TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: APRIL 9, 2013

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert|
April 9, 2013
1:00 p.m. ET

Operator: My name is (Julie). 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 speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 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, this again is the Section 111 NGHP Technical and Policy Town Hall Call. Today is Tuesday, April 9, 2013. As we state with all these calls, we want to put a disclaimer out on the front that on occasion we may say things that are somewhat different than what might be in the official written materials that are out on the Section 111 website.

Again, for the record, anything that we say that is contradictive by materials on the website, the website is the official instruction and guidance for Section 111 reporting, not the transcripts. The transcripts are published after the call, but again, please refer to the written materials where you see any discrepancies between what we state on the call and the Section 111 materials on the website.

As we do with all of these, we'll have a couple of presentations followed by a Q&A session. Folks will be asked to provide their name and company as well as limit themselves to one question and one follow-up. There's a lot of participants on this call. We haven't had one in the last few months, so we expect that there would be a lot, and there are.

After we get to the presentations and the Q&A, you know, we'll do the end of course and move on from there, and we'll, you know, have another call in the future. But we don't – I don't think we have any schedule right now, do we?

No? OK, well we do have others planned. We just don't have the dates yet. I'm looking for someone in the room. But with that, I'm going to start off with introducing Jeremy Farquhar, the Coordination of Benefits contractor who have some announcements. And also we'll go over some of the more technical questions and answers that we've received since then.

Please continue to submit your questions to the CMS resource mailbox. We do look at them and use them, and you know, we try to provide the answers either at these calls or through additional updates to the materials on the webpage.

With that, I'll turn it over to Jeremy.

Jeremy Farquhar: Thanks, John. My first item is, for those of you who may not already be aware, CMS posted an alert on the 24th of March entitled Batch File and DDE submissions. This alert is in regard to changes related to a number of required data elements.

Certain fields that have previously been required have not been made optional. Hopefully, this should have the effect of simplifying the reporting process for many RREs.

The alert is located within the additional NGHP alert section of the CMS Mandatory Insurer Reporting page. The following is a brief overview of the changes. As of April 22nd, the following fields will become optional and will no longer be required.

First off, the alleged cause of injury or illness field. That's field 15 for file submitters. Moving forward, this field will be optional, but please be aware that if a value is provided, that it will still be subject to validation. The code is provided, and if that code is not valid, it will still trigger an

error. Subsequently, the claimant fields 107 through 118, and claimant representative information fields 119 through 132 for the file submitters.

Previously, on reporting on a claim linked to a deceased beneficiary, and RRE would be required to provide claimant information and, when applicable, claimant representative information. This will no longer be a requirement. Claimant information will still be accepted although not required.

With that said, if claimant or claimant representative information is provided, we will still be editing for completeness. In a nutshell, if an RRE chooses to report claimant and claimant rep information, then the same edits currently in place will continue to apply to these fields.

It holds true with the exception of the claimant 10 and representative 10 fields. Claimant 10 and representative 10 fields will no longer be required data elements regardless as to whether a claimant and claimant representative information is submitted. And please refer to the aforementioned alert for more specific details.

Next, just a quick note about the profile recertification process as many of you are aware, beginning in January 2012, the process was put into place requiring RREs to review and recertify the information from their profile report on an annual basis.

For a number of reasons, that profile recertification process has been put on hold temporarily. While it's on hold at the present, it is slated to resume in the near future. However, where a very large portion of recertification request had gone out within a short period of time at the start of the process in 2012, this recertification request will now be evenly distributed throughout the calendar year.

As a result, the timeframe within which RREs may receive their 2013 recertification request could stray from the annual schedule. For example, an RRE that may have received the recertification request back in January 2012 may not receive their 2013 recertification request until much later into 2013 calendar year.

Account managers and authorize representatives should simply keep an eye out for the recertification emails. RREs should wait to receive the recertification request in the e-mail before attempting to contact the COBC in an effort to recertify.

Moving forward, from 2014 onwards, and RRE will receive the annual request on the anniversary of the prior year's recertification. On receipt of the recertification request, it's best the RREs to reach out to their EDI representative directly in order to provide them with any appropriate changes or simply to confirm the accuracy of their current information.

Next item, the following is just a reminder for RREs seeking technical assistance regarding the Section 111 reporting process. If you require technical assistance and are having trouble getting in touch with or obtaining the required assistance from your signed EDI representative, please utilize the escalation process outlined within Chapter III Section 13.2 of the current non-GHP User Guide.

Occasionally, we've been seeing escalations regarding requests for technical assistance being forwarded to the CMS resource mailbox in cases where it doesn't appear that the RRE had followed the documented escalation protocol.

It's important to note that the most expedient way to receive assistance and resolve any potential issues is the aforementioned escalation process, so that should be your first course of action.

One last note and updated version of the NGHP User Guide is slated to be published in the near future. It's estimated that the updated guide will be posted to the CMS website at some point in May. Please keep your eye out for that updated guide. However, while there are updates to the current information, there should be little if anything new which hasn't already been broadcasted in Section 111 NGHP community.

While the updates to the guide will simply consist of information already published via alerts since the publication of the last version of the user guide, Version 3.4, which was published 7/3/2012.

All new updates will be indicated within the summary at the beginning of each chapter of the guides. Please keep in mind that once an updated guide has been published which incorporates information from prior alerts, that the user guide should be your official source for guidance on any topics previously covered in alert form, not the old alerts.

And now, I'm just going to jump into some of the mailbox questions that we received from (this point) on our last call. One question received was regarding situations where the beneficiary may have died at the accident scene. The question is regarding excluded ICD-9 code 7981, which refers to instantaneous death.

The individual who had written into the mailbox was requesting that this code be added to the accepted list of ICD-9s. They'd indicated that in such situations, they don't receive medical records or future bills, and therefore, they're unsure which ICD-9 code should be utilized.

Unfortunately, we have no present plans to make 7981 an (exception) code. In any situation where an RRE's reporting a claim, we will always require ICD-9 codes relating to the specific injuries, or illnesses sustained. The one exception would be the very limited circumstances where the use of no INJ code is permitted because there is no current diagnosis.

In this particular situation, the RRE will need to follow up and attempt to obtain information about the injuries, which ultimately led to the beneficiary's death in order to properly (afford) that claim.

Another question received was from an RRE indicating that they have submitted a query for an individual over the age of 65, and is presently deceased and that the query did not return the match.

They're questioning whether they should submit a claim for the individual if the associated case resulted in settlement or reward. The simple answer is that if the individual truly had not been entitled to Medicare, then there's no reason to submit the claim.

In most circumstances, once an individual turns 65, they'll become entitled to Medicare, but that isn't always the case. For example, an individual may not have worked enough hours and subsequently paid into Social Security enough funds to qualify for Medicare Part A entitlement.

However, in a situation where a query on an individual over the age of 65 has not returned to match, it is especially important that the RRE double-check the personal identifying information being submitted for that individual.

If they're certain that the information submitted on the query is accurate and an unmatched 51 Disposition is returned for a deceased individual, then there should be no need for further action. The claim would not reportable because the individual is not a Medicare beneficiary.

(Barbara): Jeremy?

Jeremy Farquhar: Yes?

(Barbara): One addition to that is they should make sure that they have at least one query on or after the date of settlement in case there was a pending application that covered a retroactive period of time, et cetera because that can result in claims being paid.

Jeremy Farquhar: OK, thanks, (Barbara). OK, the next question comes from an entity reporting claims related to Texas workers' compensation. Texas is a state with lifetime medicals for workers' comp. In their e-mail, they indicate that claims don't necessarily close, but they do become inactive because the employee/claimant is no longer treating.

The claim could open up again and should the employee start treating – excuse me, the claim could open up again should the employee start treating the compensable injury. They go on to ask how these claims should be reported.

So, in situations such as these, even if the individual may not be receiving treatment at the present, the claim should be reported as an

open-ended ORM record due to the fact that the workers' compensation insurer would still technically be responsible for payment in the event that the beneficiary were to require further treatment related to the injury or illness at any time in the future.

In other words, the claim should be submitted with an ORM indicator of why with no ORM termination date. That ORM record should remain open indefinitely.

Another individual has written into the mailbox with a question relating to current liability TPOC thresholds and subsequent reporting requirements. The question had read, with the TPOC amount thresholds, if the settlement amount is exactly $5,000 after 10/1/2012, does this claim need to be reported?

The current threshold for the timeframe spanning from 10/1/2012 through 9/30/2013 is $5,000. Only values greater than $5,000 are technically required to be reported during that timeframe. So, if the settlement is exactly $5,000, then reporting is not yet required.

However, during the aforementioned timeframe, any TPOC value greater than $300 may be reported in that TPOC with exactly $5,000 would certainly be accepted if the RRE chooses to report.

