

Jeremy Farquhar: Yes. Although if you will automatically – when you're – when you register, you're automatically assigned to an EDI rep as well as the submission period. The submission periods are not something that we would adjust as a general rule. But EDI representative, let's say you have – if you decide to set up 10 different RRE IDs and you would like to have a single point of contact here with us in the EDI department, then all you need to do is make that request.

You can send that through one of your EDI reps or you can send it to me directly, Jeremy Farquhar. My contact information is in the user guide under the escalation procedure. And we're happy to oblige in that respect.

Emily Shields: OK, great. And I have one other question. It's a bit of an old question, but it has come up again. If you have a TPOC that is, say, $50,000 for company X and in terms of the way that company works, half of that TPOC will be paid by the company and half of it by one of its insurance carriers.

Do you each of those RREs report the entire TPOC amount or only the share that they responsible for?

Barbara Wright: You need to go back to the user guide and look at the examples where it talks about when the insurer reports and when the insured report. And what you can …

Emily Shields: I think it doesn't answer my question unfortunately.

Barbara Wright: Well without more facts, it's impossible to answer your question because we don't know whether the insurer does paying because it's a deductible and if it's purely a deductible issue, then the insurer reports both the deductible and the amount above the deductible.

If the insurer does paying because it's a self-insured retention, then each of them would report and they're report their appropriate amount.

You have to fit it in to the specific factual situations that's addressed in the user guide.

Emily Shields: I guess I understand that, but I guess to me it seems that the user guide is not completely clear because I'm trying to determine if you consider that to be one TPOC because there is essentially one company that is responsible only it's being divided in multiple ways between that company and its carriers or if they are all considered to be separate TPOCs assigned by RRE.

Barbara Wright: If you have those situation as I just said, if you have a situation where there's an insurance policy and part of it is deductible that's being paid by the insured and part of it is the amount above the deductive being paid by the insurer, the insurer is responsible for reporting a single amount, the total of both the deductible and the amount above the deductible.

If you get into a different type of situation, they involve self-insured retention or excess insurance, et cetera, the answer would be different about who report.

Emily Shields: OK, if I can approach it this way.

Barbara Wright: OK.

Emily Shields: Aside from what the insurance company situation maybe, if the company's independent share as they self insured, if that company share is, say, half of the $50,000, would it be responsible for only reporting half or would it be responsible for the entire amount?

Barbara Wright: It's still …

Emily Shields: I guess I was trying to tell you that to – go ahead.

Barbara Wright: If what you have is two independent settlements then they would reporting it separately. I'm still not real clear why the – if the company has insurance, what the relationship is of the amount that company is paying to the insured amount?

Emily Shields: Because – go ahead.

Barbara Wright: And that's what sort of drives who's actually going to do the reporting. Is the amount they're paying an amount – in other words, if you have a policy cap, if you have dollar one coverage and the policy was 25,000 and for whatever reason the settlement was 40 and the insured was paying an extra 15, then they're paying 15,000 for self insured and the insurer is reporting the 25 that had the cap. But I could give you that same number and divide it up differently.

And without knowing the exact factual situation, I really can't give you a generic answer.

Emily Shields: OK, I guess what I – I have a little bit more of an unusual situation because we're dealing with a historical claims that the carriers and the insured have an agreement as to who placed certain percentages.

And so in terms of there being a cap and deductible and all of that, it's a little bit different. So, ultimately if a carrier has said, they'll pay one third of any settled claim and the rest remains with the insured, that's sort of what I'm trying to decipher and how that fits into your examples within the user guide.

Barbara Wright: I'm going ask you to write in a specific example and then we'll try and figure out a way to address that in the group of examples we're going to put out because I'm afraid anything that I said in this call about right now there are so many variables, someone is going to misinterpret it.

Emily Shields: OK.

Barbara Wright: But be real clear on what you're talking about percentages and you need to tell me, you know, like if there's – assuming if what – if what you're assuming is the policy was always big enough to cover it and it's not part of the deductible and it's not part of this, you're going to have to spell out the parameters that you want to address.

Emily Shields: OK. Thank you.

Operator: And your next question comes from Louani Bascara from Sidley Austin. Your line is open.

Louani Bascara: Hi, this is Louani Bascara calling from Sidley Austin. I have a couple of questions about date of incident in connection with exposure cases where lost of consortium is claimed with medicals.

And one incident say exposure is all pre 1980s, so you wouldn't be reporting the exposure claim, but there's also loss of consortium claim where there's a claim in medicals. And the marriage is also pre 1980 and after exposure ended.

One, would you have to report the loss of consortium claim even though you're not reporting the exposure claim and if so, what would the date of incidence be on that claim?

Jeremy Farquhar: We're still here.

Barbara Wright: I mean the loss of consortium among other things, you said it included medical. So what it – what it including medicals for emotional distress or was is it including medical related to asbestos exposure?

Louani Bascara: I guess in either case, does that change the answer?

Barbara Wright: I think it could, it could because then you'd be dealing with potentially with the 12/5/80 date for her exposure.

Suzanne Kalwa: I mean – thin is Suzanne Kalwa. In terms of the date of incident when you're talking about reporting the data for exposure cases, it's always going to be the data first exposure regardless of whether that data first exposure proceeded 1980.

When with respect to what Barbara was mentioning just now if the (asbestos) claimant, I guess the, you know, the spouse, the guy, the husband, if his exposure ended prior to 1980 are you suggesting that her did as well? And if that's the case, then presumably the medical that she's claiming are related to the asbestos exposure.

What Barbara is suggesting is that if this is a loss of consortium claim and she's claiming emotional distress as the result of the loss of her spouse, then the medical that we're talking about are not asbestos related. They're related to emotion distress.

Louani Bascara: Right. And so let's take that scenario for example. If her loss of consortium claim isn't an exposure issue and I'm presuming if it were an exposure issue, then you'd apply the 1980 day and not have to report it.

Suzanne Kalwa: Right.

Louani Bascara: But say it's an emotional distress issue, so it's you know, kind of a derivative claim of the – of her, say, it's the wife who has loss of consortium claim and the – and she claims emotional distress medical. And that instance, say the – say that her – she gets married to her husband before 1980 but after exposure ended is that something that still gets reported? And if so, what would the date of incident then beyond on that claim?

Female: (Inaudible).

Barbara Wright: I hate to ask you to do this, this is about the third time on this call, but can you send something to the mail box listing your fact pattern?

Louani Bascara: Sure, sure thing. And just along those lines, I think they maybe a bit, a less thornier question. If you have exposure on or after 12/5/80 and then, you know, similar issue of loss of consortium claim with emotional distress being claimed.

Also after 1980 but after exposure has ended, what would you use as the date of incident for the loss of consortium claim?

Suzanne Kalwa: If I were in this position I would probably report the date of the dead of her spouse. If the alleged injury, if the claimed injury is related to emotional distress as a result of that then the date of incident is in effect the date that he died.

Louani Bascara: Say he haven't gone away?

Barbara Wright: Were you able to hear that OK?

