TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: May 13, 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
May 13, 2010
12:00 p.m. CT

Operator: Good afternoon, my name is (Melissa) and I will be your conference operator today. At this time I would like to welcome everyone to the MMSEA 111 NGHP Conference Call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you, Mr. John Albright, you may begin your conference.

John Albright: Thank you operator and good afternoon to everyone on the call. This is for everyone's information. Today is Thursday May 13, 2010. This teleconference is for a non-group health plan, meaning worker's comp liability no fraud (insurer) reporting under the Section 111 MMSEA 2007. This call is directed towards more technical questions or issues that people have with the process.

With us today, we have a couple of new faces, or not new faces but people you haven't probably heard from directly and the first is Mr. Jim Brady who is the project director for the Medicare coordination and benefit contractor and also Mr. William Ford who is the EDI supervisor at the OBC. They'll be providing a presentation and answering some of the questions, technical question we received through the resource mailbox and other channels regarding implementation of the NGHP reporting requirement for Section 111.

With that, I'll guess I'll make one brief note mention of an issue that we just want to remind folks that we have a lot of entities that have registered with CMS to do reporting but it turns out that some of those entities may have

decided that they are no longer RREs or for whatever reason. We would ask people to proactively go in and basically unregister RRE IDs that they do not think they will be using.

There are about 23,000 RRE IDs right now for NGHP and eventually we are going to be tasked with removing those from active status. But we would like folks to be – who feel that if they registered by mistake or for whatever reason or changing how they are going to report the data, should please go in and clean that up. We recognize that when this first started, there were still some unanswered questions regarding who is on RRE, et cetera. And a lot of that has been, we hoped, resolved through some of the more recent alerts and user guides we have published.

We will – once we finished the presentation, we'll go into a straight Q&A session, as the operator mentioned. We would ask that the participant identify who they are and what company they are with; and we will allow one question and one follow up and we will have to move on to the next participant so that we can give everybody in the queue a chance to get their questions answered.

I know it will be repeated by Jim and Bill Ford but again, for technical issues especially concerning ongoing implementation, testing implementation, error resolution, et cetera, please go to your EDI representative for assistance, you're going to get those types of questions answered more directly or more quickly by the EDI reps.

Policy questions, of course, you still need to come to CMS through the resource mailbox and on these telephone calls. But again, this is a technical call and if we receive policy questions, we may have to defer those until the end so that we can give the technical people on this call a chance to get their questions answered. And with that I'll turn it over to Jim Brady who's going to do a presentation and Bill Ford will come in later.

Jim Brady: Thank you, John. As John said, I'm Jim Brady and I am the project director for the coordination benefits contractor. It's been a little while since I've had one of these so I'll just give you a few announcements up top to cover some of the things that we received lately.

First of all, just a reminder, housekeeping-wise on this call, we'll try to cover most of the technical issues that we received in the L-box in the CMS section 111 email box in the last call. However, again, to re-state what John said, if you have a specific technical question, your best point of contact is your EDI rep. So contact your EDI rep with the specifics of any technical issues that you may have, file transfer issue, file format issues, testing, things of that sort should go to your EDI rep.

If you're not satisfied with the way your EDI rep handles it or you have a problem getting a hold on your EDI rep, escalate through the escalation process that is in section 18 of the user guide. And basically that process ends with Bill Ford and myself, so we are aware of it if you do not get your resolution. All right, keep in mind that anything what you send to the CMS resource mailbox will not receive a specific direct response back; it will only be handled through this call. So anything where you need a personalized answer, again, go to your EDI rep.

OK, that being said, we are currently working on the updated user guide, we expect to have a published update by July 1st of this year. Various corrections – the typos will be made including some related to conflicts between field data, description and the area codes associated with them.

Section 7.1 in particular will be replaced with the who must report alert language, that's already out there on the web. Appendix G, which has been a hot topic for a lot of people, will be replaced per that alert and pending correction discussed on the last policy call. Other policy updates will also be added as available. Specifically for the user guide, there's a typographical error in version 3.0, the one that's currently out there. The field description for the new foreign RRE address line 13 to 15 on the TIN reference file erroneously referred to foreign employer when they actually should only refer to a foreign RRE.

We also have some questions out there on ICD9 issues. So just some information up on top, check for the valid ICD9 is done at the time the record is submitted. And the current list of valid ICD9 used are applied to the records according to when they are submitted, not according to the date of the

incident, settlement ORM or anything of the sort. All adds and updates are checked, not delete. You do not need to send an update solely for the purpose of removing or replacing an outdated ICD9 code. However, each time you send, add or an update, the record must be checked against a list of valid ICD9s in place of the time.

Note that the zip file available on the CMS website contain the procedure codes also. And those are not relevant to the Section 111 process, RREs, should only use the diagnosis codes within that table. See Section 11.2.5 of the user guide under, "To download a copy of these files for further instructions."

We also had some questions about the ICD9 codes themselves; what should be submitted. I'm actually going to pass it over to Barbara Wright for a second and she'll give you a little more detail on which diagnosis to use.

Barbara Wright: People have asked whether or not they should submit codes related to what – codes for what the insurer believes is related or codes for all alleged injuries. And it's – the answer differs depending on your situation. If what's being reported is ORM, you need to report the codes associated with what you will actually be paying for. If what you're reporting is a TPOC you need to report the codes associated with all alleged injuries.

Jim Brady: OK. I'd also like to point out to everybody to the reporting date requirements in version 3.0 of the user guide. It's important to remember that production reporting is required to begin during your signed file submission timeframe in the first calendar quarter of 2011. Retroactive reporting will be required in your first quarter 2011 file submission. ORM is to be reported on open claims back to 1/1 of 2010. TPOCs meeting the specified threshold set for the claim are to be reported starting with TPOC date of 10/1 2010.

Next item to point out, the production claim input files can be accepted now. We are getting files from some folks now and you can feel free to send a production file at this point. You could send it outside of your assigned commission time frame for the particular quarter if you give your EDI rep a call so that they can make arrangements for that. In 2011, when reporting is

required, you must submit during your assigned file submission period. And if, again, if any changes to that come up, if you're late or anything like that, contact your EDI rep as soon as possible.

Next item to point out, reporting the ORM termination dates. Future ORM termination dates will be accepted but not when they are more than six months in the future. That's a file submission date not the date of incident. If you have an ORM termination date to report that's farther than six months in the future, you have to wait until that time period passes before you'll be able to report it.

RREs are not to submit an expected, anticipated or contingent ORM termination date. ORM termination date should only be submitted when the termination of ORM is certain. We are looking into the requirements that ORM term dates must be 30 days or more greater than the date of incident to see if we could get that changed. Stay tuned for more details. But at the present time, the ORM term date must be 30 days or greater than the date of incident.

Next item to point out, abandoned RRE IDs. Again, picking up on something that John said earlier, if you registered for an RRE ID that you no longer needed, never intend to use, for production recording, please contact your EDI rep or the EDI hotline at 646-458-6740. Again, that number is 646-458-6740, it's in the user guide, to have it deleted.

Any organizations of – have determined that they are not RRE's section 1-11 reporting since the publication of the (whole must) report alert. And if you're one of those guys, please let us know. You'll not be reporting for section 1-11, you do not need to complete the registration process or testing. And again, let us know so that we could delete that ID. The query process has generated a lot of questions of late.

A few points to mention; if you've come across specific instances where you believe you did not get the correct result on a query or a match to a beneficiary on the claim input file, please report this in a secure manner to your EDI rep for research. We've also received an example of a query that

matched to a Medicare beneficiary was returned with in 01 disposition code but the individual was deceased prior to becoming a Medicare beneficiary.

We often have Medicare entitlement dates on our files 90 days in advance, so it is possible for a person to be added to the database of Medicare beneficiaries with future entitlement but pass delay prior to the data that is set – prior to that date being reached. The query will be returned with an 01 disposition code since it is only matching the key fields and not entitlement date. A claim report would be returned within 03 though if the TPOC date or ORM date is prior to the entitlement start date.

