TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: September 22, 2010

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 22, 2010
12:00 p.m. CT

Operator: Good afternoon, ladies and gentlemen. My name is (Lorie) and I will be your conference operator today.

At this time, I would like to welcome everyone to the MMSEA Section (11) conference call.

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

John Albert, you may begin your conference.

John Albert: Thank you, operator, and good morning or good afternoon, depending on where you're calling from.

Just for the record again, this is the Non-Group Health Plan or Workers' Comp Liability No-Fault Insurer Section 111 teleconference. This conference is designed to combine both technical as well as policy question.

For the time being, we're only planning on having one call per month for the rest of the year that will combine both technical and policy questions whereas before we were having two calls. But as we've gone forward, the questions have whittled down to fewer or more of the kind of the same subjects. If we determine in the future that we need more calls, we'll of course continue to host – we'll expand that again and especially after the January go-live date. But for now, we're going to continue which is one call per month for the balance of the year.

Just – I need to of course read the normal disclaimer. I read it in every one of these. And that is while we try to state accurately everything that is, you know, that doesn't contradict the User Guides or other materials, there may be instances where we do contradict the written materials that are on the Section 111 Web site. If we do, the guidance again through the Section 111 Web site always takes precedent over anything we say on this call. So please keep that in mind.

We'll continue as we do with most of these calls. Pat Ambrose will go over some information she has to present, followed by Barbara Wright who has a short announcement regarding the Mass Tort issue. And then we will continue on to question-and-answer.

I'll remind everyone as I do on all these calls that please limit your question to one and one follow-up so that other people that are in the queue can get their chance at the microphone, so to speak; just rejoin the queue if you have more questions.

Other than that, I'll turn it over to Pat and we'll get started.

Pat Ambrose: Thanks, John.

First, recent postings on the CMS Mandatory Insurer Reporting Web site at www.cms.gov/mandatoryInsRep/, we have posted some new Medicare Secondary Payer, or MSP, course curricula on the CBT page, which provides general information regarding MSP. It's not specific to Section 111, but you might find it helpful as background material related to your Section 111 reporting. So again, that's a new MSP course curriculum on the CBT page.

We've also posted a new alert on the NGHP Alert page for Direct Data Entry or DDE. That alert is dated September 16th 2010. And also note that recent town hall transcripts have been posted on the NGHP page including the transcript from August 25th 2010.

On the Section 111 COB Secure Web site at www.section111.cms.hhs.gov, we will as of October 18th 2010 post the new error code; the Excel and text file error code files that are based on version 3.1 of the User Guide.

Currently, the error code files that are out there correspond to version 3.0. So those will be replaced by October 18th 2010 with error codes related to your NGHP reporting and the corresponding description of that error code as of October 18th.

Remember that you go to again the COB Secure Web site at section111.cms.hhs.gov and these materials can be found under the Reference Materials menu option on the log-in page.

Also remember, on that same page under the Reference Materials, there is test beneficiary data available for download. It includes Medicare coverage start and end dates for the test Medicare beneficiaries, so that you can set up appropriate test conditions for all the disposition codes including disposition 03.

Now some announcements related to Direct Data Entry, or DDE, a new DDE, using the Section 111 COB Secure Web site, CBT is available. This provides a high level overview of DDE and who should consider using it. There are more CBTs in development and will be made available shortly. So if you're currently registered for the Non-GHP or NHGP CBTs, you should have already received a notification of this new CBT that's available. And you'll receive notifications for the subsequent ones. And of course on that CBT page of the Web site, instructions are provided as to how to register for the Computer-Based Training or CBT.

A complete DDE User Guide and Help pages will be made available with the application in January. Please review the information in the DDE Alert that I mentioned previously dated September 16 and the information in the User Guide.

You may switch to Direct Data Entry, or DDE, or select it during registration in the Account Setup step starting October 4th 2010. And then you may start submitting claim information using Direct Data Entry as of January 3rd 2011.

If you originally indicated more than 500 claims per year during your Account Setup step during registration, you will not be able to select DDE. So please

contact your EDI representatives for assistance or the main EDI department number at 646-458-6740.

To prepare for Direct Data Entry reporting, since all the same fields will be required as for file submission, please review the requirements in the User Guide and the field descriptions in the file layout found in the appendices. Essentially, the same rules apply. But edits will be received as data is being entered rather than after submission. You will be prompted to correct data as you enter the claim information that you're using Direct Data Entry.

Remember that all the reporting requirements in the User Guide apply to DDE with the exception of things that are obviously specifically related to a physical file submission. So the reporting thresholds apply to DDE. The requirements related to who must report or who is the RRE and what claims are reportable all apply to the Direct Data Entry option.

Also remember that every transaction, including adding the claim report, updating a claim previously reported and deleting a claim previously reported count towards the 500 limit. So if you are close to believing that you have 500 claims to report under Section 111, then the Direct Data Entry option is probably not for you.

The Direct Data Entry application will include a counter. So as you submit adds, updates and deletes through that option, you will see that counter decrease or increase as the case may be. And you'll know how many claim transactions you may still submit under Direct Data Entry. If you're getting close to that option, you need to contact – or close to that limit, you need to contact your EDI representative. Again, more information will follow shortly in the form of Computer-Based Training modules that will take you step-by-step through those Direct Data options.

Now, so for some other announcements related to the processing of production claim input file, some RREs have begun production reporting. And we found some issues that are being addressed. There was a system issue where the CT02 error was returned on Tax Identification Numbers, or TIN,

that could not be validated as IRS-assigned TINs instead of returning the compliance flags 02.

So again, we had a system issue where we were returning an error for the TIN rather than returning the compliance flags 2. This might have also resulted in other TIN-related errors associated with the TIN name and address submitted on your TIN reference file. The correction was implemented last night on September 21st 2010.

If on a previous production file you receive a CT02 back on your response file record, check that the TIN you submitted was valid. Now and in the future, when you receive a TIN compliance flags, but you believe the TIN was actually valid, contact your EDI representative. He or she can update the system after you provide adequate documentation of the TIN's validity so you won't receive this compliance flag in the future.

See Section 11.3 in the User Guide for more information.

There was a system issue where error code FP55 was returned on a production response file. This error code is undocumented and in fact should not have been returned. Instead, the record should have been returned with the 03 disposition code and not an error at all.

We are fixing this. I'm not exactly sure of the date for implementation of this fix. But it should be implemented by the end of October 2010. In the meantime, if you get the FP55 or any error that is not documented, report it to your EDI representative and continue to resubmit the record in your subsequent file submission until it processes properly or you were told otherwise.

We are investigation situations where disposition code 50 has been returned on some response record in the production response file. While this is not a large number of records that were returned with disposition code 50, it is more than we expected. And we've been researching this issue and have identified a circumstance where this is occurring. But until I know the final resolution, we will hold off on getting into more specifics at this time. It is not a problem with the COB system nor does it reflect an inability to process files timely. It

really has more to do with how the system was coded to handle certain situations, and we might need to make a change to that.

In the meantime, follow the documented instructions for disposition code 50 in the User Guide and just resend the records. You do not run any risk of non-compliance and we will most certainly implement changes for this by January 2011. So stay tuned for more information on that.

And I do appreciate those that brought the issue to our attention. And I would encourage you to continue to do so. If you're submitting production files and even if you see something on a test file that you don't understand, bring this to the attention of your EDI representative and feel free to send an e-mail to the Section 111 Resource mailbox.

We are developing a new Computer-Based Training module, or CBT, on ICD9 diagnosis codes to address questions submitted regarding the use of ICD9 codes, how to select or derive them, what codes we might use in particular situations and so on. If you are signed up for the CBTs, you will get an e-mail alert when this new course is available.

We are still looking at the requirements for ICD10 codes. As noted in the User Guide, at some point, we will convert to the use of ICD9 diagnosis codes from ICD – I mean ICD10 from ICD9. But note this conversion will not be made until 2013. More on ICD codes is later in the – I'll provide more information later in this presentation.

We are working on an alert that will provide a default code that RREs can use in lieu of an ICD9 diagnosis code under very limited circumstances. We have a settlement, judgment, award or other payment released as medicals, but there is no actual injury. We've talked about these situations on previous teleconferences. They include possibly a settlement related to wrongful employment termination or loss of consortium, those types of examples.

This settlement has the effect of releasing medicals, but the actual claimant or injured party has no actual physical injury and has not claimed an actual physical injury. And so RREs have asked what they should report in the alleged cause and the diagnosis code fields. And as I had mentioned, we are

coming up with the default code that can be used in very limited circumstances. We expect that to be implemented in January 2011, and an alert will be posted regarding instructions.

