TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: June 9, 2009

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities- Policy for NGHP Reporting Questions and Answers Session.

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FTS HHS HCFA

Moderator: John Albert
June 9, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. After the presentation we will conduct a question and answer session. If anyone would like to ask a question at that time please press star then 1.

Today's conference is being recorded. If anyone has any objections you may disconnect at this time. Now I would like to turn the meeting over to Mr. Bill Decker. You may begin.

Bill Decker: Thank you very much operator. Hi everybody. Good afternoon or good morning wherever you are. My name is Bill Decker. I am with CMS in Baltimore, Maryland.

This is a national town hall teleconference call. The subject is the non-group health plan reporting for Section 1.11. This is an NGHP call. If you are a group health plan reporter this is not your call and you can have the next couple of hours off to do something else.

This call specifically for the NGHP folks is going to be focused on policy questions. Last week we had a call that focused on technical aspects of NGHP reporting. This week the call is policy for NGHP reporting. This call is - we have allotted two hours for the call.

We're going to have introductory statements from some of the folks here who are with me at the table. They are in fact John Albert, Pat Ambrose, Barbara

Wright and Bill Zevonia. We also have a couple of other staff members with us who may chip in from time to time.

They are Cindy Ginsburg and Katy Kerris. I have one general announcement to make before we get going and that is on the ever popular subject of Social Security Numbers. We continue to get questions from everybody asking about Social Security Numbers and how they can be collected and sent to us and who has to get them.

We remind everyone once again that our primary identifier for Section 1.11 reporting is the Medicare healthcare claim number, the Medicare ID number. So the HICN is the other term for it. We would like to get that number rather than any other number coming in from reporters.

You do know that you can send us an SSN with a certain amount of other personal information and we can check our databases to see if the person matches with anybody who is a Medicare beneficiary and we'll then identify that person for you.

But once again, our primary ID is the Medicare health insurance claim number, the Medicare HICN. If an individual does not have a Social Security Number for any reason whatsoever, we're probably not going to ever have to worry about reporting that individual to us because that individual will not be a Medicare beneficiary until such time as the individual gets a Social Security Number some time in the future.

That's the general statement about SSNs. I think that I have covered the general area that I want to go into. I will now turn it over to Pat Ambrose who has a few introductory remarks and then we'll get going. Thanks a lot Pat.

Pat Ambrose: Thanks Bill. I just have a couple of quick announcements to make. One has to do with the profile report. Currently the system is only sending the email with the profile report to your authorized representatives for the RRE ID and not the account manager.

This was an oversight on our part and a change is going in to the system this weekend such that all subsequent profile report emails will be sent to the authorized representatives with a copy to the account manager.

In the meantime your authorized representatives should forward a copy of the profile report to their account manager and/or agent as needed in order to share the information provided on the profile report with them such as the file submission timeframe.

So beginning with profile reports that are generated and sent via email, starting next week that email will go to both the authorized representative and the account manager. And of course this is the authorized representative that must sign that last page and return it to the COBC.

Another issue that has come up regarding agent information as you should know, agent information general information about your agent is supplied during the account setup step on the COB secure Web site. The COBC tees this agent information by the agent TIN or tax identification number that you provide.

When you're entering the agent's TIN please do not include dashes in that field. If another responsible reporting entity account manager has already entered information for your agent for that same agent TIN once you enter the agent's TIN into the required field that information will be pre-populated.

This agent information is stored separately and only once by agent TIN. There have been some mistakes make in the data entry for the agent information in some cases. While you're completing the account setup stuff if you note a problem with or even on your profile report.

If you note a problem with the pre-populated agent information contact your agent and have them contact the EDI department to get that information corrected. The EDI representative only needs to change the agent information once and then it will be updated for all our EIDs that are using that agent TIN for agent information.

Now agent information supplied during account setup is really informational only. It displays on your profile report but you may still sign and return the profile report even if corrections are needed.

However, you may wait until corrections are made to that agent's information and then your EDI representative can regenerate a profile report and have it sent out to you. That's all that I have and so I'll turn it over to Barbara Wright.

Barbara Wright: Thank you. The June 2 call that Pat provided most of the presentation that was technical in nature, you should all know that it takes about two weeks to get the transcripts posted on the Web page.

Sometimes the audio is available before that but she did do a presentation of about an hour on that call. So if you missed it and you need technical help please check that out. The thing I wanted to do before Q&As was go over what the status is of some of the issues that are still pending.

We're working on bankruptcy and litigation issues. We're working with the industry and we have had several internal meetings. We in fact have one

group that's working on breaking down their example into the type rules that we're putting out in terms of how you decide whether or not someone is an RRE.

So we hope to have that completed shortly. There was a question about how and whether to report clinical trials. We have language for that that is in clearance right now. Another big one, the majority of the questions that come in about RREs are tied to large deductible or deductible type plans.

And I will emphasize what we're looking at. This is not anything you can take to the bank; it's not final. As we have said before, we are trying to minimize the number of our RREs.

So what we're looking at is if the insured pays both the amount below the deductible and the amount above the deductible making them the RRE, if the insurer pays both making them the RRE, what we haven't found a way around is situations where there is only a deductible amount or below the deductible amount and that is paid by the insured.

And also we know that the insured sometimes for experience, ratings or otherwise pay directly and don't report it. And so we may be left with having to have the insured report those even where the insurer would report other amounts.

We have been asked about employment discrimination cases over and over again. Those do need to be reported if they claim or release medicals or have the effect of releasing medicals. We are still looking at potential increases to the ORM threshold for worker's compensation.

We have had a number of questions come in about hospital write off actions and we will be meeting with the industry on that shortly with the hospital industry. In terms of multiple representations we have had two or three questions come in about what if there is a conservator as well as an attorney appointed in the case?

Who should they put down as the representative? And we want the counsel, the attorney listed in that situation. We have the issue of foreign addresses and telephones. We have language on that in clearance right now so we expect to have that out shortly.

The expectation is where there is a US telephone or address that must be used. You don't have a choice of using a foreign address if you have both. Another issue that's generated a lot of questions is indemnity payments for worker's compensation.

Are these TPOC? Are they ORM? And we are expecting to conclude that they must be reported as TPOC. We're looking at how often they would need reported whether it would be one time per file submission or something else.

Because we realize that if for instance there is partial disability payments or payments that are made biweekly, that could potentially result in seven or eight TPOCs per file submission and we don't want that. So we are still looking at that issue.

On RREs, when there is a parent or a holding company above say a group of insurers - let's say you have five insurers and there is one holding company for all of them, the insurers cannot register as RREs for each other.

What we're getting clearance on right now and expect to be able to allow is if someone wishes we expect to be able to allow the holding company to register even as the RRE even though it is not technically the applicable plan. Certainly each insurance company can register as an RRE.

But if we can we'd like to allow the opportunity for it to be done at a higher level and let you minimize the number of RREs. We have had a number of questions about what other payment means. If you have seen through all the documentation and statutes, it talks about reporting settlements, judgments, awards or other payments.

And other payment is essentially a catch all. The point was many times what's paid or what's assumed responsibility for would not technically fit within the common definition of a settlement or a judgment or award. Know that when you have got liability insurance including self insurance, no fault insurance as CMS defines it or worker's compensation.

For any of those it is reportable whether or not you call it a settlement judgment award. So the other payment is essentially a catch all and also clearly encompasses the situations where there is ORM. Several questions about attorney fees and costs.

Are they included in what's reported or not included? What you need to know is if there is a settlement and the claimant or the injured party is expected to pay their fees and costs out of that settlement then you are reporting the gross amount.

If there is a situation and we understand particularly for worker's compensation this happens in some states where the attorney fees and costs

are specifically paid separately and apart from the settlement with the beneficiary.

In that case you would only report the settlement amount as the TPOC. In terms of situations where someone will register because they perhaps have one case to report. They don't expect to report on a continuing basis, we have said that once you register you must submit null or void files for subsequent quarters.

What we're looking at is whether or not we could put something in place. And obviously since we're just looking at it we don't have a date yet, is whether we could put something in place that would allow you to in essence deactivate so that you didn't have to submit null files on a continuous basis.

But we don't have any answer on that yet. We just wanted to let you know we are looking at it. ICD9 codes - we should have a list shortly of codes that are not considered valid for purposes of reporting. In essence, if you submit multiple codes then one of them is invalid.

That's not going to be a problem. But if all of them are invalid then we will have an issue. The types of codes that we're looking at are invalid, are ones that essentially don't give us any information. If it just says something like unsubstantiated symptoms that doesn't tell us anything.

So we will give you further information on that. Pat I believe answered on the call on 6/2 the questions about right and left justification and how you actually input the ICD9 numbers because we have received questions where people believed that more than one number would show up in the same way in the submission.

Before we go to questions, what I need to let you know about RRE examples is a lot of the examples that are coming in simply don't provide enough information for us to give you an answer even if we were able to give you question by question answers.

There are questions like - let me give you a couple of examples. We're a self insurance fund. Are we the RRE or are our individual members? We're a joint powers authority. Are we the RRE? To the extent we already have rules out there, they attach conditions to those types of situations.

You need to look and see whether you meet those conditions in order to make a judgment. We will certainly listen to any examples that you give of RREs right now but the fact is for the most part we're not going to answer on this phone yes or no RRE questions because it's too easy to have one fact left out that changes it.

We are - it's continuing to go through the lists of examples of RREs so that we can issue them with a generic list of rules of how you apply the concepts in order to get the RRE. If you have a specific problem and you haven't submitted that situation to our resource mailbox please do so as soon as possible.

