TRANSCRIPT
TOWN HALL TELECONFERENCE

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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
February 23, 2011
1:00 p.m. ET

Operator: Good morning. My name is (Steve), and I will be your conference operator today. At this time, I would like to everyone to the MMSCA section 111 NGHP 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'd like to ask a question during that time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Mr. John Albert, you may begin your conference.

John Albert: Thank you, operator; and good afternoon, everyone. And just for the record, today is Wednesday, February 23, 2011. This is the non group health plan policy call. We had a technical call on the 9th. Again this is for policy related questions.

Please note the January 31 alert that was sent out that discusses future teleconferences as well. Also, just for the record, as we always state, on these calls is that while we try to say or provide things, information that reflects what's in the current user materials that are out at the dedicated (mandatory) insured reporting Website, occasionally we do contradict the materials that are out on the Website, where that happens.

Until those materials are updated, the official instruction from CMS regarding implementation of section 111 is always the Website and not the transcripts from the town hall calls. Again, we take information going from these calls and your questions and hopefully improve or add to the materials that are out

there on the Web. But were there is a conflict, the written materials always take precedence over what we say on these calls.

Just a couple of notes, we're now more than a month and a half into implementation of NGHP. We've received over 7,000 RREs filed into our system. Things are working, hopefully, OK. We recognize that there are occasionally problems. We are aware, for example, that the secure Website went down late last week and that there were some problems with people getting into it. We are aware of that problem. We received numerous emails, et cetera to the resource mailbox and direct communication to the EDI department alerting us of that fact.

Again, so we thank you for quickly alerting us to that, so that we can address those issues as they come. A couple of other notes, too, is that we – there are a couple of alerts that are recently published on the section 111 Website. These are all dated February 14, with the exception of one which is February 11. And this concludes a revised implementation date for direct data entry. Also a revised registration information for the – this affects, also, direct data entry.

This just, again, reflects the delayed implementation date of the direct data entry option. Also there's an alert that talks, discusses also what will be available in online query capability for responsible reporting entities who are using the regular file submission process. That's dated February 11. Again, while we think that the automatic notification is working better, it's not always 100 percent. We don't have a lot of control over that, unfortunately. But again, there are three alerts from the 14th and one on the 11th; please take a look at those.

With us today, we have Barbara Wright, who is going to go over some questions received through the mailbox. And then that will be – I don't know how long it will be, but (Pat Ambrose) is not here today. So, again, this is a policy call, so we ask that you – if you have technical questions to please hold those for the calls where we have the technical – have more technical support. We do have (Steve Foree) here as well, who can help with that, but again, please keep these to more policy related questions. We'll probably defer

technical questions to other calls to give the people who've been patiently waiting to get their policy questions answered time on this call.

Also, I would point out also that we did send out an alert also for foreign insurers – what was the date of that one? February 7 it was dated. So, again, please take a look at those, yes. Other than that, we'll get started. Barbara wants to go over some questions that came in and make some statements. Barbara?

Barbara Wright: Thank you, John. The first thing I would like to address is what people are still labeling mass (tort). I'd like to remind everybody that we moved away from the concept of mass (tort). What we're really talking about (inaudible), ingestion, implantation or exposure not the concept of it being a mass (tort).

The next work group that we plan to have will probably be either the 3rd or 4th Wednesday in March. We're in the process of getting lines for that. As soon as I have lines, I will be contacting the people that are in the work group. I would remind everybody that if you sent me a single individual to – if you have several people signed up from your law firm, for example, if you sent me a single individual's name, that's who I'm sending the invitation to. If you neglected to send me a single individual, I am randomly picking one person.

We do not send invitations to everybody who is signed up; we have some law firms with as many as 10 different people. We have no objection to you linking yourselves together before calling in. It's just we can't support an open mic call with more than 100 to 120 people. It becomes unwieldy and we simply won't be able to do it by work group. So, if you don't have an appointed individual and you want one, be sure and send that into our mailbox.

The second thing is we've gotten – and do that as soon as possible. The second thing is we've received some more questions about fields 58 through 62 in the record layout. And as we've indicated before, we are not planning to use those fields right now. Yes, we do intend to use them in the future, but we will give everybody at least six months lead time before we use those fields.

Before the next call, before implantation, ingestion and exposure, we will have a revised draft of the language dealing with 12580. So you would receive that before the call. And I think that's all we have just as a heads up on the mass (torts).

In terms of other general issues, we had a number of questions come in about wrongful death, saying in such and such a state, wrongful death excludes medicals so I don't have to report that, correct? And the answer to that is not correct. If you have a wrongful death situation, those must be reported. The beneficiary or other may use state laws as a defense in terms of whether or not we have a recovery claim, if DMSPRC is pursuing a recovery claim.

But there are too many variations on the actual fact patterns and how the claims are filed, whether or not they're combined with survivor actions and a whole host of issues. So, it's not up to the RRE to decide whether or not we have an actual recovery claim. You should go ahead and simply report those; and we'll take care of it on the back end.

We had a couple of requests for – to expand the examples in terms of deductible versus self insured retention, et cetera, and who's the RRE. We do plan to include that the next time we revise the NGHP manual. Do we have it out in a separate alert yet? No.

Let's see – professional liability insurance of all types, particularly other than medical malpractice, we've been requested to look again at the issue of whether or not there's some way we can exclude most of the reporting for that, particularly if medicals are not claimed. And mostly, if we move forward along that line, it would definitely have to limited to situations where medicals are not claimed. And most likely, at best, we could accommodate situations where there was a broad general release. Any specific release of medicals would definitely trigger reporting.

We're also looking at what we would have to have along with that to make sure that we would be informed in the limited number of situations where there actually are medicals associated with those cases. We realize that, for example, professional insurance for a CPA most claims are unlikely to include

medicals. Nonetheless, we have to look at a way to safeguard Medicare's interest along with meeting the requirements of the reporting provisions. So, that is still being looked at internally here.

Let's see – we, on the questions that are coming in, we're seeing more questions back to very basic questions. One of the ones that was a very long question was saying that nowhere is the term Medicare beneficiary defined. And they wanted to know whether it meant eligible or enrolled. And in general, what you're dealing with is enrolled.

But what I want to caution you is we're talking about whether the person was enrolled at any point, either in the past or now. It's not just a determination of whether or not they're a beneficiary now. Additionally, depending on whether you're reporting a (TPOC) or ORM affects whether or not you would have to report.

If they have never been a beneficiary and they're not enrolled currently, and all that's at stake is a (TPOC), then if they don't meet that criteria as of the settlement date as defined in our documents, then the reporting obligation ends with respect to that particular settlement, judgment, award or other payment.

If it involves an ORM situation, you do have to monitor that person. And if they become a beneficiary at any time before the ORM ends, then that would have to be reported. So, the key is enrollment; but you also need to look at whether it was enrollment at any time. And you also need to look at whether you're dealing with a (TPOC) or ORM.

We've had some questions about risk management, the alert we did and what was later incorporated into the user guide and asking about inter – divisional or other transfers of funds and whether or not this would be reportable under section 111. And we are not concerned with how you allocate funds internally within an organization. That doesn't affect the fact that if a bill is getting written off as a risk management tool you still need to follow the appropriate billing practices with Medicare, which include showing that write off as a payment that's primary to Medicare.

John Albert: Or liability insurance. Make sure you indicate that it's a liability insurance that fulfilled these.

Barbara Wright: OK. Someone sent in a question saying that there were now three (TPOC) reporting dates. And they were referring to no fault and workers compensation dates that exist now as well as the delayed reporting date for liability (TPOC)s. But then they were counting – and they have it in quotes, "NOINJ," that code as a separate reporting date.

And that code, the date in any alert or the manual for that is when that code becomes effective. But that's not a reporting date in and of itself as to when liability, no fault or workers compensation needs reported. So you need to always distinguish between whether or not we're talking about a particular code or item being available and whether or not we're actually making some change in the implementation dates for reporting.

OK. There were several questions that had to do with lump sum indemnity situations. And at this time, we still don't have the alert on (TPOC) lump sum indemnity situations completed. We do expect to be setting up a meeting with some groups within the industry to answer some last questions before we put that out. So, we wanted to give you the status on that.

We continue to receive occasional questions having to deal with groups that are in a representative status that want to, by virtue of that representative status, be the RRE for a whole host of different entities. The fact that you may represent a particular state or something else – if you have groups that are typical to, for instance, a JPA – joint powers authority – or a situation where you have, Bill, what's the name of the self insured? The self insurance pool, I'm sorry.

And you don't meet the rules for that in order to be considered an RRE, then you cannot be the RRE simply because it's more convenient for you to act as the RRE for a particular group of entities. You can be designated as their agent. But you may not assume RRE responsibility simply as a matter of convenience.

OK, we had one that dealt with the risk management situation in a hospital and was asking whether it should be part of the billing activity for Medicare or it should be reported as a workers compensation claim. The scenario involved injury to a hospital employed physician who also happened to be a beneficiary.

