TRANSCRIPT
TOWN HALL TELECONFERENCE

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
September 21, 2011
1:00 p.m. ET

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

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Mr. Joe – John Albert, you may begin your conference.

John Albert: Thank you, operator, and good afternoon, everyone.

For the record, today is Wednesday, September 21st, 2011. And again, this call is NGHP Technical call, one of many of this that we've had over the past three years.

As I've stated at the beginning of every call, I want to issue a little disclaimer that occasionally, we may contradict official information that's published in the NGHP User Guide or occurrence of alerts and where that does occur. I need to remind everyone that the official written guidance is the official answer from CMS regarding questions on this call and so otherwise a new guidance was published.

With us, we have a couple of folks from our Coordination of Benefits Contractor, Bill Ford and Jeremy Farquhar who after I give my brief opening remarks will provide some answers to some of the technical questions we've received and then we'll go into the Q&A session.

We ask that everyone to please provide the operator their name and organizations they're with as well as please limit your questions to one and one follow-up. And again, I would remind everyone that this call is designed primarily for technical support and not policy-type questions and that's' what we're going to put emphasis on in this call.

So if you have more policy questions that have not been, you know, answered or whatever that you need more assistance on, continue to use the Resource mailbox but also I would note that we do have three more calls scheduled for the next couple of months.

There'll be one in October which will be a policy call. It's not – the date has not been set yet but it will probably be late October and we also will schedule a call in November and December as well.

I wanted to remind everyone that the new TIN Response File and address validation reporting requirements take effect on October 1st, and to see the revised May 17th's alerts posted on NGHP Alerts page and also in the User Guide, the new current version of the User Guide starting on Page 66. That was stated August 17th and it's been posted on the main NGHP page on the Section 111 website.

With that I would like to take this time to turn it over to Bill Ford who is going to provide some information regarding some of the many technical questions we received primarily through the Resource mailbox.

Again, keep those coming. We use those all the time to, you know, update or improve our materials. We're actually going through a process right now of trying to revamp and reorganize some of the materials just because we've been, you know, doing it for a couple of years.

And we look at checking into some accounts and results from a survey that was sent out to a large percentage of folks out there that – and many of who replied and we appreciate their detailed responses to the questionnaires that we sought information on and we're going to be using that information to hopefully improve the materials and offer additional information as well. So

again, for those people that participated in that survey, we do thank you. But with that, I'll turn it over to Bill and Jeremy.

Bill Ford: Good afternoon, everyone. This is Bill Ford. I'm the EDI manager for GHI, the Coordination of Benefits Contractor for CMS.

Prior to going through a Q&A session, I just have some general announcements to make. You know, John has just spoken about the implementation of address validation and the TIN Reference Response Files.

I'd like to emphasize that we are we are on track for the October 1st implementation date and there are a few things to remember about the new address validation and TIN Reference Response File.

Important things to remember are that no Claim Input or TIN Reference Files will be processed during the last week of September. If you're a third quarter file submitter, you should submit prior to September 22nd or after October 1st. There is going to be dark days between the 22nd and the 1st.

Also remember to pre-validate your TIN addresses on the USPS website prior to the submission of your next TIN file.

All RREs must submit a new complete TIN file in the fourth quarter to reprocess all TIN records against the new validation routines. We suggest that you submit your TIN file first without your Claim Input File and go through in an iterative process to get all your TIN records accepted and returned on the TIN Reference Response File with an 01 disposition code.

Once you've done that then submit your fourth quarter Claim Input File and resume norm al submission with your first quarter of 2012. You may submit as many TIN files as you need at any time during a particular quarter.

Address validation changes will affect information submitter on the Section 111 COBSW via the Direct Data Entry option as well. If the TIN information you submit with your claim report does not passed the validation process then your claim will be rejected with the TNOs. And again, please see the posted alert or the User Guide for more information.

We have received like – I believe Jeremy is going to touch on this later but we have received several questions about the TIN Reference File and information on the TPA.

We are working on long-term solution to add new fields for submission of TPA information to the TIN Reference File record. And the area is now reserved for future use (is marked as filler) so that is something that we are looking at and we are considering at this point in time to do that.

A couple other brief announcements, as you all probably know, the Non-GHP User Guide Version 3.2 dated August 17, 2011, is now on the CMS MIR webpage. That's www.cms.gov/mandatoryinsrep. You should all – if you haven't done so already, go over there and get the new User Guide.

We have updated Excel and text files with the revised Error Code tables in version 3.2 of the User Guide. It will be posted on the Section 111 COBSW as of October 1st. These files will be available for download. They'll be under the Reference Materials menu option on the log-in page.

Note that to download any of the text files on this page, you may have to right-click on the link for the text file. Simply clicking on the link for the text file will most likely result in opening the page in Notepad. You're viewing rather than opening a file for downloading.

Many people have talked about the SP32 errors they've been receiving where the ORM term date is equal to the DOI. That has been implemented so claim records with the ORM term date equal to the DOI will not be accepted.

Many have talked about receiving multiple file submission error threshold emails. We are aware of that issue. It's a known issue. And if you receive an email erroneously stating that you submitted more than one file this quarter, you may ignore it. Your EDI rep will release the file for you without your intervention.

Most importantly though (inaudible) this have to do with error corrections. Please remember that RREs are required to correct and resubmit records

returned with disposition code SP and associated error codes unless the User Guide indicates otherwise for the error in question.

We are seeing RREs resubmitting records without making the necessary corrections or not resubmitting at all. CMS and the COBC will be following up with RREs representing the biggest offenders.

Remember that responsibility for accurate, compliant Section 11 1 reporting ultimately rests with the RRE. Even if you have an agent who's reporting for you, the RRE must make sure that reporting is done timely and accurately. It is the RRE that is accountable.

Also be aware that submitting records in error is no more compliant than not submitting the record at all. CMS has specifically set past town hall teleconferences that submission of a record with errors that prevented processing to completion by the COBC is not considered compliant with Section 111 reporting requirements.

Submitting a record in error will not serve any purpose or make the RRE more compliant than not submitting the record at all. RREs must correct the known errors first and obtain all the required information and then submit the claim record.

There is no alert on RRE compliance on the MMSEA 111 Alerts page that states, "Throughout the reporting process, the RRE consistently follows CMS data submission protocols reducing quality file submissions and data that can be adequately processed and used. A record submitted and returned with errors not be adequately processed and used." So please make sure to correct all the errors.

We also had a lot of questions regarding ICD-9 reporting. Please be sure to submit only ICD-9s that describe the injury or illness. The code maybe selected/derived by the RRE for this purpose.

Codes do not have to come from medical claims submitted by doctors and the hospitals and other suppliers to the RRE. This maybe a good source but

providers don't always supply the E-Code, so you might have to derive that yourself.

Make sure that the ICD-9s are all pulled off these claims and submitted for Section 111, actually describe the illness, injury. The RRE has ORM or claims allegiance or a TPOC settlement, judgment or award.

Sometimes providers submit medical hospital claims with ancillary ICD-9 codes like hypertension and the like. If you do not assume ORM for hypertension, don't submit that ICD-9 code on your Section 111 report.

If you submit ICD-9 codes that do not apply to the illness/injury associated to the claim you are reporting, that may adversely affect claim payments for Medicare beneficiaries. In the case of a fatality, you should submit a code that describes the injury that led to death.

ICD-9 Diagnosis Codes E9670 or E9679 were removed from the list of Excluded ICD-9 Diagnosis Codes. These codes are now valid and accepted in the Alleged Cause of Injury, Incident, or Illness which is Field 15 on the Claim Input File Detail Record.

Even though ICD-9 Diagnosis Code 999.9 is not on the list of excluded codes, RRE should not use it since it does not adequately describe the illness/injury and could lead to Medicare incorrectly denying your beneficiary's claims for unrelated services and treatment.

As many of you may be aware, beginning 01/01/2012, the new EDI transaction will be going from 4010 to version 5010. This impacts RREs who submit the HEW Query File or as we call the 270/271.

The upgrades to version 5010 have the X12 270/271 eligibility query transaction that is on schedule. The COBC will accept both test and production query files created in the 5010 version of the 270/271 transaction set beginning October 1st.

You may download the new PC or server version of the HEW software as version 3.0.0 and request the main same version from your EDI rep.

Version 4010 query files and query files created with the older versions of the HEW software will be accepted until January 1st, 2012. Starting 1, it will be accepted. And again, there is no alert posted on that under the MMSEA Section 111 Alert page. It's also in the User Guide.

And as always, please submit any specific technical questions you have to your EDI rep first. Your EDI rep is your first resource to get your technical questions addressed. If you don't feel your EDI rep has addressed your questions, you can always escalate those questions to Jeremy or myself.

And with that, I'm going to turn the rest of this meeting or this piece of it open to Jeremy.

Jeremy Farquhar: OK, thank you, Bill.

So since our last call, we've received a number of technical questions via the CMS Resource mailbox, so I'd like to just attempt to address some of those questions at this point in time.

The first note that I had actually ties into what Bill was just remarking about regarding ICD-9 codes. We received a number of questions raising concerns regarding situations where Medicare appears to be denying claims as a result of records created via the Section 111 GHP reporting process.

(Inaudible) reference situations for a beneficiary who may have saw a medical treatment or something totally unrelated to the no-fault Worker's Comp or liability claim that have been reported yet the claims are being denied.