This next announcement should be good news for many RREs. We are making changes to accept an ORM termination date less than 30 days, greater than the date of incident. A modification will be made to the CJ06 edit for this. And an alert will be published and the User Guide will be updated. This change should be implemented on or about November 1st 2011.

So again, we're making changes to accept ORM termination dates that are less than 30 days from the date of incident reported on the claim report. Their – the current User Guide provides instructions to default the ORM termination date in cases where it is actually less than 30 days. And you will no longer need to do that once this change has gone into place.

As always, please submit your specific technical questions to your EDI representative first. Specific technical issues related to your file submission can't be addressed effectively if they're sent to the CMS Resource mailbox or elsewhere. You will get a much faster response to your specific technical issues if you contact your EDI representative and then follow the escalation procedures in section 18.2 of the User Guide if necessary.

With that said, I will attempt to answer some of the technical questions now that have been submitted since the last call to the CMS Section 111 Resource e-mail box.

The first question had to do with where on the 271 do we put the disposition code. So this question is referring to the query files and the X12 270/271 file format in which the query is returned. The 271 transaction set in particular.

First off, please take a look at the Companion Guide document that is posted on NGHP page of the Section 111 Mandatory Insurer Reporting Web site. And also, I encourage you to submit questions like this to your EDI representative. But with that said, if you look in the Companion Guide, down under segment ID AAA under the 271 and Loop ID 2100c, you will see what is returned on the 271 if there is or is not a match.

This segment AAA is not included if a match was found. If segment AAA is included, then that means that you – we were unable to match the information supplied on your query record to a Medicare beneficiary, and you will see then the corresponding Valid Request Indicator reject reason code and follow-up action code fields. But basically it's – if AAA is not included, a match was found. If it is included, we were not able to match the information to a Medicare beneficiary.

I had another question submitted related to incomplete information and whether a – if an RRE knows that their – they do not have enough information to submit a valid claim report, should they submit it anyway or wait until they're able to get complete information?

So in the case of having a claim report with incomplete information that you know will fail the edits, wait to report that until you have adequate information in order to pass the edits. Claim reports rejected for errors and returned with an FP disposition code do not get saved and will not help justify your compliance. So you really need to get that information and submit it prior to reporting it.

John Albert: I mean, the key thing is, again, if you're having trouble getting information, in particular claim report to, you know, document what you're doing and have that available. But as Pat said, incomplete reports do nothing but gum up the system essentially for everybody involved and will do nothing to demonstrate compliance or lack of compliance.

So again, just keep records of what you're doing. We're interested in complete and accurate data, not incomplete data.

Pat Ambrose: OK. Next I have some questions that are related to reporting of Ongoing Responsibility for Medicals or ORMs.

The first question asked how long an RRE needs to continue to query an injured party who is not yet a Medicare beneficiary. And you may either use the query option to check on the Medicare status of the injured party or submit

the claim report. In either case, they would be returned with the disposition code of 50 – 51 rather.

So if ORM still exists and the injured party becomes a Medicare beneficiary at a later date, the claim must be reported at that time. So if, for example, let's say a claim in a state where Workers' Compensation regulations require the RRE to retain lifetime medicals, you must continue to query that individual or report that individual on your claim input file until ORM actually terminates or the individual becomes a Medicare beneficiary and you submit the claim report.

I encourage you to – and for more information related to how long you should monitor the status of an injured party who is not yet a Medicare beneficiary, take a look at the description of the 51 disposition code in section 12.1 of the User Guide. And again, you will continue to query this injured party until ORM is indeed terminated. There is also other information in the User Guide related to when an RRE may consider ORMs terminated. Take a look at sections 11.8 and 11.9.

Another question had to do with ORM and queries related to a liability claim. And in particular, this individual was asking – saying that their question particularly relates to requirements – the requirements for liability insurers, stating that, for example, they have a claimant that is 59 years old and is not currently Medicare eligible or not yet a Medicare beneficiary, but the liability insurer's settlement necessarily includes the compensation for long-term medical injuries. I won't read the whole question, but again, I refer you to the information I gave for the last question.

And this also depends on whether the RRE actually has Ongoing Responsibility for Medicals. If the claim is settled and closed with a TPOC, or a Total Payment Obligation to the Claimant, then no further monitoring is actually necessary. If the RRE has ORM or pays the subsequent TPOCs and continued monitoring, the Medicare status of the injured party is required.

Let's see. Another question was submitted asking if all no-fault insurance is to be reported as Ongoing Responsibility for Medical. I can't give absolute

answer to this. But usually, no-fault is considered ORM. But it's possible that a one-time lump sum settlement, judgment, award or other payment, setting the definition of a T-P-O-C or TPOC could be made on a no-fault claim and constitute a TPOC which must be reported.

But please review the definitions of ORM and TPOC in the User Guide. In particular, section two defines both terms and section 11.8, and the field descriptions in the appendices.

Do not confuse the case where a single check is insured to an injured party for his injuries since his medical expenses reached or exceeded the no-fault limit within one day or some short period of time, don't confuse that with an actual TPOC. The RRE might have – only had ORMs for a couple of days and issued a reimbursement for all medicals in one check, but that's still considered ORM and not a TPOC. So I hope you find some of that information helpful.

Now some questions related to ICD9 and ICD10 diagnosis codes. The first question is asking about the ICD9 diagnosis codes in version 28 on the CS Web site. Take a look at section 11.2.5 of the User Guide where we described the requirements related to ICD9 diagnosis code reporting and the page on the CMS Web site where you can find list of valid – of what are considered valid ICD9 codes. CMS puts out a new version of valid ICD9 codes each year. These were originally intended for things like submitting – providers submitting Medicare or claims to Medicare for reimbursement. But we're using those same list related to section 111 reporting, and the specific requirements again for that are in section 11.2.5.

This question asked whether – since version 28 is out on the CMS Web site now, is it subject to change prior to January 2011? And it is not. Version 28 was effective within CMS Medicare for claim submission by providers, submitting claims to Medicare as October 2010. However, as you'll see in the Section 111 User Guide in section 11.2.5, the COB system that processes Section 111 files will not implement version 28 until our release in January which is January 3rd 2011.

Each year, we will take the latest version off the CMS Web site and implement it in the COB Section 111 system in our January release. Again, the versions on the CMS Web site are always effective in October but then implemented in our system for Section 111 reporting the following January.

The system retains the two prior versions and drops the third prior or the oldest version each year. So this is done so that you have more than adequate time to implement the new version in your system.

I would expect that as you update your system for the new versions that you would only use the most recent version. So once you implement the file reflective of version 28, you don't really need to refer to versions 27 and 26 any longer. But you may if you choose to do so. And that is what we do in the COB system.

The question also went on to ask about the excluded codes in Appendix H. Appendix H has not been changed since it was originally posted in version three of the User Guide in February 2010. So the Appendix H is exactly the same in version 3.1 that was posted in July of 2010 as it was in the prior version. There is no plan to add further exclusions or modify this exclusion list in the foreseeable future. Changes to Appendix H, if there ever are any, will be coordinated with implementing the new ICD9 version files in January.

Another question was asked as to whether an RRE could use version – the ICD9 diagnosis codes listed in version 28 prior to January 2011. You can, but you do runt he risk that there is a new code on version 28 that has not yet implemented for Section 111 reporting. So I would recommend that you'd stay in synch with the COBC and submit or implement version 28 in January. There's usually – I can't say as to how many differences there usually are between the ICD9 versions. But again, there's nothing to say that you can't implement version 28 sooner. But you do run the risk of certain codes, if they're new, being rejected.

The next question asked, what does the RRE or reporting agents do if they were – if they are unable to acquire the E code, E as in Edward, code from the treating provider? Is there a list of E codes available?

I refer you to the ICD9 files that we have been discussing that are listed, again, in section 11.2.5. They contain the E codes that are considered valid for field 15, the alleged cause of illness, injury, incident. And again, review the requirements on 11.2.5.

You may derive or determine your own E codes. You do not have to get the E code from a treating provider.

Other specific questions related to what ICD9 codes, to submit under circumstances, are being researched. And we're trying to include those in the ICD9 CBT that I mentioned earlier.

The next question went on to ask about the conversion – eventual conversion to ICD10 diagnosis codes. The information that you'll see on the CMS Web site right now concerning ICD10 codes has more to do with submitting medical and hospital claims to Medicare for payment and reimbursement. There are no specific Section 111 reporting requirements for ICD10 published yet. We have not determined exactly what the ICD10 requirements will be for Section 111. We certainly are considering the issues that RREs may be faced with making this conversion.

Some of the things that we're considering include performing or providing a crosswalk from ICD9 to ICD10 codes. We're also considering allowing ICD9 codes to be submitted on some claim report and ICD10 codes on others. We're not – I can say for sure that we're not going to allow mixing of ICD9 and ICD10 codes on the same claim record though. But we'd like to allow for updates to older claims to be submitted with their old ICD9 codes if possible or provide some sort of crosswalk.

