TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: September 18, 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
September 18, 2012
1:00 p.m. ET

Operator: Good afternoon. My name is (Steve), and I will be your conference operator today. At this time, I welcome everyone to the Section 111 NGHP (Non-Group Health Plan) Technical and Policy 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 that 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.

I'll now turn the conference over to John Albert. Please go ahead.

John Albert: Thank you, operator.

And good afternoon, everyone. For the record, today is Tuesday, September 18, 2012. And this call is a Section 111 Non-Group Health Plan Policy and Technical Support Call. We haven't had one for a couple of months. But, we're back and wanted to, you know, provide additional information.

As we do with these calls, we typically have some opening remarks by different participants here at CMS (and with the) COB contractor. And then, we'll go into a Q&A session. We ask that folks, when they have their questions, to please provide their name and organization they represent and to limit the number of questions they have to one and one follow up so as to give everyone on the line an attempt to (make it) one or more of their questions answered. We always have a fairly large number of participants on this call.

Other than that, I – we do have some opening remarks from our COBC contractor to provide some more technical feedback. We haven't received a

whole lot of questions since the last call. But, again, as I've stated, we try to look through these and provide those answers either through the written guidance or on these calls directly.

Also, I'm sure everyone has seen the new NGHP version of the User Guide that we've put out this summer. So, basically – hopefully, we make that a more manageable User Guide by breaking it up into multiple sections. Hopefully, you've all found that helpful. We've, so far, received good feedback. But, again, we're always interested in more.

With that, I'll turn it over to Jeremy Farquhar of the COBC and we'll probably move into Q&A unless Barbara you have anything. So – OK. So, Jeremy, take it away.

Jeremy Farquhar: OK. Thanks, John.

And, as John noted, we do have that new version of the User Guide since our last call, and it's broken down into numerous chapters. Chapter one provides an introduction. Chapter two provides information on registration procedures. Chapter three provides policy guidance. Four pertains to technical information.

And chapter five, entitles the appendices, is where you will find all of the (bio) layout and area codes. If you haven't located it yet, it's within the NGHP User Guide section, which is new within the CMS Mandatory Insurer reporting Web page.

Next, through our review of data received on the claim input files, we've been finding a significant number of dollar amount (in) related fields, for example, TPOC amount and (no bulk) insurance limit with very low values. And through outreach to our e-submitters, we found that, oftentimes, this is a result of the RRE failing to take into consideration the implied decimal point prior to the last two bytes of these fields.

Please remember, they weren't reporting these dollar amounts with the last two bytes that these fields represent. So, for example, if you have a TPOC amount of 5,000 to your reporting, it should be reported as 500000.

The value of simple 5000 would actually be interpreted as $50. Such as big difference. That's very important. Please be careful to ensure that these values are being report appropriately within your claim input files.

In addition to this, we at our outreach, we also encountered a number of scenarios where our RREs have been sending very low TPOC values due to a seeming misunderstand of what actually constitutes a TPOC. While there is presently no minimum threshold for TPOC amounts on no-fault records or for liability or workers' comp records where there is ORM, it's vital the RREs are careful to ensure that the TPOCs are being appropriate reported. For detailed information regarding proper TPOC reporting, please refer to chapter three, pages 27 through 23, of the current NGHP User Guide, as well as information provided within the (bio) layouts within chapter five, claim input file fields 100 and 101.

Another thing I want to quick note is that we continue to see RREs submitting quarterly claim files where a significant percentages of the records reject with errors. Yet, within each quarterly submission, they submit those same records all over again without addressing the errors, only to have then reject again for the same reason. It's imperative the RREs are carefully reviewing their response data and taking action to correct any errors received in a timely fashion. Please note that a failure to do so may place the RRE at risk of being considered non-compliant.

Next slide I would like to address is the use of ICD code 959.9. The description for this code is unspecified site injury. At the present, this is an accepted code, and it's not contained within the excluded listing.

However, there will be a change upcoming in 2013 which will make this an excluded code. Although this code is currently accepted, it's important to know that utilizing it may lead to issues with claim denials as it's so vague that it could be associated with practically anything for which the beneficiary seeks treatment.

It's highly recommended that if RREs are presently using this code that they do their best to discontinue its use as soon as possible. Utilizing it at the

present may cause unnecessary hardship for your covered individuals and the change will be required in the not-so-distant future regardless. Please keep an eye out for an upcoming alert with further details.

And one final note before jumping in to some mailbox questions, at the present, there are no further town hall calls scheduled. But, please keep an eye out for a new notice and agenda that will be posted in the near future. Notice will be posted, as always, to the CMS Mandatory Insurer reporting page.

But, you may also keep an eye on the Section 111 secure Web site log-in screen under the Section 111 messages heading, as a link to the notice and agenda documents will be posted there as well. And that's over to the left-hand side of the screen when you're on that log-in page. So, keep your eye up.

Next is just a couple of mailbox questions I'd like to address. First, we received an e-mail from an individual question if there was a way to report a workers' comp (set aside) allocation via the Section 111 process.

The answer to that question is no. There is no means to report (set aside) data via the Section 111 process. All that's expected to be at Section 111 is for the RRE to be reporting the standard settlement information containing the complete settlement amount. That settlement amount were to fall below the current mandatory TPOC thresholds and would not need to be submitted via Section 111 at the present.

However, if you're looking to report a workers' comp (set aside) – if you – excuse me. If you're looking to report workers' comp (set aside) information, there's a present Web portal for which you may register and report that data. I'll read you the URL. That's www.cob.cms.hhs.gov/wcmsa/login.

Please note that from that URL, you may access numerous how-to documents as well as the workers' comp and Medicare (set aside) portal site User Guide from the menus at the top of the screen. And that documentation should assist you in getting started with the process. But, we don't intend to discuss any of the details of the actual portal in explicit detail here today.

Another individual who had written into the mailbox provide us with – provided us with the following scenario. We have a care where the claim file was settle in 2008. There was a partial lump sum followed by monthly payments to be used for medical expenses. There was a threshold on the order of which we met this month. There were no ongoing medicals, only the monthly payments for the 2008 order. The claim has been part of our monthly (query) submission and (has) never matches.

OK. So, first up, it may help to clarify that for the purposes of reporting a claim such as this for Section 111, it would be expected that the TPOC be reported as the total lump sum after that settlement occurred. It matters not that the settlement may have been paid out as a partial lump sum followed by periodic monthly payments. In this case, there would have been a 2008 TPOC (date).

(For no filing of) workers' compensation, TPOCs which had occurred prior to 10/1/2010 were not required to be reported. Your liability TPOCs occurring prior to 10/1/2011 were not required to be reported. And even after 10/1/2011 (date), there are thresholds under which those liability TPOCs are not required to be reported. The dollar amounts and timelines for those threshold, if you're not familiar already, may be found within chapter three on page 31 of the current non-GHP guide.

So, in any case, this TPOC would have occurred prior to the point in time which would have required it to have been reported. However, even if the TPOC were to have occurred after the point in time which reporting would have been required, if you had queried and found that the injured party was not a Medicare beneficiary at the point in time that the settlement occurred, then the claim would not need to been – not need to have been reported. Excuse me.

And, with that, I'll turn it back over to John.

John Albert: All right. All right. Thank you, Jeremy.

Operator, we don't have any other statements to make. So, we can jump right into the Q&A session. Again, I reckon, as we've been – we haven't had one of these calls in a couple of months – so, if people have questions, now is a good chance to get them in.

We don't have another call scheduled at this point in time. I mean, there will be future calls. But, again, as Jeremy said, you just have to wait and see because we don't yet have dates. (I think it depends on a lot of stuff) internally here in terms of our availability.

But, other than that, operator, we can go straight into Q&A.

Operator: OK. Great.

To – if you would like to ask a question, again, that's star, then the number one, on your telephone keypad. If you would like to withdraw your question or it's been answered, please press the pound key.

And your first question comes from the line of Amber Lee from Claims Administrative Services.

Your line is now open.

Amber Lee: Hi. I have a couple of questions. The first one is we keep having 03 rejection – I guess (coverage) rejection. And a couple of them – over the past year, I've gone to the COB secure Web site and use online beneficiary lookup, and I've got neither a (new hit on) or some other information. But, is there any other way that we can verify, say, on the automated line on MSPRC or the COB automated line or something whether it really is entitlement or something else that's causing a 03?

Jeremy Farquhar: Well, the 03 disposition code means, basically, that this individual is or was entitled to Medicare. It's just that the timeframe that you're reporting for your claim does not overlap with their Medicare entitlement. So, they do have entitlement.

Possibly, they have entitlement at the present. But, maybe, you have a TPOC-only and it existed prior to their entitlement. Or, perhaps, you had a – or you would have had an ORM claim which is terminated already prior to their Medicare entitlement. But, its – there really shouldn't be any further need for you to follow up if you receive an 03. And 03 means basically that, OK, they are entitled.

But, during the timeframe of the claim that you're reporting, they were not. So, we're not coordinating benefits and you need not reporting this claim again unless there's a scenario where there may be a – say – or (there were to) reopen or if there were subsequent TPOC. Then, you could attempt to report that claim again. You should. And it's conceivable that it could, at that point, overlap. But, until there's something like that, (inaudible).