This has come up on past calls, we would like to reiterate and as Bill is mentioning before, it's very important that RREs do their best to provide us with a specific ICD-9s as possible. Use of vague codes could result in confusion regarding which specific illness maybe linked to the claim and that could result in claims being inappropriately denied.

Now, we've also received reports of situations where an RRE may tell us, "Well, we only have one ICD-9 on our records and it's referencing a broken

leg and our beneficiaries' claims are being denied to treatment and their treatment is relating to their diabetes."

Well, that's we've – we have received those reports. CMS is currently investigating those situations and we will – we'll be doing our best to address those types of scenarios moving forward.

Next question we received was regarding address validation changes. Bill also touched a bit on address validation changes coming up on October 1st.

The RRE had noted that they currently submit their Claim and TIN Reference Files together in a single transmission and it just simplifies their process for them. And this is something that we've always allowed some RREs who can (paginate) those files the changes tacked on immediately following the claim file or vice versa separated by their headers and trailers.

However, moving forward, it's highly recommended that the TIN file be submitted prior to the claim file. It's – the reason why we tell you to do so is that you will have time to receive a TIN Response File – if there are errors on your TIN file, you'll have (inaudible) prior to submitting your claim file for your standard quarterly submission.

If you will send the claim file along with your TIN file or without getting yourself that leeway, you could run to situations where your TIN file could have many errors and errors on your TIN file are going to result on subsequent errors on your claim file.

If a particular TIN is referenced on your Claim Input File and that record for that particular TIN error'ed out on your TIN Response File then that record on your claim file will automatically receive an error as a result.

So you want to do your best to try and resolve those issues before you submit your claim file in order that your claim records will appropriately apply. We can't stress that highly enough. We know this is just maybe different for some people but it would be highly advantageous for you to do so.

Moving forward, we had received an email in relation to the new S4 feature from the RRE Listing page on a Secure Web site. It was indicated to us that RREs who are no longer affiliated were still appearing on the exported list although they had been successfully removed from the display on the website itself.

This is a known issue which we're aware. We're currently working to resolve it. Hopefully, it should be corrected in the near future. We apologize for the current inconvenience.

The RRE Listing screen itself on the website should be accurate but for some reason at the moment, the actual Excel spreadsheet that we export to be at that option maintains the history of the past retaliations with older RREs.

Moving on, we received another question related to scenario on RRE, a case currently in litigation where both the husband and wife were involved and both were Medicare beneficiaries.

Allegations included both property damage and medicals and a settlement was made as a lump sum and the RRE had inquired about how this should be reported. But there were some questions, first of all, regarding the actual TPOC date and that TPOC date should be reported as the date the settlement was actually dictated during the court case.

But there was also a question as to how this information should be reported for each individual as both were beneficiaries. The lump sum in this example came to $50,000 and in such a situation, a Claim Detail Record should be submitted for each husband and the wife and the TPOC amount reported on each record should be reported as $50,000.

I received another question regarding proper reporting of TPOC amounts in situations where there's open-ended ORM. The question was whether the TPOC amount should be reported at the time of payment or whether they should simply include the TPOC amount at the point in time that they send an update based on final resolution which would effectively close out the ORM.

It's important to note that once the settlement has been made and the TPOC has been determined, it should be submitted on the RRE's next quarterly file submission. They should not be waiting for ORM to terminate to provide us with that TPOC information. Send it to us once you have it. But then after the ORM terminates, send us another update to provide us with an ORM termination date.

And the next question is regarding a similar scenario but slightly different so I figured out I would touch upon this as well.

An example was provided where an ORM record for Worker's Compensation claim with the date of incident of 01/01/2011 had previously been submitted. Subsequently, there was a settlement made on 01/01/2012 (inaudible) there was still open ORM.

Later on January 2013, there was a subsequent settlement made also in the amount of $50,000. But this was the final settlement and at the point in time that this settlement was made, ORM was also terminated.

So the question related to how this should be reported – after the initial settlement on 01/01/2012, the RRE should report the first $50,000 TPOC on their subsequent Section 111 claim file submission and the ORM indicator should remain as a Y.

Since ORM continued that there should be no ORM termination date reported at that juncture then after the TPOC date of January 1st, 2013, the RRE should once again submit an update on their claim file submission and this update should include the second TPOC date along with the corresponding TPOC amount for that second settlement.

Being that ORM are also terminated with that second settlement, an ORM termination date should also be included within that update records. Please note, the ORM indicator should always remain as a Y. That is something that we have a fair amount of confusion regarding that one people have ORM that terminates, sometimes will have them trying to change their ORM indicator and when they send an update, that's not appropriate.

All that needs to be done at that point in time is to send a termination date for the ORM. The ORM indicator is a key field and should not be changed. As long as that ORM was actually valid and there was a period of time for which there were ongoing responsibilities in medical, there should always be that Y reported for that claim.

And with established subsequent TPOC – excuse me – the subsequent termination date which will indicate when that ORM actually ended, so changing the indicator is not necessary and should be avoided.

And that's all I that I have so I'll turn this back over to John and Bill.

John Albert: Thanks, Jeremy.

I guess, operator, now, we can open it up to Q&A.

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of (John Meano) from Golden Land. Your line is open.

(John Meano): Good afternoon, everyone.

My question is in regard to a Worker's Compensation claim. She is Medicare eligible. Her plan insurance type is B, ORM is Yes. The state of venue does not have a statute on limitations on medical and does – and/or doesn't allow settlement of medical benefits.

In this case, there has been a settlement of indemnity benefits only and does not have the effective releasing medical. Should the TPOC still be populated with this indemnity-only settlement amounts and if so or if not, should this indemnity-only settlement count toward the total interim reporting threshold?

Male: (Inaudible) on that one. Can you hold on just a second?

(John Meano): I guess the question really boils down to indemnity-only settlements are reportable as a TPOC.

John Albert: Go ahead, Barbara.

Barbara Wright: I believe that we still have some decisions pending on that to do an alert on it. So we don't really have any answer for you today.

(John Meano): Yes, because I mean Section 11.10.2 basically states that if, you know, we're looking at a settlement judgment or award or other payment that has the effective releasing medical at TPOC that there is a lot of confusion out there especially amongst other reporting agents and RREs as to whether or not these are reportable, so guidance is appreciated.

I have a couple of other questions here but I think really what the question we have boils down to the TIN Reference File and that the Office/TIN information. The User Guide basically states that the information that should be provided is where the RRE wants their compliance information extensive.

The question here is, you know, we understand that the TIN name should be the name of the RRE but the address information quite honestly, most – a large number of RREs have claims administrators that handle their claims for them. And some of these communications from MSPRC and other vendors for CMS have some time sensitivity to them.

So if the TIN/Office/Site Code information is going to be required to be required to be the RREs, there could be a significant delay in that communication between the RRE and the claims administrators.

So I guess my question really boils down to, is that TIN Reference Site Code information – is the TIN Site Code information supposed to be the RRE's information or is it supposed to be the claims administrator's information?

Bill Decker: Hi. This is Bill Decker for the record with CMS in Baltimore.

I'm just – I just wanted to start – the answer to this question was – just as a reminder for all RREs out there that they are responsible for the reporting.

And if you are an RRE, you are responsible for the reporting and for what you report and how it is dealt with whether or not you have a claims administrator.

That said, we understand completely about how the business is set up and that it may be useful for your TPAs to be getting information that – where in most other circumstances with RREs, go directly to RRE.

And now, I think – I know that John Albert has some information about that and might want to have a few words about what we maybe going forward with on this issue.

John Albert: Well, I mean I just want to reiterate what I think Bill Ford – William Ford – said earlier and that is, you know, we're well aware of this issue and we're looking at some proposed ways to address that.

We can't make any promises at this time but again, we are very well aware of this particular issue and, you know, we want to try to offer RREs, you know, the tools and the ability, you know, to submit information that keeps the whole entire COB process not just the reporting but anything that's follow-up running as smoothly as possible. So again, we are looking at that particular issue internally. And, you know, if and when we are able to address that, of course, we'll put that information out there.

(John Meano): Great. Guys, before I let you go, I just want to let you know that, you know, there is a lot of, well, I have to say rumors going around right now that CMS is going to delay the liability reporting once again.

Can you either substantiate or refute whether or not there's going to be an additional delay with regard to liability reporting?

Barbara Wright: We can give you an answer but it will not substantiate or refute at this point. There have been requests for further delay. We – the agency is looking at those requests but we have no information on a decision either way at this point.

John Albert: And for the record, just let me say that that is Barbara Wright who is speaking. Probably all of you know her.

Thank you, Barbara.

Now, hopefully, no one else will ask that same question again.

Operator: Your next question comes from the line of (Frank Harland) from New York State Insurance Funds. Your line is open.

(Frank Harland): Yes, good afternoon everybody.

I had a question regarding the – one of the changes in the User Guide regarding SP50. We're trying to understand – I want to get a little clarification when the guide talks about locking down the information when you receive an ORM termination date.

And so we're trying to understand because there are some cases where we may have initially reported an ORM termination date in error and if we do that where in the subsequent quarter, we're reporting an update record and removing the ORM termination date.

Barbara Wright: We're not sure what your question is on that.

John Albert: Yes.

(Frank Harland): OK. Yes, the guide talks about locking down the information when you get an ORM termination date and I'm just a little confused as to what that SP50 actually…

Male: There are – I can answer that question for you. There are certain situations – they're not extraordinarily common but they do occur where a record is updated with a locking contractor number on our end to prevent further updates from taking place except for some - from somebody that actually has authority to update with that contractor number.