Our ICD9 versus 10 requirements will most likely be based on when the file is submitted and when the claims within it were originally submitted for Section 111, not when the actual incident related to the claim you're reporting occurs. And again, the instructions out on the CMS Web site for ICD9 are talking about days of service related to claims that are submitted to Medicare. And that is entirely different to what we will do regarding the dates of incidents that you report on your claims. We will most likely implement requirements

that are based on when you actually are submitting your claim report, not the date of incident related to that claim report.

So all that said, these requirements have not been defined or determined yet. But please, keep sending your suggestions and scenarios for us to take into consideration as we develop a requirement. We've gotten some excellent feedback so far, some very detailed questions related to certain scenarios. And we are saving those and considering those as we develop the requirements for ICD10.

I can't say when those requirements will be published but know it's a ways off since the implementation is not until 2013. So it really hasn't written – risen to the top of the pile yet.

Another question asked about a claim that an RRE wants to settle for $500. And the claimant or injured party indicates that they are a Medicare beneficiary. And this individual is asking whether this claim would be reportable related to the mandate that reporting starts in January 2011 and so on.

So for this question, first, review the reporting requirements in the User Guide in section 11.10.2 and really all the reporting requirements in the User Guide. The reporting date for Ongoing Responsibility for Medicals, or ORM, is January 1st 2010 and subsequent. And for TPOC, it is October 1st 2010 and subsequent.

Required reporting commences January 1st 2011, although production files would be accepted prior to that. Required reporting is to be done during your assigned file submission time frame and retroactive reporting to those dates I just mentioned is required.

After you've reviewed that, next review the reporting thresholds in section 11.4. Certain thresholds apply according to the TPOC date of the claim. So again, review the requirements in the User Guide in 11.10.2 and the thresholds in 11.4.

Let's see. The next question had to do with Workers' Compensation claims that have had settlements and have previously gone through state commissions and all had a process of federal reporting long before Section 111 reporting, et cetera. So basically, this RRE is indicating that they've already reported this Worker's Compensation claim under some other reporting requirements. But note that no other reporting obligation has any bearing on whether you are to report under Section 111 or not.

So as far as ORM goes, if the state mandates lifetime medicals, then you need to report further requirements in the User Guide. I think this is covered adequately. But if not, please get on line and ask a question about it.

The reporting of ORM does not depend on whether the RRE is currently making payments on the claim and is currently making payments after January 1st 2010. That has no bearing on whether the claim is reportable. Claims could be erroneously going to Medicare instead of the RRE. And the whole point of Section 111 reporting is to stop those and redirect those claims to the RRE or the Workers' Compensation instead.

So please see sections 11.8 and 11.9 for more information on reporting ORM and for explicit exceptions to reporting of ORM. Again, that's section 11.8 and 11.9.

And that's all I have. So I will turn it over to Barbara Wright.

Barbara Wright: We need to go offline.

John Albert: Yes. Hold on, everyone.

Barbara Wright: OK, we're back. One other question on the list that Pat had was there was a question about a situation where someone is engaged in litigation or a claim, and they have a TPOC before they become entitled to Medicare. And then ORM is also established. And the question was whether or not they have to report that TPOC once they become a beneficiary.

And our answer is no, they don't have to report the TPOC that existed before they were a beneficiary. They do have to report the ORM. But you do need to separate reporting responsibility from any MSP obligations that you have.

Beneficiaries, if they have a large amount settlement that takes into account future medicals; they are expected to exhaust that settlement appropriately before Medicare is billed.

And that's all the answer we have on that one. The short announcement I had about the Mass Tort workgroup is the call is going to be next Wednesday, the 29th. Everyone who's been submitting request for that workgroup, you should receive an e-mail no later than Friday. You should also be receiving some documentation that we'll be discussing no later than Monday.

John Albert: I told you.

Bill Decker also has something.

Bill Decker: Yes, I do. Good day, everybody. My name is Bill Decker and I'm here with CMS also.

We did have a couple of questions that came up on –and the questions that came to us in the – through the mailbox that I want to make some comments on.

One was a question from an attorney asking about Social Security Numbers. Do clients who are not Medicare beneficiaries need to provide liability insurance carriers with their SSN? And the answer is that you need to have reporting on this Section 111 made for people who are Medicare beneficiaries. We need to know if someone is in Medicare beneficiary or not. We can find that out by checking an individual Social Security Number and some other personal information against our database to find out if the person was a beneficiary.

But that is the point. The point is not that we need to collect Social Security Numbers or that we are requiring anyone else to collect Social Security Numbers. We need to establish and you need to establish when someone is a

Medicare beneficiary because that is what we need to have reports coming to us as well and about.

So that's the only way we can actually answer that question. We can't tell you what to do about collecting Medicare – who have Social Security Numbers. We can't tell you that you have to tell us about Medicare beneficiaries. And if that involves you collecting certain information from folks, that's what we need to do.

The other question that I'm going to address is one where a party asked, would an insurer of student insurance policies be an RRE subject to mandatory reporting, et cetera, et cetera, et cetera? Again, you need to tell us about Medicare beneficiaries and the coverages that Medicare beneficiaries have and any activity that involves Medicare beneficiaries.

If a student that is covered by an insurance policy that you are providing is a Medicare beneficiary, then if that student has a reportable event, you need to tell us about that. It is possible that a young person can be a Medicare beneficiary. There are…

John Albert: Or that a student can be an old person, you know.

Bill Decker: That's right. Or a student can be an older person.

John Albert: Right.

Bill Decker: (Thank you very much) John.

But that's the point. The point is you need to tell us about Medicare beneficiary.

Barbara Wright: If the question was more focused on the concept of a student policy, if it's a student health policy, then normally that would – there'd be no reason why that would be reportable. If by student policy, they meant a situation where a student was in an accident and university or wherever they were covered that accident, then you're into the realm of no-fault or liability insurance.

Bill Decker: And that's I had. And thank you, Barbara and John.

John Albert: All right. And I had – this is – before we get into Q&A, I just had one thing also. And that is I just wanted to thank all of those RREs out there who have voluntarily begun reporting data to us because as you could hear from some of Pat's Q&As, I mean, you know, we can test forever, but sometimes some issues come up during production. And we appreciate those folks out there who are reporting and giving us live data because, again, that's allowing us to make sure that the process come January 1 when the true requirements are set will be as smooth as possible.

To date, we have over 8,000 RREs that have completed testing and are in "production status." But we do have a number of those entities that are giving us live data, and that has been very valuable to us.

So again, on behalf of CMS, we want to thank you for your early participation in this process because it gives us a lot of information to make this process as smooth as possible for all involved. And I would encourage anyone who thinks they are ready to – you know, if they would like to send live production files before January, please do so because you may find some things on your end that you didn't anticipate either. So it's a good way to kind of further test the process before the actual January 1st 2011 requirement hits. So again, thank you very much.

And with that, operator, I'd like to go into the question-and-answer session.

We are asking for folks to please provide their name and the company they represent on the call and also to, as we asked before because a lot of people are on the call, limit your question to one and one follow-up, and then jump back into the – back to the queue so that other people can get their questions answered as well.

Operator?

Operator: At this time, I would like to remind everyone, in order to ask a question, star one on your telephone keypad.

Your first question comes from the line of (Larry Gorman) of Bituminous Insurance. Your line is open.

(Larry Gorman): Yes, this is (Larry Gorman), Bituminous Insurance – a first time caller but a long-time listener.

My question deals with Workers' Compensation TPOCs. And when ORM is assumed, do the lump sum indemnity-only payments need to be reported as a TPOC?

So for example, let's assume we're dealing with the CMS beneficiary that has a back injury, and the carrier assumes ORM and reports it to you in the first quarter of 2011. Then six months later, the carrier pays a lump sum payment for Permanent Partial Disability benefits which is only for indemnity and which does not affect ORM. Is that lump sum indemnity payment reportable as a TPOC, and if so, why?

John Albert: Does the state law distinguish between the payments?

(Larry Gorman): Sorry. I lost you there.

This is where there is no change or effect on ORM in the payment of medical. So we are paying medical, we'll continue to pay medical, and we just have an indemnity payment that deals with – they got a rating for their back and it's 10 percent. So we own 50 weeks of benefits and our ORM doesn't change at all.

John Albert: I would think you don't need to report it.

(Larry Gorman): OK. Thank you very much.

Barbara Wright: I mean that's – so that is a situation where the ORM stayed open and will continue to stay open until the person no longer needs the treatment.