One other issue that has come up two or three times in the last month or so is questions about the July 5, 1980 date for liability insurance and exposure issues. We're working on language to tweak what's in the user guide but the questions have focused on the word exposure and what it means.

In many instances the people making the inquiries have focused on exposure as being perceived legal exposure. And we are talking more in terms of

physical exposure. So if you have physical exposure that doesn't end on or before 12/5/80 even if for example you sell the property in question.

If you're the one that's involved with the insurance then as far as we're concerned there is continued exposure after 12/5/80. So you need to make a distinction between physical exposure and perceived legal exposure.

As I said, we are trying to work on language to clarify that in the user guide. And that's it for our up front points. Operator, any questions?

Coordinator: Yes. If anyone would like to ask a question please press star, 1. You will be prompted to record your name. Your name is required to introduce your question. Once again to ask a question please press star, 1. One moment please for the first question. Our first question comes from (Scott). Your line is open.

(Scott): Can you hear me?

Barbara Wright: Yes.

(Scott): The question relates to a hypothetical scenario where there are multiple Medicare beneficiaries who have asserted claims. Imagine you have got a scenario where a husband and wife, both of whom are beneficiaries have asserted a claim.

Say the husband is claiming a physical injury and the wife is claiming loss of consortia. You reach a settlement of that case to resolve both of those claims and the settlement includes a general release. So it releases any and all claims including future medical claims with respect to both claimants.

The question has to do with A, we assume that that means that you have to submit two separate reports, a report for each claimant. And then secondarily, how do you allocate the amount of that settlement with respect to your report for each of the two beneficiaries?

We're concerned that if you report the gross amount of the settlement with respect to both claimants that's going to create confusion as to the total amount that was paid.

Barbara Wright: You don't allocate it. You report the full amount for each of them and we do take care of that on the back end in the context of the recovery effort.

I would routinely tell any attorneys or claimants involved that they may be required to show a copy of the settlement or judgment or release showing that this amount really covers both of them.

(Scott): If in that same scenario instead of doing a single settlement agreement with both of the claimants being releasers, if you divided it into two separate settlement agreements that each contained their own respective amounts, would that change how you report the amount?

Barbara Wright: No. That doesn't change our answer because, as we said, we're not bound by allocations to parties. So you're looking at how you're distributing this particularly policy's money. And we have priority recovery rights. So you need to report the full amount and the claimants should be aware that they may need to make it clear that this was actually split XYZ or whatever.

(Scott): Guys, can I ask an additional question.

Barbara Wright: Quickly.

(Scott): Let's say you've got - here's the scenario we face in some of our situations. I know in the TPOC context CMS has made it clear that the existence of a claim alone does not prompt a reporting obligation.

However, if you have a situation where a claimant asserts the existence of an ORM but the reporting entity disagrees that any acceptance was made of ongoing liability, is there any reporting obligation?

Or is it analogous to the TPOC situation where if you're disputing the existence of the obligation you don't need to report until a payment settlement, judgment, award, etcetera, is made?

Barbara Wright: We're asking for ORMs to be reported when the insurer, worker's comp and state, etcetera, accepts ORM. However, what we need to say is we're still seeing examples where someone writes in and says I paid this hospital bill, this ambulance bill, this - and they'll list five or six bills on different (states).

And they'll say well, this is an ORM and it's not TPOC. Well, someone still needs to explain to us why ongoing payment of medical bills is not ORM. If you're paying medical bills as they're coming in, that's our definition of ORM. And so remember when - let me make this point because I want to make sure that no one confuses that there.

(Scott): Sure.

Barbara Wright: When we say ongoing responsibility for medical we're not talking about ongoing responsibility for every medical service this person gets. We're talking about ongoing medical responsibility for medical with respect to their claim.

(Scott): But let's - I'm afraid I might have misspoken or I may not have understood completely my question. Let's say you've got a scenario where a claimant says I have future medical care that's going to need to be paid for and you promised to pay for it.

And the reporting entity says no we didn't promise to pay for it. And in that scenario, doesn't make any payments for anything. The claimant may ultimately sue the reporting entity, etcetera, but there is simply a dispute as to whether ORM was accepted.

It's my assumption based upon CMS' view of TPOC situations that the RRE would not need to report just because a claimant is claiming that ORM was accepted. Is that right?

Barbara Wright: And I think that's what we said a few minutes ago. We don't want ORM reported just because someone, the injured party, says ORM exists. However, you need to make sure that where you are routinely paying bills, etcetera, that you are reporting that as ORM.

(Scott): Perfect. Thank you very much.

Bill Decker: Operator?

Coordinator: Thank you. Our next question comes - yes.

Bill Decker: This is Bill Decker. I just want to ask all of our questioners to try to adhere to the one question and one follow up rule we put in place over the last couple of calls.

Coordinator: All right.

Bill Decker: There are a lot of people out there who are going to want to ask questions and I know that we can get way deep into the weeds on some of these if we keep going.

Coordinator: Okay.

Bill Decker: So one question and one follow up. Thanks.

Bill Decker: Operator, can we have the next caller please?

Coordinator: Our next question is from Theresa Felino. Your line is open.

Theresa Felino: Hi. I'm calling regarding no fault. When we were in Baltimore in a meeting with TCI, at that point Barbara you stated that work loss and survivor's loss were both reportable.

And so when we started mapping out how we would handle that medical is one coverage with its own limits and then work loss is a separate coverage with its own limit. Would we report those as separate lines? They would be separate reports for this person?

Barbara Wright: They both fall within our definition. If they both fall within our definition of no fault and they're on the same policy then essentially if they are paid as TPOCs you're going to be reporting it that way.

Theresa Felino: They're normally paid as ORM because on work loss we just make monthly work loss payments to an individual typically. And then medical we would make the ongoing payment of medical bills. But there are separate limits.

Barbara Wright: The medical coverage you clearly have to report as ORM. We are still discussing work loss if it's in the context of no fault as opposed to worker's compensation. But at this point we have no reason to believe that we wouldn't require that to be reported as TPOC as well.

Theresa Felino: Okay. And I guess I'll just put this out there as far as if it's a TPOC then we'd have to report every month on a TPOC because we normally make monthly work loss payments?

Barbara Wright: As we said earlier, we're looking for a way to minimize the number of TPOCs. And again this isn't final but our expectation is we would probably have you do a total for each quarter file submissions as a single TPOC, certainly not if there are three payments within a quarter, certainly not three.

But we're still looking at that because it obviously poses problem sets in terms of people who have these payments on a lengthy ongoing basis.

Theresa Felino: Yeah because work loss is typically three yeas or until limits are used up, which could be up to five or six years in some states.

Barbara Wright: We understand.

Theresa Felino: Okay.

Barbara Wright: And that's why we have it listed as an issue.

Theresa Felino: All right. Thank you very much.

Coordinator: Our next question comes from Robin Pack. Your line is open.

Robin Pack: Hi. Thank you very much. I was giving you a call in regards to the profile report. I'm not sure if this is a policy question per se, however we are very concerned about it.

We're not seeing in the examples that we have gotten so far, we haven't seen anything that lists out the account designee information. And we were wondering if that was actually supposed to be on there.

And if it wasn't, it'd be very important for us to see information like that just to be able to troubleshoot problems that may happen involving collisions with file share like if Medicare beneficiary says you can only do it once a month.

But if multiple people have access to be able to submit files, it's important for I guess anyone doing reporting knowing exactly who has that access. Do you plan on putting that on the reports?

Pat Ambrose: This is Pat Ambrose. I'll answer that question quickly. No, the account designee information is not on the profile reporting.

There is no plans to put it there. It is the account manager's responsibility to track that information. They can see that by logging into the Section 1.11 COB secure Web site and looking at the designee maintenance page for the RRE ID.

There is the possibility of printing that page if they want to have a hard copy list of the account designees that they have set up. The account manager information appears on the profile report and the account manager is the only person who is able to invite and disinvite or remove account designees from the RRE ID account. Okay?

Robin Pack: Okay. I'm good. Thank you.

Coordinator: Our next question comes from Bessy Bundy. Your line is open.

Bessy Bundy: Hi. Thank you. I'm calling from Freehill, Hogan and Moharro law firm in New York. And we represent what's called protection and indemnity clubs, P&I clubs.

And basically an indemnity insurance rather than liability insurance where our lenders, vessel owners, are required to pay a settlement or a claim before the club will reimburse them. So we're assuming that in those circumstances the member is the RRE.

But they do have a rule where they can waive the pay to be paid policy and the club will pay directly. And we're wondering in that circumstance will the member still be the RRE or will then the club become the member or the RRE? Sorry. I don't know if that's enough info but let me know if you can answer that.

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

Coordinator: Our next question comes from (John Feldman).

Bill Decker: No operator, operator. You didn't cut that person off, did you?

Coordinator: I'm sorry I did.

Bill Decker: We were putting ourselves on mute for a second.

Coordinator: I'm sorry.

Barbara Wright: For that person, would you please submit if you haven't already submitted it to the mailbox and actually you have come to think of it, let us look at that. We haven't gotten to that particular question. And if we need more information what would be helpful is could you send the question as a repeat?

And if your original email did not have contact information for you could you supply contact information? And I know you can't answer back. We're just assuming that you will please do that. Next question I guess operator.

Coordinator: Our next question is from (John Feldman).

(John Feldman): Thank you. My question is regards a situation where a single defendant has multiple insurers and a settlement is reached and the insurer has paid various portions of that settlement.

Some of them - well, in the first instance they are all as I understand it RREs for whatever they pay. If some of the shares are below the threshold then below a $5000 threshold in case of liability insurance, they would not be reported.