Amber Lee: Most of our (inaudible) (Texas) work comp – or – yes – (Texas) work comp. So, it's left in medical. So, I guess we're just going to resubmit and just get 03 (use) but after we make sure everything is ...

Jeremy Farquhar: Yes.

Amber Lee: ... right. Just (inaudible).

Jeremy Farquhar: That's really all that you can do. It's just to continue to resubmit. And if eventually – presumable, eventually, at some point, they will become Medicare-entitled again. What might be happening in these cases for you is that they may been somebody that had Medicare entitlement.

Amber Lee: Yes.

Jeremy Farquhar: Perhaps, because of disability or end-stage renal disease and maybe they lost that entitlement. And then, at some point later down the line, they may either regain because the disability areas (RDR) eventually become working (age) and gain that entitlement based on their age of 65, (what have you). So, resubmitting that claim is the appropriate thing to do. But, there is – that's – it's (fine). It's not a problem that you're getting 03. You're not doing anything wrong necessarily. It's fine. You just continue to send it.

Amber Lee: OK. And then, my other question involved TPOC because we also have some actual TPOC (states). And if we have a settlement where it does pay for medical but our medicals remain open for, say, three years after, do we report that TPOC? (What would happen with) (inaudible)? Or, do we wait until the three years is up or what?

Jeremy Farquhar: Well, you should report the TPOC when it happens. And so, what I – what I think you're saying is that there is – there is a conjunction with that TPOC. There is actually ORM for a period of three years as well. Is that what you're saying.

Amber Lee: It's like – I think it's like a (side implementation). It's still we pay the medicals. And so, it's not exactly closed because they can still go to the doctor for three years or they can go to the doctor unless it's been a year since they went last, in which case we can actually close the file. I mean, it's some kind of (like such implementation), I think.

Jeremy Farquhar: OK. Well, I mean – Barbara, I don't know if you might want to provide any additional feedback here. I'm – is there – after that three years, there is no further obligation to – for medical on your part?

Amber Lee: Right.

Jeremy Farquhar: Absolutely, it is closed.

Amber Lee: Right.

Barbara Elking: This is Barbara. Right. From you've said, you should be reporting a TPOC with ORM. You've said that you still have responsibility at the time of the TPOC. And then, when your legal responsibility terminates, then you should terminate the ORM as well. Make sure you're not reporting a termination of ORM just because you closed it administratively.

Amber Lee: Right.

Barbara Elking: If you still have legal responsibility, you need to leave the ORM record open.

Amber Lee: OK. But. Yes, (on) go ahead and do the TPOC even though it is still open.

Barbara Elking: Yes. Definitely.

Amber Lee: OK. OK. Well, thank you.

Operator: Your next question comes from the line of Lisa Maynard with Hamlin & Burton Liability Management.

Your line is open.

Lisa Maynard: Hi. This is Lisa Maynard, Hamlin & Burton Liability Management. We have a question about the self-insured indicator field number 64.

Jeremy Farquhar: Hey, excuse me. Can you try to speak up a little bit? We're having trouble hearing you.

Lisa Maynard: OK. Is that any better?

Jeremy Farquhar: Yes. A little. Yes. (Inaudible).

Lisa Maynard: How about this? Is that better?

Jeremy Farquhar: Yes. Thank you.

Lisa Maynard: OK. All right. So, we have a question. This is Lisa Maynard with Hamlin & Burton Liability Management. And we have a question about the self-insured indicator field number 64. And we've studied the definition of self-insured in Appendix H in the User Guide. Sometimes, we report on behalf of the self-insured and sometimes on behalf of the insurer on the claims that we are handling as a TPA.

In addition, sometimes, a single claim will involve payment by the SIR and an insurance policy – in conjunction with an insurance policy. So, our question is, in this self-insured indicator field, are you looking for the answer to the question of whether or not SIR and/or deductible is going to fund part or all of the settlement? Or, are you only looking for an indication of whether or not all or part of the claim was paid by SIR?

Barbara Elking: Who is the RRE in your example. I mean, if the RRE, under our rules, is the insurer, then it should be indicating that it's an insurance, either liability or no-fault or workers' compensation. It it's self-insured, that is the responsible RRE. Then, they're going to be indicating the self-insured.

Jeremy, am I wrong? Or, basically, unless it's the self-insured that's actually the RRE. Our field calls for – to just describe the insurer.

Jeremy Farquhar: That's correct, Barbara.

Lisa Maynard: So, you're saying you're just describing, OK, the insurance involved, not how the claim is paid?

Jeremy Farquhar: Well, in the situation, I think, when you've got – and correct me if I'm wrong, Barbara. In a situation where you have an SIR, that entity with that – with the SIR, if they are an RRE themselves, they are required to be registered and reporting that SIR. And so, it would be the actual entity with the SIR sending that claim in. So, the self-insured indictor, presumably, would be a Y. So, I'm not of the situation that you're thinking that – you would have another RRE reporting that particular (inaudible) SIR?

Lisa Maynard: We can (inaudible).

Barbara Elking: The reason I asked who the RRE was is, if I remember the user guide correctly – I don't have it in front of me – for self-insurance (access) et cetera, a key is who is doing the actual payment. So, whoever is the RRE, it should be describing that type of insurance.

Lisa Maynard: Yes. Well, I'm really going a little bit more basic than that. I just wanted to know – the question – like we could have one claim where we are reporting both for the insurer or/and the SIR entity. So, (when we're asked) –

Barbara Elking: If they both – if they both have to report, it would be two separate reports. And each one would describe the particular type of insurance that you're reporting for.

Lisa Maynard: So, is – the question really is an answer about the type of insurance. It's not about how the claim was paid. That field number 64 is about the type of insurance the claim was – the TPOC was (bundled) under. Is that right?

Barbara Elking: Jeremy, do you have 64 in front of you?

Jeremy Farquhar: I can pull it up (inaudible). Yes. I believe that is correct. If you can bear with me in a second, I can bring up the field. That is just the self-insured indicator field, correct?

Lisa Maynard: Yes. Self-insured indicator.

Jeremy Farquhar: Yes. It is, yes, basically just an indication as to the type of insurer – insurance from what I've understand that I can – read the description field if you like.

Lisa Maynard: OK. You would say that that field, that section in there, the – where you go and look in the claim input data section, they – that part tells you to go to Appendix H and read the definition of SIR in order to determine what to put in that – what should – you know, how to answer that question for the claim. So, you know, we've studied the definition. And the definition talks about as to the definition of SIR and the deductible. And so –

Jeremy Farquhar: Right. But, if you've got an SIR, that entity with the SIR is the RRE. So, they are reporting. And, as to type of insurance – you know what I'm saying? It's –

Lisa Maynard: That we understand completely. The situation is that we have claims where we are reporting as a TPA on the same claim for SIR and the insurer. So, we're asking – when we ask the question, then you're saying that information should come from the type of policy, not how (the claim would take). And that helps a lot if that is the case.

Jeremy Farquhar: Yes. That's basically – I mean, who's RRE are you reporting under? Are you reporting for the actual insurer under the RRE?

Lisa Maynard: The RRE number. Yes, the RRE number for each entity. Yes. Definitely.

Jeremy Farquhar: Well, I mean, yes. Because if you're reporting – if you are functioning for, say – I know you're a TPA. If you're functioning as sort of as an agent for one of these RREs, if you happen to be reporting for the insurer in a situation where there is an SIR but you're reporting under – for the insurer under their RRE I.D., then the self-insured indicated would be N. If you happen to be reporting – helping a self-insured entity to report under their RRE I.D. for their portion of that claim, then that would – you would be reporting it at the self-insured indicator as a Y.

Lisa Maynard: OK.

Jeremy Farquhar: But, your – there are two separate RREs which would be reporting under for these types of scenarios, presumably.

Lisa Maynard: Right. Yes.

Jeremy Farquhar: So, it depends on who you're reporting for.

Lisa Maynard: That helps a lot. So, we don't really need to look at – to answer that question, we don't need to look at how it's being paid. We just need to look at who's reporting and their policy's situation.

Jeremy Farquhar: Yes.

Lisa Maynard: OK. That's all we have for today. I appreciate your help.

Jeremy Farquhar: Sure.

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

Your line is now open.

Anne Armstrong: Thank you. I have a question that came to me during the last town hall. And you've also, I think, partially addressed today but, maybe, in a different fashion. My question originally was – so, I'm with a self-insured entity.

But, can an RRE who, in this case, happens to be a self-insured entity, sort of case-by-case, establish their own no-fault limit and then, you know, agree that we would compensate the patient either directly or pay some bills up to a certain amount and then that would be – that would (turn) to be the end of what we've agreed to?

And, if so, my new question based on what's discussed earlier this morning is – or this afternoon is, would that be best approached by similar to what someone else has done, which is agree to a TPOC and maybe pay part of it in a lump sum and then set aside a portion. And when that's used up for whatever expenses, it's done. And then, that's just reported initially as the total TPOC amount. It's all wrapped up into the TPOC amount. Or, some other way?