(Larry Gorman): Correct, yes. So this is a case where we're paying the medical, we're going to continue paying the medical, there's just this, maybe with a loss of a finger, so we own a few weeks of benefits, or there was a rating on the back. But our responsibility to pay medical has not changed and we will continue to pay.

John Albert: OK?

(Larry Gorman): OK. Thank you.

Operator: Your next question comes from the line of 804 Bonnie Mustarde from Farmers Insurance. Your line is open.

Bonnie Mustarde: Thank you. Bonnie Mustarde with Farmers Insurance, and thank you for taking my call.

I have a question regarding joint and several liability, I think it's been brought up before. The User Guide indicates that where the (Senate) has joint-and-several responsibility, each RRE must report the total amount of settlement, judgment or award. So the question that comes to us is, you know, there's a huge difference between an accident where there are three cars involved and two drivers responsible – one insured by Farmers, one by let's say, Allstate. And we each pay to that individual and never know what the other one pays. In that case, we're not going to know the total amount of the settlement.

Another case would be if that accident is bad enough and the individuals whose both have sued in a court of law and a settlement is reached and we agree to how much, in that case we would know what the total amount was.

So we just want to clarify that in those circumstances where there are multiple individuals responsible but each claimant claim is being handled completely separate like the normal auto accident…

Barbara Wright: What…

Bonnie Mustarde: …we are not expected to know that total amount.

Barbara Wright: What we said depends on whether or not you are legally, jointly and severally liable for that settlement, judgment, award or other payment. If there's two insurers and they each reach separate settlement, even though they may have each had some responsibility, that's not a joint and severally liable situation. If you have a situation where you have a joint settlement, and that settlement either by state law or by the terms of the settlement makes the entities jointly

and severally liable, then yes, they do have an obligation to know the full amount and report it.

John Albert: We're…

Bonnie Mustarde: That's what I – that's what I understood the intention of this would be. I just wanted to confirm that…

John Albert: Yes.

Bonnie Mustarde: …with some questions…

Barbara Wright: But it's not a question of whether you know the amount in a particular situation. If you are jointly and severally liable, you have an obligation to make sure you do know that amount. And I would think from a practical standpoint, jointly and severally liable means you're potentially on the hook for that money if the other settling party defaults. I can't – you know, we find that hard to understand exactly why people are saying that's something that they wouldn't know or know how much was at risk there.

So if we're missing something in what everyone is trying to convey, please try again with the mailbox.

Bonnie Mustarde: OK. Thank you very much.

John Albert: Thank you.

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

Teresa Folino: Hi. We saw an accident in health policy, well, different – many different kinds. One of the benefits to that policy is they'll match your days when you're hospitalized. And it doesn't have to be hospitalization for an accident. It could be hospitalization for cancer, for a gastric problem, for other diseases, it doesn't matter. So when we're trying to then put an ICD9 E codes to it, the E codes are strictly for accidents. So if I have – when we're paying benefits to someone with cancer, I don't know the cost. So what do we use?

Pat Ambrose: That's one of the questions that I had pulled aside and asked someone to research for me and to include in the ICD9 CBT. And I could also provide that information on a subsequent call.

I don't have an answer yet. Now that said, possibly the folks from CMS here have a different take on it. But I don't – I don't have an answer for you yet, but I did see your question.

Teresa Folino: OK, I appreciate that. I just wanted to – our goal is to try to report in our October period. So we're trying to get all of these details and things that come up ready to then do the appropriate reporting.

So thank you so much.

John Albert: Let me read what the regulations state no-fault insurance means.

No-fault insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insurer, or in the use, occupancy or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes, but is not limited to, automobile, homeowners and commercial plans. It is sometimes called Medical Payments Coverage, Personal Injury Protection or Medical Expenses Coverage.

I read that to indicate that there has to have been injuries sustained on the property or premises of the insurer. I don't see how a cancer policy would relate to injuries sustained on the premises of the insurer.

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

(John Miyano): Yes, good afternoon. (John Miyano) with (Golden Lam).

A quick question with regard to bankruptcy. Now I'm familiar with the – what the User Guide states with regard to bankruptcy. However, we have a third party claims administrator that is currently handling claims for an RRE which is in the process of going through bankruptcy proceedings. The

company has not gone into liquidation as yet. As far as we know, there is no one left remaining at the carrier that has the ability to contract as the authorized representative.

What is the TPA's responsibility with regard to reporting these claims if there's no one left at the carrier to complete the profile report in order to register the RRE? Would it then be up to the trustee and/or the various state guarantee funds?

John Albert: So who's filed for bankruptcy?

(John Miyano): It would be the carrier who would be the RRE in this circumstance.

John Albert: OK. The carrier still has – someone that's representing the carrier has legal authority to speak on behalf of the estate in bankruptcy.

(John Miyano): So that would be the trustee?

John Albert: Someone – technically, it's the carrier that would still have to file.

(John Miyano): Well…

John Albert: If the carrier has someone who's legally empowered to act on their behalf, I would think that they could do the filing.

(John Miyano): All right, well, in this set of circumstances, we have a third party claims administrator who does not have the authority to enter into a contract on behalf of the carrier. So they're asking us as the reporting agent what they should do with these claims because they're not getting a response from the carrier with regard to, you know, whether or not the RRE profile has been completed or whether it's even been requested, you know?

So, you know, their question to us as the reporting agent is what is our responsibility, do we have any responsibility, what should the next step be or recommendations.

So am I to understand then that your recommendation would be that they should be in contact with someone as a defunct carrier to determine who

would have the responsibility of making decisions and/or entering into contract to complete a profile report?

John Albert: Someone has the authority to speak for the carrier, whoever that party is. Now you said they hadn't filed yet for bankruptcy. At least that's what…

(John Miyano): But they have not gone into liquidation as yet. So the bankruptcy proceedings can take a long period of time to complete.

John Albert: No question about it. But someone is empowered to speak for the estate and to make decisions and to perform functions on behalf of. And if it's – and that has to be legally empowered to do so and not just…

(John Miyano): OK.

John Albert: …doing it on their own.

(John Miyano): All right. We'll see if we can identify who that party is then. Thank you.

Barbara Wright: Well, and hopefully the trustee could answer that question for you, whether or not they were in fact that entity or there is some remaining person connected with the carrier, that is

(John Miyano): Yes. Because I know once the – once the carrier does eventually go into liquidation that the various different state trust fund would – state guarantee funds would be responsible as the RRE where they would have direction and control in funding of the claims. So that's not the issue with that. In between part, between when the carrier actually goes into liquidation and when the state guarantee funds actually take control of the claims.

John Albert: So I appreciate it. Thank you very much.

And as always, document what it you're doing. As always.

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

(Frank Furland): Yes, good afternoon.

I just had a question on ICD9 codes. We're running into a little bit of an issue. It's kind of like an internal issue. And on an add record, what we wanted to know was would it cause any issues on Medicare side if we were to report a valid ICD9 code in the first ICD9 code field but potentially leave a field one of those fields – subsequent fields open and have a valid ICD9 code after an empty field with the default value?

Pat Ambrose: I'm not entirely sure I understand the question.

(Frank Furland): OK. We – potentially, we would report an ICD9 code in the first ICD9 code field. We would have the second one with the default value, which I believe – I forget what the default values off the top of my head. But we would report it with the default value and then we would have a valid ICD9…

Pat Ambrose: OK.

(Frank Furland): …code in the third field.

Pat Ambrose: OK, I understand your question. You would have a valid code in ICD9 diagnosis, one and then a – and spaces in ICD9 diagnosis two, and then put another valid one in ICD9 diagnosis three?

(Frank Furland): Right. And we would – and we wanted to know whether or not this would be acceptable, whether we could do this for an – for an add record. I know for an update, if we remove an ICD9 code, we are to leave that field with spaces in future reporting. But we – it doesn't – you know, it's not in the guide and that's kind of an unusual question. We're just – we're running into an issue on our end with something that we're working and it would make it easier if we could do that. It would be a rare occurrence, but we just wanted to know whether or not that would be acceptable or if it would cause issues on your end in taking the, you know, the information.

Pat Ambrose: Right. Right. The answer is yes, you can do that. And if I'm incorrect, I will absolutely follow up. But – and I encourage you to test it. But…

(Frank Furland): OK. Yes, we'll do – we'll get it. We're hopefully going to be testing on the reporting soon. So we'll try that, you know, we'll use that as one of our test scenarios.

Pat Ambrose: Yes. But my understanding is that it's perfectly acceptable to do that.

(Frank Furland): OK. And it's just a matter – we want to make sure that we report. We're taking in a file from – we're using two (RIDs) – two (REIDs). One of them is for TPA to handle some of our claims. And we're in taking a file from them. But we're going to validate ICD9 codes on our end to make sure that we don't report anything invalid.