Louani Bascara: Yes, I believe I heard that use date of incident as the date of the spouse's death?

Suzanne Kalwa: The rationale for that is primarily because what you're alleging is that her injuries are emotional distress related to his death. If she's bringing a loss of consortium claim is it fair to say that he passed away?

Louani Bascara: All right, say he hasn't.

Barbara Wright: Hang on a second. For various reasons, we're going to retrench on that. Can you just include that in your e-mail that comes in?

Louani Bascara: Sure.

Barbara Wright: Because there's – there was some misunderstanding in the room here about consortium claims.

Louani Bascara: OK, thank you.

Operator: Your next question comes from the line of (Tanya Graft) from Kindred Healthcare. Your line is open.

(Tanya Graft): Hi, we are a meeting resistance in getting a social security number when at the injured party's deceased then we have to get a claimant tax I.D. And the usual response that we're getting from our plaintiff attorneys or from the plaintiff's attorneys is that that's not required in reporting and so we don't need it or we already have the injured party social security number and that's good enough.

And I just wondered if there was an approach besides maybe sending them the user guide of how we should emphasize that with them.

John Albert: Yes, I mean I don't know if I'd say it is in the user guide, that's probably lengthy.

(Tanya Graft): Yes.

Barbara Wright: You could send the particular fields though …

John Albert: Yes.

Barbara Wright: … that shows that …

(Tanya Graft): Right, right.

Barbara Wright: … find what that claim in his and say that we needed – what they wouldn't like hearing is technically the reason is required is under the Debt Collection Improvement Act among other things.

John Albert: Yes.

Barbara Wright: We're supposed to collect the TIN of any entity in which we quote, potentially have a business relationship which includes a potential debt.

(Tanya Graft): OK, that's helpful. OK, I think we can go with that. It would be helpful too – I don't know, you know, I know they have the reporting requirements on their end, I don't know if there'd be any plans on changing or at least add in that to their list and then that way they would not have that question for us but that's helpful.

I do have a follow up question as well, also for deceased injured party. Can we use the model for them and for – I don't know for that – that person's representative to sign – but I'm a little confused on that because it looks like it is directly related to the living beneficiary.

Barbara Wright: Well, the point is we don't want that form to be your first line of attack. You should always be attempting to get the health insurance claim that the Medicare number that's on their red, white, blue Medicare card. And if you can't get that we will accept the Social Security Number but certainly if they're saying the person was not a beneficiary or they're saying they didn't have a Social Security Number, although that's offly rare anymore or if they're simply refusing to cooperate then you ask that that form is still your second line approach, regardless of whether the person is alive of deceased.

(Tanya Graft): Yes. OK, yes, you know it's just – it's because when we query with them same as on the monthly basis where sometimes we get that undetermined back and we just want to double check that that is correct since it's not really definitive no. OK, so – but it's not really intended to go to I guess the person representing a deceased beneficiary. Then it would only be for the living Medicare beneficiary for them to sign.

John Albert: Well, I mean the – you know, the point of putting that all out there is to kind of offer tools for people to utilize. I mean, you know, every organization might have its own way of doing business. We're not trying to say, you know, these types of things that we put out there which should apply to the universe of companies out there that need information, whatnot. We're just, you know, putting out this as a suggestion.

I mean if you have, you know, other things that work for you and would like to share them with us, and this is to everybody out on the phone, we'd like to

hear about them because, I mean obviously, you know, depending on how the message is said and who the audience is, they may do it or not do it and there's no necessarily right or wrong way for getting that information.

The main thing that we're trying to say to people is they need to make that effort to get it and when they can't get the information document, that they were not able to do so, so.

Barbara Wright: But I do have one follow up question for you. When you're saying use it where the person is deceased, are you talking use it because you haven't been able to get the Medicare number for the deceased person, are you talking about use it when the representative of the deceased person's estate or the quote "claimant" won't give you theirs.

(Tanya Graft): It's when we don't have it for the injured party. Or if we don't have that or if we just want to double check, you know, that we – that our information, our query information is correct it is – because we we're talking earlier about heirs happening and maybe that information is not correct.

So sometimes we get this undetermined and we're like, "Oh, we're not sure about it" and then we're relying sometimes to hear the plaintiff attorney say, we'll they didn't have Medicare. So I guess there's those two, you know, two bits of evidence have come back that they're not but then …

Barbara Wright: Right.

(Tanya Graft): … still because it says an undetermined, we're concerned that we're not following up enough to make sure that they didn't have Medicare.

Barbara Wright: No, we have no problem with you using that as the second line approach when the injured party is deceased. I mean – but if you have other – the main thing is to be able to show what your standard of practice for your business is and how you've got it documented, how you keep that record. The model language was put out there as suggestion of what it would be helpful to have.

(Tanya Graft): OK, OK. Thank you.

Operator: Your next question comes from Doug Savage from State Farm Insurance. Your line is open.

Doug Savage: Good afternoon. Our company's RRE authorized representative is receiving many calls concerning Medicare claim denials as a result of open Section 111 Reports. And these calls have exponentially escalated over the last two weeks.

The beneficiaries are told that the denial of benefits is a result of State Farm's action and the COB representative instructs them to contact their authorize representatives and provides his direct phone number.

Since our authorize representative is the individual and the organization has a legal authorization to bind the organization, he is not familiar with all the individual claims and he is definitely not equipped to handle the volume of calls the COB is directing his way. I'm just wondering why COB providing the authorize representative's telephone number.

Jeremy Farquhar: Doug, we've spoken about this in the past and I know that one of your RRE's previously when the RRE was set up originally and registration, the authorize representative's phone number was given as the company phone number. And that's how they were getting back to the authorized representatives.

Our call centers does not have authorize representative information to pass along but if the company number that is set up under a particular RRE I.D., and I know State Farm has many, if it is set up as the authorize rep's number being the company number then that's quite possible that it could be occurring.

So I – if you maybe have other ID's that have your authorize rep's phone number as the company phone number, erroneously that could be what's causing it and that's what I would expect.

Doug Savage: But I don't believe that's correct because we've talked with our EDI rep, and she has confirmed that they're not listed that way. We have an email from her.

Jeremy Farquhar: She has looked at every one of your RRE ID's?

Doug Savage: That's what she tells us.

Jeremy Farquhar: Well, then …

Doug Savage: And since we've talked two weeks ago, the calls have went from maybe 5 and 10 a week to 5 to 10 a day.

Jeremy Farquhar: Yes, there is …

Doug Savage: I mean this would be like having people call you or Barbara and ask the questions.

Jeremy Farquhar: Yes.

Doug Savage: I mean we would never do that to you. We would never direct people to call someone like that about these questions but yet COB is doing the same to us.

Jeremy Farquhar: Well, you know that's …

Doug Savage: This is not the person that needs to handle our client.

Jeremy Farquhar: Doug, we do not even provide the authorize representative. We don't provide any contact information for specific individuals to anybody in our call center that people that are dealing the calls.

Doug Savage: We have called call center representatives and they have told us that they give out the name and number, they have access to it.