Whereas the shares in excess of the threshold amount would be reported. Is that correct?

Barbara Wright: If they are completely separate settlements, yes. If you have a situation where you have got a joint settlement and you're arguable joint separately liable, then you each need to report the total amount. And again it would be something we would clarify on the back end.

(John Feldman): Okay. I'm not sure I understand what you mean by joint and separately.

Barbara Wright: I have seen settlements where the insurers - the settlement specifically says there is like 100,000 due and it doesn't break it apart by the insurers. It is clearly a joint settlement.

And the injured party can pursue any one of those entities to get the full 100,000 if it's not coughed up individually. So if in essence what you've got is a single joint settlement, then that amount needs to be reported by each RRE.

If you have what is in essence an individual settlement then the thresholds apply to each RRE that's involved in that.

(John Feldman): I see. So you'd have in the case that you had just described you would have multiple insurers all reporting the total amount.

Barbara Wright: Yes we would. And as we said, in situations where there is potentially some duplication of reporting on the backend when pursuing a recovery claim, it is expected beneficiaries/their representatives will clarify by providing the settlement document.

In the same way that if only part of it is reported because of threshold, the questions that go out to them ask or pull information on the settlements that are involved.

(John Feldman): All right. Thank you.

Coordinator: Our next question comes from Barbara Whitfield. Your line is open.

Barbara Whitfield: Hello. My question is very similar to the previous gentleman's. I submitted a question to your mailbox on May 15. And I'm wondering will I get an individual reply or will there be a reply that will be put on some general site where I would find my answer? How do you handle that kind of a thing?

Barbara Wright: None of the ones that come into the mailbox are generally replied to individually. We couldn't possibly reply to the thousands we've got.

What we're doing as I was attempting to explain earlier in the call is we have pulled together all the questions that we believe deal with our RRE type questions and certain policy issues and we're using those to expand our list of rules or concepts that you need to use in determining if you are an RRE.

And we expect to put those out as a draft that will include information that's already in the user guide plus additional. And we expect to put that out as a draft with examples to go along with that. And it will allow the public to make further comment before we put it in final in the user guide.

Bill Decker: That material will be available to folks who are going to or potentially going to be reporting on the Section 1.11 on the Section 1.11 dedicated Web site. As it's developed it will be posted there and that's what we're referring to when we say it will be made available to you.

Barbara Whitfield: Okay. So when I go to the Web site and I don't find anything right now it's because you haven't gotten that far along?

Barbara Wright: Correct.

Barbara Whitfield: Okay. And so to get back to the gentleman's last question succinctly, is if the settlement is for $100,00 and all of the insurers behind the scenes have said I'll pay my 2000, I'll pay my 1500 or whatever their shares are.

At the end of the day if we have to report the total amount that's on the settlement release that the plaintiff signs?

Barbara Wright: Yes. Unless the settlement is specific to I am settling with insurer A for 10,000, insurer.

Barbara Whitfield:: I'm settling with not insurer. I'm settling with the policy holder, the insured.

Barbara Wright: Okay. If the release does not break it out then it is from our perspective joint several liability and everybody would need to report the total amount.

Barbara Whitfield: Thank you very much.

Coordinator: Our next question comes from Tanika Lewis. Your line is open.

Tanika Lewis: Thank you. On the May 12 conference call I think it was someone asked about the additional claimants, claimants 1 to 4. And the response leaned towards ensuring that there weren't multiple Medicare beneficiaries.

But that's actually not the case. We actually have beneficiaries that are deceased and the check is paid to more than four additional claimants. So what do we do when we have more than four?

Barbara Wright: We'll have to get back to you.

Pat Ambrose: At this point your only choice is to report up to four as allowed on the claim file layout. Do you expect that this would be a frequent occurrence?

Tanika Lewis: Yes.

Pat Ambrose: Okay. But at any rate right now you need to plan to just report as many as you can fit into the record and we'll take it under advisement but it would require a pretty major change to the current file layout, which we're trying desperately to avoid.

Tanika Lewis: Okay. Thank you.

Coordinator: Our next question comes from Norman Reese. Your line is open.

Norman Reese: Thanks. My question is similar to the previous question. Let's assume you have a deceased beneficiary and there is an executor of the estate. I assume you would report the executor.

Barbara Wright: Yes.

Norman Reese: But let's assume no estate was opened and the heirs filed suit. So we could report up to four heirs.

Barbara Wright: Yes although and if you're dealing with them individually again we need to take it under advisement. But in many cases that we have seen the insurer is dealing with one of the siblings or one of the children or all of the others and is essentially working through them.

Norman Reese: Well, you normally deal with them through their attorney who has filed a suit, not individually.

Barbara Wright: We have seen both.

Norman Reese: Well, if they were represented by an attorney and a suit was filed, would you assume the attorney is a representative or would you still list the heirs?

Barbara Wright: It's still the heirs but as we said, we'll take into consideration your comment about four and see if there is any other way to adapt an answer so that it doesn't impose any other burden. But yes, there is additional information.

Norman Reese: Because in some cases it will exceed four.

Barbara Wright: That's what the other caller said.

Norman Reese: Right. Okay. Thanks.

Coordinator: Our next question comes from Carmella Faraday. Your line is open.

Carmella Faraday: Hi. Okay. Actually I submitted like five questions through your mailbox. I'm hoping I do at least on these calls get a response to the last one. One is if we have a member of a JPA who the JPA pays the claim.

And so they would be the RRE in this particular case but the member of the JPA inadvertently registered as an RRE. How does that member unregister?

Barbara Wright: If you erroneously registered for an RRE ID that you will no longer use or if you had one and were reporting under it and then reporting will discontinue under that RRE ID you contact the EDI representative assigned to that RRE ID and they will put it in a discontinued status for you.

Carmella Faraday: Okay. So just contact them and they will remove that RRE ID?

Barbara Wright: They will. I do need to say that with respect to joint powers authority you need to look at the requirements that we set forth in the user guide.

Carmella Faraday: We have done that.

Barbara Wright: No. I'm just finishing for everybody else's consideration that there are also situations where there are joint powers authority that meet the requirements to be RREs.

But there are also ones where they may have members that are administrative services only members and where we have said that for those purposes the JPA is not the RRE.

Carmella Faraday: What do you mean when you say administrative services?

Barbara Wright: That they simply pay the claims. They don't meet the other criteria that we have set forth for JPAs to be the RRE.

Carmella Faraday: Okay. So if that's all that they're doing is just paying the claims then the JPAs would not be the RRE.

Barbara Wright: Right.

Carmella Faraday: Okay.

Barbara Wright: There is also another question that I think is from the same group and I'm not sure whether Pat can answer it but I'll ask it for her anyway. That is if an RRE

has a separate TIN for liability and a separate TIN for worker's compensation, do they need to register twice even if they are submitting the files together?

Pat Ambrose: No. in that case - I can't speak to who the RRE is but you may register once using one TIN, obtain one RRE ID and submit your file together for both lines of business or subsidiaries or whatever they happen to be.

And then submit the applicable TIN on your claims input file records and associated TIN file reference records for each of those organizations on as I said whatever records they apply to. So you can register using one TIN and then report and use multiple TINs more than one TIN for your RRE or plan TIN on the claim input file and TIN reference file. Next question please.

Coordinator: Our next question comes from JoAnn Gilliam. Your line is open.

JoAnn Gilliam: Thank you. This is for Barbara Wright. I was following up on your comment regarding the registration of the different companies and the holding company.

The holding company doesn't have an NAIC number. Is that going to create an issue with regard to registering the holding company for the other companies?

Pat Ambrose: No. We just ask - this is actually Pat Ambrose answering that question.

JoAnn Gilliam: Okay.

Pat Ambrose: But we just ask that you if you have more than one NAIC company code associated with the entity that is registering to just provide one of those five-

digit NAIC company codes. We can actually associate that company code with the group NAIC group number and so on. We just need one.

JoAnn Gilliam: Great.

Barbara Wright: Also remember that I said this is where we are looking right now and expect to end up that that clearly wouldn't be possible under the existing user guide. So you need to wait until we have got the final language out.

JoAnn Gilliam: We have a timeframe of - because that's what we're waiting for to register is just that answer.

Barbara Wright: Okay.

JoAnn Gilliam: Do we have a timeframe of when we should anticipate receiving that information?

Barbara Wright: We're scrambling as fast as we can.

JoAnn Gilliam: Okay. I appreciate it. Thank you very much. That's all I have.

Coordinator: Our next question comes from Scott Olmstead. Your line is open.

Scott Olmstead: Hi. Thank you. I have a question about the Texas Non-Subscriber Programs. And if they are not like a traditional worker's comp program would they still fall under kind of the worker's comp criteria?

Barbara Wright: No. I mean if you - information for instance is on the TXANS site, etcetera, makes it clear that under Texas state law that entities are actually if I

remember correctly prohibited from advertising or presenting anything that is done as a responsible non-subscriber as being worker's compensation.

So if what is provided actually qualifies as liability insurance you need to report it that way. If it qualifies as no-fault you need to report it that way. And in limited circumstances where you may actually be providing group health plan insurance then you need to report under the group health plan rules.

Scott Olmstead: Okay. So the verbiage on Page 13 of worker's comp in that first paragraph where it says the term includes similar compensation plans established by the employer would also be included as worker's comp. That doesn't apply?

Barbara Wright: Page 13 of our user guide?

Scott Olmstead: Yeah. The end of the first paragraph - that last sentence.

Bill Decker: We're reading it now.