RREs should get the same results on test versus production query files and at query versus claim input files except for possible timing issues, where the beneficiary database maybe updated in between the query and the claim submission or something like that. If you get a discrepancy you cannot explain, then report it to your EDI rep. Remember that you must query after ORM is assumed or after the TPOC dates to know for sure whether you need to reflect the claim to us.

Make sure that you're sending data for the injured party. Make sure that when you're sending data for the injured party, you submit their data and not their spouse. We've received records where an RRE is reporting a widow, the injured party as the injured party, but submitting her dead husband's SSN or HICN. She will have her own SSN and HICN and it is one of those that must be submitted. Her HICN may be based on her husband's SSN or will have a different suffix than her husbands. His might be an A, hers B for example, but it's critical that you send the correct party's SSN or HICN and not that of his spouse.

And another item is that you do not have to use the information returned in gender or date of birth field on a positive beneficiary match. If you get a match in 01 disposition code, you must have at least three of the four fields correct and that's enough. The same matching algorithm is used on the query and claim file, CMS does not want you to use the HICN returned on all record submission as well. CMS does want you to use the HICN in all future submission; that's one of the things to remember.

Threshold errors in small volumes, RRE's submitting a small volume of data on their claim input file are more likely to hit the delete and error threshold. There should be no concern, your EDI rep will realize this and release the file for processing. You should follow-up via phone or email with them to be sure. Your interpretation of small files may be different than ours so always follow up on any threshold errors that you received.

Please note that your TPOC dates must be greater than the CMS date of incident. You will receive one of the following errors associated with TPOC date 125; CJ 03, CT01, CT11, CT21, CT31. And the user guide will be updated for this.

Another item CMS has removed the requirements for submitting empty files if an RRE has nothing to report for a particular quarter. Empty files will still be accepted but will not be required. By empty file, we mean the file with a claim input with a header record, no detail record and a trailer record and a record count of zero. So those are no longer required, they are acceptable but they are not required.

The test beneficiary data on the section 1-11 COBSW will be updated on 5/21, on May 21st, to add the entitlement dates for the test beneficiaries to make it easier for RRE's to set-up the test conditions for the 03 disposition code. We've had a lot of people looking to simulate that; so we've heard you and we will be updating that on the 21st. We're also looking at making the – making some revisions to the display of file processing results on the website to make it a little easier to read. So stay tuned for that.

All right, so now we've gotten all that out of the way, I'm going to pass it over to Bill Ford for some of the specific questions that we have received in the email box to give you the answers that we have for those. So, Bill?

Bill Ford: OK. Hi my name is Bill Ford. I'm the EDI manager for the COBC, and these are technical questions that we received subsequent to the 3/11/2010 technical call.

Question one, in section 11.7.2, the user guides states there is no need to send the delete record, or a record for which you previously received in 03. The description of the 03 disposition is very similar to that of the 51 disposition and indicates the injured party was identified as a Medicare beneficiary at states that the RRE should continue to check the injured party's Medicare status. This is a bit confusing. Is the description of the 03 disposition really correct?

You would get the 03 disposition code if the TPOC date or ORM termination day is prior to the start of Medicare entitlement or of the date of incident is after the end date for Medicare entitlement. When the claim report is sent it does not overlap the period of time the injured party is a Medicare beneficiary. (inaudible) can go on and off Medicare be titled then not and entitled again.

If your ORM remains active, you must continue to submit the claim reports in case the injured party becomes entitled for Medicare again and there is overlap. The user guide will be updated to reflect this. Getting an 03 means that the CODC did not save a copy of the claim report. So there is never a need to send a delete for a record that you only received in 03 disposition code on. Only send deletes as needed for records that's received in 01 or 02.

In the 8/11/09 tech conference call, there was a recommendation to remove suffixes after the last name. Such as junior, senior, II, III, IV, et cetera. Is this still the recommendation?

There has been language in more recent calls about some social security cards having the name imprinted with the suffixes. We have found no inconsistency whether SSA uses a suffix or not. It must depend on what the beneficiary provided Social Security administrations. So the only recommendation is to try to use what is printed on the SSA or Medicare card. Remember that we match only on the first six characters of the last name. If you get a 51, you might try removing or adding the suffix.

My question involves the four claimant records in the detail and auxiliary claim files. Let's assume I didn't add with three claimants. At some point in

time, it is determined that claimant one is not applicable and should be removed.

Which of the following is the correct action? One, I submit an update record with a blank claimant one and no change to claimants two or three. Or two, I submit an update record or claimant two is moved up to claimant one and claimant three is moved up to claimant two. And the answer is, it's option two. The claimants' fields are not considered positional and the aux record is not to be used for claimants unless claimant one fields are filled out first.

Will the following claim be reportable? Claimant is a Medicare recipient. The claim is open as of 1/1/2010. ORM was only paid in 2009 and we do not anticipate ORM in 2010. Claim will have a TPOC settled prior to 10/1/2010. Even though there has been no ORM payment in 2010 and the TPOC will take place prior to the 10/1/2010, does this need to be reported solely because it was open as of 1/1/2010? If the RRE technically has ORM as of 1/1/2010, regardless of when a medical claim was last paid or what the RRE anticipates and the claim is open as of 1/1/2010; yes, it's reportable.

Looking for clarification and our responsibility for checking for eligibility. Here's the scenario, we do a query scan monthly during dependency of the claim and Medicare has not confirmed eligibility. We administratively close our file and limits are not exhausted. Do we need to continue to do query scan checks or eligibility until the statutes (rise)?

Yes. As long as the RRE has ORM, you must monitor the Medicare status of the injured party and report accordingly. Administratively, closing the claim is not grounds for ORM terminating. I realized that there are issues with the language used in the user guide and that an alert is forthcoming for clarification. As for additional discrepancies in the claim response file, the applied data fields 16 to 25 are used to proclaims returns with dispositions 01, 02, and 03.

Please take a look at what values you are returning in field 24, applied termination date for disposition 03. Often, you are returning an applied term date when there was never an ORM term date on the claim input file. Even

when an ORM term date is on the claim input file, the applied termed date is being returned with a date that appears to be garbage; unrelated to the claim in question.

Please note that I do not see this discrepancy happening for claims return with disposition 01 while we are investigating when and how the system is plugging the applied term date on claim response file records. However, there really should be no need for an RRE to use to it or be concerned about it. It should really only apply to this disposition code 01 accepted with ORM where the ORM indicator equals Y.

We have submitted our first successful submission of the initial test file and have received the claim response file. In the claimant input file, we sent a total of 13 ORM records for injured parties. We reported the closing dates in field 99 ORM termination dates. We downloaded and reviewed the claim response file. Of the 13 ORM records for injured parties submitted, only one record returned a date in field 24, applied MSP termination fee, the remaining12 records filled this field with zeros.

We are unable to determine an obvious pattern since five of the 13 ORM records had met the policy limit payout and where the claims – and where the claims were closed. Since we are reporting it closed, we would not report it again unless the claim is reopened. What is the basis for which a file close date is returned or is not returned in the claim response file? And again, we all researching how the system is setting the applied MSP term dates. However, the RRE does not need to steal and the claim does not need to be reported again unless ORM starts again where there is a TPOC to report.

I'm trying to clarify what I thought was said in the March 16, 2010 teleconference. Is it true that CMS is now anticipating a fourth quarter of testing before production can begin? You need to pass the testing requirements and we believe that will take most RRE's at least 90 days. RRE's that don't register now, since they have nothing to report, need to register in time to allow for at least 90 days of testing and probably more. There is no testing needed for the DDE though.

If an RRE is registered for reporting workers compensation claim payments, do they have to also register separately to report court liability claim payments, such as payments made to qualified individuals for product liability injuries, or can they use the registration they already have for the workers compensation claim payments? These can be reported in the same claim input file. Use the appropriate insurance time type; E for workers comp, L for liability.