There were not enough specific facts for us to make any type of call. If you're handling the matter as a write off then you need to follow the appropriate Medicare billing instructions. If you're handling it as a workers compensation claim, then you would report it through the workers compensation claim process.

Someone asked whether or not personal lines carrier must report as well as a liability carrier. Again, this goes back to one of the basics. All liability insurance including self insurance as defined under the MSP statutes must be reported as well as all no fault and all workers compensation. It doesn't matter whether it's considered a personal line, for example, as home owner's insurance or it's considered a liability line. If it qualifies as liability insurance, no fault insurance or workers compensation as CMS defines those, then it is reportable under section 111 within the scope as we've defined the reporting instructions.

There were questions about what a defense evaluation, a one time defense evaluation meant and whether or not it was reportable. If you're doing a defense evaluation to determine whether or not you have any responsibility at all, that's what we meant by defense evaluation. If you're paying for a particular assessment to determine the extent or dollar value of what you pay, that's not determining responsibility, the underlying responsibility. It's simply an assessment of the extent of your risk. And that would be reportable.

We had questions come in that were talking about there was an allegation which released medicals; but the settlement was allegedly for property damage. And so, the question was since we're really only paying property damage, should we put in zero as the (TPOC) amount or should we put in the amount we paid? We've talked in several of the calls about the whole concept

of allocation of the settlement amount. You need to report the entire (TPOC) amount.

If there is a valid defense part of it being considered in terms of Medicare pursuing its recovery claim, then that can be raised at the time any demand is made or contact for recovery claim is made. But it is not up to the RRE to allocate the settlement amount among different funds and say that they're only reporting part of it.

This is also important in terms of Medicare determining the amount of a recovery claim because under 42CFR411.37 we do, where fees and costs are borne by the beneficiary, we do allow for a pro rata reduction in our conditional payment amount to arrive at our recovery claim amount. So, we can't have just part of the settlement reported for that reason.

We had one that I'm going to ask Bill Decker to address a little bit. It was a person calling in and saying that they actual had the HICN card and were told there was no match. And then they later found out that this was happening in situations where the beneficiary was not the wage earner. And basically, if you have an HICN card, you will have not only the applicable social security number for that Medicare claim number but you will also have the letter that goes after it.

So, what this person has described is an impossible situation. Bill, do you have any?

Bill Decker: You should be sending – for someone who's a dependent of a covered worker – the Medicare beneficiary a covered dependent of a covered worker – you need really to get that covered worker's precise health insurance claim number, Medicare ICN to send us.

That gives us the precise identification for that covered beneficiary. Sometimes, a covered beneficiary will be covered under the subscriber's ICN. And in that case, the covered beneficiary should have a separate and distinguishable suffix letter or letters on their own ICN, no their own Medicare ID card. That's what Barbara was referring to.

John Albert: In other words, do not assume that the number that precedes the suffix – or there also may be in some cases prefixes to the number – is that individual's social security number. If it is an A suffix and an A suffix only, it would generally be that individual's social security number.

Any other suffix or prefix may or may not be that individual's number. Use the entire ICN in your reporting.

Bill Decker: Thank you.

Barbara Wright: So, some more questions that go to basic issues or just whether or not someone's a beneficiary, and tie back to one of the comments I made earlier. We got a question that was asking about whether there were any reporting requirements for liability settlements who don't have Medicare or Medicaid.

First of all, we'd emphasize that section 111 has nothing to do with Medicaid. With respect to Medicare, again, a key is whether or not you have a (TPOC) situation or ORM. It's rare for liability to have an ORM situation. But if you have ORM, even if someone has never been and is not a beneficiary at the time of the settlement, judgment award or other payment, you do have to monitor them as long as the ORM continues to determine if there's reporting in the future.

If it is only liability, and it's only a (TPOC) settlement, if they have never been and are not at the current time, then your reporting responsibility with respect to that settlement, judgment award or other payment is over.

We received some additional questions about particular types of civil suits. And again, it's not the type of civil suit. I think the one mentioned in one of the questions was a serious and willful petition, some type of civil suit. And they wanted to know whether reporting attached to that if there was a settlement, judgment award.

Again, we go back to if it constitutes liability insurance, no fault insurance or workers compensation as those are defined within our regulations and instructions, then it must be reported.

Another general question was asking about whether payments made to Medicare or sent to the MSPRC needed to be added into the (TPOC) amount that's reported. Yes, you have to report the total amount of payments. If there's a settlement for $250,000 and you cut a check for $200,000 to a lien holder, and $50,000 to Medicare, or $50,000 to (inaudible), either way, you're reporting the whole $250,000.

Two or three questions had to do with situations where the person writing in believed it was fairly clear the person should've been a beneficiary; but they were getting an error code 51 indicating no Medicare number should – could be found. So they wanted to know if they still put those on the claim input file. Well, if you're not getting a match, it does no good to put it on the claim input file.

However, if someone's over 65 and you're getting an error code of 51, then you may want to do some further checking with that individual to make sure they're absolutely not a beneficiary.

There were questions, Bill, about the manual query process and when it would be available. Do you have any update on that?

Bill Decker: Manual query process, meaning going through the (COB) (inaudible)?

Barbara Wright: I assume.

Bill Decker: I assume. I don't know when that's actually going to be available. The – I think it's supposed to be available on March 1, isn't it? March 1 is the due date for that. I actually do know, and I thought I didn't. How about that.

So, the instructions and the alert concerning that availability are going up on the Website this week, we believe. It should be up by Friday at the latest. And everyone will be able to view querying of the Medicare beneficiary systems to see if someone is a beneficiary by going to the (COB) secure Website and querying directly through that Website, beginning at the beginning of March.

Barbara Wright: OK, another very basic question asking about whether or not guardians should be reported as a non party claimant. If the beneficiary is still alive, you're not using that claimant field. You should be reporting the guardian or other entity as a representative.

OK. Another general question about if they're settling a bodily re – injury claim for nuisance value and haven't admitted liability, how is that communicated to (CMF)? Is it put in as ORM or a (TPOC) or whatever?

Remember that under the MSP statute, MS – Medicare does not need to establish causation. Primary payment responsibility can be established by a release, a settlement or judgment or otherwise. I would imagine that for most liability insurance situations you will rarely, if every, have an admission of liability. That doesn't change the fact that, yes, the settlements, judgment awards or other payments are, in fact, reportable for purposes of section 111.

That's the general questions that came in with several each month. And, John, do you have anything before we open the mic up for questions?

John Albert: No, I don't.

Barbara Wright: Operator, no one else in the room has any announcements. If you want to go ahead and open the mic up for questions.

Operator: As a reminder, if you'd like to ask a question, please press star then the number one on your telephone keypad. And you're first question comes from the line of (John Miano) from Florida. Your line is now open.

(John Miano): Yes, good afternoon. (John Miano) of (Golden Lamb). I just have a question regarding thresholds. In terms of the 20 percent threshold imposed on the quarterly file, EDI states that all claimed errors should be corrected and resubmitted the next quarter. However, we've received directive from some EDI reps to resolve errors and resubmit the claims in the same quarter.

My concern is that by submitting a second file in the same quarter that the second file submission will back up into the first file submission of the next

quarter. Say, for instance, you have an RRE that's in reporting group one. And the claims file is sent on January first.

A notice is received indicating a 20 percent error threshold has been reached, and the file's been suspended. After an email exchange with the EDI rep, the file is released for processing on January 3. And the EDI rep states that the errors must be resolved and resubmitted this quarter. Assuming a 45 day turnaround, the response file is provided on February 17.

The problem here is that there are 45 days prior to April 1, which is February 14. So, you can see that you've already missed the window of opportunity to submit a second file in the same quarter. And there would be no time available to correct any remaining errors prior to the April 1 submission. Since the Q1 file contains – since Q1 contains February, the shortest month, the problem is exacerbated.

But the issue still applies to the other three quarters, too. I mean, this also assumes a fairly quick discussion between the account manager and the EDI rep to release the first file for processing. So, I guess the point that we're driving at here is in terms of policy, that the requirement to resubmit a file that's met threshold within the quarter is not going to work out. It may possible cause additional threshold errors for the subsequent quarter.

John Albert: Yes, you're right. I mean the files stack up; that's obviously a concern. This is – this is something that, I mean, we can take this back to our EDI department. But when a file can be corrected timely, we would prefer that it be collected and submitted and be able to be processed before the next quarterly file is submitted.

But if, for example, there's an error or whatever that comes up and it's right before your next submission, we would expect you to hold that data until that next submission, so the files don't trip over each other.

(John Miano): OK. But the EDI reps, once again, are basically advising us that – they're recommending that you do resubmit that file. Now what exacerbates this whole situation is sometime where the threshold notifications are being

received by email, hence the email is not getting to the appropriate party who can effectuate those corrections and changes, such as a reporting agent.

And that further delays the situation. And I guess our recommendation would be, here at (Golden Lamb) is that if these threshold errors and other notifications of that type were made available in the form of a response file rather than just in the form of an email, it might accelerate the process. So, the likelihood of these errors occurring, or additional cascading threshold errors occurring, would be diminished.