Scott Olmstead: Okay. We kind of wondered if that maybe was applicable to this.

Barbara Wright: We'll look at that language as we're doing revisions. But we did look at the information about specifically the Texas law and our understanding of that law is it specifically prohibits going from advertising, calling, representing the responsible non-subscriber benefits or other provisions as being worker's compensation.

Scott Olmstead: Okay. I'm not quite sure where that leaves us.

Barbara Wright: Well, you need to analyze what you're providing. In many cases it will be liability insurance. In other cases it will be no-fault because it simply pays in certain types of situations.

In others we have heard described to us situations where basically they provide a group health plan and they keep on paying when there is an accident and that's it. They don't provide anything beyond the group health plan.

So you're really going to have to look at what you're providing and whether in many cases it might be self-insurance that is liability insurance. In others it will be a group health plan.

Scott Olmstead: Okay. All right. Thanks.

Coordinator: Our next question comes from Jake Reisen. Your line is open.

Jake Reisen: Yeah. Hello. If you have a situation where you have a JPA and then the business is being handled through a TCA, can you set the situation up where all of their reporting can be in the same window?

Otherwise it creates significant problems with the TCA in terms of managing that account if there are numerous RREs that have to report (at the same time).

Pat Ambrose: Right now we are not making a habit of changing file submission timeframes. But that is something that you could take up with the COBC and one of the EDI representatives perhaps given special circumstances.

Generally speaking though we're not able to be changing the assigned file submission timeframes. But I'm not saying that exceptions wouldn't be made

for extraordinary circumstances. So I would advise that you work through that issue with your EDI representative.

Jake Reisen: Okay. Thank you very much.

Coordinator: Our next question comes from Burt Anderson. Your line is open.

Burt Anderson: Thank you. I wanted to follow up with a comment that Barbara Wright made that you're considering weekly indemnity payments if I understood this to be right to be TPOCs.

And if that is the case, did you mean - we're a worker's comp policy - I'm sorry, worker's comp carrier - and we send out a check each week to any claimant we have accepted a claim for. If that's the case, did you mean each week's payment would be a separate TPOC?

Barbara Wright: You've got several people speaking at once because you're on speakerphone.

Burt Anderson: I'm not on a speakerphone.

Barbara Wright: Well then I guess someone else is. I'm not sure how they got through. I'm sorry. In terms of - we're trying and it is somewhat of a struggle to figure out exactly what to do with the indemnity payments.

The information that we've had from the industry as a whole is that first of all they're not always limited to two agents. They may in some instances include medical, etcetera. And to the extent that our statute regs policy interpretation requires that we not defer to the allocation of the parties, right now we're looking at the idea that they must be reported.

And that would be as a TPOC. As we have said earlier in this call, we're looking at a way to minimize what those would be. We certainly at this point don't anticipate if you do weekly payments that those would be reported each as a separate TPOC.

At most it would probably be one per file submission. We're looking for a way to change that. We're also looking for a way if we can come to a clear enough definition that it would not put us at risk for protecting the trust fund. We would like to find some way to exclude wage type payments from the reporting process in general.

But what we hear that causes us some concern is situations where for example we're paying wages but we're not paying any medical. And we haven't found any justification for a situation where you have assumed responsibility so that you're paying wages but you are not paying related medical.

Some of the - if someone can give us a clear explanation, some of this doesn't make sense to us if it's actually a legitimate way to pay. If it's one where you're allocating it so that it arguably puts us at risk for the trust fund, that's our concern.

So anyone out there that can help us in terms of a way that we can segregate out wages and ensure that it's clearly wages and it's not a situation where someone is allocating in a way to put us at risk, as I said, we'd like to be able to eliminate the wage payments in total.

Burt Anderson: Okay. Actually we're just the opposite. If we pay one day's indemnity we own the medicals. And we have actually figured that in for our treating mechanism for reporting ORM to you people.

Which brings my second question. Since payment of one day's indemnity is accepting some liability in our state, would you expect us to report it assuming you do want us to report it, the TPOC, as both TPOC and ORM?

Barbara Wright: Yes.

Burt Anderson: Okay. And then finally there is a threshold of $5000 for the TPOC. How would that work as we pay indemnity weekly? Would we have to wait until $5000 of weekly payments have added up?

Barbara Wright: Yes. I'm trying to remember the date of the alert right now.

Burt Anderson: It's the first one in March I think.

Barbara Wright: Well, but there is a further alert. I think it's in the one where we extended the timeframe that talks about how you report multiple TPOCs including reaching the threshold. We can go back and look.

Burt Anderson: Yeah.

Barbara Wright: I think it is in that one. We'll cover that but if you think it would be helpful or other people out there in the audience would be, if you want to take a stab at draft language that you think.

Burt Anderson: Sure.

Barbara Wright: What I'm hearing part from what you're saying is if under state law you will always be reporting ORMs if you've got a situation where you're separately paying wages, then we can look at that to see whether or not we could eliminate the reporting of wages for at least those states.

Burt Anderson: All right. I'll send a question into your question.

Barbara Wright: And if you're sending that again in - again, anyone who would like to particularly if it's something we've talked about on one of the calls and we might need to get back to you personally, it would help if you give specific contact information including the phone.

Burt Anderson: Sure. Thank you very much.

Coordinator: Our next question comes from Tracy Meador. Your line is open.

Tracy Meador: Hi. I was just wondering when you were going to address recovery periods and how you were going to handle those?

Bill Decker: Could you clarify what you mean? From your question I really don't know or don't understand what your question is.

Tracy Meador: Is there going to be a session regarding recovery periods?

Barbara Wright: For purposes of Section 1.11, Section 1.11 doesn't include recovery efforts.

Tracy Meador: Okay.

Barbara Wright: So at this point we don't have a specific 1.11 call that's going to address recovery issues.

Tracy Meador: Okay. All right. Great. Thank you.

Coordinator: Our next question comes from Neil Heiss. Your line is open.

Neil Heiss: Hello. I had a question regarding the designees. If we have an account manager does that account manager have to be an employee of the RRE? I have several TPAs that handle claims for us throughout the country.

Two of them say they will be our account manager and handle the day to day communications with CMS etcetera. The third one though says that the account manager has to be an employee of the RRE and then designate a reporting agent.

But from what I have read it looks like CMS will be contacting the account manager, which in our case would have no knowledge of what is going on with the data transmissions, the actual day to day data transmissions. Which way would it go?

Pat Ambrose: It's actually up to the RRE. You may - the account manager does not have to be an employee of the RRE. The account manager could be an agent or TPA or you may wish to maintain that responsibility within the RRE and have them invite agents or TPAs to be account designees. So it's really your choice.

Neil Heiss: So if I designate one of my employees as an account manager our name as the account manager and then say we're designating XYZ TPA then CMS would automatically contact the designee?

Pat Ambrose: No. The account manager is to be that person who is responsible for the day to day management of that account and the reporting process.

Neil Heiss: Okay.

Pat Ambrose: Generally speaking email communications and most contacts would likely be going to the account manager in that case. So it needs to be someone who is knowledgeable of the reporting process and able to then refer questions to the appropriate account designee as necessary and so on.

Barbara Wright: We can look at whether or not we need to slip another sentence in the user guide on this but you have our position right now. You're free to tell the TPA you have that as far as we're concerned TPAs can be account managers.

Neil Heiss: Excellent. That's what I need. You had a question regarding what's wages but not medical. I can give you an example in California.

Barbara Wright: Okay.

Neil Heiss: You could have a situation where a doctor has determined that the person does not need any further medical treatment but they are awarded a permanent disability award.

And the award is not based on the amount of medical but is based on their ability used to be to compete in the open marketplace. And now it's based on the AMA guides. So you could have a situation say for example an amputation where a person has lost a limb.

They're not going to need any further medical treatment. Or someone who has recovered enough that they won't need any medical treatment but they will continue to get permanent disability payments.

Barbara Wright: Okay. And I don't have a problem with that type of example you were referencing. And I assume in that case you would have reported ORM until their needs for medical ceased.

Neil Heiss: Correct.

Barbara Wright: Okay. What I'm talking about is we've got a question where they indicate there is no ORM at all. There is just wages period, which I hear you saying hmmm as well.

So like I said, we can take a look at to the extent you want to help out with a possible draft language as well, something along the lines of state law requires such and such. Can we potentially not report the wages? We're at least willing to look at that because we don't want information that won't be helpful to us.

Neil Heiss: Yeah because you're going to have a lot of situations where we have to pay for years an award but no medical treatment is being paid.

Barbara Wright: We understand. And the whole concept of TPOC over and over again makes - (that plays over) as well.

Neil Heiss: Okay. Thank you.

Barbara Wright: Thank you.

Bill Decker: Thank you.

Coordinator: Our next question comes from Jill Gregg. Your line is open.

Jill Gregg: Thank you. We have a question. Here in Oregon we are allowed to settle claims and have the worker's comp claim remain in a denied status so that the insurer does not assume ongoing responsibility for medical benefits.

But as part of the settlement if we have any medical bills in the file those get paid out of the amount going to the claimant. We know that we would report this for TPOC but the insured, because they never assume any ongoing responsibility for medical benefits, we assume we would not have to report that for ORM even though some medical bills are being paid via the settlement agreement. Is that correct?

Barbara Wright: Possibly. If you're not paying any at all and the whole amount is fully done as a TPOC, fine. But there are situations where people - if you're paying pending that settlement and then if your sole concern is the future medical then someone could have a situation where they report ORM where it starts.