Barbara Wright: Remember that we said that, you can't – an RRE can mix any and all lines of NGHP business. So it's not just limited to reporting worker's comp and liability if you also have no fault since many auto policies will have a no fault as well as the liability component that can all be reported under the same RRE.

If you choose to have separate RRE numbers, you may do – you may do that as well. What you cannot mix is an entity that is an RRE for GHP purposes and also has some NGHP reporting responsibility cannot mix their GHP and NGHP file.

Bill Ford: OK. Thank you. Thirteen RRE's have five different reporting submission dates. If the RRE's could all have the same submission dates for the quarterly claim file, it would solve our issues and make for a smooth, less error-prone process. The other factor causing the issues are the 45-day requirement, having to report all claims that occur up to the 45 days prior to reporting date and the fact that they can take two weeks for a response to be returned during the query process.

This cut short the time to collect the information needed for the claim file with the Medicare eligible claimants. Also, it is not very clear as to what the specific penalties will be if the claim is considered late, not in accordance with the 45 day rule. Can you provide more information or let us know when more specific penalty information will be provided?

We can change your file submission timeframe. It's set by RRE ID. We also ask that you please review the 45-day grace period in section 12.4. If the most recent TPOC or ORM term date is within 45 days prior to the start of your

seven day file submission timeframe, then you may submit that information on your next quarterly file. Another way to look at it is that any add record received on a quarterly file submission will be marked as late if the most recent TPOC day or ORM term date is more than a 135 days older than the start date of that same file submission period.

My question is related to the auxiliary record notes paragraph. It states that you must continue to send this record unless the information it contains no longer applies to the claim. If we sent the claim with an auxiliary included and CMS accepted the transaction; and if next quarter, the aux data is no longer valid, can we omit the aux record completely or do we need to send aux record with all spaces? Do not send the aux records if the data previously sent on it no longer applies.

Could we please get an email generated response when CMS or an EDI has deleted a query submission? We are not receiving notices on a consistent basis. We have received one or two when there was threshold error but if there has been a header record error or something else, we don't seem to get any notice that the file has been deleted. But you should always be in contact with your EDI rep in the event of a severe error. I will take the email notification under advisement and we will look into it.

We are a self-insured municipality. We are concerned with certain types of workers compensation claims and whether or not they are reportable. Under New York state workers comp law, the employer is not required to report record-only claim. These are incident reports where there is no lost time and no medical treatment beyond first aid. Normally, we would not open a file unless the injury subsequently resulted in medicals. Do we need to report these first aid record only incident when they first occur or after we received medical which could be as much as two years later?

Please see the interim reporting requirements in section 11.4 for worker's comp ORM. The claim is likely not reportable since it probably meets all the criteria listed there. However, starting in 2012, if you have technically assumed ORM, you must report it and not wait until you receive a medical claim.

Specific to medical malpractice liability claims, are we allowed to submit multiple records for a particular injured party policy number when the injured party has filed the claim against more than one doctor insured on the same policy? Each record would have a unique claim identifier. The answer is yes if the claim numbers are different. It should be reported separately.

When would the funding delay beyond TPOC's start date apply? Probably never. It was originally intended for use with the product liability fields 58 to 62 and it most likely won't be used for those either. So, just fill it with zeros.

If we reported an ORM term date and received a disposition code of 01, 02, or 03, do we have to report subsequent changes to keep field's critical information and/or additional TPOC's? You won't get an 02 on a claim with ORM indicator equal to Y. For 01 and 03, no, you do not need to ever report it or update it again unless ORM starts back-up again or you pay a TPOC.

If a case that was retired prior to 1/1/2010 is subsequently re-opened, do we report only those TPOC's meeting the $5,000 threshold and paid after 10/1/2010? You are only required to report TPOC's with TPOC dates 10/1/2010 and subsequent. And those are the only TPOC's you have to consider for the threshold. You can report earlier once but you don't have to. Note that you are adding up all the applicable TPOC's for the threshold check, not looking at them individually.

We will get the MSP termination date and MST effective date back from CMS. If yes, where will you get this information from? Yes, the system derives it from the date of incidents. ORM term date and if any, entitlement dates. It's not applicable to claims with only TPOC's and ORM indicator equaling no or N.

The user guide provides a 45-day grace period for reports of TPOC and ORM termination dates. Thus, the 45-day grace period also apply to assumptions of ORM. And the answer is yes. And section 12.4, particularly the last paragraph, deals with that.

And does the 45 day grace period apply if the claim was actively closed or removed from current claims records prior to January 1, 2010 but the claim is either re-opened after 1/1/2010 or payment is made on the closed claims after 1/1/2010? Old legacy claims will not necessarily have all of the data coded, and if that needed for Medicare quarterly reporting. If a reopening or payment unclosed claim occurs shortly before the RRE's reporting time frame begins, there may not be enough time to verify and enter the data needed and this may result in a lot of errors.

We need the grace period to apply to this situation as well, in order to have an orderly process for constructing our claimed input file in time to transmit it on the first day of our transmission timeframe and have an opportunity to have all reportable claims coded as completely and correctly as possible. CMS should provide a date of field that RREs can use to indicate the date on which a claim that did not require reporting per the special qualified reporting exceptions becomes reportable due to reopening or making a payment so that CMS does not erroneously read such situations as late reporting of ORM assumptions. And the answer was the same as before, yes; and section 12.4 should be read.

We have a case where the individual was a Medicare beneficiary and has died. We have his social security number and all key details we would need to report the CMS. Because he is deceased, we have had to identify his claimant beneficiary for reporting purposes. We have basic information on the claimant beneficiary but do not have his social security number and he refuses to provide it to us. What do we do in this situation? And all you do is just report the claim with the deceased injured party and no claimant.

I have been searching on the CMS website for a link to your ICD 9 diagnosis codes. This will be necessary for Medicare secondary payer reporting. I see several links and not sure which one to use as a tool for our office. I need the code with the description so that the correct code can be identified for reporting. You should refer to section 11.2.5 of the user guide, the link is provided in there. The user guide is also on the CMS website and it should be www.cms.gov/mandatoryinsrep.

Jim Brady: Excuse me. No more; cms.hhs.

William Ford: No more?

Jim Brady: No more. All right.

John Albright: Either one will work for the next (inaudible).

Jim Brady: Thank you. This one, it'll the work for the next 90 days, I think.

William Ford: Yes. Yes, either one. If ORM is assumed and no settlement will be made and payment made directly to the provider of service, the doctor, hospital, et cetera, as they come in, do these payments have to be reported? In addition, how would your answer apply to a situation where the assured reimbursed the provider and/or the injured party directly and then the assured comes back to the insurer requesting reimbursement, do these payments have to be reported?

Well, that's the definition of ORM. A claim report must be made once to report the assumption of ORM. Just report ORM equal to Y, and note TPOCs. And as for the second part of the question, the appropriate RRE still needs to report.

Are subrogation claims reportable under section 1-11? The Medicare beneficiary is not a party to the claim and the only benefits recovered are benefits already paid so Medicare will not have an interest. And that's, no, subrogation is not reportable.

ACE registered each active underwriting company as an RRE. RREA had previously done eligibility checks and subsequent reporting for six claimants defined as Medicare eligible and the claims are still open getting actively reported. We are now merging RREA into RREB, because the underwriting company which RREA references is getting merged into another within ACE. My question is, if we deregistered RREA today and continued to report these claims which exist in your world as RREA, what would happen? Conversely, should we back these out and report it in error and report them under the active RREB instead?

We are not commenting on whether or not the merging of the two RREs is appropriate. From a technical perspective, they can maintain these records going forward using either RREA or RREB. If B has a subsumed A, then they should maintain these records under B. By maintain, we mean send updates as needed. They should not, under any circumstances, delete their records and report them again as is. And this is documented in section 8.3.2 of the user guide, where it states that different RRE IDs can be used to update and or delete records originally added under another RRE ID as long as the key fields match.