So, once again, anything that could be published to clarify, or any policy that could be created surrounding resubmission of input files within the same quarter with corrections versus waiting until the following quarter would be greatly appreciated.

(Steve Foree): Well, the – I'm sorry, this is (Steve Foree). Please remember, you do have access to the Website. The Website, you should be able to look up the submitted files and see whether it's received a threshold error if you're not receiving that email directly.

(John Miano): Well, when we have 4,000 RREs submitted, it's not always the easiest thing to do.

Bill Decker: I guess that's a good problem to have. I think that probably to move ahead, we're going to have to work with you offline on this.

(John Miano): OK. I appreciate it.

Bill Decker: (Inaudible) question through the section 111 email.

John Albert: Well, we recognize, again, that some of the larger agencies out there have different issues to deal with than the single reporters. But, we'll continue to work with you offline on this if that's OK.

(John Miano): Wonderful. Thank you so much.

John Albert: Sure.

Operator: Again, if you'd like to ask a question, please press star then one on your telephone keypad. And press the pound sign if you'd like to withdraw your question. And as a reminder, please limit your questions to one question and one follow up. And your next question comes from the line of (Susan Jones) from (Pendulum). Your line is open.

(Susan Jones): Hi. At the beginning of the call, you mentioned the three alerts – one – or I think you said, like, two from the 14th and one from the 11th. I didn't see those. I never got any emails. I just checked to see and I don't see any on there. Where are they posted?

Bill Decker: They're in the NGHP alerts page, right?

John Albert: Yes.

(Katie Harris): I'm sorry. This is (Katie Harris). The defined share alert that John Albert referred to is posted on the general NGHP page. And the revised (PDE) alerts – I checked this morning and they were not up yet.

However, I was told that they should be posted today, by latest tomorrow morning. And they would be on the NGHP alerts tab. Also, we just wanted to preface that we were told that the notification that often goes out has been down again. So, that would be why no one is receiving that because we also did not receive the notice...

(Susan Jones): OK, got you. I just though you guys said they were already up. And I only...

John Albert: No, actually, I'm sorry. I misspoke. I mean, those have been basically approved and are just waiting to go out there in the next day or two, so...

(Katie Harris): (Inaudible) the general NGHP tab.

John Albert: Yes, the ones for the 14th are probably not visible yet. But they should be in the next day or two.

(Susan Jones): OK. And then one of the questions you guys were answering earlier about the attorney expense and it being reportable – were you meaning that it's reportable because it's – you were saying determining your risk of liability?

So, that would be toward reporting as ORM or included in a (TPOC) – that expense being included in a (TPOC)?

Barbara Wright: I'm not sure. You need to back you question up a little. When you say attorney expense, what do you mean?

(Susan Jones): And I might have misunderstood the question. The question earlier that you had was – it was like an investigation – I think – I'm trying to think of exactly what the question was. But that's what I misunderstood.

Barbara Wright: Well, we had one about a defense evaluation where someone asks whether – we had earlier said that where there was a one time cost to an entity for a medical exam purely for defense evaluation, that that did not have to be reported.

But we've had variations on that where people are asking when they've had an additional exam or a different type of thing to evaluate how much it's going to ultimately cost them. That's not a question of whether or not they have responsibility. That's a question of how much – our analyzing how much they're ultimately going to pay. And that is not an exemption from reporting.

So, if they're paying for that type of provider, visit or anything, that is reportable.

(Susan Jones): And you're saying that as ORM?

Barbara Wright: Whichever if fits the circumstances. If you haven't assumed any ongoing responsibility, then it would be a (TPOC). But if you've assumed ongoing responsibility, if would be a part of any ORM.

(Susan Jones): OK, thank you.

Operator: Your next question comes from the line of (Anne Cosper) with North Carolina School Board. Your line is open.

(Anne Cosper): Thanks. Just wondering for – we've got some Med Pay claims that are – were closed just after the January 1 – I guess, 2010, the reporting date. And is it necessary for us to go back and re – open those files and contact those

individuals and get their social security numbers to query and ultimately submit?

And I guess my question is, is there a date beyond which we don't need to go back and get that information?

Barbara Wright: That was the January 1, 2010 date. And you're saying that it was closed after that. So you do have an obligation, yes.

(Anne Cosper): OK, thank you.

Operator: Your next question comes from the line of (Sheira Buckley) with Syracuse University. Your line is now open.

(Sheira Buckley): Hi, good afternoon. I have a question about the special exemption – or, I'm sorry, exception – for reporting termination of ongoing medical. The example they used on page 86 of the guide is actually perfect. We handle to comp claims and good stuff for reporting.

Do the detailed office notes that we receive with our billing releasing the individual from care due to a resolution, healing, whatever of the injury serve the same function as a signed statement from the physician would?

Barbara Wright: If you want to send us more detail on who those notes come from, what the content is then we could address it. But as a broad parameter question, there isn't an absolute yes or no. If they're not coming from the treating physician and they aren't making it clear that the person requires no further care for that...

Bill Decker: Period. No further care period. I mean, it's different if it comes from the primary physician for the all phases of treatment as opposed to coming from the physical therapist who says the physical therapy's over and no further physical therapy is required.

(Sheira Buckley): It's from the treating physician.

Bill Decker: Well, there could be more than one treating physician.

(Sheira Buckley): I guess I hadn't thought of that.

Bill Decker: There can be – you can have a – just to give you an example, and in turn could refer it out to four, five different specialists depending on the nature of the injuries.

Barbara Wright: Although, the beneficiary or the individual may no longer require – let's just take someone who had a lot of physical injuries, whether they're broken bones or sprains or anything else. Perhaps he's being treated by a particular doctor who specializes in the back as well as someone who specializes in knees.

And he could be released for all further treatment related to the knee without being released for all further treatment related to the back. So, just saying notes coming in, that really doesn't give us enough. What we've said all along is essentially a statement from the treating physician that they require no further care for the injuries that are at issue – for what's being claimed their release.

If you haven't got that, then you haven't got a statement that they don't require further treatment.

(Sheira Buckley): OK, thank you.

Operator: Your next question come from the line of (Kathy Seagul) with Lumbermen's Underwriting Alliance. Your line is now open.

(Kathy Seagul): Thank you. We have a question about the claimant dependent social security number. How do we report the information, the (TPOC) data, if no social security number can be obtained because they won't give it to you or whatever?

Barbara Wright: You're required to report for someone who is in fact a Medicare beneficiary. We have a cover memo or cover directive from CMS as well as model language on the Website that was designed to protect RREs if they're unable to obtain that information. We've said more than once that that should not be your first line. You shouldn't just be sending out that form and saying complete this.

But if you're unable to get a social security number to do a query then we have asked that you then have that language completed and document your files of your attempts to obtain the social security number.

Bill Decker: And of course, you would only be looking for the social security number first if you were sure that the individual did not have a Medicare Id number.

(Kathy Seagul): Correct. The follow up question is on the reporting of the claimant individual for workers compensation claims, do we only have to report if the (TPOC) information is medicals are released or included?

Barbara Wright: I have yet, pretty much, to hear of workers compensation claims that don't involve some degree of medical.

(Kathy Seagul): Well if your claimant has died and then you're settling out with the spouse or dependent child, there's no medicals to release.

Barbara Wright: I don't – from our understanding here, that's not necessarily true under all state laws. If someone has a claim for survivor benefits that, under state law, it's only for state – it's only for survivor benefits and those are clear under state laws that that's all that's being funded, then no, that doesn't need reported.

But if it's any claim by the estate or there's any way that medicals are included in that, then yes, you do have to report it. I mean, it's very fact specific.

Bill Decker: And assuming that you haven't reported the ongoing responsibilities for medicals that under workers comp.

(Kathy Seagul): OK, thank you.

Operator: Your next question comes from the line of (John Armant) from Michigan Guarantee Funds. Your line is open.

(John Armant): Thank you. On the technical conference call, (Pat) made reference to a single claim where a back injury was alleged and a knee injury was alleged, that you could have multiple ORMs on the same claim's detail file. How is that possible?

So, she's saying if you accepted the knee injury but didn't accept the back, but ended up doing a (TPOC) for both, then you would report the ORM flag as yes for the knee with a (TPOC) and no for the back with a (TPOC). But I thought claim detail records were one per claim.

Barbara Wright: I think that that was an area that (Pat) said needed looked into further. One of the things that her answer was looking to cover – we need to make sure nothing's overlaying here – but part of what her answer was to cover was the fact that when you're reporting ORM, we've told you to report only the injuries for which you've accepted responsibility.

But when you're reporting a (TPOC) payment, you must report everything that's claimed and/or released, regardless, because it doesn't matter whether or not you believe you've accepted responsibility. That (TPOC) settlement is what establishes Medicare's recovery rights. So, that's why she was talking about a different (TPOC) for the injury for which you believed you had no liability but were settling out nonetheless.