And then they terminate ORM as of the date of the settlement if there are no more future medicals after that point. So I mean keep in mind it would be either way depending on the specific facts of your case.

Jill Gregg: Okay, I guess maybe I'm not being clear. Because we normally do not pay any medical bills pending a settlement on a denied claim until the time that the settlement is completed.

And then we as part of our disbursement of funds will pay the claimant their amount, pay the medical bills that are in the file directly to the provider. And then if there is an attorney there, the attorney also gets paid. But we have no longer and we never have as part of the claim any responsibility to pay ongoing medical benefits while the claim is in a denied status.

Barbara Wright: Okay. So let me repeat that back to you. I'll give you an example with numbers. You're settling for $100,000 and the medicals that you're going to disperse to providers are being taken out of that $100,000.

Jill Gregg: Yes.

Barbara Wright: Okay. And the fees to the attorney are being taken out of that $100,000?

Jill Gregg: Yes.

Barbara Wright: Okay. Then you would simply be reporting the $100,000 as a TPOC.

Jill Gregg: Okay. And the other issue in relation to this, if we have a denied claim, sometimes as a courtesy if the person just needed to go for one office visit but it doesn't meet the requirements under Oregon law for a compensable claim.

We will pay a medical bill as a courtesy at the time of the denial but because the claim stays denied we have no responsibility for ongoing medical. Should we report that as a TPOC or do we report that as ORM or both?

Barbara Wright: As a TPOC.

Jill Gregg: Okay. Just the amount of that initial bill that we're paying?

Barbara Wright: If that's the sole payment and that's essentially the equivalent of your settlement, etcetera - can you hang on just a second and operator, please don't cut this person off?

Jill Gregg: Sure.

Barbara Wright: Okay. We're back.

Jill Gregg: Okay.

Barbara Wright: Did we answer your question?

Jill Gregg: I don't know. We didn't hear anything after you guys went away.

Barbara Wright: But I think we've lost track of exactly where we are.

Jill Gregg: Okay. So we would report it as TPOC and that's it.

Barbara Wright: Right.

Jill Gregg: Okay.

Barbara Wright: Now this is one where you did not make any payments while it was pending and basically you ended up...

Jill Gregg: Yeah. Sometimes we don't make any payments usually while the claim is pending denial. And then if it's just one office visit but we normally wouldn't accept a claim because there are other requirements to have a compensable claim in Oregon.

But the person had to go to the doctor to get checked out. Sometimes we will deny the claim and pay the medical bill as a courtesy.

Barbara Wright: Remember that we said that if you are paying a medical bill because it is the medical exam was for purposes of investigating the claim that we said that that is definitely not reportable.

Jill Gregg: Right. And we also were confused by that because does that mean just a defense medical evaluation or any evaluation like by a treating physician that eventually says hey, this person doesn't have a work related injury?

Barbara Wright: People have only asked us that question in the context of defense exams. So I guess we'll have to think about it in terms of plaintiff exams. But we'll have to think about it.

Jill Gregg: Okay. Thank you.

Coordinator: Our next question comes from Thomas Moses. Your line is open.

Thomas Moses: Yes. I have a question regarding liability claim settlement. Oftentimes we will settle a liability claim with a TPOC but also have what we call a scheduled medical release, which would allow for payments of additional medical bills for a specified amount for a specified period of time.

It does not mean that a claim would necessarily be presented and paid but we have agreed to make a payment if a demand was made for that following the settlement. Will we report that both as a TPOC and as an ORM at the time of settlement or would we need to hold off on the ORM part until a portion of it was actually paid?

Barbara Wright: I'll give you a couple of examples and you tell me if your differs or generally fits with it. What we have seen in most of the liability situations is a settlement or a set amount with defined conditions for someone to get additional set amounts or certain amounts covered.

And example is some of the Fen-Fen had a surgical guarantee if a person had a valve replacement within an X amount of time they got an additional $100,000. There are some situations where very specific care, they would get an additional payment.

And in those types of situations our standard policy has been that those get reported as additional TPOCs. And we have potential recovery rights against those additional amounts.

Thomas Moses: Got you. But these payments would potentially be paid out piecemeal over a period of time. So we would say - let's say we settled the VI claim for $1000 and we agreed to pay up to an additional $5000 over a six-month period of time if additional medical bills were incurred and presented.

Barbara Wright: That specific description we found like ORM does what you have essentially said is okay for related future medical medicals for a set period of time. So in that case you should report it as ORM.

Thomas Moses: Report the entire amount, the 6000? Or report 1000 as TPOC and 5000 as ORM?

Barbara Wright: Now let me make sure I - you're saying you had the TPOC for 5000?

Thomas Moses: We made payment of $1000 to settle the claim. In addition to that we have agreed to pay up to $5000 over a six-month time.

Barbara Wright: Okay. Your $1000 would be a TPOC, which as long as it's under the threshold you wouldn't have to report. The additional 6000 would be the ORM and you would report a start date and you would report a term date.

Thomas Moses: That would be a separate amount. Even though we have not made an ORM payment we would still be reporting?

Barbara Wright: Right. As soon as you have assumed responsibility for ORM we want that reported because the point is that we want to have an open MSP occurrence on

our internal files so that we don't pay inappropriately so that we don't have to play pay and chase.

Thomas Moses: Got it. And then following the initial report for the ORM we would just complete the closing report after the scheduled release had finished.

Barbara Wright: Yes.

Thomas Moses: Okay. One more question - this is real quick and I'm going to squeeze it in real quick. We had an update to the threshold on March 20 that gave us the minimum reporting threshold amounts.

If we over report, if we send you a report on a claim that did not need to be reported, will that be considered an error and be included in our error rate for our file submission? Or will that simply be ignored?

Pat Ambrose: If you submit a claim that falls under the threshold for the TPOC reporting it will be returned with an error code and it will go into that overall error percentage count.

Now in a subsequent alert because of the changes of the file submission states for this type of reporting, you only have to include TPOC amounts dated 1/1/2010 and subsequent. However, we are accepting TPOC amounts prior to that.

So but we are basically adding up all of the TPOC amounts submitted on the claim and seeing and checking whether it meets the threshold or not. And if it does not we'll reject the claim with an error.

Thomas Moses: Okay. So in that circumstance that I just described earlier we had a claim that had elements of both TPOC and ORM. So we would assume that we would go ahead and make that claim reportable in July on both aspects of that claim, correct?

Pat Ambrose: Yeah because the threshold amounts don't apply to or aren't changing for the ORM.

Barbara Wright: But I think you were asking whether you had to report the TPOC amount as well.

Pat Ambrose: Well, I thought so. But I guess we need to talk about that internally.

Barbara Wright: I guess we're going to have some internal discussion here.

Thomas Moses: Yeah, if you could. I mean I wouldn't say any numbers but I'll tell you it's a significant portion of an injury settlement.

Barbara Wright: Okay.

Thomas Moses: I believe you have addressed my questions. Thank you.

Coordinator: Our next question comes from Marsha Macrow. Your line is open.

Marsha Macrow: Thank you. You may have answered this in a previous meeting. I'm sorry if I missed it but I'm going back to the railroads and FELA. We're just trying to confirm that we're understanding this correctly.

If for example - FELA has two different parts to it. For example a railroad may have their own insurance company that's taking care of the past and

future medicals; it's a health program. FELA may also have a payment with regard to the pain and suffering and future lost wages.

If the medicals are being paid by the insurance program, which is separate from the CO action and we're assuming that this insurance program is continuing to report to CMS, do we also have to report the settlement that is reached for the pain and suffering and future lost wages?

Barbara Wright: Yes. Assuming that medicals are claimed and/or released or has the effect of releasing medicals, again you're back to the issue of allocation by the parties.

Marsha Macrow: Okay. But in the release if it does not release medicals, we would not have to report it?

Barbara Wright: Was it a single claim to start with?

Marsha Macrow: Yes. Yes. A railroad worker loses his leg. He's age 65, loses his leg and he is at 50% fault. So the CO action is diminished but the - yes. The answer is yes.

Barbara Wright: Yes. You're going to have to report it but if under the separate payment someone is actually taking care of his medicals and they aren't being billed to Medicare then no one is going to get a recovery claim.

Marsha Macrow: Okay. Just as long as you want to know that we actually have a settlement then.

Barbara Wright: Yes.

Marsha Macrow: Okay.

Barbara Wright: We only recover for payments we have actually made that are related to what claims are released. So we aren't - and as I said on several of these calls, we do not intend to change our typical process.

So in most situations demand will be going to the beneficiary or if they are deceased, the beneficiary's estate, etcetera, for our recovery claims.

Marsha Macrow: Okay. Thank you.

Coordinator: Our next question comes from Marilyn Jones. Your line is open.

Marilyn Jones: Yes. Good afternoon. I'm calling from Pennsylvania on a worker's comp claim once again in regards to the TPOC. I know that a decision is going to be coming out eventually regarding our biweekly payments.

But when we report these TPOCs is it the date of the agreement, the date of the payment?

Barbara Wright: You need to look at the user guide. And for instance we said if the settlement is asked to be approved by the court, that's the date. If there is a written settlement that's signed, it's normally the settlement date.

If there is a check that's issued with no settlement, judgment or other award then it's the date of the check. You really need to take a look at the user guide and see which set of facts meets your particular situation.

Marilyn Jones: Okay. And I do have something for you. On our sales benefits there is no medical whatsoever paid for any of the beneficiaries.

If a claimant is injured and dies they just receive stable benefits, indemnity benefits. There would never be any medical paid for these beneficiaries. Now would that relate to anything that you were asking before regarding when...?

