TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b)(8)

DATE OF CALL: June 30, 2010

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

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Centers for Medicare & Medicaid Services

Moderator: (Bill Decker)
June 30, 2010
12:00 p.m. CT

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

Mr. (Decker), you may begin your conference.

(Bill Decker): Thank you very much, (Simon). Hi, everybody, my name is (Bill Decker), and I'm with CMS in Baltimore, Maryland. Good day to all of you who have signed on, we think this will be a very interesting call, and a very useful call for all of you. I'm going to go over some initial ground work here, and then we'll get started.

First, this is an NGHP call, non-group health plan call, not GHP. If you are a GHP (RRE) or interested in GHP matters, this is not a call for you. You may leave the conference at this time.

As I said, this is an NGHP call, and it is specifically a policy call, we will be dedicating this call to answering your policy questions. And as a consequence, we will not be answering any of your technical questions.

If you have a technical question, please, I ask you not to bring it up on this call. There will be opportunities in the future for you to bring your technical questions to us today.

The date today, for the record, is June 30th, 2010. At CMS today, we have me, my name is (Bill Decker), we have (Barbara Wright), we have (Bill Zagonia), and we have (Pat Ambrose). When we get started, the CMS presentations – when the presentations are complete, as I said before, we will – we will go into a Q&A session. During the Q&A, we ask you to limit yourselves to one question and one follow-up question. If you have more than two questions for us, we may in fact ask you to stop, and we will move on.

Just, again, for the record, the most recent NGHP technical call was June 10th. If any of you have technical questions, and you have already signed up and are an (RRE), and you have already had an (EDI) rep assigned to you, you may call your (EDI) rep or contact your (EDI) rep for follow-up on your technical questions between now and the next national teleconference call.

Also for the record, the most recent NGHP policy call we had before this one was on May the 27th, so it's been a little bit over a month between policy calls, and that's why we're anticipating this one to be very interesting.

After today, there will be – there are no additional NGHP calls scheduled, you will not find a schedule for any additional NGHP calls on the Web site yet. We are planning on additional calls, however, throughout the remainder of this year, 2010. To begin, in both July and August, there will be only one NGHP call scheduled each month, the July and August calls will address both policy and technical issues. From September going forward, there will be two calls each month, one policy call and one technical call.

The tentative date for the July NGHP call is Wednesday, July 28th. The complete final schedule for all NGHP calls during 210 – during 2010, rather, will be posted on the section 111 Web site within the next couple of weeks. Let me say that again, the final schedule for all the upcoming NGHP calls for the remainder of 2010 will be posted on the section 111 Web site within the next two weeks or so.

I will now address some of the various questions we received dealing with (SSN) and (HICN) questions. I will then turn the discussion over to (Barbara

Wright). When (Barbara) has completed her discussions, we will open it up to all of you with the Q&A portion of today's section 111 NGHP town hall call.

We received a variety of very interesting e-mails from all of you since the last policy call we had, and a number of them had to do with either social security numbers, or (Pickens) healthcare – Medicare health insurance claim numbers, or both. And I'm going to answer the five or so that we got on those – on those issues.

The first one I'm going to take a look at, really the crux of this one was some of my clients do not possess a social security number. In such case, I can tell you that your clients will not be a Medicare beneficiary until such time as they do possess a social security number. No social security number, no Medicare ID number, you have to be – the social security administration issues all Medicare ID numbers, and they issue them as a consequence of involvement in the social security system. It is an exceptionally rare case when anyone would be a Medicare beneficiary without the social security number, and most of us here have never seen such a case. So I'd like to make sure that you all fully understand that.

Along with that question – you know along with that question and answer is the fact that what we are dealing with here, and what you are dealing with here as a consequence is reporting about Medicare beneficiaries. We are primarily interested in the Medicare health insurance claim number, Medicare HICN, the Medicare (Hick) number, and the Medicare ID. It's all the same thing, when you send us information about people you're reporting to us, that is the number we require you to send to us. If you do not possess a Medicare HICN for someone that you need to be talking to us about, and you do have a social security number for that person, you can send in the social security number. In case where we can match that social security number to our records for Medicare, and find a Medicare beneficiary, we will respond to you with the Medicare HICN, and you will go forward in your relationship with us using that Medicare ID number, not the SSN.

Another question came in on the same issue, essentially, let me just check this out here. If I can't get a social security number or a HICN from someone if

they will not respond to my request for a social security number or a HICN, what should I do? The answer to that question is always document that, and keep the documentation with you in your office, or at your place of business, or wherever it is you keep your documentation, in case it should ever be a situation where we wonder why you didn't report. If you have documentation that says you attempted to get the proper IDs from people, and they don't give them to you, document that and keep the documentation.

We got another letter – another letter – another – they all seem like letters to me, I'll say that. We got another incoming question from someone who asked about translations of some of our documents of some of our documents into Spanish, and one particular document was she wanted to know if she could use her translation into Spanish. The general answer to that is that if you have something you want to translate into a foreign language, we need to see it, we need to vet it, and then we will release it back to you. I believe the questioner here actually did send the documentation us, and we will take a look at it, and see if it meets our standards. And if it does, you can go ahead and use it.

We got another question about what happens if I can't find a number for someone, they won't give me a number? The answer is, document, document, document.

The next one I have, on the June technical call, participants were informed that an (RRE) submitted both the HICN and SSN, that if an (RRE) submitted both the HICN and SSN on the claim in put file, but you were unable to get an exact match on the health insurance claim number, then processing would not move to the – to the SSN, meaning we would not then check the SSN to see if we had a beneficiary, that is correct to this point.

The questioner goes on, and our follow-up question is, what happens if no HICN is divided, and only the SSN? That is, if you send in only the SSN with no HICN? We will check the SSN. If we find a Medicare beneficiary, we will get back to you with a HICN. If we do not find a Medicare beneficiary, we will get back to you with information saying we don't find a Medicare beneficiary. That's the extent of what we will do that way. If you send a HICN and an SSN on the same record, and we don't match on the HICN, we

don’t look to the SSN. If you send us a SSN with no HICN on an incoming record, we will match – try to match the HICN, and if we – the social security number to a beneficiary, and if we can find a beneficiary, we will send you back the HICN, the health insurance claim number, that's how that works.

Finally, we had another question concerning what do I do if I don’t get a HICN or an SSN? And again, document that, and keep the documentation. However, this person did use the term can we just ask claimants if they are Medicare eligible on our claim forms? You can ask them that, they may be Medicare eligible. But you – what you really need to know is, are they Medicare enrolled, or are they Medicare participating? There are cases where people are eligible, but do not get issued, they're helping Medicare ID numbers. There are not – that doesn’t often happen, but it can happen. That doesn’t mean that they won't get their Medicare ID number the next day, or the next week, or the next month, you really need to make sure that when you're talking with folks, you're asking them if they have a Medicare ID number, not simply are they eligible.

That covers all the HICN and SSN questions that I wanted to go over before this. And I will now turn the discussion over to (Barbara Wright), who will carry it forward from here. Thank you.

(Barbara Wright): Thanks, (Bill).

On the last policy call, we notified everyone that there has been four new alerts that were in queue to be posted. We've – these were an alert for clinical trial, one having to do with risk management and write-offs, one having to do with periodic worker's compensation and no fault, and a revised version of the who is the (RRE) alert that was done in order to correct language in the appendix. We got a number of incoming questions, primarily directed at clinical trials, people were saying they couldn’t find that document, and it was elusive for a while. And then I'm not sure whether it's actually changed location again, but all four alerts are up, three of the four are on the tab for NGHP alerts, and one is on the tab for what's new. So if you haven't found any of those four alerts, they are out there, please check them out.

With respect to the alert for clinical – I'm sorry, not for clinical trials, for risk management, we got – we received several questions about specific phrasing in the last three bullets of the alert. And we took a look at that, and we do expect to make some minor changes. Conceptually, we have a provider physician or other supplier, and you're reducing charges or doing a write-off the corresponding amount of times involved have to be reported when you're submitting your bill to Medicare, they are part of that claims process. You have to have the amount included as a primary payment.

And so we will change the phrasing at the very end of that bullet where it talks about reporting the write-off, or value of properties, so that it more specifically says reporting the write-off, or reduced charges. The second bullet, it's the same type of issue in all three bullets are similar, in the second one we're talking about providers, physicians and other suppliers, and we're talking about providing property of value. And we will change the phrasing to make sure that it's consistent throughout the paragraph.

The third bullet is for non-provider physician or other supplier entities, and we will change that bullet to make sure it consistently addresses taking a write-off, reducing charges, or providing property of value.