I don't have an answer for where they've looked so far to determine whether or not there's any type of overlay and whether we need to take any further steps because of that.

(John Armant): So, the only time we have to report a (inaudible) for an alleged is if we're doing a (TPOC)?

Barbara Wright: Well, I'm not going to say that in a complete open ended question. What we've said again is if you're reporting ORM, you need to report the cods associated with the injuries for which you've taken responsibility.

And if you're reporting (TPOC), then it goes beyond that, and you must include the codes for whatever has been claimed and/or released.

(John Armant): OK. So, is there going to be an alert or further communication on this? It was a bombshell for the whole industry when she made that comment.

Barbara Wright: I know this has been – we'll go back and talk to (Pat) – but I know this has been addressed on calls more than once. And I thought it was already in the user guide. But we will check.

(John Armant): Thank you.

Bill Decker: And to answer your question, there will be follow up information coming out to you.

Barbara Wright: And I guess in terms of could you explain what you meant in terms of bombshell or what it's causing for you?

(John Armant): Well, the fact that it'll imply that you can have two types of ORM on the same claim file.

Bill Decker: You could have ORM for more than one diagnosis code.

(John Armant): Yes, but in your claim detail record there's only one flag. And I was under the impression that there's only one claim detail record per claim. Then if someone's alleging six different things on one claim to me, I'm reporting that to you all as one big claim record. I'm not saying the knee injury is one claim record and my back injury is a second claim record. It's one claim.

Barbara Wright: You generally are if it's all the same type of insurance, same policy, et cetera. But what we've said is unless – this is – this is in some ways to help the industry as well as help us. We don't want situations that involve ORM. We want to use those to stop payment where payment should properly be stopped by Medicare.

And if we were to have you report one, everything that's alleged, even if you haven't accepted responsibility for it, then we would be potentially churning claims to you just so you could deny them, just so they could come back to us again. So...

(John Armant): Yes, and that's our concern.

Barbara Wright: And you don't want that. And that's why what – that's why we said when it's ORM, you report only the codes for which you've accepted responsibility. So,

that means if you've got a situation where part of the injuries you have not accepted responsibility for, then we have to have a slightly different way to report it.

As I said, we need to go back and check whether this results in any overlay, and if it does, what we need to do about it. But that's the rationale behind what she was discussing last time.

(John Armant): And I agree with the rationale. I was just concerned that you were expecting two separate ORMs on any particular file. I understand you could have it, but in the...

Barbara Wright: Well, no, wait a second. ORM is only for what you've accepted responsibility. So, with ORM it would be all on one file. What you gave an example of is you could have two separate records – you could have two separate (TPOC) records for the same claim.

(John Armant): Based on the example that was given on the technical call, yes. But the ORM flag, when we refer to ORM as far as the flag, it's yes or no. So you can have ORM yes and ORM no in her example.

John Albert: You could.

Barbara Wright: Well, and that's why we need to go back and check about what overlays what and figure out how to guard against that or protect against that.

(John Armant): Yes, because it's more comp – we all know they allege a million different injuries. And trying to include all those and say whether I got to do a separate claim detail record for everything that's alleged because I do a settlement that waives all – settles all medical, there's a lot of stuff that's alleged that could be very tricky for us.

John Albert: OK, yes. And this is something we had as an action item from the last call. So, it is definitely on our radar. So, again, we thank you for your input. Our recovery contractor as well is looking at this issue.

So, with that, operator, could we move onto the next question? Thank you.

Operator: Your next question comes from the line of (Deborah Daniels) with (Alpha Insurance Companies). Your line is open.

(Deborah Daniels): Hi, thank you. How is everyone today?

John Albert: All right.

(Deborah Daniels): Great. My question is with the new query process that's going to be in place on the COBC Website, so we'll have that where you can only submit 100 claims per month – excuse me, 100 queries per month. Does that also include if you want to do it the other way? Is it a combined 100, or can you do 100 through this process and 100 through the (hue) translator process of loading the file.

John Albert: That query function – that 100 is separate from the query process. You can – so the (flat) file. You can query as many as you want on that. This is just something to – an added feature for when you need to look up someone like between quarterly file submission.

Barbara Wright: If you missed five or 10 and you've already sent your monthly file.

John Albert: Yes, yes.

(Deborah Daniels): OK, so we can do, like if I had 150 to look up, I can do 100 on your Website and then the other 50 through the other way – the flat file?

John Albert: If you'd like. And again, this is for people who are submitting through the (flat) file process, the folks who will be doing DDE. That's all kind of one and the same; there's no separate query process. But if you're submitting the (flat) file, you can do the query file once a quarter. And then as an add on feature you can do the 100 per month manual look up through the secure Website.

(Deborah Daniels): OK, because I thought we could submit once a month for our query now on the flat file?

John Albert: Once a month. Yes, I'm sorry, I misspoke. We have a lot of different data exchanges, so.

(Deborah Daniels): No problem because we submit through the (SFTT) for our client input file. But I did a query process by uploading the (flat) file on the Website.

John Albert: Yes, but the (flat) file can be as big as you want. So, what is the term, the new term for it? Yes, the beneficiary look up, you can do 100 a month on that.

Bill Decker: (What's funny is that) they're unrelated. The 100 through the Website is unrelated to the (flat) file submissions. So, we don't count one against the other...

(Deborah Daniels): OK, great. That's what I needed to know. Thank you very much.

John Albert: Sorry I misspoke on – sorry I misspoke on the monthly versus quarterly.

(Deborah Daniels): No problem. Thank you.

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

(Keith Bateman): I was just raising – going to raise the issue about the alert, so I have no question.

John Albert: OK, thanks.

Operator: Your next question comes from the line of (Wendy Godtroph) from One Beacon Insurance. Your line is open.

(Wendy Godtroph): Hi, yes, thank you. I'm calling about – asking about the SIRs and deductibles. I know, Barbara, you mentioned earlier that you would be adding some examples to the user guide. But for the time being, I wondered if you could just kind of confirm the scenario that I submitted to the mailbox.

It's a liability policy with a $250K SIR as defined by CMS. And the policy holder does not report the claims to us other than in a quarterly (inaudible) file. All the claims that fall within that 250 – and they handle them. And we're not really involved in them.

So, for those claims that they report to us quarterly, just some basic information, but they handled it, resolved it and paid the claimant, who is the RRE? Is it the policy holder or is it the insurance company?

Barbara Wright: We're still seeing people that perhaps don't want to report arguing that they're self insured retention is actually a deductible. An example of self insured retention would be, let's say there was a self insured retention of $250,000 and then there was insurance beyond that of $500,000. That would mean that any claim through $250,000, the insurer is not involved in it at all.

But the insurance company's liability would run from $251,000 through $750,000 if it was a $500,000 policy. We've had examples where someone will say the exact same scenario – the $250,000 self insured retention and will say and we have a $500,000. That means we cover from $251,000 to $500,000. No. If it's a self insured retention any insurance is going to be totally on top of that.

So if you have accrued self insured retention, then the entity with the self insured retention is the RRE.

(Wendy Godtroph): OK, that's what I wanted to hear. And I have just another real quick one that I think I also submitted, but I think I know the answer to. But I just wanted to confirm with you. In New York state in the workers comp law there is a provision called 25A that under certain circumstances, the workers comp board will file a decision that will relieve the insurance carrier of its duty to pay any ongoing medical or indemnity benefits under certain circumstances, at which point the state assumes the responsibility for the payment of the ongoing medicals.

So – and they pay the providers directly at that point. And we as the insurance company would close the file. When this occurs, would it be proper for us to enter an ORM termination date?

Bill Decker: You could enter an ORM termination date as far as your company is concerned. But if the state of New York is picking up the responsibility, the state of New York would need to submit a new record indicating that they're responsible from whatever date forward.

(Wendy Godtroph): All right. Well, I'm not so concerned about what they have to do. But I mean, on behalf of our company we can close out and provide an ORM termination because we're done, right?

Bill Decker: Right. We have to be concerned about everybody reporting the way they should.

(Wendy Godtroph): Right, I know, I know. All right. Thank you.

Operator: Your next question comes from the line of (Bonnie Muthard) from Farmer's Insurance. Your line is now open.

(Bonnie Muthard): Yes, thank you. I have a question regarding querying. If we have – if we believe someone to be – to be a Medicare beneficiary but we do not get that (inaudible) in, but they provide us with their social, and let's say, for example, we have a spousal situation where we've got the wife's social. We submit the wife's social.

If she's a Medicare beneficiary under her husband's social, will that be identified in the query response?

John Albert: Yes.

(Bonnie Muthard): Yes, OK. Thank you very much.

Operator: Your next question comes from the line of (Marcia Nycro) from (Federal) CMS. Your line is now open.

(Marcia Nycro): Thank you. I had a question on joint and several reporting when states (that have) joint and several statutes. And I just want to clarify what you've said in the past. If it is a joint and several state we are to report the entire settlement. If it is not, we report the RRE's portion of the settlement. Is that correct?