Barbara Elking: OK. There's a couple of issues in the question you raised. First of all, if you – if you are self-insured, then no matter what you're calling a no-fault type limit et cetera, yours is liability insurance, and you need – you need to report it as such.

The second thing is we can't give you legal advice. So, we can't tell you how to structure your settlements or arrangements. If you have a TPOC arrangement, then you need to report the full amount of that TPOC even if it has a structured payout.

If you have a situation where your settlement or agreement is that you're going to pay a thousand dollars and you're going to pay up to X amount of medical, if they occur in the future, if they occur by such a date et cetera, what you're describing is the situation where you have a TPOC for a certain amount and you have ORM, in which case you would report both of those. So, depending on how you structure your settlement agreement or whatever you want to call your arrangement, will determine whether you report just the TPOC or a TPOC and ORM or just ORM.

Anne Armstrong: OK.

Barbara Elking: That it would all be –

Anne Armstrong: All right. I didn't mean to interrupt you.

Barbara Elking: That's OK. Go ahead.

Anne Armstrong: We have been doing that, I think, the second way. We have been reporting that as ORM. And so, that leads to – I guess, my original question is – which is, you know, if – so, we've entered into an obligation but we have imposed the limits of what we've agreed to do. So –

Barbara Elking: So, it doesn't make it no-fault insurance. It was the point I was thinking.

Anne Armstrong: OK.

Barbara Elking: You can have ORM even if your liability is self-insurance. So, if – like I said.

Anne Armstrong: So, we can – and – can we have ORM that's a liability self-insurance that covered by our self-insurance (fund) but also impose on, you know, a case-by-case basis sort of a cap amount and say we agree to do this but only up to X amount of dollars? And then, can we terminate that? Because (inaudible).

Barbara Elking: Whatever you're (inaudible). If you reach a settlement that you have potential future medicals of X amount, if either that amount is used or a certain time runs out, then that is still ORM. It's just liability ORM. And the parameters of that ORM are dictated by your settlement. A lot of the time, when we've been talking about ORM, we've been talking about it – the context of workers' compensation where determination of that ORM is, in part, dictated by state law.

Anne Armstrong: All right.

Barbara Elking: (Yours, because it)'s liability, it would be dictated by the terms of your settlement.

Anne Armstrong: OK. So, I guess, what I'm – OK. I think that helps me a lot. I think that I am – I think maybe where I'm mentally – I'm struggling a little is just typically when we – when I use the term settlement. (It also includes) the release. In other words, we're releasing all claims in that and so forth.

But – and so, when I use the phrase no-fault, I guess I am – I am thinking of an arrangement where, you know, we're neither admitting liability nor obtaining a release. We're just agreeing to some kind of payment. But, I'm probably going beyond what you want to talk about on your town hall. But, I appreciate that. Thank you.

Barbara Elking: OK.

Operator: Your next question comes from the line of Bryan Hager from Texas Healthcare Foundation.

Your line is now open.

Bryan Hager: Thank you. Could we please possibly start receiving the GHP formatted to 71 EDI file instead of the NGHP-formatted one? There's a lot more detailed information in the GHP, including the Medicare dates and the Medicare cost code – (recent) code. That will be very beneficial to receive.

John Albert: This is John. Unfortunately, we're not able to provide that information based on our routine uses regarding the, you know – (it relates in the) Privacy Act. The reason we provided the additional information to the GHP reporters is so that why have – they fall under the type of entities covered under our Privacy Act (inaudible) that's related to disclosure of beneficiary information.

We had a hard enough time trying to convince them just to give out their Medicare health insurance number because, in the case of GHP, there's an actual contractual relationship between the beneficiary and that insurer, whereas in most non-group health plan situations, there isn't. So, we're precluded from providing that information, unfortunately.

Bryan Hager: This is for employers. We handle employers that are not in workers' comp. And so, their primary liability is self-insured. And they just – they would like to have that if there's any way at all possible in the future for us to get that. Our clients would really like to have that information. So, if there's any way in the future we could get that, we would really appreciate it.

Barbara Elking: Liability insurance is typically one that it's hard to (inaudible) ...

John Albert: Yes.

Barbara Elking: ... given the information because we're – we really don't even pursue any recovery unless there's a settlement, judgment award or other payment. There isn't any, really arguably, protected interest for you, the insurer, unless and until you agree to a settlement, judgment award or other payment. So, unfortunately, under our rules, we cannot give you that information.

Bryan Hager: OK. Well, thank you.

John Albert: Yes. I mean, if the employer has other obligations that – you know, that they can access that information for purposes of coordinating benefits for Medicare in terms of group health plan – but, there is, again, nothing covered because there is no – again, that relationship doesn't exist until there is (benefit settlement), judgment award or other payments Barbara pointed out. So, we apologize for that. We know that can be frustrating. But, we can't – we just can't do it and there's nothing that we can do about it. So –

Bryan Hager: (I asked).

Jeremy Farquhar: Yes. That's – (hey), that's free.

Bryan Hager: Exactly. Well, thank you.

John Albert: I appreciate it.

Jeremy Farquhar: I'd be asking the same thing.

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

Your line is open.

Stacy Tromble: Hi. Good afternoon. My name is Stacy Tromble, and I'm with Ropes & Gray. And I have a question with regard to the clinical trial language on page 40 of the user guide.

The language there reads, "When payments are made by sponsors of clinical trials for complications or injuries arising out of the trial, such payments are considered to be payments by liability insurance, including self-insurance, and must be reported. The appropriate RRE should report the date that the injury and complication arose as the date of incident. The situation should also be reported as one involving ongoing responsibility for medical."

Now, my question is, if you could take a minute to explain what this means in the context of a clinical trial sponsor that settles with the research subject for a study-related complication or injury where the settlement consists of a one-time payment with the subject, releasing all future claim. There is no assumption of ongoing medical. And it would seem to be a (inaudible) outside the clinical trial's context. And yet, the language that I just read seems to suggest that, in the clinical trial-related payment context, it must always be reported as an ORM. And so, hopefully, you might be able to clarify that.

Barbara Elking: We'll take your comment under consideration. I think we've got at least one other along the same line. The purpose of the language on page 40 is the questions that we're originally getting were in terms of, OK, there's injury or complication that's arisen (and we paid) for this doctor bill. So, we should just report that as a TPOC, right? And the answer to that was no.

If what – if what the clinical agreement was you'll pay for all injuries or complications, once you had an injury or complication identified (inaudible) some type of TPOC settlement, then you would have ORM. You would need to report the ORM. And what we are running into are situations where people automatically believe that all payments were TPOCs. And they're not. Yes, we can conceive of a situation where you will have done an actual settlement that release all future medicals related to it. So, we will look at your question and whether we need to add to that section of the guide.

Stacy Tromble: Thank you very much, Barbara.

Operator: Your next question comes from the line of Janice Ziegler from SNR Dentor.

Your line is open.

Janice Ziegler: Hi. This is Janice Ziegler from SNR Denton. And I have a couple of questions about accident and health and short-term travel policies. I know that the user guide says that they are no-fault insurance and there are a couple of hypotheticals I wanted to explore with you all.

Let's assume there's a company, and it offers travel insurance policy that provides accidental death and dismemberment coverage only. Payments are made on a schedule, either for loss of body parts or for death. The policy does not provide for medical expense coverage. And the schedule of payments is computed without regard to any medical expenses and (whether) they're actually incurred. So, the product provide claimants with no right to claim for medical, and the company doesn't seek a release of medicals. In this context, I assume that there is no reporting obligation. I just want to confirm that.

Barbara Elking: Can you confirm for me, Janice, that you've actually sent that into a mailbox?

Janice Ziegler: Yes, I have.

Barbara Elking: Because I thought I've read it there. I think we want to take another look at what you've written. But, based on what you've said today, if it doesn't cover medicals and no medicals are released and it does cover like specific – if they're paying for certain things like loss of an arm, loss of a leg, that –

Janice Ziegler: Yes. So, that's exactly (inaudible).

Barbara Elking: ... et cetera, we will consider whether or not that would be allowed. Certainly, there are – obviously, someone would have medical cost if they lost a limb et cetera. But, we will take a – we will take a look at what came in in the mailbox.

Janice Ziegler: Right. And then, how would you respond to that Barbara? So, would that be an individual response? Is that something I could call you about? Or, is that something that we just have to wait until the next call?

Barbara Elking: Probably the next call, unless we can send you something that (actually get out an alert) because we're pretty much dedicated to getting the same information to everyone at the same time.

Janice Ziegler: Right. Well, there were a couple of other questions that I had. So, for instance, I guess if there's a company – well, one question I have is that the CMS definition of no-fault is very specific. The user guide says that the regulatory definition is going to control. And that definition says, "No-fault is insurance that pays for medical expenses for injuries sustained on property or premises of the insured or in the use or occupancy or operation of an automobile, regardless of, you know, who's responsible for causing the accident."

And so, I guess one question I have is if we assume a situation where there's an accident and travel insurance policy that will only cover trip-related accidents and the trip is a mountain climbing accident, for instance. So, it doesn't – it's not for injury sustained on property of premises of the insured and it's not in connection with use or occupancy or operation of an automobile. So, in that instance, the regulatory definition is not met. And I – so, I want to confirm that, in that instance, reporting would not be necessary, even though it is a travel insurance policy.