And we also received another more general question about the current reporting thresholds and the location of applicable documentation. The individual was looking to confirm the current thresholds for 2013 and was unsure whether they were referring to the appropriate documents.

So, for the most current detailed information relating to liability and workers' comp, TPOC thresholds, and associated timelines, please refer to Chapter III Section 6.4 of the current NGHP User Guides, and that contains all of the appropriate timeframes and the corresponding thresholds for those timeframes. All the information we require should be present there.

Another question received reads as follows; we have workers' compensation claim where we have entered into a final settlement, (enclosed) medical. But the query confirms that the claimant is not a current Medicare beneficiary and the file is not reportable in the next quarterly reporting cycle post settlement, do we need to continue to query – to continue the query process on that file into the future? If so, for how long should we continue to confirm Medicare status on a file that is permanently closed via final settlement?

In this situation, the RRE could seize querying on the individual in question after they've confirmed that they were not a Medicare beneficiary at the time of settlement. If there happened to be a subsequent TPOC (inaudible) taking place further down the line in the future, then they should query the individual's entitlement status again at that point, and if they become entitled, they may need to report at that point in time after the subsequent TPOC.

However, if there are no further TPOC events and there is no ORM, then further maundering of that individual's Medicare entitlement status fee, then the query process would be unnecessary. As (Barbara) had just stated, after that settlement or after the case is closed, it's best you should be sending one last query to double check that individual's Medicare entitlement. If that comes back as negative, then you should be in the clear.

The following scenario was submitted to the mailbox in our quest for guidance. The (submitter had a) question whether there would be a duty to report in the following situation, and this is some overlap with the prior questions but just a little bit different, a little more detailed.

So, here it is. An injured party settles his case with numerous defendants on August 29, 2012. A release is executed that day. Settlement funds are due in 30 days from receipt of this signed release. In August 2012, he is not eligible for Medicare. On September 1, 2012, he becomes eligible. September 1, 2012 is his Medicare entitlement date.

Settlement amount exceeds the threshold for reporting. The purposes of this example, this is a liability case. OK, so the following is general guidance for scenarios of this nature.

First, it's important to note that the Section 111 query process must be utilized in order to properly determine Medicare entitlement status. An RRE should not rely solely on information that may receive via other sources. As a general rule, if the RREs to query the time of the settlement and that query response indicates that there is no entitlement for the injured party as of the settlement date, then that claim would not need to be reported.

As long as the RRE has queried the injured party's entitlement as of or after the settlement date, and that query response comes back negative, they would not need to continue to query for that individual moving forward unless there are subsequent TPOC or ORM.

If there are an additional TPOC at a later date, the RRE would need to query entitlement status again as of the date of that subsequent TPOC. If that query were to return positive results indicating Medicare entitlement, the RRE would then be required to report to claim.

If ORM exists for the claim in question, then the RRE would need to continue querying the individual's entitlement status as long as they continue to have ongoing responsibility for medicals. If the query were to come back positive, indicating Medicare entitlement while ORM still exists, the claim will need to be reported.

Please keep in mind that RREs must be very careful to ensure that all of the personal identifying information for an individual is accurate when submitting a query. If the personal identifying information submitted is inaccurate, and a negative response is returned as a result, the RRE is not off the hook regarding the reporting responsibilities.

And that's it for me, so.

(Barbara): One addition to what Jeremy said is keep in mind as we've said on a number of prior calls that as long as an entity legally have responsibility for ORM, they cannot terminate ORM just because they would've otherwise administratively closed their case or have administratively closed their case.

The ORM is not tied to their administrative decisions. If they legally have a continuing responsibility, then the ORM needs to stay open for purposes of Section 111 reporting.

John Albert: Thanks, Jeremy. This is John again. A couple of quick things, one of them is we received a lot of questions these past few months regarding ICD-10 codes, and I wanted to provide an update in terms of where CMS is with this.

As of right now, October 1, 2014, any claims coming in must be using the ICD-10 format. So, any – you know, again any claims filed by providers will be required to use the ICD-10 format.

Questions have come in regarding the requirements of ICD-10 for Section 111. I can tell you that we have a planned October 2013 release to implement the changes to our systems that will afterward allow for testing of that process. We haven't formally announced this yet, but I just wanted to put that out so that our goal is to give everybody a year to get ready for ICD-10 implementation for any reporting.

So, again, you will be able to begin some limited testing right after October 2013 with more to come in the future. We will issue an alert in the near future concerning the final requirements for reporting of ICD-9 versus ICD-10 on the record layout itself. All I can say is that, again, with the world moving to ICD-10 meaning that all documentation after October 1, 2014, will be ICD-10 claims, I would encourage everyone to get ready for that because, again, after October, there will not be any claims accepted by CMS that have ICD-9s on them. It'll only be ICD-10.

But again, we will provide additional information in the near future regarding the October 2014 date for the go-live that is the date as of now. I'm not saying that that's necessarily final but for now, it is. It'll never be moved up, but it could be possibly delayed again. You'll never know. I don't want to make those promises because I can't speak for the agency as a whole in terms of their implementation of ICD-10.

Another thing too is that I'm sure there are people who have questions about the smart act out there. I just want to tell everyone right up front that we cannot answer those questions. You know, it will be, you know, implemented per CMS timelines and whatnot, but we really can't, you know, don't ask us to interpret it and things like that because we really can't.

There's processes in place to do, you know, more proposed formal rulemaking et cetera and that's all in the bill and the requirements, and that's all we can say on that. So, please don't bring it up because we're not going to be able to tell you anything.

But other than that, if there's anybody else here – if no one else here has anything in terms of announcement. So, Operator, we can turn it over to questions from the audience. And again, please limit your question to one and one follow-up so that others in the queue can get a chance at the microphone. Operator?

We have some dead air. Operator?

Operator: At this time, I would like to remind everyone, in order to ask a question, press star then the number one on your telephone keypad. Your first question comes from the line of (Greg Savage) from (inaudible). Your line is now open.

(Greg Savage): Good afternoon. My question is regarding loss of consortium and other derivative claims. And as we understand it, if we have a claim where we have an injured party and their spouse signs a release that includes releasing of all claims, then we would do a report for that party and place that as a no INJ report. Is that correct?

(Barbara): Well, did the individual who had the consortium claim make any claims regarding emotional distress or any type of physical injury or anything? If they did, you should be using the correct code. If they didn't, I'll let Jeremy answer that as far as the no INJ code.

Jeremy Farquhar: Yes, I mean, if they didn't actually make any claims, emotional distress or otherwise, and there are technically no diagnosis than the no INJ should be reported – you would report that claim, and you would use that special circumstances no INJ code.

(Greg Savage): OK. If they make no claim of injury, but they signed a release, then we'd use no INJ?

Jeremy Farquhar: Right.

(Greg Savage): OK. And that is a common practice for us to obtain a release from a non-injured spouse, releasing them of all claims. So, I just tell you that because after the release, it leads to a large number of reports. And as I read the user guide, I understood this was probably something you'd see in limited situations.

(Barbara): We realized it may involve a large number of claims. We don't really see any way around it right now.

(Greg Savage): OK. The second part of my question then is if both parties are injured and they present a loss of consortium claim in addition to their injury claim, do we complete all that on one report and send it to you or is there a separate report for the no INJ?

(Barbara): There is a separate report for each individual. So, you would have a claim for – I don't want to call it the primary injured party because that's not a good term, but if it was the husband that was hit by a car and his wife has the consortium claim, you would have to report on the husband, and you would also have to report on the wife.

And to forestall your next question, you would have to report the full amount of settlement for both of them. Yes, we realize that that is potentially over reporting, but that's an issue that can be handled on the

backend. What we can allow is for the parties to simply report whatever they've allocated to either the husband or wife because that's not binding on us.

(Greg Savage): But there has just been one report per plan type per injured party. If they have the loss of consortium claim and an injury claim that would all be combined onto one?

(Barbara): If it's the same insurance – if part of it is covered by no-fault and part of it is covered by liability insurance, then you're going to have a report for each of those, for each of the people.

(Greg Savage): OK. Thank you very much.

Operator: Your next question comes from the line of Lenox Godfrey from Florida Insurance. Your line is now open.

Lenox Godfrey: Good afternoon, everyone. Got a question on ORM on no-fault claims where the special limitation has grant. I believe that the termination date should be listed as these tests limitation as the (ongoing) medical responsibility will cease at that time. Is that correct?

(Barbara): Yes. The no-fault insurance is going to cease payment. We have seen instances where they have either made a prior arrangement or for whatever reason are continuing to make payments. And if they're continuing to do that, then they need to continue the ORM.

But if in fact, they are ceasing and will not pay anything for services on or after the statute of limitations, then yes, they should terminate the ORM.

Lenox Godfrey: Thank you very much.