Barbara Wright: Not quite.

(Marcia Nycro): Oh, good. Go ahead.

Barbara Wright: What we've said before is the industry's comments originally weren't giving us enough detail to understand quite where they were coming from. And there's a difference between whether or not an entity might have general joint and several liability under state law and whether or not they have joint and several liability for a particular settlement judgment award.

We expect to be tweaking the language that's in the user guide. Our intent there all along has been to say if there is joint and several liability for a particular settlement, judgment award or other payment, then both or all three or whatever – however many entities that there are that have that joint and several liability for that particular settlement or judgment award or other payment, then they both need to report the entire thing.

But if the joint and several is just based on general state law and not the – they don't have it with respect to that particular settlement, then no, they don't need to both report.

(Marcia Nycro): Excellent. That's what I was hoping you'd say. Thank you.

Bill Decker: Bear in mind, however, that if there is joint and several responsibility and the parties agree among themselves that they're going fund differing levels, the agreements among the parties themselves is irrelevant. They all still need to report the total amount.

Barbara Wright: We're talking about a particular settlement with the beneficiary, not among the defendants.

Operator: Your next question comes from the line of (Angela Anglum) from Home Insurance Company. Your line is now open.

(Angela Anglum): Thank you. With regard to the mass (tort) committee that you mentioned earlier in the call, are you able to tell us what specific issues are being addressed by the committee?

Barbara Wright: The thing that's going to be addressed first is revisions to the draft language we circulated before the last call that has to do with the December 5, 1980 issues – which basically affects exposure, injustices and implantation cases.

So, what we're looking to set up is a bright line rule that the requirements are clear and definite. And if the requirements are met, ultimately what we'd want is no one tells us about the case through the COBC, and no one reports it through 111. If the parties can certify that the requirements we come up with are met, we don't want to hear about it at all – it's our eventual goal.

(Angela Anglum): OK, will you be addressing who the RREs are in those circumstances?

Bill Decker: Nope, if no one needs to report, there aren't any RREs.

(Angela Anglum): OK.

Barbara Wright: I mean, the RRE rules aren't changing. If it were reportable, your RRE would be under the normal RRE rules. But this goes beyond that to hopefully eliminate any pre settlement contact with the COBC and, thus, to the MSPRC and to eliminate any post settlement contact for reporting purposes for the cases where we can do so.

(Angela Anglum): OK. Do you have any idea of timing with regard to what you're going to be issuing?

Barbara Wright: Well, part of it will depend on what the reaction is to the next draft. We did get – we got some fairly detailed comments on the last draft. But we didn't get huge numbers of separate comments. We know that, for example, one set of comments came in from an organization where it was contributed to by a whole range of insurers so that their comments were all on that one document.

So, at this point, I can't give you an answer until we see what happens with the next draft.

(Angela Anglum): OK, thank you.

Operator: Your next question comes from the line of (Susan Cornbliss) with NY State Insurance Fund. Your line is now open.

(Susan Cornbliss): Hi, I have two questions. When you talked before about correcting a file and resubmitting it in the same quarter, we were under the impression that we could only submit one claim input file per calendar quarter.

John Albert: There's always exceptions. If a file bombs out, errors out, we would ask that you resubmit that file. And again, it comes down to timing issues and making sure that another file's not submitted that would cause it to trip over the next due file.

I mean, every situation is unique. But, yes, we do allow off submissions to occur.

Bill Decker: Think about it this way – if you submit a file that is rejected, you can correct it and resubmit it. You're still submitting your original file. That's one way to think about it.

(Susan Cornbliss): OK. And then the other thing is with threshold errors. It says 20 percent or more failed record level edits. What does that mean? Are those formatting errors?

(Steve Foree): It can run the gamut from formatting errors to cross field checking errors. We're just basically looking to see that you provide a complete and accurate file.

Barbara Wright: And there will be instances where after communicating with your EDI rep, you'll be told that they're going to go ahead and process it.

(Steve Foree): Actually, the email that you receive, I believe, also indicates the type of errors that were found on the file.

(Susan Cornbliss): Right, but that's what's called record level edits?

John Albert: Yes.

(Steve Foree): Those are record level edits, yes.

(Susan Cornbliss): OK, all right. Thank you.

John Albert: Yes, that 20 percent is just indicative of a problematic file across the board. If there are that many records that have that many errors, there may be something bigger than just that 20 percent to error out. And that's a way for you and our EDI department to make sure that what you submitted was what you thought you should've submitted. Things like that. But that's what we mean by record level. It's at the individual record versus a file error, which is the entire file.

(Susan Cornbliss): OK, all right, thank you.

Operator: Your next question comes from the line of (Virginia Lonker) from Iowa. Your line is now open.

(Virginia Lonker): Thank you. In claims where we have an ongoing responsibility for medical and there's subsequent injuries involving the same body part or other responsible parties, who gets the conditional payments that are from Medicare going forward?

Barbara Wright: It would depend on what the claimed injury was. If you still have open responsibility, then you can't complain if you receive the letter. If someone else shares that responsibility, they can't complain if they get the letter.

(Virginia Lonker): So, are you saying several parties could get the letters? Or would it just go to the last one that's listed?

Barbara Wright: I can't tell you for sure what would happen in a particular case. But I'm saying as long as you have that ongoing responsibility, there's no really valid complaint for...

(Virginia Lonker): If there hasn't been a termination date or an exhaust date for the ORM, we'll get it, too?

Barbara Wright: It's quite possible, yes.

(Virginia Lonker): OK. Will the ORM every change from a Y to an N? Or once a Y always a Y?

Barbara Wright: It stays a Y. And, John, correct me if I'm wrong – or (Steve) – the point is once you put in exhaust information, we internally show it's closed. But you don't ever change the Y back to an N.

(Virginia Lonker): OK. Can you give us an example of what would constitute a no fault (TPOC)?

Barbara Wright: There are some states where there's lifetime no fault, et cetera. And I can't quote you chapter and verse on all state laws. But we have heard of instances or did see instances where there has been a settlement or judgment award that ends all responsibility for those future medicals.

And so, that would typically in most cases, that's typically when we would see a no fault (TPOC).

Bill Decker: In other words, they've incorporated an estimated future medical amount in the amount of the check.

(Virginia Lonker): OK. All right, thank you.

John Albert: And to reiterate the last caller's question about will ORM every change to N for no. It's basically a scenario, typically, that would start out with somebody establishing a record with ORM, and the ORM indicator would be Y.

That ORM ends, say, a year later. They would submit an update transaction with that, basically, termination date of that ORM responsibility. But again, the ORM indicator is still Y. Operator, you can go to the next question.

Operator: Your next question comes from the line of (Diane Duffy) with ACR. Your line is now open.

(Diane Duffy): Hi, thank you. I'm just wondering if there's any updates in terms of allowing the account designees to start receiving the automated updates regarding claim files and query files processing status. I know that was something you were discussing at one time, and I'm not sure if that was – if that's on the table to actually start happening.

(Steve Foree): That is something that has been discussed. That refers back to the – just the call that we had earlier. Right now there is no development efforts related to that. But there is an item of enhancement that's being considered.

John Albert: Yes, but we have not been able to commit any resources to making those changes at this time. It's one of our many projects that we would – enhancements we always look at. But again, at this point in time, there's nothing formally scheduled to change that.

(Diane Duffy): OK, just to put in two cents worth about it – as an agent, as I'm guessing many other people on the call are, when our clients have chosen to be the account managers themselves and are not really very good about forwarding the updates for us when we're the one's submitting the data, it really takes a lot of extra steps. Sometimes the CMS side is down, et cetera. It would really help us speed up the process if we could get access to that information earlier.

So, just putting in another plug for it.

John Albert: OK.

Male: And do they or do they not? They can look it up, although that may be inconvenient if you have a lot of clients.

(Diane Duffy): It is, yes.

Male: But you do have the ability to look it up.

(Diane Duffy): And I do. It's just, like I said, it is inconvenient to do so. And it'd be a lot speedier if we could get them automatically. So, thank you.

John Albert: OK.

Operator: Your next question comes from the line of (Mike Stinson) from Physician's Insurers Association. Your line is open.

(Mike Stinson): Thank you. I've got a little bit of a unique question here, a little circumstance where the insurer to one of our member companies is making risk

management payments to a Medicare beneficiary; but they did not make a lump sum payment. They're making them over time.

And they're confused as to whether or not this needs to be reported in ORM or in a (TPOC). I think it's not an ORM since they're not actually paying the medicals, but I wanted to get your input on that.

Barbara Wright: Is it liability insurance? I'm assuming yes, not workers compensation?

(Mike Stinson): Yes, it's a medical liability insurance.

Barbara Wright: OK. And the question is did they put a cap on this, or they're going to pay it for the rest of their life or what? If they haven't assumed responsibility for ongoing medicals that they're paying it out, remember that our definition where we have settlement date takes into account situations where there's a structured settlement or you're making payments over time. It requires you to calculate a total settlement amount.