So this is just to let you know that there'll be minor changes, but the concept is the same. We did get a couple of questions about this from provider physician or supplier groups, or related entities, or those who represent them. What we need you to understand is there won't be a code that says I'm doing this as section 111 reporting, whereas part of your billing, you have information showing a primary payment, it's not going to have a separate code that says this takes care of section 111. You don’t need a separate code, you have been required all along to report primary payments when you bill us. What we're saying is where it's reduced charges, or a write-off, we're making it clear that you have to follow those billing instructions, and that eliminates the need to separately do section 111 reporting for that sum of money, for that portion of the payment. So don’t expect any new codes, don’t expect anything in the billing process for you to mark that this is somehow some type of section 111 reporting.

Again, what we're saying is the existing process already takes care of what we need in that specific circumstance.

OK. We are looking at some additional alerts, which we expect to have out shortly. We were asked about cumulative trauma, and we're close to having an alert up on that. The language in terms of the date of (instant) will essentially be tied to when it's first diagnosed, or when there's first treatment for it, but there will be very specific language, so don't rely on anything from this call, but do expect to have an alert up shortly on that.

Let's see, we have been asked whether or not there is an exception for the reporting of lump sum indemnity payments. We are still working on the language for that, in large part, we expect that when it's not simply a periodic payment, we are going to need the lump sum reported, you may be able to define some very specific exceptions to that, but part of this ties into how we calculate the amount of our recovery claim, and the fact that we do a pro rata reduction for fees and costs that are borne by a beneficiary. In order to do that calculation correctly, we have to have the complete settlement amount. So stay tuned for that, we do expect to do an alert, but the alert is really to give you an exception to what already exists. It's not to give you something new that you have to do.

So last but not least, I'm sure someone will ask about mask torts. No, we have not scheduled the next call yet, I would remind you that this is not simply a mass tort call. At this point, we've said you don't have to fill out, and (Pat), correct me if I get the numbers wrong, I think it's fields 58 through 62 …

(Pat Ambrose): That's correct.

(Barbara Wright): … until we provide you with further information, and we will give you adequate time to make that change. One of the issues that entities want to discuss in that call is reporting connected to liability and no fault, and the December 5th, 1980 date, what people are looking for is a way to exclude certain types of situations from reporting, even when medical are claimed and/or released on or after 12/5/80. So again, it's a call that people are looking for us to add a further exclusion, not add a further requirement, but potentially

to relieve you of some reporting situation. What we would also caution everyone is section 111 is a reporting requirement, and CMS is determining what needs reported for purposes of coordination of benefits and recovery. It's not a matter that the insurer or the plaintiffs or anyone else first make a determination of whether or not we actually have a recovery claim, and based on that, they decide whether or not they have to report. Our instructions are telling you what you have to report, and we will subsequently determine whether or not we have a recovery claim for that specific beneficiary. If there's a settlement, judgment or award that's primary (to us), then you know we're telling you, you have to report it.

So please keep that distinction in mind, we have heard of instances where either insurers or plaintiff's attorneys are now attempting to sit down what they believe are their rules for when Medicare will have a recovery claim, and that they're assuming they have no reporting obligations if they determine that there is unlikely to be a recovery claim.

That's pretty much it as far as just general announcements. We'd like to go through some of the questions we got in. Again, we're continuing to get a limited number of questions that indicate that the inquiries are coming from individuals or entities who are new to this process, or are looking at it for the first time. We received one that's quoting to the statute and talking about reports needed – need to be submitted with the frequency and timing secretary specifies, and then say how soon do we have to report a settlement?

Again, if you're new to this process, and you have not read the user guide and any current alerts, that's what you need to read, the user guide spells out how soon you have to report, it specifies the timeframes we have, it tells you how to sign up, it goes through the whole process. You can't simply look at the statute and believe that you will understand the reporting requirements from the statute, you need to make use of our user guide and alert.

OK, some of the questions that have come in. We were asked whether we required of all (TPOCS), or only those that had the effect of releasing medical. We would remind you that our standard all through the discussions has been we're looking at situations where medical have been claimed and/or released,

or the settlement judgment award or other payment has the effect of releasing medicals, not just those that quote have the effect of releasing medical.

The second part of this same question was talking about a situation where there was a monetary award for compensation benefits, and a separate provision that said that medicals would continue to be paid on a – on a continual basis, and they asked whether or not this eliminated the need to report the monetary award for compensation benefits. One of the things is it would clearly have to be where compensation is non-medical benefits, if there's any way that settlement judgment award or other payment could be viewed or have the effect of releasing medical, then it would have to be reported.

Another issue is whether or not (ORM) ceased at the same time. When (ORM) ceases at the same time, as when there's a (TPOC), we would expect that the (TPOC) always has to be reported. So that's the general answer on that one.

We had a question of what if you have a situation where (ORM) termination is in dispute? In other words, the entity reported that they had a scenario where one medical source said treatment was over, another one said medical treatment needed to continue, and they indicated this would be more likely in a situation that was based on exacerbation of an existing situation. So they wanted to know whether or not they had to continue to report, whether they'd turned the (ORM), or what.

You need to report – ultimately we need to make sure that Medicare is made whole. So when the (ORM) is open, Medicare will deny payment for related claims. But if the judgment on that ultimately comes out that there should be payment for medical, then how do we go back and capture that? Our initial reaction on this is that if you have a situation where you've had our (ORM) open, and it's continuing to be resolved, then you need to leave the (ORM) open, at least until that's fully resolved. If you in the meantime with it open, if a provider bills you, and you deny a specific claim, we can't stop you doing that, but we do want the (ORM) open on the record. And if in fact the determination is that (ORM) should have continued the whole time, there

needs to be some way for you to contact us so that we can arrange for payment so that it can take place. And if you look at (42CFR411.25), it does impose an obligation on third party payers in situations where they know that Medicare pays primary, and should have in fact paid secondary.

So a situation like this would clearly lay some obligations under that, if the final determination where that Medicare in fact should continue to be secondary.

OK, we had a question that was really recovery related, it was talking about a settlement being split three ways, and they were asking whether they needed the tune for the bank that was going to be dealing with the annuity. And no, we don't need that tune, but we would remind everyone that simply splitting a settlement between a spouse, children, an annuity, et cetera, doesn't mean that you just report one of those three amounts, or two of those three amounts, in that type of situation, you should be reporting the full (TPOC) amount.

Another question was asking again about errors and omissions claims, and whether or not those had to be reported. So that is still on our list for further consideration, but under the instructions we have right now, those claims do need to be reported if the claim were released, or have the effect of releasing medical. What we would remind you, though, is there was an alert published relatively recently about the direct data entry option, which does at least allow if you really believe that you will have minimal to none as far as claims go, that does give you a different way to report in those rare instances where assuming that you're assessment of the situation is correct, in those rare instances where medicals are claimed or released, then you would have a way to report it other than through going through the whole setup.

OK. We had a question that had to deal with an insurance company that was in liquidation, and the injured claimant assigned their claims against the insurance company to a claim buyer, and gets immediate cash for the claim rather than waiting for distribution. It was asking about who's the (RRE). The (RRE) is still the insurance company, the issue is more one of when to report. If the – if it involves the beneficiary, and they've sold their claim, that doesn't mean it needs to be reported at the instance where it was sold, or that

it has to be reported by the claim buyer, the point is when money is actually paid out to the claim buyer, and that's technically on the beneficiary's behalf, that's when the actual reporting would take place.

One of the questions I'm going to ask (Bill Zagonia) to answer a couple of questions that have to do with worker's compensation. (Bill), could you sort of summarize each question, and then give an answer?

(Bill Zagonia): The first question dealt with death claims where the injured worker died as a result of the claims, related injuries, and then the (ORM) extension. Reported CMS are they're required to report of no reclaim information for the settlements payments made on the indemnity benefits only.

The issue here is the relationship between the payment. If the claims are somehow or other interrelated, it would need to be reported. If there – or the claim payment amounts are interrelated. If the claims are completely separate and have separate funds of money, and are not related in any way, the indemnity payments on the auxiliary claims don't need to be reported.

The second part of this dealt with what happens when somebody's pronounced DOA, or dead on the scene, and they used the World Trade Center or the recent oil rig explosion as examples. And they're saying there was not any medical treatment, those may be extreme cases, the typical situation is medical services are provided trying to revive someone who is injured before they're pronounced dead. So your situation would be you would need to report this, and you would have it to the extent documentation that there was no medical treatment provided.

(Barbara Wright): And then there was one more was along a similar line, (Bill).

(Bill Zagonia): Now this is a case where the inquirer has indicated that this can be a situation where (adult call) carriers could be making indemnity payments that would be assuming no obligation for medical, and they used as an example an auto policy, and worker's compensation. The worker's – the injured party was also – was entitled to worker's compensation because it was work related, and the auto policy would generally defer to worker's compensation to make the medical.

Under the applicable Medicare law, individuals who are beneficiaries are required to file a claim with worker's compensation. They are not, however, required in every instance to receive services from the approved or designated worker's compensation position, or other supplier or provider. In those cases under the Medicare law, I believe the no fault insurer would be liable, so I would say they would need to report it.