And we're at our last question. On an initial report, if we have an injured party with both ORM and TPOC we send an add record. But what plan type will we use, D or L? It depends on what part of the policy the ORM and TPOC are paid under. Claim reports are submitted by insurance type so if you have a policy that covers no fault and liability, they will report separately for each insurance type even for the same policy and claim number.

If they have ORM responsibility under no fault, D, and also have TPOC that meets the threshold under the liability portion of the policy L, they report two claims. One is reported with the insurance type of D for the ORM, with the ORM indicator equal to Y and no TPOC. And the other is reported with insurance type of L, ORM indicator equal to N, and the TPOC amount and date.

The two records will have the same policy and claim number if the RRE had one claim for both coverages. If the ORM and TPOC relate to the same coverage under the policy, then one report with both ORM and TPOC would be submitted. This is more likely to happen in a worker's compensation situation and not automobile no fault liability, where usually the ORM is no fault and the TPOC is liability. And we're going to update the user guide event table to make that clear.

Barbara Wright: Before we go on to the next question, there was, about three or so questions ago, there was a question about whether or not subrogation claims were reportable, and the answer was given that, no, subrogation is not reportable. We're retracting that answer?

We're certainly going to look at it further, but we can come up with situations here where a subrogation claim would clearly be something that would have to be reported. So, no, for purposes of this transcript and otherwise. You need to ignore the answer that was said before. We are not giving a flat statement that subrogation is not reportable. Back to you.

William Ford: OK, and that was the head of the...

John Albright: Prepared questions that we've received in our inbox?

William Ford: Yes.

John Albright: Bill or Barbara, do you have anything before we...

Barbara Wright: I have one, although this is not a policy call and we're not going to be taking policy questions. We received some incoming questions after the last call that we're a little bit concerned that we're still seeing these. That there were two or three questions that were indicating the parties had no familiarity at all with this process, including whether or not reporting for NGHP was limited to beneficiary.

If you are new to this process, you need to go to the website which was given earlier on one of the questions and you need to read both the user guide and any alert. All the questions about timeframes, thresholds, et cetera are all address in that documentation. We are not going to be answering those questions individually, repeatedly.

Additionally, the basic question about knowing whether or not to report if an individual is not a Medicare beneficiary, this whole concept is on reporting in situations where Medicare is secondary. And we are secondary when a Medicare beneficiary receives liability insurance including self insurance, no call insurance, or worker's compensation.

So, we believe these questions are largely from entities that for whatever reason are new to the process. But you need to go read the material on the website rather than submitting individual odd questions.

John Albright: This is John Albright. There was a brief reference in one of the questions to what's referred to as direct data entry and on the last policy call we had, we did announced that there is a forthcoming alert concerning this pending new reporting option for small employers that will – or small, or a small entity RREs to submit data to us through a direct data entry option via the secure website that tentatively is scheduled to go live in January.

We don't have any other information about it except to say that it will be geared towards the small occasional reporter which represents, in our opinion, the majority of RREs registered at this time. But please stay tuned for an alert coming out in the next week or two at the latest. Our goal is to have as much information out prior to July to give everyone what we consider to be as a courteous six months advanced notice of changes through the process.

But we won't be taking any questions on that but we just again to alert folks out there that that option is going to be available in January. But stay tuned for an alert for more. Other than that, operator, we can go to live Q&A.

Operator: At this time, I would like to remind everyone in order to ask a question press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Your first question is from the line of (Paul Schaffer) of (VCM). Your line is open.

(Paul Schaffer): Hi. My question's related to the foreign RRE. And we're a captive manager and our – each of our captives have registered and received their IDs and they're following up with their EDI representatives. Now, we've actually had one captive receive their profile report and even though we had given the foreign address it came back with their U.S. address.

And – I guess to make a long story short is that their TIN number, they received that through filing a 9-53 D election. And as such, they had to designate a U.S. representative to receive any notices from the IRS. So is that, is that process being fixed? I mean, because right now your system is basically going to the IRS website and pulling the U.S. address over and basically putting that as to RREs address instead of using its foreign address.

Jim Brady: (Paul), so, we don't actually match to the IRS to collect the address data. I'm not sure...

(Paul Schaffer): But that – Basically I was told by my representative that your system was pulling the address over, and that's how it got put on there.

Jim Brady: Yes, it doesn't sound like that's an accurate description. I tell you what, this is Jim Brady. My phone number's in the user guide. If you want, just give me a buzz tomorrow or leave today a voicemail on my machine with the tax ID number?

(Paul Schaffer): OK.

Jim Brady: Check it out. See what the audit trail says on how we got that.

(Paul Schaffer): OK, great.

William Ford: And leave your RRE ID.

Jim Brady: Yes.

(Paul Schaffer): That, too.

Jim Brady: Thank you.

Operator: Your next question is from the line of Catherine McLaughlin of the WorkMed Benefit Services. Your line is open.

Catherine McLaughlin: Yes. I'd like to know if when we get a beneficiary match, may we use that information in the litigation of a worker's compensations claim if the claimant asserts that they are not a Medicare beneficiary?

Barbara Wright: We can't provide you with legal advice.

Catherine McLaughlin: Are we prohibited from using it by the user agreement, the Medicare user agreement?

Jim Brady: Yes, unfortunately we can't. We can't provide that type of advice.

Catherine McLaughlin: OK. OK, all right. Thank you.

William Ford: This is not actually a technical question.

Jim Brady: Yes.

Catherine McLaughlin: OK, all right. Thank you.

Operator: Your next question is from the line of (Lisa Riley) from (CCMI). Your line is open.

(Lisa Riley): Hi, this is (Lisa Riley) with (CCMI). There had been in the past few calls questions about you all changing when someone is getting partial payment, let's say on a bi-weekly or a monthly basis. And whether – and how you want us to report those and there was alert way back when that it said it had nothing to do with ORM then we would not have to report those at all. And – but then since then it sounds like there's been some language that's out there. It just hasn't been published yet, and I wondered if there was an ETA on that.

William Ford: If it's still in the clearance process then it should be out there.

Jim Brady: Yes, we don't, we don't have an estimated timeframe at this point. I mean, there's a couple of outstanding issues that we're working on that we need to basically consult with our internal council as well and basically get those answers out. And unfortunately a few of them are tough nuts to crack and take a while.

(Lisa Riley): OK. No, that's fine. I just – we're trying to wind down our programming, so.

Jim Brady: We understand. I mean, our goal is to have as much of this done by the beginning of July if possible.

(Lisa Riley): OK, great. Thank you.

Operator: Your next question is from the line of (Ruben Allen) of Martin Lewis. Your line is open.

(Ruben Allen): Hi. This question doesn't fit tightly into either technical or policy question so it's really easy. Has a date been set for the (inaudible) conference call yet?

Barbara Wright: No.

(Ruben Allen): OK. Follow-up, is it still planned to take place sometime before the end of May?

Barbara Wright: If we considered in, yes. That's still – our hope at this point are at least have, you know, notice of the meeting out by then.

(Ruben Allen): OK. Thank you.

Operator: Your next question is from the line of Karen Yu from New York State Insurance. Your line is open.

Karen Yu: Hi. What kind of error code – I asked this at the last teleconference and they said it was going to be answered but I didn't hear the answer, so. What kind of error code will be sent in the response file if an RRE sends an update or a delete record and it doesn't any of the previously CMS accepted records for that RRE?

Bill Ford an example that, you know, if the record was sent to a deleted action and it previously got a disposition code of 50, and CMS indicated that the RRE would need to be – previously said in another teleconference, that they would need to be sent at the same record with the same action type in order to get a real disposition code. But they may receive an error as the record would have been deleted and would not match any of the CMS accepted record.

So, what kind of error code would we get back in our file or an email or something, anything, you know, to let us know that, you know, that there was an error on – that you can match any of your records?

William Ford: Yes, that's a very good question. And that is something we are still researching, and we will get back to you very soon with that one.

Karen Yu: OK. And a follow-up record is, if the insurance policy number changes for a record, would an RRE submit that as an add record or a delete record? It's not

listed as a key info field, but I believe in the user guide that indicates that it is needed to be able to identify the record. So it is sort of like treated as a key info field. So would you submit that as an add record or a delete record?