Barbara Wright: If that's a provision of state law.

Marilyn Jones: Yes.

Barbara Wright: Then I would appreciate it if you could point that out in a resource mailbox question including the cite to the applicable law.

Marilyn Jones: Very good. Okay. Thank you.

Coordinator: Our next question comes from Jeff Hodges. Your line is open.

Jeff Hodges: Yes. Hello. I have another question about ORM versus TPOC situation. In Montana there is an advanced payment requirement for liability claims. And an insurer must advance payment to an injured third party's medical expenses until there is a final settlement.

Now normally in a settlement of this kind it would be a TPOC payment but would these advanced payments also be considered ORM?

Barbara Wright: If I understand what you're saying, you're saying that under state law you're required to pay medicals essentially while it's pending.

Jeff Hodges: That's correct.

Barbara Wright: Okay. And I think we have already said in the user guide, we can check the specific language but that would be reported as ORM and you would put in a term date when that responsibility ended.

Jeff Hodges: So that would not be a TPOC situation when you finally make a settlement or would it be both is my question?

Barbara Wright: When you finally make a settlement if you have an additional cash payment you would be reporting that I guess. My question for the Montana situation, if you have been making those advanced payments, do those automatically get subtracted from the final settlement amount?

Jeff Hodges: Yes. Yes they would be subtracted.

Barbara Wright: Off the top of my head I don't know. I think we need to discuss that internally here so that we can give you a consistent answer on how to report that.

Jeff Hodges: Okay. Okay.

Coordinator: Our next question comes from Mike Brown. Your line is open.

Mike Brown: Hi. I have a question regarding ICD9 codes. On the claim input file detail record layout there are enough places for 19 ICD9 codes. Sadly to say our system can exceed 19 ICD9 codes.

What would you like us to do in cases where we have more than 19 ICD9 codes on a claim?

Barbara Wright: Put in 19. Hopefully the way you're setting your system up or you're doing it that you're putting the ones that you consider to be more primary as the early ones.

But at this point so far everyone has been telling us the opposite. I'm only going to give you two. So but again, the more specificity you can give us, the better any efforts at recovery will take place.

Or in terms of not inappropriately denying payment up front and referring someone to worker's comp, etcetera, we're able to have specificity then we should clearly only be denying exactly those claims that you're already planning to pay.

Mike Brown: Well, sadly to say I mean the system does not necessarily - you don't enter the highest priority per se.

Barbara Wright: I know. But I guess what we'd say is if you're getting into that many ICD9 codes hopefully you will at least be reporting those that factor into the major aspects of whatever your injury is.

That you aren't telling us about someone's rash if they went out and broke three limbs and excluding the three limbs. We really don't have an answer for you other than that. We have expanded it to 19.

Mike Brown: Okay. Perhaps a follow up question. Let's say we are able to come up with an algorithm that will determine the highest priority per se for the 19 ICD9 codes and then something changes next quarter and now we think we have a higher one.

Will there be - is there a down side to us changing the list of 19 that we send to you the next time around?

Pat Ambrose: No. You can send that on an update record and we'll take and accept that information.

Mike Brown: Okay.

Pat Ambrose: There is a list that we're working on. I think Barbara mentioned at the beginning of the call of codes that will essentially be treated as excluded codes.

However, we would accept them as long as other diagnosis codes are included on the record. And I don't want to get into a real thorough explanation since we haven't finished this requirement yet.

But realize that you will have a list that you can check against to and in a sense weed out diagnosis codes that aren't as helpful to CMS and it will help you prioritize which ones are more significant.

Mike Brown: Okay. Thank you.

Coordinator: Thank you. Our next question comes from James Park. Your line is open. Please check your mute button. Our next question comes from Sherry Woods. Your line is open. Please check your mute button.

Sherry Woods: Hi. This may be a very early or a late question but I'm very new to the process. If the insured, which is either the employer or an insurance policy holder has multiple parent/child relationships and the insurance policy is in the name of the parent but covers the parent plus the subsidiaries.

Does each of the legal entities of parent and subsidiaries covered by the insurance policies need to register as an RRE or can the parent register on behalf of the subsidiaries? Hello?

Barbara Wright: I'm not sure if some of us lost you in that recitation. But so again, if you want to submit that exact one if you haven't already. If you have then it may be in the whole stack of ones that we're going through.

But in general a parent can register for a subsidiary. And if you want to think about it from a very simplistic standpoint, it's kind of like the higher you are on the tree, the more people you can register for. You can register for those that are below you.

And as I said in the beginning, we are looking at whether or not if the top entity on the tree if you want to call it that doesn't technically qualify as an applicable plan, whether we would still let them register as the RRE for everyone below them.

Sherry Woods: Okay.

Barbara Wright: Does that help or not?

Sherry Woods: Yes. Absolutely it does. That really answers my question. And then secondary to that, if we are going to assign the actual reporting of the data to you to a third party, like a TPC or the insurance carrier in some cases.

Does their reporting ID number have to be included when we actually register to get an ID number?

Pat Ambrose: To provide in the account setup step on the COB secure Web site you are asked to provide an agent tax identification number and agent contact information.

Sherry Woods: Okay.

Pat Ambrose: So I recommend that you sign up for the computer-based training that can be found on the Web site.

Sherry Woods: Okay.

Pat Ambrose: And go through that process so you understand what would be collected. And then contact your agent or your TPA or whoever will be doing reporting on your behalf and get the necessary information that you need from them to complete the new registration and the account setup then.

Sherry Woods: Okay. Well, thank you for letting me ask probably questions you answered 100 million years ago.

Barbara Wright: That's okay.

Coordinator: Our next question is from David Tyus. Your line is open.

David Tyus: Hi Barb, it's David. I think I got my question answered before. I was sort of interested in the multiple TPOC situation as a lot of people are. And I was a little bit confused about if the insurer continues to put their TPOCs in representing themselves as a primary in the plan so it can be put out there on TWF.

I didn't really understand what the difference between that would be. And what would be a good date to record and ORM? So I guess you're still working on that. So I don't have any other questions. Thanks.

Barbara Wright: For everyone else on the line, we want ORMs as we define them reported and TPOCs as we have defined them reported.

We have said over and over again the ORM information helps us in terms of front end processes for us, in other words whether or not we should pay claims to start with. TPOCs and ORMs can both be helpful in terms of recovery actions. So we do want them reported in the two different ways.

David Tyus: Yes. I was just saying Barb, that if I reported multiple TPOCs I would assume the effect would be the same as if I had recorded one ORM over that period of time.

Barbara Wright: And I'm saying David, please for everybody else that's on the call, this is not about how we're going to use these in our recovery, etcetera. We need them reported as we have defined them.

And as I said, ORM has a particular additional help to us in terms of helping us with our pre-pay processes while both can help us with our recovery processes.

David Tyus: Thank you.

Coordinator: Our next question comes from Claire Bellow. Your line is open.

Claire Bellow: Good afternoon. How are you today?

Barbara Wright: Fine thanks.

Claire Bellow: I have a question with regard to a couple of fact patterns that we have seen. I'm with DCM and we have seen some fact patterns that have raised questions with regard to reporting requirements.

In one fact pattern we have actually seen several times since the guidelines have been issued and that's a situation where we have a medical malpractice suit where we have a Medicare beneficiary and we have medical bills that we believe would be subject to a Medicare lien.

Claimant's counsel has contacted Medicare about the lien and has been told that there is no lien. And we want to settle the case.

Barbara Wright: Well, two things. There is no way that the MSPRC, our recovery contractor, should be saying no lien before we have a settlement date because we continue to make payments through that settlement date unless the individual is deceased.

In which case we might have information that we have nothing that's related. So and the second is whether the beneficiary or plaintiff's counsel is actually interpreting what they hear correctly because the standard conditional payment letter that's issued by our recovery contractor specifically says this is an interim amount even if it's zero.

Claire Bellow: Okay. But even if we have a response that says it's an interim amount that's zero and we believe that there are medical bills that will at some point perhaps be subject to a lien, how do we as the insurer or on behalf of our insurer fulfill the obligation to protect that lien when we don't have?

I mean we're having trouble getting information to satisfy a lien that we believe will be there at some point. I mean how do we protect the obligation under these reporting requirements for the insurer?

Barbara Wright: That's the whole area that you're getting into is really beyond the scope of this call right now. This is 1.11, which is not really recovery issues. I realize that may be frustrating for you but we really can't get into all of the recovery issues right here right now.

Claire Bellow: Okay. Thank you.

Coordinator: Our next question is from Carl Pickle. Your line is open.

Carl Pickle: Good afternoon. We're a small auto insurance carrier in Florida doing business in multiple states. But in Texas we are an MGA among other MGAs for a different carrier.

That carrier is saying that they want us to be their RRE and to separate our business from their business and we're confused as to whether they are the RRE or are we.

Barbara Wright: Can you define MGA? Is that an agent?

Carl Pickle: Sorry. Yes. Managing General Agent. In other words we're basically doing business in Texas on their paper but as are other companies.

We're not sure whether to report any settlements in Texas just in our normal report or do we have to have a separate RRE for them? Or are they the RRE and we are then the account manager for their business?

Bill Decker: We're going to go offline just a second and we'll be right back to you.

Carl Pickle: All right. Thank you.

Barbara Wright: All right. We're back. I think in the question that we're going through and trying to fit in with our rules right now we have at least one that deals with MGA issues.

If that's from you, know that we're still looking at it. If it's not from you can please submit your specifics to the mailbox so we can make sure that your type question is differing from the other MGA question that we're looking at?

Carl Pickle: I submitted this question on April 23.