Barbara Elking: Your assumption, in that case, is not true at this time. We've had that question raised. And the answer we gave before is we'll go back and look at the phrasing in the user guide. We would consider your scenario to be one where reporting isn't that required.

Janice Ziegler: OK. So, even though it's broader than the regulation. OK.

Barbara Elking: (Inaudible).

Janice Ziegler: OK. One other question I have is if there is a – and this will be my last one, I know – if there is a company that offers a policy that provides a limited cash benefit, for instance, for each day of hospital confinement and the payments are made pursuant to a set schedule so they are not – they don't correspond to what the actual medical expenses are, they are not payment for the medical expenses, the amount is paid regardless of whether the claimant has any legal

obligation to pay for medical expenses. Does CMD require TPOC reporting in that context?

Barbara Elking: I will go back and look at the prior policy pronouncements. But, I believe that we said that reporting was required in that situation. That would still be considered as – I believe when that was presented to use before, it was, again, presented under accident and health. And we said it was reported .

Janice Ziegler: OK. Because I haven't – I haven't seen in a town hall any discussion of that.

Barbara Elking: Well, all I can promise is (inaudible).

Janice Ziegler: OK. All right. Thank you very much.

Operator: Your next question comes from the line of Teresa Folino from AAA Auto Club Group.

Your line is open.

Teresa Folino: Hi. Thanks for taking the call. In the beginning, you talked about the ICD code 959.9 and the fact that it's extremely generic. And what I wanted to comment on, because you kind of implied that that code is not going to be accepted in the future, the reason we use this code is when there was a fatality in the accident.

Many times, we don't know what the injury was that actually caused them – caused it to be fatal. We don't exactly what they became deceased from. But, they were in an accident and it was a fatality. And, a lot of times, on the death certificate, it will even say that it is just fatality from multiple injury. So, how else would you code something like this?

Jeremy Farquhar: I'm honestly not certain. Normally, we would tell somebody in that situation that we would expect them to provide the injuries that caused the fatality. So –

John Albert: Or, at least, one of the injuries.

Jeremy Farquhar: Yes. (Inaudible).

Teresa Folino: (Inaudible) most of the time, we wouldn't – yes. We wouldn't know. I mean, if they were pronounced dead at the scene of the accident, the death certificate says "Multiple injuries from a" – you know, from something like "Multiple injuries from motor vehicle accident." How – you know, the reason there was a code for that because we don't know what happened to that individual. All we know is that the accident was fatal.

John Albert: Well, let us – let us take that under advisement because – I mean, the balance we're trying to strike is to get a specific when it's available versus people defaulting generic codes that don't, you know, tell us anything when they really should have the information. So, that's the – kind of a struggle we have with this.

Teresa Folino: And I do appreciate that.

John Albert: (Inaudible) and, you know, let us take that – let us take that under advisement because, again, we want to make sure that, you know – I mean, obviously, if there are obvious situations that had – there's just no way for somebody to find out what any of the diagnoses are, you know. But, we want just to take that under advisement for now.

Teresa Folino: Well, can I suggest – I mean, there is an ICD code for fatality. But, maybe, you allow that code.

John Albert: OK.

Teresa Folino: Because, then, it would just be that specific situation of – if this incident was a fatality. As far worrying about future medicals, well, there wouldn't be any. So, it probably wouldn't be an issue or shouldn't be an issue.

John Albert: Yes. OK. All right. Like I said, we'll take that under advisement and, you know – like I said, we'll – if we do something like that, we'd definitely would want to, you know, put out some type of rules around the use of that code as an exception. But, I can't promise you anything at this time because, unfortunately, we had folks – the reason why we (cracked) down the use of these codes is that people have been using them, you know, exclusively versus

any of the other codes. And that doesn't help anyone. If – but, at the same time, like I said, I understand that there are going to be some situations where it's just (inaudible).

Teresa Folino: Yes. OK. Thank you.

John Albert: All right. Thank you.

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

Your line is open.

Suzanne Jordan: Hi. Good afternoon. My question is surrounding the questions on TPOC payments. I am looking to see what's truly a TPOC and if it has to do with permanent or partial disability under workers' compensation. If we have an individual, for example, who is injured and have – that have lost capacity. And let's say they have 30 percent lost capacity and that's what the state has assigned and it requires that that settlement be 150 weeks of payment. Is that a reportable TPOC?

Hello?

John Albert: Yes. We're here. All right.

Barbara Elking: We're still trying to find a way to help you report that better under current directions. I believe it is still reportable, unless there is ORM along with it.

Suzanne Jordan: Well, these would have ORM. But, the payment would be a payment that's required, let's say, in a state that assigns and says they've , you know, lost 30 percent capacity due to like a shattered elbow or, you know, someone who's has a partial amputation. So, they're not permanently disabled. But, in that state, the state requires that you pay, you know, 150 weeks of payments, for instance.

Barbara Elking: Jeremy, do you have access to where that policy is access in the policy (part)? Doesn't it say that they only have to report the interim payments if there is no longer ORM or not?

Jeremy Farquhar: I believe that would be the case. I would have to hunt for that. (Inaudible). I don't know how quickly I will – we might – I mean, would you want –

Suzanne Jordan: Well, (inaudible) Jeremy. The other question – you know, and (this just) (inaudible) what you're saying at the beginning of the call. If a state does require us as part of permanent partial disability to pay 150 weeks, are you saying that we need to roll those up into one payment, so take what we would normally – because it comes out of our system and it's assigned as a TPOC payment? Do we need to roll up those 150 weeks into one payment amount if it is a reportable TPOC?

Jeremy Farquhar: I would say yes. Barbara, would you agree. I mean, we don't want you to report periodic payments for a TPOC. So, it would really be a lump sum that you're looking for in a TPOC.

Barbara Elking: That was the ongoing issue because I think we've decided this technically qualified as TPOC. But, if you're saying that, in your situation, that normally have the ongoing ORM, then it should be an issue.

Suzanne Jordan: (I'm not sure I understand) that shouldn't be an issue. If it has ORM, TPOC would be, you know, kind of (inaudible).

Barbara Elking: We're looking – we're looking for the policy part in the manual right now. But, both Jeremy's memory and mine is that if there is ongoing ORM which is being reported, then the TPOC – indemnity TPOC don't need to be reported.

Suzanne Jordan: With this, you consider it an indemnity? That's kind of what we're trying to figure out. I mean, we (started) reporting them as TPOCs now. But, we've been questioned. So, now I'm trying to make the call.

Jeremy Farquhar: I did find the passage in the user guide that, I believe, you're referring to, Barbara. And it reads, "In situations where the applicable workers' compensation or no-fault (law) or plan required the RRE to make regularly-scheduled periodic payments pursuant to the statute or an obligation other than medical (inaudible) or on behalf of the claimant, the RRE does not report these periodic payments as long as the RRE separately assumes/continues to assume ongoing responsibility for medicals and reports these ORM

appropriately. Otherwise, such scheduled periodic payments are considered to be part of and are reported as ORM."

For example, if an RRE is making periodic indemnity-only payments to the injured party, the compensation for lost wages related to the underlying workers' compensation or no-fault claim, the RRE has implicitly, if not explicitly, is ORM. Therefore, the RRE shall report the ORM. Periodic payments to compensate for lost wages are not reported as TPOCs. Summary under the aforementioned circumstances, one claim report record is submitted reflecting ORM.

Suzanne Jordan: And what we have here is capacity loss because the state has assigned that they have lost 30 percent capacity due to their injury that requires us to make payments for 150 weeks.

Barbara Elking: And I'm not sure what that doesn't qualify as "for something other than medical" and fall under what Jeremy just read.

Suzanne Jordan: We are reporting the ORM on it.

Barbara Elking: OK.

Suzanne Jordan: But, we're also responding each of those payments that are coming through. And we want to make sure –

Barbara Elking: And I – and I think – I think what Jeremy and I are telling you is, from your description on the phone today, it sounds as though all you should be reporting is the ORM. Do you agree, Jeremy?

Jeremy Farquhar: Yes. Yes.

Suzanne Jordan: I'm saying for like a temporary permanent partial where were compensating for lost wages during the time that they're unable to, you know, do their particular jobs. So, maybe, if they are doing a different job and part that settlement –

Barbara Elking: Yes. Again, as long as you're reporting the ORM, you should be fine.

Suzanne Jordan: OK. So, no need to report TPOC in those two situations.

Barbara Elking: Well, to report this type of interim payment if you had some type of a TPOC that was a final settlement, that's a little bit different.

Suzanne Jordan: Well, would this type of TPOC be covered at final settlement as the state have required you to pay for 150 weeks and that was part of the settlement. Does that make sense.

Barbara Elking: I understand your question. But, I think what you read is – what we have in the manual seems to fit almost exactly with your situation, that you're paying them under state law for a purpose other than medical and you have opened our ORM. And so, all you have to report is the ORM.

On the other hand, if there was some aspect to the case that was in dispute and it wasn't like paying the regular lost wages or lost capacity, there was some issue that was in dispute and you settle that part of that dispute by a TPOC, then that TPOC would be reportable in addition to the ORM. Does that help, Suzanne?