Operator: Your next question comes from the line of Catherine Goldhaber from Segal McCambridge. Your line is now open.

Catherine Goldhaber: Thank you. This is also submitted to the mailbox on Friday. In an exposure case such as an asbestos case where plaintiff amends a broadly

applied complaint so they have a complaint I've worked from 1960 to 1985, and was exposed throughout my work history then, evidence in the case is for example, as to the (Widget) defendant, the exposure was only in 1975.

If plaintiff amends his case against (Widget) to alleged exposure only in 1975, would that then become a non-reportable claim?

(Barbara): We're still looking at the two questions you sent in. I believe you sent a sort of companion question at the same time.

Catherine Goldhaber: Do you know when you may have an answer?

(Barbara): I don't have a definite date on that. I'm sorry.

Operator: Your next question comes from the line of (inaudible) from Sedgwick. Your line is now open.

Female: Good morning or afternoon, I guess. I have a question, and it's in conjunction with the no injury code. What we have here is an instance where the claimant is deceased but was not a Medicare beneficiary at the time of loss.

The estate is obviously making a claim for wrongful death and survivorship action. But the brother is the executor is the estate. In the course of the discovery, it turns out the mother, who is a Medicare beneficiary, has been for depression. We're going to settle the case with the estate.

Is there anything reportable even though the mother is, you know, she's scheduled to receive some money, but not for her injury. It's really for the wrongful death.

(Barbara): If she's made a claim, you know, if there's associated medical, then it should be reported separately under her name.

Female: Even though the medicals are not part of the settlement? I mean, she's just saying that.

(Barbara): We have a priority right of recovery, and we…

Female: OK.

(Barbara): Unfortunately or otherwise, we can't say that the RREs are entitled to interpret state laws for us. Many states permit recovery of medicals. Some states don't permit recovery of medical. And then there are situations that fall in between just because of the specific facts.

Female: And even though she's not named plaintiff, she's not a named plaintiff. It's just (an estate). We still would have to report under her name?

(Barbara): Who's actually filing the claim?

Female: The estate is filing the claim. She's not in the name plaintiff but in the – you know, when we go through the discovery process, she announces, "Well, you know, I'm depressed and I'm being treated for depression."

And again, she's not named on the complaint. It's just the estate. And the executor is the one bringing the action.

(Barbara): Can you send that – and if you already did, tell us what date. But can you send that back in through the mailbox?

Female: Sure, absolutely. Thank you.

Operator: Your next question comes from the line of (Simone) (inaudible) from AWH Company. Your line is open.

(Simone): Hi. I have two questions. The first one is if there's a defendant who has insurer, would this defendant and insurer each need their own RRE, or would one RRE (inaudible) to have both?

(Barbara): It depends on the actual circumstance. If you have a situation where the only settlement is the responsibility of the insurer, then the insurer is going to be the RRE. But if you have a situation where part of it is the insurer and the entity, the alleged court (inaudible) has some self-insurance, you know. They're paying something directly as well other than the deductible.

If you want the rules and everything, go to the user guide. But if they have some separate self-insurance, then they would both be reporting their settlements or the total of both if they're jointly and (inaudible) liable somehow for the settlements.

(Simone): OK. And what if the defendant pays the full settlement amount and is reimbursed by the insurer, are they both (inaudible)?

(Barbara): You're going to have go back and look at the rules for deductible and co-insurance. If they're separate obligations and they're not part of the insurance policy, then you'll enter the self-insurance versus the insurance policy.

And if it's strictly under the insurance policy, then our rules that address deductibles, co-insurance, et cetera would apply.

(Simone): And what section is that in?

(Barbara): Jeremy, can you help?

Jeremy Farquhar: Yes, bear with me, (Simone).

(Barbara): I apologize. Since we rearranged the user guide, I don't know the section numbers as well.

Jeremy Farquhar: Well, actually, you know, if you'd like to – maybe the easiest thing is if you'd like to contact me, and I can get back to you and give you this section after the call. It's going to take me some time probably to locate this. I don't want to hold things up.

But this is Jeremy Farquhar. My contact information is in within Section 13.2 of the current guide under the escalation protocol.

(Barbara): And it's clearly in the part of the user guide that deals with policies.

Jeremy Farquhar: It should be Chapter III somewhere presumably but…

(Simone): Can you spell your last name, please?

Jeremy Farquhar: Farquhar, F-A-R-Q-U-H-A-R. It's in the guide. I'm the first person on the escalation tier. My e-mail and my phone number are both there, Section 13.2.

(Simone): OK. Thank you.

Jeremy Farquhar: That's Chapter III, Section 13.2.

(Simone): Thank you.

Operator: Your next question comes from the line of (Berry Miyagi) from (inaudible) (Miller). Your line is open.

(Berry Miyagi): Good afternoon. My question relates to potential liability related to future medicals in a liability-only case. And I have a factual scenario that hopefully will help narrow the question.

We will assume a settlement was reached between the plaintiff and the defendant. The plaintiff will incur future medicals related to the incident at issue in the case. The settlement includes those future medicals. In other words, the plaintiff agrees that he releases the defendant from any and all liability for future medicals.

Plaintiff and his counsel are informed by defense counsel that there is a duty to protect the Medicare trust funds from paying the plaintiff future medicals. And when I make statement, I refer to the (inaudible) style cup letter, which seems to indicate that in a liability case, there is no duty for a formal (set aside).

However, the parties do need to take measures to protect to Medicare trust funds from paying the plaintiff's future medicals. The plaintiff agrees in writing that he will pay his future medicals. There is correspondence back and forth between plaintiff, counsel, and defense counsel acknowledging the need to protect the Medicare trust funds from paying the plaintiff's future medicals.

However, plaintiff will not agree to put that language inside the four corners of the release. In that situation, if the plaintiff fails to pay for his

future medicals, Medicare in fact has to pay his future medicals. Is the defendant subject to any liability to Medicare?

(Barbara): You're not going to be happy with my answer. I mean, that's completely outside the scope of this call. The agency is currently dealing with a variety of future medical issues. We've published an ANPRM, and as we move forward potentially for any future regs or anything else, further guidance and direction will be furnished.

But I don't have any answer to give you on the call today.

(Berry Miyagi): Thank you very much.

Operator: Your next question comes from the line of Keith Bateman of PCI. Your line is open.

Keith Bateman: Hi. I have two questions. First, normally you have given more lead-time when you're making changes. This last alert was a rather short period of time and, in terms of the reporting periods, fell in the middle of some reporting periods.

Is this only because you were saying you don't have to report something or do we have to look forward for a less lead-time in the future? That's question one.

Jeremy Farquhar: I mean, the alert was basically making some of the fields optional.

Keith Bateman: Right. So, but if it has been the other way when you're making an optional field mandatory, then you would've given more lead-time.

Jeremy Farquhar: Oh, yes, definitely. Definitely. Just like I said with, you know, ICD-10. I mean, we want to give people like up to a year to test that process. So, I mean, our goal is whenever we're implementing new requirements to give everyone a minimum of six months to implement, so.

Keith Bateman: OK.

(Barbara): And longer whenever we can.

Jeremy Farquhar: Yes, and longer when we can so that's why, you know, we're trying to nail down like the ICD-10 requirements so that we can – even before we do our release on October, we'd be able to tell people, hopefully within you know, the next month what the final requirements will become, you know, October 2014.

(Barbara): So, you won't be penalized for continuing to report these optional fields.

Jeremy Farquhar: Yes.

Keith Bateman: Right. I understand. OK, but it was a concern to one of my companies. Second question, when a question has been asked through the mailbox, it's been over a year and it hasn't been answered to be resubmitted again?

(Barbara): It wouldn't hurt.

Jeremy Farquhar: Yes. I mean, there's some things that you know, we're not going to be able to answer because you know, like I said, you know, there's rulemaking involved and things like that. So, we aren't necessarily going to be able to answer every question, you know, on the sooner rather than later side.

But we do make every effort to answer as many of these as possible, and that's why, you know, we release alerts and an updated user guide, so. But yes, I would submit again.

Keith Bateman: OK, thank you.

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

Victoria Vance: Good afternoon. I think this question has been essentially answered by (Barbara)'s remark a few minutes ago. But, with respect to the advance notice of proposed rulemaking that was out last summer regarding future medicals, the comment period I know closed in mid-August of last year.

(Barbara), do you have any sense of timing as to when we can look forward to getting proposed rules or the agency's next statement or guidance on the subject of future medicals.

(Barbara): I don't have anything that I can give you in terms of any time there is further rulemaking effort of any manner or shape, CMS has the regulatory agenda and any potential regs that have actually been started down a third party (apps) are always announced there just as the ANPRM was. I'm sorry, the ANPRM was before it was published.