Barbara Wright: Okay. So your probably is the one that's in the stack we're working on.

Carl Pickle: Okay. Great. One other real quick question. In Florida we have a very serious bad case climate.

And if our asking for the HICN or the Social in order to report a settlement is interpreted as conditioned upon the settlement and thus placing ourselves into a very bad case situation on a catastrophic loss, say, is there any kind of hammer to get them to give us that number?

Bill Decker: The number that we need is the healthcare identification number.

Carl Pickle: And if they refuse to give it to us?

Bill Decker: If a beneficiary who has that number refuses to cooperate with you, you might want to remind the beneficiary that the law does require the beneficiary to

cooperate with CMS in order for CMS to properly pay claims on behalf of that beneficiary.

Carl Pickle: Okay. Thank you.

Bill Decker: All right. I mean we're working on additional materials that we're going to provide that you can use to help facilitate collection of that information and approaching it from many different angles including to the beneficiary directly themselves.

We recognize that this can be challenging. But in terms of identifying a Medicare beneficiary, I mean they do have an obligation to cooperate as part of their agreement to take Medicare.

Carl Pickle: Okay.

Bill Decker: So someone's paying claims on their behalf that Medicare is also paying.

Barbara Wright: And one of the more recent questions in fact in just the call last week, people were asking again whether in order to do the query function if they had to have a release from the beneficiary in order to check with us whether or not the person is in fact a beneficiary.

And from our perspective for that, no. Anyone who is a beneficiary in line with their requirement to cooperate with us, they have in effect by regulation give permission to anyone to release information to us for purposes of coordination of benefits.

This includes settlement information even if there is a confidentiality provision.

Coordinator: Our next question comes from Sharon Hernandez. Your line is open.

Sharon Hernandez: Yes. We handle worker's comp. And we were in the very beginning stages of this information. And the question that comes up is what type of claims you have to report.

Is it all work related injuries regardless of how much medical we're going to pay, how old the individual is or only if they're Medicaid eligible?

Barbara Wright: Well, first of all it's not Medicaid at all. If you have someone who is Medicaid eligible you probably need to be coordinating with that state for purposes of Medicaid.

But if it's a Medicare beneficiary, those are the individuals you have to report to us. If they're not a Medicare beneficiary or were not in the past a Medicare beneficiary, we don't need to have you report them to us at all for purposes of Section 1.11.

Sharon Hernandez: So only if they're a Medicare beneficiary.

Barbara Wright: Yes. Now remember if you have got ongoing responsibility for medical you do need to monitor that because if they become a beneficiary while you still have ongoing responsibility for medicals then they would need to be reported at that time.

Bill Decker: You also may have responsibility under different laws to report to state Medicaid agency information on Medicaid recipients.

Sharon Hernandez: Okay. Just a follow up - is there a place that you can go for just basic information of what's reported and when it should be reported?

Pat Ambrose: Have you seen the user guide at www.cms.hhs.gov/mandatoryincrep?

Sharon Hernandez: Yes. I do have that printed off.

Pat Ambrose: Okay. And then subsequent to the user guide dated March 16 there are several alerts posted on the same page that are applicable to basic reporting requirements.

We're in the process of incorporating the information in those alerts in the current user guide. So you need to read that user guide and it should answer many, many of your questions.

Sharon Hernandez: Okay. But you won't hold a program that just goes over everything from the nuts and bolts?

Pat Ambrose: Actually another good source would be the computer based training. When you're on that page that I mentioned earlier, the mandatory INSREP page on the left hand side there are various different pages to go to.

And one is computer based training. Read that and sign up for the computer based training and that will cover a lot of the same information that's in the user guide with some additional examples then and information for you.

Bill Decker: Although there still are courses of computer based training that are still under development.

Pat Ambrose: That's true.

Bill Decker: But the courses that you seem interested in are up. And for everyone who is out there, those particular training courses that are there now and that will be there in the future are free for your use. And anyone can take them at any time.

Sharon Hernandez: Thank you.

Coordinator: Our next question comes from Rhonda Kern. Your line is open.

Rhonda Kern: Hi. I was going to ask about the threshold because we got into this kind of late. And we were kind of wondering where we could find some general discussions regarding the threshold amounts?

Barbara Wright: That's in one of the alerts subsequent to the user guide. And then there is a follow up that addresses some TPOC information in another one of the alerts. So in addition to the user guide you need to look at the three alerts that were issued subsequent to the user guide.

And know as I think we said at the beginning of this call, we still are looking at data to decide whether or not to increase the threshold for worker's compensation ORM. Because I know that was in one of the discussions here not too long ago because then the user guide, the only thing we could find is where it discussed errors.

Pat Ambrose: Yeah. The user guide that was published on March 16 does not contain information on the reporting threshold.

Barbara Wright: Right. So it will be more so in the alerts now.

Pat Ambrose: Yes. There is an alert dated March 20 that is found on the same page as the user guide that discusses the threshold.

Rhonda Kern: Okay.

Pat Ambrose: Then there is an alert dated April 7 that discusses the reporting multiple TPOC amount.

Rhonda Kern: Okay.

Pat Ambrose: And then May 11 is an alert that changes the implementation schedule and also talks about not reporting TPOCs prior to January 1, 2010. So unfortunately at the current time, until we get all that information updated in the user guide, you have to look at all of those sources.

Bill Decker: Yeah. Because we're running through everything right now.

Barbara Wright: Well, basically when you go to the Web page and you see the date on the user guide, you should be looking at any alerts that are issued after that date. There are I believe two other alerts that specifically are not in the NGHP user guide.

There was one that was a quick reference guide for registration. And of course that applies to NGHP as well. And we also put a revised implementation timeline, which was on the overview page I believe.

Rhonda Kern: Okay. Yeah because we just signed up for the computer based training.

Barbara Wright: Okay.

Rhonda Kern: We'll go through that and then I'll read those alerts then. Okay. Thank you.

Barbara Wright: You're welcome.

Coordinator: Our next question comes from Hashou Katkar. Your line is open. Our next question comes from Margaret Casting. Your line is open.

Margaret Casting: Hi there. I am wondering for ORMs and worker's compensation you have an open ORM claim but for whatever reason you are in a state where you cannot close out the ORM.

But we do not get a physician's opinion, a treating physician's opinion but no further medical care is needed. And we don't get it for various different reasons. Do you want that claim to continue to be reported even though we're not getting any medical bills and realistically the claim is done?

Barbara Wright: Yes.

Margaret Casting: Okay.

Barbara Wright: I mean we're still open. I actually can't tell you if we have gotten any recently but if people have a framework they want to suggest or anything in terms of this other solid basis for us to allow you to close that ORM, we're willing to listen.

But what we don't know how to deal with to make sure it's covered is a situation - the biggest example or easiest example is for instance someone who has a knee replacement. And you know he's going to have another knee 15 or 20 years down the line. We want to make sure that we don't inadvertently pay for that.

Margaret Casting: No. Okay. That's fair. Thank you.

Coordinator: Our next question comes from Thomas Daily. Your line is open.

Thomas Daily: Thank you very much. Good afternoon to everyone. Ms. Wright, I think these are two RRE example types of questions but I think and I hope that they are general enough in nature that they might be dealt with usefully this afternoon on the phone.

They're both related to worker's compensation benefits. And the first question Ms. Wright is does CMS consider uninsured employers funds where a division within a state worker's compensation agency pays medical and temporary disability benefits? Would they be considered to be an RRE?

Barbara Wright: I think that's covered in the list of criteria that we set out for worker's compensation that's in the user's guide and yes, they generally would be.

Thomas Daily: Okay. Thank you. And the second question would be with regard to second injury funds, which are slightly different. With second injury funds there is no medical benefits that are being paid by the state agency.

The employer for the last injury would be responsible for the medical payments. But permanent total disability payments are paid by the second injury fund by the state agency. Therefore would the state agency be considered to be a responsible reporting entity then?

Barbara Wright: Could you submit that to us in writing? I think the answer is probably going to be yes and that we will plot it under one of the things that we've already listed for worker's comp. But if you haven't already submitted that could you submit it?

Thomas Daily: Will do. Thank you very much Ms. Wright.

Coordinator: Our next question comes from Victoria Vance. Your line is open.

Victoria Vance: Thank you very much for taking the call and also on behalf of everybody for hosting these seminars. I find them to be very helpful.

A quick question and that has to do with whether CMS has made any determination regarding mass tort claims and in particular claims that may be seeing process through things such as what's called MDLs, multi-district litigation or also asbestos, which are often again dealt with on mass scales.

But at the time of any particular settlement or resolution often is done then on an individual by individual basis. But those are usually very large pieces of litigation with hundreds if not thousands of claimants. And the people who work on processing those and working on those would be interested in CMS' proposed treatment of this program with regard to those litigation programs.

Barbara Wright: Those of you that are heavily involved I think we offered before but I haven't seen too many actual requests or agreements to do it come in. If you are particularly interested on a work group on that, if you have a lot then I would like to know full contact information.

So because as we clean up some of the rest of this and we need to concentrate more on the mass torts, what we have said in the past is we definitely want to narrow down our refined language that's in the user guide about product liability so that we're not getting that information except in limited circumstances.

For the mass torts, some of the other things that we have discussed is that the fact that right now people don't - not people. I will say that entities that are RREs don't always right now know specific payment amounts for particular individuals or know their Social Security Numbers.

It doesn't mean that's necessarily going to stay that way under this reporting. We under many of the globals have seen a number of cases where what the insurer can ask for or the plaintiff can ask for or the two of them are jointly working on doing it to make sure that we get our interests protected.