Suzanne Jordan: OK. All right. I think it does. OK. Thank you.

Operator: Your next question comes from the line of John Miano from (Golden Lamb).

Your line is now open.

John Miano: Hey, good afternoon. Just a quick question regarding ICD-9. I just – first, I wanted (inaudible) (find) the ICD-9 code that we were discussing, the unspecified side entry. But, we've done that. We've seen a lot of e-mail traffic recently regarding ICD-10 and the new implementation. Is there any update from CMS as when this may apply to Section 111 reporting?

John Albert: No. I mean, you know, when we have to use the code. (And so), we have to use them. So, it's the way (it's out). I know that.

John Miano: Right. It's October 2014. And, you know, we've received a lot of questions from our RRE customers as to, you know, what preparation is being undertaken and how it will be implemented and so forth. You know, the most

recent user guide that came out, you know, it essentially states that ICD-10 is not currently accepted and that there will be further notification as to how – you know, how and when that that would be implemented. You know, where we're receiving the e-mail alerts and notifications from one side of the house at CMS, we were just curious as to when we may expect to hear something with regard to Section 111.

John Albert: Well, I guess that other side of CMS was what's driving this. So –

Barbara Elking: Yes.

John Miano: Yes. Yes. (So, there)'s nothing currently.

John Albert: No.

Barbara Elking: No. But, when we have to (deal) with it before, John, do you remember, wasn't it tied to the implementation deadline for the rest (of CMS)?

John Miano: Yes.

Barbara Elking: So, if they have projected deadline for the rest of CMS, the likelihood is that we will join in that deadline.

John Miano: OK.

Barbara Elking: We can't give you anything firm right now. But –

John Miano: OK. That's fine.

John Albert: Now, it's October 2014, or whatever the date is right now.

John Miano: Yes. All right. Well – and there's just no projection in terms of when we may receive an alert or something of that nature that's going to advice how that's going to be implemented? So –

John Albert: No.

John Miano: Just wait and stay tuned for that one, then?

John Albert: Yes. Luckily, it's (inaudible).

John Miano: All right. All right. Thank you for your help.

John Albert: Sure.

Operator: Your next question comes from the line of Joanne Wohl from (NAMEC).

Your line is open.

Joanne Wohl: Thank you. Good afternoon. I have a question about term dates. We have been running into a lot of situations where (engine) may have had a minor injury with us. And, basically, the effects of their injury have ended, thought we don't have a decree or any sort of a decision advising that the effects have ended.

But, maybe we've paid over $750 on it. And the (statute) limitation after that is six years (and may) – for somebody to pursue additional medical cost. So, legally, our ongoing responsibility for medical is there. However, if somebody then, say, you know, later hurts the same body part at home or somewhere else and they are Medicare recipients, they have some problems getting their medical treatment paid through Medicare because we're showing an open ongoing responsibility for medical.

And I spoke to my contact person at Medicare, and she told me to put on the term date on the date that we closed our file. But then, I went to a training a few weeks back and they were like, "Oh no, you don't put it – you don't put a term date in there unless you have any sort of a decision for that." So – and, last week, we just ran into a situation where a gentleman had a knee injury with us a couple of years ago and he needs heart surgery.

And Medicare was denying any additional treatment to him because we're still showing an ongoing responsibility for medical. So, I am just looking for some directions with respect to the term dates and what is the correct way to do this to help this people to get the appropriate treatment that they need when it is no longer due to their work-related injury?

Barbara Elking: You raised a couple of different situations there. There first one were they had a minor injury and now they've reinjured the same body part but it's not included in workers' compensation this time, but you still, legally, have responsibility from the first injury. The easiest thing for that, although you may not think it sounds easy in and of itself, is if the beneficiary would get a written statement from their doctor that they no longer require any treatment for that body part because of the initial injury. Then, that record could be termed. So – I mean, there is – there is a way to get a term.

The second one, if they are being denied cardiac care because of a knee injury, then they should be appealing that denial to the claims processing contractor. The claims – (unless) you submitted with the ORM codes indicating cardiac, they shouldn't be denying those claims. That's an error in claims processing.

John Albert: it just kind of goes back to the need for specific codes that we are always asking for because generic codes (most often) or can result in (blank or) initial denial of the claims that are unrelated to the injury that was – you know, that occurred such as, in this case, is the knee. So, I just want – again, that's a good example, although not part of this question, in terms of why we ask for such specific code.

Barbara Elking: The first one (inaudible).

Joanne Wohl: I'm sorry. If we get – if we get a medical note indicating – if we (let them do our) SOAP notes on this and indicate that the person is released from care for this injury, would that be – would that be appropriate for the term date?

Barbara Elking: Release from care doesn't really do it because, particularly if you go to specialty doctor, he may release you from his care, but that doesn't mean you're not still getting some ongoing treatment for the injury. What you really need is a note that's a little bit more specific that says the individual does not require any more care for that injury.

Joanne Wohl: That's very difficult to obtain.

Barbara Elking: If the individual – I know – I don't want to sound – we don't want to sound (hardheaded) or anything else. But, if this person is actually having problems

having claims approved, then it might be worth the extra effort on their part. We cannot simply say that ORM records could be terminated when the workers' compensation administratively closes the cases.

It defeats the purpose of our open records. If the person needs further care and just goes to their doctor and the doctor automatically bills it to Medicare, you're never going to hear about it if we don't have any (type of that in).

Joanne Wohl: Right. If we have somebody who, basically, the effects of the injury have ended, they had a minor sprain and then a year or two later they have a new injury –

Barbara Elking: What we are saying is we need documentation that the – that the original injury – that it did not require any further care in order to terminate that record.

Joanne Wohl: OK.

Barbara Elking: Either that or that legal responsibility is terminated.

Joanne Wohl: OK. Thank you.

Operator: Your next question comes from the line of Paul Wilkinson from VA Transit Liability Pool.

Your line is open.

Paul Wilkinson: Yes. How are you doing? I just have a question as far as decoding the error codes on the response files for claim file. Is there an easy way to do this and to go to line one column (461) and then hit the enter bar, (enter), and then do the same with line two? It seems like those response files are difficult to decode.

Jeremy Farquhar: Well, I – we typically when you're utilizing the files submission process that you've got a system in place, that you've got programming that takes in those error codes for you and that – say, you're reviewing your response files manually?

Paul Wilkinson: Correct. Yes.

Jeremy Farquhar: That's going to be tricky. It's – I mean, if you can do it, you can view the response files manually. I mean, we look at them here using a text editor manually. And it makes it a little bit easier if you have something – a text editor because it will give you the displacement and the row and – you know, so it's – you'll have the numbers there on screen. It's easy to find the appropriate spacing and (what not). And let's – I mean, how – do you have a very small volume of claims?

Paul Wilkinson: We have – we have – we have a very small volume.

Jeremy Farquhar: Well, I think, what's probably better for you then in you're really small is that we have a direct data entry option.

Paul Wilkinson: Yes.

Jeremy Farquhar: And you don't have to deal with those files at all. I mean, it is terribly complicated to try and manually create and then read the data from those files.

Paul Wilkinson: (So) I've found out.

Jeremy Farquhar: If you would like to switch to the direct data entry option, basically, you are limited to 500 transactions per year under direct data entry or DDE.

Paul Wilkinson: Yes.

Jeremy Farquhar: So, if you think that you're well within that 500 – you know, if you have anywhere near 500 claims that you need to check or that you feel you may need to report on but you're not sure necessarily of the Medicare entitlement status of people, then it might be not for you.

But, if you're – if you're well within that range, I'd highly recommend switching to the DDE option. It'd be a lot simpler for you. You don't have to try and read the response files for most things. It should actually stop you and tell you right on screen if there's a problem with that you are submitting and you don't even get as far as submitting it.

So – and, in some cases, it's somewhat more – you know, it's not terribly frequent, but there are some situations where an error may occur in processing after you've actually submitted that claim via DDE. It will actually give you back the specific error within the direct data entry screen so you don't have to go hunting around through the file to try and figure it out and (what's not). So, I think DDE is probably a good idea for you. And all you need to do is contact your assigned EDI rep.

Paul Wilkinson: Yes.

Jeremy Farquhar: And they can switch you over to DDE if you like. Or, if you – if you – if need be, my – this is Jeremy Farquhar. My contact information is also in the user guide under the escalation process. So, you can – you can reach out to me directly and I can also help you with that.

Paul Wilkinson: OK. Jeremy, as far as – as far as having a text editor, is there a program I want? My EDI rep, at one point, mentioned, maybe, UltraEdit.

Jeremy Farquhar: That's what we use here. It's – we like it. I don't have a lot of experience with other text editors. So, I don't know – I don't have – I can't give you too much feedback on that. But, UltraEdit is very useful. It works great for us. And if it's something that you were looking. You know, if you do want to continue to (inaudible) file submission (inaudible) and review these things manually, that would be a very useful tool for you.

Paul Wilkinson: OK. Very good. OK. Thanks, Jeremy.

Operator: Your next question comes from the line of Chris Gelling from Generali.

Your line is open.