So, I would keep checking that even when the agency does, whether it's an ANPRM or an NPRM, or the final rule or notice, et cetera. Those of us who might be involved in writing it and drafting it don't necessarily know the publication date ahead of time. Often we find out about it on the day it's published or after that date, so.

Victoria Vance: And one quick follow-up to that. I recall that with the advance notice that came out last year, a lot of the texts and the discussion of potential options for addressing future medical seemed to be oriented towards the beneficiary, options for how the beneficiary can handle his or her responsibilities with respect to future medicals.

And on the defense side or the RRE side, there was a question that was lurking as to will this provide ultimately some sense of protection or guidance for how the defendants will go forward? Do you have any – are you able to offer any comment about where you see the ultimate rulemaking going in that respect?

(Barbara): And that would be a substantive comment on rulemaking, and no I can't make any of those comments.

Victoria Vance: OK, thank you.

(Barbara): I'm assuming your concern was expressed in any way in the comments that the people here in the agency that are working on any follow-up would be looking at those comments.

Victoria Vance: Very good. Thank you so much.

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

Your next question comes from the line of (Chris Frier) from Travelers Insurance. Your line is open.

(Chris Frier): Hi, good afternoon. I've two questions surrounding ORM, just some clarification. (Barbara), you had made a comment earlier that ORM needs to stay open even if you administratively close your file so that if you have a period of ORM that (inaudible) by session or contract, and you close your file, you're ready to close your file in six months.

You're responsibility for that ORM goes with whatever the statute of your contract is. But if our process is that we administratively close the file, and then if more bills or treatment is presented, then we would reopen it and we start the process of sending those queries. Is that what you're sayingt, or does it say that it can't be closed?

(Barbara): No. The ORM has to stay open on CMS' records and the reason that is is the Section 111 reporting is not just to deal with any potential recovery claims that we have at the time of the settlement, judgment, or other payments.

In ORM situations, it's to help us identify times when we're being billed incorrectly and the workers' comp should in fact be billed first. If the only time you had to post ORM was when you pay the bill, then if someone decided to bill us all the time, we'd have no way to stop inappropriate billing.

(Chris Frier): I'm sorry. For clarification, I'm only talking about med pay on the liability side. So, in that situation, it's not a work comp or where pay incurs.

(Barbara): Well, it doesn't matter whether it's workers' compensation, no-fault, or whatever. If you have legal responsibilities for the ORM by contract, by

state law, or whatever, then it needs – the ORM that's been reported to us needs to stay open until that responsibility is terminated.

And the easiest example that we were given in the past, because I believe we did had mentioned it. It may not have been a topic for a year or so but a situation where the beneficiary is injured, and they appear to require or require a relatively short course of treatment, but under state law or otherwise, there is – let's say lifetime medicals.

I understand in most states that's (inaudible) to no-fault, it's not liability insurance. But in the rest, there's lifetime responsibility for those medicals then that ORM record needs to stay open.

(Chris Frier): I guess maybe I'm confused when you say, stay open. So, if we report the ORM is three years in the future and yes we have ORMs. So that field says, yes, and the date is three years in the future.

(Barbara): You are not allowed in the Section 111 reporting to report a term date for that ORM until your legal responsibility has ended. The fact that administratively, you would've in the past prior to 111 reporting, administratively closed it because you truly don't expect to get any more claims or anything, you can't close the ORM or send it in term date based on that.

What the agency has posted on its general information site, I believe for our Coordination of Benefits contractor information about if there is an individual for whom is – essentially his primary care physician believes that there is no further treatment that will be provided or needed actually, the important issue is needed that there will be no future medical treatment associated with claimed injuries, then in that case we send an ORM term date can be reported.

So, it's not – if someone comes in and they let's say they tripped over, I don't know, the bumper guard in front of a car in a parking lot, and basically what they had was a sprained ankle and it's treated and completed. And there's a certification, you can get a certification or the beneficiary gets you a certification from their primary care physician

that there is not reasonably expected that there will be any future care for this injury needed, then the ORM can be terminated.

But terminating it essentially for administrative convenience, no.

(Chris Frier): OK. So, as long as we're not sending in a term date and leaving that open because, you know, our obligation is in the future, and then that's satisfying that leaving it open?

(Barbara): Sure. And assuming there's no other future associated payment, such as a TPOC or something that you would have to separately report.

(Chris Frier): Right, great. Thank you so much.

(Barbara): OK.

Operator: Your next question comes from the line of John Spellman at Nationwide. Your line is open.

John Spellman: My question was about the affected amended pleadings on pre-1980 cases, and I understand that's already going to be addressed. I just like to underscore the importance of that. It has wide applicability, and we'll appreciate a response on that.

We've been waiting over a year for it. It wasn't just this past week that it was teed up for a response, and that's all I have. Thank you.

(Barbara): Could you repeat your name?

John Spellman: John Spellman.

(Barbara): OK. And you're with who?

John Spellman: Nationwide – Nationwide Indemnity Company.

(Barbara): OK. Thank you.

Operator: Your next question comes from the line of Melissa Harkins-Rose of I.U. Health. Your line is open.

Melissa Harkins-Rose: Yes, I have a couple of questions. The first one is as it relates to the special exception for terminating ORM. It says that you can terminate if you have a signed statement from the individual's treating physician.

Will you accept statements from nurse practitioners or other care providers who are providing the care?

(Barbara): We're basically looking for something from the primary care physician. If for instance, someone has a primary care physician but they broke their leg so they went to an orthopedic doctor to start with, this treatment might end after the first visit or when the cast is removed. It doesn't necessarily mean there's going to be no further care related to the injury.

So, you know, we're basically looking for something – someone, generally a primary care physician that can assert that there's reasonably no care expected to be needed for that injury, not just that my specialty doesn't need to treat him anymore.

I don't believe that we've been specifically asked about nurse care practitioners. We can certainly look at that particularly if the person doesn't have a primary care physician.

Melissa Harkins-Rose: OK, so in the case of work comp, that we're directing their care and they're being seen through our work comp offices, and you know, our work comp outpatient services that's providing the care, and that's the person who's considered primary for the work injury.

Is that physician – is that work comp physician, not appropriate to sign that and that the individual has to seek their own personal treating physician (inaudible)?

(Barbara): I don't think anyone in this room is prepared to answer that from the particular angle you post today. It would be helpful if you would put each of the points you just made in the mailbox, and we can take it up with some of the other people that are involved with the policy decisions.

Melissa Harkins-Rose: OK. I'd be happy to do that.

(Barbara): OK.

Melissa Harkins-Rose: And then my second question is we're still continuing to see issues as it relates to our employees who have work comp cases in which, you know, we send a report for the ORM and they're seeking treatment not related to the work comp injury and then being denied coverage from their Medicare coverage.

Or, we also have cases, we also have liability cases wherein the plaintiff has reported a case. We've denied liability but yet they've reported the case, and then the providers that the claimant is going to see is being told by the Coordination of Benefits that we are primary and not getting covered.

Do you have any recommendations and suggestions on how to handle those?

(Barbara): Well, we've send in the past and well within the last year, John, we issued a (MedLearn) article to all providers et cetera that there were two types of issues that were coming up.

One, where people were alleging that specific care was being denied. I mean, not that care was being denied, that payment for the care was being denied, and then there were situations where when we looked into them, people were alleging that they were refused care because of that record.

The (MedLearn) article we've sent out, and it was available to all providers, physicians, centers, and suppliers made it clear that an open liability no-fault or workers' compensation record is not a basis for denying treatment.

And that, in terms of payment, we have prompt pay rules. And as long as those rules are met, we pay when cases are pending. We won't pay if there's ORM posted because in that case, the workers' comp, or no-fault, or liability insurance should be paying first, and we should be getting a secondary claim at that. And in most cases, no secondary claim at all.

But the majority, to the best of my understanding, I'll ask John to chime in or Jeremy if he has information. Most of the cases that we actually investigated were denied appropriately. The beneficiary would come in and say, "Well, I was told because of my liability record." But when you look at the – when you look at the MSN, the Medicare Summary Notice, or look at other information in the claim, it was actually denied on another basis, and the denial was appropriate.

The other thing we would repeat again is when people have a claim about this whether it's being reported to us through you or by a beneficiary directly, we need as much information as possible.

We need to know the beneficiary's name, their HIC number, the date of service, their provider, et cetera. We can't operate just on general allegations that this is happening. So, the long answer is we're doing whatever we can do.

Melissa Harkins-Rose: Sure.

(Barbara): Most of the actual cases have not involved inappropriate denial of services.

John Albert: And the beneficiary can appeal that denial, and, you know, there's a (proper place) for that. Anecdotally, I mean, we've done a lot of things in terms of outreach and whatnot to providers that from overseeing this issue is much less than it was a year ago. But obviously, you know nothing is foolproof when you're processing, you know, those billion claims a year.

Melissa Harkins-Rose: But as the insurer, my interests there are divergent from the claimants.