And if we had to take one out, we were hoping to be able to leave that field blank so that we don't mix things up for update records and stuff like that.

Pat Ambrose: Yes, I understand. Yes, you should be able to do that.

(Frank Furland): OK. All right, well, like I said, we will – we'll use that as one of our test scenarios and make sure it works.

Pat Ambrose: OK, great. Thanks.

(Frank Furland): Thank you very much.

Pat Ambrose: You're welcome.

Operator: Your next question comes from the line of (Sheen Lunobi) from Steptoe & Johnson. Your line is open.

(Sheen Lunobi): Good afternoon.

I don't know if this will be addressed or in next week's Mass Tort Working Group call. But I have a question regarding the exposure date that needs to be reported when there's a settlement payment and total release of the claim based on exposure to a toxic substance. Does the RRE need to report the beneficiary's entire period of exposure to the toxic substance or only the dates of exposure for which the RREs are responsible?

Barbara Wright: It's neither exactly. And we had an issue on that. Can you hang on just a second?

John Albert: Hold on for just a minute.

Barbara Wright: I'm trying to find where the notes on that were.

John Albert: We can always go back to it later.

Barbara Wright: Let us rate that question down and we will interject an answer in a little bit.

John Albert: OK. And did you have any other follow ups?

(Sheen Lunobi): No.

John Albert: Have you submitted this question in the mailbox?

(Sheen Lunobi): Yes.

Barbara Wright: Yes, I found it. I'm sorry. I wanted to make sure that I was getting – that it was, in fact, the same question, wasn't any different. The one that came in said when reporting a settlement for Medicare beneficiary related – beneficiaries exposure to a toxic substance that occurred prior to 12/5/80 and continued after 12/5/80, did they report the entire exposure period released or only the exposure that the RRE has responsibility for even if that is entirely prior to 12/5/80?

And what we wanted to emphasize again is that what we're dealing with is what's claimed or released. When people talk about what they have responsibility for, it seems to allocate or at least imply that they choose what period they are responsible for from our perspective, it's a case where we have a recovery claim, then whatever has been claimed or released, it is for that entire period.

We talked about the sum in some other calls for instance, if there is property that an entity owns in 1978 and they sell it in 1979, and the person who is suing or has filed a claim, continue to live on that property until 1982 or 1985, we have heard some arguments where – questions, people come in and say

well, if I only owned it until 79, I'm only responsible till then so I only have to report with respect to that.

And that's not true. It's – when we're talking about exposure, we are talking about physical exposure and if you have the exposure on or after 12/5/80, then we recover – we have a potential recovery claim for all our services on or after 12/5/80.

We don't – we don't allocate it in quite the way your sentence – your question seems to imply. Does that help at all or have I mixed you up further?

(Sheen Lunobi): Wasn't there some kind of exception in the user guide regarding exposure attributable to a particularly the defendant?

Barbara Wright: It is defendant specific. But – so if for instance, I'm trying to think of a good example, some of the asbestos -- they'll will be one claim against a respirator defendant. There will be another claim against a factory owner. Yes, it's specific to the exposure for that defendant. So a person could be exposed for 40 years and you don't – what you're really talking about is date of incident, the report, and it's the first exposure related to that defendant.

Does that help?

(Sheen Lunobi): So I'm – what will the last period of exposure – date of exposure be in that …

Barbara Wright: You are not reporting the last date of exposure. If you're – if there is a lawsuit or a legal action and there is a settlement judgment award based on the exposure at all, then we develop our recovery claim.

But for reporting purposes, all you are reporting is that date of first exposure and that date of first exposure is defendant specific.

(Sheen Lunobi): I thought there was a field industry date of incident which would be…

Barbara Wright: That field is optional because many in the industry said absolutely, they wanted to report that. We said that you must always report the date of incident as defined by CMS if you also wish to report the industry's date of

incident, whatever is defined in your particular area, you may do so but – Pat isn't that field…

Pat Ambrose: Yes, it is optional and it is passed on to the recovery contractor but we – I don't know what they might do with it.

Barbara Wright: In either case, you are still talking about the – you know, the initial exposure. You are not talking about when exposure terminates.

(Sheen Lunobi): OK, I understand. Thank you very much.

John Albert: I mean, the industry date that is in that field, my understanding is that it is used to check for – you know, to check against other conflicting information that may come in through other sources because section 111 will surely result in the majority of information coming into CMS. We may get repeat information from others that might not quite match up to what we will receive via section 111.

So that additional field can help sort that out in terms of coming up with CMS's demand amount if any.

Barbara Wright: We also don't recover for any claims that we may have paid that are prior to the date of incident so someone – let's say someone worked in the shipyards from 1978 to 1982 and then from 1988 to 1992, they worked – I don't know, in the auto industry and they were dealing with brake linings that had asbestos. With respect to the brake lining defendant, we would not recover for any services that we paid before that exposure started with the brake lining.

We could recover from either one of them with respect to asbestos on or after their respective dates of incident but we do not recover for anything prior to the date of incident.

(Sheen Lunobi): So if the exposure was entirely before December 5, 1980 but everything is released, is broad released, then that – would that still be reportable?

Barbara Wright: That's in large part, what most of the conversation is going to be about next Wednesday.

(Sheen Lunobi): I see. Thank you very much.

John Albert: All right, thank you.

Operator: Your next question comes from the line of (Joanne Bargo) of (Southwest General Healthcare) your line is open.

(Joanne Bargo): Yes, thank you. This is (Joanne Bargo). I have a question. I have actually two questions regarding the periodic payments, I think one was pretty much addressed by an earlier caller regarding permanent partial disability but just to confirm, permanent partial disability payments are not reportable. Is that correct?

Barbara Wright: That is not entirely true. I believe – and Mr. (Inaudible) is out of the room right now. I believe the question earlier today was a specific situation where there was a permanent partial disability TPOC payment made when ORM actually continued and responsibility was going to continue until nomadic – no further medical care was required.

(Joanne Bargo): Right. ORM and PPD are – it's really two separate things but if we have ORM and that has been reported or maybe it hasn't been reported because the amount paid was below the threshold, and then years later, we pay a PPD…

Barbara Wright: There is no threshold for ORM for reporting purposes.

John Albert: Workers comp, there's a…

(Joanne Bargo): There's $750.

Barbara Wright: Not for ORM in general in order to have that $750 threshold, they have to like – no loss of work...

(Joanne Bargo): Correct.

Barbara Wright: Et cetera.

(Joanne Bargo): Correct. So if we made all those requirements and we still pay less than $750 and later on, we pay a permanent partial, we don't report ORM. We never did report ORM because that was below the threshold. Would we report the permanent partial?

Barbara Wright: If …

(Joanne Bargo): Permanent partial is a strictly – it has nothing to do with medical. It's strictly to compensate for ongoing problems or limitations that the person claims to have.

Barbara Wright: OK. (Mitch) is going to just walk back in the room so I want to repeat what we've talked about…

(Joanne Bargo): OK.

Barbara Wright: She is asking about a situation where there is permanent partial paid and we repeated the question we had before, when ORM continues, we have no problem with not reporting a TPOC. She wants to ask that a situation, for example, where it meets all the requirements to not be reportable because there was no loss of time for work. It was under $750 on medicals. All medicals were paid directly to the provider or supplier and she is asking whether or not the TPOC would be reportable on that instance?

I guess what my question is there, is the $750 threshold, in many ways, envision that you haven't accepted that there are no additional medicals and you haven't accepted responsibility for ORM on an ongoing basis. It – that threshold was never meant to be used in a situation where you expect the medicals to exceed that, you are just waiting to see when they exceed $750.

You know, in a situation where the medicals are ongoing and they are likely to exceed $750, you should be reporting that ORM.

(Joanne Bargo): I realized that but if we paid below $750, I mean I can give you an example of a claim, you know, it's nothing claim, but maybe an E.R. visit and that's it, nothing else. We pay less than $750, we didn't' report it because it's below

the threshold. Years later, the person files for permanent partial disability, might be two to three or four years later. We pay permanent partial, d we report either the ORM at that point or is the permanent partial TPOC?

John Albert: What's included in the permanent partial? Are medicals included in that?

(Joanne Bargo): None. No. It is strictly a form of compensation to compensate for ongoing pain or problem or limitations that the person claims to have related to whatever condition is allowed on the claim.

John Albert: Under state law, are you still responsible for medical items and services?

(Joanne Bargo): The claim may be open by statute but there has not been any medical activity in years. And it never exceeded the threshold.

John Albert: The claim is open by statute I believe, you need to report it as ORM.

(Joanne Bargo): Even if it's below the threshold?