It's typically done when we have scenarios where there's been flip-flopping on a record and we find that something has been updated incorrectly. So

So via your Section 111 file submissions, unfortunately, there is no way via that file submission process to actually update those records. However, if you do have – if you're merely certain that there – I mean sometimes you might not actually need to make an update.

You could be – and say if you're saying an add record and you've got an SP50, it could be because we actually have that claim on file already and we're not allowing you to overlay the records that we already have. The information might be exactly what you're attempting to report and there may not be any further action required of you.

However, if you feel that you have an update to make a view and post a record previously, you're coming back to make an update to that record and you're unable to do so and you know that you need to make a change to that record, the only way that you can actually accomplish that is by calling our call center and you'll end up having to be patched over to a supervisor that would be able to – you can explain your situation to the supervisor …

(Frank Harland): So don't go through the EDI rep on it?

Male: The EDI reps unfortunately don't have the ability to make those types of updates so it's – in that particular situation, most of the time, we would tell you your EDI rep should be your number one point of contact. This is one of the very few situations where that would not actually be the case.

Our call center would be the number to call. It's 800-999-1118. And you will at that point in time at least be able to speak to somebody that can take a look at the record with you and make a determination to whether there is actually an update that needs to be applied.

(Frank Harland): Because obviously, you know, if we submit it and got an SP50, my assumption would be that if we just kept on resubmitting it, we keep on getting that SP50 without knowing why we're getting it.

Male: OK.

(Frank Harland): So that explains it.

And just one other comment, going back to the, you know, idea with the Worker's Compensation in New York State. And we also do these indemnity-only settlements. Now, we've, based on our interpretation of what's going on in the previous teleconferences and also what's in the guide, we have been reporting those as TPOC amounts and leaving the ORM termination date as blank.

And if the medical side of the case was to settle, our assumption would be then we would report with an ORM termination date and a second TPOC amount which would give you the full TPOC amount for the entire case.

Male: That's appropriate.

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

Operator: Your next question comes from the line of (Beth Beguise) from MEMIC Insurance. Your line is open.

(Beth Beguise): Hi there. How are you this afternoon?

Male: OK.

(Beth Beguise): My question has to deal with the thresholds – the error thresholds. There was a question earlier – I don't think I heard it on this conference call about the disposition codes 51 counting towards the threshold.

And I remember some talk about it being changed so that it would no longer count towards the error thresholds. Where does that stand?

Male: That's actually a change. It's going to be applied in our October release. So as of October, that should no longer occur. The 51 dispositions will no longer count towards your 20 percent error thresholds. It should be actually just as records that receive errors. So that will be cleared up very shortly.

(Beth Beguise): Beginning of October? And – because we…

Male: Yes, beginning.

(Beth Beguise): OK, great. Thank you so much.

Operator: Your next question comes from the line of (John Russell) from (Pepino). Your line is open.

(John Russell): Hi, guys.

I have a question regarding – I've been working with registration of a foreign captive that's held by U.S. citizens, notable citizens. And speaking with you folks via email before, it seemed like it was OK to proceed, however, going through with the EDI reps now once we get an RRE number, it's kind of awhile again. So they suggested I talk to you today about this.

And what it is, is the company itself is Bermuda-based but it's not foreign controlled. It's controlled by individuals in the United States and so therefore it doesn't have a parent company as what your definitions in the manual have.

So we need to register that captive as the actual RRE but he doesn't have a tax I.D. number and elected for the 953(d) election into the IRS tax code. So how should we go ahead and register this thing.

Have he gotten any further – an EDI people so, you know, (inaudible) understand is that needs to be clarified, I guess, by your office.

Male: I won't, in fact, take that example back with some other folks here. I don't think anyone here can really…

Barbara Wright: He wants to get his RRE number.

Male: Yes. Do you have – well, you know, he's trying to register him so they don't have an RRE.

(John Russell): We actually have the RRE number and everything.

Male: Oh, you do?

(John Russell): Yes, and I can get that to you. I did send an email over to that email address, that PL110 or whatever comment email…

Male: OK.

Male: Yes, just the RRE number anyway if you would please.

Male: (Inaudible).

Male: (Inaudible).

Male: (Inaudible).

(John Russell): What was that?

Male: Give us the RRE number.

(John Russell): 41995.

Male: OK.

Male: And, you know, per the User Guide, it does indicate that the captive should not be the RRE.

(John Russell): I understand that but it doesn't have a parent corporation. It is truly in the payments, yes.

Male: (Inaudible).

Male: (Inaudible).

Male: (Inaudible).

(John Russell): There are individual investors (inaudible) in it but it's not – but it's not a parent corporation as what you have in your definition.

Male: The individual investors in other words are loose group of folks who are…

Male: (Inaudible).

Male: (Inaudible).

Male: (Inaudible).

Male: OK.

(John Russell): Well, we started kicking this thing around with you guys a year ago and it's…

Male: (Inaudible).

Male: (Inaudible).

Male: (Inaudible).

Male: Yes, and your question was asking (inaudible). We'll get back to you.

Who actually holds the RRE ID number?

(John Russell): It's actually a comp any here that is insuring in the states for its exposures – liability exposures, but it – again, it just has one company it's taking payments for.

So that's – it's very – it's not a large captive. We have a group of people going in. It's just people we're having investment in it but, you know, they've done the 953(d) and everything and set up properly. It's typical Bermuda captive situation.

Male: Can you hold on just a second?

(John Russell): Yes.

(CROSSTALK)

Male: Yes, I have – a note was made here about the description of who an RRE is. I just want to reiterate that. A captive can't be an RRE. They just can't be an RRE for a parent or a sibling.

(John Russell): And so it's not for a parent. As I've said, there is no parent. It's held by loosely lay individuals. So he doesn't have TIN number. That's (inaudible) to register?

Male: That's not the question of could it register, it's the question of we don't have a TIN number to register with.

(John Russell): Yes, we used that pseudo TIN that's referenced on Page 4…

Male: You cannot use that anymore.

(John Russell): Well, that was in the…

Male: (Inaudible).

Male: (Inaudible).

Male: (Inaudible).

(John Russell): … 43 in the User Guide.

Male: All right. Use of pseudo TIN in conjunction with an FC state code, it's a problem. When you're actually technically trying to register, it will reject in the system – or without – excuse me – with an FC and the state code or – it will reject it. If there's a U.S. address and there's a pseudo TIN then it's not accepted.

(John Russell): That's what the problem was. We were using this U.S. address for…

Male: Then use the address for the captive (inaudible) which is offshore, I presume.

(John Russell): Yes. It's Bermuda.

Male: And use the pseudo TIN and you should be able to register.

(John Russell): So just change – just use that…

Male: (Inaudible).

Male: (Inaudible).

Male: (Inaudible).

(John Russell): All right. So I'll go back to my EDI rep. I should tell him who's telling me this.

Male: They're listening right now.

Male: We'll tell them.

(John Russell): OK. (Tom Heinerick) over there. All right, I appreciate it, guys.

Male: Yes.

John Albert: Next question.

Operator: Your next question comes from the line of (Emil Demall) from (Pento). Your line is open.

(Emil Demall): Hi, everybody. Thanks for taking my call.

My first name is Emil and spelled E, M with Mary, I, L.

And I'd sent an email to the PL110 mailbox and I didn't hear it discussed, maybe I missed it, but I'll see if I can cover it here with you folks if I could.

It has to deal with some – what I would call customer friction that we're experiencing occasionally. Our customers were Medicare beneficiaries. There can be a significant lag time between to-date or an RRE's no-fault coverage limit is exhausted and then the next date of the quarterly reporting information finally reaches Medicare and they're able to act on it.

So for example, let's say on June 1st, my policyholder, Joe Smith, drives into a tree and has an arm fracture and Joe has $10,000 in PIP coverage with my company that applies to his arm injury.

So in June 15, we report Joe's ORM through the co-release Section 111 reporting submission, so it gets reported. And then on July 15, we exhaust our

$10,000 in coverage, but Joe needs additional treatment. And he continues to go to doctors and the doctors are aware that we've exhausted our coverage so they submit the bills for this additional treatment to CMS for payment.

While the reporting won't catch up to you guys until we submit in our next quarterly report, which would be September 15, so our customers are coming to us saying CMS won't – Medicare won't pay my bills and neither will you guys and they're kind of caught in the middle.

So one the ways we've been doing is we've been trying to communicate with MSPRC/NGHP in Oklahoma City, and I'm wondering if that is what we should be doing, or if does it do any good, or that's a better way, if there's a better way of doing it. And also, I'm just wondering if you can provide some direction to RREs on how they can generally direct their policy holders who find themselves in this lifetime reporting situation that I just described.

Bill Ford: Well, I mean, I totally understand that issue and how it can come, but Section 111 is not meant to be the gatekeeper in terms of when records are updated it's the COB contractor. Obviously, (inaudible) is meant to provide as much as, you know, on a fairly regular basis, you know, which include updating of the existing records.

Obviously, you know, if the beneficiary, themselves, is having their claims inappropriately denied, they can contact COB contractor directly. In fact, that often occurs in a situation where there's a lot of treatment going on, and they're being reported to us either via this NGHP process or the regular group health plan insurance process as well because the same thing happens there.