John Albert: Yes.

Melissa Harkins-Rose: You know, especially in liability and by, you know, virtually, I can't act as their advocate. When they call me and ask me to help them, I can't do anything more for them. And so I'm getting these, you know, older people who are – I do have an open ORM for them because they had a knee injury.

However, they're not being to be billed out for a dermatology visit, which I don't understand that. And I don't know what – and I can tell them until I'm blue in the face to these providers, you know, go look at this (MedLearn), but there's nothing more I can do.

(Barbara): Beneficiaries should be calling the Medicare 1-800 number. If the 1-800 number cannot satisfy them, they can go to their local or regional office for CMS.

Melissa Harkins-Rose: So, my answer to them is, "It's up to. You have to figure it out. You can't send the bill to me."

John Albert: Well, the answer is like what (Barbara) said, I mean, they have the regional office to contact. And 1-800 Medicare is usually the first stop. They should be going to them.

Melissa Harkins-Rose: Sure, sure. And they do. And I've actually sat on the phone with them as they talk to these people. And I've been told by the Coordination of Benefits that we're primary. They will tell me, I'm primary. And I would say, I haven't accepted liability for the claim.

(Barbara): If you're getting that type of answer, and you believe it's wrong based on the circumstances, then take the information since you've got the beneficiary on the phone, and they're asking for your help. Get the bene's name and HIC number. Get the name of the operator you spoke to. Whatever number it was that you called, and they're not probably going to give you a last name as far as I know.

Melissa Harkins-Rose: No, they won't.

(Barbara): But they have an ID number or a name, and the date and time of the call, et cetera and then, we have some way to trace that back to find out if there really is a problem with 1-800.

Melissa Harkins-Rose: OK, great. I will do that.

(Barbara): OK.

Melissa Harkins-Rose: Thank you.

Operator: Your next question comes from the line of (Maria Lauper) from MRC. Your line is open.

(Maria Lauper): Hello. I had submitted a question in regard to tobacco cases, and we were wanting to know if we can get some clear guidance in regard to whether CMS would consider that as an exposure cases or what's our stand on it?

(Barbara): I guess one of our questions would be, you believe that makes a difference because of why?

(Maria Lauper): Due to the exposure language that's stated in the bill. Per the addendum language, the exposure, ingestion, and inhalation sediments are excluded from the minimum recovery-reporting threshold.

So, we're trying to decide are they – do they report everything or do they only report anything over $5,000 or would Medicare even – or would CMS even consider those are exposure cases?

(Barbara): As we said, we cannot advise you on interpreting the smart bill at this point. If you're referring to thresholds that are in there, for the time being until further instructions are issued, if there are any further ones needed, you need to just go with whatever reporting thresholds we have in the NGHP User Guide.

(Maria Lauper): OK. Thank you.

Operator: Your next question comes from the line of Robin Fry of Nationwide. Your line is open.

Robin Fry: Good afternoon. I'm calling with a couple of questions. First, my question relates to payments that are made under a med-pay liability claim that incrementally exceeds the threshold, but we still have an outstanding bodily injury claim that remains to be settled.

Are we supposed to be reporting these med-pay payments as soon as they exceed threshold, or do we wait until that bodily injury claim settles and report at the same time?

(Barbara): If it's ORM, there is no threshold except for the various…

Robin Fry: It's not ORM.

(Barbara): How are you making payments if it's not ORM? You did say payments for…?

Robin Fry: Med-pay liability.

(Barbara): Med-pay is ORM.

Jeremy Farquhar: Yes.

(Barbara): And med-pay is inherently ORM. I mean, it's a type of no-fault.

Robin Fry: No, no, no. Under a liability claim, a med-pay – a medical payment portion of a liability claim where we have $5,000 in medical payments coverage.

(Barbara): Yes, that is ORM if you're making those payments. That should be being reported as ORM. It shouldn't be a hit and miss, like if they bill us, we stop paying first, but if they happen to…

Robin Fry: OK. But it's not no-fault. It's contractual.

(Barbara): Whether it's contractual or not, med-pay if you look if you look in our regulations and otherwise, it is routinely considered – treated as no-fault and report that. But it's ORM whether it's liability or not. You are making payments pretty much on an ongoing basis based on your description.

And until that amount is exhausted, you should be – or otherwise, legally terminated, you should be reporting the ORM.

Robin Fry: OK. Thank you.

Operator: Your next question comes from the line of (Teresa Seleno) of AAA Auto Club Group. Your line is open.

(Teresa Seleno): Hi, everyone. Thank you for taking the call. I need to go back to the ORM termination issues and the people getting denied benefits, and the whole situation that everyone in the industry seems to facing.

(Barbara), I heard you say that, you know, people can appeal though a lot of issue is the provider refusing to treat the people before there's an official denial from CMS. The other piece of that is when we do call, we're told, well if your claim is closed, you know, they say, you know, triple A still has an open claim, but it's Michigan no-fault unlimited lifetime benefit.

Based on the rules as we interpret them, and I believe you do too, we cannot close ORM unless we have a letter from the doctor, which 99.9 percent of the time we're not able to obtain.

And they say, well then, just fill out the no-fault closure form and put the date they stopped treating. Well then, are we violating the rules by doing that because on one hand, MMSEA says you cannot terminate ORM without a letter from the doctor or these other things that won't ever happen in Michigan. But on the flipside, they're telling us to fill out this form no matter what.

(Barbara): If this is 1-800 that's telling you that, we want to know the name of the beneficiary, the date and time of the call, and we'll get to stop saying that because they should not be saying, "Well, just do this," because I don't think (they can carry) your problem. They need to be giving you a legally appropriate answer.

(Teresa Seleno): OK.

(Barbara): And they can't make up new rules.

(Teresa Seleno): Well, you know, that was our feeling. It's like, well, wait a minute. We feel as though we're not – we're violating the law by filling this out

because MMSEA says this, and that's what we wanted to confirm if the information we were being given was incorrect.

(Barbara): We've heard your complaint at least a couple of times. But every time we hear it, no one can give us specific information to track it down. And when we go to 1-800-Medicare, they say, well, no, of course – our telephone representatives or analysts or whatever their official name is, the CSR or customer service representative, they say, "No, of course. Nobody is saying that."

So, you know, I believe a certain percentage if not all of their calls are taped. So, if we had more specific information, at least they could go back and investigate and/or listen to specific calls, and then do you know, refresher training or whatever training they need to make sure people are answering the phone appropriately.

Jeremy Farquhar: Yes, they have 3,000 call center reps, so that's why we need more specifics because you know, we can say that but you know?

(Teresa Seleno): And I do understand that, and I'm truly trying to get that. Unfortunately, we have a lot of people also. And a lot of times, the customers are relaying this information though they would not – you know, they wouldn't know anything about a no-fault closure form unless someone had told them that.

Jeremy Farquhar: And we do – I mean, some folks from our division here, we do meet with 1-800-Medicare because obviously, you know, there's you know, they get calls that relate to COB and things like that, and MSPRC. So, we do meet with them regularly. So, we can definitely bring that up with them.

Did you submit that to the resource mailbox by chance?

(Teresa Seleno): Yes, I have. Yes, I can submit it again if you'd like.

Jeremy Farquhar: OK, if you don't mind.

(Teresa Seleno): Not a problem. Thank you.

Jeremy Farquhar: We can give that to our person here who works at 1-800-Medicare, and they can bring it up because, I mean, if you hear it a few times, that means it's probably happening more than a few times.

(Teresa Seleno): Definitely.

Jeremy Farquhar: OK.

(Teresa Seleno): All right. Thank you.

Jeremy Farquhar: Uh-huh.

(Barbara): But we would repeat what John said earlier that any time, refusal of service is something that in many ways is outside what we can (cure) directly. We can inform providers, physicians, and suppliers, et cetera. But when there is a claim that's actually submitted and payment is denied, the beneficiary always receives appeal rights on that and has a way to formally challenge it.

(Teresa Selena): OK. And I guess, that's my question when you say that. So, they can appeal even though it actually hasn't been denied by Medicare, it's just being denied treatment by the physicians. Say, they're looking at the website or looking at you know, their Medicare records.

John Albert: Denial of service is different than denial of a particular coverage of service. You know, the application of somebody else's coverage to that, you know?

(Barbara): Yes, I mean, I was trying to make sure I said that correctly. But when a doctor says to someone, "I'm not going to treat you because Medicare's record shows someone else's primary." That's not even within our systems. So, there's you know, not really anything we can specifically do if there's a particular physician that's routinely saying that and it would come to our attention, my guess would be our most likely route would be to have someone in our regional office contact that provider, physician, or supplier.

So, you know, if you in any way know that this is actually happening, that's a possibility for us to pursue for the beneficiary.