Jeremy Farquhar: That's not correct. They do not have contact the names, they have – what they have, and I'll tell you what we give them, we give them a list, it's got the company name. It's got the associated EDI rep and it's got the company's telephone number and the RRE I.D.

And that's all that our call center representatives have to hand out. So they're not giving you or not giving people your authorized representative's name. The situations before where the one that I have teamed before, your authorize representative's phone number was set up as the company's phone number.

Why don't you send me a list of all of State Farm's RRE ID's at some point. I will go through them personally and I'll verify that we don't have any bad numbers still. And you can give me the phone number for your authorized rep, that person who's receiving the calls and I can investigate further.

But this is, you know, this is by no means standard operating procedure on our part. And in any research that I've done when I'd looked into it, you know, our CSR's are not giving out this type of information. So something is – has got to be fishy here.

Doug Savage: I'll send you the numbers.

Jeremy Farquhar: OK.

Operator: Your next question comes from the line of John Miano from Golden Land. Your line is open.

John Miano: Good afternoon, everyone. Just a couple of quick questions. First, in the context of a risk management right off, I have a customer that has an RRE that has a subsidiary organizations also registered as subsidiaries on their profile report.

The question is, should they have risk management write offs, several write offs, which are associated with the same CMS date of incident. There are write offs in association with this one date of incident, one situation. However, the bills are from different subsidiaries with any organization.

Are these considered to be multiple TPOCs where there might be considered to be individual settlements or will they can be considered to be say for instance, a singular TPOC where it is in regard to one specific incident. Should they be, you know the write off amounts be rolled up into one TPOC amount or should they be, you know, reported as separate TPOCs?

Barbara Wright: Are these entities providers or suppliers or physicians?

John Miano: Yes. It would be a hospital and an assisted living or a nursing home type kind of situation.

Barbara Wright: So, they need to be addressing those right-offs in the context of billing Medicare.

John Miano: I believe that the way that the – that the way the billing was being handle was that their primary payer was being billed in the context of the claim and that in regard of your all settlement of the claim that some of the bill was being written off or actually in exchange for settlement of the claim, the entire amount of these bills was being written off as risk management tool.

Barbara Wright: But …

John Miano: Therefore, Medicare's not being billed at all which is …

Barbara Wright: At minimum, for institutional providers there should be a no-pay bill, so.

John Miano: But I believe in the MLN it says that the primary payer is suppose to be billed first and then when the primary payer refuses billing, that Medicare is supposed to be billed even if its balanced billing showing the charges.

Barbara Wright: But when – the risk management tool idea, what we've put in the user guide is when write off is done, when that's what your plan is that you're writing it off as a risk management tool, the bill that's submitted to Medicare need to show that amount as a payment by a primary payer. In that case yourself, the self insured entity.

Even if there's – even if you're technically secondary to someone else or you believe you're secondary to someone else, you're still primary to Medicare. And when you're doing the write off action it should be reflected on your bill to Medicare.

John Miano: OK, well in that circumstance then, if we are showing the balance bill or rather the fact that there is no balance bill to Medicare, then wouldn't be billing of itself to Medicare be consistent with taking Medicare's interest in the consideration and not requiring a TPOC be reported?

Barbara Wright: I guess I'm not – that's what the user guide says, is when you got a write off amount and you – for a provider position or other supplier, and you address it

in the context to your billing, you do not have to separately report it. You're not supposed to separately report it.

John Miano: OK, thank you.

Barbara Wright: I think – am I missing something in your question?

John Miano: No, I believe you've answered it quite adequately, thank you. The next question I have actually is directed to the COBC folks. And I just wanted to know if they had an update for us with regard to any restructuring or revamping of the annual profile report certification process.

Jeremy Farquhar: No updates further than what we have discussed previously at this point John.

John Miano: OK.

Jeremy Farquhar: But we can talk about that more of offline and there may be some changes upcoming. But at this point time I don't think that there's anything further than what we discussed, but I won't get into the specifics with that on the call here today.

John Miano: OK. Well, that was all I had for today, thank you very much.

Operator: Your next question comes from the line of Annie O'Neill from Faegre Baker Daniels. Your line is open.

Annie O'Neill: Hi, this is Annie O'Neill at Faegre Baker Daniels. I have a question about Section 111 reporting in the clinical trial context. So, it relates to the May 26, 2010 alert that CMS put out.

And my question arises from basically the lack of guidance on any further interpretation on this alert since its original publication. And so my question is twofold. First, is there any further guidance you can give regarding how one should define complications or injuries arising out of a clinical trial?

The alert states that when payments are made by sponsors of clinical trials, the complications or injuries arising out of the trial that subjects the sponsors to go Section 111 reporting requirements. And I'm wondering if you could

provide any further guidance on what exactly you would consider should be complications or injuries arising out of the trials.

And then my second part of the session deals with the timeframe for registering as the response for reporting entity but I can get into that after you address the first part.

Barbara Wright: OK. Well, remember that for purposes of recoveries, our touchdown is what's claimed or released or effectively released. So, if there's an allegation and/or determination that that it's something that's related to the clinical trial then that needs to be reported. It is say – we are talking self insurance, liability insurance, which again means that Medicare does not have to prove causation.

So basically, if you're paying for it and see their alleged or proven that it's caused then it needs reported.

Annie O'Neill: Is there any de minimis requirements on that, say somebody gets a paper cut during the clinical trial, and we pay to, you know, give them a band aid or some other small treatment like that or there's some small, you know, little side effect that's not an ongoing injury or illness, what – but there's payment made for that. So, is there any de minimis, you know threshold?

Barbara Wright: If you go to the MSPRC, the Medicare's Secondary Payer Recovery Contractor's website and examine the information they have about a $300 threshold. It may fit your situation. The full report and for the injury but I'm not prepared to go into detail on that right now. All the details is on the website. So if you could take a look at that.

Annie O'Neill: OK, the MSPRC.

Barbara Wright: Yes, it's www.msprc.info, I-N-F-O.

Annie O'Neill: OK. All right, that's helpful. So there's no other definition you can give for that as long as payments made it's – it has to be reported?

Barbara Wright: Within any thresholds we establish – yes, I mean right now, certainly there's still the $5,000 minimum threshold for reporting for liability insurance.

Annie O'Neill: OK, so how does that relate to the $300 threshold you just mention?

Barbara Wright: If you've got what's clearly a TPOC situation but, you know, what I don't know in your particular situation is whether you have a TPOC or an ORM situation. Presumably, you would argue in your particular case that it was a TPOC situation. But again …

Annie O'Neill: And what do you mean a TPOC or an ORM situation and the clinical trial context, it states the situation is an ORM.

Barbara Wright: And you would have ORM specifically for that paper cut or whatever but I mean again, it would seem like that's the type of situation where you would have proof that treatment is complete. So that you'd essentially be submitting a one time record with the term date or and everything.

Annie O'Neill: OK.

Barbara Wright: If you will – if you literally have a paper cut.

Annie O'Neill: So a one time injury that was paid for one could be a TPOC where it's something that might give rise to ongoing treatment would be an ORM situation?