Barbara Wright: We need to go offline just a second please? Remember it's … I'm sorry, we looked up in our own manual and we were missing a very important point on that threshold for 750 is the claim has to be for medical only and if you…

(Joanne Bargo): Correct.

Barbara Wright: OK. Well, you describe the situation now where that claim is no longer for medical only in which case the ORM should be reported.

(Joanne Bargo): So we would report it years later when we pay the permanent partial on that would be a TPOC?

Barbara Wright: If you are reporting the ORM, then you don't have to report the TPOC.

John Albert: When the claim was no longer medical only, we would report the ORM.

(Joanne Bargo): So that could be years later when we pay a permanent partial?

John Albert: That's correct.

(Joanne Bargo): OK. OK. I guess I'm confused on with regards to the earlier question about permanent partial and that being a TPOC.

So under certain circumstances, it might be.

Barbara Wright: They are asking you to report the ORM, not the TPOC. There – it is not a TPOC and they are asking you to report a claim report with the ORM indicator equal to Y and no TPOC amount when you are paying that criminal partial because the claim that no longer fits that exclusion…

(Joanne Bargo): OK.

Barbara Wright: The claim is no longer medicals only.

And maybe what I sort of heard in what you said about possible confusion and I will make sure everybody here in this room is on the same point. When we were talking before about the partial disability, we weren't saying it wasn't a TPOC per se, we were saying it wasn't a reportable TPOC.

(Joanne Bargo): OK.
So we still don't report it as a TPOC but years later, I might have to report the ORM even though I didn't report it initially because it was below the threshold.

Barbara Wright: Yes. You didn't report it initially also because at that point it was a claim for medicals only.

(Joanne Bargo): OK. Now permanent partial can be awarded in a claim order with no loss time? So it would still – I would still report it at the time I make the payment but not report the payment, just report the ORM.

Barbara Wright: Right.

I mean, go back and look at thresholds; a key point which we didn't click on right away or has forgotten was the claim has to be for medicals only. It's not just that it's direct payment of medicals or that there is no lost time and that it doesn't exceed $750. It does have to be a claim for medicals only.

(Joanne Bargo): OK. I have one other question regarding payments on a death claim. I understand that ORM, we will report that it opens and it will end on the date of death. We also pay the dependant children and survivorship benefits provided they go to college full time or the bi-weekly payments considered periodic payments and therefore not reportable?

John Albert: They are not reportable…

Barbara Wright: They're…

John Albert: They wouldn't be reportable because they are not – payments to or o behalf of the inured party.

Barbara Wright: OK. And then same would be true. We were paying our surviving spouse, survivorship benefits. He remarried and as required by law, when he remarried, we paid him a two-year lump sum payment which was not a settlement.

We still pay the children now. We don't have to report either of the payments to him or to the children as TPOCs.

John Albert: What we mean is the payments to him.

(Joanne Bargo): She just said that – the spouse got a lump sum spousal payment when he remarries…

John Albert: Yes. He just said something else about making the payments to him and to the spouse and then to the children, at least I think that…

(Joanne Bargo): Initially, we paid the spouse and the children.

Barbara Wright: All right.

(Joanne Bargo): The spouse eventually remarried.

John Albert: Oh, the spouse remarried.

(Joanne Bargo): Correct.

John Albert: Sorry, I thought it was – somehow the claimant was remarried.

(Joanne Bargo): No, no, no.

OK but neither with TPOC, the payments to the spouse or the children, correct?

John Albert: I thought they were…

Barbara Wright: They are technically TPOC.

(Joanne Bargo): They are not reportable TPOC?

Barbara Wright: They are not reportable TPOC.

(Joanne Bargo): OK, OK, got you. OK, that's all I had.

Operator: Your next question comes from the line of (Laurie Nielsen) from Century Insurance – Century National Insurance. Your line is open.

(Laurie Nielsen): Yes, hi. (Laurie Nielsen) with Century National Insurance. We are a liability carrier and starting to settle some of our third party claims. We are getting from work comp carriers who have intervened, issues about Medicare satisfied and is there somewhere that we can find out more information about how Medicare satisfied work?

Barbara Wright: Or worker's compensation actually - I don't know if you can find it quick or not…

(Laurie Nielsen): My internet connection is not working, I'm sorry.

Barbara Wright: Let me see if I can find it quickly, in the user guide…

(Laurie Nielsen): In the user guide.

Barbara Wright: In the user guide, there is a particular page that talks about other resources and it gives the web – the particular websites at the COBC that will pull you right in to all their discussion of requirement.

Pat Ambrose: I can try to help navigate you there. So go to www.cms.gov and on that home page, click on Medicare and on the Medicare page, you will see coordination of benefits listed and under that, there is information on workers' compensation and various pages underneath that related to workers compensation, MSA, and the process and so on.

(Laurie Nielsen): OK.

Pat Ambrose: And then as Barbara said in the user guide on – since I've been talking, I didn't look it up in the user guide, there are some references to that as well.

(Laurie Nielsen): OK.

Barbara Wright: I found the exact page but there is a section that is somewhere near the beginning that talks essentially about other resources and it gives you references to the COBC including, I think specific ones for workers' compensation.

(Laurie Nielsen): OK, all right. Thank you very much.

Operator: Your next question comes from the line of (Victoria Vannes) of Tucker, Ellis and Roth. Your line is open.

(Victoria Vannes): Thank you very much. I had a question regarding clinical trials in the reporting surrounding clinical trials from both the standpoint of the clinical trial sponsor companies that are sponsoring the clinical trials as well as any reporting obligations that rest with the sites where these clinical trials may take place.

The alert that cane out a couple of months ago stated that when clinical trial sponsors, a drug company for example who has an obligation to pick up the cost of a clinical trial event if there was a bad occurrence or an adverse event and the sponsors on the hook for any associated medical bills, the alert says the sponsor has to pay and has to report that in the form of ORM.

But as we were thinking through how that is supposed to operate, one of my questions is what if the clinical trial participant who got hurt, let's say, first

person they turn to to voice their complaint is not the sponsor but they go to their doctor, they go to the hospital, they go to the site where they were enrolled in the clinical trial. They assert a claim and they say they are mad, they want to get out of the clinical trials, they got bills, they've got injury claims and they present a claim and let's say the clinical site makes – settles that claim and then turns around to the sponsor and say, hey sponsors, part of this is on you.

So in that kind of a situation, is it conceivable that there will be reporting obligation potentially by the sponsor but potentially also by the clinical trial site and if so, how do we sort of tease out those?

John Albert: OK, now in the case you just mentioned, you said a claim was filed against the site so the site would – the site reached the settlement that is just like any other liability situation, liability insurance or self-insurance. The fact that the sire later went to the sponsor and have fully or partially reimbursed does not change your reporting requirement because you were the one that made the payment either under liability insurance or liability self-insurance.

(Victoria Vannes): OK.

And so if a site comes back to the sponsor and say hey, part of this is on you, reimburse us partially or wholly, that site does have a reporting obligation?

John Albert: Correct.

(Victoria Vannes): And then if I can – just as a corollary to that from the sponsor's standpoint, if there is no formal or claim asserted, but they simply learn of an adverse event in the course of a clinical trial, that kind of reporting has to go on all the time, sponsor learns that an adverse event occurred at a particular site and the sponsor knows that pursuant to the clinical trial arrangement, that means the sponsor will have obligations to take on and pay for medical bills, they therefore upon that notice of the adverse event, they know that they have triggers, their ongoing responsibility to start making payments.

Is that when they are sort of the ORM light comes on and that for them becomes the starting point of their ORM assumption?

John Albert: I would think the ORM assumption would arise when the adverse event occurred.

(Victoria Vannes): OK, and when the sponsor learns of it?

John Albert: Well, we have to be…

Male: It's not the same thing.

John Albert: It's not quite the same thing.

Male: Right.

Barbara Wright: Their responsibility – there's a difference between their responsibility arising and you know, the actual reporting. Obviously, they can't report for that particular beneficiary until they know that the adverse event has affected that particular beneficiary but once they report…

John Albert: It would report the date of the incident not the date that they found out about it.

(Victoria Vannes): Got it, got it. OK.

Very good. Thank you very much. That helps me enormously. I appreciate it.

Pat Ambrose: Operator, before we go to the next question, the previous caller was asking where information regarding Work Comp Medicare (status sites) can be found on the CMS website. And I just wanted to state that it's on the links that Barbara Wright was referring to. We are at the end of section 19 in the user guide is one place in the user guide where you can go to find links to the CMS website to find more information on that topic.

Thank you.

Operator: Your next question comes from the line of (Mark Tipettal) of (I-Space Incorporated) your line is open.

(Mark Tipettal): Hi, good afternoon. I have a question regarding the applicability and the correlation of M.A. plans to NGHP in light of NGHP, the guide says M.A. is out of scope. What is the situation with M.A. and NGHP?