John Albert: And (inaudible) Medicare would advise that you know, they would basically, you know, hopefully help them get in touch with that regional representative. Because again, that's a – I mean, they should not be refusing treatment. That would be violation of the provider agreement with Medicare.

And we know that occur sometimes. Sometimes it's willful, sometimes it's just a mistaken understanding of what they should or should not be treating for, but again, the processes are in place.

But again, 1-800-Medicare is the first place to go, and they would hopefully walk that person through the process depending on the particular situation that it is because there could be all kinds of situations that would (inaudible) need them.

They may need to go get a record updated by COB, or they may need to have someone contact the provider directly, or if they find out that the claim was appropriately denied for another coverage that the beneficiary had.

So, the likes of the provider may say you have an open liability, but they are not actually denying or liability denying because they have an open GHP coverage.

(Teresa Seleno): Yes.

John Albert: So.

(Barbara): Now and again we said that we would like the beneficiary's name and their Medicare number and knew the provider is and the date of service, and I'm going to ask Bill Decker, he had a short list of the other things we're asking for to repeat those.

Bill Decker: Hi, everybody. This is Bill Decker. When you're talking to us about problems you're having, but whether you're at Medicare or any of the

other call centers that you may be involved in, first of all, we like to have you report those problems or, otherwise, we don't know that exist, but when you do, we really need to have as much information as you give, as you can give us about the particular beneficiary and case.

In addition, we really need to have a date of the call, the time of day that the call was made, and, if you can get it, either the name of the individual you spoke with or the ID number or other identifying information about that individual. What we will do in those cases is be able to go back to our own call records to see if we have a record of the call and examine it. That's very useful to us. We have been able to do it in the past, but we can only do it if we have enough information available to us to make that trace.

(Teresa Seleno): OK. Thank you very much. I will try my best to get information.

Operator: Your next question comes from the line of (Susan Gleason) of Church Mutual Insurance. Your line is open.

(Chris): Hi, this is (Chris) not (Sue). The question I have concerns the E codes and the claimant representative field. I understand that will be optional going forward after April 22nd or 23rd, but specifically, we're expecting an error response file probably the next week or two from our early March submission.

If we had errors that pertain to an E code say for example either with missing or you know blank entirely or we just had a wrong digit and knowing that those areas wouldn't be submitted again until our next submission in June, what do you recommend that we just disregard them or we have to make the correction?

Jeremy Farquhar: Well, you need to be careful because as noted at the beginning of the call, if you have an incorrect E code…

(Chris): Right.

Jeremy Farquhar: … it's going to trigger the edit. So if you do provide us a value, we are going to edit to make sure that that value is appropriate.

What you could do if you did have the, whether you had a situation, if you did have a situation where you had a code that received an error, the E code received an error, there's a problem with that code, on your next quarterly submission, you could simply remove that E code and if there was a situation where you receive the error because it was blank and we've yet to actually make that change whereas you considered optional, you could simply resubmit that claim on your next file submission, and in either case, you know, as long as you leave that E code blank, it will be accepted on your next quarterly submission.

(Chris): OK. So, if it's blank, just leave it be, but if there was an error like a wrong digit, to make sure we make the correction. OK.

Jeremy Farquhar: Yes.

(Chris): OK. Thank you.

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

Susan Bolster: Hi. And first is just with respect to the denied claims and beneficiary is calling, who could we direct them to to contact you because right now when I get a call, I explain to them that I need to go back to the COBC because we cannot submit ORM Termination Dates and that they were given incorrect information, who should we tell them to contact if they have continuing problems?

John Albert: If, again, if they are not successful with Medicare 1-800 then their local regional office.

Susan Bolster: No, I'm talking about the beneficiaries. You go to their local regional office?

John Albert: Oh.

Susan Bolster: I'm talking beneficiaries are calling me and telling me that they've been told by the COBC that we, Zurich, have to submit an ORM Termination Date and close out their file and I explain to them…

John Albert: Again.

Susan Bolster: … I explain to them no.

Jeremy Farquhar: If you are receiving information that the COBC is telling people that they need to close out their file with the termination date, and then that seems to be inappropriate because they shouldn't necessarily be closing out the record because they have inappropriately denied claim if that record is out there and it was reported properly and there is actually ORM. If you are receiving complaints, I mean, if you can get us information as to who that individual you spoke with, the time even the day…

Susan Bolster: Right. I understand that it truly has…

Jeremy Farquhar: … the estimated time of the call, we can follow up and find I mean that's inappropriate. We shouldn't be telling people here at the COBC. We shouldn't be giving people information that the only way to solve their problem is to close out that record because that may not actually be appropriate if there is actually ORM and so you.

Susan Bolster: I understand. Who do we – Who do we contact? Who do we give that information to?

Jeremy Farquhar: You can contact me directly…

Susan Bolster: OK.

Jeremy Farquhar: … and I can follow up.

Susan Bolster: OK because we still get these, and we even talk to where I've even insisted for a supervisor and the supervisor understands it, but I was, but the person who answered it kept insisting that by Federal Law we have to close it. So, sometimes you have to escalate it to a supervisor, but I'm just wondering who I can give or who do I direct these people to contact when they have all these problems because I'm still getting calls on almost a daily basis. So…

Jeremy Farquhar: Right.

Susan Bolster: … I will give them your information and let them follow up with you.

Jeremy Farquhar: Yes, I basically, you know, if they can give me the time, the day…

Susan Bolster: Sure.

Jeremy Farquhar: … when they call and if I have their personal information so I can identify them we can find the call and find out…

Susan Bolster: Exactly. Exactly. So, this is…

Jeremy Farquhar: … (who is that) and educate that person.

Susan Bolster: Perfect. That will be – That will be very helpful. Thank you.

Jeremy Farquhar: OK.

Operator: Your next question comes from the line of Linda Tatka of Fireman Fund. Your line is open.

Linda Tatka: Ah, yes. My question is where an insurer relies on an amended complaint and determining not to report a settlement as the amendment exposure is all pre 12/5/80, are they exempt from reporting and reimbursement obligations while we await a decision from CMS?

John Albert: I believe we said earlier on the call that we're still looking into that. I believe it was Catherine Goldhaber that raised that question.

Linda Tatka: So, you want us to report them or are we going to be exempt…

John Albert: If I…

Linda Tatka: … during this interim period?

John Albert: … - If I have had an answer that I could provide you right now then we will have provided that as we said earlier that it's still under internal discussion. You're, right now, if you want to err at all, err in favor of reporting.

Linda Tatka: Thank you.

Operator: There are no further questions at this time. I'll turn the call back over to the presenters.

John Albert: OK. It's running a little early. I'd like to thank everybody for their participation. I mean we have a couple more minutes obviously, you know, I'd ask the operator if we – if we, if anyone else had anything, I'll give them a minute to chime in. Is there any – are there any last questions coming in still?

Operator: There are a couple of questions that have come up.

John Albert: Yes. You, we can keep going. We've got plenty of time.

Operator: OK. Your next question comes from the line of Liz Gayle of North Carolina Firm. Your line is open.

Liz Gayle: Yes, hi, thank you. I may have misunderstood something that was said earlier in the call, and I just wanted to clarify if a settlement is exactly $5,000 that is – that is currently below the threshold, but did you say that those could still be reported voluntarily?

Jeremy Farquhar: Yes, absolutely. There…

Liz Gayle: OK.

Jeremy Farquhar: It's there that…

Liz Gayle: Because we…

Jeremy Farquhar: I'm sorry. Go ahead.

Liz Gayle: I'm sorry. We have some of those, and we're getting an error. The error is TPOC amount does not exceed reporting threshold.

Jeremy Farquhar: Oh, well, it depends on the date of the TPOC that you're reporting. So, for TPOCs after 10/1/2012, you can report that voluntarily, but if that

TPOC date is prior to 10/1/2012, that's before the actual threshold change.

So, you want to look at the timeline and the user guide for those particular thresholds and make sure that your dates are within the appropriate timeframe. It's not when you report it, it's the date of the actual TPOC that's going to trigger that thresholds.

Liz Gayle: OK. Thank you.

Jeremy Farquhar: If you do have examples where you think that the threshold is being triggered when it shouldn't, then please by all means let us know and you can read. This is Jeremy Farquhar. Again, my information is in the escalation procedure within the user guide. You can send those examples to me directly or you can reach out to your EDI rep and provide them with your examples, and they can follow up and we can take a look, but I'm not aware that we have problems at the present.

(Barbara): And the workgroup…

Liz Gayle: All right.

(Barbara): ... layout does provide you with the information on how to decide what the TPOC date is.

Liz Gayle: Thank you.

Operator: Your next question comes from the line of (Boni Maastricht) from Farmers Insurance. Your line is open.