We continue to look for ways to allow for more self-service for the information to allow like ad-hoc reports to come in things like that. We're actually discussing some improvements to the process which will allow for electronic updating if information on a more frequent basis than is occurring right now. But in the meantime, I mean, the beneficiary, themselves, you know, should be contacting the COB contractor for official, you know, additional information.

(Emil Demall): OK, thank you. Can I ask for more questions, please?

John Albert: Hold on just a second. Yes, this is John, again, and also to the insurer, themselves, can contact COB as well with that information directly, so it's calling the COBT number not only to talking to your EDI rep. I mean there are certain – you know, to close these records, I mean, there are certain requirements that are needed, you know, depending on what the record is.

And I think it was mentioned earlier, also, about the issue of conflicting information that comes into the COB contractor that, you know, in some cases we can't just accept new information at face value without additional information. Oftentimes we, you know, receive detailed documentation either at our MSPRC contract or COBC and that we're not just going to overlay that, you know, valid documentations, but, again, there are plenty of processes in between submissions to prevent this from occurring. I mean this – it's a natural occurrence. I mean, it happens, again, with not just NGHP even with GHP as well.

Bill Decker: And again, one other thing, one other issue you raised – this is, Bill Decker, again. You need not go to the MSPRC on this issue at all. That's our recovery contractor, it won't have any influence at all on what is actually being reported at the COBC by you. And if there changes in what you need to tell the COBC about, you need contact the COBC and now you know that you can just call them. If you have a change like this, it would benefit either you or the beneficiary.

Jeremy Farquhar: If it's a matter of exhaustion, I do have one caveat to add to what Bill just said is far great. You would be calling the COBC so they could get the exhaustion date in there, but (inaudible) that any report of exhaustion with the payment ledger would still have to be submitted to the MSPRC. So, you know, they are two slightly different things, but in order to get claims paid, going forward, yes go ahead and contact the COBC with the exhaustion date.

(Emil Demall): And does the COBC phone number listed in the user's guide?

Jeremy Farquhar: It's 800-999-1118, but it is in the user guide as well.

(Emil Demall): Thank you.

John Albert: That's the general number for the COBC call center, which is outside of the EDI department.

Jeremy Farquhar: Yes, in situations, that is the number you would give.

(Emil Demall): May I ask another question, please?

John Albert: Sure.

(Emil Demall): I brought this up in the town hall teleconference back in February, I think. And it relates to public service television ads. And I'm in Seattle, and we're seeing just a slew of these television ads, great television ads, advising Medicare beneficiaries to not give out their HICN over the phone. And that's primarily how we get HICNs in a lot of instances is over the phone.

And I now brought this up and I can't remember what you guys said, but I hadn't seen one in a long time and now I'm just starting to see them a lot again here in the Seattle market. And I'm wondering if there's any way you folks can influence that or maybe – or if you care to influence it.

Bill Decker: This is Bill Decker. The object of those ads is – the ads are concerns you want to get now because there are often various open seasons beginning to take shape around the country for Medicare beneficiaries to change plans on plans, do this, do that.

And, basically, these public service announcements are aimed at beneficiaries to not give their Medicare ID numbers to anybody who – we should be making it clear to anybody who is actually not associated with the healthcare reform, and these are to help plan or Part D plan or anybody else.

They're probably a little bit – or really broad in their prescriptive message, but we understand why they have to be done if there are a lot of folks who – a chance to contact Medicare beneficiaries and sold them things that or may not be very useful for a particular beneficiary.

This is program by the way of outreach to beneficiaries that's been going on pretty much for the last 25 or 30 years. So it's not new, it's just every so often

it comes around, and to people like you, who actually do ask for Medicare HICNs over the phone and have a legitimate need for those HICNs can get some adverse influence like this.

There's not really a great deal that we can do about this. We tell everyone that Medicare health insurance claim numbers is the Medicare insurance number, and what you're asking for, for a Medicare beneficiary when you ask for that number is their insurance ID number.

They will be not significantly different than if you are asking someone who is a member of a Blue Cross or Shield plan for their Blue Cross or Shield ID number. That's technically what you're asking a Medicare beneficiary for.

If you can just try and make it clear that this is for something that is legitimate, that is tested, that beneficiary can actually call someone in Medicare and see if it's OK. That's about the only way we can – that's about the only thing that we can (play) during, you know, any advisory can give it (inaudible).

Barbara Wright: I believe we did have added to the Medicare a new handbook. A sentence that is translated indicated that they should be able to release their Medicare health insurance claim number to their insurers.

Bill Decker: Absolutely.

Barbara Wright: Whether or not it's a way you want to operate, if someone doesn't want to give it to you, if you can give them the broad general insurance number that they could call back as opposed to if it's an unsolicited call that you're making to them, then they might feel more comfortable.

Bill Ford: You're right.

John Albert: I just personally would not give out my social security or HICN notes if somebody calls me and I didn't know who they were, but at the same time, sure, and this is for everyone's information. I mean, obviously, you know, that's, you know, we're caught between ones that would make sure that we properly validate the information you send us and so that, you know, J. Smith

is in fact the J. Smith you're trying to report to us, you know, versus trying to loosen up the matching requirements when we are doing some internal studies that involve potential use of partial SSN or HICNs as well as other matching criteria, but we have to build a proof to our self that it will not result in false positive matches because if there's one thing we don't want to happen is that you tell us about J. Smith and it's not John Smith, it's Jeremy Smith, and we post a record on the wrong person to our system. And then the claims are denied, and well that's, you know, that's worse than no information at all.

Bill Decker: After examining that, I would say that, that's a major change for us, and I think it's going to happen very soon.

John Albert: Yes, but it is something we are definitely looking at, and, you know, we totally understand the difficulty that some folks have in getting the numbers out of people for whatever reason they know. But it's totally just the ads or other reasons we're trying to figure out ways to help, you know, make this a little bit easier for you and everyone else, as well as protect the privacy of our Medicare beneficiary population.

(Emil Demall): OK, that's great. Thank you very much.

John Albert: Next question.

Operator: Your next question comes from the line of (Norman Reith) from (Louisiana Guaranty Fund). Your line is open.

(Norman Reith): OK, thanks. Question on worker's compensation case, that the claimant or beneficiary and we are denied benefits for indemnity and medicals, ORM indicator would be no. But during the course of the litigation, we settled the case, say for $10,000. At that point, we would report a TPAC of $10,000, would we leave the ORM indicator is no or change it to yes?

Barbara Wright: If you're not separately assuming responsibility for ORM, you would be reporting only the TPAC.

(Norman Reith): Well, yes. I realized that, but what should my indicator be?

John Albert: If you're not reporting on your responsibility for medicals in any way you should have performed, you would report your ORM indicator would be given as no.

(Norman Reith): But in the release, we are releasing indemnity and medical.

Barbara Wright: ORM is not just on going – I mean ORM is ongoing responsibility for Medical and the fact that if settlement covers Medical does not automatically mean there's ORM involved. If the only payment recompense is going to be through that (what) some type of settlement, the TPAC, then the only thing you report is the TPAC, I'm assuming you've got a situation where you were denying it, you settled it. Now, whether it was from a risk standpoint or anything else, you did it in a lump sum settlement and at no point did you assume responsibility to pay any bills directly. You're doing this single settlement.

(Norman Reith): That's correct.

Barbara Wright: OK, so your ORM is no.

(Norman Reith): OK, second question. Law says we can a portion settlement on a liability case, but assuming you have a Medicare beneficiary who's in an automobile accident, and you have injury claim and a property damage claim.

The property damage claims are normally settled immediately, and, in this case, we would settle the property damage and take a property damage release, say for $5,000 on his car. Six months later, we settled the injury claim for $10,000. At that point, the report to CMS would be due, and we would report out soon the $10,000 and not the total of $15,000.

Barbara Wright: Is that two separate settlements and two separate releases? Then the first claim was solely for property damage and all that released was property damage, correct?

(Norman Reith): Correct.

Barbara Wright: Then you would – for the settlement you would not be reporting anything.

John Albert: In other words, you would be reporting all the $10,000 not the $15,000.

(Norman Reith): Right. But if we settled the whole thing at one time, we'd report the whole $15,000 correct?

Barbara Wright: Yes because your release would be your release on the entire $15,000 would include medicals.

(Norman Reith): OK, thank you.

John Albert: Yes.

Operator: Your next question comes from the line of (Romiria Reach) from (Littleton Joyce). Your line is open.

(Romiria Reach): Hi (inaudible). I have a question on – it may not necessarily be policy or may not be technical, but it's just a question of one of the fields – one of the reported fields. It asked for a product liability indicator. Many of our clients been involved in product liability losses and I'm not exactly clear on what that is asking for.

Barbara Wright: What's the field number?

(Romiria Reach): 58.

Barbara Wright: I believe, and Jeremy or Bill, can you confirm, didn't we delay any input for fields 58 through 62? And can you tell me where that is in the user guide?

Jeremy Farquhar: We're looking at (inaudible) I believe you're correct, just want to verify. Yes.

Bill Decker: It's currently (marked) and is fill with spaces, and it's on Page 177 of the user guide.

Barbara Wright: Again, make sure that you're looking at the current version of the user guide. In the very early version, yes, there were directions to fill this field in, but it's had description to fill with spaces for some time.

(Romiria Reach): All right, just so that I'm clear. Where it says fill with spaces, which means no information is to be put in at this time. It may be used for future day?