Barbara Wright: It's out of scope but it's not out of scope. You cannot assume simply because a beneficiary is in the Medicare Advantage plan that Medicare fee for service has not paid for any medical items or services.

People can go in and out of the M.A. plans; there are rare instances where they have claims paid under fee for service even when they are in a Medicare Advantage plan. There are situations where Medicare Advantage enrollment is actually retroactive and so claims have been – being paid for under fee for service so if they are a beneficiary, your reporting obligation exists. It's not – your reporting obligation is not determined or affected by whether or not they also happen to be in a Medicare Advantage plan.

(Mark Tipettal): OK. Thank you. So to be safe, we should definitely report all of them then?

Barbara Wright: Yes. You absolutely need to. What happens in terms of recovery, if everything was in fact paid only by a Medicare Advantage plan, then the – any obligation or any repayment would occur directly with the Medicare Advantage plan who the beneficiary has an obligation to deal with directly.

(Mark Tipettal): OK, thank you very much, I appreciate it.

Operator: Your next question comes from the line of (Anne Armstrong) from (Inner Mountain). Your line is open.

(Anne Armstrong): Thank you. (Anne Armstrong) again from (Inner Mountain Healthcare) and I have a couple of questions concerning reporting – I think they may – both related to ORM but in the first case, this corporation is self insured for liability including premises liability in a malpractice.

And so this is not a workers' compensation claim, no fault or other statues supplied. But for example, a patient who is suffers a complication let's say, related to surgery and our risk manager agrees without determining whether or not we are liable from a legal standpoint, agrees to reimburse the subsequent

medical treatment, visits to a doctor or medications or something along those lines.

And then at some point, there is a settlement made to resolve that claim, can we use that TPOC settlement date as the termination date for ORM without a formal Medicare (set aside) agreement and without a written physician statement to the effect that no further medical treatment will be needed for this injury?

Barbara Wright: You have several things going on in your question.

To the extent in the beginning, there – any services that your particular – I guess I didn't hear in the beginning whether or not you also happen to be like a hospital or a doctor?

(Anne Armstrong): Yes, we are a provider.

Barbara Wright: OK, so if you're a provider and you decide that any services you provided, you are not charging for, you are reducing the cost for, then with respect to those, those would be taking care of through the billing process where you make sure that anything that you are writing off is shown as a liability payment in your billing process.

And that is covered under the normal billing procedures.

The second thing is since you said that you are assuming responsibility for other associated care, you would need to report the ORM. Your last one was about termination of the ORM in a liability insurance situation, if by the terms of the settlement, it terminates any ongoing responsibility for medicals, then yes, you would terminate ORM with that date.

Last but not least, you asked about (set asides) and that doesn't have anything to do with whether or not you can terminate the ORM date for reporting purposes.

John Albert: You also need to report the TPOC.

Barbara Wright: Someone reminded me that I didn't note – in that litany that I just gave you that you are of course, also reporting the TPOC but as far as the (set aside) arrangements, we will repeat what little we talked about these in prior calls, is that Medicare beneficiaries and insurers have an obligation to protect Medicare's interests but Medicare does not mandate the specific mechanism they use to do that.

So can we say a set aside is required? No. But Medicare's interests do need to be protected and any TPOC or settlement should be exhausted appropriately before Medicare is billed for related services.

(Anne Armstrong): OK so I'm hearing you say that the settlement documents, it would be a good idea for the settlement documents to include language clarifying that the ongoing responsibility for medicals is terminated with the agreement and that – is it necessary to include language regarding a portion or anticipated portion of the settlement amount that would go toward future medical expenses.

Does that kind of detail…

Barbara Wright: We're straying over into a little bit of territory that we can't take responsibility for. We cannot give you legal advice. The terms of your settlement are the terms of your settlement. If for liability insurance, if those terms terminate any ongoing responsibility for medicals, then that is what they do and you would report the termination of the ORM.

In terms of future medicals, whether or not you wish to specify in the settlement how much is for future medicals is an issue for you and your council and for the beneficiary and their council. All I can tell you is that the parties do have an obligation to protect Medicare's interest and as I said…

Pat Ambrose: Separation of the medical from what isn't, right? (Inaudible).

Barbara Wright: Yes, again, as I said, that we can't mandate the set aside, the settlement should be exhausted appropriately and as we said on other calls, we are not bound by the allocations of the parties to any settlement judgment or award.

(Anne Armstrong): OK, thank you.

I just want to also clarify, I think, at the start of your answer, you may have answered this question but this is another question I submitted through the e-mail mail box. We do have occasions where I understand the billing requirement and I think those are nicely laid out and clear in the user guide but we do have occasions where a patient after they are discharged from the hospital and all the billing has been submitted, contact us and complain about non-medically related concerns like their food was cold or something along those lines.

And we do sometimes – reduce the amount of out of pocket after insurance payment that we require from those individuals. I don't know – I cannot tell from the user guide whether in that situation, we need to report that amount to you in some fashion and if so, whether we should resubmit the billing to reflect that or report a TPOC or how we would…

Barbara Wright: Are you paying them cash out of pocket or are you reducing your charges? If you are reducing…

John Albert: You said you were…

(Anne Armstrong): Reducing our charge.

John Albert: OK, you are in essence, really reducing the charges, plus there are also things with respect to the cost settlement process where if you are not selecting the full deductibles or co-insurance, you got other issues with respect to settlement of your cost report.

What I would do on that case is do an adjustment claim indicating on the adjustment claim what you originally had and indicate the amount that you're "writing off" is liability insurance payment.

(Anne Armstrong): Thank you.

Operator: Your next question comes from the line of (Susan Jones) of Pendulum.

Your line is open.

(Susan Jones): Hi. I just wanted to get some clarification earlier when you were talking about the ICD-9 codes and what version to use. I understand that version 28 is going to be active and we can use it for reporting in January.

And if we're going to the DDE option, then is it OK for us to go ahead and say that we're going to use version 28 since we won't be reporting until January 3? Or is it those claims that for instance, say we have record in October to December that we have to report for you? Are those records we can only submit ICD-9 codes from version 27 or…

Barbara Wright: You know, it's all dependent on when you submit the claim and whether you submit it versus DDE or a file doesn't matter. So when you start using DDE in January, the system online will edit the ICD-9 codes that you provide and it will, in that – the course of its edit, it will be using version 28, 27 and 26.

(Susan Jones): Because we are using the DDE which doesn't start until January 3.

Barbara Wright: Correct.

(Susan Jones): OK, that's the one…

Barbara Wright: You know, if you're accumulating information now and validating it, you could take a look at version 28 because by the time you enter those claims via DDE, we'll be using version 28.

(Susan Jones): That's exactly what I want so thanks. I appreciate it.

Barbara Wright: You're welcome.

Operator: Your next question comes from the line of (Kerry Salahi) from Texas Mutual. Your line is open.

(Kerry Salahi): Yes, hello. I have a question. If you could clarify an area concerning the 11.4 in the interim threshold reporting requirements for workers' comp and ongoing responsibility for medical specifically.

On that page 50 of the manual, applicable to reporting is for false submissions that are due through December 31, 2011 and if it's a medical-only claim, no

indemnity payments and they don't exceed $750, they would not be reportable.

Considering the example that we have a workers' comp claim applicable to ORM reporting only, medical-only claim, no loss time, and no indemnity anticipated, the ORM was assumed on 7/1/2011 so and the medical payments were less than $750.

In 2011, the claim didn't qualify for reporting but it qualified for the interim threshold but when that threshold expires on January 1, 2012, does the same claim become reportable in the first quarter of 2012 when there are no changes on the claim otherwise?

Pat Ambrose: Not, it's not reportable.

(Kerry Salahi): And based on what are we saying that? Because the threshold requirements don't state anything about when you assumed ORM.

Pat Ambrose: It really is a matter of you know, when you would make the report. I mean, I guess we can go back and see if we can adjust the language but we are basically saying if those conditions were true, there is no need for you to make that report.

And again, it's based on file submissions that are due through or claim submissions that are due to December 31, 2011. So if something changes with the claim subsequent to that, then you might need to reconsider but if nothing changes to the claim subsequent to December 31, 2011, then you are off the hook.

(Kerry Salahi): Yes.

Barbara Wright: The example you gave us, I think you said the accident or whatever was in July of 2011.

(Kerry Salahi): We assume the ongoing responsibility for medical…

Barbara Wright: OK, if you did that in July, even with the 45 day grace period, that is – your file submission date would be no later than some time in the fourth quarter

and so by the time the new requirement's applied, you would be past your file submission date.

And the threshold does specifically say four file submissions due through December 31, 2011.