(Barbara Wright): One of the other questions that came in was specifically, it said we mentioned no fault insurance, worker's compensation laws or plans, liability insurance, including self insurance, but we did not specifically mention long-term disability, particularly lump sum settlements. And I'm going to ask (Bill) to comment on this too, but in general, you again have the issue of whether or not there was any claim or release of medical, or whether the settlement had the effect of releasing medical. And …

(Bill Zagonia): Yes, I mean if the long-term disability is strictly for lost wages, medical aren't involved or not claimed or released. But if there is – if medical can be included, or claimed or released, because of the release language that was used, it needs to be reported.

(Barbara Wright): OK, another question that came in was asking about when there is payment for a body part quote without prejudice, did this need – did the ICD-9 code need to be included even though we quote haven't accepted essentially that body part, and it hasn't been established by the (WC) board? And then they want – went on to say, we reported initially, can we delete the body part if it's later found to be unrelated?

Again, for a Medicare secondary payer, there does not have to be a determination or admission of liability. It can be established through other means, including any type of compromise, any actual payments, any waivers. So where you are paying for it, even though you're saying it's without prejudice, and you haven't accepted it, you need to report, because you are in fact paying for it. And yes, if a subsequent determination is that that body part is not in fact covered, then you can do an update to your record to reflect that.

We did receive a question about how never events relate to the language we gave for the risk management write-off. We are going to take a further look at what came in on that. We do not do the billing rules here, so before we comment on never events, again, in connection with that risk management or write-off, we do want to take a look at that area, and we will be getting back to everybody.

This question is actually more for (Pat), she'll be the most up to date. They were asking whether or not – if the have a situation where it falls under the (ORM) threshold for worker's compensation, where there's no lost time, it's below the dollar limit, et cetera, if it is easier for them to report, may they do so, even though it's under the threshold.

(Pat Ambrose): Yes, (ORM) would move (TPOC), we won't be – have the ability to check any thresholds. So yes, you may report that worker's compensation claim, or other claim with (ORM) regardless of the thresholds or the reporting exceptions given to you in the user guide.

(Barbara Wright): Thank you. There was a question about a situation where the beneficiary is deceased, and the claim handler does not need quote claimant information to issue payments, or to continue handling the claim, and the example was the claim handler is quote just issuing payments to a medical provider, end quote. Does the claim handler need to obtain the claimant information for purposes of 111 reporting?

If they're reporting (ORM), and that's all they need to report, then if you can not get the claimant information, and I'm asking this of (Pat), so if she can give a final answer, fine. But if the – all they're reporting is (ORM), and they can't get quote claimant information for the deceased beneficiary, should we tell them to default for simply a state of the beneficiary? Because the beneficiary is deceased. Or do they just leave claimant blank?

(Pat Ambrose): Well they would be reporting the Medicare beneficiary in the injured party fields, first of all, and then it really is a – I can't say, but it would certainly pass the system technical requirements to use the estate of the beneficiary in the case of claimants won. However, I believe there are (tens) required for

that claimant, so you'll have to you know be able to provide full information for claimant number one.

(Barbara Wright): We can take a further look at whether or not it will accept the beneficiary's own (ten) again.

(Pat Ambrose): Yes, it will.

(Barbara Wright): Or as the estate (ten) if you don't have a separate one.

(Pat Ambrose): Yes, it will.

(Barbara Wright): But the key here if it's a (TPOC), and you're paying out to someone, we basically need to know who's entitled to receive (TPOCs). If it's ongoing responsibility for medical, it's slightly different.

OK, someone asked about a statement they said that on one of these calls, either myself or someone else said that we were not interested in having the provider submitted as additional quote claimants on liability claims. Are they to be submitted as additional claimants on no fault claims?

And providers, normally you're going to be paying them when you have an ongoing responsibility for medical, in which case they are certainly not one that you need to list as a separate claimant, or if there's a (TPOC) involved that you're paying out on behalf of the beneficiary, and you're giving the beneficiary like X amount of money, and you're writing a check directly to a provider, both of those sums should be included in the overall (TPOC) amount. You should normally either have an ongoing responsibility for medical where you're paying the claims as they come in, or you have a settlement that encompasses specific medical, then you need to report the total.

We did receive several questions that had to do with our (COBC) contractor, and our (MSPRC) contractor, those questions are generally beyond the scope of this 111, they specifically had to do with the operations of those two contractors. So we will not be addressing those.

(Bill Decker): I should say that if they are specific enough, or germane enough – this is (Bill Decker) again – we will forward questions like that to the contractors, they may answer them directly, they may not. You – the questions you do send in the mailbox to – or who need to see them in any case.

(Barbara Wright): Correct.

(Pat Ambrose): And, (Barbara), this is (Pat). I need to go back to the question about the claimant number one field, there is actually an edit in the system, error code (CC02) for the claimant 110 tax identification number. And this field is looking for a non-zero nine-digit numeric value, and it must not match the injured party's social security number or other claimant SSN. So we'll have to take that question under advisement and perhaps add it to the – an adjustment to the user guide, and possibly the system in that case. Because I'm not sure if it makes sense in the case of a deceased beneficiary, and you're reporting claimant one as the estate of that deceased beneficiary.

(Barbara Wright): Yes, the key here is in essence the question was indicating that they had responsibility for (ORM). So how do we make sure that we can get the record updated for that purpose so that if any claims come in, they are essentially rerouted back to the responsible entity? So we will take a look at that, and see what problems it causes with the (ten) issues, and we will have to get back to everyone.

(Pat Ambrose): Yes, and given that it's an (ORM) claim, and if you were to submit it with no claimant, but the – include the Medicare beneficiary obviously and the injured party, that will post the record to prevent erroneous claim payments for ongoing responsibility for medical by Medicare. So you know in the meantime, it doesn't actually – you know we – you can still get the record through without submitting that claimant number one's information. But we will get back to you on that.

(Barbara Wright): OK. We continue to have some questions that come in and are essentially saying do we have to report this? Because we're not self insured. But the questions that come in continue to describe situations where the entity is in fact responsible for making payments with – without regard to any insurance

policy. One of the examples given had to do was where they had a judgment against them, and were responsible for the excess over any insurance. Under the definition of self insurance for purposes of Medicare's secondary payer program, an individual or entity engaging in a business trade or profession is self insured to the extent they bear the risk. So yes, that payment that they were responsible for in excess of the insurance that would have to be reported. Whether they agree or not, under the (MSP) rules, they are self insured for at least that portion.

I guess maybe the way to think about it for those of you that haven't is self insurance does not require any formal plans of self insurance. Essentially go back to if you bear the risk, if you have to pay it, then if you meet the entity engaged in a business, trade or profession, then you're self insured for that amount.

We also continue to see some confusion in terms of parties agreeing there's no medical, so does this have to be reported? As we've said I think more than once on these calls, we are not bound by the allocation of the parties, we do in general defer to a finding where there's a hearing on the merits, but again, go back to what we said earlier on this call. The reporting entities are to report what we said should be reported in the user guide. They are not tasked with deciding whether we would ultimately have a recover claim against that amount.

So do make a distinction in what you're looking at. Your java responsibilities do the reporting and in some instances we may not have a claim at all. In some instances the entity that we send the demand into the individual that we send the demand to may have a defense of that demand. But that's not the same thing as the determination of whether or not you should report. Last but not least we had a question that was talking about as non GHP carriers are we required to report beneficiaries with part C plans with Medicare advantage etcetera.

And yes. Anyone whose in a Medicare advantage plan, they could be in or out of that plan at different times. There is situations where there is retroactive enrollment in the plan and fee for service may have paid. They're

limited situations where we may have paid either erroneously or for other reasons when there is part C. Where we – where the fee for service plan has paid, we're still going to have recovery rights so we need to have that reported to us.

(Barbara Wright): And with that operator, could you open it up for any questions.

Operator: At this time, I would like to remind everyone that in order to ask a question, please press star, then the number one on your telephone keypad. As a reminder, we ask that you please limit your questions to one and one follow-up. Thank you. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of John Arment with MPCGA.

Your line is open.

John Arment: Thanks. I just want to clarify on a No-Fault/PIP with the data loss prior to December 5th, 1980. It's now saying we have to report those Medicare as primary?

(Barbara Wright): No. What I was trying to make is the distinction that, in most instances, you're not making a judgment whether or not we have a claim in that specific case. If you have a liability, are no-fault situations, that's a trauma-based injury and that took place prior to 12/05/80, no, that does not need to be reported. And that's in our user guide, where things get a little bit stickier and there are still some discussions going on, is really the ones that primarily involve exposure where there are medicals being claimed or released on or after 12/05/80.

And as I've said, we're continuing to have some discussion on that, but clearly when it's trauma-based at least and it's prior to 12-05-80, no, there is no reporting obligation, if it's liability or no-fault. We have always been secondary to workers' compensation so that 12/05/80 date has no relevance there. Does that help?