Barbara Wright: If you can establish that there's no continuing ORM then you're free to do so and terminate the ORM record.

Annie O'Neill: OK. My second question have to deal with when an entity should first register as an RRE, so say for example you have a small company that's conducting clinical trials and today they haven't had any injury so they haven't registered but they've agreed that in the future a certain injuries arise from the clinical trial bill of paper specified injuries to subjects.

Should they register that at the outset at the point that they, you know, enter into the agreement with the subjects of the clinical trial where the pay for injuries in the future or should they should register at the time when an actual injury occurs and a payment is made?

Logistically speaking, would it be difficult to wait until the actual injury occurred or would you rather recommend that they register at the outset so that they are setup as an RRE? (Inaudible) many injuries which is a small (inaudible).

Barbara Wright: It depends on what (inaudible) they're going to use for reporting and Jeremy …

Annie O'Neill: Most likely it would be the direct entry method.

Barbara Wright: I think that Jeremy would agree that you don't need to do it at the time because it doesn't require testing or a lot of setup.

Jeremy Farquhar: That's correct. It's pretty self-explanatory, it's user friendly, you know and it's basically, once you determine that you have something to report you can register and pretty much jump right into it just write off the bat.

Annie O'Neill: So you'd recommend that even though they agree at the outset of this trial that if certain injuries occur they will pay for them the obligation to register doesn't arrive until an actual injury has occurred that they have to pay?

Jeremy Farquhar: Yes, you really – there's no need to register ahead of time given the fact that you may have absolutely nothing to report. It's just the – it's going to place an undue burden on you ahead of time that it's just unnecessary.

Barbara Wright: If you're not planning to use the direct add entry though, you have to register early enough that you have time to test before you'd actually have to report. So, even a pending claim, if you're choosing the other method to report may require an earlier registration.

John Albert: Although we would expect small reporters to use DDE just because of this – for occasional reporting that's definitely the better way to go based on our opinions.

Annie O'Neill: And DDE only used if there are 500 or fewer claims per quarter, is that right?

Jeremy Farquhar: Per year, actually.

Annie O'Neill: Per year, OK.

John Albert: I think I heard someone at COB mentioned, you know, if you're interested their – you might want to check out some of the computer based training modules that are out there regarding and if you just look some other pleasant way to present the information you might find them useful.

Annie O'Neill: OK. Thank you very much.

Operator: Your next question comes from the line of (Sean Sheehan) from (Cape O'Byrne). Your line is open.

(Sean Sheehan): Hi, Barbara, I have a question about the interplay between the 12/5/1980 exposure date and joint and several liability among defendants. My firm represents asbestos defendants. And we have defendants sometimes where the exposure to our client's products that's claimed, released and defectively released, it all predates 12/5/1980.

But in some of the states where we defend our clients, there's joint and several liability. So if there's – in mass tort litigation there's a lot of different defendants that they're not related to our client. Their exposure may go on or after 12/5/1980. How was the joint and several liability going to affect our client's analysis of whether they should report or not based on a date of exposure?

Barbara Wright: Well, part of it's going to be what their ultimately responsible for. We've said in several meetings and we're hoping to include it with any updates that when we're talking joint and several liability we're not necessarily talking the joint and several liability that may exist under state law. We are talking settlement judgment award or other payments specific.

So if you have 10 defendants and one of them settles out and the entity that settles out is their only responsibility, now that they've settled out is to pay that settlement. They are the only one that has to report that settlement. If none of the other defendants are jointly and severally liable for that particular settlement, no one has to report it except the actual settling entity. Does that help you?

(Sean Sheehan): It does, it does. Thank you very much, I appreciate it.

Operator: Your next question comes from the line of Catherine Dickenson of Husch Blackwell. Your line is open.

Catherine Dickenson: I have a kind of similar scenario to (Sean's). It's not common for many of our defendants the mass tort cases to each pay an amount over to one defense attorney who will put that money into trust and then pay one month amount to the plaintiff. The idea of being the plaintiff won't necessarily know how much each defendant is paying.

And I understand that everyone reports depending upon after joint and severally liable for the full settlement amount or their individual amount. So my question is, is there any risk in all of the defendants paying the money over to one defendant's count list or to the RRE. In other words, is that defendant then taking on the liability of reporting for everybody or should everyone still report what they paid over.

Barbara Wright: It sounds like you've set up some type of situation that's essentially joint and several – severally liable because none of these people have separate – none of these defendants have separate settlement agreements. They're all part of a single settlement with the plaintiff.

And presumably, I'm making an assumption here, I have no idea the – the plaintiff could arguably enforce any – the full settlement amount against anyone of them. If that's true, then yes they each need to report the full amount.

Catherine Dickenson: And I guess my question would be if only one defendant is paying the money over or even if it's the defendant's counsel paying that over from a trust account, is that one defendant then, the RRE because they are the one directly paying the plaintiff or would you still look to really the intent of the party – would that everyone pays (inaudible).

Barbara Wright: We look at whether or not they're jointly and severally liable. And as you've described it, based on my assumptions, for purposes of this question right

now, it appears they're jointly and severally liable. So they would all be reporting the full amount. Does that mean there's going to have to be some clarification on the backend, yes?

Catherine Dickenson: Yes.

Barbara Wright: But you know, the parties can't transfer their RRE responsibility.

Catherine Dickenson: No, that was my main concern. I just didn't want the defendant that, you know, sort of by default was paying the plaintiff to be the RRE because he's the one writing the check. You know what I'm saying. It's really not intended to be an (inaudible) situation.

Barbara Wright: The only time I believe, that's my memory, the only time in the user guide where we were talking about payment meaning physical payment, we were talking about distinguishing between when the insurer versus the insured was the RRE. We weren't just making a generic statement that RRE is always – it could always be determined by who physically wrote the check.

We moved away from that concept several years ago. I mean, you know, when we put out the advice about when essentially that the insured is normally the RRE both for the deductable and the amount above the deductable, so.

Catherine Dickenson: No, I appreciate your clarification.

Barbara Wright: Operator?

Operator: Yes? Your next question comes from the line of (Suzanne Jordan) from (Inaudible). Your line is open.

(Suzanne Jordan): Hi, good afternoon. I just had a couple of quick questions. One, was whether CMS might consider having some type of sign-offs, I guess if you would if you're moving claims from one RRE to another or from one TPA to another would be a better question. Some type of process to kind of relinquish responsibility for reporting of this claims so that CMS is aware that they – in

the future they would be reported by another company or various future activity.

Barbara Wright: This goes to your issue of the fact that there's a work around right now in terms of including an address where you want correspondents to go for NGHP, correct?

(Suzanne Jordan): Right. Tying that TIN Reference File to claims that were previously submitted and then if all of the claims moved to a new TPA which is known in the industry of the takeover, you know, might there be a way to have smooth transaction for that down the road?

John Albert: Jeremy?