Jim Brady: Our opinion is you wouldn't need to send that record, that update, to begin with.

Barbara Wright: And if you're submitting and it be as an update.

Jim Brady: Yes.

Barbara Wright: Because it's not, it's not listed as a key field.

Jim Brady: One of the key fields.

Karen Yu: OK. OK, thank you.

Operator: Your next question is from the line of Susan Freeman from Pendulum. Your line is open.

Susan Freeman: Hi. I wasn't – I couldn't hear you guys at the very beginning. There was two comments that you said something about CMS does and then you all said doesn't want you to use the HICN. I couldn't hear what you were saying.

William Ford: So for – once you've got that HICN you should use it from that point forward. So, do use the HICN.

Susan Freeman: So, if we are just – if we are only using this social security number we – you're saying yes, you do want us to use the HICN when we get it back.

Jim Brady: Yes, but because that is our official ID for Medicare.

Susan Freeman: Yes, I – Sorry. When you – I thought said you don't and so I kind of got confused. And then something about the hitherto not being required or something not being required, I couldn't hear that part either,

William Ford: The empty files. So we had previously been telling people that you must send us an empty file if you have nothing new to report. And that empty file is

constructed of a header, a trailer, with a record count of zero. That is not a requirement anymore. You can send it to us if you'd like but it is not a required quarterly submission.

Jim Brady: We basically considered it to be good process management to send the file, but again it's not required.

Susan Freeman: So is the new option available, that we can just go online now, and say that there's nothing to report?

Jim Brady: Not yet.

Susan Freeman: OK. Thank you.

Operator: Your next question is from the line of Bill Thomson from the Hartford. Your line is open.

Bill Thomson: Hi. I've got a question about the alert from February 24, 2010 on who must report, and it focuses on the bullet at the bottom of page four and to page five and this is a bullet about deductibles and who is in RRE. And essentially, I think that speaks to an exception to the rule that in deductible situations the insurer is the RRE, and the exception has to do with the insurer that acts without recourse to its insurance. So, my question is this...

John Albright: Hey, this is – Can I interrupt you for a second? I can't stress enough that this call is geared toward technical advice. But you're seeking regarding the electronic process itself and we're not saying that we won't entertain that question. But if that question could be saved to the end because most of the people on this call are here to solicit technical advice on the reporting process itself.

William Ford: And we will have another.

John Albright: And we will have another policy call. So, we would ask if you could please save that to the end. And if we have time we'll get to some policy question.

Bill Thomson: OK.

John Albright: We will have them. We appreciate that. Thank you.

Operator: Your next question is from the line of (Nika Ku) from Commerce Insurance. Your line is open.

(Nika Ku): Yes. You had mentioned something earlier and I couldn't hear. It was about the ICD9 issues. Could you just repeat what you said earlier?

Barbara Wright: One of the statements we made about ICD9 issues is when you're reporting the ICD9 code. If you're reporting ORM you need to report the ICD9 code for which that's related to the illness or the injury that you have accepted responsibility for; either by law, because you're required to do it while a claim is pending, or because you've agreed that you have responsibility. That's, you know, that's when you limit it to what you've accepted responsibility for. If you're reporting a TPOC payment you need to report all ICD9 codes associated with what has been alleged.

(Nika Ku): OK. So for the first code that we submit we always have to submit an E code. So all the other optional codes we can submit up to 19?

Barbara Wright: Right.

(Nika Ku): OK. When you mentioned the valid codes for each version that comes out each year, when we submit we can only submit the ICD9 codes that are valid for the new versions that you've released. But if we have something in the database that reflects a version from two years ago, those won't be accepted?

Like, for example, if I – like this year, you version 25, 26, and 27; that's valid for reporting. If next year you say 25 is gone or you're replacing it with 28 like the manual says, you wont accept any codes in our first quarter submission that we set at version 25?

William Ford: Right. The oldest one would roll off. And the three current prior and prior-prior would be the ones enforced.

(Nika Ku): OK, all right. Thank you.

Barbara Wright: When you're looking at which set of codes to use to the extent you can you should always be using the most recent, because you may not fully resolve a claim before we're rolling to the next set of codes. So you should not slip in to the pattern of being comfortable with one year and planning on staying there two years, because you know that we allow one from a choice of three. Ultimately, you'll be best served if you're moving to the most recent set of codes this year.

(Nika Ku) OK, all right. Thank you.

Operator: Your next question is from the line of (Vicky Suet) from the Golden Circle Temporary Services. Your line is open.

(Vicky Suet): Hello?

Operator: (Vicky Suet), your line is open.

(Vicky Suet): Yes, hello. I'm sorry if this is a policy call rather than a...

John Albright: This is a technical call.

(Vicky Suet): I know. We have our ID set up, but we don't disseminate ORMs. We only make one-time medical payments of no more than $500. And according to the new criteria for reporting published on February 16, 2010, we will not have a portable instance until after January 1, 2014 when there is no threshold because of our TPOCs not being greater than $500. Should we cancel our IDs or put them on a hold status?

Barbara Wright: What type of insurance are you? Are you liability insurance?

(Vicky Suet): No, we're actually a temporary employer and we have work as comp coverage. We have – we just pay the minor medical ones and everything else goes through our records comp and that's all reported already.

Barbara Wright: Yes, if your policy limits make it such that you don't have anything to report.

Jim Brady: Yes. We were – we're OK. I mean, if you don't maintain that registration.

William Ford: In fact, if you know that you're not going to between now and 2014, we'd actually want you to call your EDI rep and get that deleted so that we're not haunting you for submission.

Jim Brady: Yes.

(Vicky Suet): OK, very good. That what I was looking for. Thank you.

Operator: Your next question is from the line of (Jim Rolston) of (Call Paradise). Your line is open.

(Jim Rolston): Hi. This comes from our technical staff. The question reads, there are instances on page 91 and 92 of the user guide which describes this disposition code definition. It states that reporting takes place when ORM termination is established such as for disposition 51 and ORM termination is established and that date is passed disposition 03, do we need to enforce different date logic based on the previous of this division code?

Jim Brady: You – you broke up during most of the first half of the question. Could you just...

(Jim Rolston): Pick that up again?

Jim Brady: Pick up.

(Jim Rolston): Apologies. There are instances on page 91 and 92 of the user guide, this is the discussion of this division code definition, that states that reporting takes place when ORM termination is established, such as for this disposition code 51, and ORM termination is established and that date is passed, such as for disposition 03, disposition code 03. The question is, do we need to enforce different date logic based on the previous disposition code?

Jim Brady: Can you elaborate when you say "enforce different date logic"? I'm not – we're all kind of looking tuffled here.

(Jim Rolston): Actually, I'm reading verbatim from a question provided to me if a – we'll take, we'll take it off line right now.

Jim Brady: OK. I mean, if you haven't submitted it and you want to, you know, (inaudible).

John Albright: If it's a specific technical question with it, you want to send it to Bill Ford. His email address is in the book. We'll get that.

(Jim Rolston): OK. We'll submit it to Bill. Thanks.

John Albright: Thank you.

Jim Brady: Yes.

Operator: Your next question is from the line of Donna Bausano from Farm Bureau Insurance. Your line is open.

Donna Bausano: I also have a question about the disposition codes. If I get a disposition code 03 back, I'm going to keep sending an add if I have ORM open. Is that true?

William Ford: So your question is if you get an 03, do you need to keep...

Jim Brady: Keep sending.

William Ford: ...sending it as an add?

Donna Bausano: Right. Because I do an 03 on an ad and I have ORM and I am – I'm not terminated. So every quarter I think I'm going to keep sending this as an add.

Jim Brady: Right. Because they could become...

Donna Bausano: Entitled?

Jim Brady: Entitled again.

Donna Bausano: OK.

Jim Brady: The answer is yes.

William Ford: That would be a situation where, you know, they had entitlement that it was outside of the original establishment of your ORM. But it's possible again

that the person would achieve Medicare status again and usually very likely. It's kind of unusual for people to...