(Boni Maastricht): Yes. Thank you. My question relates to the ICD-10. I know that we'll be using them beginning with 10/1/2014, but a question has been raised when we have a file that only has ICD-9 reported in it from a carrier - from a provider and, you know, then we're settling after that date when ICD-10s are required, is there a transition over the thought process being that if a health provider doesn't have to use the ICD-10s until 10/1/2014, you know, when we report at our very max reporting time period after

that date, we won't even have the ICD-10 at that point in time, do you have any thoughts on that?

John Albert: Yes, I mean again if the – if the dates of service on the claim are prior to October 14 that mean our intention is to allow those ICD-9s to be, continue to be reported so.

(Barbara): And putting together an alert as John indicated, there'd be more detail on that relatively soon. That is one of the specific issues that we're looking at.

John Albert: And we're not expecting people to have to interpret necessarily 9s, 10s and 10s and 9s. It's just that we do, you know, we do encourage folks to report ICD-10, you know, when they can, but again, we'll provide a specific guidance I mean obviously updates or records for example things like that. I mean I expect that we will be able to continue to accept the ICD-9 codes, but there will be some uncertainties, of course, is that whether or not I mean while we have – we have more control over our intake process in terms of we take or don't take. We don't necessarily have sway over the agency's policy, but again the goal is to make this as easy as possible for everyone so.

(Boni Maastricht): Thank you.

Operator: Your next question comes from the line of George Cullen of NH. Your line is open.

George Cullen: Yes. Howdy, this is George (inaudible) a quick question for you Jeremy. We continue and always have been getting code 50 quarterly rejections and the next quarter and so forth. Have you guys had any progress of resolving those? I know back in December or January I think that's in our list, we get above 60, 70 reports with that code on.

Jeremy Farquhar: You're always going to receive 50 dispositions, and the reasons for receiving those 50 dispositions will vary. They should be in small numbers on any given file. You shouldn't see significant numbers.

I don't believe that you had significant numbers in any given file. I know you had quite a few (uproll) and your significant amount of report, you know, if there's a particular, I mean, there is one particular circumstance that I can tell you at the top of my head that will generate the 50, which would cause you to receive 50 each time that you submit, and so if you receive a 50 disposition code back each time you submit that same claim and it's several quarters in a row, you keep getting that 50 disposition, the reason being maybe that it's a locked record on our side. That is one reason why you'll receive the 50 disposition.

If you have a locked record, you can – you can see that. That's something that's not going, you know, and you see it just keeps coming back, got you. It's a strong possibility that's why.

Typically, if it's not a situation with the locked record, you won't see that same 50 repeat itself over and over again quarter after quarter, and you should simply resubmit the claim as per the guidance within the documentation, but if you have, I mean, is it the case at the present that you're receiving these 50 disposition codes repeatedly quarter after quarter on the same claims?

George Cullen: On some of them, yes, and the other ones I just don't have the time to go through 60 claims and retrace if he has a claim history, but I guess I'm wondering how are we supposed to know they're locked records if we just get them.

Jeremy Farquhar: Well, it's tough to say, I mean you were to contact our call center about these records that you're trying to update and you're getting a 50 disposition and it's a locked record they will tell you that. If it's something, when it's a locked record, if it is actually a record that requires an update if they determine that's the case, they will pass you along to a supervisor and that supervisor can assist you in getting that record updated, you know.

So, determining that, I know it's not by any means perfect scenario having to manually follow up on these things is not something that anybody wants to have to do, but in some cases, that's really the only –

the only option. There's no way at the present determine based on your response that it's, you're receiving the 50 because it's a locked record.

George Cullen: What's a locked – What is a locked record? What causes it to be locked?

Jeremy Farquhar: A locked record is basically, you know, there's a contractor number that we would update the record with on our side, and it prevents your average user from actually updating it or from being updated via file transmissions that we receive such as Section 111.

George Cullen: I know they could do it far between.

Jeremy Farquhar: Yes, there are not a lot of them, but it's – it's quite possible that over a significant period of time that you could (mass list) to them that you're getting the 50 on, and they could be, you know, you could have bunched there are that you know. You're not going to see a bunch of them at any given time, but eventually they might build up.

It's a – it depends on the scenario. It could – It's most often something where we know there's been problems with some flip-flopping with data where the record will be locked. If the record has been repeatedly opened up when we know that it should be closed and it's causing problems for the beneficiary or there's a record that had been deleted repeatedly and we know it should remain, we may create it and use the locking contract number to prevent that from occurring.

So, you know, it's like I said, you can contact your call center, they will look at the records, you can tell them the update that you're trying to apply. If it's not a locked record, they may be able to assist you in updating that record appropriately. If it is a locked record and it does require an update, they can ask their supervisor for assistance, pass you along, and they can help you in making those updates.

George Cullen: (Inaudible).

Jeremy Farquhar: And the call center. I'm sorry. Go ahead.

George Cullen: I was going to say the volume that we do handle we don't have people in our claim's offices looking to make phone calls to do this. It seems like it's kind of an issue on your end. Will you be able by identifying it since you know it's a locked record and we don't, can you take the corrective action or the update action on your end to handle it? Update action with locked.

Jeremy Farquhar: Well, I mean the action on our side we've locked the record to prevent you from updating it because we're with the information coming in via Section 111 or otherwise could be…

George Cullen: Could you just send us a different response other than code 50 to differentiate between code 50, locked record…

Jeremy Farquhar: That.

George Cullen: … versus the unlocked so that we can say OK, it's locked, we won't send updates anymore.

Jeremy Farquhar: Well, we, that's something that we can take into consideration and take a look at to see if it might be possible for a future enhancement, and I agree that that would be helpful and it's something that would be nice. It's we'll have to have discussion internally with our development team to see if that is a possibility.

George Cullen: OK. Get back to me next week will you.

Jeremy Farquhar: OK. I'm not going to have any answers for you that quick on whether we're going to be able to implement something like that George, but we'll keep you posted.

George Cullen: Yes.

(Barbara): But also.

George Cullen: Just send it to my mailbox.

(Barbara): OK, George, the other thing would be is if you have new information that might cause the COBC to change its mind about what had locked in to the record. That's important that that be presented to us.

George Cullen: How would we know that? I mean there we had outside records.

(Barbara): Well, you wanted to know for sure, but…

George Cullen: No. We don't know the record that they (inaudible) that intimately, you know, it's not like one and zero.

(Barbara): No.

George Cullen: We, you know…

(Barbara): No, but presume…

George Cullen: … we have to use (inaudible).

(Barbara): … presumably you have some basis for what record you're submitting or trying to change, and the contact that the COBC could at least tell you whether your information is purposely being overwritten or whether the information you have is now something that's new and additional that we should know about. Is that a fair statement, Jeremy?

Jeremy Farquhar: Yes, that's correct and until you, you know, and as a general rule as noted previously, you know, if you receive a 50 disposition, the guidance is to resubmit that record on your subsequent claim submission, and, you know, not all of these situations are going to be scenarios where there is a locked record. There will be scenarios where you will receive a 50 and you continue to submit it.

It will actually go through subsequently so you may wait until you see a record kickback to claim files in a row, receives a 50 and then with certainty you think there might be a problem then you can only call on those, but as a general rule, the guidance is to resubmit that record on your subsequent claim submission. Just the simple fact that there is a 50 disposition coming back on your response file doesn't mean that there's

actually an issue that's out of the ordinary that you are going to see 50 disposition codes come back there and never going to disappear in entirety.

George Cullen: OK. Just the inception of Medicare and then you guys have said this should be a rare occurrence.

Jeremy Farquhar: I think the interpretation of rare is where we get hung up in that case sometimes. Infrequent volume wise would possibly be a better way to put this. A low, a very low percentage of your overall total volume and (approach them to).

George Cullen: OK. Thanks Jeremy.

Operator: Your next question comes from the line of (Scott Aldis) from (inaudible). Your line is open.

(Scott Aldis): Thank you very much for taking my call. This is a follow-up to a question I think that a gentleman who may have been representing a police department raised several months ago, and I've also submitted some to the mailbox on this.

It's the scenario where say the RREs employee is exposed for example to blood or blood products and the RRE agrees in response to that scenario to provide testing over a period of time to that employee for various conditions that might have been contracted from that exposure. It's our understanding that while the first question is, is that reportable that testing that promise to test reportable as an ORM and then the trickier question is if it is, how do we ICD-9 code that scenario because they don't necessarily have any conditions, the testing may end up being negative, so we're not sure how to code that scenario.

(Barbara): I don't know whether it was yours or not. I do know that in at least in the most recent group and possibly before we've had some questions about medical monitoring in general, and it's another one of the areas that we're looking at. Certainly, at minimum, you should be making sure those are paid appropriately so that anyone you made that agreement

with has instructions that those they need to have their provider or physician or supplier bill those to you, but as far as the general process for Section 111 reporting for something that's medical monitoring only, we don't have a reply for you today.