John Arment: Yes. Yes. So I know you know we continue to make payments for Medicare doesn't cover on those losses and that's why I was a little confused, because

we're making medical payments and it almost sounds like we need to report it. But I agree we don't report those. Thank you.

Operator: Your next question comes from the line of (Maria Kraus) with Broadspire. Your line is open.

(Maria Kraus): Thank you. Good afternoon. You briefly addressed an example of access insurance as it relates to the RRE assignment. And I know this question gets asked often, so I apologize up front. But can you provide an additional clarification as we're continuing to get varied opinions and interpretations from our clients in regards to the RRE assignment.

So using an example of a million-dollar policy with a self-insured retention of $500,000, does the existence of that million-dollar underlying policy result in the RRE being the carrier?

(Barbara Wright): For what dollar amount paid when?

(Maria Kraus): I'm sorry.

(Barbara Wright): I mean, I am not under – well, first of all, the discussion we're having before, if it wasn't clear, I was referring to a question where what was asked about was a situation where there was a judgment in excess of a policy. I wasn't really talking about a formal excess policy.

(Maria Kraus): Right. I understood that. I guess the one that we're seeing varied opinions coming in from our clientele is specific to self-insured retention. So there – in the example I was giving, there's a million-dollar policy, but the client had the self-insured retention of $500,000. The policy, again, is for a million. Does the existence of that policy then require the RRE to be the carrier?

(Barbara Wright): Well, all right, let's take a specific example. In the case you're talking about, the TPOC amount is $300,000.

(Maria Kraus): OK.

(Barbara Wright): And one of the questions would be, "Who's paying out that 300,000?"

(Maria Kraus): Typically, it is the client not the carrier in a self-insured retention scenario.

(Barbara Wright): OK. And the second question I was asked – would ask, is that million-dollar policy, does it pay $500,000 after the $500,000 self-insured retention?

(Maria Kraus): Yes.

(Barbara Wright): Or does it pay a million on top of it?

(Maria Kraus): In this – in this example, we'd pay up $500,000.

(Barbara Wright): Then that's a deductible based on the language that we have in the user guide.

(Maria Kraus): OK.

(Barbara Wright): I mean, you know we need to look at the policy. What's in the policy – if your policy is for a million and the most it's ever going to pay out is $500,000 then we would consider the other $500,000 a deductible, not self-insured retention.

(Maria Kraus): OK. And that's where it's getting difficult, I think, in the industry. And a lot of us are feeling this, because self-insured retention, although different, is somewhat – is oftentimes treated as if it is truly a deductible scenario. So that's where we're getting a different – differing opinion from various clientele, where many are saying they're treating (SIR), even though it's like the example I just gave you, as if it were the client's responsibility.

(Barbara Wright): Well, in the example you just gave us, if – like I said, the policy is for a million and they're only going to pay out $500,000 once you paid 500,000. The language we've written would consider that to be a deductible. And if we need to go back and look at possibly revising again the language of who's an RRE, if you can give us language or examples that you would like to see incorporated that you think make this clear, please send them to our mailbox.

(Maria Kraus): I will do so. Thank you very much.

Operator: Your next question comes from the line of Katherine Siegel with Lumbermen's Underwritten – Underwriting Alliance – pardon me the – pardon the pronunciation. Your line is open.

Katherine Siegel: Hello, good afternoon. In speaking about the death claims where we talked about the three different scenarios, in scenario unit number two, you said that it was hard to – we talked about the World Trade Center and like the BP oil rig explosion, where the body might need some sort of medical treatment in order to determine death. In some of the cases, there was no body to be found, but the ultimate decision was that we would need to report those claims as no medical treatment provided.

How would we go about doing something like that, because currently the reporting formulary does not allow for that set of …?

Male: I believe I've said those claims needed to be reported. I would report them as (ORM) and then I would indicate if what should receive (inaudible) that the services in question were not related to the underlying incident.

(Barbara Wright): If they weren't, I mean, with the date of incident (the same). Using the World Trade Center as example, if the date of incident was 9/11 and there actually was instantaneous death, we would not be pooling any claims for any date before that. And it would be hard to see how you would come up with – no, I meant, any date before.

The only thing we would be pooling claims for would be starting with the date of incident, which means it'd be highly, highly, highly unlikely that there were any other services on that date that were for anything, except something related to the World Trade Center. In which case, there would be a defense, but the (ORM), when you report it, keep in mind reporting (ORM) doesn't actually mean that you pay the bill to a provider or physician or supplier, it's that you've assumed the responsibility.

So in the 9/11 situation, reporting (ORM) and then reporting a termination, say, on your next input file, the effects on you should be none, if there were actually no medical examples.

Katherine Siegel: OK. So that any payments made to any survivors, as long as it doesn't include medical benefits, we're fine?

(Barbara Wright): As long as it doesn't claim a release or has the effect of releasing medicals. And if you have a situation where the person died on site or whatever, there should be no need to include that any type of release.

Katherine Siegel: OK. Thank you.

Operator: Your next question comes from the line of (Cynthia Stackhouse) with Union Pacific Railroad. Your line is open.

(Cynthia Stackhouse): Hello. And thank you so much for taking my call or my question. And I kind of went over the manual a couple of times and I just need to clarify on an exposure question. I know you've been discussing it quite a bit today.

And if we have a case where the exposure on asbestos or tox is prior to the 12-05-1980 date and signed the release, the claimant signed the release stating that they had no exposure after the 12-05-1980 date, then as an RRE we are not expected or not required to report the TPOC or the settlement judgment or award specific to the case. Are we required to report the (ORM)?

(Barbara Wright): First of all, just as a general caveat, the date is on or after. It's not just after 12-05.

(Cynthia Stackhouse): Right.

(Barbara Wright): Secondly, the issues that you're talking about, as what I said, we're having further discussion on, because technically the reporting requirements call for reporting of any situation that has the effect of you know claim or releasing or the effect of releasing medicals on or after 12-05-80. So we're trying to come up with a way to deal with this that lessens the burden on (RREs) but also does not essentially subject the program to gaming.

To give an extreme example, we were on the phone with an entity that was talking about this and they were saying, "OK. So we don't have to report if there are – if there isn't anything on or after 12/05/80." They were just telling

us that there are – and that fact was the exposure in the cases that they were dealing with and then they turned around and said, "So if we just find that there was no exposure, then we don't have to report, right?"

And so you can see – hopefully, you can see how there is somewhat a problem from our perspective. That is a main issue that we're continuing to look at. We've asked for a suggestion in terms of language that we would feel comfortable with, and that the parties could be – that the parties didn't have a real problem with either in terms of how we would establish that there was no continuing exposure et cetera, so that we could eliminate the reporting requirement.

But as I said earlier in this call, we haven't finalized that yet. I have heard that there are at least some plaintiff's attorneys that are attempting to impose their own interpretation of that, including telling, insures that, because (X) exists or because no exposure exists that they have no responsibility to report.

And at this point, we can't give you legal advice, but we would think that insurers would want to think twice about accepting anything others in our official reporting instructions as to whether or not they're off the hook for reporting purposes.

(Cynthia Stackhouse): Yes. I know that's kind of where we're at with plaintiff attorneys. They're you know in our settlement area. Do you foresee and alert coming up prior to our October 1 deadline? Or do you see – and I missed the right – the very beginning of the call, so if it was previously discussed, I apologize.

(Barbara Wright): So we are certainly moving toward that. I mean, we've, unfortunately, had another – a number of issues that we've had to deal with of higher priority, but that is an area that we're specifically looking at.

(Cynthia Stackhouse): OK. Well, thank you so much. I appreciate it.

Operator: Your next question comes from the line of Clare Bello with Vertical Claims Management. Your line is open.

Clare Bello: Good afternoon. I have a question on the write-off alert. And I'm trying to help our programs develop rules around the reporting requirement in the alert. And I'm wondering if you can give me some guidance on the distinction between the second bullet, which is the section that requires the reporting of any property or value provided over and above the write-off, because the write-off is the first bullet that is an access of the TPOC amount is subject to reporting one that's made to a Medicare beneficiary and I've got that.

But bullet number three talks about any other entity that has reduced its charges. And I'm wondering how bullet number three – can you give me some guidance on what you mean by any other entity? Because I've got my entity covered, but I want to make sure that I'm not missing something when you talk about any other entity.

(Barbara Wright): Not to be overly simplistic but the first two bullets are specific to providers, physicians, and other suppliers. And it's providers, physicians, and other suppliers that have that obligation to include reduced charges or a write-off as actually a liability payment when they do their billing. But other entities may have some reason to do some type of write-off or may be reducing their charges in another contract or providing property values.

The third bullet is the rule for entities other than providers, physicians, or suppliers.

Clare Bello: That is extraordinarily helpful. Thank you very much.

Operator: Your next question comes from the line of (Karen) (inaudible) with (Parkland). Your line is open.