Chris Gelling: I actually had the same question presented by Janice earlier about travel insurance, that is, is travel insurance a – is it required for reporting? I understand under the definition of non-group health insurance. Is that true?

Jeremy Farquhar: (Inaudible).

Chris Gelling: The – where. OK. And where in the definition is it? If you don't mind.

Barbara Elking: I know I have the user guide in front of me. But, you know, it's our policy that accident and health and travel insurance are all classified as no-fault.

Chris Gelling: All right. Well, (my question was asked and answered) by Janice earlier. So, I have nothing further.

Barbara Elking: OK. Thank you.

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

Your line is open.

Peter Foley: Hello, everyone. (I've rather been) worried about ICD-10 in 2014. I'd like to go back five years and see if you are ready to issue any alerts on policy (buybacks) coverage (and place) agreements, cost-sharing agreements, (inaudible) insurer, (BI) settlements on non-(BI) lines where the release is the only reason we're reporting it and, of course, you know that we do feel that you have taken an incorrect position on accident and health by calling it no-fault. Anything coming out on any of those issues?

Barbara Elking: We were actually working on the – I forgot how you just described the one for the release – or the broad general release like (ENO) (DNO).

Peter Foley: Right.

Barbara Elking: Employer liability, we were actually working on that earlier today. So, we are working on the things on your list. Do I have any updated information that I can share at this point? No. And, as promised to Janice Zeigler earlier in this call, we were already aware of it. And, obviously, we are looking at the definition – the regulatory definition – for no-fault and what issues that raises.

Peter Foley: Can you talk about any of the comments on the ANPRM.

Barbara Elking: We're not – we're not at a liberty to do so. We would say that it is an ANPRM. So, we sincerely – we're soliciting not just comments on what the (actions) that were listed as (maybes) in that ANPRM. We were soliciting

comments on ideas for the whole area. Period. And we will look at everything that we received and response during the comment period.

Peter Foley: Thank you very much.

Female 1: This is (inaudible). I just wanted to let you know that we will be replying to your e-mail that you send to us, though.

Peter Foley: OK. Thank you. I appreciate that.

Female 1: (Inaudible).

Peter Foley: Thank you. I appreciate it.

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

Your line is open.

Louani Bascara: Good afternoon. This is Louani Bascara at Sidley Austin. I had submitted a few questions on loss of consortium to the mailbox back in June and just wanted to follow up on them. And, based on prior calls – and correct me if I misunderstood.

My understanding was the date of incident for a spouse claiming loss of consortium in an exposure case would be the date of incident for the exposed (staff). Or, if they weren't married until (actually the exposure) began, it would be the date of the marriage. Is that correct?

Barbara Elking: I don't remember. And we were going to go back and check. I don't remember our policy saying anything about date of marriage as being necessarily a triggering point. I believe we did say if there was a spouse, it would be the same as the date of exposure of the – if you – the injured party who is actually exposed directly, I guess you would say (inaudible).

Louani Bascara: Yes.

Barbara Elking: I know – I am no – I know of no reason off the top of my head that if there was a pair that was a couple and had a consortium with the claim, that the exposure wouldn't start when they were a couple as opposed to the date of marriage. I don't believe we made that distinguishing point. But, it is on our list to go back and look.

Louani Bascara: OK.

Barbara Elking: If you actually remember it being a detailed point, if you could point out where.

Louani Bascara: You know, it may have been something that was just what I thought would be, perhaps, an extension of what the policy was. But, that is something you're looking at. I take it.

Barbara Elking: We're looking at it as a response to your question. I don't believe anyone ever asked whether it would be tied to the date of marriage.

Louani Bascara: All right. Thank you. I guess the issue there is just it's – you know, that they're not a couple until after exposure starts. (Or what) –

Barbara Elking: I know. But, the issue – the issue is really when the – when the exposure started.

Louani Bascara: OK.

Barbara Elking: And were someone with a spouse, we presume it would have started at least at the same data of the person who had the more direct exposure. The fact –

Female 1: (What you're suggesting, in a sense), isn't always true.

Barbara Elking: Yes. It may – it may not always be true. But –

Female 1: (Inaudible).

Louani Bascara: OK. I appreciate it. So, it's the one open issue right now. Is that correct?

Barbara Elking: Yes. But, if it's clear the exposure – what – you know, went on before the date of marriage – in other words, they weren't a bride-by-mail marriage and they never saw each other before marriage, then, you know, it goes back to when did the – we're really looking for when the exposure started. So –

Louani Bascara: OK. And, along the loss of consortium line, I know in prior calls it has been talked about providing further guidance when the cause of reporting is just because of a broad release. And I think that's the point you were addressing just a moment ago. To that language, also, is it still being under consideration?

Barbara Elking: Yes. It was one of things we were looking at in the discussion we had this morning.

Louani Bascara: OK. Great. Thank you so much.

Operator: Your next question comes from the line of Jim Franz from Key Risk Ins.

Your line is now open.

Jim Franz: Yes. So, this is Jim Franz with Key Risk Insurance. And my questions has to do with the response records that we get back. We are reporting an ORM termination date. We send the claim in one quarter, and we get an 01 saying that the record is accepted.

We may, in a later quarter, send an update to that record. And it's usually around some of the – either the depending information or the dependent's representative information that we're updating. And we're always – we're receiving a compliance warning indicating that, in the later reporting, we're late with the ORM termination date filing.

And it's causing a lot of concern for our claims department that we get these compliance warnings. And I think it's been discussed in one of the previous town halls. But, I was wondering if there is any effort under way to correct that to not issue the compliance warning for a date that's not changed and was previously accepted.

Jeremy Farquhar: That there hasn't been any change in that at the present. So, although – as I'm sure, we indicated in the past, if you had submitted that ORM termination date previously, they're – you are in no danger of being considered non-compliant, although the flag is generated. It's a little bit tricky.

It – when our – when that update comes in via our system, it is just looking for that transaction type and looking for the ORM termination date. In most cases, we don't really expect that there is anything that you need to be sending us as an update after you send an ORM termination date.

And, as far as – you know, those – the fields that you're referencing and updating aren't things that are actually noted as being required updates in the user guide, although we're happy to take the information if you want to send an update for that info. It's – you know, you would be OK, probably, not to – depending on what that is. But, presumably, I don't know that you even need to be sending an update at that point in time. (That is all) I can tell you at this point in time.

Jim Franz: Yes.

Jeremy Farquhar: (There aren't any plans) to change the process for the compliance flags. We can – we can take it into consideration and look at it. But, I couldn't give you a timeframe or say for sure that it will actually change.

Jim Franz: We just – because I'm on the I.T. part of this. And we just keep getting question from our own claims department as to why we have the compliance flag. And I've tried to explain it to them. And I understand where you're coming from.

I have once – a second question. And this is about the ICD-9 that you mentioned at the beginning of the town hall, the 959.9. And will that notice of something no longer being accepted, would that come out in an alert? Or, will it just be in the file that might be issued as to the excluded ICD-9?

Jeremy Farquhar: It will – it will come out as an alert.

Jim Franz: OK.

Jeremy Farquhar: There will be a – and we – typically, the general rule is that we give – you know, we need to give six months lead time before we make a change of that nature. So, you should have at least six months to prepare when that change is coming. Presumably, we'll have an alert out at some point in the near future. So, keep your eye out for that.

Jim Franz: OK. Thank you very much.

Operator: Your next question comes from the line of Megan Warner with (inaudible) Insurance.

Your line is now open.

Megan Warner: Thank you. My question has to do with, maybe, like an automobile and trans policy where we might have no-fault and liability insurance coverage under the same policy for the same individual. In the past, there are a bunch of circumstances where we may have reported both the liability TPOC and the no-fault ORM under the same file. That's not my understanding.

But, that's not the correct way to do that. And I'm wondering if that's something that we need to go back to those records and correct or, if – because we provided all of – all of the information that you would need, if it's necessary to go back and make those corrections.

Barbara Elking: How did you report it in the past when you combined it? Did you make it like one big TPOC? Or –

Megan Warner: Well, what we would have done is, maybe, we reported it as liability. But, we put that we had – we're in Michigan. So, we have lifetime ORM. So, we may have reported that we had no-fault with zero limit. And then, if there was a (UM) or (IUM) settlement on the same file, we would have reported the TPOC and just done that all under one.

Barbara Elking: Jeremy, can you (inaudible) (it)? Can you take her RRE I.D.? And we can get back to her on this one.

Jeremy Farquhar: Sure.

Megan Warner: Yes. I can – I can get that to you. It is 15258.

Jeremy Farquhar: I'm sorry. Your name again?

Megan Warner: My name is Megan Warner.

Barbara Elking: And the issue is, in that past, you've combined the no-fault and liability for a single policy in a single report as opposed to two separate reports?

Megan Warner: Right. As opposed to two separate reports.

Barbara Elking: And you need to know if you need to do any remedial action?

Megan Warner: Yes.

Barbara Elking: OK.

Jeremy Farquhar: And, Megan, are you – are you a contact, is either a designee or an account manager for that RRE I.D.?

Megan Warner: I am.

Jeremy Farquhar: You are. OK. So, I'll have your contact information so you don't need to (hand that all over).