Jeremy Farquhar: You know, we don't have anything in line at this point in time. But it's something that we can, maybe, keep in mind and discuss internally as far as future enhancements go. I'm not – at this stage of the game I'm not sure how we would facilitate that but it is something that we can – we can discuss and definitely take into consideration.

(Suzanne Jordan): OK. We would appreciate that. And then my second question just went out to the caller earlier on the TIN Reference File and the phone number, could it be that the phone number was updated and they're calling or they're still looking at claims that might have previously been associated with that TIN Reference File and phone number?

I was just trying to problem solve when you guys are having that discussion. I just wondered – I thought I would bring that up because I know that we've had claims where some of the previous submitted TIN Reference File data, you know, depending on when it got submitted might have a different, you know, phone number or name if something changed.

So I just didn't know if that might have been that earlier issue possibly.

Jeremy Farquhar: I think there issue just because it's spoken with (Mr. Savage) previously and I was thinking that we know that (Rod Spire) had an issue of that same nature and it's spoken with you about that previously. That was something that I had

question to them about but I think that their scenario was slightly different and it was – the phone number was actually coming from somewhere else. They entered it during registration as opposed to including that on their TIN Reference File.

So their reason to (inaudible) sure …

(Suzanne Jordan): OK.

Jeremy Farquhar: … but thank you for that and I appreciate the assistance or advice.

(Suzanne Jordan): OK. Great. Thank you.

Operator: Your next question comes from the line of (Vicki Curtis) from State Farm Insurance. Your line is open.

(Vicki Curtis): Good afternoon. I have a question about SP32 error code. We received a couple of those recently. We were advised by our COP rep or COB rep that treated the same as the disposition 03 that they had Part B only and that we don't need to report it.

Do you have any information because that was the new (inaudible). That's a new …

Jeremy Farquhar: I'm sorry.

(Vicki Curtis): Sorry.

Jeremy Farquhar: I can confirm that why your EDI rep told you is to treat as an 03 is correct. This dates back and you may have heard I speak to this before. We previously had problems where if an individual is entitled to Medicare Party B only, we were not giving back positive matches on query files and we were not able to take in information successfully on a claim files.

That was corrected back around the February timeframe. And I think when we first made the fix, there were some minor issues and there were some of those types of errors that begin generating. And this is something that we're

looking at presently. We believe that we may – that this is something that we may have already corrected with a subsequent follow up system fix.

But we're – actually, we have spoken with a number of RREs that received the 32, so our development team is looking at a percentage or that we had actually solve that. Basically, the SP32 does mean the same thing as the 03, but we would typically convert that to your 03 disposition code before the SP32 is generated.

That code is something that we going to kickback from the external database to which we post our ORM data and it's not something that we typically give to the outside RRE population and that's why it's not documented. But if you're in the interim, I don't know that you'll see them any further on any of your subsequent files, if it is still occurring where we – like I said, we're looking at it at the present and we should have the result relatively quickly.

So even if there – it is outstanding at the present, it will not be for long so in the very short-term, you should cease to see that, but in the interim, just treat it like an 03. It's basically the same thing.

(Vicki Curtis): OK. Jeremy, can you tell me the time of those fixed so we can watch the date?

Jeremy Farquhar: They're thinking that it was sometime – did back towards the end of April that the subsequent fix came in. When is the – do you know when you submitted the file that received the SP32s by any chance?

(Vicki Curtis): Let me see. I might have the information here in the email. That's what I was thinking is that maybe we received this before.

Jeremy Farquhar: If you submitted it before we made the fix even, even if you received …

(Vicki Curtis): Yes. It was before 4/18.

Jeremy Farquhar: … those files afterwards.

(Vicki Curtis): We got it (inaudible) …

Jeremy Farquhar: 4/18?

(Vicki Curtis): … and some 4/18 and then later, you know, it came back with the code after April 18th, so – and this was (inaudible) …

Jeremy Farquhar: OK. Yes.

(Vicki Curtis): … but I'm not sure about the other one.

Jeremy Farquhar: Yes. That would be within the time – probably, you know, prior to the timeframe that we would have made that adjustment. So it's possible that they may have cut that. But I'm waiting for confirmation at the present. We actually were discussing this earlier today.

(Vicki Curtis): I will just give you examples after – day after April – after May 1st that we've seen them.

Jeremy Farquhar: If you see it didn't come up on your subsequent files anything that you submitted after the end of April, yes, OK, please …

(Vicki Curtis): OK.

Jeremy Farquhar: … give me examples. We might have it resolved before you even get to me with that if it is an issue. Like I said, we're looking at it. You can touch base with me after.

(Vicki Curtis): OK. Thanks, Jeremy.

Jeremy Farquhar: Sure thing.

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

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

Norman Reese: Yes. Thank you. Gentlemen, I asked a question long ago about asbestos. I'm not sure I got the right answer. Let me give you the question. The beneficiary

is exposed to asbestos from Defendant A from 1975 to 1979. He's then exposed to asbestos from Defendant B from '79 through '85.

The plaintiff sues Defendant A and B. A makes a settlement with him and does A have any obligation to report because he was still exposed by Defendant B after 1980? And A has positive proof that he had no exposure.

Barbara Wright: If A had a separate settlement and was not jointly and severally liable if he met the criteria that were in the 12/5/80 policy memo then he would have no reporting and we would have no recovery with respect to that settlement.

What we were talking about is if there was – if there was joint and several liabilities that made A responsible for part of the settlement that B was also involved in, then there's potentially some reporting responsibility for A because he has to report the amount of the settlement that he's jointly and severally liable for.

Norman Reese: OK. That clears that. Thank you.

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

(Bonnie Mustard): Thank you. I actually was just going to clarify with regard to the issue of the authorized rep being contacted. We actually were having the same exact situation. And one of our managers called and really pushed hard on one of the COBC contacts and the person – I guess in his term is cave and gave him a phone number to call and it turned out to be our authorized representative's phone number and after that happened, we actually had the authorized representative's phone number changed to the phone number for our account manager. So just as a …

John Albert: Who?

(Bonnie Mustard): … a heads up to some of those of you who think you're having that same situation, I might offer that a suggestion. I don't know who or how they're getting that and I respect the fact that you don't think that they are, but they

found that information somewhere in your system and provided it when the manager was pushing hard.

Jeremy Farquhar: Well, the fact of the matter is that we do not, you know, the actual contact information for any of the individuals within any RRE organizations specifically as far as what is used to register as an authorized rep, account manager, or an account designee is not provided to anybody outside of the EDI department here at the Medicare COBC. Nobody has that. If you are to call our 1-800 number, the call center, they don't have access to that information. The call center management doesn't even have access to that information. So I'm not sure …

(Bonnie Mustard): I don't know how they got it but it happened. I mean …

Jeremy Farquhar: Well, maybe they spoke to somebody outside of the call center, maybe with somebody in EDI. But, like, what didn't happen and what has happened, there are a couple different scenarios that we've encountered. We have had people that when they registers for RRE I.D., when you're registering during the first stage of registration, you enter company information, the company address, and it asked for a company telephone number.