(Karen): Yes. We have a question. How are you all this morning? We had a question. If we decide to go with direct-entry reporting and for some reason we have more than 500 claims that we have to report on, how could we report for those additional claims?

Female: It's really depending on the circumstances, but essentially you will have to convert to a file-submission method.

(Karen): OK.

Female: If you have – if you feel like you might be close to the 500 claim threshold, then you really need to be looking at a file-submission method. The directed entry application on the COB Secure Website will have a counter that lets you know how many more claims you have for the year that you may use direct data entry for. So hopefully, that will give you enough time. But if you're asking this question, in my opinion, you probably should be looking at a file-submission method.

(Karen): OK.

Female: OK, because it's really intended for those that are going to have very few claims per year to report.

(Karen): OK. Thank you.

Operator: Your next question comes from the line of Dennis Motsinger with Indiana Farm Bureau. Your line is open.

Dennis Motsinger: Hello. Right now, the production data feeds aren't being accepted. So when we have an unrepresented beneficiary and the beneficiary has not reported the case to you all, how are we supposed to notify you?

(Barbara Wright): Are you saying how are you supposed to notify us because the reporting hasn't started yet?

Dennis Motsinger: Right.

(Barbara Wright): OK. There's two things going on here. One is the mandatory Section 111 reporting, which does not take place until there's a settlement, judgment or award and you're not required to report any TPOCs that occurred prior to 10-01-2010. And you do have certain further obligations that you have ongoing (inaudible). This doesn't change the processes that existed before Section 111. You have always had the opportunity as (inaudible) to contact our coordination of benefits contractor and provide the basic data so a case is set-up, so that by the time you have the settlement, judgment, award or other

payment, we have had a chance to determine our conditional payment and can update an issue, any appropriate demand.

That opportunity hasn't gone away. You can still do that on an individual basis. There is information available on the COBC website and I know that address is given in the user guide in the section that talks about other references, etcetera. Or additionally, on the MSPRC's website which is www.msprc.info, I-N-F-O. They have information about a rights and responsibilities letter and a brochure that accompanies that. And I know that on one side of that brochure, it specifically lists the detail that must be given to the COBC if you're calling in a pending case.

Dennis Motsinger: Well we've – the trouble is we had tried to call the COB and left messages, asked them to return call, and they don't return the call.

Female: What number for report of a claim situation outside of Section 111 that Barbara is referring to, you should be using the 800 number for the COB contractor. That number can be found on the CMS website if you go to www.cms.gov and then select Medicare and then select coordination of benefits. And if you look under the COB general information, there's a link for contacting the COB contractor and there's an 800 number there – (inaudible) office on addresses that you may use as well.

I also wanted to state that you can actually – we are accepting production files for Section 111 reporting. They are not required at this time and, of course, the direct data entry is not ready until January 2011. But just so that there's no confusion by other callers, we are accepting – we are actually accepting production files at this time.

(Barbara Wright): And I do want to reiterate, you can go to the site at (inaudible) or if you're already familiar with MSPRC site, they do – as I said, they specifically have – when you go to their site, you can look where it says rights and responsibilities and there's also – it points out whether it's a brochure and either those. The brochure has in detail, the number and address for the COBC, as well as the data elements that need to be reported. And when you're reporting to the COBC, normally that's being done when the claim is

still pending. Again, remember Section 111 reporting doesn't take place until there's a settlement, judgment, award or other payment. And pre self-identification as in COBC does not eliminate the Section 111 reporting.

Dennis Motsinger: Well, the – I mean we have called the (800) number and we leave messages and we don't get a phone call back. I myself have left three messages.

(Barbara Wright): If you want to send that information into the mailbox and label it "The COBC issue," we will pass that specific information on to the right folks to deal with it. Please give us full contact information and be sure and tell us who – what number you were calling for the COBC.

Dennis Motsinger: OK. Thank you.

Female: Yes. And I can give you the number for the COB contractor. Now, again, this is not the number to be used for Section 111 reporting, not to be used to contact your EDI representative. But if you have a self-report to make as an insurer related to a claim as we've been talking about, the number is 1-800-999-1118.

Male: All right.

Female: And again, (as Barbara said), if you're having difficulty getting through, you should be able to get through Monday through Friday excluding holidays, federal holidays from 8:00 am to 8:00 pm Eastern Time. So we definitely like to you know we're definitely be interested in finding out on why you were having trouble getting through.

Female: What is exactly is going on? I am not familiar enough with the (COBC's) internal procedures to know about their callback setup or anything. The (MOPRC), once the case has already been reported, so don't turn around and call them instead.

Male: Right.

Female: But when the (COBC) – when the (MOPRC) have the record of the case that's already established, they do – on their website – advertise this specific

callback function where you can leave information for them to call you back. If the (COBC) offers that same thing and they're not returning the calls, we need to know about that. And as I said, if you can give us as much specificity as possible, we'll pass it on to the right people.

Male: Certainly.

Operator: Your next question comes from the line of (Rick Zerrick) with Catholic Health Care.

Your line is open.

(Rick Zerrick): Yes. You referred to an example on which there was an excess verdict and said that the entity would be responsible for reporting the payment in excess of the verdict, in excess of the amount of their insurance, is that correct?

Female: Yes.

(Rick Zerrick): Doesn't that mean that every insured out there then has to register as an RRE?

Female: First of all, you don't have to register unless you have a reasonable expectation that you're going to have to report. And you do have the DDE option unless you expect to have more than 500 judgments against you a year in the excess of you know any insurance, et cetera. Arguably, if that's your only basis for having to report, you should have limited risk of having to report. That doesn't change the fact that in a specific situation you may have to report.

Female: And (Barbara), aren't – also the definition of a responsible reporting entity is one that is involved in – engaged in a business trade or other profession?

Female: Business trade or profession so …

Male: Health insurance (inaudible).

Female: Yes. That's the definition of self-insurance which plays into the judgment that's been excess of the insurance policy. So, if for example, you have (Joe Smith) who's a Medicare beneficiary. He happens to still work and he

happens to be – I don't know – he's a physical fitness trainer and someone falls in his studio while this goes on. If there's an excess judgment against him in excess of the policy he holds, it was part of his business trader profession, so he has to report that.

But if (Joe Smith) is the beneficiary and he's out just driving his car, it has nothing to do with any – he's not working, it has nothing to do with the business trader profession and there's an excess judgment against him, then that's not self insurance for Medicare secondary payer purposes.

But to your point that any company may arguably be involved in this situation at some point, yes, there's a technical possibility of it. But as I said, unless you frequently experience judgments in excess of the value of your policy you know you should have limited risk and we do offer the DDE option for those situations.

Male: Wow, OK.

Operator: Your next question comes from the line of ((Meg Felice)) with Discover Re.

Your line is open.

(Meg Felice): Thank you. Good afternoon. I have a quick question regarding the information in the 2-24 bulletin around a fronting arrangement. It was an exception to the carrier being the RRE in a situation where a fronted policy was issued. And the definition I think that you had in the memo said if it's insured, has a fronting policy and pays all claims arising into that policy, the insured is the RRE. And then it further said the expectation of both the insured and the insurer is that the insured will retain the ultimate risk under the insurance policy.

My question was whether in the situation of a fronted policy where the person taking a hundred percent of the risk is not the insured. So if you have an insurance company that issues a policy to an insured, that somebody else fully reinsures that policy, takes a hundred percent of the risk and pays all those claims, would that fronting policy….?

Female: Well, remember you're then into what we said about reinsurance. And for the reinsurance, if the reinsurance is paying the claimant directly – the injured party directly, then the reinsurance is the RRE.

(Meg Felice): OK.

Female: But if the reinsurance is paying the fronting policy, then you're back to the rule for the fronting policy.

(Meg Felice): I lost you there. I'm sorry. If the reinsurance …

Female: If – OK.

(Meg Felice): I know there's a section on reinsurance where they attached excess of a layer that talks about excess and reinsurance. But in this case, there's only one entity picking any risk on the policy and paying any claims.

The insurer puts up a, say, a million dollar limit, it's a hundred – the million dollars is reinsured by the entity who is then paying the claim. Would that fronting policy exception to the insurer being the RRE apply?

Female: I missed part of what you said (inaudible).

(Meg Felice): OK.

Female: We have company A, who will purchase. This is the fronting policy. We have company B who is the fronting policy.

(Meg Felice): Yes.

Female: Then company C that reinsures the fronting policy, right?

(Meg Felice): Right, although company A just purchases a policy. In their mind, they wouldn't necessarily know that some reinsurer is fully reinsuring it. They purchase a policy with a million dollar limit from company B, then company …

Female: And they purchase – then they purchase it with the intent of it being a fronting policy.

(Meg Felice): No.

Female: OK. Well, you know, you asked the context of a fronting policy. If they didn't purchase it as a fronting policy with the arrangement and the intent that they're going to be paying …

(Meg Felice): In this case, you've got C as reinsurer who's taking the risk. C might not be at all related to A.