Megan Warner: Yes. It will – yes. Actually, the last name (that'll) show is (Caroline). Just had a name change. So –

Jeremy Farquhar: OK. Yes.

Megan Warner: But, that's still – contact information is still the same.

Jeremy Farquhar: OK. Great.

Megan Warner: Thank you.

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

Todd Simpson: Yes. Good afternoon. This is Todd Simpson with Central Mutual Insurance Company. And I've just got a question on TPOC date. And I hate to go back to work comp because that always seems to cause a lot of strife. But, our company will oftentimes – if we're – got a work comp claim with a Medicare beneficiary, if we – we'll initially report the ORM.

But then, if we go out and we settle the claim, we might settle it, say, for $100,000 for the indemnity. But, due to the Medicare set aside need, what we'll also agree to is we'll say we'll either fund the MSA or we'll leave the medical open continuously. And so, the reason we do that is because we will have out Medicare set aside, but we need to see what CMS is approving as far as the MSA amount.

And so, my question is, if we go that route, (that say), we settle for $100,000 indemnity-only on January 1, 2012 but we leave our medical open and then CMS approves the Medicare set aside on, say, September 1, 2012, and then we agree to fund the MSA, what TPOC date do I use? Do I use the date of the original agreement? And does that get me in trouble for late reporting if I do so?

Barbara Elking: So, your – you had a TPOC to settle the indemnity? Or –

Todd Simpson: Yes.

Barbara Elking: We're talking about (if you have) ORM plus the indemnity TPOC plus potentially a separate TPOC for an MSA. Right?

Todd Simpson: Correct. And if we settle with the indemnity – if we fund the MSA, then we would cut off our ORM. So, we would – we would also go and say that we terminate – (we'll put a term date in for our) ORM.

Barbara Elking: I'm going to rely on Jeremy again. So – he's the one that has the access to the user guide right now. But, I believe that our current instructions say that when you have ORM and you have any type of TPOC settlement as opposed to a periodic payment situation, that you do have to report that TPOC settlement even though ORM is open.

So, I believe that, under our current instructions, you would have to report both of those additional TPOCs, one settling what you say is settling the indemnity and the other for the MSA. And any issues about whether or not we had a recovery claim directly against either of those TPOCs would need to be settled on the back end.

Jeremy Farquhar: And you – and you send them as two separate TPOCs, I believe. So, I think you are concerned as to the lateness of the TPOC reporting because were you considering combining those two amounts for a single TPOC. If you send them separately when the two separate events occur, I think that would alleviate that concern. Correct?

Todd Simpson: Yes. Yes. It would. I guess – so, my understanding was that on the indemnity-only settlement, we wouldn't have to report that.

Barbara Elking: I believe the current instructions say that the only type of payment that you don't have to report is the periodic payments for indemnity et cetera as long as ORM is open. You do have to report any TPOC (actual) settlement et cetera. The only thing we've given any exception for, again, is the periodic. And then, only if the ORM remains open. So, under current instructions, I believe you do need to report both of them.

Todd Simpson: OK. So, if I have to report the original, like $100,000 indemnity-only settlement, if I had to report that as a TPOC as of the date of the settlement, January 1, then, for the MSA that gets approved later, do I use the date the CMS approved that as the TPOC date?

Barbara Elking: You will – you use whatever date – that sets our definition of date of settlement for the MSA. If – also, in terms of reporting it, you've got different choices there. If it's – if it's something that needs (to be) approved by a court in a particular state, then the date may not be when CMS approved it.

It may be when you get court approval. If you don't have the necessary signatures at the time that you got CMS approval, then it's got to be when you have the necessary signature. You really need to look at the definition of the TPOC date to see when it should be reported.

Todd Simpson: OK. Yes. And we do do that as far as the court orders and all that. But, typically, my choice is either the date MSA – the date Medicare approves the MSA or the date of our settlement agreement or regional settlement agreement. And the original settlement agreement can be 9 to 10 months earlier than – and when CMS approves the MSA.

Barbara Elking: In situations where people have an opportunity to go back and essentially get more money, whether it's in this case, a separate MSA amount, or if it's a situation, say, in a liability case where if there is – a certain event occurs, they can come back and apply for additional money et cetera. CMS basically treats those additional TPOCs as the – as an additional settlement. And if we had a recovery claim against the first one, we may or may not have further recovery against the second one. So, I would use whichever one best fits our definition of TPOC date for that second payment.

Todd Simpson: OK. Well – and thank you very much for that. And I just – I guess, just for my own sense of finality, I just want to make sure then, if I have an agreement that I agree to pay $100,000 indemnity-only but leave the medical open, I have to report the $100,000 as a TPOC settlement.

Barbara Elking: Under current instructions, yes.

Todd Simpson: OK. Thank you very much.

Operator: Your next question comes from the line of Mike Boggs with EMC Insurance.

Your line is open.

(Jason Krebs): Hi. This is (Jason Krebs) actually from EMC Insurance Companies. And, last quarter, we submitted a few (delete) records on our file and we received error codes saying that the add records did not exist. And then, checking with our EDI rep, we had a response that basically says that individuals health record can be altered or deleted by other individuals or other organizations.

We're just curious as to what element can be changed. Can they change our TPOC amounts or (inaudible) code or (OR) and terms dates? You know,

we're just kind of concerned about other organizations changing or deleting the information we've submitted.

Jeremy Farquhar: (There is – yes). Via the Section 111 process alone, (even) one RRE's data could, technically, be altered by a different RRE. It comes down to the key fields indicated in the user guide, basically, that the date of incident ORM indicator and the type of insurance. And, if those things match up and we receive an update – I mean, the RRE sends update for that same date of incident for that – with that information, then they can, technically, update that record.

And that does, on occasion, occur, although it's pretty uncommon. And I – and I think that – there is also (insinuating) circumstances where we have documentation that would lead us to believe that there were (inaudible) (that need to be updated) or if a record needed to be removed. We could end up updating that records here at the COBC as well directly or manually.

John Albert: Hey, Jeremy. This is John. I mean, that is one of things we are looking at as adding additional matching criteria within the COBC processes. Obviously, it's not a matching criteria, things like the policy number for the matching criteria beyond – you know, for CMS' other systems.

But, that is something that we are looking at. I guess the other thing, too, is that the COBC themselves could change that data as well if somebody contacts us with information at the call center or if it's (kicked up) to a (inaudible) analyst, right? I mean –

Jeremy Farquhar: Yes. Yes. If they have appropriate documentation.

John Albert: Yes.

(Jason Krebs): I guess that just kind of disconcerting to us that, you know, we could be paying for a finger and somebody calls in to change that to an arm and we're (on note) for an arm now. Or changes (to the) (inaudible) amount from 5,000 to 50,000. And, you know, it's not our doing.

Jeremy Farquhar: That's not, typically, the kind of thing that you will see happen, to be honest with you. I mean, that would be kind of odd and rare for something – an update like that to occur. More often than not, the things that you might see happen is, you know, you might try to delete a record and you find that it's already been deleted or something of that nature, like that scenario. But –

John Albert: Yes. It's extremely unlikely that one RRE would change someone else's record. I mean, I'm not saying that it couldn't happen. But –

(Jason Krebs): (Inaudible) I think – eventually, if they can happen, it eventually will.

John Albert: Yes.

(Jason Krebs): Over time.

Barbara Elking: (Inaudible). If you were contacted directly as to responsibility to pay us for something connected with that finger that wasn't part of your original report, then you would – you would simply document why it's not part of your responsibility and reply.

John Albert: Right.

Barbara Elking: It's not a foregone conclusion that you absolutely have to pay for something that's on a record, particularly if you're not the one that changed it.

John Albert: Right. We understand that. But, we're just –

(Jason Krebs): OK.

John Albert: And, also, if that the case – I mean – you know, if we get into a situation with conflicting information somehow overlaying one another, the COBC can lock a record and – you know, if it's (just viable).

Jeremy Farquhar: Yes.

John Albert: So that nobody can't update it.

Jeremy Farquhar: And then, we do do that when we see scenarios where that's occurring, where we receive multiple calls and then the complaints hit that the records have been updated inappropriately. We will lock that record so that the other entity can't come back and update it again. And it's something that – if you were to find the scenario where you weren't able to update your record because it had been locked, if you were to contact us, you can call our call center and get it escalated to a supervisor. They would have the ability to assist. They (can review) your scenario. And, if appropriate, they could update that record even though it has been locked. They can change it for you.

(Jason Krebs): OK. Thank you very much.

Operator: Your next question comes from the line of Bonnie Mustarde from Farmers Insurance.

Your line is open.

Bonnie Mustarde: Thank you. I recognize that it's not a hundred percent specific process, but I'm working on the recovery portal access. We have found an issue. It seems (we finally) have 20 individuals from a company that have access to the portal. And, for large companies, that seems to be a really big issue. Is there a way to extend that access to more than 20 individuals?

Barbara Elking: I remember seeing that question. Did you send that in to the mailbox?

Bonnie Mustarde: I actually did not.

Jeremy Farquhar: Another entity may have had the same question. I remember that one as well.