Donna Bausano: Yes.

William Ford: Come on and off. Yes.

Donna Bausano: Did I also hear that I might receive an 03 if the Medicare beneficiary is deceased?

William Ford: That could make the coverage but...

Jim Brady: Yes.

Barbara Wright: When John was just giving you an answer though, I believe he was referring specifically to when we're dealing with ORM not the TPOC.

Donna Bausano: Absolutely. Absolutely, Barbara. I have – for TPOC, I'm a done deal. I don't – I'm not going to send it again.

But I thought I heard a couple of minutes ago that we could get an 03 if the injured party is deceased; because I might not know that they're deceased. We're, you know, we're in the great state of Michigan, where we have an unlimited lifetime medical benefit. So I'm thinking if I start getting an 03 it could be because they're deceased.

John Albright: Hang on, we'll just verify it.

Donna Bausano: Thank you.

William Ford: You are hearing great silence from (inaudible).

Donna Bausano: This is great. I'm asking great questions.

Jim Brady: We don't like you to think that we just walked away.

Donna Bausano: And I would never think that of you.

Barbara Wright: Do you have an example where that's happened to you at all?

Donna Bausano: Barbara, we're not in the morning's status shift.

Barbara Wright: OK.

Donna Bausano: You know, I think it's OK. You know, if I, if I get an 03, I'm going to get it on an add. I think at that there's a possibility I could get it on an update. Although the field that you're asking for updates on, they're really aren't that many, and I probably wouldn't be sending a lot of updates on ORM. So I'd send you the add, I'd go (inaudible) other way. But if I did get enough – I'm sorry were you saying something? Hello?

John Albright: We're here.

Donna Bausano: OK.

Barbara Wright: We were just checking on something further.

Donna Bausano: Yes. My – the other one though, that I'd – I'm – I think you were alluding to earlier that you're still discussing is the disposition code 50. I'm still a little unclear, if I get a 50, if I had sent you an add, do I send the add again? And will it process, or.

William Ford: Yes. If you get disposition code 50, you should send it again.

Donna Bausano: Let's say, so if I sent an ad, send an ad. If I did had an update, send the update.

William Ford: Yes.

Donna Bausano: Perfect.

William Ford: Exactly.

Donna Bausano: OK.

John Albright: We'll get an answer on that for...

Jim Brady: If you want to, if you want to just follow up with Bill or I tomorrow, we could, we could give you the results of our research.

Donna Bausano: OK, thank you so much. Have a great day.

William Ford: I'll have something to add to that very lengthy description on the user guide.

Donna Bausano: OK. Thanks guys.

William Ford: Thank you.

Operator: Your next question is from the line of Alessandra Vires from Nationwide Insurance. Your line is open.

Alessandra Vires: Yes, thank you. I have two quick questions. I heard earlier that the TPOC date needs to be greater than the date of incident. Can that be greater or equal to or does it have to be greater than?

William Ford: (inaudible) is equal to or greater?

Jim Brady: It's greater than; not greater than or equal to, greater than.

Alessandra Vires: All right, no equal to. Thank you. And the next one is I believe we heard earlier in one of the questions that you answered about the deceased injured party. Right now, I think it states that if the injured party is deceased, a claimant is required. And I think I heard you say that we could send just the injured party as the deceased without a claimant?

William Ford: If that's all you have, yes.

Alessandra Vires: OK. Thank you.

Operator: Your next question is from the line of (Jean Enterio) from The Doctor's Company. Your line is open.

(Jean Enterio): Yes, hi. Just to clarify earlier about the ICD9 codes. If it's TPOC-related then we use TPOC alleged cause of injury. What about if it's ORM related? Should we use that just the ICD9 codes?

Barbara Wright: You need both types of codes, but what I'm saying is where you're doing ORM, you need to confine the codes you're using. You must – you need to use ones that are related to what you're accepting responsibility for.

(Jean Enterio): OK. Thank you. And the second quick question is regarding the question that was submitted in the email, regarding the multi-claimants scenario. Do you say that if claim has three claimants and the first claimant has been removed, the next update record for me to send claimant three to claimant two and claimant two to claimant one? Is that correct?

William Ford: Yes.

(Jean Tonio): Thank you. That's all.

Operator: Your next question is from the line of (Ken Stellar) from the Ohio Bureau of Workers Compensation. Your line is open.

(Ken Stellar): Yes. In previous calls, you have talked about how the TPOC amounts are positional, and in the new user guide we didn't see anything where we could reposition these. If one, we sent an error then we can reuse that field if we do get another settlement on that claim. Is that true or not?

William Ford: We believe it's true, but could – well, we'll have to look into that.

(Ken Stellar): OK. And then our next question is if we send a delete transaction to you and if for some reason errors to – from – on your part, but we really should not have sent it to you in the first place. So we find out well, really, we shouldn't have delete, to try to delete it from you in the first place. Do we need to send something again to fix that error that we received from you?

Barbara Wright: In other words, you submitted a record that was accepted, you then try to delete it, but your deletion failed and then you find out you should have never submitted the deletion. Do you need to do anything further?

(Ken Stellar): Correct.

William Ford: No.

Jim Brady: No.

(Ken Stellar): No, OK. OK, thank you.

Operator: Your next question is from the line of (Nora McClain) from the Selective Insurance. Your line is open.

(Nora McClain): Hi. We had a question about products med pay and whether that's treated as liability TPOC or ORM. We thought it should be ORM, but we're the reading the user guide it seems to indicate that it's treated as TPOC.

Barbara Wright: Could you give us a little bit more information about what you mean by product med pay? If it's no fault insurance.

(Nora McClain): Right.

Barbara Wright: Basically, you're reporting it as ORM.

(Nora McClain): OK.

Barbara Wright: In most instances.

(Nora McClain): And that's what we thought as well, but I guess when we were reading the user guide, it wasn't clear. It looked like the user guide wanted us to report it as TPOC even though...

Barbara Wright: Is there's a specific part or paragraph or something in the user guide that made you think that, if you could send in a note with your concerns to the resource mailbox, we'll take a look at that language.

(Nora McCalin): OK, great. And just a second quick follow-up question with regards to the delete indicator, if we have the case where we have more than one coverage and one meets the threshold and one does not, would that be proper use of the delete button?

Barbara Wright: You said more than one type of coverage. Meaning you have like liability and no fault?

(Nora McClain): Yes. Like, we have liability and, let's say, GO and then a no fault case that does not meet the threshold.

Barbara Wright: And you reported both of them?

(Nora McClain): Right. And we want to delete the one that doesn't meet the threshold.

Barbara Wright: But if they were accepted, why would you want to bother to delete them? The threshold, you know, to the extent we've said you can report TPOCs before you need to, et cetera. I'm not sure why you would be...

Jim Brady: You're not prohibited from submitting them, you just don't have to, you know?

(Nora McClain): OK.

Jim Brady: So in that case, no delete would be necessary.

(Nora McClain): OK. All right, thank you very much.

Operator: Your next question is from the line of Connie Mehan from the Society Insurance. Your line is open.

Connie Mehan: Yes, hello. I have two quick questions. We are in production and we have a – like our submission window was on a Saturday and we submitted the file on a Wednesday, the preceding Wednesday. And in the manual, it says that we can submit up to 14 days early and the file will automatically be picked up on the first processing day in the window. But we get an email back and it looks like it's an error saying, you know, you have an early file submission and call your EDI rep. Is that just a poorly worded message or do we do have to call the EDI rep to have her do something?

Jim Brady: As of right now we're releasing all of these just because, you know, we've opened the doors to people submitting outside of the production windows. Come January we've, you know, then this would require a phone call from you.

William Ford: In other words, come January, that's a meaningful email message. Right now, there is a – it's just – it's sent automatically because it's programmed to. And so we're not telling you that you've done anything wrong now.