In some cases, we've had RREs give us the authorized rep's telephone number as the company telephone number. Now, that information, that's something that the call center has. They don't know that is the authorized rep. They just say, "OK. Here's the phone number for the insurer on file. You need to speak to the insurer to resolve this issue," and that's sometimes is how this has been – this call has been directed to authorized reps.

And then we've had scenarios also where RREs have erroneously or mistakenly provided authorized rep contact information within their TIN Reference File in a TIN detail record. Instead of giving the actual contact information for the RRE, they put the authorized rep's name and address in that information within the TIN file and this stuff has been directed to that individual in that manner.

But as a – there, you know, there's just not any way that the call center staff here at the – our 1-800 number would have been able to direct you to those

authorized reps unless it was somehow entered somewhere other than during the A.R. or, you know, authorized rep registration. The number could be kicking around somewhere else in our system. It was entered somehow mistakenly elsewhere. That seems to have been the case and all the situations that we've investigated previously.

(Bonnie Mustard): OK. I just thought I'd share that. I know that initially he did not get the information, but he pushed like some of the individuals who have been upset and calling about these issues did and managed to finally – it was like, "OK, fine. I'm going to give you a number almost like a number I'm not supposed to give you," and got that number.

Jeremy Farquhar: OK. If you – if you have any kind of more detailed information about anything like this happening and you could pass along to us, it'd be much appreciated because if it's something like that is occurring when it shouldn't be, we certainly want to put a stop to it.

We do not want to be directing individuals to your authorize representatives. We know that's not appropriate and that it can cause major headaches and be bored, obvious, be frustrated and rightfully so.

(Bonnie Mustard): OK. I just wanted to mention that.

Jeremy Farquhar: OK.

Operator: Your next question comes from the line of Jennifer Selzler from Claims Associates. Your line is open.

Jennifer Selzler: Hi. Thanks for taking my question. I wanted to return to the comment made earlier about the increase in claim denials due to Section 111 reporting. It's reassuring to hear that other people are getting increase calls as well and that the system is working but I don't think it's working to the extent that – or it's working too well.

We're getting calls from employee patients saying that they're going to the doctor and Medicare is denying their charges and they call COBC and COBC

tells them to call us or the insurance company and – to have us reverse that we – that we have basically our ORM and it's not termed yet.

The only thing that we can do that I see is that we can confirm that the ICD-9 code that we have in our system and that we have been recording is correct and current and I don't know how else we can assist the beneficiaries if – at all. And so I was just looking to see what other people are doing.

John Albert: This is John. I mean, we recognized this, you know, with all the new data coming in that obviously coordination of benefits is going to be more than just Medicare paying and that's it. There's a lot more data coming in to CMS as a result of 111.

Jennifer Selzler: Yes.

John Albert: Usually, the first thing that would go to is the (bene) needs to go back to the claims processing contractor if there's something on there and the summary notice should have that information regarding, you know, why the claim was denied. And, you know, if the data is incorrect, yes, I mean, the 111 reporter needs to correct that which is why we, again, like, offer the interim submissions for records if they find that it was – their, you know, the record of diagnosis codes are not correct.

But, you know, oftentimes though, the claim is not denied because of the open ORM record or could be some other reason. I mean, we did release a couple of change request that these are documents that go out to instruct our Medicare contractors regarding the nuances of processing NGHP claims in particular because there you're talking about, you know, specific diagnosis codes versus a traditional group health plan or basically the group health plan is generally primary for everything and you don't get into the what is covered and what's not in terms of the detail you are with – typically with an NGHP claim which may be only related to like you said a specific, you know, injury or something like a broken leg.

But generally, the first thing that should be doing is going back to the claims processing contractor. Obviously, we would say they should go to everyone. But the first thing is to just determine whether or not that claim was denied

appropriately because oftentimes, it was denied for inappropriate reason. They did recent diagnosis codes, for example, and denied that claim that was unrelated to the particular liability situation that has nothing to do with Section 111. Just go to their claims processing contractors which is again which is the first step we would advice people would go to.

Now if claim was denied and it was because of an ICD code, you know, that matches in the existing record, that may be wrong but then obviously they need to get that correct and there are different processes for doing that. But, you know, that's the first step as what people should be doing. And I think oftentimes they jump ahead of themselves and go to the COB contractor or MSPRC contractor which the most case they shouldn't be doing because they just assumed it's a Section 111 record and oftentimes that's not the case.

We've, you know, we've always asked for specific examples and the majority of the case is the claims were denied correctly because of other coverages or, you know, something else, you know, like a record was wrong or the provider wasn't doing what he's supposed to do in terms of denying service. Or that – you know, there's a lot of different reasons and there's no one answer for it.

So, you know, it's – saying it's Section 111 is like doing a disservice to the beneficiary because oftentimes it isn't Section 111. It needs to be looked at on a case by case basis.

And, again, we have implemented as a result of this, you know, a bunch of changes that recently went in for Medicare contractors as well as MedLearn articles for our providers to address a lot of these issues. So, you know, it does …

Jennifer Selzler: How does – OK. How does the patient know the claim process or contractor? Is that – how do they gain that information?

John Albert: They get in the summary (inaudible).

Jennifer Selzler: OK. From their, like, EOB basically?

Suzanne Kalwa: Yes. It's called …

Jennifer Selzler: With the denial.

Suzanne Kalwa: … summary notice this and we've referred to them as MSN and each time Medicare designs a claim, the beneficiary will get one of these.

Generally, I understand they're only issued quarterly I think. But usually when a claim is denied, the beneficiary will receive one and on it, it will have a reason for why the claim is denied, a claim – a reason code as well as an information and it will also include the claim processing – excuse me, the claims processing contractor phone number who process that claim.

Jennifer Selzler: OK.

Barbara Wright: The other big thing if you're getting a call is to make sure that – and we've said this before, is to make sure to distinguished between whether or not the person actually had payment denied by Medicare or they had services refused by their doctor or other provider.

If they've gone to a doctor or provider and they refused to treat them saying they have someone else's primary meeting, that means the claim didn't even come into our contractors. In that case, they really need to show their doctor the MedLearn article that we put out which is readily available on the website.

Jennifer Selzler: Yes. I think I do have that because I was hoping it would give me as a – as the insurance company rep some guidance, but I did see that it was more really geared toward the provider and how they're supposed to submit their bills and double-check that everything is correct.

When we're getting phone calls, we're getting phone calls from the patients because they've already done the calling and they're telling them that it's our problem, that we're responsible for payment and that's what their system shows, otherwise, they wouldn't have come back to us.

Barbara Wright: All right. But that doesn't change the question of making sure the person already had the services. If they haven't had the services then they've had services refused by the doctor or provider and then the education really needs

to go to the provider. There isn't anything we can do to process the claim for that person if they haven't even had any services. If they've actually had services and Medicare denied payment, then you're in the other sort of path.

Jennifer Selzler: Those are the only examples I have so far is that they're getting services and either the provider or the employee is calling saying Medicare won't pay. And the most traumatic one – I mean, some – one of them is a little bit more complicated because the ICD-9 code correct. He hadn't had treatment for two years on our insurance claim, but the ORM term date hasn't run yet and he went it for the same diagnosis.