Barbara Wright: Correct.

John Albert: Yes.

(Romiria Reach): OK, all right. That's all I have. Thank you very much.

Operator: Your next question comes from the line of (Joey Ward) from (Empire Pacific Risk). Your line is open.

(Joey Ward): Yes, I just wanted to clarify, there was a blackout period mentioned earlier in this call for 922 for the end of the month, and our reporting comes due during that period. With the best play to handle that be to submit a (inaudible) on Monday 10/3, wait for a response and then submit our claim input file?

Jeremy Farquhar: Yes.

Bill Decker: Yes, that would be the best way to handle it, yes.

(Joey Ward): OK, thank you.

Operator: Your next question comes from the line of (Emily Cook) from (McDermott Will & Inc.). Your line is open.

(Emily Cook): Hello. I've been trying to better understand the requirements for reporting total write off for risk management purposes by hospitals, the user guide instructs to report partial write off via the claims processing process and on a previous call, I was instructed that this also applies to total write off service management purposes. And that this requirement was consistent with claims processing requirements and claims submission requirements that otherwise apply to Medicare providers.

I have been unable to find such a requirement and had been working with these folks in the provider billing group to get a resolution to this actual requirement and how such claims would be quoted, and they referred me back to this call today for further guidance.

Barbara Wright: OK, this is Barbara, again. I asked for some further information from other staff, and they told me or confirmed, first of all, that no pay bills are supposed to be submitted both by providers and suppliers.

Therefore, if you had a total write off, that would be a situation where you had a no pay bill, and I was also given the – I haven't had the chance to read it, but I was given the information that no pay bills are discussed in Publication 100-5, which is the MSP manual, Chapter 3, Sections 30 and 40 and that there are also claim examples in Chapter 5 under 40.8.

So I've been given the information that there is specific directions on how to – related to billing in those sections. What I was also told previously, but no one has given me a site yet, is that there is information on billing where there's another primary payer in the claims processing manual itself. And all of our manuals are on CMS's website.

I believe the site is www.cms.gov/manuals, and when you go on CMS's website, you can look for the information on manuals. And it does list all the titles of manuals, and you can go into them and look at the indexes or otherwise.

(Emily Cook): I have reviewed most of those sections, I believe, and they don't seem to specifically address a circumstance where a provider has actually voluntarily made a decision to write off the claim and a situation where the provider is not actually admitting liabilities for the circumstances that arouse resulting in their decision to write off the claim for risk management purposes so…

Barbara Wright: There is two things going on here. When someone makes the payment, it doesn't require the admission of liability or a determination of guilt or responsibility in order for Medicare to be secondary. The settlement or write off – it constitutes a primary payment from our standpoint. It is the primary payment to yourself. But, nonetheless, we are secondary to that.

So you would bill it the same way you'd bill a situation where an insurer gave you the primary payment. You are – in that case, you are essentially self insured and that write off is taking into account that self-insured payment

whether it's a payment that doesn't actually result in someone passing dollars back or forth or not. It's still a situation where you are self insured, and that write off constitutes the primary payment amount.

(Emily Cook): OK, I will take a look at these provisions, and I will circle back there…

Barbara Wright: Also, I'll talk to your billing people. When you talk – or when you talk to the provider billing people and any of the contractors, what you want to talk about is how would you bill it if you had a situation where another insurer were paying that same amount of money? It's really – as far as I know there's going to be no difference in the billing because the write off constitutes, from a MSP prospective, a primary payment to yourself.

(Emily Cook): (Inaudible) OK.

John Albert: Yes, I mean, this is a comment that, you know, we still see a lot of confusion over that or there was no settlement or there was – it doesn't matter. I mean, if the effect of that it releases medicals, it's – you know, it's a payment that is secondary to or part of their Medicare.

Barbara Wright: But some of the confusion seems to be from the idea that risk management is somehow different from some other type of primary payment. From the perspective of a claim being submitted to Medicare, there is no difference. They're both primary payments.

So I really think if you go back and approach the provider billing in terms of how would I bill it if the insurer handed me this check for the same amount, you should get your answer.

(Emily Cook): OK, thank you very much.

Operator: Your next question comes from the line of (Gayle Wiseman), would you please state your organization? Your line is open.

(Gayle Wiseman): Hi, Farmers Insurance. I have a question regarding the disposition codes 03 as compared to SP31 it kind of read very similarly, and I was wondering if you could clarify what would be the difference in those two codes?

Jeremy Farquhar: 03 is just general – they basically do kind of both indicate the same thing, but I believe, specifically, when you see and SP31, it's a situation where the beneficiary is yet to become entitled just to Medicare. And they will be at some point in the near future.

So I would say that if you see an SP31, you'll know that you're going to need to report this information probably on one of your upcoming files most likely even could be your next quarterly submission because typically you'll be – about a few months that we have their entitlement information on file in advance.

So come next quarter, they could actually be entitled to that point in time, and we may accept your record then. So you could resend the SP31 records, and we will eventually post them.

With an 03, that may not necessarily be the case. With an 03, you might not actually need to do anything. It could be that their entitlement period was in the past. So basically, 03 is just general coverage period you've reported just not overlap with your Medicare entitlements, you know.

And that being said, if you were with the SP31 scenario, if you actually were reporting say a TPAC settlement amount and that was the end of the claim and there were nothing further that you need to sort of report, then you received an SP31, then well, as long as there's no further activity after that point in time, you're not going to end up overlapping with their Medicare coverage period and resubmission wouldn't be necessary.

But, yes, the situation are there's – or there could be subsequent TPACs you may need to report those for somebody that use CMS SP31 coming back on.

John Albert: Jeremy, this John. So in the case of these codes, I mean, I guess it's the point is there are times when people have a sign taken but they don't have a current period of entitlement, which is what could cause that to occur.

Jeremy Farquhar: Exactly. Their period of entitlement is in the future when you see an SP31. That's typically the scenario.

(Gayle Wiseman): OK, thank you. Let me ask one more other – I also got an example of (FMOs) returning a positive match to a query, but they were in fact not entitled to Part A causing us to get a disposition code 51 when we attempted to report them. Is that a known issue? Or is that something that I should look further to see why we're getting that situation?

John Albert: That is a known issue. And that's something that we are intending to address in the near future. You could receive – if there are no Part A benefits, you could receive a 51 response back even though there may be Part B entitlements. The best thing to do in those scenarios is continue to query on that individual. What happens is once that – you know, when there are changes that we make, there may be an announcement, but once you were to receive a hit on the query, you would know that we will be able to accept your record.

We know it's an issue. There is not going to be a problem with your record not posting as far as us being upset or coming after you in that respect now that you're unable to post it at the present. If you continue to query on that individual, once you actually get a hit, you'll get the hit once that issue has been resolved, hopefully soon. And once you get that positive match, you can then send your claim record at that point in time.

Bill Decker: This is Bill Decker (inaudible). Of the entire universe of almost all beneficiaries, some 48 million people, just as a general note for everybody, there are some who are not actually enrolled in Part A. They are enrolled in other parts of Medicare but not in Part A.

There aren't very many, but in a 48-million person universe, it's not very many. It can be quite a large number, actually. Don't be surprised if you find someone who's not enrolled in Part A if they are enrolled in Part B in particular because that does happen.

Barbara Wright: Part B requires a premium for everyone, and Part A is premium free for the majority of beneficiaries. So when you tend to see people with Part B only is when they would not add premium-free Part A and decide that it's simply too expensive or have some other method of receiving that coverage.

(Gayle Wiseman): OK, thank you.

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

(Houston James): Could you go over a little bit information regarding the not inputting any – not sending any claim input about in late September. What are the dates again? And if we're able do we put those late if they're outside of – beyond that weekly timeframe?

John Albert: It's between September 22 and September 30. We won't be processing any claim or TIN files at that point in time. If you've sent that during that timeframe, we should be putting time frame, we should be putting them on hold. And they will begin to process as of October.

However, as I think a gentleman had referenced previously, it would be – well the best course of action be for them to hold off and then send their chain file first as of the third of October, which will be the first Monday in October and then make a response and then send their claim file.

And I would probably be your most appropriate course of action. That way, you know, and as validation goes into effect as of October 1, you'll have a TIN response file then you can review prior to submitting the claim file, and then you can send your claim file afterwards in case there might be adjustments you need to make to your TIN reference file prior to actually submitting that claim file as well. I will accept it if you send them both together, but we're advising against it. But we'll hold them if they are received in the blackout period.

(Gayle Wiseman): No concern about late reporting then?

John Albert: No.

(Gayle Wiseman): And also – but these apply to the query files?

John Albert: Query files, we'll be processing still, just the claim and the TIN files that will be on hold.

(Gayle Wiseman): OK, thank you very much.

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

(Suzanne Jordan): Hi, good afternoon. You mentioned earlier on the call that you – when you were covering some of the questions that one of the examples that you were given was the claimant who has done denied benefits and had an unrelated illness.

But they were denied based on their worker's comp claim. And we're starting to see quite a few of those, and what's happening is they're contacting CMS to find out why they were denied. And the explanation they're given is talk to your employer because there was inside a report, a worker's compensation report, but the illness or injury they kind of stated in one of my earlier examples, seems to be unrelated.

Aside from having done or trying to assist them because we're trying to do our best on behalf for our clients, aside from assisting them and identifying what the most appropriate appeals process should be, is there any other thing that we should be instructing them to do?