Connie Mehan: OK. And then on our production query response files, they aren't opening in the ATW2 software. And it has been referred to EDI rep and it's been up or passed up to the programming people. We're coming up on our time that we're going to submit the query production file of this month and we're going to start it running into a backup here.

And I know it's not that we're, you know, one year in production on claim files too. There won't be any late problem or late reporting problem, I would assume?

Jim Brady: But still, we want to get you going, it's OK. You said you're using our Q software, not – it's not a homegrown translator, it's...

Connie Mehan: No, we're using your software and it's your return file.

Jim Brady: I guess, you know, it's the way that you're downloading it. Can you...

Connie Mehan: What? It will – no, it works. It just crashes with the mismatch 13 error.

Jim Brady: Yes. And that sounds exactly like that you're picking up an extra character.

William Ford: Shoot me an email.

Jim Brady: Yes, if you shoot Bill an email, he'll have one of the technicians give you a call and walk you through the (inaudible).

Connie Mehan: OK. And that email is?

William Ford: In the user guide.

Connie Mehan: It's in the user guide? All right. Thank you.

Jim Brady: Please include your RRE ID, as well.

William Ford: Thank you.

Jim Brady: Thank you.

Connie Mehan: Just one of them will do?

William Ford: The reason why we say it's in the user guide rather than giving it out on the phone should be thrown out.

Connie Mehan: OK. Thanks.

Operator: Your next question is from the line of (Anita Patiya) from the State Compensation Insurance Fund. Your line is open.

(Anita Patiya): Hi, good afternoon. I know it has previously mentioned that we're not supposed to ask any questions on the alternate direct entry med pay. However, I have a slight variation of the question. I needed to know if the query input file process would also be accommodated in this proposed alternate direct entry.

William Ford: We can't answer that question right now.

(Anita Patiya): OK, thank you.

William Ford: (Release out) to follow shortly.

(Anita Patiya): Thanks.

Jim Brady: We'll say again it's going to be for smaller entities; but that's it.

(Anita Patiya): OK. Thank you so much.

Operator: Your next question is from the line of (Nikki Lohan) of LWCC. Your line is open.

(Nikki Lohan): Hi. I had a question concerning (law). The TPOCS and the ICD-9 codes that Barbara had stated earlier, where specifically in the user guide does it state that we have to report all alleged injuries on a claim as ICD-9 codes will report at TPOC?

The reason why I ask is because we need help figuring out the logic and normally, we go to the user guide for our logic. And we currently don't have anything in our system to capture the alleged injuries that we weren't covering. We only capture the injuries that we're covering.

Barbara Wright: Well, we've said you need to report alleged injuries. To mechanically make it through the system, you need the one ICD-9 code. But the problem is the fewer you give us, then the more likely we are going to have to make contact with either you and/or the beneficiary for further information to develop our recovery claim appropriately because we're entitled to recover for anything that is claimed or released.

(Nikki Lohan): OK. So you not only want the injuries that we are covering under the claim, but you want the injuries that the claimant alleged that we should cover under the claim.

Barbara Wright: Right, if it's a TPOC. We don't want a churn paper or claims, so when it is an ORM, where it's what you've actually accepted responsibility for and you're currently paying, that we want the ICD-9 for what you've accepted.

(Nikki Lohan): OK. So if we had an ORM where ORM is Y, we report that. And we report the, you know, accepted ICD9s to you and then we have a TPOC, we wouldn't need to add the alleged ICD9s later on. Correct?

Barbara Wright: You really should be reporting the alleged, the ICD9s for the alleged injuries. Yes?

William Ford: Correct. Right.

Jim Brady: When you're reporting the TPOC.

(Nikki Lohan): OK, thank you.

Jim Brady: Now, we can't stress enough that, you know, comprehensive...

(Nikki Lohan): It doesn't.

Jim Brady: ...record will reduce work on the back end for everybody involved in terms of recovery actions. A point of this record layout, again, is to allow us to take your information and leave you alone.

Operator: Your next question is from the line of Joanne Davis from Zurich Insurance. Your line is open.

Joanne Davis: Hi. I have a question concerning disposition code 51. We're going to be using a third party vendor to our reporting. And we're also going to their – going to do the query process for us as well. But the confusion comes into play as, and maybe you can help in here, is if we get a positive response at the person, if we get an 01 disposition code on our Medicare query response file, what would be the circumstances that we could ever get a 51 disposition code on our reporting claim data?

Jim Brady: We can't think of any situation where that would happen.

Female: OK. So what you're saying is...

Jim Brady: Because it's possible that in going from responding – getting a response to a query file and building your reporting file that you, you know, mess up the SSN or HICN or the name or something like that. But I mean, once there's a HICN that should result in a positive match.

Female: OK, so it'll only be like an error on our part.

Jim Brady: That – yes.

Female: In the data.

Jim Brady: The result, it goes to the machine but I mean, theoretically it should – if you receive an 01, you should – you should not receive a 51 later on when you actually report a record.

William Ford: Unless you change some of the keys.

Jim Brady: Yes.

Female: Right. Well then we would re-query, obviously. But OK. Thank you very much.

Jim Brady: We have seen that where people have, you know, truncated digits or something like that on a SSN and not realize this and (inaudible)...

William Ford: Accidentally or whatever.

Jim Brady: Yes.

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad. Your next question is from the line of Mike Boggs from EMC Insurance Company. Your line is open.

Mike Boggs: Yes. Earlier, you were talking about the, it didn't matter which RRE ID you reported under, that there was an acquisition and you were changing companies. How do you keep multiple records separate when there are multiple defendants all reporting the same claim underneath different RRE IDs? Why would those not be duplicate records then?

William Ford: I mean, if you're talking about a situation where there are multiple liability or responsibilities to report, then we would receive separate records from each of those entities, so.

Mike Boggs: Right. But are you – how are you doing that without keeping either the RRE I.D. or the TIN or something to keep those as separate records?

William Ford: We do.

Barbara Wright: Well, they come in with an RRE ID and we keep that. The functions that we do on the back end with respect to any recovery claim, they have processes in place to sort this out because there obviously are going to be situations where a person has multiple settlements or they may have a liability record information come in as well as med pay, et cetera.

Mike Boggs: OK. Then when one of those do an update on their record with a different RRE ID, which one do you update?

William Ford: The one associated with that RRE I.D. You might be confusing situations involving our common working file that exist, but this data is not going to the common working file.

Mike Boggs: What? I was talking about the situation where you've got going from RRE ID A to RRE ID B and if you we're saying that it doesn't matter on your subsequent update which RRE ID you report under. Or do you have to report underneath the one that you originally use?

Barbara Wright: OK. I think we just heard you ask a slightly different question than we understood you now at first.

Mike Boggs: OK.

William Ford: I think the – so you're talking about where the responsibility for that particular claim or whatever moves from one RRE to another RRE?

Mike Boggs: Well, let me start over. There are two RRE IDs that I have reported a claim because there's multiple billed defendants, OK? Now, one of those two RRE IDs get purchased or merged with another company. Now, that new company needs to send an update on their record and they've got a brand new RRE ID, a brand new TIN. How do you update just their record and not the one from the other company?

Jim Brady: You need to turn the RSD records associated with that RRE that has been basically absorbed by the other company and then send an add to reestablish that record under the new RRE ID.

Mike Boggs: But you just told us not to do that. That we're not to do a term on the prior...

Barbara Wright: Could you hang on just for a second?

Mike Boggs: OK.

Jim Brady: Hold on just a second.

John Albright: Just a clarification, are we talking TPOC or ORM?

Mike Boggs: That could be either.

Barbara Wright: Well, in most instances for TPOC, you wouldn't be doing an update. You'd only be reporting once and that would be it, period. You would have no reason to update the record unless.

Mike Boggs: Unless you made a mistake on your TPOC. You need to – you've reported an incorrect amount, you need to correct the amount.

Jim Brady: So the prior entity – the prior entity reported it wrong and now the successor entity is to looking correct that?

Mike Boggs: Yes, that can happen.

Jim Brady: Hold on just a second.

Mike Boggs: Sure.