Understandably, that's going to probably take a little bit more communication between the provider, the employee, and the contractor to say this is really something new and it doesn't go back to my work comp claim.

But the most drastic one is an example of an employee who three years ago had a work comp claim and now he's having cancer treatment. They're not looking at the ICD-9 codes or something because it's clearly not indicated in the Section 111 reporting.

The only other alternative is that no, it's not because of Section 111, it's because of something else. And well, that's not what we're being told. We're dealing with elderly people as well and we don't always have maybe clear information. And just we just aren't sure how we – what our role is in it if anything, and how we can explain that to the beneficiary.

John Albert: Well, I mean, I could say that unfortunately if it's – there's often a lot of layers you got to peel back to get to the root of a particular issue in it.

Jennifer Selzler: OK.

John Albert: You know, like I said, we started with the summary notice – I mean, you know, that's the first question was, was a claim file – I mean, that – we're looking at providing additional types of materials like that for our, you know, stakeholders like, you know, insurers and employers and all that kind of stuff to help with this issue.

We definitely recognize that, you know, again, with – being a lot of people involved at COB that a few years ago weren't, that this, you know, there's a lot of what ifs.

But, you know, the first is, you know, was the person treated and then, you know, looking at that summary notice, just be what the reasons were because any concerns of drill down, so OK, was it because it was related or not related or was it because the provider, you know, just misread something or claims processor didn't – you know, a lot of this stuff is automated and that's part of the edits that we put in to some of our – you know, make some changes, to clean some of that up, and get down to them more on a granular level in terms of these, you know, somewhat – in coordination of benefits now applies, you know, most people have multiple coverages that they didn't have years ago so you're going to have some conflict.

And I know it's challenging. It's challenging for us because, you know, CMS is only as good as the data it gets and so we can't just tentatively say that, you know, this one is your primary payer so this other insurer, you know, that kind of stuff. All we can do is look at what we have.

But the first thing is look at the, you know, the MSN as the first thing and, you know, again, we'll continue to work on this issue. We've heard, you know, like that's why the MedLearn are our close put out because, you know, we know about providers who's basically denying, you know, treatment, if they should be doing that and things they needed to do or hoping that it helps.

We know that there are still these issues out there. We've, you know, heard from some folks that the problem has decreased dramatically. So that's better, I mean, you know. But the main thing is that we continue to – all we can say is we continue to try to get the message out to everyone to help them work the way through this. And we'd certainly appreciate when you're dealing with the beneficiary how challenging it could be to get through it all.

Jennifer Selzler: Right now from our position, what we've been told and what we've been trying to tell our staff as well is that if everything in our system is correct and accurate, there's nothing that we're going to do to change it. If the ORM

legally has not termed yet, we're not going to term it just because they're having problems getting their claims process.

John Albert: Right.

Jennifer Selzler: And it's really between them, the patient, the provider, and their Medicare rep …

John Albert: Yes.

Jennifer Selzler: … and who did – who did the denial.

John Albert: Yes. We don't want you fudging records.

Jennifer Selzler: Yes.

John Albert: If anyone's going to make conditional payments, you know, it's going to be us because that's …

Jennifer Selzler: OK. OK. Well, I appreciate your help.

John Albert: Yes. You know, I wish we could give, you know, everyone a magic, you know, a magic (ball) answer but unfortunately there isn't. So, again, as I've said at the beginning of this call and previous calls that when working with, you know, your contacts, you know, the more information, specific information you have the better.

I said – and looking at this for a while now, in many of the cases, the claims are being appropriately denied for (primer) payment by Medicare but it's not related to the Section 111, it's the other coverages. But they may be retired but they have a group health plan like they're open through a working spouse so that's family coverage. That was – a whole batch of them we got and most of them were that.

So, like I said, it's not always – we encourage people not to just default to its this or that and we encourage them to keep and open mind in terms of looking at the situation and working through it logically because to say it's Section 111 only prevents the process from being resolved because oftentimes it distracts

resources both here and other contractors and everywhere else where it's really is, OK, what is – what is the reason for the denial and getting down to, you know, OK, was the claim paid, what was denied, what was paid, what not and then working, you know, through it like that.

Jennifer Selzler: But once again, we're very limited part of that conversation …

John Albert: I know.

Jennifer Selzler: … because we have no access – you know, we don't have any right to be …

John Albert: Yes, I understand.

Jennifer Selzler: … looking – digging around in their stuff, so. OK …

John Albert: That's why we're trying …

Jennifer Selzler: I appreciate it.

John Albert: We're trying to get people to go to the contractors, so – because they're the ones who actually process the claims, so.

Jennifer Selzler: Yes, yes. That's what we'll do then.

John Albert: OK.

Operator: Your next question comes from the line of Judith O'Grady from Shook, Hardy, & Bacon. Your line is open.

Judith O'Grady: Hi. Thanks for taking my question. I wanted to clarify on a topic that came up a little while earlier on page 114 of the User Guide, the final bullet point talks about payments made that arise out of complications or injuries from clinical trials. The final sentence of that bullet reads the situation should also be reported as one involving on-going responsibility for medicals.

Is that truly meant to say that any payments arriving in clinical trials even if they otherwise qualify as a TPOC should be reported as an ORM? Or are

there words missing like should it say it should be reported as an ORM if applicable?

Barbara Wright: I think where we ended up in the last question on this basically the – part of the reason to say that it's ORM is if you assumed responsibility related to that injury, it should be on a non-ongoing basis. It's not a TPOC type situation.

If you – if you have a situation for clinical trials where you're – where the clinical trial sponsor is responsible for injuries arising – injuries or complications arising out of the trial, that doesn't mean that they're responsible or part of the care. And once they have assumed responsibility, they should be paying for all the care related to that injury or complication.

What you – what I think the last person talk about on this is they went to the extreme example of a paper cut. In a situation like that even if it's reported as ORM, you should be able to document why the ORM needs to terminate is all. Or the …

Judith O'Grady: OK. So you truly …

Barbara Wright: Or the diagnosis code should be so specific that it's not causing anyone any problems. And if they get another pay per cut, yes, it will be paid for.

Judith O'Grady: OK. So no clinical – no injuries or complications arising out of the clinical trial should be reported as TPOC even if the sponsor foresees no possibility of future payment. So it truly is a one-time payment.

Barbara Wright: Well, if it's truly a one-time payment, then you ought to be able to document why the care is done, finished, in which case you can put in a term date for the ORM.

Judith O'Grady: OK. OK. Thank you.

Operator: Your next question comes from the line of Todd Simpson from Central Insurance. Your line is open.

Todd Simpson: Yes. Thank you and good afternoon. It's Todd Simpson with Central Mutual Insurance. And my company will oftentimes used what we deemed a

schedule benefits release and it's a basically a release that we use to settle a third-party liability claim quickly. And what we'll do is we'll say, "OK, we'll pay you $5,000 and if we stop there, that's a clearly a TPOC."