John Albert: I don't know. In terms of claims processing, I mean, there's nobody here that can necessarily answer those questions. But I did want to let you know that, and everyone else on the call, that you know, again, we are aware that – and the first thing of course to make sure that, you know, when information that's submitted Section 111 that is in fact accurate so that, you know, inappropriate claims – these claims are processed correctly or not, you know, are not denied. But, again, there is some pending instructions, system changes, et cetera that are kind of be going out to our claims processing contractors to, hopefully, address some of these issues.

I mean, this has been an ongoing issue for years. I mean that, you know, no matter how you do it, whether the extremely specific ICG-10 codes that are coming in the future versus the current ICG-9 codes that we use now versus verbal descriptions of injuries, you're bound to have some confusion when it comes to claims processing.

Unfortunately, I can't offer you, along with everyone else here, kind of guidance about what they should do in terms of their claims processing. I mean, obviously, if claim is denied, there are, you know, there are various appeal rights and what not that are with the beneficiaries you'll be…

Barbara Wright: And the provider also has appeal rights upon any denial at least. Some of the – there seem to be a variety of reasons. We'll be told it's because of the open record, but then when we check a specific case. In one case, yes the contractor did do it because of the open record and shouldn't have done it.

In another case, the provider billed it incorrectly. He indicated, he or she, indicated that it was, in fact, related to the worker's compensation. So I mean, it very much depends on the specific case. We do know that this is happening in some instances, and we are trying to figure out ways to correct this to the extent possible.

John Albert: I mean these issues have been ongoing. And (instead) Barbara's corrected that the provider should, too, because we definitely know from our GHP side of the house about provider billing issues as well. But has not – you know, the claims processing contractors. And we continue to, you know, try to provide additional information.

I mean, the fact that we're now doing just a better job at coordinating benefits because of all the reporting that's going on, is just kind of bring more light to the issues and hopefully, you know, this can be addressed sooner rather than later because – but that we'll – always to continue no matter what we do, there will still be those issues from time to time because in a lot of cases they involve human error as well. But, again, we are aware of that and we continue to reach out to the providers' community as well as to our claims processing contractors.

Barbara Wright: My understanding is that the remittance advice to the provider if it's denied because it's related like the workers' compensation and often they do get a reason code on denials. So if they know they're treating the beneficiary that's not related to that, they have the perfect reason to appeal.

John Albert: And whether they do or not, I don't know. And it depends on the provider.

(Suzanne Jordan): So we're taking the right action having them file an appeal, correct?

John Albert: Yes.

Bill Decker: Absolutely.

(Suzanne Jordan): OK, all right. Thank you. And then just a quick follow up, you had mentioned a number that if you don't get an answer from the EDI rep to call, would you mind repeating that number, I'm sorry?

John Albert: It's 1-800-999-1118. That's the general's COB call center. That's where questions should be directed related to particular coverages that are outside of the daily exchange processes and these are things that the EDI department handles.

Jeremy Farquhar: There's also a general EDI department number. So if you have a technical question there – there are a lot of situations where you may want to actually speak to the EDI department but you're not able to get something from your specific EDI rep, maybe they're out or maybe you're just having difficulty, we do have a hot line number and an EDI department that you can call as well, which is 646-458-6740, and somebody in the EDI department will be able to assist you.

So if it's questions like regarding your actual, you know, files, submissions, technical types of stuff it should be the EDI department that you call. As far as dealing with records that need to be updated like in the beneficiary, where to call, or if you already needed to update, or the determination date on a record prior to the next quarterly submission, then it will be the number that John had just (inaudible) to that type of situation.

(Suzanne Jordan): Great, that was the one I was looking for, thank you.

John Albert: And, obviously, if you need an escalation because you don't feel you got an answer or didn't like the answer you got, escalation process (inaudible).

(Suzanne Jordan): Perfect, thank you.

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

(John Brandle): Hi, guys, it's me again. Quick question, with regard to the delete threshold, what we are seeing from the EDI representative is a situation that we are submitting records with a delete/add transaction step that these deletes are still being counted towards the delete threshold, is that intended if so, why? I mean the delete/add transaction is a valid transaction step when key fields are being changed.

John Albert: But you need to explain that to us, and if that's a situation and you're changing your key fields, then we'll release that proper processing. But it is intended that the threshold catches those particular files.

Jeremy Farquhar: Or exactly that reason.

John Albert: Yes, because we are not necessarily sure what the scenario is. If we get a valid explanation, we're happy to release the file, but that we are expecting those to trigger in those scenarios.

(John Brandle): Do you need those on a record-by-record basis or is it sufficient to say that you can show that, say for instance, that you've got pairings of records that are definitively delete/add transactions. Is just sufficient to say that these represent key field changes? Or do you have to go into a detailed explanation in the future record?

John Albert: We don't want an explanation for each record. We know that would be a bit much and more than most folks could probably handle if you're dealing with a large file. But, what we would like is basically a general idea. OK, say the bulk of these records were submitted because we needed to change – we erroneously submitted an ORM indicator of Y for all of these records and it should have been N. It wasn't actually ORM, but we have TPAC to report, too, so we want to need to add it back as the TPAC only or something of that nature.

You now, it doesn't have to be as specific example for every record, but just kind of a – this is the basic scenario that we're dealing with, with this file. This is why you see so many deletes. And as long as it's a fairly reasonable explanation, then we will release that for you, but we need to verify that before we do so.

(John Brandle): OK, and just one comment. I know in the event table of the user guide version 3.2, that there is a scenario listed there that shows a worker's compensation claim where, you know, you have ORM and TPAC that are being reported in the same quarter.

And you have, of course, ICD-9 codes that are related to the conditions of which you are assuming ORM, but there may be ICD-9s related to the TPAC which are conditions of which are (not) being accepted, that are being released pursuant to the settlement.

Now most of the RREs that you're going to encounter out there have claims management system that only handle one record per claim. So what do you recommend in terms of how this should be reported?

I mean, you know, obviously, it's not going to be a situation where they're going to be able to split the record and report, you know, split the claim and report two separate records for the same claim. I mean that's going to be a difficult situation. I mean most are RREs, most TPAs, most claims administrators, they're claims management systems don't have the capability of splitting a claim into two separate records to report two separate sets of ICD-9 codes.

I mean, from the COBC computer base training that we have done, basically, you know, they've stated that the ICD-9 codes regarding the ORM are probably the most important, especially the diagnosis codes versus the e-codes, but, you know, just to be mindful to the effect that, you know, most claims management systems don't have the ability to bifurcate a claim market into two separate submitted records within the same quarter. It's just a comment, but if you have any recommendations as to how to report those, all yours.

Bill Decker: Thank you for your comment. We probably aren't going to be able to give you any recommendation for how to report that in the next half hour. But we understand where you're coming from on this, and we'll take a look at it. That's COBC folks on our call, too, as you very well know. I'm sure that we'll be talking about it in a couple of minutes.

(John Brandle): I could think that it was just to recommend that, you know, that they report the ORM first and that set of TPAC instead of ICD-9s that go with the ORM, but when they turn around and then report the TPAC to report a set of ICD-9s that go along with the TPAC in the subsequent quarter, but then you may run into a compliant situation where you're more than 135 days from the TPAC date.

And you know, although we don't have specifications yet as to what is considered late reporting, if it's more than 135 days in the TPAC date, that's when you throw a compliance flag. So that's what I'm assuming as late. So I'm not quite sure there, you know, if we decide to send ORM first and then follow up with TPAC after, you know, you might run into a situation where you're now late.

John Albert: And we don't want that. We don't want you to be late. We don't want you to get into a situation where you would be. Thank you for your comments. We will, certainly, be discussing them in a few minutes.

(John Brandle): I appreciate it, thank you.

Operator: Your next question comes from the line of (Shaun Belamy) from (Johns Eastern). Your line is open.

(Shaun Belamy): Yes, I had called in on the April 6 teleconference regarding the settlement of worker's compensation claims that settles all accidents past, present and future and during that call, you stated that the RRE has the obligation to report all claims for that claim regardless of the age of the other claims, even a specific loss states are mentioned in the settlement, or if they were closed or we did not have ORM as of 1/10 on the other claims.

We understood that we have to report every single claim, whether they're opened or closed, and we wanted in an opinion or to get, you know, some sort

of conversation on this because of the challenges present in getting all the information for these old claims.

You may have claims that are 10, 15 years old and yes they are settling all actions past, present and future, but, you know, in the original roll out of this program, you know, you stated that the qualified exception was that if the claim was actively closed or removed from the current claims records prior to January 1, 2010j, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to January 2010.

So we wanted a clarification on this to, you know, ensure that we are reporting all the claims we are supposed to, but also the challenge that we would have in reporting, you know, small medical-only claims with maybe – that we did not have ORM on as of 2000 – 01/01/2010.

Barbara Wright: If you're settling all these in one settlement, you are – are you saying that you're settling them all in one TPOC?

(Shaun Belamy): Well usually, the situation is you'll have one open claim and maybe the person had five or six medical-only claims or other claims that have been closed for a long time.

Barbara Wright: OK.

(Shaun Belamy): And part of that settlement says all action in past, present and future.

Barbara Wright: Yes.

(Shaun Belamy): And it's part of the standard settlement language, the way I understand it.

Barbara Wright: And my question still is, what type of settlement are you doing now, TPOC, ORM or both or what?