William Ford: I think the answer that we've come up with is that it's OK to send that information under the new RRE ID. I mean it's not necessarily going to be clean when it comes to any recovery process we do.

Mike Boggs: I know but how do you update our record as opposed to the other dependent's record? When you've got multiple dependents reporting on the same incident and one of those two dependents needs to update their records, how do you protect this from updating the wrong record if RRE ID and TIN's not part of your key record?

Jim Brady: We pass the RRE ID and the TIN of the back end so from a recovery perspective. Hold on. We're sorry.

Mike Boggs: That's fine.

William Ford: Yes, I mean and another – to basically, to basically deal with that situation, we all agree here loosely that probably the best action is for that, when that responsibility is transitioned, that old RRE needs to come in and delete that old record and then the new RRE re-establish it with the new add record. If there was a mistake and, you know, with the old RRE hadn't reported.

Barbara Wright: But if you're talking a situation where the old RRE went out, it's gone. It's been gone a year, you discovered a mistake later and you're reporting that mistake, then just do a new add record under your RRE ID and we will have sort it out on the back end just as we have to do in a joint in several liability situation where each entity is responsible for reporting the full settlement amount.

Mike Boggs: Yes, and I'm just concerned that another company could update my record that I've reported.

Barbara Wright: No. That...

Mike Boggs: Or I'm reporting, updating somebody else's record when...

Barbara Wright: That's not possible. I mean, what we will have is information for your RR ID – RRE ID that you submitted. And when anyone else submits under another RRE ID, it's not that that establishes...

William Ford: It doesn't overwrite. In fact, in the case you described, we would actually be building another record which...

Nathan Crawford: What we do – sorry, this is Nathan Crawford. What we do is actually we'll take your record and assign it to the case, like associated it to that case. So it never overlays anything. It just adds a separate associated record so we know that there's multiple TPOCs out there or different records that are associated to it. But we'd never overlay anything and we'll always have a record of which RRE sent what.

William Ford: Yes, one RRE ID submission cannot overlay another RRE ID.

Mike Boggs: But I mean, that would confuse me if you have us sending an update on a record with a new RRE ID and that's actually creating an add record, really not an update. Is that what you're telling me?

William Ford: Yes. Yes, where you're submitting that update under a new RRE ID, that essentially treats and functions the same way as a new add record but that's

something that we're going to have to sort out here. Hopefully, that's not very common.

Mike Boggs: OK, because that wasn't – that's not very clear in the documentation. So there's, you know, I had major concern that other companies could be updating my records.

Barbara Wright: No.

Mike Boggs: With the way this thing is documented and the user guide, they could.

William Ford: Do you have a specific area in the guide you would refer to?

Mike Boggs: I'll send, I'll send you information on the – at your eSource mailbox so you can go on to other questions.

William Ford: OK. We appreciate it.

Jim Brady: We'll take that under advisement. We're in the process of updates, so.

William Ford: Yes.

Mike Boggs: OK.

Jim Brady: Thank you.

Operator: Your next question is from the line of (Tina Kenowitz) from Mutual Insurance Company of Arizona. Your line is open.

(Tina Kenowitz): Thank you. I have just a follow-up from what was spoken earlier, the ICD9 validations are done on the submission of add and update records. In April, we sent a delete record, actually sent a few delete records, some things we sent in January. And we had V codes and the diagnosis codes and we actually got the area code for invalid diagnosis code.

So I don't know if it was – if what you said earlier today has been fixed since we've submitted our deletes in April but we did get validation of ICD9 codes on delete records.

Jim Brady: Are you talking production or test?

(Tina Kenowitz): Test.

Jim Brady: Could you give us – shoot one of us an example, that way we can take a look as it? It should – that add should work the same in both ways.

(Tina Kenowitz): OK.

Jim Brady: An example would be tremendously helpful.

(Tina Kenowitz): OK, yes. I will do that.

Jim Brady: Thank you.

William Ford: Thanks.

(Tina Kenowitz): Thanks.

Operator: Your next question is from the line of Brenda Smith from PMSI. Your line is open.

Brenda Smith: Hi, thank you. I have a question in regard to attorney representation information. If there's a situation where a claimant was represented at some point in time but maybe their attorney's retired or out of business, maybe it's an ORM claim that's been gone on for a while. When it's time to report, if the RRE doesn't have all the required information such as the attorney's phone number and there's no way to provide that, can they just not report that information? How should that be handled?

Barbara Wright: If you got a situation where the attorney's been gone a long time or retired, et cetera, fine, don't report the representative. They're clearly not associated with the current record. However, if you have, particularly with the TPOC or something, a situation where the beneficiary is represented, their association doesn't automatically end with the issuance of the TPOC.

They are still involved from our perspective. So do not consider a representative association automatically terminated with the resolution of the case from the insurers' standpoint. That would be our caveat.

Brenda Smith: OK. But if they're actually retired, out of business or maybe even if the claimant has rescinded that representation, then it's OK not to report.

Barbara Wright: If the beneficiary – if you have documentations that they've rescinded that representation, then no, you don't have to include them either.

Brenda Smith: OK. Thank you.

Operator: Your next question is from the line of (Wendy Raider) from State Compensation Insurance Fund. Your line is open.

(Wendy Raider): Hi. My question is another follow up on what you said about ICD9 code, and being different depending on whether you're reporting ORM or TPOC. Now, on some cases, we might be reporting ORM and TPOCs in the same record and the same submission, so are you saying that we should – would make two separate records for the same person in the same case?

Barbara Wright: No. If you have a TPOC involved, then you have to report the alleged one.

(Wendy Raider): OK.

Barbara Wright: And if you want on a subsequent update once, you know, once the TPOC is done to update it further because you're getting claims for services that you're not covering, fine. But at least with the TPOC, you have to give us the full range of information.

(Wendy Raider): OK, and then also when you were talking about the 51 and 03 disposition code, so we have to continue to monitor it if we give an 03. Now, is that monitoring it in the QIF or the CIF? I mean the query file or the claims input file?

Jim Brady: You couldn't modify this diagnosis on the query file. You would have to...

Barbara Wright: No, she said monitor.

William Ford: You can. You can, if it's a situation where it's an ORM and the person, you know, is not of any – at the time, or that you get an 03 or a 51, you can continue to reach the (inaudible) that MSP reporting record, you know, until you get an 01. Or, you can use the query file if you've already got the MSP record built. I mean, it seems logical. Just continue to send that until the ORM either ends or they become a beneficiary.

(Wendy Raider): So in other words, we get a match on the query file that they are a Medicare beneficiary, but then we get an 03 on the CIF. So you're saying we should put it back in our query file and continue to query it.

William Ford: You could. You have that option. It does, you know, in terms of how other folks do this where the closest thing in the NGHP world, the ORM, would be the group health plan reporting. A lot of people just continue to send MSP add records until the person becomes a beneficiary.

So, you know, under the working age rules for MSP, they may start building a record at age 55. And in some cases, people attain Medicare entitlement prior to age 65, but they basically keep sending that full, that MSP add record, assuming that when building that record, it's assuming that if they do have Medicare, Medicare would be the secondary payer.

(Wendy Raider): Oh, OK. So that implies that we're sending it in the claims input file, because of the (inaudible).

William Ford: Yes, you have the option of either or.

Jim Brady: Whichever works better in your business process.

William Ford: Yes.

Jim Brady: We can take it in either way.

William Ford: Yes.

(Wendy Raider): OK. Thank you.

Jim Brady: Thank you.

Operator: Again, to ask a question, press star then the number one on your telephone keypad. There are no further questions at this time. I turn the call back over to you.

John Albright: OK. We'd like to thank everyone for their participation today. Please keep a lookout for future alerts, postings, et cetera. Also, please note that the teleconference schedule is also on the (inaudible) reporting webpage as well. We'll be back with another policy and technical call in the near future. And with that, thank you everyone for their participation. Please continue to send those questions in. Thank you.

Barbara Wright: And operator, can you come back to us after you close the call?

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

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