Pat Ambrose: It might not be that explicit about when ORM is assumed, I mean you don't report a specific ORM assumption date, but that is implied in these thresholds. So like I said, I mean, we can take a look at revising it but you know, in the circumstance that you gave, that claim would not be reportable.

(Kerry Salahi): All right, thank you very much.

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

(Ramilia Reach): Hi, good afternoon. Thank you.

I just wanted to find out if you were led to use the DDE option, how are query searches done under that? There seems to be an indication that they wouldn't be done the same way as the other options.

Pat Ambrose: There is really no query so to speak, but what will happen is you will enter on those first page of information on injured party information, the name, birth date, gender, et cetera. And the system, before it goes any farther and asks you for any additional information, online, real time, will check whether that the information that you supplied for that injured party matches to a Medicare beneficiary.

And it will come back to you with an indication on – of whether it was matched or not. Now, you might have entered the information in correctly and you need to re– you know, re-key some fields or something.

But so at that point, that is considered a claim submission. It will count against your 500 limit, but you don't have to enter any more claim information because the system is telling you that that person is not matched to a Medicare beneficiary and if you are confident about their – the specifics

of the information that you put in, then you don't need to go any farther with that claim report.

So it's not really a query but of course, it is checking the Medicare status of the individual for you and you know, to cut you a break, we are not going to collect all the rest of the other claim information since it's been determined for you that the claim is not reportable due to the interparty of the Medicare status.

Barbara Wright: Someone that only has 50 claims a year or 100 or 200 maybe a good candidates for DDE. Someone who has 5,000 claims a year and needs to do the equivalent of querying or ascertain beneficiary status for that many people, probably doesn't want to use DDE unless they have another reliable source to do the equivalent of a querying so that the only time they need to touch our files is when they actually do the data entry.

If you need to do the equivalent of querying, then you need to look at your whole universe not just how many people ultimately are Medicare beneficiaries.

(Ramilia Reach): Sure. I have clients who will fall into the former category where they don't have – they will not have claims or fees, they may not even have claims that exceed 50 or 100 in the course of the year. That would be subjected to these reported rules.

So as those claims come into our office and we determine we might need to do a search, we can do them as they come because they will number under 500 so in other words, we can do them as they come, we don't have to batch them together to do them at once as the query option would be for those RREs who have more than 500…

Barbara Wright: That's right, it is an enter as you go type of method. You know, there is no file submission period obviously on – as you get a claim that you believe to be reportable, you would go to the COB secure website and enter the – and begin the claim entry process.

(Ramilia Reach): Just as a follow up to that. Once we do that entry and if it turns out that the plaintiff is indeed the Medicare beneficiary, now that CMS has alerted of this particular case, at some point down the line, if we receive a – I'm sorry, if we receive a conditional payment or a consent for a release from the beneficiary, we can submit that and receive information on the conditional payments that might be necessary in…

Barbara Wright: OK if you are using the DDE, you are not going to be submitting anything or trying to enter until there has been a settlement judgment award in which case – in which case the process is going to proceed forward pretty automatically and doing a consent to release is not necessarily going to get you anything faster.

You already had you know, a settlement judgment award and in situations where insurers want that information and want to get it by getting a consent to release from the beneficiary, you are talking about following our normal process which requires that the COBC be notified of the pending case and given appropriate information.

Whether it's done by the beneficiary and or their attorney or whether it's done by the insurer that is the only way anyone is going to have any conditional payment information before there is a settlement judgment award.

Pat Ambrose: Yes, you can't, in a sense, get on the list for conditional payment information via your section 111 reporting.

It's not used for that purpose.

(Ramilia Reach): OK so we are talking essentially then two steps, right? So if I received a claim, my client received a claim and is not sure that that particular claimant or plaintiff is a – first of all, they are using the DDE option, right? And so they are not sure that that plaintiff is a Medicare beneficiary so they go to the site to enter the information real time and it comes back that that plaintiff is indeed a Medicare beneficiary.

I mean this is – this has happened before any settlement, judgment, or award has to take place in this case, it's very early on.

Barbara Wright: No, I think – excuse me, I think you are missing a major point in what we are saying. You don't enter – through using DDE, you do not enter information about the beneficiary unless or until there is a settlement, judgment or award. You don't do it once to query and once to enter the case.

You are entering it only if there is a settlement, judgment or award or other payment which would include ORM.

Pat Ambrose: So your first step in that circumstance prior to settlement is as Barbara said, to follow the current process where you contact the COBC to make the report and supply the information.

(Ramilia Reach): OK.

Pat Ambrose: I mean if you..

Barbara Wright: And if you look at on www.msprc.info, there is information about how to make that report to the COBC. There are all kinds of you know, documentation out there on that MSPRC site about contacting the COBC but it is outside the section 111 process.

(Ramilia Reach): OK, all right. I've seen those documents. That was actually a point of – I understand that now. OK.

Operator: Your next question comes from the line of (Lynn Kennedy) of MJM Insurance Group. Your line is open.

(Lynn Kennedy): Yes, thank you. At the beginning of the call, Pat, you mentioned some changes that were being made to allow entry of an ORM termination date that was less than 30 days from the date of incident. And we thought we heard you say a 2011 implementation date for that. Was that correct?

Pat Ambrose: Let me see if I – you know, I did misspeak; it was supposed to be November 1, 2010 so I did misspeak. So let me just reiterate. We are making changes to accept ORM termination dates less than 30 days greater than the date of incident, a modification will be made to the CJ06 edits for this. An alert will

be published and the user guide updated and this change will be implemented by November 1, 2010.

Thank you for bringing that to my attention. I had a typographical error in my presentation material.

(Lynn Kennedy): Thanks for clarifying.

Barbara Wright: Operator, can you tell us how many people are in queue?

Operator: We have about 12 or 13 still in queue.

John Albert: All right, we have time for unfortunately, one more question. So go ahead.

Operator: Your next question comes from (Peter Gunn) of Applied Underwriters. Your line is open.

(Peter Gunn): Hi, thanks for taking my call.

My question relates to the reporting exception in section 11.9 of the user guide which indicates that for claims closed prior to January 1, 2010, the RRE is not required to identify and report ORM unless the claimant will later subject to reopening of a further ORM.

Our question is for claims code prior to 110, if we pay for a medical bill after the claim has been closed, both dates of service prior to claim closure, does that claim have to be reported? But is that payment considered reopening with further ORM? Or since the claim has been closed since prior to January 2010, can we continue to exclude it from reporting?

Pat Ambrose: Just hang on a second please.

Barbara Wright: We are back. I think we have said something along this line in some prior calls but the distinction we would make is that if you have a situation where there is a prior payment, where there was a lost check and you are simply replacing it after the case has closed, fine, you are not reopening.

But if you are paying new bill, even at the date of service was prior to that date, then you have essentially reopened it. And you do need to report.

(Peter Gunn): OK, just wanted to clarify.

Barbara Wright: Thank you.

John Albert: I guess we have time for one more.

Operator: Your next question comes from (Bryan Johnson) from the Louisiana Insurance. Your line is open.

(Norman Reese): Yes, this is (Norman Reese) for (Bryan). The first question asked by (about two minutes) is your manual contradicts your answer. On page 72, 11.7.3, in the third paragraph, it says that any TPOC made has to be reported even though you still have ORM.

Now I think your telephone answer is the best answer but it contradicts the manual.

Pat Ambrose: What section was it again?

(Norman Reese): 11.7.3. The third paragraph, second sentence.

Barbara Wright: OK, that is talking about a situation where you are submitting a record update.

(Norman Reese): Probably – many times, you are going to be reporting ORM and then subsequently, you will do a TPOC on indemnity and still have the medical open. According to your instructions, we'd have to report the indemnity TPOC.

Barbara Wright: Let us look at this section because I'm not sure how much this language was really intended to deal with the content of the TPOC or ORM as it was to say when you are doing an update, this is how you handle an update.

Pat Ambrose: Yes. Barbara is exactly right. This section was indicating on you know, more technical instructions and it's making the assumption that the TPOC is

reportable and Barbara earlier explains, you know, that there might be a settlement or a TPOC that is not reportable versus is reportable.

So we will…

(Norman Reese): If it doesn't include medical, there would be no sense in reporting it.

Pat Ambrose: Well, we will take a look at the language and see what we need to do to correct it. Thank you for bringing that to our attention.

(Norman Reese): OK, that's it.

John Albert: Thank you. Operator, we have to conclude the call. There are folks waiting to get into this meeting room. I'd like to thank everyone for their participation. Keep your eyes on the Medicare Insurer reporting websites for future teleconference events and we will talk to you again in about a month.

Thank you very much.

Operator, if you could let us know the total participants and all that, we'd appreciate it.

END