(Shaun Belamy): TPOC.

Barbara Wright: OK. You're doing a TPOC settlement and did we infer or imply in any way that you would be doing multiple reports or just that you would be doing one report for that TPOC?

(Shaun Belamy): The way that we interpreted the call was that we had to report that TPOC on all of their claims regardless of when the claim occurred if the language included all claims, past, present and future.

Barbara Wright: And the difficulty that causes you is identifying the ICD-9 codes or what?

(Shaun Belamy): Yes or, you know, we may have gotten claims through a data conversion or a PPA. We may not have complete information, and yes, it would be very challenging to get the ICD-9s on every single claim in many cases because we may not even have the medical records, and in some cases they may even be purged from the system.

We may have…

Barbara Wright: OK. I don't think we have a further answer for you today but you've, at least, clarified what your issues are with us.

(Shaun Belamy): Yes. It just seemed like when you started the program, you know, you were aware of the challenges and you weren't going to – you know, you limited the look back period to January 1, 2010, you know, because of these issues. We weren't going to have to go back 10 or 20 years to report ORM that was that old and in these cases, it's very similar to having to do that on claims that you just don't have complete information.

Barbara Wright: It is except that you are doing a legal settlement on that particular claim at this point by including them. So you have, in effect, re-opened or opened a record on that one way or another. I mean, we will, you know, look at this some further but it's not the same as the case, which you administratively closed five years ago, and you don't have anything to do with. You are actively doing something with it to the Workers' Comp or ensure other's advantage or you wouldn't have the language there.

(Shaun Belamy): Yes. OK. So our next action on this, you know, of course, we do want to be compliant. What should our next action be on this? Should we wait for an alert? Should we wait for a direct response? I've sent Bill Decker a couple of emails and he said to bring it up at the next call.

Bill Decker: Yes, we did.

(Shaun Belamy): Exactly.

Barbara Wright: I think you should certainly be reporting the information for all settlements, judgments, you know, all other claims for which you have information that would clearly be the minimum.

(Shaun Belamy): All right. Well, thank you very much.

Operator: Your next question comes from the line of (Ellen Itfull) from (Chubenson). Your line is open.

(Ellen Itfull): Hi. Just was wondering if there's any further thoughts on the disposition code 50?

Bill Ford: Well, I don't know if there are any further thoughts that we, you know, they do occur. There are some things that you will actually – one thing that was noted in the new user guide that was a source of disposition code 50s in the past and we talked about this a little bit earlier in the call, where those records that you'll see in SB 50. When we had situations previously where in RRE we try and update one of those locked records.

(Ellen Itfull): OK. That's a probably different situation.

Bill Ford: No, it's not. We were matching back. What I'm trying to say is that previously, we weren't giving you an SB 50 after error that comes back from the database to which we're trying to post this information but we weren't passing that back to you instead of getting you an SB 50, we were giving you a 50 disposition.

So, some of those 50 disposition codes that you're seeing could be a result of those scenarios. So, now that we're going to be passing back those SB 50s in the future, you will possibly see fewer of the 50 disposition codes as a result.

Other than that, there's not a lot further to know as far as the 50 disposition. So, in some cases, we just not had received a response back on that record

within a period of time that allowed for the processing of your claim file and we can only instruct you to go ahead and re-submit that claim again and hopefully it will process successfully on your following file.

(Ellen Itfull): OK. One of the things that – the new release of the (U) software that still going to be available October 1 for us to test with?

Bill Ford: Yes.

(Ellen Itfull): OK. That's it then. Thank you.

Bill Ford: Thanks.

Operator: Your next question comes from the line of (John Titmus) from ISO. Your line is open.

John Albert: John, are you there?

(John Titmus): Yes, I am. I'm sorry. Good afternoon. I was reviewing the latest edition of the manual and I noticed that you have a new threshold there on any NGHP no-fault insurance limit amount that exceeds $100 million, and that threshold is on a single-claim basis but yet you are rejecting the entire file. Can you comment as to the rationale behind that?

Jeremy Farquhar: I believe this was the threshold where it was determined that these were probably typographical errors, but we didn't want the $100 million et cetera to go through. Can you comment on it, Bill?

Bill Ford: No, that's exactly what it is. We decided we would so rarely get financial report of that size that it was likely to be an error and so we would reject the file, ask the RRE to recheck the factual basis of the submission and proceed from there. That's all that is really.

(John Titmus): Bill and Barbara, I understand the rejection but what's the basis for rejecting the entire file as opposed to rejecting the claim with some kind of (SPR)?

Bill Ford: There's one issue with rejecting it within (SPR) which is a technical problem which is a little tricky and I think this is part of it, (John). But if we reject

anything over $100 million with an (SPR), there's not really a successful way for the RRE to ever post that dollar amount, if it is actually a legitimate number. So, that part is – that's a piece of it, but there's not a lot that I could add to it other than that. So I think that's the reason why just an error alone was possibly avoided.

Albert John: John, what exactly is it that you find problematic with the rejection?

(John Titmus): Well, I agree that this will be, I'm sure, a typo but to have the entire file reject on the basis of a single claim to me seems, you know, a little excessive though. I just could not – I was wondering if there was any specific rationale behind it, any real reason why and I guess, as Jeremy is saying, as to difficulty in being able to reject a single claim that way may be difficult. But, I just, you know, seems like the old attitude shooting a mosquito with a howitzer, you know?

Jeremy Farquhar: Yes.

(John Titmus): All right. I thought, Jeremy, I heard you say a little bit more than that that it's a problem that in the rare case where the $100 million were actually correct. If you rejected only that file, they wouldn't be able to post that record. Yes or no?

Jeremy Farquha: Yes. If we were to actually give an (SPR) that would prevent anything of that nature from ever passing through our edits properly. So that's that tricky aspect, I mean, an actual (SPR) wouldn't work well in this situation?

Bill Ford: Right.

(John Titmus): You know, I only used that as example, it was not a solution. But there was one other item as well. We did get a file for an RRE that did hit this condition and I know it sounds like a net, but your rejection threshold there says the no-fault insurance limit is greater than $999,999. So, you know, I was questioned as to, is it more than $10 million or $100 million? Is it $100 million or what because of the system item here?

Bill Ford: If you hit $100 million, it will reject. It is actually the 99. But if – so if you actually input a dollar amount of $100 million or greater than $100 million, that is when the threshold will trigger.

(John Titmus): OK. And again you're rejecting – the manual says exceeds, so...

Jeremy Farquhar: I'll fix that.

(John Titmus): OK. That's it. Thanks.

Operator: Your next question comes from the line of Gary Jones from State Farm Insurance. Your line is open.

(Cheryl Devine): Good afternoon. This is actually (Cheryl Devine) from State Farm Insurance. I'm not certain that I heard you correctly a little bit ago, Barbara, but wondered if you might re-visit a statement you made that if you take one release that includes property damage with TPOC that you would report the entire amount?

Barbara Wright: If you got a single settlement, a single release and it's releasing medicals, you need to report the entire amount.

(Cheryl Devine): OK. So if that includes a property damage amount, you would include that property damage amount?

Barbara Wright: Remember that there will be situations that if depending on how the policies written or depending on anything else, there can be a defense presented to a demand. So there are going to be some issues where some things reported that we may or may not have a recovery claim against the entire amount. There just have to be some issues that are resolved more on the back end.

(Cheryl Devine): OK. So, at that point, it would be up to the Medicare beneficiary or them and their attorney to...

Barbara Wright: And it would depend really on how the, you know, in some cases, I can see circumstances where we might not have a recovery claim against the whole amount. I can see ones where we would and so there's no way that we can parse it that narrowly on the front end in terms of reporting.

(Cheryl Devine): OK. Thank you very much.

Operator: Your next question comes from the line of (Scott Wynn) from New York State Workers. Your line is open.

(Scott Wynn): Good afternoon. My question is concerning the blackout period of 22nd to the 28th this month, how you're not going to process claim input files. So will the claim response file that we give back include the TIN response file that would be occurring next quarter even if we submit it before the end of this month?

Jeremy Farquhar: Yes, it would. If you submit it during the blackout period, we would actually not begin processing your file until October and as a result, we would be generating a TIN response file along with that submission.

(Scott Wynn): Is this the first time that we are being informed of this blackout period? I missed that in the user guide.

Jeremy Farquhar: In the user guide and I believe it's in the alert as well. Yes.

(Scott Wynn): OK. If it is somehow possible for me to put our file in tonight, would that be acceptable?

Bill Ford: It may not load until…

Jeremy Farquhar: Five PM.

Bill Ford: Yes, if you can get it before 6 PM it may, but it's cutting it close. It should load with the nightly batch, but to be honest, I'd have to double check because sometimes with our batch, the files won't actually – the batch will begin to run but it won't actually, you know, the file might not go up until the middle of the evening, and if were in the early hours of tomorrow, which is the 22nd, the first day of the blackout, it might be placed on hold. So, it's borderline that you could get under the wire, but you might be too late at this point in time. You could give it a shot if you wanted to try, but I don't know that I could guarantee that it won't be put on hold.

(Scott Wynn): OK. Thank you.

Operator: Your next question comes from the line of (Tricia Lee) from Walt Disney World. Your line is open.

(Tricia Lee): Hi. Good afternoon. I had a case where the file was settled on May of 2009 and at the time of the settlement, a Medicare set aside estimate was included in the paperwork and then after the settlement, the case went to CMS for approval.