Male: Who's cutting the check?

(Meg Felice): C or somebody on C's behalf.

Male: (Inaudible) directly in the injured party?

(Meg Felice): Yes, or C is, say, (TPA) or somebody on C's behalf. But C is providing the funds to pay those claims.

Female: (Inaudible). There's a difference between providing the funds and actually paying. And if you look at the language we had about reinsurance, self-insurance …

(Meg Felice): Yes.

Female: … we've specifically said in those in – for reinsurance, stop loss insurance, excess insurance, et cetera, the key in determining whether or not the reporting is required for these situations is whether or not the payment to the injured claimant/representative of the injured claimant versus payment to the self-insured entity to reimburse the self-insured entity.

(Meg Felice): Correct.

Female: So your excess policy in this case, is it actually making payment to the injured party or is it making it to the insurance company?

(Meg Felice): It would be making it to the injured party. There's no excess per se. You've got a million dollar policy that A purchases, then C pays a million dollars to the claimant, the medical beneficiary or whoever.

Female: You have A, who purchased policy B.

(Meg Felice): Yes.

Female: And you have – then you have C which reinsured policy B, right?

(Meg Felice): Correct. Yes.

Female: And policy C is paying directly to the injured party.

(Meg Felice): Yes.

Male: (Inaudible), check, their letterhead, their bank account.

Female: The point is that, if you go to page five of the most recent alert which is dated May 26th and under reinsurance, you're talking about a reinsurance situation. And it says there where the payment is being made directly to the injured party or a claimant by that reinsurance then they are the RRE.

(Meg Felice): OK, very good.

Male: (And that provides them the fund, making the payments).

(Meg Felice): Well, it gets a little tricky where there's a (TPA) in the middle, so, I mean …
Male: (Inaudible). Who is cutting the check?

(Meg Felice): A (TPA).

Male: A (TPA) is (cutting) the check to whom?

(Meg Felice): To the claimant, the Medicare beneficiary.

Male: And who cut the check to the (TPA)?

(Meg Felice): C.

Male: Company C, the ...

(Meg Felice): Company C, the reinsurer.

Male: And whose (TPA) is – what company owns the (TPA)? It's – who's the (TPA) – (their pages) for?

Female: We're not going to get into a lot of nitpicking in terms of who's (TPA), and who funded the (TPA), and everything else. In bottom line, if the reinsurance is making the payment to the injured party, whether they hire a (TPA) or not…

(Meg Felice): OK.

Female: … then they are in fact the RRE, if they're, in essence, paying company B, the insurer, or paying some representative of that company no matter what happens to the money later, but they're not paying the injured party.

(Meg Felice): Very good. That answers the question. Can I ask one other question?

Female: OK.

(Meg Felice): All right, you may have addressed it earlier and I apologize if you did, it had to with a claimant who files a Loss of Consortium claim. So, for example, a husband and wife have a – or husband has accident, wife makes a Loss of Consortium claim, wife is the Medicare beneficiary.

Wife doesn't specifically have any medical treatment, doesn't claim any medical treatment, but the release has the effect of you know releasing the (inaudible) dependent from all possible claims.

Female: (Claim their release, there has) the effect of (inaudible) medical.

(Meg Felice): Right. So I think it – in one of the prior calls you mentioned that you thought that that would be a reportable situation. But the question, I think that the prior caller had is, how would you code – what kind of ICD-9 code would you use for any kind of claim, I guess, in this circumstance, the wife's claim, when

there was no treatment? So how would you decide what type of code to report?

Male: Did the injured party file a claim or just the wife?

(Meg Felice): Well, the injured party, let's say, the husband got the medical treatment, the wife's Loss of Consortium claim gets released along with that claim and the general release says it has the effect of releasing the insurer from any and all claim.

Male: (Inaudible).

(Meg Felice): Sorry?

Male: (Inaudible) finding on the merit by a court of competent jurisdiction that indicated of the amount to be distributed, X goes or the medical services and Y goes for the Loss of Consortium. Or was it just an agreement amongst the parties?

(Meg Felice): Just an agreement amongst the parties.

Male: And everything has to be reported.

(Meg Felice): Yes. That's what I thought. But I just was trying to figure out how would you guys expect someone to report the claim for the – the Medicare beneficiary here is the one that doesn't have any alleged treatment. What kind of coding would you use for – when there's no specific medical treatment, you know what I mean?

Male: Would they claim their release?

(Meg Felice): They were on the release for a general release, but there's no alleged medical and so, therefore, nothing to code in.

Female: Yes. You're not asking whether you should report. You're saying, understanding that, you need to report …

(Meg Felice): How would you report.

Female: … you just need to figure out what code to use.

(Meg Felice): Yes. I mean, you don't want to just make one up. But there is no medical – I mean, would you just use a general sort of psych, mental distress type code or is there any – I think someone else in the past had asked the same question and you were taking it under advisement, I mean, I just wanted to see if there was any further decision?

Female: Yes. We don't have (inaudible) answer for you today than we had before. I'm sorry.

(Meg Felice): Oh, that's OK.

Female: But you know we are getting a number of questions. We recognize the fact that – so if we're struggling in certain cases to not only find the appropriate ICD-9 diagnosis code for those fields, diagnosis code fields (one to 19), but also field 15, the alleged cause, the E code. So we don't have a better answer for you today. I'm sorry.

(Meg Felice): OK.

Male: But we will try to find one.

(Meg Felice): That's very good. And then the last thing I have is not a question, but there was prior caller who asked the question. I think it was one of the first callers from Broadspire. And their situation was a million dollar policy and they said there was a $500,000 SIR.

As a carrier, I think you guys said that you wouldn't expect that to be an SIR. And my comment is it can't be. If there's some sort of retained amount that a company is taking as part of a policy limit that's included within the policy limit, it can't be an SIR. I think the industry tends to use that term when somebody is taking risk. But it is a deductible.

Female: That was the point we made.

(Meg Felice): Exactly.

Female: But if it's a sum that's covered under the policy, we don't consider it self-insured retention. We consider it deductible even if it's normally paid by the insured.

(Meg Felice): Agree. I just thought I'd clarify that because I know that (TPAs) out there, they're dealing with clients who are taking risk, who are referring to their deductibles as self-insured retentions when they're not. So that was just two cents I thought I'd throw out there. And thank you very much for your time.

Female: Thank you.

Operator: Your next question comes from the line of (Martina Buck) with Travel Insured International.

Your line is open.

(Martina Buck): Hello. Thank you. I have a question. If we have our policies in excess of any other insurance and we get a (claim in) for an individual that has Medicare and (the supplements) were excess, do we wait for the (EOB) from Medicare and the supplement or that does that raise us to be primary?

Male: You cannot – you're not an excess as far as Medicare is concerned if it's under liability or no fault.

(Marthina Buck): OK.

Female: What – and remember how you're using the term excess. (In – who's an RRE), if we're talking reinsurance, stop loss, or excess, essentially liability insurance, or excess no fault, et cetera, then you look at our rules for reinsurance, stop loss or excess.

But the fact – liability of and by itself is never excess to us. You're looking at the issue of reinsurance, stop loss and excess to decide who is the RRE, not to decide whether or not you're primary to Medicare.

(Martina Buck): OK.

Male: (It says) we pay. (Inaudible).

Female: Yes. Our policy is an individual policy that states that we pay.

Male: (Inaudible).

Female: If you are the liability insurance, no-fault insurance, or workers' compensation, by law, you cannot make yourself secondary to Medicare.

(Martina Buck): OK. Thank you.

Operator: Your next question comes from the line of (Julie McDonald) with (Hudson).

Your line is open.

(Julie McDonald): Thank you for taking my call. This is a follow up question to a question that I posed during the last town call meeting regarding the self-insured indicator field which is field 64 and the related policyholder information fields in the claim input file.

I am with an insurance unit with Hudson which writes predominantly professional liability insurance. However, my question actually centers around the reporting required by self-insured parties.

And it's my understanding that the self-insured parties who are deemed to be the RRE are to place a Y in the self-insured indicator field. And at this – will then make it such that the self-insured party will be required to complete the policyholder information fields.

Does the self-insured party place its own name in these fields, in the last name first name fields? It would seem that, I guess by their nature, that a self-insured party would not have a policy and therefore no policyholder related information, but perhaps I'm misunderstanding the reporting requirement.

Male: (Inaudible) didn't we eliminate the need to put down the policy number?

Female: We have the self-insured indicator of yes or no and it only applies to no-fault or – excuse me – it does not apply to no-fault. It only applies to workers'

compensation or liability. Then there is a self-insured type of individual or other.

And then if the self-insured type is individual, we're looking for a policyholder's last name and first name. On the other hand, if it's other than an individual, then we're looking for the "doing business as" name and legal name. So you know, the policyholder would be the self-insured individual.

Male: Yes.