Barbara Elking: Yes. I'm – I mean, my understand right now is they don't have an answer to your question that it is limited to the 20. But, I –

Male 1: (Inaudible).

Barbara Elking: Yes.

(Suzanne Colva): Yes. It is limited to 20 at this point. But, part of that is because the Web portal is new and we will most likely be reviewing what sort of restrictions are

currently in place. Once we have a better feel for how the Web portal is working and (inaudible) of it. At this time, I don't (think that we can do a whole lot) about the limitation on the 20. But, we do (inaudible) (do it). We've been certainly looking it further.

Barbara Elking: And for whoever is doing the transcript, that was (Suzanne Colva).

John Albert: So, (check down and heard).

(Suzanne Colva): OK.

Bonnie Mustarde: Thank you. I have a question going back to the prior caller's issue where one RRE and then information in another RRE submission update the original RRE's records. And that would be relative to the issue of compliance with Medicare reporting requirement. I guess the perception I'm trying to clarify is if one RRE sends in a submission and another RRE make an update to that first RRE submission, is there – it seems to me that there is a potential in that process for what would appear to be a lack of compliance on the part of the first RRE reporting. Am I misconstruing that?

John Albert: Well – I mean, we would have record of who's submitted all transactions to that particular record. So, you know, if somebody else submitted something that turned out to be correct over the original submission, then that is an issue. But, if the original submission is correct, then you have nothing to worry about.

Bonnie Mustarde: Yes. OK.

John Albert: But, again, all of the – all the transaction is in terms of – you know, the audit trail exists so that, you know, if you submitted the correct data and someone overlaid it with bad data, you know, you'd be able to easily demonstrate that if there aren't any questions about compliance (here with you). Again, if you – if you receive – just going back to some of the previous questions, just receiving compliance flags are not necessarily an indication that somebody is not in compliance with reporting requirements. Again, keep you audit trail just like we keep our audit trail and we should all be OK.

Bonnie Mustarde: OK. OK. Thank you.

John Albert: But, we would never go after somebody because somebody else has updated their information with bad data. So –

Bonnie Mustarde: Yes. OK. Thank you.

Operator: Your next question comes from the line of Michele Taylor with (Teco Book).

Your line is open.

John Albert: Hey, operator, I wanted to interrupt real quick. And that is we're going to have to end the meeting probably about 10:03 today because we have a conflict with this room and some people need to get in here and set up for a (big teleconference). I just want to keep that out that we have about 10 minutes. Thank you.

Operator: OK.

And, Michele Taylor, your line is open.

Michele Taylor: Thank you. I've submitted a couple of questions on – by e-mail. But, the one question that I was really most interested in had to do with exposure cases involving pre-'80 only allegations. Any my question is whether an RRE can rely upon a CMS letter confirming a point of (desertion) that all exposure was – or pre-dated December 5, 1980.

I'm referring specifically to a letter that I've seen numerous times that has to do with – that basically says that they have received the information and based on the point of (desertion), you consider it a pre-'80 exposure and there is not payment to do under conditional payment. So, my question is, can an RRE rely upon that letter from CMS in their file to – so as not to have to report that claim, the settlement, and/or any liability issues that may arise down the road?

Barbara Elking: (There aren't) letters that's currently being issues, if any at all, because the instructions say that you should be contacting (as at all) if you meet the criteria. The most we issue is a letter that simply says, "We received your

statement and your request to close your case and we're doing that and you should maintain any documentation to support your position."

If an RRE has situation where the documents they have indicate that the correct procedures have taken place, right, they should document their records, basically, and move on. CMS is not issuing individual letters in cases. The only one that we're issuing at all are in cases where someone has mistakenly asked us to establish a care and we're simply notifying them that we're closing that.

Michele Taylor: OK. Thank you.

Operator: Your next question comes from the line of Shannon Nessier from Hanson Bridgett LLP.

Your line is open.

Shannon Nessier: Excellent. I think I may be the last one. So, I want to go back to the loss of consortium caller earlier because I'm having – I feel like I have some conflicting information. The loss of consortium claim is specific to the spouse. And it's her injury.

And yet, I'm understanding you to say that the date of incident would be the date her spouse is exposed to a toxin? But, I don't – I don't know that if the injury is loss of consortium, it doesn't seem to be consistent with the way we've been treating these as each person's own injury, as his own claim file submission. Wouldn't her injury be the date she suffers the loss of consortium?

Barbara Elking: If she can establish a separate date from the date of exposure of her spouse, fine. But, for the most part, people were looking for a convenient way to talk about what caused their loss. And if the person who was directly exposed, if their loss started on the date on initial exposure, then we said that for the loss of consortium, we would accept the same date. If you have documentation to show that it – that it started later, you can always present that. But, otherwise, we would expect to see the same date as the date of the person who was directly exposed.

Does that help?

Shannon Nessier: Well, I just – I don't understand how her loss of consortium – I mean, there is no loss when he is 20 doing, I don't know, whatever toxic work he is doing. I mean, her loss begins when he is, I would think, ill. So, like, I just can't imagine –

Barbara Elking: And, for some people, that's going to be the date of first exposure. Not all exposure cases are ones that have a latency or –

Shannon Nessier: Right. I'm sorry. I should have clarified. I was talking about latency cases. So – and I guess that's why it seems inconsistent with treating them as two separate divisible, however legally related, but two and divisible individual injuries.

Barbara Elking: And the best we can do for you is to say that, clearly, the case could have gone back to the date of first exposure for the person who was directly exposed. If you have evidence to the contrary for some reason, then establish your case. But –

Shannon Nessier: OK.

Barbara Elking: We can – I don't think we can do any better than that.

Shannon Nessier: OK. Thank you.

John Albert: OK.

Operator: Next question.

Operator: Your next question comes from the line of Emily Sayed from NS – (NCSBA).

Your line is open.

Emily Sayed: Yes. I see frequently in the new user guide the terms no-fault insurance, TPOC and liability insurance ORM. And I just wanted to get clarification on the definition of those two terms because when I read no-fault insurance

TPOC, I get confused when I – because when I think no-fault, I think ORM. And then, when I read liability insurance ORM, I'm confused because when I think liability, I think TPOC. So, I'm confused about what those two terms actually mean.

Barbara Elking: Workers' compensation, no-fault insurance and liability insurance including self-insurance can all have TPOC settlements, judgment awards or other payments. And they can all have ORM settlements, judgment awards or other payments. So, language in the new user guide, if it's gotten a little bit specific, is just to remind people that, for instance, we've had some people that assume that you can't have liability insurance ORM when they are self-insurance liability insurance.

And were reporting situations that would involve ORM as no-fault because they assumed if it was ORM, it has to be no-fault. So, I think we wanted to make it clear that, whether it's a TPOC or an ORM is not tied to whether it's particularly workers' comp, no-fault or liability. Whichever one it is, it can have either situations.

For example, one state we know of, all of its coverage is liability self-insurance. It doesn't have any type of no-fault policies or liability policies. But, it handles claims that are below a certain level as – the same way as no-fault.

Female 2: (Inaudible) system, press one. To disconnect from the system press (R). (We'll now) (inaudible) your connection. To remain in the system, (inaudible).

John Albert: Bear with us for a second. All right. Are you OK.

Barbara Elking: So –

Female 2: Thank you for calling.

Barbara Elking: We apologize for this intrusion.

In any case, in that example, we explained to that state that the situations that they were treating as though they were no-fault because they were actually being paid for out of their self-insurance, they should be reporting those as liability ORM.

Does this help you at all with your issue? Hello?

Emily Sayed: Yes. I'm here. Could you – I'm sorry. Could you just go through that one more time quickly, (what you had said)?

Barbara Elking: The example?

Emily Sayed: Yes.

Barbara Elking: We had a state – we had a state that everything was self-insurance for it. But, it had assumed, because it handles claims below a certain dollar level as though they were no-fault, then they needed to report those as no-fault. And we explained to them, no, since it is liability self-insurance whether they assume an ongoing responsibility for medical or do it with the TPOC settlement.

Either way, it has to be reported as liability self-insurance. So, my assumption is, without going back and having you point out places they did this, (is that) any extra addition in language like that in the user guide was simply to make it clearer, again, that TPOC or ORM can exist for any of the three.

Emily Sayed: And when you say any of the three, you were talking liability, no-fault or workers' comp?

Barbara Elking: Liability insurance, no-fault insurance or workers' compensation. And we're also talking settlements, judgment awards or other payments.

Emily Sayed: OK. OK. Thank you.

Barbara Elking: OK.

John Albert: Operator, we're going to have to end the call now. As you probably heard, some interruptions have taken place (because they're setting up a) (inaudible) here.

I'd like to thank everyone for their participation. Again, we apologize for – we continue to have issues of getting some of the transcripts out. I'll try to make sure that we get this next one out as soon as possible.

Again, we don't have any calls scheduled at this time in the future. But, there will definitely be more calls, you know, to be determined as the fall moves on.

Again, continue to submit your written questions with as much detail as possible to the Section 111 resource mailbox. We do take those in and evaluate them and use those to either answer them on these calls or improve our materials.

With that, I'll close the call and ask (that the) operator and also the COBC folks to stay on the line once we get off the call.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END