We didn't get the final approval until 2010 and Medicare had suggested the change in the amount and then in October 2010, we issued the additional amount requested by CMS. The question is, since the case was actually settled and closed in 2009, we only re-opened to issue the additional payment and then we re-closed the claim. Is this claim reportable?

Bill Ford: How much was the additional amount?

(Tricia Lee): I do not know. It was a significant amount. Unfortunately, they did not provide me with that information.

Jeremy Farquhar: I think, we would like you to contact your EDI rep with more information on that particular case, so we can look at what's happened here. If it's already been resolved, then...

(Tricia Lee): OK.

Jeremy Farquhar: ...there's nothing further that we would want to do with it.

(Tricia Lee): All right. Thank you very much.

Bill Ford: Jeremy, if whoever she contacts can send the information to John and I.

Jeremy Farquha: OK, we'll do and we'll pass it on.

Operator: Your next question comes from the line of (Garry Correal). Would you please state your organization, please? Your line is open.

(Garry Correal): Hi, this is (Garry Correal), from the Louisiana Insurance Guarantee Association. My question concerns liability reporting and in particular toxic tort and asbestos-related claims. Barbara, we've had several telephone conferences concerning the parameters such as the 1251980 reporting date or exposure date.

However, I believe the last telephone conference we had was in April. And at that point, nothing was finalized. Can you tell me if we are going to have additional telephone conferences and when the reporting criteria should be finalized? What the upcoming liability reporting dates?

John Albert: You may ask tort.

Barbara Wright: You mixed a lot of issues in there. What I can tell you is that, remember that the workgroup started originally in part to deal with fields 58 through 62 which were tied to so-called mass tort issues. The 12580 issue was a related issue. In terms of 12580, CMS expects to be issuing some guidance shortly, fairly shortly, you know, I don't have an exact date.

In terms of other issues such as field 58 through 62, obviously, before we would activate those fields, we would have to have further discussions. And we've had discussions like group one, group two, et cetera. But in terms of the 12580, expect something soon.

(Garry Correal): Thank you.

Operator: Your next question comes from the line (Elisa Riley). Your line is open.

(Elisa Riley): Hi. I just had a question about the caller who referred to disposition code 51, where the entered worker or entered party has no Part A benefits. If we query the person – the only reason that we're sending the claim input file to begin with is because we query the person and Medicare told us that they were a Medicare beneficiary.

And then we send in the claim input file and then we get the disposition code 51 that basically says they're not a Medicare beneficiary. So, I think the suggestion was to keep queering. I mean, my assumption is if I keep

queering, I'm still going to get a positive response from you all every time. So, you're really saying to keep sending that claim input file over and over each quarter?

Bill Ford: I think what happened in your situation most likely, is that you had query this individual possibly back in 2010.

(Lisa Riley): OK.

Bill Ford: Earlier in 2010, we actually – the problem basically was – as a result of a change that was made late in 2010. So, if you had queried them early on in the process, you could have gotten an 01, you could have gotten a match. But then the process, we made a change to our process and this was an oversight with – I think there was confusion based on GHP and the non-GHP Part A benefits. For GHP reporting, we do not coordinate benefits if there is no Part A but a non-GHP, we should be taking in information if there's B only.

(Lisa Riley): OK.

Bill Ford: Anyhow, there's a change made late in 2010. Now if you were to query that individual anew, you should actually receive a 51 at this point in time, it should be in sync. And we apologize for the confusion that that has caused. We understand that is – that a lot of people have the same question and it is confusing.

However, if you query them now, you should receive the 51 at this point in time. And once you actually received an 01 again, you'll know that it's the time that you can actually send that claim again on your claim input file. And we should be capable of actually posting your data at that point in time.

(Lisa Riley): OK. So, technically, I could just do it quickly with the beneficiary look up?

Bill Ford: Yes.

(Lisa Riley): OK. Right, thank you. That's it. Thank you.

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

(Lisa Web): Thank you. This is (Lisa Web) from the State Farm Insurance. Related to reporting – accurately reporting ICD-9 codes, at Page 103 of the user guide, note a special exception regarding reporting termination of ORM. Is there perhaps any thought being given to allowing an insurer to report some similar sort of closure of a particular injury on a claim so, that when, for example, in this example, the minor flesh won't heal, the insurer can notify that that ICD-9 code is closed while it is discontinuing to accept ORM on other reporting codes.

John Albert: Are you asking specifically if we have some or are considering having some methodology in place? Where we can take in a report from an insurer or RRE that a one component of a larger claim is no longer active based on the components identification to an ICD-9 code?

(Lisa Web): Yes, say for example, somebody has a minor flesh wound on the ankle that required a few stitches while they're being treated for a head injury. And a minor flesh wound on the ankle, the few stitches that healed and there's no further treatment for that ankle injury.

Is there any consideration being given to permit an RRE to report that there is no further treatment being considered for the ankle injury, while they're continuing to take responsibility for the primary injury, the closed head injury?

Bill Ford: OK hang on just a second, please. We're going to go offline just for a moment.

(Lisa Web): Thank you.

Barbara Wright: I believe that Pat Ambrose in prior calls had said, we may not be doing it in exactly the structured way that you're talking about but it will tell us XYZ. But I believe that Pat Ambrose has said in prior calls that you may submit an update to show – to in fact remove the code that's no longer being covered under ORM and is there is some reason that wouldn't take care of your concern.

(Lisa Web): That would take care of it. I guess, I didn't really understand that but I do now. Thank you.

Barbara Wright: And then we can go back and double check with her but I believe on, you know, prior calls that that what she had said should be done. Now, you have to have a legitimate basis for terminating ORM for that particular thing. The same as you would for anything else. But if you do, then remove that code in an updated report.

Jeremy, is there any reason that that could not be done?

Jeremy Farquha: As long as that's OK with CMS, that would be technically feasible.

Barbara Wright: OK.

(Lisa Web): That would work. Thank you very much. Appreciate your time.

John Albert: Yes, we have time for one more question.

Operator: Your last question comes from the line of (Jason Pap) from Publics. Your line is open.

(Jason Pap): Yes, I was just wondering, if we send the query file and you send it back a yes because you said that you may know, like a month in advance this persons going to become Medicare. So, you give us a yes even though it's kind of a future event. So, if that individual were to die before that date rolled around, if I queried again, will I get a no?

Bill Ford: I mean, there are some, you know, lag times in terms of removing beneficiaries in a data, that – things like that. I mean, that information – the data that information closed through social security administration to us. It's possible that – it could be both ways depending on how fast the information is received by CMS.

Jeremy Farquhar: But depending into a large realm, why it is we believe that individual is about to become a beneficiary. And we don't have much control over that frankly. And so, probably, we can't give you a definitive answer to your question. It does seem from one perspective logical and from another perspective illogical

that we would carry someone who is (inaudible) of beneficiary if they were never officially a beneficiary. But quite frankly, that's not probably going to be a call that we can make on a case-by-case basis.

Barbara Wright: Social Security makes the entitled decisions in general. And just from a practical standpoint, when someone dies, he's already a beneficiary. Forget about they're not yet a beneficiary. There are instances where the family doesn't report that for months.

And so, Social Security doesn't know about it, doesn't put through the process. We don't get it and they don't get it. In fact, they continue to pay and then ultimately end up with an over payment.

So, you know, we have no control over how fast – we don't have any interface with state death records or anything else like that that lets us get that information. That's probably most often reported by the family themselves.

(Jason Pap): So, are you saying that potentially then, if I get a yes back for a future situation and that never takes place, then potentially I may never – that may never get corrected, I may always get a yes for someone that never actually became Medicare?

Jeremy Farquhar: No, it would eventually be corrected. We're just saying we don't know the timeframe…

(Jason Pap): Timeframe, OK.

Jeremy Farquhar: …on a case-by-case basis. That's all.

Barbara Wright: And if by the time you reported there were no – you know, they had never become a beneficiary, then taking care off then you get a reject.

(Jason Pap): Right and that's what I – that's what concerns me because we would get a yes in the query, a no in the claim. And we would really had no way of squaring that away because we wouldn't understand if we send you proper data for someone you already told us was a yes and now we're getting a rejection.

Barbara Wright: If the person died within a – near the beginning of your claim, that is most likely that your – you would be notified of that, so you could be making the check out appropriately or dealing with any settlements there. So, you know, it should be a somewhat limited issue.

Jeremy Farquhar: I guess, the basic issue is that, you know, on a very unusual circumstance like this, but that's where you would want to reach out to your EDI department for further assistance. Because I mean, yes, there are – we get – we sometimes get misinformation or it's delayed or wouldn't out from Social Security Administration on because the data has to flow through them to us and, you know, there are some time lags for them, all kinds or either, so.

Bill Ford: I just can't tell you what on a case-to-case basis what you probably would want to know. Unfortunately, also we're out of time, John.

(Jason Pap): Thanks.

John Albert: Sure. I'd like to thank everyone, again, for their participation. This was a great call. I'm glad that we're able to hopefully get a lot of information out there. Please, again, stay tuned to the Section 111 website for a future notification of calls. Again I mentioned earlier, there will be a policy call in late October.

Most likely, that data is forthcoming, as well as there'd be future calls in November, December. Also, pay attention to the website for any additional learns to come up concerning the end of the year.

Operator, if you - after you cut everyone loose, could you please stay on the line?

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

END