But sometimes we'll go on and we'll say, "In order to get a settlement done, we'll pay you $5,000 plus we will pay up to like $2,500 of medical expenses incurred in the next two months." Would that all be referred as a TPOC or would I have to claim that two months like as an ORM?

Barbara Wright: I think we've said in past – a past call or past calls that basically you need to report a TPOC and also report the ORM because the ORM isn't a sure thing. If they don't incur any medical care, then, you know, the time limitation is going to run out. You're going to put a term date on it. There won't be any money associated with it. On the other hand, there might be the thousand dollars.

Todd Simpson: Correct. OK. I just wanted to make sure because we can't – we have our computer system kind of mapping and so that's – we pay that under a liability reserve line and so we're kind of cost ourselves some of the internal strife, I guess.

Barbara Wright: All right. But …

Todd Simpson: We have to (inaudible) as ORM.

Barbara Wright: Yes. I don't remember the numbers you used. But let's say you said the TPOC was $5,000 in the ORM and the additional money was up to an additional $10,000. You don't want to report that as $15,000 because obviously the second – the $10,000 may never even occur.

Todd Simpson: Yes. Yes.

Barbara Wright: There really needs to be – and also the point is the ORM record is supposed to help us prevent inappropriate payment. If we've got the open record, if someone erroneously bills us, the idea is with the codes you've given us, we should be able to properly deny that claim until it's paid by you.

Todd Simpson: OK. I appreciate your input. Thank you very much.

Operator: Your next question comes from the line of (Marcia Naigra) from Cedric. Your line is open.

(Marcia Naigra): Hello. This is (Marcia Naigra). And my quick comment and I guess more than question, we have seen an increase in denied claims and I think – and we've spoke to that – of that before with Barbara and her team.

The question I have or comment is there are not a way that CMS can designated in a situation team that when this happens with these elderly folks that they can call someone who can see everything and try to work it out for them.

Because we've had – the most critical one we've had recently, the woman in her last 30 days was fighting for denied treatment and we intervened which we shouldn't have because everything was – as Barbara told me, I should never terminate ORM, but we're on the verge of terminating ORM just because we needed to get her treatment. And after intervened and spoke with someone, she was able to get her treatment then died six days later.

That's not really what we want to see for our – for our Medicare beneficiaries. So is there any way that you guys can consider having and escalate a SWAT team or some sort of catastrophic team that can help these folks when it is a serious case and treatment is being denied?

John Albert: Well, that's – I mean, that's something that we do consider. And one of the reasons behind, for example, you know, consolidating some of the business functions within CMS. You know, we don't have anything on paper but obviously this is, you know, an important topic and part of this is, you know, first of all, educating our various internal CMS stakeholders such as (winning) her a Medicare as well as her contractors.

But it is something that, you know, we've considered. In fact, we sort of have a – something like that right now in terms of just addressing the denied claims issue as a whole but not on a – not on a case by case basis which is not something that we can do right this moment because we process, you know, a

billion claims a year. And we really look to our fee for service contractors as the frontline because they are the ones who actually process the claims. But that's the kind of stuff we're looking at for sure.

(Marcia Naigra): Well, even your fee for service contractors, there should be escalation, phone number we can give out to the Medicare population when things like this happen. Maybe that's something you all can consider. But thank you.

Operator: And your next question comes from the line of Maryann Reed from SCF Arizona. Your line is open.

Maryann Reed: And thank you for taking my call. It's Maryann Reed. One of the biggest concerns we have with Medicare denials and I guess I'm still on that recurring theme is that their – the beneficiaries are being told by the contract – by your recovery contractors that since the insurance company has reported it as open electronically with an open ORM for the, you know, covered body part, that until we close it electronically, they will not process any bills or any treatment however unrelated it might be.

So we've been sending letters to CMS, our regional office to the providers, to the patients to let them know what specific body parts were responsible for and what we aren't responsible for, and then we're getting kickbacks saying, "Well, what was your settlement amount," where there was in fact no settlement and that's why we're reporting claim.

So I guess my real question is should we be addressing those letters to the contractor as opposed to our regional office at CMS? Would that help expedite this?

Barbara Wright: Could you repeat the last sentence you said?

Maryann Reed: Would it help if we, instead of sending the letters that, you know, detail what we're responsible for and what we aren't to our CMS regional office, should we be directing those letters to the contractors who are refusing to process the bill because they think we're the responsible primary payer?

Barbara Wright: First of all, you should be getting a response out of the regional office, if you're directing something there. But secondly, what continues to confuse us somewhat on this is we hear everybody keep saying that the MSPRC or the COB is telling them they have to close these records.

And the MSPRC – just so everybody hears this again, the MSPRC doesn't even have access to our claims process and system and does not process the payment of claims. So a beneficiary who talks to them about an upfront denial, there isn't really anything the MSPRC can do.

When they get the MSN that Suzanne referenced, it gives them appeal rights. It gives them a contact telephone number. If you're giving them a document showing what you're responsible for, they should be sending that document or keeping a copy of it for themselves and sending a copy to the claims processing contractor and saying, "My claims should have been paid. See, this relates the record," and the claims process and contractor should be able to take that and reprocess the claim to get it paid directly.

Maryann Reed: So then it really would have to come from – what we're sending to the beneficiary, they would need to forward a copy on to the contractor that would be the best case for them?

John Albert: Yes. Best case, sure.

Barbara Wright: Which would be – which the information would be on the MSN, the Medicare Summary Notice, they got denying claims. Again, as long as you're talking claims denial, if you're talking denial of services that provider, supplier, physician really needs potentially to see the MedLearn article that we had to point out to them …

Maryann Reed: Right.

Barbara Wright: … that they shouldn't be refusing services.

Maryann Reed: Yes. I realize that's a different issue. But our concerns have primarily been denial of payment after the service was rendered.

Barbara Wright: OK. And for that …

Maryann Reed: So thank you very much.

Barbara Wright: … there really is a claim …

Maryann Reed: Thank you.

Barbara Wright: … processing contractor.

Maryann Reed: OK. That's great. Thank you very much.

John Albert: All right, Operator, with that, it's about 3 o'clock. We have to wrap this up. I would like to thank everyone for their participation. Hopefully you got some good information out of this call. Stay tune to the – to the website.

I don't have in front of me – I don't know what the time the next call is. But anyway, there will be more calls and they should be posted on the website. You know, continue to meet your written questions in the 111 resource mailbox, again, we look at every single one of those that come through and tried to answer those on these calls or even in some cases, directly when it's specific information.

But, again, we would prefer that you, you know, stick to more policy and technical type of questions that you need clarification on.

Other than that, thanks everyone and we'll be in touched. And, again, we'll be reminding folks that in late June, early July, we should be posting a couple of new alerts on a new user guide so stay tune for that as well.

Also, for everybody on the call, we did find out that the transcripts for the last one was not posted on the website, so we're going to get that up there as soon as possible hopefully by early next week. We apologize for that.

Thanks, everyone. And if, Operator, you could stay on the line. Thanks.

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

END