(Mike Stinson): OK. I believe they do have a cap on it, but they haven't told me what that was.

Barbara Wright: OK, well take a look in the file layout at where it talks about the (TPOC) amount and says if it's a structured settlement you do X, if it has a cap it would be that, if it – you need to take a look at that and apply it to the facts.

(Mike Stinson): OK, great. Thank you.

Operator: Your next question comes from the line of (Jennifer Liddick) with Erie Insurance. Your line is now open.

(Jennifer Liddick): Hi. We have been calling no fault claims involving Medicare into the COBC in order to report the fact we were primary. Now that we are reporting ORM electronically, which is basically the same information, do we still need to call these claims into the COBC?

Barbara Wright: If it's a case that only involves ongoing responsibility for medical and there is no expectation of any type of (TPOC) settlement, nothing that's really under discussion, it's up to you whether or not you're going to call it in.

The only thing you have is a possible delay where we may pay and ultimately assert some recovery claim because it was reported slightly later by you doing it through the section 111.

Bill Decker: It's probably in your interest to report at the COBC so that it goes onto (CWS), so that the claims are paid properly at the time the services are provided.

(Jennifer Liddick): OK, so basically, in order to not delay our reporting, we should continue to call it in?

Bill Decker: Well, it's your decision. But I mean, the – if there's a delay as Barbara indicated, Medicare could pay claims that would later send a recovery demand upon.

(Jennifer Liddick): Right.

John Albert: Yes, I mean, obviously section 111 has its own reporting requirements. And because of the way it's set up, it's always going to be after the fact, so to speak. We're not – responsibilities under the statute still exist regardless of section 111.

But at the same time, I mean, that's something that is a judgment call on your part.

Barbara Wright: We need to put you on hold just for a second.

(Jennifer Liddick): OK.

John Albert: Hi, we're back. We wanted to talk about this a little bit off line. I mean, in a nutshell, the preferred way of reporting the information, and we think the easiest way, is for you to submit it through electronic file process so long as it's timely. We're not going to say that you can't still call the COB contractor.

But it seems to be an awful lot of extra work when the data's going to come in anyway. Now if for some reason you make the judgment call that you feel

like you need to call the COB contractor at a particular point in time to manually report something, we're not going to stop you from doing that.

But again, from our point of view, the electronic file processes is probably the most efficient in most cases for all people to report data to us, which is why, at least in the GHP world, this goes back at least 15 years – because it is, overall, the most efficient way for people to coordinate benefits. So through these electronic file exchanges rather than having to get on the phone and talk to somebody on a case by case basis.

Barbara Wright: And remember the caveat with your question was that you were talking about a situation that is solely ORM. It's not where you've got a pending settlement or anything else where there are different considerations.

(Jennifer Liddick): OK, thank you.

John Albert: Right. And, yes, in the case of the pending settlement, that's something that is worth someone's time to come to us prior to settlement to basically efficiently resolve the case. As we've said in the past for recovery purposes in particular, the earlier you let us know about a pending settlement, the easier it is for us to gather up the information on our end to help you resolve your case.

(Jennifer Liddick): OK, speaking of which, we are noticing a lot of delays on the MSPRC side. Can you speak regarding those at all?

John Albert: No, we really can't on this call. That's outside the scope of this call.

(Jennifer Liddick): OK, all right. Thank you.

Operator: Your next question comes from the line of (Janet Salby) with NPA. Your line is now open.

(Janet Salby): Yes, hi. Good morning. I am calling with a question regarding ORM. Earlier in the call this – somebody mentioned – or I think you mentioned that in order to terminate liabilities for ORMs, you need something from the physician.

In workers comp here, we often encounter situations where the person, the injured employee, does not return to the doctor for treatment. They sort of

abandon their treatments. We assume that they're fully recovered in those situations and letters are sent accordingly. But we never do get anything from the doctor that discharges the patient and says that the patient is fully recovered and not in need of any further treatment.

But we certainly would not want to have to continue reporting those as ORM cases. So, can you tell me what it is we would need to document in our file in order to terminate our ORM with CMS?

Barbara Wright: What we've said is you need a statement by the physician unless the case is closed by state law. If you, for example, have a state law that says if there are no bills submitted within two years then the case is considered closed, then you would close it under state law.

What we've said is you can't, for our reporting purposes, you may not make an administrative assumption that it's closed simply because you haven't seen any bills lately. And remember that it doesn't result – it doesn't require an additional reporting action on your part once you have ORM opened. You don't have to report anything until it's ready to be terminated.

(Janet Salby): So, there is no state law, first of all, that addresses when we're able to close our file. It is an administrative decision. And I understand what you're saying about there only needing to be one report. However, if we are never able to end our obligation for our ORM with CMS that could linger on and there's nothing that would prevent us from getting a lien many years later on a case that was administratively closed because of treatment abandonment years before.

John Albert: Would you still be legally responsible for payment?

(Janet Salby): If the person was to return later on for treatment. And that doesn't happen very often. Usually these are cases of, I would say, fairly minor injuries that resolve themselves. And the people just don't want to go back to the doctor. They don't feel like they need to. They just strop treating.

And they may tell us verbally that they're fine and they don't want to go back to the doctor because they don't feel that they need to. Legally, if that person

were to resume treatments later on it would depend on how long there was in between the time they stopped treating and the time they resumed. And it would be a medical question as to whether or not their current treatment is related back to the original injury.

Barbara Wright: You said this was workers compensation, correct?

(Janet Salby): Yes.

Barbara Wright: OK, well remember, we do have the one very low thresholds for workers compensation, basically, designed to help with this particular situation. So, if we would receive sufficient information from the industry that this is a threshold that we really need to maintain, then we might maintain that threshold indefinitely.

We're not completely against considering whether it should be raised slightly if we had information to support that decision. But that's really the best we can do at this point. It was designed for specific situations where it's really a minor injury and there aren't any lost days from work, et cetera.

So, we've tried to accommodate your concerns to the extent we can.

(Janet Salby): My next – just one more follow up. You mentioned something about the secure Website being down or having function problems. I did submit a query file last week and have not received an acknowledgment. Are there ongoing problems with the Website?

(Steve Foree): Nothing in relation to the process of query files. Please make sure you contact your EDI rep and they should be able to tell you the status of that query file, whether it was received or not, or if there was any issues related to that file.

John Albert: Was it on Thursday?

Bill Decker: Yes, what day of the week last week did you submit the file?

(Janet Salby): I submitted it on Friday.

John Albert: Oh, that was the date that it was down.

(Janet Salby): So, I should just resubmit it?

John Albert: Yes.

(Janet Salby): OK.

(Steve Foree): If the system was down, you wouldn't be able to send the file.

(Janet Salby): It did say uploaded successfully.

(Steve Foree): If you got a message saying it was uploaded, then you need to reach out to your EDI rep to verify that.

(Janet Salby): OK, thank you.

Bill Decker: Yes, because the problem was people couldn't even log onto the site.

(Janet Salby): Oh, yes. I had no issues with that. I just normally get an email acknowledgment telling me that the file was received and being processed. And I haven't seen that yet.

Bill Decker: In general, if anybody gets no reply, call your EDI rep.

(Janet Salby): OK, thanks.

Operator: Your next question comes from the line of (Susan Bolster) with Zeric. Your line is now open.

(Susan Bolster): Hi. I was wanting to clarify something that (Golden Lamb) initially questioned and it was regarding the thresholds for 20 percent of the errors. Were they saying that when they get the initial threshold notice and there's 20 percent of errors, are they saying that they want the file to be rejected so that they can correct those errors and then get it resubmitted during that first quarter?

And the reason I'm asking is they brought up about the 45 day period, which seems to me that they should continue processing the file, they get the file back. Now they have errors. Do they have to correct those errors on the first

report prior to the next quarterly submission? Because it seems to me in the user guide that if you get the (SD) disposition code for errors that the RRE is supposed to have the opportunity to correct those errors and resubmit it during the next quarterly submission period.

John Albert: Yes, that's correct. But there may be situations where, again, depending on how many errors there were that a decision is made between the submitter and the EDI rep to process and interim file before the next regular submission. But again, it comes down to – it's a case by case basis.

(Susan Bolster): OK, so now let's say we get a threshold error. We say continue processing the file. We get the file back; we don't correct the errors during that quarter because there may be too many. We submit it during the next quarterly submission.

Now, since they weren't accepted during the initial submission, when we resubmit would we get a compliance flag back?

John Albert: Yes. I mean, if you haven't corrected the errors from the previous file, there's no point to submitting those records again only to have them error out again because that would...

(Susan Bolster): No, no, no. I guess what I'm saying is that we get our first file back, we correct the errors. Now, we submit those records with the corrections during our next quarterly submissions, OK? Now, those are now accepted. Now when we get a return on that second submission, are we going to get a compliance flag?

John Albert: If they're now late, yes.

(Susan Bolster): But they're going to be late because there were errors during the initial submission, correct?

John Albert: Yes because when the record is submitted does not determine the date of compliance. It's when the record was due to CMS.