(Scott Aldis): OK. I do appreciate it. Thanks very much.

Operator: Your next question comes from the line of Catherine Goldhaber of Segal Cambridge. Your line is open.

Catherine Goldhaber: Hi. Just, I'm trying to clarify in regard to your response to Ms. Tatka's question. So, to be clear on an exposure case, the user guide in Chapter III page 38 exempt reporting where there's no claim and no evidence and no specific release of exposure is occurring on or after 12/5/80, and that's still the current policy.

(Barbara): The policy that's in the user guide is still the policy.

Catherine Goldhaber: And CMS is aware that many insurers have been relying on this policy and not reporting when a complaint is amended to become pre 12/5/80, which is an accurate reflection of the fact.

(Barbara): I don't know that we have any specific knowledge that has been that a situation has been relied on by the majority or anything else, but I mean that policy stands by itself, and all I can really say is yes, we're still looking at your questions that have to do with amended complaints and no, we have issued a separate answer on that by itself at this point and, you know, as I think John has said in the past and I've said, we apologize that we can't always get your answers as speedily as you would like, but the last group of questions I was looking at it and had been printed out would have been about 180 pages of questions, so we do go through a considerable amount of material in trying to answer everybody's questions.

Catherine Goldhaber: Do you have, will that be addressed in the May revision? There are just so many cases that are being revolved right now where a plaintiff doesn't hand the complaint because you know, pleading is very different

than what make (inaudible). There are different reasons why pleadings may be broad and when it comes to plaintiffs…

Jeremy Farquhar: I believe – I believe that the changes that are going to be made in the updated version that's expected to be out shortly or already made or no I don't anticipate that's part of it. I mean when we provide any definitive answer it would probably start out first does it work just as many of the things do so that there are out there before any changes are made.

Catherine Goldhaber: Are there any other people we could involve in trying to seek a response to this? It has been – It has been inquired about for as John phone in reference for over a year now.

Jeremy Farquhar: No, I mean this is one of many issues that we're working on. Unfortunately, we, I mean we are aware of it and want to address it and but, you know, we have to unfortunately, there aren't too diligent to make sure that the answers provided, you know, or properly interpret the MSP statute and all the other provisions that are out there so.

Catherine Goldhaber: When an answer finally is directed, will there be some consideration of, you know, what's been done in the past for primary payers have not reported because the complaint was amended as reflective of the facts? Who all should they be going back in reporting this or are they, you know, sort of in a clear (inaudible) determinations?

Jeremy Farquhar: Your assumption assumes that our response will be one that you will view unfavorably, and I don't think it's fair to say that at this point. We truly don't have a response to give you. We're not hiding anything. We don't have a final response that we can give you.

Catherine Goldhaber: Well, I'm just concerned because of the comment you should err in favor of reporting, and there are many primary payers who erred in favor of not reporting because I do think they're acting in good faith based on what the user guide provides, you know, page 38 and 39. I just don't want people to suddenly start feeling that they should report based on the conversation on this call when they haven't done reporting and are doing so in good faith.

Jeremy Farquhar: That was I was making the comment about erring in favor of reporting as a general construct. People who come in with all kinds of hypotheticals that are listing a fact here or listing a fact there that, you know, could potentially change things. In general if you're not sure whether to report or not, you're not going to be harmed by reporting. It was the intent of that comment.

Catherine Goldhaber: So, you did not mean to tell people that in this while we're waiting for a decision they should start reporting. It was just meant.

Jeremy Farquhar: We have – We have never said that anytime you believe that you disagree with our policy that you should ignore it until you get a further answer and I know that's maybe exaggerating the other way, but I'm really not sure what to say in between. I mean, you're asking whether the amendment complaint could be an exception. If you believe it has to be an exempt - that it has to be an exemption that implies that the current policy doesn't allow for it. I don't really know what to tell you since we don't have an answer.

Catherine Goldhaber: Oh, I didn't mean that it should be an exception, the way I would see it is that an amendment complaint would fit within the user guide as there would not be no longer a claim of exposure pre rather…

Jeremy Farquhar: I don't know if John wants to make any further comment about penalties or anything else, but you know, obviously, we don't have an answer.

John Albert: I mean obviously I mean we're, you know, in terms of that concern I mean we're – we're not going to end up erring on the side of assessing penalties against folks that will, you know. Obviously, we know there are issues out there that need to be resolved, and we're certain that there're not going to be, you know, any policy that comes out, you know, related to CMPs and what not, we're not going to focus on these types of issues, but, you know, regardless of 111, I mean the MSP statute is the MSP statute whether it's reported on 111 or through other process does not mean, you know, you can't ask us to, you know, basically take away responsibilities that have existed all along into the MSP statute regardless of whether it's required under Section 111 so, you know, we

can't – we can't be boxed in on a call like this to provide these kinds of answers, so I hope you understand.

Catherine Goldhaber: I do. I'm just hoping we can I mean cases get held up on this, so we're just hoping we can get some direction.

John Albert: Yes. We hear you.

Jeremy Farquhar: We're trying.

John Albert: Yes.

Operator: Your next question comes from the line of Marsharee Wilcox of Century Indemnity. Your line is open.

Marsharee Wilcox: Good afternoon. My question relates to a situation that we're seeing being applied in numerous courts around the country where the courts are actually entering Omnibus orders conforming the pleadings to the proof, and I know we sent some stuff in to the mailbox, but in these – in these situations, the court actually finds, makes a finding that the evidence in the case for any of these claims actually is what prevails and they are actually conforming the pleadings with the proof and in those situations we have plaintiffs that don't actually have specific evidence that aligns up with post 12/5/80 exposure. So, the court then conformed the complaint with the evidence in the case where they may have had some broad sweeping allegations than the originally filed complaint.

In that circumstance, it's a little bit different than an amended complaint because the court actually is finding, making a finding based on the evidence in the case. In those situations, would it be your interpretation that there is no obligation to report?

(Barbara): We saw the question about the Omnibus orders, and we will be discussing that with our counsel because remember that under the MSP statute we don't have to establish causation and, you know, we will be looking at the argument and everything, but no, we don't have any answer on that. That is one of the things that's scheduled to be discussed with our own counsel.

Marsharee Wilcox: OK. So, but in that circumstance, (Barbara), we actually do have a situation where the complaint has been changed and the court has actually had a finding on the evidence and with the instructions in the user guide that does talk about where there is a finding by the court.

(Barbara): Well, again, we are going to be, I don't remember the exact wording and what came in to the mailbox, but we are going to be discussing it with our counsel on how to answer that in detail because we're assessing the situation where people come in and say well, this was a court finding and all of this is the court bluffing a stipulation of the parties and everything else. I know from the incoming e-mail that it sounded different. If someone hasn't already sent one in, I don't remember any attachments to the incoming in the mailbox or at least what was forwarded to me, but I think we would certainly like to see some examples of this Omnibus orders as well.

Marsharee Wilcox: Yes, I believe we actually did submit the actual language of the one (presenter) in Philadelphia, Pennsylvania, but there are a number of areas around the country where similar orders are being contemplated or being brought by plaintiff's counsel, so this is something that, you know, we then are treating those where there is no evidence of post 12/5/80 exposure, we then are treating those accordingly as insurers and primary payers so you know, it's something that the train already left the station in some places on this issue within the court system, so the sooner we can get some very specific instruction on those issues, we're happy to provide you more information on that, but we did actually submit the actual language of the order that was entered in Philadelphia.

John Albert: If you have a couple of any other examples, we won't mind seeing that as well. It's fine if you want to redeck the beneficiary name or hid number, but we'd like you to leave the information about the jurisdiction or anything.

Marsharee Wilcox: Yes. They actually are entered with the court so they are not specific to the defendant because it's talking about the actual evidence on a case-by-case basis so that the allegation that they may have had broadly pled that

you have to look to the specific evidence as to the defendant that is resolving so, but we can certainly send you – send your copy of that and give you more information as needed.

John Albert: Yes, we can go – we can go back and check with the person for files or some other things make sure we got the attachment that was sent in, but if anyone has any copies from any other jurisdictions, it will be helpful to see them too.

Marsharee Wilcox: All right. Will do. Thank you.

Operator: There are no further questions at this time. I'll turn the call back over to the presenters.

John Albert: OK. We're getting close to 3 o'clock, so I guess I'll wrap it up since we don't have any more questions. Again, I wanted to thank everyone for their participation today.

We hope to have the transcript out within the week to the Section 111 mailbox, oh, I'm sorry, not the mailbox to the website. Please continue to submit your question.

As (Barbara) mentioned, we definitely received a lot. We're trying to go through them and answer as many of them as we can as timely as we can.

Otherwise, stay tuned to the Section 111 website for announcements regarding future calls. With that, thank you.

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

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