Female: And, yes, there is kind of some – I can see some confusion there that it has. You know they don't – by virtually being self-insured they don't necessarily have a so-called policy. But we are looking for that individual thing.

(Julie McDonald): OK.

Male: And again, remember for them to be self-insured for (MSC) purposes, we're looking in the context of the business trader profession. (Joe Benny), out driving his car and not doing his thing related to work is not self-insured if he's in a wreck.

(Julie McDonald): OK, great. I appreciate your help.

Female: OK. I guess I should note. Operator, before you go on to the next question, that this policyholder last name and first name may also be supplied on other records is not – it's just required when field 65 or the self-insured type is an (I). But it's may be supplied under – other circumstances as well. And that is basically the rationale behind the name of those fields being policyholder first and last name, OK?

Operator: Your next question comes from the line of (Della Hume) with (EAGF) Corporation. Your line is open.

(Della Hume): Hi. You got me confused on the Loss of Consortium claims. I'm finding – I can't follow your logic as to when we have a Loss of Consortium claim in which the injured party is not the Medicare beneficiary, but dies as the result of the accident that were responsible for.

Then the injured party's spouse who is a Medicare beneficiary but was not involved with the accident files a Loss of Consortium claim. When we settled that claim, that spouse had no injuries associated with the claim.

Female: The issue is whether or not medicals were claimed or released or…

(Della Hume): But what medical …

Female: … or the release has the effect of releasing medicals for her.

(Della Hume): But what medicals were associated with the claim? What if her medicals are associated with that claim?

Female: What?

(Della Hume): The spouse had no injuries associated with the claim.

Female: Then why are you requesting that she release medicals?

(Della Hume): Because there is a standard release that all attorneys give us.

Female: Well, unfortunately, our touchstone is – whether or not medicals are claimed or released, there's a settlement, judgment, award or other payment – has the effect of releasing medicals and (inaudible).

(Della Hume): For an injured party. But she was not an injured party.

Female: Well, in the situation that you're describing where she is the Medicare beneficiary and she is filing the claim for Loss of Consortium, she is, by definition, the injured party that you're submitting on the claim record. Now, whether that claim is reportable or not, I'll turn it over to back to Barbara, but just to be clear …

(Della Hume): No. In our system, the injured party is the person – the individual who was actually injured and died. And then there's a subsequent claim that comes in, a subsidiary claim.

Female: Right. And we're talking about that subsequent claim, that's the claim report that you're making and that is – in your example, is the spouse who now is the injured party in the subsequent claim. And with the (inaudible) …

(Della Hume): For Loss of Consortium.

Female: Well, I can't speak to that. So, (Barbara), I'm Sorry.

Female: I mean, we're still back to what's claimed or released or has the effect of release in medical. It maybe rare, but there are some consortium claims where there are associated medical. We can't give you a blanket pass.

Female: If our injured party's spouse was involved with the accident, she would have a separate – there would be two separate claims—one for him, one for her. And we would pay on the bodily injury portion of that.

But when it comes to the Loss of Consortium, that is solely the, "Oh, my. I lost my spouse. Give me money." And I don't understand why it becomes a reportable claim for you when it is just a solely Loss of Consortium claim in the …

Male: (Indeed). If you rewrite your release so that medicals are neither claimed nor released, you don't have an issue. But as long as you're using your release that includes the release of medicals, it must be reported. Now – Medicare – if there were no medical services provided by Medicare, then Medicare would have a recovery claim, but that's a separate and distinct issue, that obligation, separate and distinct from your obligations to report.

(Della Hume): OK. I'm trying to find a nexus between the …

Female: And we're telling you what the nexus is, is that we – we're required under the legislation to setup a program, to report situations where Medicare is in fact the secondary payer including liability insurance, no-fault, workers' compensation.

(Della Hume): I understand that.

Female: And whether or not there were actually any medicals involved that Medicare paid is not the determinative factor in terms of whether or not you have to report. That's our decision in determining whether or not we have a recovery claim.

For purposes of defining what you must report to us are touchstone and it's also used in the context (through our) recovery is whether or not medicals were claimed or released or had the effect of releasing medicals.

And although you postured a situation in where you believe there would rarely, if ever, be medical, you have chosen to use a release that fits within our definition of what must be reported.

Female: So, the problem you have is that type of detail isn't simply in our data system when I query for claims. I can't query down to what the actual release looked like, so now you're going to force me to query all of our loss of consortium claims.

Male: You're telling me you have the standard release, so therefore, you would know without going an ...

Female: We deal with you know dozens of attorneys. I'm not sure what attorneys you would use, which releases.

Male: All we can tell you is what we're requiring to be reported.

Female: OK. I'm still trying to find. I still find it difficult to find the nexus because the person that we are paying was not injured at all.

Male: I think it's inadequately described here, and we do need to move on to the next question now.

Female: Okay.

Operator: Your next question comes from the line of (Leslie Wilson) with (Tara Cares). Your line is open.

(Leslie Wilson): Hi. Thank you. We have a question related to professional and general liability settlements where we're dealing with a wrongful death settlement claim. And this – specifically, one of our questions specifically related to Alabama where counsel has advised us that in a wrongful debt action, punitive damages only are awarded and that Medicare liens do not apply for punitive damage award. So, if that's correct, does that mean we do not have to report any wrongful debt settlement or verdicts in Alabama that require payout?

Male: Again, for reporting purposes, we're looking at what's claimed or released or has the effect of releasing medical. If under state law, their can be – for punitive damages only, then, again, our question would be, why are you releasing medicals? If it's reported to us and we believe there are associated claims and state law prohibits any payment for – except for punitive damages, we would have our counsel as necessary examine the state law and that – depending on what they determine that may or may not be an appropriate to sense to any recovery claim we have. But, unfortunately, probably from your prospective, our touchtone (inaudible) yet, again, is it's claimed or released or has the effect of releasing medical.

Female: Well, I guess, in that instance, I'm trying to figure out if it's a wrongful debt action, the person that – I mean, we're paying beneficiary so that may have – that could be at any age. I mean the person that we treated – and this is long-term care is deceased.

Male: I know. But you're paying or in association with harm that was done to them. And we would be looking at their medical. And you know, if state law allows for a defense, then so be it. But, again, for purposes of this call, what we have to tell you is for reporting purposes, we'll look at what claimed and released or what it has the effect of releasing.

Female: OK. So, if the release does not specifically release medical, then that prohibits us from having to report.

Male: If they weren't claimed to released as well, that's fine.

Female: OK. We had, like, three or four other questions that we submitted probably three or four weeks ago that weren't addressed on this call. What do you

suggest I do about those, that we sent in as soon as we were informed that this call would take place?

Male: OK. Can you hold on for just a minute?

Female: Sure.

Male: (Inaudible).

Female: (Inaudible).

Male: Yes. (Inaudible).

Male: Can I ask you a question?

Female: Go ahead.

Male: We're back. I know that one of your questions that you've came in with was you were talking about a situation where you didn't believe that you were self-insured. And, again, we would go back to what we said earlier that there doesn't have to be any formal plan for self-insurance.

Female: Right. And we understand that. That, we do understand. We submitted six questions in total.

Male: OK. And you asked whether reporting applies to the resident who was rendered the services or to the actual award recipient. In other words, that the plaintiff for the matter maybe someone in the resident's family and the award could go to that plaintiff.

What we're talking again that you're reporting on the injured party and – is that – if I remember correctly, your questions had to do with wrongful debt settlement. So, you're clearly in a situation where the beneficiary is deceased.

So, the other member of the family or whoever was the actual claimant, that is being reported in that claimant's field when the beneficiary is deceased. But the party – what we're looking at is being the Medicare beneficiary in that situation is the injured party, the deceased beneficiary.

Female: OK. But you're still telling me I have to report the claim and all the payers, all the people that we've paid the settlement to.

Male: You have to tell who the claimants are because we may be pursuing our recovery claim against them.

Female: OK.

Male: Let's say there's a situation where there's a deceased beneficiary, and just to make absolutely clear and not raise any questions right now about wrongful doubt, this is survivorship action. So, clearly, the estate would have had rights, everything else. But the claimants are, I don't know, two family members.

And so, you're going to be listing the beneficiary as the injured party. You're going to be listing to two family members as the claimants.

And when we do our recovery claim, we would basically be sending the demand to those family members that who in a liability situation would be our first choice. In other words, to pursue recovery.

That's why we need the claimant. You certainly don't want us routinely coming back to you every time the claimant is someone other than the beneficiary.

Female: Now, that's true. So, then, I guess, that kind of leads right into the fourth question about what are we reporting then, for like an ICD-9? I mean…

Female: You're reporting the ICD-9 code associated with that deceased beneficiary, with the injuries they received.

Female: OK. But isn't it that, I mean, if I get a lawsuit for wrongful death they could have alleged everything under the sun. Now, I'm not sure I could find an ICD-9 code associated with all of that. I mean, we're providing care in a long term care facility.