Bill Decker: This is all something you need to discuss with your EDI rep. They will be able to walk you through this and tell you what it is you need to know. We're happy to try to answer these questions. But these are really quite clearly not policy questions.

(Susan Bolster): Well, I was only bringing it up because of what (Golden Lamb) – I was getting a little confused because they were talking about the threshold, 20 percent. Then they brought up the 45 day period, so it was like two different things were being discussed. And I just needed that clarification.

John Albert: I can tell you that if a record was due to be submitted in the current calendar quarter, and it either errors out or it's just not submitted, which is one in the same, and it's submitted the following quarter, it's possible it will receive a compliance flag for being late, whether it's an error or just wasn't submitted.

We weren't able to accept it, so in our eyes it was not reported.

(Susan Bolster): Because you don't keep records of that – of the errors, correct?

John Albert: And again, we couldn't post it. I we can't post it, it's not considered a valid, timely submission, based on the reporting time frames that are in the user guide. Yes, yes. But again it's not an accepted record; it's not in compliance. Yes, right, right.

(Susan Bolster): OK, and then...

John Albert: Anyway, we need to move on because this is a policy call; and again, we'd ask that you work with your EDI rep on this question.

(Susan Bolster): OK, well the follow up is, is there a problem with the files being returned within the 45 days?

(Steve Foree): Again, no. There has been no general notification that there has been a response time issue with your file. Again, if you haven't got your file back, if you haven't received a response notification that the file was – I'm sorry, not a response, but the received notification that your file was received, please reach out to your EDI rep.

They can identify what's the status of the file, where it's at, and what's – and where it is within the process.

John Albert: I mean, if folks are having a problem getting their files returned timely, then of course we want to know. And you can submit those comments not only to your EDI department but also to the resource mailbox as well.

Obviously, no process is 100 percent correct all the time. But again, if someone is having problems, the first line is to go back to your EDI department and then use the escalation clause. And if you're still not getting what you need, then you need to come to CMS to the resource mailbox.

Operator: Your next question comes from the line of (Carlos Sepolvada) from Xchanging. Your line is now open.

(Carlos Sepolvada): Actually, the question was answered. Thank you.

Operator: Your next question comes from the line of (Amber Lee) with (Queens Administrative Services). Your line is now open.

(Amber Lee): Hi. I just have a couple of questions that are unrelated. First of all, IC9 codes – we've been picking from the (bottled) list from you all. But I want to know are there any rules from the official guidelines of IC9 codes that we have to follow, like according to the official guidelines you have to order fractures a certain way. Or if you have a fracture, you don't put the contusion also. Do we just pick anything in any order from the (bottled) list?

Barbara Wright: It would certainly be helpful for you to put them down in order of importance to the extent you know that order. If someone has a hang nail along with a broken collar bone and a ruptured spleen, it would probably be nice to have the hang nail last.

But in terms of our vetting them the same way claims processing does, no. If you're going to have a lot of codes, again, we can't tell you the exact outcome. But certainly, having the ones that are the major codes first would be, in general, helpful.

John Albert: I mean, the codes are used to pay correctly and also settle up any outstanding recoveries owed to Medicare. And we expect those to be relatively accurate. If they're not that's another issue that we'll be addressing later. Can you hold on just a second.

(Amber Lee): Yes.

John Albert: So, I mean, yes, the short answer is they need to be accurate in terms of any claims that are claimed in or released.

(Amber Lee): Right. But accurate being we just choose that go along – if they broke their foot and we had ORM for that, then we use the broken foot code.

John Albert: Yes. I mean I guess I'm not quite – I mean you're – I mean, yes there's a lot of codes. But we're asking you to provide the codes that relate to the specific injury that's claimed in or released as part of your either ORM or (TPOC).

(Amber Lee): Right, OK. I was just reading the guidelines and I was a little concerned because we don't do things that way in general. We don't process claims that way. And so we were wondering if we select from that list if it would have to be...

Barbara Wright: I mean, I guess to repeat some background I think we've done on other calls is the ORM record is a record that's up there. And it means that any time any provider, physician or other supplier bills us, that's a code that their claim hits up against in our system.

And if there's an open record with ongoing responsibility for medicals, then our claims processing contractor should be denying payment unless they have proof that claim has been appropriately denied by the primary care.

On the other hand, when it's a (TPOC) situation and it's not ongoing responsibility for medicals, that's used largely in recovery claims, not as much – not as much in the front end payment. And that's why for ORM we said just put in the ones you've accepted responsibility for. But for the (TPOC), by law, it needs to be anything that's being claimed or released.

(Amber Lee): Right. All right, I think we've got that. We just were concerned about that one thing. The other question not related to that is about the administratively opened or closed files. If we have a file, say, that was closed several years ago administratively – so, we're in Texas, we have ongoing responsibility once it happens.

But we administratively closed it before 1/1/10. And then say we had an open event in our file because a bill payer opened the file by accident electronically because they thought they needed to pay a bill. But it turned out they actually needed to pay a bill on a different claim. Does that count? We've been reporting those as they had an open event, but is that actually what you mean as it was opened in 2010?

Barbara Wright: Basically, we picked the date of 1/1/2010 so that we weren't making people search hundreds of thousands of files for something that should've remained open the whole time. The overall intent was if you have to touch that file again to open it for any reason and you legally still have responsibility, then at that point, yes, it really should be reported to us.

(Amber Lee): OK, good. That's what we've been doing. All right, thank you.

Operator: Your next question comes from the line of (Teresa Berliff) from New York Law Department. Your line is open.

(Teresa Berliff): Hi, can you hear me?

John Albert: Yes, we're here.

(Teresa Berliff): Hi, thank you. If we're aware that a plaintiff has an HICN, which could be because of a response to our CMS query to you or possibly we saw a letter such as a conditional payment or final demand letter – in those circumstances, we report the settlement in our quarterly report. And that report may end up being sometime pretty far after the check may have been cut.

Is CMS then the entity that's responsible for the collection of the amount due from the beneficiary, or are we expected to hold the settlement out or cut a check directly to CMS?

Barbara Wright: We've never had a requirement that an insurer has to hold the settlement or cut a check directly to us. It doesn't change the whole legal scheme in terms of who's ultimately responsible. Our standard recovery process at this time when there's a (TPOC) situation is basically to recovery directly with the beneficiary against the beneficiary's settlement.

There are some insurers that in order to insure compliance and avoid any liabilities for themselves wait until they see a demand letter and cut two checks. Or they cut once check and tell the attorney hold on to it, give it back to me when you have a demand letter and I'll split it into two checks. We don't control that part of the process.

(Teresa Berliff): OK. I was concerned because we seem to be headed down the road of expending more than full time labor hours of one or more people to actually making sure the money is collected. And from the prior calls and our prior conversations, I did not believe that to be our responsibility. But I wanted to make sure what your position was.

Barbara Wright: So, I mean, the regulations that are applicable to the MSP recoveries are in 42CFR part 411. I think they start at 411.20. And there are – we have had some insurers that have expressed some concern about their ultimate liability.

But nonetheless, we aren't requiring that you hold onto the funds. We aren't requiring that you pay us directly as a standard way of operating. And our standard recovery process still is, particularly for liability insurance including (health) insurance, that we typically pursue recovery through the beneficiary.

In no fault and workers compensation, particularly where there's ORM, we're more likely – or more likely than we would be in a liability situations to (do) demands directly to the no fault or workers compensation.

(Teresa Berliff): Right. Our situations are 99 percent (TPOC)s. So there's very little ORM. But I wanted to make sure that as long as we were doing our due diligence on the queries, getting our HICNs and finding out about letters – we usually do know at the time of settlement because of all the things we've put into place, whether or not the person has or is – has been or is a Medicare beneficiary.

I just didn't know that we were – whether we were required to take that further step. What we are doing, then, is reporting of the claims on all the ones that we know about.

Barbara Wright: One other thing that's not atypical is quite often we see settlements where at minimum the beneficiary is signing that they will indemnify the insurer if their recovery doesn't take place to the beneficiary.

But that again is not our requirement.

(Teresa Berliff): Right, OK. Thank you so much.

Operator: Your next question comes from the line of (Susan Corin) from the City of Portland. Your line is now open.

(Susan Corin): Hello there. I just have two quick questions – this is regarding workers compensation claims. We, too, have lifetime medical here in Oregon. However, sometimes we accept – this goes back to the big discussion that you're still going to work on ORM when there's more than one accepted conditional or ICD9 code.

I think your discussion was when there's one accepted condition and one denied and how do you report ORM and (TPOC). My question is that there is one claim with two distinct accepted conditions. The claim is closed due to – due to state whatever – the state statute.

But we have ongoing responsibility for medical. We were able to get, like, OK, we have cervical strain and headaches. We did get the doctor to say no further treatment is needed for the cervical strain as of March 9, 2010. And – but the doctor said, yes, he still needs medication for his headaches. And that's ongoing.