They'll ask a for a qualified protective order for example to get Social Security Numbers, etcetera. So there are ways to do some of these things that aren't necessarily practiced in all cases right now. And that's what once we get the next version of the user guide out, that's what I would expect we would be focusing on is the mass torts.

Victoria Vance: And if we wanted to offer our services to participate in that sort of working group, how can we get that information to you?

Barbara Wright: Send it to the resource mailbox and just put mass tort participant. And give me in that email, give us all your contact information, your telephone and email, etcetera.

But also if you could if you don't mind putting a brief description of why you're interested. Are you typically involved in MDL or are you this or that? Whatever you are, it would help.

Victoria Vance: Very good. We'll be happy to do that. Thank you.

Barbara Wright: Thank you.

Coordinator: Our next question comes from Katherine Bernowski. Your line is open.

Katherine Bernowski: Hi. I'm with a public entity and my question involves the clearing process. We are self-insured and self-administered. And we intend to use a vendor for our reporting services.

However, in order to save some costs, what we would like to do is to do the query portion ourselves. Now I haven't heard anything about this and I know I have missed a couple of these seminars. But is it possible for us to do that, to submit our query function ourselves but then use a vendor as our actual reporting entity?

Pat Ambrose: Yes it is possible. You'll see during account set up that you may select a file transmission method by file type. So you may use the same file transmission method for your query file and your claim file or different ones.

And then you are able to use - the RRE is able to set up the RRE ID and play the role of account manager and invite the agent as account designees as you probably would want to do in this case.

And you as the account manager may submit files via HTTPS or a secure FTP using your log in ID and password and your designee, your agent may submit files under whatever method they are using separately. So it's perfectly possible to do that.

Barbara Wright: Is it also true of they wanted the agent to be the account manager but they could simply have the account manager list them as one of the designees?

Pat Ambrose: Yes. Most importantly, your authorized representative obviously needs to be with the RRE organization and authorized to sign that profile report. But yes, that's all true. Okay?

Katherine Bernowski: Thank you very much.

Pat Ambrose: You're welcome.

Coordinator: Our next question comes from (Kara). Your line is open.

Man: Yeah. (Kara) actually had to step out but I think you aren't going to answer her question anyways. It was about the recovery side as far as protecting an RRE's exposure in the future. But I guess that will be addressed later.

Barbara Wright: You're right. We're not including those in the scope of this call.

Man: Okay. Thank you.

Coordinator: Our next question comes from Lisa Ku. Your line is open.

Lisa Ku: Hi. I was calling because there was an earlier question about wage claims and medicals. Does that apply just to worker's compensation claims or is that for all injury claims?

Barbara Wright: It's basically across the board. Keep in mind it comes up most frequently in worker's compensation that they're potentially designated separate funds by law or otherwise.

But in a liability situation again, if there is a single liability policy whether it's self insurance or an actual policy, we're not bound by the allocation of parties.

You need to report the full amount. And then it's up to us to determine how that applies to any recovery we might have.

Lisa Ku: Okay. And the second question I have is with regards to the May 26 alert. It's actually for the group health plan but actually it's a template for certain wording that can be used. Can that apply to non-group health plan as well?

Bill Decker: Yeah. Right. The template is for GHP users only. It's not for NGHP users at this time.

I believe that we intend to have something out for NGHP registrants and others involved in the NGHP process on this issue but it's not there yet. That template is pretty much strictly for the use of GHP insurers.

Lisa Ku: Okay. Do you know when those templates would be coming out?

Bill Decker: As soon as we can get them out is the best answer that we can give you now.

Lisa Ku: Okay. All right. Thank you.

Coordinator: Our next question comes from Suzanne Safara. Your line is open.

Suzanne Safara: Thank you. There have been a couple of questions about this earlier and I guess it hasn't been addressed as succinctly as I think I need. There were two memos, one on May 11 and one on May 12 talking about the reporting of a claim.

And it states that the dates for ORM are not changing and that date is 7/1. But if the TPOC is before 1/1/2010 it doesn't need to be reported. So how do we

reconcile that? If it's open as of 7/1 but settled before 1/1/2010, how do you recommend we handle that?

Barbara Wright: As we said earlier, we apparently need some internal discussion here. But I assume that you would like whatever we put out to cover various examples such as it was open for ORM as of 7/1 and it continued beyond January 1, 2010.

As of 1/1/09 it was open for ORM but it continued beyond 7/1 but not beyond 1/1/2010. We will try and make sure we cover those.

Suzanne Safara: Thank you.

Coordinator: Our next question comes from Susan Freeman. Your line is open.

Susan Freeman: Hi. Earlier you were talking, Pat, I think you were talking about the TINs for the different lines of business. If there is an RRE that is going to report for all of their subsidiaries, do the subsidiary TINs have to be recorded on the claim record files?

Pat Ambrose: It really should be the TIN associated with the plan TIN defined on that file. On the claim input file and TIN reference file the TINs there are used in the event that CMS needs to make contact regarding coordination of benefits.

And those TINs will also be used by the recovery contractor in their normal business processes that aren't changing by the way for Section 1.11 or as a result of Section 1.11.

Barbara Wright: And this would include any correspondence if part of what a beneficiary came back and said was well, I don't have any claim with that particular insurance company.

So at the record level information specific to the claim in the long run is going to benefit everybody because it means there is less chance we're going to have to come back to the RRE.

Susan Freeman: Okay. So if like me as the agent, if I can confirm from the RRE that they would be the one that would be contacted in all of those situations you just explained then their TIN would be the only one we would need to reference, correct?

Barbara Wright: That's right.

Susan Freeman: Okay. Thanks.

Bill Decker: But if it makes sense to report other TINs then do that. That option is available and we would recommend it if it makes sense to you.

Susan Freeman: If it makes sense.

Bill Decker: Right.

Susan Freeman: Okay. Thank you very much.

Coordinator: Our next question comes from Bonnie Massardi.

Pat Ambrose: Susan? Bonnie?

Bonnie Massardi: Yes. Thank you. I had submitted a question a while back and I have listened in on everything and I haven't heard the answer yet.

If there is a trust, I'm trying to figure out how we report those when the fields are set as being first and last name, if you have a specific requirement or if we can follow some semblance that would identify it as a trust?

Pat Ambrose: Hold on just a minute please.

Bonnie Massardi: Okay. Would it help if I tell you that I'm referencing Page 113, numbers 106 and 107?

Pat Ambrose: Yes perhaps.

Barbara Wright: Hang on just a second please.

Bonnie Massardi: Thank you.

Barbara Wright: We will need to look at that and get back to you. Apparently we haven't reviewed that issue yet. Part of it would be how long the field is, whether it's simply long enough to take the information or what we'd do.

And also operator, before you go on at all, it is 3:00. If you could let us know how many are in queue, I think several of us here have meetings that we have to attend.

Bonnie Massardi: May I ask one last related quick question? I have several others that were submitted and these were all around the first of May. Would it be helpful if I just go ahead and resubmit those? I have not heard a response from you so far.

Barbara Wright: Sure. That's fine. But please label them as a repeat question.

Bonnie Massardi: I will. Thank you.

Bill Decker: Provide your contact information because we'll want to talk to you.

Bonnie Massardi: Yes. It's there.

Barbara Wright: There have been situations where we believe the answer has been provided and for whatever reason the person inquiring is still confused.

Bonnie Massardi: That's possible too. Thank you.

Coordinator: We still have 14 questions in queue.

Bill Decker: About how many callers have been dialed in today?

Coordinator: 700 and about 30.

Bill Decker: Okay. All right. We'll take one more question and then we're going to wrap it up.

Coordinator: Okay. Our last question then comes from Brenda Smith. Your line is open. Ms. Smith, your line is open.

Brenda Smith: Hi. This is Brenda Smith from CMSI. I have a question in regards to the December 5, 1980 date for liability settlements as it relates to exposure claims. And I realize that the date of injury as defined by CMS is the actual first date of exposure.

So if you're dealing with a case where the first date of exposure is prior to December 5, 1980 but the exposure continues past the December 5, 1980 and the carrier is handling a claim where the exposure goes past that date, would that be reportable because the exposure continued?

Or would it not be reportable because the date of injury is defined by CMS is prior to that December 5, 1980 date?

Barbara Wright: We have said where exposure continued it is reportable.

Brenda Smith: Okay. Thank you.

Bill Decker: Thank you all.

Brenda Smith: And can I ask one other quick question?

Bill Decker: All right.

Brenda Smith: Thank you.

Bill Decker: Then we have to stop.

Brenda Smith: I will. I promise. Will the for ORM termination dates, will the system accept a date in the future?

Pat Ambrose: Yes it will.

Brenda Smith: It will. Okay. So if there is a statute of limitations and you want to put a date in the future, will it be accepted?

Pat Ambrose: Yes. And I'll update the user guide to reflect that information. Yes it will accept the ORM termination date may be a date in the future.

However, I caution you if you're in a state that has - it's open for three years but it also has other provisions such as if they have additional medical care then it extends for an additional period. Or if it closes and they do exit reopen, you need to be monitoring those situations so that you haven't submitted a termination date that is in effect overridden by some other corporate account. That's all.

Brenda Smith: Okay. Understood. Thank you.

Bill Decker: Thank you. Thank you everyone. We'll talk to you soon. Thank you operator.

Coordinator: Thank you.

Barbara Wright: How many people - I think you already told us.

Bill Decker: 730.

Barbara Wright: 730. Okay.

Bill Decker: Thank you.

Coordinator: Thank you.

END