Female: You can provide multiple codes up to 19 different diagnosis codes that probably isn't necessary, but there is the opportunity to provide multiple ones through singular diagnoses that are related to the injury.

Female: But do we provide, I mean, do we provide the ICD-9 codes for what they're alleging?

Female: Yes.

Female: Not what we treated them for?

Female: For liability, no fault et cetera, you're generally reporting the ICD-9 codes for what was alleged. The one exception that we've named on this call was where you're reporting ORM, we said in that situation you should limit the code to the ones you've actually accepted responsibility for.

Female: (Inaudible) accepted liability necessarily, but accepted responsibility for.

Female: Whether it's with or without prejudice, you've got ongoing responsibility for medical. You're actually paying medical bill, then give us the codes for what you're actually paying for that are – that you've agreed to pay for whether or not you've actually received the bill for. But if it's a lia – generally, a TPOC situation, you're reporting the codes for what the alleged injury was.

Female: And reporting them as a description of what that alleged injury is.

Female: In light, we did make sure in the record lay-out and (Pat) can confirm this, that we used the term alleged. So, it's putting the codes in there is not an admission on your part that you agree that that's what you're paying for. It's simply reflecting what was alleged.

Female: OK. OK. And what about our – the TIN if we have the actual insurance company that pays…

Female: In the user guide, this was a situation where you had the insurer for this facility is not based within the United State and does not have an IRS assigned task identification number.

Female: Right.

Female: Looking the user guide is, first, in the registration section if there is a section on how to – how a foreign RRE or one that does not have a U.S. address and/or an IRS assigned task identification number can register for section 1-11 reporting and you make up essentially a fake task identification number in this case. And there'll be some interaction between the RRE and the EDI department throughout the course of that registration.

And then, when you report your claim information, the claim input file and the TIN reference file, there are also specific instructions on what to use there. There's information about what to use in the TIN. It would be that same fake TIN number for which the RRE registered under. And on the TIN reference file, again, you would use that same fake number and since you're insurer who is not based in United States may have an address outside the United States and it can't be formatted in the regular field, their instructions could, the letters (FC) in the state coding use the foreign RRE address fields that are provided there. So, all of that information is covered in the user guide.

Female: OK.

Male: Can we ask another question regarding worker's comp? If lifetime – if – do all lifetime medical payments need to be reported or only those made from a settlement after a previous date?

Female: It depends what you're dealing with. If you're dealing with ongoing responsibility for medical, the user guide tells what they – if an ongoing responsibility for medicals existed on or after – I forgot what the date week.

Female: 1/1/ 2010.

Female: And they were in your records as an active record for whatever reasons, then you have to report those and subsequently report any termination date. If there's one that you had taken affirmative action to close before that date, but technically under state law, you have for example, lifetime responsibility for medical, if that person comes back in and you reopened that case for any reason or make additional payments, then you need to report it at that time.

If you're dealing fully with a TPOC situation, then, unless the TPOC occurred on or after 10/1/2010, it doesn't need to be reported. And the (tag along) go list is like we said throughout all the calls, is the reporting requirements are in addition to all your pre-existing obligations and rules and procedures for Medicare secondary payer. If there's a situation where a TPOC occurred before 10/1, that doesn't mean that you may not ultimately have some responsibility for it when we find out about it when we taken action on it.

What we're saying is we've given you certain, relatively, firm deadline in terms of what must be reported specifically for section 1-11 and that's the reporting responsibility versus all our other rules and procedures.

Male: So, for lifetime medical agreements that were reached prior to 1/1/2010 that are made after 2000 – 1/1/2010, those do not have to be reported?

Female: What are we talking about? Are we talking about no-fault insurance (or worker's) compensation?

Male: I work… worker's compensation.

Female: If worker's compensation, you essentially – what I'm hearing you describe, is that you had an ongoing responsibility for medical before 1/1/2010. So, yes, you had to report that.

Female: And I heard you say, if you had a claim for ongoing responsibility for medicals after 1/1/2010, it most certainly must be reported. And if those lifetime, if you know if those – if that ORM remains open due to your responsibility to provide lifetime medical services, then, you will never close that record. It will be…

Male: Here's an example, a claim is settled, say before 1/1/10. Say, 9/30/09, the claim is settled except that lifetime medicals remained open?

Female: Well then, you have to report that. You have responsibility for life – you have ongoing responsibility for medical on and after 1/1/2010, so you must report that.

Female: Take a look at section 11.8 and 11.9, 11.9 in particular in the user guide. I think – and there are some examples there. I also recommend that you sign-up for the computer-based training. On the website you'll see a "Menu" option on the left hand side. Go there; register for the CDPs and you can pick and choose what courses you want to take. And this topic is covered there, too.

Male: There is specifically one form.

Female: Yes.

Male: Ongoing responsibility for medical. So, any of you that have confusion on that, that's one of the ones you make, want to be sure and take.

Male: OK. Thank you.

Operator: Your next question comes from the line of (James Price) with Aon Global Risk. Your line is open.

(James Price): Yes, thank you guys for taking my call. I do appreciate it. I just want to get a clarification on this deductible issue. And if I understand this correctly, in a – in a deductible program which used the example where there's a $500,000 deductible on a million policy. If the insured pay – actually pays the claim within the $500,000 deductible, will that be considered without recourse to their insurance?

Female: Well, I mean there are many policies where the insured is actually required to pay the deductible and has to deal with their insurer without recourse essentially means then we did not expect they give us a finite detail, legal definition. But without recourse means, essentially, you're not operating within the bounds of your agreement with the insurer.

So, if, for (inference) that someone in the past has had a deductible and for claims below that deductible, they have not told their insurer, they haven't reported them to their insurer because they know those claims are used in determining their experience rating and therefore their premium. That's the

type of action we envisioned under without recourse if they're not – they're not really operating within the bounds of their agreement with their insurer.

(James Price): OK. But there's oftentimes where insurers are operating – they have what's called a self-directed deductible you know where they are handling and managing claims within that deductible. And there's not a recording of those claims to the insurance carrier until you know usually a year afterwards and which time you know they sort of reconcile what's been paid.

Female: If that's the case, then obviously the insurers – then they have to make some arrangements to get that information from you because the insurer does have to abide by our timelines for reporting.

(James Price): OK. So, it's still you know – so, under your interpretation of that, then it would still be the insurance carrier's obligation to report it even though they may not be getting information.

Female: Whether it's the deductible and you're operating within the bounds of the agreements for the policy, then yes, we expect the insurer to be the RRE.

(James Price): OK. Thank you.

Male: And operator, we'll take one more call, and then when the answer to this call is finished, and we're all done, that will be our signal to you to terminate the call. Take one more call.

Operator: Your next question comes from the line of (Cynthia) (Inaudible) with Union Pacific Railroad.

Your line is open.

(Cynthia): Thank you so much. I feel so lucky. And I appreciate your taking the call especially the last one.

I just needed one more clarification on – and with the railroad, we do fall under the FELA guidelines, which I know, (Barbara), you have met and spoken with the railroad industry previously.

And in the policy issuance itself for the national plans which would be the plan, obviously, that is chosen by the actual railroad, labor unions and such. Their plan booklet specifically states in circumstances, Medicare is actually the primary carrier. And I know in previous calls I've heard several times that Medicare will always be secondary, Medicare will always be secondary. However, in these particular plans, the plan booklet specifically states that Medicare would be primary. (Inaudible)…

Female: I think if you want to send some more specific information on that policy into our mailbox…

(Cynthia): OK.

Female: We will look at it. But liability insurance, no-fault insurance and workers' compensation insurance as the Medicare secondary payer program defines them is always secondary I mean is always – definitely get my correction here. This is always primary to the Medicare program.

(Cynthia): Right.

Female: Medicare is always secondary. So, I have no familiarity with what you're talking about and…

(Cynthia): Under this federal guidelines, under FELA. And because these policies are written under the FELA guidelines which is a Federal Employer Law Act. And so that's why I did the clarification.

So, do you need – do you want me to submit like a copy of the plan booklet or…?

Female: (Inaudible) be at least curious to see it because I know our regulations. How can I say this? I know that our regulations specifically mention FELA and then say that we you know in essence that we are secondary. So…

(Cynthia): It's kind of confusing. Well, the national plan actually is primary over Medicare, but the railroad takes the secondary payer and so that's where meaning the copays, the co-insurance and deductibles. And so what they're

stating is is that Medicare would be primary for just the copay's insurance – deductibles. But the national plan would be the actual group health plan carrier paying as the primary carrier.

Female: I don't think we're remotely in a position to answer that.

(Cynthia): OK. That's fine. Well, I've submitted it a couple of times and it's never been addressed and so that's why I thought maybe I could get lucky enough. But I will…

Female: Can you resubmit it with FELA in the line that states just – on the subject line, say, from what is the June 30th call.

(Cynthia): June 30th call. All right, thank you so much. I appreciate it.

END