So, when I went into the field, I went in and I put ORM responsibility yes; but then I didn't want to put in a termination date for both those ICD9 codes. So, I entered a separate record with the same claim number with just an A after it. But one of them is ORM yes with the termination date for the cervical strain.

But the second one – two separate records, same claim – I added an A to it and put in the headaches and just left it as ORM yes.

Is that the way I should be doing it? Or should I just be removing the cervical strain ICD9 code from the one record – just deleting it?

Barbara Wright: I think (Pat Ambrose) has said in the past that you remove the one code. But we'll have to check. The other thing is if truly the person doesn't need – if you really have lifetime responsibility, and truly the person doesn't need any care for that cervical, then Medicare shouldn't be being billed for any of that. We won't have any claims to reject; and even if you left it open, nothing would happen.

(Susan Corin): OK, well that's in a perfect world. I mean, he might injure himself again in a car accident for cervical strain. So, that could happen; and so that's why I wanted to kind of keep it separate. But, yes, if I can get follow up on that, that'd be great.

And the other thing I have is if, OK, workers comp was July 1 of '09, right? Ongoing responsibility for medical. So we've had Medicare hits that there was no ORM as of July 1 of '09. The person was closed medically in, say, 2003. So, when I go in to enter the ICD9 codes, I put it in but I enter ORM no. Is that incorrect? Is there a different way I should be doing it for those claims that were no ORM as of 7/1/09?

Barbara Wright: I'm getting some mixed signals in some of the dates you're using. Could you...

(Susan Corin): OK, we have a guy that it came up as a Medicare hit. We use ISO claim services, OK. So all of our claims go in there and they're going to CMS for query. Query's coming back and saying, oh, this one's a hit. So, I pull the file. I look; it's accepted for bilateral carpal tunnel. The date of the injury is March 8 of 2002.

The person was declared medically stationary, no further treatment of July of '03, so when...

Barbara Wright: Do you still have responsibility now?

(Susan Corin): No.

Barbara Wright: OK, and so why are you looking at this person back as far as 2003?

(Susan Corin): Because it's in the database – it's in our database of accepted claims that went through. And as we're going through with this query it just came up. So, maybe it shouldn't have been queried. Should this be one that I don't put in ORM no? I just put in delete this party coverage from CMS?

Barbara Wright: Well, first of all, you were mentioning, I think, 2009. And I believe if you go back and check the dates we changed that date to 1/1/2010.

(Susan Corin): OK, well either way.

Barbara Wright: Well, for the ORM. And so, if it was appropriately closed before 1/1/2010, and you don't have any current responsibility now, then you don't need to report that ORM. But as I said earlier during this call, our intent in that whole thing was to not make people look at thousands of claims that they closed years ago and don't have active access to.

If you uncover any claim that you know you still have ongoing responsibility for ORM, then there's no reason not to report that.

(Susan Corin): OK. So, then I could just say delete the party coverage from CMS because it says it's already been reported to CMS. And I could just delete it now because I think we did go back and we did look at the dates and all that. But there's a few, like four or five that slipped through the cracks and came up as hits and weren't deleted prior to the query.

John Albert: If it was a valid period of coverage and we accepted it, don't delete it. Don't bother. Just leave it there.

(Susan Corin): Just leave it as ORM no?

Barbara Wright: Well, you don't have any reason to report ORM no unless you were reporting a (TPOC). Your only reporting where you actually have ORM or you had a (TPOC).

(Susan Corin): Right. Well what happened because this got queried it came back as a hit. And now, on the CMS Website, it's saying I need to complete these fields. So, that's what I'm asking. I'd either have to delete it or complete all the ICD9 codes, the incident dates, date of venue – all those mandatory fields.

Barbara Wright: I think we're mixed up here. You need to send a more detailed question to the mailbox. And then we may have your EDI rep get back to you.

(Susan Corin): OK, all right. Will do. Thank you.

Barbara Wright: In your incoming question be sure to specify that it came up on the call and we said you needed to send something more detail.

John Albert: Yes, provide you RRE number on the email as well.

(Susan Corin): OK, thanks.

Operator: Your next question comes from the line of (Maria Boro) from Nordstrom. Your line is open.

(Maria Boro): Hi, I had a question on denied workers comp claims. So in some states we are required to pay the medical bills until I guess the claimant has time to reply to the denial. And so, we're denying all the body parts and yet we have to report. I guess I'm a little confused. When I contacted our EDI rep he said we do have to report the ORM.

But I'm not 100 percent sure how that works.

Barbara Wright: You said a state law or other law requires you to assume ongoing responsibility. In other words, to pay claims during that interim period you need to report that interim period.

(Maria Boro): So, then I guess I'm confused. We report ORM. We say the head was hurt and we pay the bills. And so we report it. Then, the denial is approved or the

claimant never – I forget the terminology – they never kind of complained about the denial, so it just went through.

Then, do we report the termination date? And then do we – what happens with ICD9 codes since we denied it? We never took responsibility for it, and that happens.

John Albert: Can you hold on for just a second?

(Maria Boro): Yes.

Bill Decker: OK, if you were responsible for the claims even up to the point where some denial is affirmed, you need to report it as ORM. And then when the denial is affirmed by whatever state agency affirms it, you can put in a termination date on the ORM. However, if the state law says you were never responsible, you can go get your money back – then that's a different story.

You would terminate the ORM at the date of the original claim or delete the record.

John Albert: Yes, delete. You would delete the record if you were never responsible.

(Maria Boro): OK, so if the state says yes, indeed, we were never responsible, then we can – and we have reported ORM, then we just go ahead an delete it. Is that...

Barbara Wright: If state law permits you to go back and get your money back for any claims you've paid in the interim. If state law doesn't permit that, then you just put in a term date for the ORM that equates with the date where your denial is upheld. It's very fact specific to your state law.

Some states are required to pay while that appeal is pending or while an evaluation is pending. In that situation, you must report the ORM. And if states – if it's ultimately a denial or a decision that's not in the beneficiary's favor, and state law permits you to go get that money back, then you can delete the record.

If state law does not permit you to get that money back from the beneficiary, then you need to put in a termination date on the ORM.

(Maria Boro): OK, and then when the – even if the state permits us, it's not if we actually do go get the money back, right? It's only if it allows us – because we would never say, hey, can we have our $500 back or whatever. We would just take it as a loss. So, could we still delete it then?

Bill Decker: No, you've made the payment.

John Albert: If you've made the payment...

(Maria Boro): So, if we paid it, the state allows us to go back and get our money back. But we don't because that's just bad customer service, we are still...

Bill Decker: Then you still paid it, and you put in a termination date from the date you're no longer going to be making payments.

(Maria Boro): So, we would have to report it as a termination and not delete it. Is that what you're saying?

Barbara Wright: Part of what this ORM record does is prevent us from paying inappropriately. And if you already repaid – if you already paid, and someone bills us a second time, we should not be paying for that, particularly if you haven't gone after your money and gotten it back.

If you've paid and let that payment stand, then you did in fact pay primary.

(Maria Boro): OK, I guess maybe I'm just getting confused with the responsibility versus – actual responsibility versus payment. Is that pretty much two different things then?

Barbara Wright: Well you've assumed responsibility in two different ways. First you've assumed this under state law because you were required to. And the second situation where you don't go back and get your money back, you assumed it because you decided you're not going to recover.

(Maria Boro): Got you. OK, that makes sense. All right, thank you.

John Albert: We have time for one more question.

Operator: Your next question comes from the line of (Bonnie Muthard) from Farmer's Insurance. Your line is now open.

(Bonnie Muthard): Mine is a bit complex. My question comes from page 95 of the user guide. I did send it in, in December and have not heard it discussed. It's talking about situations (workers) comp and no fault requires the RRE to make scheduled periodic payments for obligations other than medical expenses, and then ORM – actually assuming ORM in those cases.

In most cases it's not going to be a problem because we do accept ORMs if they've lost time from work and we're paying lost wages. But there's cases where, for example, the injured worker dies in the accident, and there's no medical bills to pay. I know we've talked about other situations where someone dies in an accident and there's no medical bills.

But in terms of us, we pay the lost wage death benefits to the surviving beneficiary. But according to the guide, we think that we're reading this that we have to report this as an ORM acceptance.

Bill Decker: It's hard to believe that there would be no medicals. Usually, even though the person quote unquote died in the accident, an ambulance comes, takes them to the hospital where they're pronounced dead. There are charges for the ambulance, and there are charges to be pronounced dead.

(Bonnie Muthard): OK, I will take that back to that group and point that out to them. OK, thanks.

John Albert: OK, it's now 3:00 o'clock eastern time; and we have to end this call. I'd like to thank everyone for their participation. Again, keep your eyes on the (mandatory) insured reporting Website for additional alerts that we talked about earlier that are forthcoming.

Also, again, keep in touch with the schedule as well in terms of future calls for both policy as well as technical calls. And with that we'd like to thank everyone for participating. And if, operator, you could stand by after you turn everyone else lose, we'd appreciate it. Thanks.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

END