TRANSCRIPT

TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007

42 U.S.C. 1395y(b) (8)

DATE OF CALL: November 17, 2009

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

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS' DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.

FS HHS HCFA

Moderator: John Albert
November 17, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants will be in a listen-only mode until the question and answer session of the conference.

At that time if you would like to ask a question you may do so by pressing Star 1. At that time also we are asking that you please ask one question and state your name and organization at that time.

Also I would like to remind participants that the call is being recorded. If anyone has any objections you may disconnect at this time. Now I will turn the meeting over to Mr. Bill Decker. Sir you may begin.

Bill Decker: Thank you very much operator. Hi. Good afternoon everybody. This is Bill Decker. I am with CMS in Baltimore Maryland. And this is a NGHP policy call not a technical call -- a policy call. And not GHP, NGHP. If you're a GHP person you don't need to be on this call. And if you're an NGHP organization or individual we're asking you to limit your questions to policy issues, not technical issues.

With me in - at the desk today is Barbara Wright and Pat Ambrose and Bill (Zavonya). We have a couple of other staffers here on our team who may chip in in a while. And if they do I will ask them to announce themselves ahead of time.

I don't have any major announcements myself this afternoon for this audience. I'll be happy to chip in on any of the policy questions I can contribute to as the call goes on.

But at this point I would like to turn it over to Pat Ambrose who strangely enough actually has some technical issues she wants to bring to you even though this is a policy call. Well thanks a lot and Pat take it off.

Patty Ambrose: Thanks this is just a brief announcement to possibly help some of you are having, experiencing difficulty with the SFTP or Secure File Transfer Protocol file transmission methodology on the COB secure Web site.

CMS and the COBC continue to work on improving this SFTP process and issues that RREs and agents are experiencing. They're working with a vendor of a software product that we're using for our SFTP server and getting closer to resolving those issues.

If you are experiencing problems with SFTP please note that if an authentication error is received it should be reported to your EDI representative.

What I'm going to explain next might help resolve errors where authentication is obtained but the connection times out before a directory list is provided.

So the recommendation is that you do not perform a directory listing. Users processing SFTP in a batch mode should refrain from specifying the LS command.

Specify the RRE ID mailbox as part of the SFTP address. For example use sftp.section111.cms.hhs.gov/ followed by your nine digit RRE ID. Make sure it's nine digits with the appropriate leading zeros.

Specify forward slash followed by your nine digit RRE ID as the remote site folder when creating connection parameters.

Please contact your EDI representative for further assistance and more information on the suggestion if you didn't manage to understand the information that I provided. Your EDI representative will be able to help you with this change, possible change that may help your issues.

Again if you have an authentication error contact your rep. This suggestion about going straight to the RRE ID mailbox may help in those timeout issues. Thanks Bill.

Bill Decker: Thank you very much Pat. That - for those of you who have not registered yet to be an RRE that won't make a lot of sense you probably. For those of you who have registered and are in the registration process and are into any kind of file exchange, that may make a lot of sense to you and we hope it did.

I have one general announcement actually that I will give to you folks at this point. It concerns the collection of Social Security numbers.

Remember that as you - if you need to ask for Social Security numbers from anybody who you might want to report on, remember that our primary identifier is, for this program is the Medicare ID number because the individuals that we're concerned with here are Medicare beneficiaries.

And keep in mind that if you don't have a Medicare identifier or Medicare health insurance claim number or Medicare (HICIN), you can ask us look for one if you can provide us with someone's Social Security number and a bit of other personal identifying information. All of that is outlined in the User Guide. And you should take a look at that.

We want to stress one thing and that is that if an individual does not have a Social Security number they cannot be a Medicare beneficiary. There is just no way for that to happen.

So if they actually don't have a United States issued Social Security number there won't be a Medicare beneficiary and you don't need to worry about trying to collect any information about them.

Barbara Wright: And no RRE should be telling individuals that they're required to obtain a Social Security number if they don't have one.

Bill Decker: That's also correct. And with that, that was Barbara Wright who's chipping in there. And now I'm going to turn the discussion over to her. I have one more announcement for you which may be useful for you as we go on.

This call may not in fact go beyond one hour today. I know these calls are scheduled for two hours but because of some pressing CMS business here we may have to cut this off at the end of an hour. We'll let you know as we get closer whether that will actually happen.

And Barbara I'll turn it over to you know.

Barbara Wright: Thanks Bill. The first thing I wanted to do as we usually do is go over the status on a number of issues. Clinical trial instructions, that languages is still in clearance so I have nothing that I can give you on that.

Language for hospital write-offs and other risk management write-offs, that language again is in clearance and we can't supply anything until we've gotten a certain level of clearance here in CMS.

We've also been working on the issue of foreign insurers and delineating more specifically when foreign insurers would be RREs.

We've had some preliminary discussions. And we're including with the insurance bureau a trade association in another country and we're meeting with some other groups too.

But where we're looking right now is at least in situations that involves transportation across the border like for instance between Canada and the US, if it's auto insurance or truck insurance et cetera that is sold in Canada and has no connection with sale or solicitation et cetera, in other words the insurance company is not doing business with respect to that auto insurance or truck insurance in the United States, then that will not be reportable.

We will give specific information regarding what we consider to be doing business as.

What's not as clear cut right now is we're having further discussion in terms of situations where there is for instance a manufacturer who has a product and that manufacturer is being insured and the intent is for that product basically to be sold in the United States or be sold in foreign countries et cetera.

So we want you to know that we are looking at that so that you'll have more specific delineation but we don't have it at this point.

The - another area that we've been working on is what we were calling mass torts. And I can give you information on where we're largely headed on that right now. It's information that's being discussed in the workgroup. And so there's no reason not to provide it to all of you as well.

We're looking first of all at the idea that we will completely revise the definitions or descriptions for fields 58 through 62 on the claim input file detail record.

These were the fields that asked for information regarding whether or not a claim involves a mass tort, what the product's generic name was, what the product's brand name was, what the product manufacturer is and product alleged harm.

What we're looking at is instead using terminology that would be group one and group two. And the first basic cut off is that we're trying to limit the description to non-traumatic illnesses, incidents, injuries.

So we're basically talking about situations, or physical trauma. So we're basically talking about situations involving absorption inhalation, ingestion, injection or implantation or exposure of some type.

The second thing between the groups one and group two is group one however we arrive at the final wording is intended to involve situations basically for the underlying actions such as ingestion, injection, implantation et cetera was intentional. But the action wasn't intentional with respect to the alleged harm.

Where group two will be ones that are more widely what people think of as general exposure cases. And that they tend to be ones where there may be some instantaneous results but often there's a time lag in terms of when any illness or injury shows up.

For group one some of the types of claims we would see there are ingestion of drug implantation of a medical device et cetera. And it could include things such as tobacco products.

Group two examples would be claims relating to asbestos, benzene, chemicals, silica, welding rods that lead paint. And those claims were generally involve exposure through the environment regardless of whether or not that environment is an indoor or an outdoor environment.

Claims would not be reported under both groups in one and two. It would have to be one of the two groups.

You would only have to report specifics if your claim fell into the fields 58 through 62. You - everyone will answer field 58. But the rest of the fields are only applicable if you have a yes answer for 58.

The last thing is it would apply from a technical standpoint, the fields apply to liability insurance including self-insurance, no-fault insurance and Worker's Compensation.

As a practical matter our expectation is that most if not all Worker's Compensation claims would routinely fall into group two, the ones where I mentioned like asbestos or benzene.

And the no-fault to the extent they occur would most likely fall in group two, although we would expect to see no-fault rarely if at all. So that's the general information I have on what - oh one other thing with respect to the other fields, the language that we're leaning toward right now is 58 would be asking instead of whether or not something is a mass tort. It would be looking at whether or not it's group one or group two.

And if there's no inhalation, ingestion et cetera the answer would be no. If it's a yes answer you would answer whether it's group one or group two.

And if it's group one you would have to provide the product generic name, brand name, manufacturer and the alleged harm.

If it's a group two you do not need to provide the product brand name or the manufacturer. And that was a big concern of a lot of the industry. They were giving examples in terms of how that information wouldn't be readily available in the types of claims that we're putting in to group two.

With respect to the draft language that we put out for RREs dated July 31, 2009 we do not have final language on that yet. That is also in the clearance process. So I don't have anything further on that that I can share with you right now. And that's pretty much it for right now.

Bill Decker: Thanks Barbara. This is Bill again. As you can readily see here things are going more slowly on the NGHP side than we would have hoped they were going. But on the other hand there are still moving.

There's a little bit of a light at the end of the tunnel on a number of these issues. We thank you for your forbearance as we go forward. And we're hoping to get more information out to you pretty quickly.

However operator we are now ready to take questions so if you want to open it up to the questions we're ready to go.

Thank you. At this time if you would like to ask a question please press Star 1. Please record your first and last name when prompted. To withdraw your request press Star 2.

Once again to ask a question please press Star 1 and I'm sorry, please state your first and last name and organization.

Once again to ask a question please press Star 1. One moment please for your first question.

Your first question comes from (Marsha Nigro) of CMS. Your line is open.

(Marsha Nigro): Hello. It's (Marsha Nigro) from (Centra) CMS. I have a question about captives. And I think in a conversation that we had in a meeting I just want to clarify it for the group that if a captive issues a policy, it's a corporate captive. It issues a policy and there are premiums involved, they would be considered the RRE is that correct?

Barbara Wright: If you look at the draft there are some options available to entities. According to the language in the draft a captive could either be its own RRE or it could have an entity above it in the corporate structure as the RRE.

It cannot simply have an entity, a sibling company or an affiliate. But it can have for example the holding company be the RRE.

The other thing is you need to look at the examples in the draft in terms of who would be the RRE between an insurer and the insured.

There are certain situations involving deductibles and even situations where the entire payment is actually being issued by the insurer to the claimant where the insurance company is not the RRE. So there isn't a simple yes no to what you asked.

(Marsha Nigro): Are you referring to the alert?

Barbara Wright: The July 31, 2009 alert.

(Marsha Nigro): Exactly. And I think this is a subsequent conversation that we had in the meeting where we were trying to explain that corporate captives are actually insurance companies and that if they are - if they - there is a premium. If the siblings pay a premium and there is a policy issued that they would be considered an RRE.

Barbara Wright: Okay I didn't get that impression from when you first framed your question a few minutes ago. If you're talking about if a captive is actually the insurer or a particular entity and would be the RRE based on that, that's fine.

What they can't be is you can't have a situation where a sibling company is itself an RRE and have that captive insurance report on behalf of it. So you still have the issue of deductibles and situations depending on how the payout does.

(Marsha Nigro): Right.

Barbara Wright: So you still need to look at how that plays out in your specific factual situations.

(Marsha Nigro): Okay thank you.

Barbara Wright: The other thing before we go any further since I don't think we said it at the beginning of this call, all the various things I was telling you about mass torts and how we're moving there and some of the other things that we're looking at, as with all these calls instructions are not final until we have them in writing on the User Guide or in a written alert particularly for the mass torts through because it was such broad interest to everybody.

We did want to, and those on the workgroup have been privy to what we've been talking about. We did want to give you an opportunity to know where we were headed on that.

Bill Decker: We'll take the next call operator. Thank you.

Coordinator: Your next question comes from (Neil Pecy) of Foster Farms. Your line is open.

(Neil Pecy): Hi. This is (Neil Pecy) of Foster Farms. Do we have some sort of schedule or you have some idea of how fast the responses to the registration are going?

We registered oh probably around the 27th of September. We received registration on two of our RREs but not on the other two. We received the - and we never received a letter.

((Crosstalk)).

Bill Decker: Go ahead Pat, sorry.

Patty Ambrose: I need some clarification. So you have registered three RRE IDs?

(Neil Pecy): Right and...

Patty Ambrose: And what tax - did you use the same Tax Identification Number for each?

(Neil Pecy): Yes.

Patty Ambrose: And when you and so the two are completed as one is waiting in what state? Have you - are you waiting for your PIN letter or are you...

(Neil Pecy): We're waiting for the PIN letters.

Patty Ambrose: To your authorized...

(Neil Pecy): Right. I called the EDI representative or the name they gave us when we registered and they gave us one PIN number on the one registration but not the other two.

Patty Ambrose: Okay. Well we need to follow-up on that. And I can take if have your RRE ID handy and I can follow-up and we can take this off line?

If not, you know, continue to report this to your EDI representative and follow the escalation procedure. You know, I can't say - you definitely should have - the third one should be finished. So perhaps the PIN letter was misplaced or something. I really don't know.

(Neil Pecy): Oh okay. I thought maybe you guys were just running behind or something.

Patty Ambrose: Not to my knowledge there is no particular delay. If it was a different Tax Identification Number, you know, we have to do some authentication or validation of the TINs and I thought maybe it might be hung up there. Otherwise it should not be taking this long.

(Neil Pecy): What is the escalation process?

Patty Ambrose: The - in the chapter of the User Guide that talks about contacting the COBC I think it might be Chapter 18 or Section 18. But I don't have it up in front of me. I apologize.

(Neil Pecy): Okay.

Patty Ambrose: There is a process to first contact the supervisor, EDI supervisor and then manager. And then of course you could take it all the way up to the project director.

(Neil Pecy): All right.

Patty Ambrose: There's contact information for those individuals in the User Guide.

Woman: Don’t forget to get his (RRE ID)?

Patty Ambrose: Yes, did you happen to come across your RRE ID?

(Neil Pecy): No.

Patty Ambrose: Okay.

(Neil Pecy): I was writing down this. Yes, because we had one entity who has - does have a different PIN. They sent theirs in, registered, and they got their letter right away.

The other entities are all under the same ID or TIN, tax ID, and we've never gotten a letter on any of them, although the gentleman called me, left a message and said the PIN number's X and but we just don't have the other two.

Patty Ambrose: Okay. Well like I said please follow-up with your representative.

(Neil Pecy): Okay. Thank you.

Coordinator: Your next question comes from (Jeff Hames) from (Segorik) SMI. Your line is open.

(Jeff Hames): Good afternoon. This is (Jeff Hames) from (Cedric) CMS. My question actually addresses the comment that Barbara made about the language still pending on the items that were in the July 31 alert.

On the last couple of Town Hall calls that I had attended, I know it's been stated several time that there won't be any penalties assessed for RREs that have not yet registered but the expectation was that they would do that by December 31.

The question I have is do you have any thoughts on when you see some kind of release being actually made relative to that alert language on the 31st?

And do you see that there's going to be any impact on people who are still waiting for registrations based on the language that's forthcoming? Because

I'm just wondering whether or not that's going to now dovetail into the testing period if it takes a lot longer to get that information out?

Barbara Wright: Well we certainly expect to have the information out by early - our aim is early in December at the latest.

But I would say that for most of you if you look at the draft language and you have any scenario where you're going to be an RRE then why wouldn't you go ahead and register?

Some of these questions may go to the scope and how much you're going to report but that there are many things in here that will make most, you know, a huge percentage of you, you've got enough information to know that you're going to be an RRE for at least certain things.

(Jeff Hames): Okay thank you.

Coordinator: Your next question comes from (Rebecca Justice) of Disney. Your line is open.

(Rebecca Justice): Yes hi. This is (Rebecca Justice). We just had a quick question in regards to if we register for separate RRE for one of our business units.

Essentially we're using one claim system to report claims out of two different business units. They both have different tax IDs but one of the business units is actually reporting claims for the other business unit.

We went ahead and we registered as one RRE just from our understanding of how the user guide was written. Is that correct?

Barbara Wright: You haven't said whether each of those business units was technically an RRE by itself. Is - are you all within a single legal entity? You said you have different TINs, right?

(Rebecca Justice): Correct. We have different TINs but essentially one of the business units is reporting the claims for the other business unit. So regardless if they're a separate entity would that matter if we're...

Barbara Wright: Yes. Yes it does. I mean if you look at the draft language in July 31 is part of what I'm saying. If from your limited description you're really affiliates or sibling companies one of you cannot be the RRE for the other. You've got...

(Rebecca Justice): Even if we're paying out the claims?

Barbara Wright: What?

(Rebecca Justice): Even if we're paying out the claims to the other?

Barbara Wright: TPA status by itself does not make you an RRE. Again we would tell you to go back and look at the July 31 '09 alert.

If you have - one of the ways if you - you said you're getting a separate RRE ID for both or not?

(Rebecca Justice): No. Right now we have the same RRE ID...

Barbara Wright: Okay.

(Rebecca Justice): ...after being - for EDI rep we weren't able to get the question answered.

Barbara Wright: Okay so if you have, if you're sibling companies and you have an entity that is above both of you in the corporate structure that entity can register as the RRE and be technically the RRE for both of you.

And we don't care how you then designate who will actually be the agent or do the physical reporting.

But you cannot if you and an affiliate or sibling et cetera are each technically an RRE one of you cannot just report for the other. On...

(Rebecca Justice): Okay so...

Barbara Wright: ...RRE ID.

(Rebecca Justice): ...overrides the TPA. But the problem is we're using one claim system. We're not using multiple claims systems to do this. So it becomes more of a technical...

Barbara Wright: Well one of the questions I asked you I haven't heard an answer to is if you're sibling companies is there any entity above you in the corporate structure that's above both of you?

(Rebecca Justice): There is but they have their own TPAs. From a technical perspective...

Barbara Wright: So...

(Rebecca Justice): ...there's no way we can report all of those in one file, the more RRE. From my understanding one RRE has to report to the...

Barbara Wright: Stop.

(Rebecca Justice): ...same claims file and that's not...

Barbara Wright: No, stop a second. They can, that entity that's above both of you, it could have a dozen RRE IDs for all we care. It can be the one to register and use the RRE ID that you have assumed right now just for one of the two of you.

It can do the registration. It can designate for purposes of the discussion let's call one of your companies A and one B. And A is doing the reporting for both A and B. right now, correct?

(Rebecca Justice): Correct.

Barbara Wright: Okay. And company Z is above both of you. Company Z can register. And it can have an RRE just that it wants to use for A and B. and it can designate A as its account manager or as another designee.

So from a physical standpoint you can accomplish what you want but you need to have the corporate structure above you registered as an RRE for companies A and B.

(Rebecca Justice): Okay. Either that or register company B as a separate RRE?

Barbara Wright: Yes. But then you would have to submit to separate files. If you haven't registered at an entity level above you, you can submit one file under that RRE ID they can cover both of you.

(Rebecca Justice): Okay. So how do we change our registration? We've already got our profile report back. We've already got our submission date, everything is said and done. We are actually in test status right now and we are testing.

Patty Ambrose: You can contact your EDI representative provide them with the changed information and they should be able to make that update for you and regenerate a profile report to be signed again.

(Rebecca Justice): Right, but is that going to change our submission date?

Patty Ambrose: No, no, no. Your RRE ID will stay the same. Your submission date will stay the same. What we're basically going to do is I think I heard change the TIN related to that RRE ID perhaps.

Bill Decker: And the name.

Patty Ambrose: And the name.

(Rebecca Justice): Okay. Thank you.

Coordinator: Your next question comes from (Susan Cornbook) of New York State Insurance Fund. Your line is open.

(Susan Cornbook): Hi. I have a question about Field Number 98, the ORM indicator. Can you give me an example of when that would be a no?

Patty Ambrose: If you have a claim that is settled via just a one single lump sum payment, one settlement there is no ongoing responsibility by the RRE to pay for individual medicals, medical bills that are submitted say by a provider doctor or supplier then you would submit that claim with the lump sum settlement amount as your TPOC amount, the TPOC date, and your ORM indicator would be an N.

Barbara Wright: Most liability situations are settled through a TPOC amount not through an ORM. Worker's compensation and no fault are the ones most likely to have ORM.

No fault is probably the one most likely to have only ORM, although it can have both ORM and TPOC. Now I'm not sure if I said that right.

No fault is the one most likely to have only ORM. Worker's Compensation, if ORM is accepted at some point there may be a separate settlement judgment or award for Worker's Compensation that would result in the TPOC which could be in addition to the ORM or might terminate the ORM.

(Susan Cornbook): Right. But in that - in the User Guide it said that as long as we ever had ORM it would have to be prefilled with the line.

Barbara Wright: What happens is once you've - if you have ORM...

(Susan Cornbook): Right.

Barbara Wright: ...you have to report that. Once you report that even if you separately report a termination date for the ORM what that's saying is you don't change that Y indicator.

(Susan Cornbook): Right.

Barbara Wright: We will have the information showing when it terminated. But if you would change it to a no it would in effect be telling us you never had ORM.

(Susan Cornbook): Okay, all right. Another question I have is in the User Guide it just - some of the information seems to be conflicting. There's on Page 137 it says

something about not being able to report TPOC in ORM termination at the same time.

Yet on Page 67 it states that we can report ORM termination and a TPOC in the same report.

In 137 it states that we should report TPOC fields on the second or final report. And I don't - we don't know what that means?

Patty Ambrose: Well I do not necessarily have the same page numbers. But let me say this. I am making updates to the User Guide and I'll check for discrepancies. I'd appreciate if you send those discrepancies to the CMS Resource Mailbox for Section 111.

(Susan Cornbook): All right.

Patty Ambrose: But I will tell you this. On one claim report you may submit ORM information and you may submit TPOC information.

(Susan Cornbook): Okay.

Patty Ambrose: You may.

Barbara Wright: Do you happen to know which field you were talking about even if our pages aren’t the same?

(Susan Cornbook): Is it 100? Maybe 100. But I was reading from, you know, through the text in the User Guide not the field.

Patty Ambrose: Right. So perhaps, you know, something taken out of context.

(Susan Cornbook): So it's Field 100.

Barbara Wright: Yes in part of the sentence Pat reads if there's a TPOC amount/date reportable at the same time as ORM termination is being reported, report the TPOC fields on the second parens final report for the ongoing responsibility.

(Susan Cornbook): Right and we didn't understand what that, why...

Patty Ambrose: Yes I mean what it's getting at is generally speaking let's suppose you had a claim that you assumed ongoing responsibility for medicals, so you reported it with an ORM indicator of a Y and you still have that responsibility. So the ORM termination date is zero defaulted to, you know, it hasn't ended yet.

And then through the course of, you know, months go by and negotiations take place...

(Susan Cornbook): Right, it would be an update record.

Patty Ambrose: Right. Then...

(Susan Cornbook): Right.

Patty Ambrose: ...you would send an update record with the ORM termination date. And at that same time with that same report if the agreement or negotiation ended with some sort of TPOC...

(Susan Cornbook): Right.

Patty Ambrose: ...then you would submit an update with ORM equals Y.

(Susan Cornbook): Right.

Patty Ambrose: ...the ORM termination date...

(Susan Cornbook): Right.

Patty Ambrose: ...and the associated TPOC that might have been the settlement amount that closed out your ORM responsibilities.

(Susan Cornbook): Okay. So if you have everything in one you can report it in one reference?

Patty Ambrose: Yes. And in fact with your retroactive reporting you might the very first time you send an add record you might be sending ORM...

(Susan Cornbook): Right.

Patty Ambrose: ...the ORM termination...

(Susan Cornbook): Right.

Patty Ambrose: ...and a TPOC.

(Susan Cornbook): Right, we understand that.

Patty Ambrose: Okay.

(Susan Cornbook): All right, can I have one more question? If we get a 50 - it says, you know, I don't know what field that is but on Page 51 it said if we get a 51 and our

info is correct with no ORM, we don't need to submit it unless a subsequent TPOC payment is made. Now why would we submit it?

Patty Ambrose: That's right. I mean if you submit a claim or a query after a settlement date, after a TPOC date and you are confident that the information that you sent to the injured party is accurate and you get a 51 back that means that we did not match it to a Medicare beneficiary.

And the assumption that you have to make is then that that injured party is not yet a Medicare beneficiary.

(Susan Cornbook): Right but why...

Patty Ambrose: ...because if you have - so if you have no ORM that, you don't have to do - continue to monitor that person. You don't have to do anything.

(Susan Cornbook): Right.

Patty Ambrose: ...unless the claim is re-opened for an additional settlement or TPOC amount. And then you would have to query them or send the claim report after that second TPOC.

(Susan Cornbook): Okay only if they’re Medicare eligible?

Barbara Wright: Yes.

Patty Ambrose: Right, right, right. But you've got to check if you have a subsequent - I mean just because you got a 51 on the first...

(Susan Cornbook): Right.

Patty Ambrose: ...report does not mean that you might get a different result six months from now.

(Susan Cornbook): Okay.

Patty Ambrose: So, you know, if you have a subsequent payment then you got to check again because their Medicare status could have changed.

(Susan Cornbook): Okay. All right, thank you.

Coordinator: Your next question comes from (Carolyn Bailey), Blessings Corporate Services. Your line is open.

(Carolyn Bailey): Okay my question is then we would just be reporting from a liability standpoint. If we have like an injured party and we just write off their bill meaning their entire bill so there's no cost to Medicare or anybody, is that something that would be reported? Like that was the total settlement that we're just writing off...

Barbara Wright: First of all you said we. Who is we in this case? Are you a hospital, and insurance company? What are you?

(Carolyn Bailey): Oh I'm sorry, a hospital.

Barbara Wright: As we said at the beginning of the call we have language that's in clearance to address both write-offs by providers, physicians and other suppliers and risk - and I won't say all write-offs. I need to be careful and say risk management write-offs as you've been describing by providers, physicians and suppliers or by other entities.

And that is in clearance right now. So I - we cannot give you an answer until we get clearance from our management on that.

(Carolyn Bailey): Oh and sorry I missed the beginning of the call because I couldn't get into the call.

Barbara Wright: That's okay.

(Carolyn Bailey): And I guess my next question and then this might have been talked about too, I just want to clarify. If we have a claim that is settled after, you know, the reporting period starts but it was from a claim that originated like last year. Do we still report that?

Barbara Wright: It depends on what type of settlement judgment, award or other payment you have. If it’s ORM then your start date you're looking back to 2009.

If you're talking about a settlement judgment or award that qualifies as a TPOC...

(Carolyn Bailey): Yes TPOC.

Barbara Wright: ...you're only reporting the TPOCs that are 1-1 2010 or later and you may also apply the current dollar threshold that we have.

(Carolyn Bailey): Okay. That's what I thought. Thank you.

Barbara Wright: And I would caution again the thresholds are for purposes of reporting. They do not change or relieve any obligations under the Medicare secondary payer provision.

(Carolyn Bailey): Okay.

Coordinator: Your next question comes from (Claire Bello), Vertical Claims Management. Your line is open.

(Claire Bello): Good afternoon.

Barbara Wright: Good afternoon.

(Claire Bello): I have a question we are trying to work through with some of our programs most of which are hospitals on the liability reporting side.

And a couple of them have come up with some questions with regard to the difference between never events and hospital acquired conditions and the report ability of those under Section 111.

And I think I recall from one of our prior calls that never events are not reportable because they would not be reimbursable by Medicare under any circumstances. Do I recall that correctly?

Barbara Wright: First of all I don't - could you just as a follow-up point put your question in writing to the Resource Mailbox? I don't remember seeing that specific one although it's easy to miss them in the thousands we now have.

(Claire Bello): Sure.

Barbara Wright: But I will say this and it's not an official CMS statement. I am not an expert in this area. But I believe never events and hospital acquired conditions the rules surrounding those, they tend to be referring to the same thing.

I've heard them called both. And to the extent it does not qualify as liability insurance then it wouldn't be reportable.

Bill Decker: Not all hospital acquired problems are never events. Never events are a defined category. Never events...

Barbara Wright: Yes.

Bill Decker: ...would never be reported as we would never pay them. But not all hospital defined...

Barbara Wright: This whole issue goes into a lot of billing rules which is not the expertise of those of us here in the room. If something is being done again, as they risk management write-off we will have specific instructions for you about that.

But in terms of something that is purely a billing issue then, you know, that won't - we have no reason to believe that that would be reportable if it doesn't otherwise qualify as liability insurance no-fault or Worker's Compensation.

Remember that liability insurance includes self insurance as defined in the statute which essentially says that any entity that engages in a business trade or profession to the extent they do not purchase insurance and bear risk, they are self insured to that extent.

(Claire Bello): Okay. I guess what we're struggling with a little bit is for many of these there's no ability for reimbursement by Medicare under any circumstances.

And so they do tend to pay for those things through their liability insurance program. And I think...

Barbara Wright: Well if it's something that’s covered under liability insurance you're telling me that you're paying a liability claim.

(Claire Bello): But Medicare hasn't.

Barbara Wright: Well the fact that there’s a TPOC settlement doesn't mean you only have to report when you think we paid something.

(Claire Bello): No.

Bill Decker: Yes make that - that distinction’s got to be very clear that none of this conversation is about whether Medicare is paying for something or not. It's about whether you're reporting about what you are covering.

That's what - we need to have you tell us what you are covering. That's not necessarily related to what we will actually pay for.

(Claire Bello): Yes and I think that's kind of where the clients are struggling because they are, you know, the hospital acquired conditions can be part and parcel of other treatments that are being paid through the liability program.

And I think there's just a lot of confusion in terms of how, you know, how this would be reportable under Section 111.

Barbara Wright: We hope to have, you know, like I said we've had the language pending for the risk management write-offs. And if it goes through the way is drafted right now I think it'll provide a great deal of clarity for what you're looking at. And I'm sorry I can't give you more details.

(Claire Bello): No that's okay. I appreciate that. Thank you.

Coordinator: Your next question comes from (Carol Sheehan) Highpoint Insurance Company. Your line is open.

(Carol Sheehan): Yes, quick question about securing Social Security numbers. When in - on a liability case that could have the life of anywhere from two to five years for example, when you ask in the beginning of the claim for a Social Security number and the attorney says my client doesn't have one how many other times do you ask the question or is that good enough?

Barbara Wright: It's...

(Carol Sheehan): ...because what if four years later they get one?

Barbara Wright: Well precisely. It's not good enough. You need to know as of the time you have a settlement judgment award or other payment whether they are or have ever been a Medicare beneficiary.

So that means for instance if they give you a Social Security number you probably want to do one last query at the time you do your settlement judgment award. And the 45 day grace period we build in does make sure you can do that.

And if you don't have the Social Security number, if they're refusing to give it to you so that you're using perhaps our model language, then you need to have that pretty much signed contemporaneously with the settlement so that you know it’s true at that time.

(Carol Sheehan): Okay, thank you.

Coordinator: Your next question comes from (Erin Viker) of Smith Moore Leatherwood. Your line is open.

(Erin Viker): Hi. Thank you. I have a quick question with respect to Social Security numbers. If we - for hospital clients who already have Social Security numbers and a lot of the information on a patient, if then later on in a litigation matter a patient or the claimant now is refusing to give a Social, is it possible for the hospitals to just access the information they already have from basically another database that would have that patients?

Barbara Wright: I'm not going to opine or give you legal advice on that.

(Erin Viker): Okay. But as far as Section 111 you - you're better off to use your model language they refuse?

Barbara Wright: I'm not saying you're better off to use your model language. If it's information that the hospital has a right to use then they probably want to do a query.

But I can't and neither can anyone else here in the room make an assessment of what databanks you have information in and what you're allowed to use it for. I mean we're not remotely going to be able to get into that level of detail or define that for you.

That's something you would have to talk to your legal counsel about whether or not that's information that if it's something you have in the course of billing for that patient can you use it for this other thing particularly if both issues involve Medicare.

(Erin Viker): Right, okay. And then as a follow-up also do you know or I mean maybe you're not going to opine on this either.

But in terms of working with a settlement with an individual who may not want to give out some of the information to protect the entities that RREs, is it possible in - I mean are you all looking at anything with respect to the negotiations and saying okay well we're not going to settle until or we're not going to pay you this amount of money until you give us information?

Barbara Wright: Are you talking about you paying until you get information?

(Erin Viker): Yes as an RRE. Are you able to sort of say okay well Section 111 requires you...

Barbara Wright: We can't comment on what you can or cannot do legally in the course of your negotiations or settlements.

(Erin Viker): Okay. Okay, thank you.

Coordinator: Your next question comes from (Bill Donlon), Standex International Corporation. Your line is open.

(Bill Donlon): Yes this is (Bill Donlon) from Standex International Corporation. My question has to do with who is the RRE?

And right now our insurance carrier is saying that because we pay the - we pay our third party claim administrator directly for reimbursement of claims that are paid out of a claim fund that Standex is the RRE?

However we've also looked at the July 11 guideline, July 31 guideline I mean, and there was some language in there about a TPA contract.

And the contract that we have - excuse me, we don't have a contract with the TPA. The contract is between our insurer and the TPA.

And so we look at that as by paying the TPA we're actually paying an agent of the insurance carrier. And I had - and I guess and therefore the insurance carrier in that circumstance would be the RRE. And I guess that's one of my questions? Hello?

Bill Decker: Sorry we're having a sidebar I'm sorry we should've let you know that we are...

(Bill Donlon): That's fine.

Bill Decker: ...we'll be right back to you.

(Bill Donlon): Yes that's fine. Thank you.

Bill Decker: Thank you.

Barbara Wright: Bill would you like to address it for him?

Bill Decker: If you're making a payment to an agent of the insurer you're making a payment to the insurer. But I would want to make sure that I that indeed the TPA was under some kind of a contract to act as the agent of the insurer.

(Bill Donlon): Okay. All right but my other question and maybe that really is the, you know, the primary question. But secondary question has to do with, you know, state

compulsory insurance laws, you know, such as Worker's Compensation where it requires the insurer to fund the loss first and not - you know, and again this isn't a deductible (realized) program.

In that circumstance would the insurer or the insured be the RRE?

Bill Decker: Who's making the payments?

(Bill Donlon): Well, you know, it's again it's the same situation. You know, the payment is actually being made to the, you know, to the third party administrator. The third party administrator's making the payment to the claimant though, the Worker's Compensation claimant.

Bill Decker: Who is the third party administrator the third party administrator of?

(Bill Donlon): That's the third party administrator of the insurer. You know, in other words the contract is between the insurer and the third party administrator.

Barbara Wright: Let me try and put it in a concrete example. What you're saying specifically is it's a situation where a decision has been made to settle or have a settlement judgment award so it's reportable. But under state law it requires you as the insured to fund it first and then seek reimbursement from the insurer?

(Bill Donlon): No it's actually the opposite. It requires the insurer to make the payment first and we have reimburse the insurer.

Barbara Wright: I think under our draft language that falls with the RRE, the insurer actually being the RRE.

(Bill Donlon): Yes, okay. I guess my question is this going, you know, my concern I guess is this is that I think it's fairly, you know, it's clearly stated in your July 31 letter, you know, those two questions really are already answered in your letter.

The problem I'm running into is my, you know, the insurance carrier is interpreting that letter differently.

Is your new guideline that you come out with or I should say you're revise guidelines, is it going to have any clarification of, you know, what, you know, of those two issues or is it just going to remain the same language as the July 31?

Barbara Wright: We're still, you know, that's under review right now. But I guess as you said you find it clearly stated. We thought what was in the draft is for the most part clearly stated.

I guess we're not clear what it is about the language there that your insurer is disputing?

(Bill Donlon): Well I think what they're disputing is they're basically saying that the payment is being funded by Standex and not by the insurer when in fact the payment is being made to the TPA, you know. And their position is that because it's being made to the TPA then it's the - and not reimbursed to the insurer that the Standex is the RRE.

Barbara Wright: But you - this is a situation where the TPA is not an entity that you have under contract. The insurer has it under contract, right?

(Bill Donlon): That's correct.

Barbara Wright: So what you're potentially looking for is in - when we issue the revised language you would like us to make it clear that funding alone is not determinate is if of who is the RRE.

(Bill Donlon): That's correct.

Barbara Wright: Okay.

(Bill Donlon): Okay thank you.

Coordinator: Your next question comes from (Nancy Todd), Western litigations. Your line is open.

(Nancy Todd): Yes my question was previously answered by another caller as it pertained to write-off which you say is going to be addressed later. I do have one scenario I would like to ask you.

If a patient falls on the premises which would be a GL claim and has an ED visit to be checked out the cost of which is billed to Medicare and then the hospital waives any out of pocket costs as a courtesy even though there's no liability involved, does that waiver need to be reported? And I'm sure you're going to tell me that that language is still in clearance right?

Barbara Wright: I mean you're saying that that's a waiver based on risk management...

(Nancy Todd): Right.

Barbara Wright: ...considerations or a risk management write-off so it will be covered by the language we put out.

(Nancy Todd): Okay. Thank you.

Coordinator: Your next question comes from (Susan Wilhite) Access Insurance. Your line is open.

(Susan Wilhite): Yes we're an auto carrier. And we make a lot of one time med payments. And I'm confused that in that - in that I understand we don't report them the same day that we would close them out.

So how are we supposed to handle those?

Barbara Wright: Well.

(Susan Wilhite): Usually it's like $1000.

Barbara Wright: Is it - first of all is this a med payment that's under like med pay provisions or PIP provisions so that it qualifies as no fault insurance under CMS's regulatory definitions of no fault?

(Susan Wilhite): Yes, yes.

Barbara Wright: Okay.

(Susan Wilhite): But they're frequently a onetime payment. We get notice of a claim a demand as $1000 we pay it one payment.

Barbara Wright: But you have an obligation under those no fault provisions to potentially pay up to that total amount. You should be reporting ORM for that no fault insurance. And there's also, Pat isn't there a provision for policy limit?

Patty Ambrose: Yes there are thresholds for the no fault amount and the date the threshold was met related to no fault.

And I think Barbara we might be looking for clarifications here that that $1000 is a no fault limit but not an actual TPOC amount. Since...

(Susan Wilhite): That's correct. It’s the limit. And we're making it in one payment.

Patty Ambrose: Right so you could report your claim from a technical perspective as insurance type no fault, the date of incident being the date of that accident. ORM equal Y. