# TRANSCRIPT
# TOWN HALL TELECONFERENCE

## SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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**DATE OF CALL: JULY 28, 2010**

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

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**Centers for Medicare & Medicaid Services**

**Moderator: John Albert**
**July 28, 2010**
**12:00 p.m. CT**

Operator: Good afternoon. My name is (Jessica) and I'll be your conference operator today. At this time, I'd like to welcome everyone to the Section 111 conference call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. John Albert, you may begin your conference.

John Albert: Thank you, Operator. And good afternoon to everyone on the call. Just again for the record, this is the Section 111 Mandatory Insurer Reporting Teleconference for Non-Group Health Plan meaning Worker's Comp liability no-fault insurer reporting. Today, for the record, is Wednesday, July 28th. We're going to – for those that have never been on this call, which I mentioned most you have, we generally provide some presentation materials initially and then we move into a Q&A session.

As a disclaimer, we also need to mention that on occasion, we may contradict some of the materials that are out on the Section 111 Website which contains all the official user guide and the instructions for implementing the Section 111 reporting requirements where we do, you know, if we do contradict that written material, we just need to make sure that everyone understands that the written material is the final guidance of reporting instructions. We're only human and occasionally do contradict it.

We have a cast of characters here today as usual and there'll be a couple of presenters. The first will be Mr. William Ford of EmblemHealth or GHI, the coordination of benefits contractor. He has some announcements. We'll have

a couple of brief statements by William Decker followed by Barbara Wright who will go over some of the questions that have come into the resource mailbox. Also with us is (inaudible) (Williams) who serve as resource on all this as well.

Other than that, we can jump right into it. Once we get into the Q&A session, you will be asked for your name as well as the company you represent and we would ask you to please limit your questions to one and one follow-up so that we have time to answer as many folks in queue as possible. If we get to the point of 3 o'clock Eastern Time when the call has to end and people are still on queue, I mean we have to end it anyway because we have other meetings to attend, et cetera after this.

So again, as the courtesy to the others out there, please don't hog the line. So with that, I'll turn it over to William Ford who wants to go over to a few announcements.

William Ford: Yes. Hi, this Bill Ford and I just want to talk about some of the recent announcements of – one thing is for the Non-GHP user guide dated 7/12/2010, it is now on the CMS Website. It's version 3.1. And, of course, you can always get it at www.cms.gov/mandatoryinsrep. Additionally, I'm going to talk a little bit about the direct data entry option. And again, as always, please review the information in the alert dated 5/25/2010 and the user guide. The DDE option will be available in January 2011 which will be in time for the initial reporting requirements for NGHPs. RREs will be able to change to the DDE option and select it during the registration starting October of 2010.

There will be additional information published in the October timeframe and CBTs will be available in December. Before deciding to switch to this method or choose it for new RRE IDs, you need to consider the limitations of the direct data entry. It is specifically intended for RREs that will only have an occasional claim to report for Section 111.

Every add, update, and delete transaction counts towards your 500 limit. The DDE is limited to 500, and every transaction will count towards that number.

If you have anywhere near 500 claims that could possibly be submitted via direct data entry, then this option is not for you. It is also not intended for use as a query function. It will check the Medicare status of the injured party early in the data entry process. If the injured party is not matched to a Medicare beneficiary, no further data will be needed or required.

However, this will count towards the limit of 500 claim reports per year. So for every query that doesn't get a matching record or a matching beneficiary, it will still count towards that 500. RREs should not use the DDE for query purposes only using one RRE ID and report claim files under a different RRE ID. And conversely, RREs may not submit query file and then enter claim information via DDE. If you select DDE, you can only use direct data entry.

Since all the same data elements will be required as with file submissions, the data entry for a claim report may take the RRE a significant amount of time. Do not select this reporting option if you will be making regular claim reports each quarter. You are advised to opt for the file submission method instead.

Abandoned RRE IDs. If you registered for an RRE ID that you no longer need and never intent to use for production reporting, then please contact an EDI rep or the main EDI department number at 646-458-6740 and ask that RRE ID be deleted.

Many organizations have determined that they are not RREs for Section 111 reporting since the publication of the Who Must Report alert. If you will not be reporting for Section 111, you do not need to complete the registration process or testing. And again, please call to have your RRE ID deleted. For the latest user guide, there were major and significant changes made in version 3.1. I'll go over a few of those now. And Section 7.1 has been placed in its entirety with language from the alert for Non-GHPs RREs who must report. That alert was dated May 26th, 2010 and it's on the NGHP alert tab of www.cms.gov/mandatoryinsrep.

Sections 11.1.1 and 11.1.2 were added to consolidate information regarding matching injured party information to Medicare beneficiaries and update and delete transactions to previously submitted claim records. It was noted in

Sections 11.1.1 and 11.10.1 and 12 that RREs must store the HICN return on response files in their internal systems and are required to use it on future transactions. The SSN may be submitted initially for an injured party on the claim input file and query input file if the RRE does not have the HICN. But once the HICN is returned after matching the individual to a Medicare beneficiary, it must be used going forward.

The requirements for reporting ICD-9 diagnosis codes in Section 11.2.5 were updated to clarify that ICD-9 diagnosis code submitted should be those that reflect the illness, injuries claimed and/or released by the settlement, judgment, award or for which ORM is assumed. The file for version 28 or valid ICD-9 diagnosis codes from a CMS Website which will be added to the system as of January 1, 2011 was documented and the documentation is CMS28_DESC_LONG_DX.txt.

Note that this file is a long description file instead of the short description file for this version as the short description file is not for this version and the short description file is not formatted with character terms like the others. Also note that CMS is now posting Excel spreadsheets for the latter version that you might find easier to use in the text files. Be sure to use the files with DX in the name which contained ICD-9 diagnosis codes rather than the files with FG in the name which contained procedure codes.

Sections 11.7 and 11.10.1 were updated to remove the requirement related to submitting empty files or otherwise notifying the COBC when you have nothing to report for a particular quarter. Empty files will still be accepted but are not required. The proposed change to the Section 111 COBSW to allow account managers to indicate they have nothing to report for a particular quarter has been rescinded.

A new event was added to the event table in Section 11.7.4 to explain that two separate reports may be required for the same incident, injured party and insurance policy claim when ORM and TPOC reflect different insurance types. For example, this may occur in the event of an automobile accident where ORM is covered under the no-fault coverage of policy and the TPOC is covered under the liability coverage on the same policy.

Section 11.10.2 was updated to reflect the language in the alert dated May 27, 2010; periodic, workers compensation, and no-fault payments. The language from the alert regarding risk management write-offs dated May 26, 2010 was added to Section 11.10.2 along with changes announced during the June 30, 2010 Non-GHP Town Hall teleconference. Please read the section in its entirety as the language in this guide supersedes the language in the original alert.

The language from the Non-GHP alert clinical trials dated May 26, 2010 has been added to Section 11.10.2. Section 12.1 was updated to correct the description of the O3 disposition code. While our record returned with an O3 is considered error free and matched to a Medicare beneficiary, the record is not considered accepted since the dates reported do not overlap the beneficiary's Medicare coverage dates at the time the record was processed.

In other words, MSP does not apply at the time the record was processed. The description of the O3 disposition code was updated accordingly in Appendix E. This was changed to add clarity. The actions in RRE must peak after receiving and O3 have not changed. A new paragraph, special consideration for the SP 31 error, was added to Section 12.2. Section 15.5 was added to provide information on the direct data entry option.

All descriptions of TPOC date fields on the claim input file detail and auxiliary records in Appendix A were updated to state that they must be greater than CMS date of incident which is field 12 of the claim input file detail record. This edit only applies if the TPOC date is actually required. It may not be submitted in the case of an ORM report. Field descriptions in Appendix A for claimants one through four TINs were updated. The requirement that these TINs cannot match the injured party SSN was removed.

There may be certain situations were claimant one reflects the beneficiary's state and there is no separate TIN to identify the state other than the beneficiary's SSN. Remember that claimants one through four should only be use if the injured party Medicare beneficiary is deceased and this other

claimant may be the beneficiary of state or entities or individuals in the case of wrongful death or survivor action. Claimants one through four are not to be submitted where the injured party or Medicare beneficiary is alive and an individual is pursuing a claim on behalf of the beneficiary.

See the section for the injured party's attorney or other representative information. The error code descriptions in Appendix E associated with the claimant one through four fields were updated accordingly. Error code descriptions for CJ03, CT01, CT11, CT21, and CT31 were updated in Appendix E to state that TPOC dates must be greater than the CMS date of incident which again is field 12 of the claim input detail file.

Error codes SP 31, SP 48, and SP 49 were added to Appendix E. Please note the SP 48 and SP 49 should be treated exactly the same way. One is triggered if the beneficiary never had any other insurance primary to Medicare and the other is triggered when the bene has had insurance primary to Medicare but the delete doesn't match any of those, or the record was already deleted. You don't need to be concerned about the distinction; just treat them the same way. Check the keys and correct and resubmit. Or if we the keys were submitted correctly, do nothing. There's nothing to delete.

Appendix G has been updated to match the language from the alert for Non-GHPs RREs must report. Alert dated May 26, 2010 on the Non-GHP alerts tab of www.cms.gov/mandatoryinsrep. And those are all the announcements.

John Albert: OK. Next, Bill Decker is going to – has a few things.

William Decker: I have a few things. Hi, everybody. My name is Bill Decker. I'm here in Baltimore with John and Bill Ford. And the rest of the crew, good afternoon to all of you. I have only a few things before I'll turn it over to Barbara Wright who has more than a few things. And I'm going to start with my few things answering – responding to a question that we got in through our dedicated mailbox. Regarding translations of the model language form, the form that is used to give to people if they are reluctant to provide either their Medicare ID number or their Social Security number.

We've had a number of inquiries from folks who have asked if they can have the form translated into Spanish, they or others who have said they've had the form translated into Spanish and is that OK? Our general answer is this. If you have translated that form, that model language into another language Spanish or any other language, we would appreciate it; and if you could send us a copy of the model language in the language that you have translated it so that we can take a look at it.

We will assume that they are OK but we do want to see what they look like and how they would actually read. If the examples that we get in here are useful, we actually may post them on the Section 111 Website. It would be useful to us if we could see how you're translating this – the model language and to see if we can use it. So we will appreciate it if you would do that. In the meantime, use what you have translated but, as I say, please forward copies of that to us here. You can copy it to – where would you have...

John Albert: Send it to the research mailbox.

William Ford: That's right. Send it to the Section 111 dedicated mailbox and we'll take it out of there and see what it looks like.

William Decker: Thank you, John. The other issue I'll address is the Social Security number issue. Specifically, the question that was asked, is it appropriate to collect Social Security number on our entire medical claim population or can we just ask claimants if they are Medicare-eligible on our claim form? This would mean that if they checked off, no, they are not Medicare-eligible; we would not submit this to Medicare to determine Medicare eligibility.

In general, the first overarching response is that the Section 111 requirements require you to tell us about all Medicare beneficiaries. We want you to send us Medicare ID numbers. We really don't want to get Social Security numbers unless you can't get a Medicare ID number for some reason or other. If you can't get a Medicare ID number from somebody, a Medicare HICN, the Medicare Health Insurance Claim Number, that's the insurance claim number that Medicare uses and that all Medicare beneficiaries who are enrolled will have, you can't that from an individual and you suspect the individual may be

at Medicare beneficiary, you can query on that individual by giving us the individual Social Security number and other pertinent personal information which we can then use to look at our databases to see if we have a Medicare beneficiary with that identifying information on our database.

If we do, we return to you, we send back to you the individual's Medicare ID number which you will then use. The problem is or the question is always, what happens if people won't give me their SSN? The answer to that can only be if you believe they may be a Medicare beneficiary and you want to query the database, you're going to have to either use the Social Security number or better, send us their Medicare HICN, their Medicare ID number.

You can request that using the model language that's available to you on the Website. If an individual receives the model language from you and doesn't return it, won't return it, refuses to return it, refuses to cooperate in any way, shape, or form with you then we say to you, you need to document your efforts to collect the information and keep the documentation on hand in case it ever gets to a point where the individual turns out to be a Medicare beneficiary and we come to you asking why you didn't report.

If you have documentations on hand that says you tried to find a way to identify the person and you could not, then that will at least satisfy our question as why didn't you report. It's a compliance question for you all. And the best we can do is say to you, if you can't get identifying information from an individual and you believe that individual should be reported to us or may need to be in the future and you still can't get the identifying information, you need to document your efforts to find the information, to get it from the individual and to keep that documentation on hand in case we ever ask you for it.

Barbara Wright: This is Barbara. And I guess, Bill, would it be fair to say that the very short answer to the question asked, is it enough to simply have a check-off within your records that the person said yes or no to being a beneficiary; I would say based on what you said, no, that's not sufficient. They have to take the extra steps and potentially use the model language form.

William Decker: Right. And if someone doesn't give you their Social Security number or their Medicare ID number, that does not mean you should not or may not report them. If they need to be reported, then you have to report them. And if you can't identify them, you need to keep that information on hand. Merely saying, I'm not a Medicare beneficiary. We have found from vast bodies of experience, it does not necessarily mean the individual is not a Medicare beneficiary. So you have to keep that in mind.

Those were the two points that I had that I wanted to cover and that's it for me. And I'll turn it over to Barbara Wright. And thank you all. I'll be here to answer your questions if you want to be with the call.

Barbara Wright: OK. This is Barbara Wright. The first general comment I'd like to make is when Bill Ford was talking earlier, he mentioned about using the alerts. And I just want to emphasize that in any situations where we have an alert that has been rolled into the guide, please refer to the copy that's in the guide. As Bill mentioned, sometimes, at the time it's being rolled in, there may be some change in the language.

And he mentioned specifically, I think, in the latest version of the NGHP guide, one of the alerts that was changed was the one that had to do with risk management taking to account some comments we received at the time of the last call, just to firm up the language there. So please take that into account.

The second item I'd like to address is the date of injury or date of incident for cumulative injury. We don't have a formal alert out yet. The language that we're leaning towards right now is that the date of incident would be the earlier of the date of treatment for any manifestation of the cumulative injury began, when such treatment preceded formal diagnosis; and the second would be first date that formal diagnosis was made by any practitioner.

In other words, it would be the earlier of those two. That's where we're leaning at this time. Another alert that we're looking at is one to deal with TPOC associated with Worker's Comp or no-fault indemnity issues. At this time, we still believe that we will need to have those TPOCs reported. There are may be issues in terms of the indemnity language that would be a potential

defense to the beneficiary or whatever entity we sent a demand letter to. But for purposes of reporting, we do need the information.

On the last call, at least, a couple of the people who posed questions asked if we would do additional examples of who is the RRE when we're dealing with deductibles or self-insured retention situations. And we said that if people wanted to put together additional examples, that we would consider adding those additional examples to the user guide. We received, as far as I know, only two such list of examples.

I have asked for both of those lists to be flushed out a little bit more and the two people that – two people or two entities that submitted them are going to be working together and submitting a more complete document to us. So we are still looking at that.

In terms of the questions that came in, we got – we received several that had to do with the risk management alert and subsequent inclusion in the user guide. And one question that came up more than once were situations where whether it's a never event or some other item that, for whatever reasons, the provider/supplier is prohibited from billing Medicare for – that they have reduced their surcharges. They wanted to know whether they had to bill it despite this prohibition just so they would comply with the reporting requirements. And our answer on that is no, they should not be billing it solely for that purpose. Another question that came up in more than one variety had to do with situations whether or not they were – it actually seemed to us they have more to do with whether or not the funds or issue actually involved risk management.

One question was comparing taxi cab vouchers which they were assuming based on the language were potential TPOCs, with situations where the hospital offered a free community transport service and didn't believe that would implicate the Section 111 reporting requirements.

Again, what we sent in the alert is where you're dealing with risk management situations. If you regularly have a van service and, for whatever reason, you're giving someone a taxi voucher as a substitution, you're not doing it to

mitigate risk or for that – or mitigate potential risk and we're not saying that that's automatically something that needs – reported nor are we saying – and I'm going to stick to exaggerated examples but, say, you have a situation where your hospital has a policy that you give a free meal voucher in the cafeteria for anyone who has to wait more than two hours in the emergency room. You know, that doesn't seem to us to be necessarily constructed as a risk management situation.

You aren't doing it for a specific person to mitigate risk in a specific situation. You're doing it in some cases as a community service. In terms of a van transport and others, you're doing it in terms of just general customer satisfaction. So you need to assess your own situation and determine whether or not it's really a risk management issue or it's something more benign.

I know some hospitals that routinely give free – otherwise, they have metered our expensive parking and they routinely give free parking to family members for anyone who's in ICU. So we're not saying that every single thing that's provided free is necessarily a risk management issue. But that's an assessment. You have to specifically make where you have may have ignored making a distinction in the past.

There are several questions that had to do arguably with the issue of indemnity. The question would come in and talk about so and so has responsibility here and they purchased another policy which indemnified them. Does that mean that that new policy is the RRE?

We have said in the past that you cannot transfer RRE responsibility. If you have a situation where a company, for instance, is bought out or through other means, there is now a legal response – underlying legal responsibility for the death or for the TPOC, whatever, in that type of situation, we're expecting that if it's a situation – let's say, company A was bought out by company B and two insurers. And if company B is responsible for all ORM on or after the date of this sale, then in that type of situation, any ORM records, existing ones, would need to be termed for the one entity and a new record added for the second entity with the effective date.

On the other hand, if company B took over the responsibility for all ORM regardless of the date of the service, even if there were past claims still due for dates prior to the date of the sale, then in that type of situation, there would have to be a delete of the original ORM and a new record added going all the way back. But again, if it's indemnification, it doesn't transfer RRE responsibility. If you have a true situation such as a buy-out or sale or something like that where it's not just indemnification then in that situation, yes, there can be a change in the RRE.

We were asked about wrongful death situations. Could the entities that are reporting look at state laws about wrongful death and if they decided that there was no Medicare recovery claim, not reporting those situations? And our answer to that is no. The specific wrongful death statutes for a particular state would be something CMS would consider in terms of whether or not it has a recovery claim. But in your reporting, I guess what we need to emphasize is there's a distinction between your reporting responsibilities and whether or not CMS will in fact assert a recovery claim in a specific situation.

This ties back to what I said about the TPOC for Worker's Compensation as well. The instructions we have on the dedicated Webpage are for when you have to report. And yes, there will be a limited number of situations where you may have reported and we may not assert recovery claims. But that doesn't change your reporting responsibility.

We had a couple of questions that had to do with situations where there was a settlement that was paid out on an annual basis or otherwise. And as we have said in the past, when it's a TPOC-type settlement, the fact that you're going to pay it out by a structured settlement are pay it out on an annual or weekly basis doesn't change a need to report it as the TPOC.

Tied into the same question, people were asking whether or not – if they had the workers compensation settlement that occurred years ago and the injured party was a beneficiary and they're paying continuing benefits to a spouse, indemnity benefits, do they have to report those? Well, first of all, the description they gave made it sound as though it was a TPOC settlement and you only have to report TPOC settlements that are honored after 10/01/2010.

And, you know, secondly, if it's not one – if it's purely an economic one that doesn't involve the beneficiary, as we said, it's not reportable. You look to the key where we're looking at, whether or not medicals were claimed and/or released or had the effective release in medicals. I think I already mentioned, we had several about indemnification and, to repeat again, indemnification doesn't change the RRE responsibility.

We did get some questions about direct data entry or the implication of the direct data entry. A question – the person sending the inquiry didn't seem to realize there was any option to the system submission and felt that they would have to go with an entity that was acting as an agent. So I'll just reiterate, look at the language in the user guide about the use of direct data entry and determine whether it's appropriate for you to use or not.

William Decker: Direct data entry does not require – there's no requirement to use direct data entry through an agent. Let me put it that way. Direct data entry is – can be used by anyone. You don't have to work through an agent to do that. That's – there were a number of seemingly conflicted, you know, questionnaires, wondering about whether they had to use an agent with DDE and they don't...

Barbara Wright: You don't have to use an agent under either methods...

William Decker: Right.

Barbara Wright: ... but many entities, if they're doing a systems option and are small, don't feel they have the capability to do the systems, one, but the DDE – look at the instructions for that. The biggest issue would be the time it would take you to actually do the data entry for all the fields that are required.

We had a question that was asking about a situation for no-faults before the file was opened as of January 1, 2010 but ORM had terminated prior to 2010. We could read the question in a number of ways. Where the statement was made that ORM terminated prior to 1/1/2010, we don't know exactly what was meant. If the file was opened but legally all responsibility for ORM had terminated prior to 1/1/2010 as opposed to you simply have a situation where you might have otherwise administratively closed it, if it's legally opened,

then you have to report it. But if it's a situation where, let's say, it was no-fault or mid-pay that had a limited $10,000 hat was already exhausted prior to 1/1/2010, then no, you don't have to report it.

We were also asked about ORM in situations where there was a reopening to pay an expense or reissue a lost check. Or if you have a situation where ORM has been formally closed and you're taking action only to reassure a lost check, then we see no reason for you to report that. But if you have a situation where the case either should be opened from a technical standpoint because you still have legal responsibility or is opened – would be open for that reason then, yes, you need to report it. You've got ongoing responsibility and you're paying an expense whether it's for past or present time.

We had another question that had to do with errors and omissions. And that type of insurance I was talking about, the idea that, first of all, CMS has said that it's looking to see whether it can exclude any of these. And the incoming was mentioning a specific situation. If there is, for example, an (E&L) policy, that the policy very specifically includes all medical or bodily injury coverage then no, those don't need to be reported. But it has to be absolutely clear in the policy. We're not talking of situations where the parties have agreed there is no medical. We're not talking of situations where the parties have agreed there is no medical. We're not talking of situation where you're interpreting some language to say, well, this really means that we would never cover medical. It has to be very explicit that the policy does not and will not ever include medical or bodily injury coverage.

And as a case like that, you're sued and it includes disclaimer release for body – I'm not being able to talk today – bodily injury coverage for medicals. One thing you need to look at is what type of settlement is going on here. If you had a settlement and in fact, there was some self-insurance going along with it or a self-insurance before an actual policy, if you're self-insured, we're not going to accept the statement that my self-insurance never covers bodily injury or medical. That's not what we mean by saying that there's a policy that specifically excludes you. So I hope this comment was helpful to those of you who are looking at errors of omission.

If in fact, this would take care of a large part of your issue, we would appreciate knowing that. It's still on our plate to look at this further but if this would help you somewhat, we would like to know that. We had another question that had to deal with the risk management alert.

If you have a situation where the hospital is reporting reductions or write-offs of its own charges via the normal billing process, but is also paying for other medicals for the physicians or other entities that are involved, the reduction or elimination of their own charges would be to the billing process that the amounts that they're paying for other physicians or other entities related to that – and that would be a matter of reporting ORM.

A last question that had to do with the risk management is we were asked whether this aspect of properly including it in the billing was something that starts effective 11/2011 or effective with the 10/1/2010 date. And no, it's already in existence. What we're saying in that alert is that this is how it is properly billed. And because this is the way that particular type of reduction is billed, it does not need to be separately reported. But there was no indication in the alert or anything in the user guides that this was some new billing procedure. Any provider, physician or other suppliers should have been doing this all along.

Another person asked a question on statue of limitations in ORM. They wanted to ask whether the status of limitation applies to the RRE's obligation to monitor the status of an injured party who's getting ORM. And no, it's not – we're not talking about an obligation to monitor; we're talking about an obligation to report when someone becomes a beneficiary. So as long as the ORM continues, you have that obligation to report. And whatever it takes you to monitor it, that's a separate issue. There is no statute of limitations that applies to that aspect.

I think that's most of the questions right now. I don't know whether Bill Ford has any additional comments.

William Ford: No.

William Decker: I do though. This is Bill Decker. I just wanted to acknowledge the entity that sent in the question about the relationship between gender code and the determination of a Medicare HICN, that we received the question and we are examining it at this – examining the implications of it at this point and we'll get back to you one way or the other, get back to all of you one way or the other with our answer on that. And that concludes my part, too, John.

John Albert: OK. Thanks, everyone, and with that conclusion of the opening remarks, we can move on to the Q&A session. We, again, ask that folks limit their question to one primary question and one follow-up to give others on the call a chance to get their question in. Please go back and rejoin the queue if you have multiple questions. So, Operator, we can open it up.

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

Your first question comes from the line of (Janet Trosber) from (inaudible). Your line is open.

(Janet Trosber): Thank you and good afternoon. I have a question regarding the MSP effective dates. Our understanding is from the user guide that the MSP effective date will only be returned when the ORM indicator is set to Y or yes. When we're testing our claim response, or when we're testing our claim input file, our response file, however, is returning MSP effective dates on every record regardless of the ORM indicator. We were expecting zeros in there, and I just want to make sure we have the right understanding in how to use this date.

John Albert: And that – and this is in your – in test status?

(Janet): Yes.

John Albert: OK, I could do it.

William Ford: Well, it really shouldn't be returning the MSP effective dates only if the ORM indicator equals Y. So we'll have to...

John Albert: We'll have to look at that.

(Janet Trosber): OK. Thanks.

John Albert: What's your – if you don't mind, could you, if you want to send us through the resource mailbox, if you'd like just give it on the phone, your RRE ID and contact information?

(Janet Trosber): Yes. I can send that to you, to the resource mailbox. Is that OK?

John Albert: OK. Yes. And just reference that question in the subject line.

(Janet Trosber): OK, will do.

John Albert: OK.

(Janet Trosber): Thanks.

John Albert: Thank you.

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

John Albert: OK.

(Lisa Riley): Hi. I have a question regarding what originally was the May 27th alert regarding periodic payment. I sent this in to the mailbox a couple of times but I'm still not clear on this. I want to kind of give an example. If you've got a Work Comp claim, my understanding is, say, we've accepted responsibility and we've assumed ORM against the person who's a Medicare beneficiary then we report that.

So we report that ORM as yes, and then later on in the claim ORM terminates, so then we would provide an update with an ORM termination date. When we get to the settlement part of it, normally, if we can settle for a lump sum whether that includes medicals or not, say, 50 grand, then I know we could do an update and provide that TPOC information.

But my question comes up as if a settlement can't be reached on the indemnity and it would go to trial and a judge would then decide that settlement agreement. What happens if we then actually paid the – pay the settlement out in increments, say, week to week depending on what the state law said. Would those be considered periodic payments and not reportable under that alert or would we be obligated to report the whole, say, 50,000 that the judge awarded from the beginning regardless of when we pay it or when it's all paid out?

Barbara Wright: It's not our current instructions; you would be reporting the lump sum.

(Lisa Riley): OK.

Barbara Wright: We said we don't care whether it's a structured settlement or paid annually or, you know, whatever.

(Lisa Riley): OK.

Barbara Wright: If it's a settlement, you report the whole thing.

(Lisa Riley): OK, great. Second question along the same lines is what if we're dealing with the death claims and, normally, you know, we would report ORM as yes, we would report the ORM termination date most likely as the date of death of the Medicare beneficiary and then we would settle the claim with the widow. If we settled the claim as a lump sum, we would report that as a TPOC. But some widows want to be paid out for their lifetime.

So if there are notes set, you know, if we just basically agree to pay them, say, $1,000 a week for their life, how do we report that since we don't really know what that total payout will be over the lifespan?

Barbara Wright: I believe that the file layout essentially tells you what to do in that case. I'm sorry. I'm having trouble remembering the exact field number.

(Lisa Riley): OK.

Barbara Wright: It essentially says that – to the best of my memory.

(Lisa Riley): OK.

Barbara Wright: It essentially says that you calculate it based on life expectancy or whatever.

(Lisa Riley): OK.

Barbara Wright: In other words, your calculating gives us what the minimum payout. If I don't have it, you know, it's...

(Lisa Riley): Right.

Barbara Wright: TPOC amount. TPOC amount is field 101 and it says dollar amount of the total payment obligation of the claimant, if there was a structured settlement, the amount of the total payout amounts, if the settlement provides for the purchase of annuity, it's the total payout annuity based on the total amount on the time period used in calculating the purchase price. It essentially says if there's a minimum payout and gives us whichever calculation results in the larger amount. So it sounds like you have a similar situation to that.

(Lisa Riley): OK. Thank you.

John Albert: That's actually in the record layout itself.

Barbara Wright: Yes, it's field 101.

(Lisa Riley): Right. Thank you so much.

John Albert: Yes.

Operator: Your next question comes from the line of Roy Franco from Medicare Advocacy. Your line is now open.

Roy Franco: Thank you very much. On the topic of risk management write-offs, would it be appropriate to use as a guide to report TPOC whether a release through medical is given by the beneficiaries?

Barbara Wright: No. I mean, we've said along and the industry has said all along, there's numerous situations where there is no written settlement agreement and

there's no release between the parties if you limit risk management to situations were you actually get a release. What you're actually – I would argue coming much closer to actually settling a liability claim than you are at taking just a risk management activity.

Roy Franco: OK. So the fact that the exposure still remains for the settling part or the party that does the risk management write-off for a subsequent claim or litigation is not relevant then?

Barbara Wright: Not determinative.

Roy Franco: Not determinative. OK. And then, I just have one more follow-up – one more question and that has to do with the Town Hall Conference Call that was had, you know, the last time around. At the tail end of the conference call, there was a question on the deductibility of reporting or being an RRE under a deductible policy. And I think the question was being asked by Jim Price from Aon, and it had to deal with where an insurer, you know, without recourse to their policy, handles the claim as the normal part of the business, did not report it to their carrier beforehand, concluded the claim but subsequent to the conclusion whether it would be for marketing purposes or it be for, you know, a subsequent reports because the carrier may have wanted the information, a report that information that the RRE would be the insurance company and not the insured?

Barbara Wright: The insurer is the responsible reporting entity for the deductible. If the normal agreed-upon procedures are being followed, we wouldn't view that as being without recourse.

Roy Franco: OK.

Barbara Wright: We would not view that as being without recourse. So I would – I would assume – CMS would assume that in situations where in the past, some entities that have a deductible, have been taking care of that with minimal or no reporting to their insurer, that under the insurer's new reporting requirements, that information is now going to have to be exchanged.

Ropy Franco: OK. Well, I appreciate that very much. Thank you. That's the clarity I was looking for. Thank you.

Operator: Your next question comes from the line of James McMorrow from Pacific Gas and Electric. Your line is now open.

(Jim): Hi. This is (Jim) from PG&E in California. This regards a Worker's Comp claim where there's a third party defendant who was responsible for the accident. And, oftentimes, what happens is that the third party defendant will put up money to settle the lawsuit against – that has been filed against them by our employee.

To the extent that the employee recovers net money after attorney fees, let's say, a settlement for 100,000 but the employee net 60,000 of that. We have credit, right, against that $60,000 for our future medical that we would owe on the Worker's Comp claim. So, essentially, what happens is we petition the court for – to acknowledge that we have this credit right and they issue an order of credit.

And then it's up to the employee to prove that somewhere down the line that they've expect that $60,000 on medical treatment that would have otherwise been covered in the Worker's Comp claim. So when we enter into a settlement where we have this credit right – because oftentimes what we do is we waive the amount of money we've already paid on the comp claim in order to get this credit right. So we waive what we're entitled top be paid by that third party defendant because of what we paid so far but we use that $60,000 to offset any future liabilities.

How does this situation get reported because we're not really entering into ORM if the employee can prove with cancelled checks, et cetera, which rarely ever happened that they've spent the $60,000 then we would be on the hook thereafter. But essentially, usually, that just closes the claim down and we never hear from the employee again.

Barbara Wright: You're talking specifically only those situations were you would have ORM versus some additional lump sum?

(Jim): Yes. Well, yes. We're not – I'm not talking about the situation where the entire claim was settled up with a three-way settlement between the third party defendant, Work Comp insurer, and the employee. I'm talking about where we do what's called a stipulation with award which generally carries with it an award for future medical, but there's an acknowledgement by the court that we have $60,000 credit so we don't have to spend any money on that future medical, but there's an acknowledgement by the court that we have $60,000 credit so we don't have to spend any money on that future medical award until the employee can prove who cancel checks, et cetera, that they actually spent that money for medical treatment that the comp case would have covered.

Barbara Wright: When you say that they actually spent it, they have to prove that they personally spent it or any other entity on their behalf spent it.

(Jim): Well, actually, I don't think the courts have actually decided that. My understanding is that they have to prove that they spent it. I don't think that they can say, oh, I have the health insurance over here and they picked up $60,000 worth of treatment. And I don't think they can turn to Medicare and...

Barbara Wright: No...

(Jim): ... ask Medicare to start paying without them improving the Medicare paid for $60,000 either.

Barbara Wright: Well, let me ask you, I don't remember seeing your specific question in our resource mailbox. Did you submit it?

(Jim): No, I thought of it today during the conversation.

Barbara Wright: OK, lucky guess. OK, could you submit it? I mean, I know precisely the situation you're talking about because particularly, I think, Longshoreman, under that act, there's often credits involved, et cetera, too. But for the time being, unless we can find a way out of it, I'm afraid what we may have to say is that these are still reportable and that it would be a defense to payment that you have this credit, which means, you know, to the extent a person goes to regular doctors and everything, if – when a bill is submitted here, you would

just simply reply with the credit. And then they would be, you know, they would be going back to the beneficiary, et cetera. But I don't...

(Jim): Yes. I mean, I agree with you. I – 100 percent it's reportable. I mean, that's after all what you're after...

Barbara Wright: Yes.

(Jim): ... in this type of situation. My question is, how do we report whether we've agreed to ORM?

Barbara Wright: Report it as ORM.

(Jim): OK. And then – and then if we get a letter in the mail, we just argue that in this particular case, we still have the credit?

Barbara Wright: Yes, or if a provider bills directly...

(Jim): Yes.

Barbara Wright: ... because of what they see on our records, et cetera. I – you know, I can't think of any way right now to eliminate the reporting. And there are some situations, as I mentioned a couple during the earlier part of this call, there's – now, with this reporting, there are going to be some situations where we are going to have to require the reporting and ultimately the resolution will be more through defense against any possible demand as opposed to excusing the reporting.

(Jim): Right. And, you know, my own personal feeling is that there are so many wrinkles that that, in the end, is what's going to happen, that you probably are better off just getting people to report and then sort of details out when somebody becomes a beneficiary. That's my personal opinion with that.

Barbara Wright: Well, remember, you're only reporting if they are or have been a beneficiary.

(Jim): Right, that's true, you know, right.

Barbara Wright: But, you know...

(Jim): But reporting – but, I mean, this is what the – even for – probably, it won't come up on the daily report. Most likely, it would be two or three years later when that physician sends a bill a Medicare not knowing that we have a Worker's Comp claim. That's sort of what I'm thinking about, when you get those bills. So you have, you had – it has been reported to CMS, so you're going to get a hit. But, anyway, that's enough.

Barbara Wright: OK.

(Jim): Thank you.

Barbara Wright: If you want to send further information on this to the resource...

(Jim): Yes, I'll send it.

Barbara Wright: Please do.

(Jim): OK. Thank you.

Operator: Your next...

(Jim): Go ahead.

Operator: Your next question comes from the line of Scott Seaman from MBT. Your line is now open.

Scott Seaman: Good afternoon. My question concerns the RRE status. If you have an insurance carrier that ceased issuing a writing liability insurance in 1978 so some time before the December 1980 cutoff, is it considered to be a RRE regardless of whether or not the claimant had post-1980 exposure to a product?

Barbara Wright: If there is a claim against the policy, regardless of when it was issued, if it's a claim, you know, if there was continuing exposure involved, then we have a potential recovery rate. And it does need to be reported. We've said that for purposes of the section 111 at this point that our touchstone for reporting is whether medicals are claimed and/or released on or after that date.

And it's, again, this is splitting – trying to split hairs between whether or not you have to report it and whether or not we have a recovery claim. We have said and I'm hoping to schedule it within the next two to three weeks. We are working with a group of folks to look if there's any way we can give some release in terms of reporting once where it's most likely we won't have a recovery claim, where the issue, in part, centers around this 12/5/80 exposure.

But for the time being, at minimum, under current instructions, if, you know, medicals on or after 12/5/80 are claimed and/or released, it must be reported or it has the effect of, you know, releasing such medical. And I'm sure that's not the answer you would have preferred, but it is our current position.

Scott Seaman: All right. And any updates will be set forth in an alert or...

Barbara Wright: Right.

Scott Seaman: OK. Thank you.

Operator: Your next question comes from the line of (Susan) (inaudible) from New York State. Your line is now open.

(Susan): Hi. I have a couple of questions. In the user guide, one of the updates talked about correcting a TPOC amount. And so do we have to put the value in the same field as previously reported? But it said that if we're removing a TPOC previously reported, we have to put an update and two zeros in the same date and amounts field that we previously reported.

It also said that if we do any subsequent updates, we have to continue to report that field with all zeros. So let's say in the TPOC two fields, we have all zeros. If we are removing that TPOC, we have to continue sending an auxiliary file?

Barbara Wright: We don't have someone here to answer that question at this point. They will take it back and look at it. My question to you would be are you Worker's Compensation or...

(Susan): Worker's Comp.

Barbara Wright: OK. I guess, whether you're Worker's Compensation no-fault or liability insurance, we would generally expect it to be very, very rare...

(Susan): Right.

Barbara Wright: ... for someone to have to delete or alter a TPOC.

(Susan): Right. But in the user guide, it just, you know, it allows for that and it said that we would have to keep reporting it with zeros.

Barbara Wright: OK. Well, Bill Ford is going to take it back for them to look at and, I guess, what I would say in the meantime or even as we go on, if you have a question on that issue because it's so rare, consult with your (EDI) rep before you do the actual reporting of it.

(Susan): OK. And I have another question. When you talked about delete records, in the user guide, it said that the key info must match as well – as well as all other submitted information previously submitted on the add record?

I – we thought that like only the key fields have to match and we could send whatever was the current information on the file.

Male: It's true, the fields.

Male: Yes.

Male: Yes.

Male: Only key fields have to match.

(Susan): Oh, because in the user guide I was, you know, checking it – you know, all the changes and it said, key info must match as well as all other information submitted previously on the add record.

Male: OK.

Operator: Could you hang on a minute?

John Albert: Hold on just a minute.

(Susan): Yes. Did you look at it yet, (Frank)?

(Frank): Which document?

(Susan): 1172, correcting key fields.

(Frank): If correction was made...

(Susan): Well, it's section 1117.

Male: Page 17 – it starts on 17 and goes over to 29, the bottom of 17 section there.

(Susan): And that we have to tell IT that. That's why I wanted...

John Albert: We're back.

Female: If I heard you...

(Susan): That was in Section 11.7.2, I believe.

Female: If I heard you correctly, you were saying that, you know, obviously, the key fields have to match and then you were saying something about putting updated information on the record.

(Susan): No, no. It said, as that...

Female: So, you...

(Susan): If we do a delete record, the key info must match as well as all other information submitted previously on the add record.

Female: Right. And then you are saying if you wanted to change?

(Susan): No, no, no. We were saying that in the interim, between the time we did the add record, we might have done a subsequent update record or really the information on our file might have changed.

Female: OK.

(Susan): So, we have to go back to that first add record and put all the information that was originally submitted or only keep the key fields the same.

Barbara Wright: It sounds like something we'll have to double check from a technical standpoint. What I hear you saying is that the way the manual is phrased right now, if your internal records have changed, then that might even be causing you, you know, to do the delete. We believe the manual is telling you that you have to – our user guide is telling you that you have to go back and have all fields match your last update record in order to delete it.

(Susan): Right.

Barbara Wright: OK.

(Susan): Not only the key fields but all...

Barbara Wright: All fields. Well, Bill is going to take – Bill Ford is going to take that question back to – also for the purposes of anyone transcribing this, the individual giving the answer before was (Cynthia Ginsberg).

(Susan): Right. I believe that's addressed in 11.7.2.

William Ford: All right. And we might – we might get an answer for you before the end of the call so...

(Susan): OK. Well, that's all my questions.

William Ford: Yes.

(Susan): Thank you.

William Ford: All right. OK.

Operator: Your next question comes from the line of (Scott) (inaudible) from (inaudible). Your line is now open.

(Scott): Thanks very much, guys, for taking my call. I had a follow-up regarding something, Barbara, that you mentioned during the beginning of the call relating to the risk management alert and the issue regarding billing, et cetera. And I want to make sure I have a good understanding of what we're supposed to be doing.

I think maybe the best way to approach it is with an example. Let's say we're a hospital; a physician has ordered a series of X-rays on a patient and a different patient, the wrong patient actually is the one who has those X-rays done. So we now discover this, we're going to have to obviously not charge the wrong patient who had those X-rays taken but my understanding is that the way the billing process works is that, excuse me, Medicare does not receive a bill for those X-rays that are adjusted off that were never ordered for that second patient. And so, in my understanding, that would not necessarily be a situation where Medicare would be made aware of the fact that these X-rays were taken but then adjusted off. It sounded like what you were saying earlier is that that's not a situation that's going to create a separate section 111 report. We don't necessarily need to change a billing process and somehow create a bill on that scenario. But I wanted to make sure I understood that correctly.

Barbara Wright: Yes. I think you did. What we said is where billing is essentially otherwise prohibited, you should not be billing it just to show the information that would show up that we talked about in the risk management activity.

(Scott): OK. OK, great. That's very, very helpful I presume.

Barbara Wright: But we also said, remember that even if you're not billing us for whatever reason or even – or even if you are and putting it on the billing process, to the extent that you're paying for other physicians, suppliers, or anybody else connected to your risk management assessments, that needs to be separately reported as ORM.

(Scott): It would be ORM. If it was sort of on a looking forward basis, you know, I guess, it could also be a TPOC if it was done after the fact; wasn't necessarily

pursuant to a promise to pay but was, oh, this happened, we need to reimburse person X or person Y, wouldn't that be more of a TPOC than an ORM?

Barbara Wright: That would have to be a very factual assessment.

(Scott): OK.

Barbara Wright: In general, if you've taken the position that you're paying for the associated medicals, then that's ORM as opposed to well, I'm paying Dr. X and then I'm paying Dr. Y. As we've said with Worker's Comp, when you assumed the responsibility, you're not reporting each payment; you're reporting your responsibility.

(Scott): Right. OK, so if it's pursuant to an agreement that we're responsible for all care associated with this, then it would be an ORM. But if it's just an agreement to pay for something that's in the past is sort of a resolution of a possible claim, that would be a TPOC.

Barbara Wright: If – I don't think that we can give you a definitive answer on the call because there's so many variations to the situation you're talking about. We've said, to the extent, you know, your entity as a risk management – if you're generally taking the position, you're going to take care of the bills and the point is you should be reporting the ORM to us so that if we paid any mistakenly, we can get repaid for those as well. It shouldn't just be a matter of – well, we know about Dr. X but we don't know about Dr. Y so it's a TPOC to Dr. X.

I mean, you really need to look at this specific factual situation and what's going on. And more than that, I don't think that we can tell you.

(Scott): OK. Well, like – we can sort of think about that. And if there are scenarios, and if we have further questions then, we can follow up on those questions.

Barbara Wright: Yes. I mean, you generally shouldn't – from our perspective, you generally shouldn't have a situation with multiple TPOCs where you're paying doctors because the reason you'd have those multiple ones is because you assumed some type of responsibility formally or informally. And the other thing I would say about claims on liens or claims directly to providers or suppliers,

remember that, if you have a settlement with the beneficiary, et cetera, it – let's say the settlements says I'm going to give you Mr. Beneficiary $10,000 and I'm going to pay the lien of hospital X and the liens of doctors Y and Z, the total TPOC amount you're reporting is all those summed together.

(Scott): Right, right. We understand that.

Barbara Wright: OK.

(Scott): Yes. The – I do have a second question, a follow-up question, I think, to an issue that has been raised during prior calls but I don't think it was addressed at the beginning of this call. And that's the question regarding how we code using ICD-9 code for claims where we are settling with a general release but one or more of the settling claimants have never asserted any injury claim.

The situations that people have raised before are let's say, you've got a loss of consortium claimant and when we settled that, we want to get a general release to make sure that a year from now, the loss of consortium claimant doesn't assert that, well, now because of the stress involved, I now need treatment for high blood pressure, or whatever it may be. But those claims haven't yet been asserted. So there's no damage claim. Do you have any guidance on how we should be coding that scenario yet?

Barbara Wright: I know that (Pat Ambrose) was looking at ICD issues in general and she's not here today. The one thing I'd say with consortium, that there seems to be some confusion back and forth. If the injured party was the beneficiary and there is a consortium claim but the spouse who's filing the consortium claim is not a Medicare beneficiary, then you have nothing to report for them.

But, in most cases, the consortium amount – I can think of a rare exception through, you know, a trial and hearing on the merits, etcetera. But in general, the consortium amount is going to have to be reported as part of the total settlement for the injured beneficiary.

(Scott): Right. And we understand that you don't – a portion, et cetera; you want to know the total amount. The scenario we have is where, let's say, both of the – in our case, if it's a healthcare provider, the patient who's bringing the claim,

who's asserting the physical injury is a Medicare beneficiary, but his or her spouse is also a Medicare beneficiary and they assert a consortium claim. We reach a settlement and sometimes that settlement maybe a global settlement worth a single payment to both, and they both sign a general release.

We understand that in that scenario, we're going to have to do a report for both of them since they're both Medicare beneficiaries signing a general release. It's not a question of whether that's reportable. We understand that it is. It's a question more of how we go about reporting with respect to the consortium claimant on the alleged diagnosis, alleged injury fields.

Barbara Wright: OK. I appreciate that. I guess, what I'd have to say is repeat what we said a few minutes ago that I know (Pat Ambrose)...

(Scott): OK.

Barbara Wright: ... was looking at some of the ICD issues but she's not here this week.

(Scott): OK. Well, I appreciate that. Thank you very much.

Operator: Your next question comes from the line of (Julie Cumming) from Franciscan Healthcare. Your line is now open.

(Julie Cumming): Hello. I just wanted to go back to when you were talking about whether or not you, as a hospital, were writing off, if you were paying outside to a doctor that you may need to report, were you just speaking of TPOC or is that the ORM? I know that was a question. If we – we're paying our own claims, that we would be – whether or not we would be need to actually...

Barbara Wright: In that type of situation, what you'd typically be reporting is ORMs because, essentially, you're taking responsibility for the associated cost and you may not know all of the doctors the person is seeing. And what we were saying is it's not a matter of if you got the general position that, yes, we should be paying these medicals, then it's not a matter of, well, we're going to pay Dr. X because he came to us.

If you've, essentially, taken that responsibility, we need to know about it so that if Dr. Y comes to us, we can, you know, get the bill paid appropriately.

(Julie Cumming): In our situation, we employ the doctors in our system, and therefore, all of those bills that come through for somebody who's treating with us, which those are the claims we keep and don't send on to our carrier. We're writing those off and they're never being billed outside of our system. Do I need to report those types of charges that are our own charges?

Male: If they would be billed by you in Medicare and aren't being billed, then you don't have to do a separate report. If they would be billed by the doctors separately to Medicare and again the doctor is not receiving, you know, is not billing Medicare then the same general rule would apply.

Female: So if we are doing all the billing – all the billing is coming through our own system...

Male: I don't want to talk about whose system is going through.

Female: OK.

Male: I want to talk about...

Female: My doctor – it's my billing. Medicare is not getting it because it's coming to me and I'm writing it off with my responsibility. I don't have to report that as ORM?

Male: No, that's – that is the – let me just go back to you don't have to do it through the Medicare billing process. That doctor's payment doesn't have to be reported that way.

Female: OK.

Male: But the fact – the fact is there could be two more doctors who aren't through your process. The whole point is if you've essentially assumed responsibility, then you should be reporting the ORM. And if you know all the doctors and got them then you don't need to worry about us coming back to you or anyone else approaching you because you've taken care of it. But if you haven't, then

yes. If we get any associated claims, we should be having them paid appropriately by you.

Female: Just to clarify then, too, if the claims that I have that are mine that you'll never get are more than 700 but the doctor that is out there that maybe we find out about on the side later is less than, do I still need to report because the combination is above?

Male: ORM for liability doesn't have a threshold.

Female: OK.

Male: I can go back and check the manual but that's certainly my memory of it, that there is no ORM threshold for liability.

Male: There's no threshold.

Female: OK.

Male: The memory has been verified.

Female: All right, thank you.

Operator: Your next question comes from the line of Keith Bateman from PCI. Your line is now open.

Keith Bateman: Thank you. I have two questions unrelated to each other. The first deals with the direct entry in the 500 claim limit. It says 500 claims per year. But you could have a situation where you have 300 claims in one year. Those claims, 125 remain open the second year; third year, 100 of those are still open. So if you add the 300 in the open claims, the total amount that you're reporting comes over 500. Those are different claim years. Is it the total 500 or is it per year new claims?

John Albert: Let me – this is John. Let me try to explain it in a different way. It's basically 500 data entry operations per year. So if for example you enter 300 cases on the direct data entry and it turns out 200 of them were Medicare beneficiaries, you've used 300 hit against – it's the number of hits against our database; it's

500. So if you report somebody with ORM this year, you don't report them again next year unless you're terminating the record. So it's 500 hits against our database whether it's for query which is the first step in every entry and/or reporting of an actual...

Keith Bateman: And I just wanted to clarify because the point I'm going to make is people need to look very carefully at the nature of their claims disposition process.

John Albert: Yes.

Female: Yes.

John Albert: Yes. I mean, we would expect, you know, if you think you're going to – you're going to settle 450 cases a year with Medicare beneficiaries and have to report that many, probably direct data entry is not the best option for you because you're probably – you know, if you have a claim base where you're, say, settling a total of 5,000 claims a year and maybe only 300 are beneficiaries, if you want to use that as the query and reporting process and want to query beyond 500 to begin with, you know, direct data entry is not the option for you.

But if you were a small mom and pop shop who's self-insured and maybe, you know, have to deal with a couple of claims a year, even 100 claims a year out of a base of 300 settlements which you know is not really a mom and pop then direct data entry is something that you should consider. But basically, it's 300 hits against our database – or 500, I mean, I'm sorry.

Female: You won't be doing...

John Albert: Five hundred, I'm sorry.

Female: You won't be doing a separate query ahead of time if you do direct data entry. It's not a separate query function.

John Albert: Right, because we looked into it.

Female: Your inherent query happens at the time you report the settlement judgment award or other payments. So you would only ever – you generally should

only ever be entering an individual once when you're doing the direct data entry. You wouldn't have two separate steps.

John Albert: Yes, you don't query, leave the system, and then come back and report them. You would query and if you find out they're a beneficiary, you continue on and report the full record on that individual to us.

Keith Bateman: All I'm suggesting is people better understand that they need to know – if they build up an inventory of claims, that they may hit 500 transactions even though they have under 500 claims a year.

John Albert: And we agree with that – with that analysis.

Keith Bateman: And my second question deals with the statement regarding reporting of worker's comp, indemnity TPOCs. I thought it was a pretty broad statement. Too much of what I'm concerned about is people labeling something indemnity that includes settlement of medical; but you could have a situation for example where there's still ongoing responsibility for medical and only the indemnity portion is being settled, discontinuing responsibility for medical. Are you saying that the TPOC would then have to be reported?

Female: As of right now, yes. It's not just an issue of whether it's indemnity or not. Some of the – some of the TPOCs will contain indemnity plus others. And one of the things we need to have is an accurate picture of fees and cost against the total settlements, not just against the part that's considered medical, et cetera. So we haven't figured out anyway to do it right now other than to have it reported and the indemnity issue would be addressed as a defense if we asserted a recovery demand.

Keith Bateman: Can I suggest that we do a little more thinking about future recovery issues in that statement?

Female: We are continuing to think about recovery issues. We – for you and me, we also made today. Yes, we would love to eliminate any reporting where we would not assert a recovery demand but there are – as I said a couple of times I think on this call that we believe that, you know, we're starting to identify certain situations where we cannot appropriately give up the reporting

requirement even though we may not have a recovery claim associated with that specific report.

Keith Bateman: Quick comment. CMS has got a number of public service announcements trying to protect the elderly folks from Medicare scams. And in that, they're basically telling people you don't have to report any personal information. It's not very helpful when we're trying to collect the HICN or Social Security numbers.

John Albert: Yes. We are – we are aware of those and we are, you know, trying to get some of the stuff modified.

Female: And I think we still have...

John Albert: We have actually modified the – is that the new handbook?

Female: Medicare.

John Albert: Medicare, a new handbook for example.

Barbara Wright: But I think we still have posted on the overview page the document that we put up way I think fairly early in 2008 that explains about this mandatory reporting and that they may be asked for their social – their health insurance claim numbers in connection with this effort. And certainly that document you are free to use in connection with any efforts you make.

Male: Thank you.

Operator: Your next question comes from the line of (Sylvia Perava) from Hartford Insurance Company. Your line is now open. (Sylvia Perava), your line is now open.

John Albert: Next question?

Operator: Your next question comes from the line of Vicky Vance from Tucker Ellis & West. Your line is now open.

Vicky Vance: Thank you, everybody. Just a question inquiring about the status of the mass tort working group and whether a meeting will be taking place and what a timeframe might be that we can expect.

Female: As I said, we're probably going to try and schedule it within the next two to three weeks.

Vicky Vance: OK, very good. Second question is somewhat related to that. It goes to the issue of how to define exposure. And I know that will be something we'll take up in that context. But I have – I have a specific situation in mind and I wanted to see if I could get some initial guidance. This is a situation in which a gentleman has had radiation exposure and clearly that event occurred before December of 1980. 1975, there was no doubt about it, that was the date of his event of high radiation exposure.

The litigation or liability question now comes up 15 years later when this gentleman goes on to have children and he has offsprings who have allegedly suffered in injury that they attribute to being the children of the gentleman who had this radiation. It's a radiation-related exposure and injury that has been sort of pass down genetically. For the children who clearly are after December, 1980, you know, what date do we ascribe as their date of – date of injury? Is that the dad's exposure date back in – before 1980 thus none of this will be reportable or...

Female: I think you can bring some of those up in the context in the work group. I think you're actually potentially undercutting us not asserting a claim because how did the children have it if the exposure didn't continue. So, you know, I don't think that's appropriate to this call right now. You can send – you can send me the issue separately through the mailbox. I mean, we are going to look – have to look. We are continuing to look at 12/5/80 issues. Hopefully, it's the case you're talking about. The children wouldn't be Medicare beneficiaries so it would be moot with respect to them. But...

Vicky Vance: You know, that's an example that sort of typifies some of the questions. Is it the direct exposure of the individual claimant or is it something that becomes

somewhat of an, quote and quote, "indirect exposure," because they themselves didn't...

Barbara Wright: It is...

Vicky Vance: ... have the injury but they...

Barbara Wright: It is arguably exposure however it happens and you are arguably drafting an argument for why we would have recovery claims. So, again, I think that needs to be addressed outside of this call.

Vicky Vance: OK, very good. Thank you.

Operator: Your next question comes from the line of Kathy Byrne from Cooney & Conway. Your line is now open.

Kathy Byrne: Hi, how are you?

Male: Great.

Barbara Wright: Good.

Kathy Byrne: I'm calling regarding a specified liability cases in the 12/5/80 days. The descendants – I represent plaintiffs. The descendants are telling us that they need to report all cases regardless of the last date of exposure even if their exposure – if my plaintiff's exposure ended before 12/5/80 in order to issue a general release and they're basing it on some language in the manual. I think the examples are crystal clear. But in the manual, it says exposure not only allows you to establish if it's and/or released.

So in other words, they're saying in order to issue a general release, that has to, you know, list, you know, all time, from here to eternity, and if that is requiring them that to report cases that – or with the exposure...

Barbara Wright: Yes. I don't know how long you've been on the call today but we have addressed this. What we've said is there needs to be – people need to mentally make a better distinction between the issue of what's required to report it – be reported and whether or not we may in fact have a recovery claim. The way

the instructions stand now, if it's claimed and/or released, they have to report it. That doesn't mean that they're might not be a dissent against any recovery claim that we would assert. And that's really all I can give you at this point.

Kathy Byrne: If it's not claimed but it is released. I guess that's the...

Barbara Wright: Yes, our touchstone is claimed and/or released. So, you know, if it's released, for purposes of reporting, that's where we stand right now. One of the issues that we want to look at further is if there's a way that we can eliminate reporting for some of that where we can absolutely establish that we wouldn't assert a recovery claim. But our experience in talking to some of the attorneys involved in this has led us to the conclusion, at this point, we don't have a good way to do that. We are still exploring ways.

Kathy Byrne: OK, thank you.

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

(Mickey Lohan): Hi, thank you for taking our call. I'd like to go back to the scenario where widows' benefits are being paid. And Field 101 specifies that the total payout is used when there's a structured settlement. But if we're simply paying – making periodic benefit payments based upon our Worker's Comp law, then we're treating those as periodic payments and reporting the ORM equal to Y rather than considering those TPOCs and trying to estimate a total payout. Are we OK doing it that way?

Barbara Wright: The way you've described it, I don't think so. Would you please send us a note to the mailbox? Because if you're not paying her medical, then reporting ORM is going to cause problems.

(Mickey Lohan): OK. I'll send you a note to the mailbox and give you a specific example then.

Barbara Wright: OK.

(Mickey Lohan): Thank you.

John Albert: Thank you.

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

(Lisa Riley): Hi, I was on the call earlier and I just have a third question regarding claims that are with RREs that have gone bankrupt. We have an RRE that controls a lot of bankrupt companies and in those claims, someone made a question before. We may have had work comp claims where either we agreed to settle an amount which would be a TPOC or we took it to trial and a judge issued an award for, say, $30,000.

But since the clients are in bankruptcy, the state has taken over and they tell us to pay those out monthly. Some months, we have some money. Some, we have other money. It varies month to month. So, again, would we still report it as one TPOC, say, the whole 30,000 at the beginning regardless of how we're paying it out or when we pay it out because that's like to this date or are those considered separate TPOC amounts?

John Albert: Can you hold on for just a second? Were, the third guy, the $30,000 in payments committed?

(Lisa Riley): Well, I don't know. I'd have to go back and look. My understanding is that we pay what we can pay each month. And as long as the funds are there, we keep paying. But I can go back and check that.

John Albert: But it makes – I think it's going to make a difference and I want to see it written up and sent into the box.

(Lisa Riley): OK.

John Albert: The issue is, is it $30,000 subject to the availability of funds or is it 30,000 that's to be paid?

(Lisa Riley): OK. In this scenario, I believe it's subject to the availability of funds.

Barbara Wright: OK. Well, if you would write that up and send it in, we'd appreciate it.

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

Male: And for the purpose of the reference, that was (Bill) (inaudible) who answered that last question.

John Albert: And please, for the folks that we're asking to follow up on the resource mailbox, in addition to the regular subject line, please add something like, you know, from today's call or something like that.

Barbara Wright: Yes, as explicit as you can be in the subject line is helpful. When someone sends it in and says MSP, it doesn't really help us.

John Albert: Next question?

Operator: Your next question comes from the line of (John Salmon) from (Nationwide Indemnity). Your line is now open.

(John Salmon): My question has been answered. Thank you.

Operator: Your next question comes from the line of Melissa Arkwell from Liberty Mutual. Your line is now open.

Melissa Arkwell: Good afternoon. You mentioned early on the call that there was going to be a mass torts working group meeting in the coming weeks. Can you tell me how confident CMS is on the meeting actually taking place in a few weeks?

Barbara Wright: Fairly confident.

Melissa Arkwell: And I ask only because we've been hearing that for quite some time. And as October 1st approaches, we're quickly running out of time to deal with this issue.

Barbara Wright: OK. I understand your concern but the current instructions require reporting in certain instances. As I think we said on the last call, we're looking for some way to help relieve you of some of the reporting. But if we can't do that before 10/1 then you're not going to be relieved as of 10/1. It doesn't mean that we'll let the issue go away, that we won't continue working on it. But unfortunately, we have to be deal with certain priorities here to be ready for

10/1. And where that's an absolute priority, it will take precedence over something that relieves you of some existing reporting obligation.

Melissa Arkwell: I appreciate that. And you also mentioned that you have been over the past few months been working with the group on the mass torts issues. Can you tell who is involved in that particular group?

Barbara Wright: We haven't had a meeting this year. I believe the last meeting was actually in November or December. It's reconvening that. And we asked for people – people who were interested in participating, we basically let them sign up. So there's a range of people that are involved. There are people involved from – for instance, from AIA. There are people involved from PCIAA. There are people involved from MARP. There are people involved – let me think of some other organizations that are there. I think...

Male: Individual companies.

Barbara Wright: We have some people from individual companies. We have...

Male: Attorneys.

Barbara Wright: ... you know, some individual attorneys that are involved as well as a number of insurance companies. So we did not dictate who was involved. We left it fairly wide open. I don't know, you know, to the extent I can, if other people requests, we may be able to accommodate some. But bottom line, this have been open mike call as opposed to the type of call we're doing right now or we'd never be able to, you know, have any discussions at all and that means there's – from a practical standpoint, an open mike call is hard to do beyond 50 or 60 people.

Melissa Arkwell: And I appreciate that. Liberty is one of those parties and I just want to make sure there was not some other group that we weren't aware of. I was wondering on it but you've answered my question if there hasn't been a meeting since last year. That was the last you were involved. So I appreciate your help. Thank you.

Operator: Your next question comes from the line of (Wendy Rader) from (State Compensation). Your line is now open.

(Wendy Rader): Hi, this is (Wendy Rader) and I'm asking a question regarding multiple settlements with the same individual and the same carrier being involved. And the user guide says that this would be cumulative rather than duplicative. So for instance, if we have – the individual has filed two or three claims, maybe one is a continuous trauma, another is a specific date of injury, say, at the end of that period and maybe another specific somewhere in the middle of that period, you're saying that we should report each of those separately with – and attribute separate amounts to each. Is that correct?

Barbara Wright: If they're a separate settlement?

(Wendy Rader): Well, they wouldn't be. They would be written up as one single document.

Barbara Wright: OK. Well, then it would depend on what insurance is involved. If you provide, for instance, both liability and no-fault then you're going to have to report those amounts for the plan.

(Wendy Rader): This is entirely Worker's Comp. And, normally, we do attribute certain proportions of this joint settlement to each claim. That's for our own bookkeeping purposes. But we want to know if that's how you want it reported or do you want the total amount of the settlements that includes all three reported on all three.

Barbara Wright: Are they three separate injuries or they're multiple claims essentially for the same injury?

(Wendy Rader): Well, you know, it depends on how you view it. I mean, the person is alleging three separate causes of action.

John Albert: Are the last injuries interconnected or interrelated?

(Wendy Rader): Yes, they are. And – well, I mean, and even if they're not, we would settle them. If they're all from the same person and all from the same employer, we would settle them together in one document – one settlement document.

John Albert: Can you hold on just one second?

(Wendy Rader): Yes.

Barbara Wright: We'll be back with you in just a second.

(Wendy Rader): OK.

Barbara Wright: OK.

John Albert: We believe what you would do is you would report each claim separately but report the total of the payout without allocation on each claim.

(Wendy Rader): OK. And then I have – the second question and you may have answered this earlier but this has to do with the settlement of liens for medical treatment on a claim where we denied liability, we did report ORM yet because we had $10,000 during discovery that had to be – medical treatment had to be paid. But after we denied the claim, then we settled that eventually and then we started settling the lien.

Now, it is stated in the settlement documents that we are going to settle certain liens and generally that would include any lien that comes up that even if we didn't know about it at the time of settlement. So you're saying that all of those are part of the same TPOC but we wouldn't – I guess we would then just keep adding amounts every time we settled another lien, is that what you're saying?

John Albert: What is the nature of your settlement?

(Wendy Rader): Well, this is worker's comp and it's a denied case and we're settling the casing fees. But within that, we say we will settle these liens in addition.

Barbara Wright: Well, remember, if you're settling it all, from our perspective, it does not matter that you've denied liability because your primary payment responsibility is established by the settlement, judgment, award by compromise or otherwise. So the fact that you've denied liability is not determinative of whether you report and how much you report report.

(Wendy Rader): So are you saying that even though we deny liability, we're supposed to report ORM at the point when we settle it as a denied case?

Barbara Wright: If you're going to be paying the associated medicals, yes.

(Wendy Rader): Hey, well, this is extremely confusing and now I really don't understand it at all. But, OK, thank you.

Operator: Your next question comes from the line of (Janice Wiggler) from (Tone & Shine). Your line is now open.

(Janice Wiggler): Hi, good afternoon. My question relates to the risk management write-off guidance, and it was very helpful to have your clarifications about some of the examples that you provided. And I was wondering, given the discussion, whether CMS is considered modifying the guidance definition of what's a risk management write-off.

Currently, it says the risk management – it's a risk management tool to lessen the probability of a liability claim against it and/or the facilitator-enhanced customer goodwill. So the way that it's defined right now – I think I understand where all these questions were coming from because, you know, some of the things that you indicated were things really designed to enhance customer goodwill. And it seems as if really what CMS is focusing on from the discussion before is lessening the probability of a liability claim and using what you're doing as a risk management tool. Is that right?

John Albert: You have to be careful, (Janice), because I can see someone arguing, well, gee, reducing the person's hospital bill by $10,000 because we – his bill is holding water on him, we're going to consider that a gesture of goodwill rather than a possible procedures action.

(Janice Wiggler): Well, I guess that's...

John Albert: Ye, I can see that being gained left and right so – I think that's something we got to check for language. Why don't you send it to the mailbox?

(Janice Wiggler): OK. All right, OK. I'll do that.

Operator: Your next question comes from the line of (Beth Degree) from Munich Insurance. Your line is now open.

(Beth Degree): Hi, I'm glad I got my question in. We are – yes, we're right down into the time. We are getting close to being able to submit but we have one problem. We don't currently capture the ICD-9 code. We are working with the company, a bill review company to get that information from them but we're not sure we're going to have that project completed by January 2011. So our question is have there been any discussions about delaying the ICD-9 requirement?

John Albert: Unfortunately, no.

Barbara Wright: And that requirement has been known since the beginning.

(Betsy Wade): Right, and we've been working on this project, I think...

Barbara Wright: Yes, keep in mind that it shouldn't always be a matter of capturing it. If you have medical bills that you're easily taking it from, that's fine. But you should have a process in place. If you have a situation where you don't have medical bills to review, it's better that you are assigning the appropriate ICD code.

(Betsy Wade): OK.

Barbara Wright: We've never said, and in fact we've specifically rejected the idea that you should obtain codes only from existing billing.

(Betsy Wade): OK. Well, thank you very much.

Operator: Your next question comes from the line of (Jaren Jones) from Deseret Mutual Benefit. Your line is now open.

(Jaren Jones): Hello, I have a question about the ICD-9 codes. In our testing, we verified the codes against the short description valid file, and we had some of the response records come back with those codes rejected. And I discovered that those codes were also in the excluded codes, Appendix H, of the user guide. Will the codes really be in the valid file and the excluded list?

John Albert: I guess the short answer is that's what testing is for, to discovery issues like that. But, yes, obviously, we don't want excluded codes in the same list as included codes. So I assume you pointed that out to whoever it is you're working with.

(Jaren Jones): Yes, I believe we've submitted it to the mailbox, too.

John Albert: OK. OK, well, thank you, but that's again why we want everyone to take their time and we encourage people to test this early and often as they can because no process is perfect out the gate.

(Jaren Jones): Right, but that is the answer I was hoping for. Thanks.

John Albert: OK. Operator, we wanted to go back to a question that came in earlier regarding the matching criteria for doing a delete record. The caller was referencing Section 11.7.2 which mentions the information needs to match which include the injured party, HICN or SSN, the CMS Date of Incident, Field 12, the plan insurance type as well as the ORM indicator. And then there's a cross reference in there to Section 11.1.2, which is on page 50, and goes into a little more detail regarding also that we ask that they also include the policy and claim numbers submitted with that original submission.

It's not part of the quote matching criteria but it is something that we ask you to keep the same when you do a delete transaction or update transaction. That's for downstream use and downstream matching on that particular record, so maybe that's what the call – we think that's what the caller might have been asking about is the policy and claim information. I don't see why you would need to change any of that, and we would encourage you if you're going to delete a record to delete exactly what you sent us across the board. But the one thing we definitely ask for, again although it's not part of that matching criteria, is the policy and claim numbers submitted. So, hopefully, that answers the caller's question.

Barbara Wright: Yes. The inquiry that came in, part of her concern was that she – they knew they had situations where their internal records were updated.

John Albert: Yes.

Barbara Wright: So do they have to go back and check every single field...

John Albert: Right.

Barbara Wright: ...and see whether it's the same.

John Albert: So, again, the two fields referenced in 11.1.2, we would ask that you keep those the same because while there are matching criteria at the record level for you to submit, we look at the more detailed record – more of the detail on that record down – and downstream processes here at the CMS.

And with that, Operator, we're about out of time, and I'd like to thank everyone for their participation today. Again, please note that the minutes or the transcripts, I mean, will be posted on the CMS website and, again, as we actually put on the transcripts, if there's something that we say or – that contradicts the written guidance, the written guidance until modified is still the official CMS instruction regarding implementation of Section 111. And with that, again, thanks to everyone here. And if, Operator, you could close off the call and stay on the line for just a moment. Thanks.

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

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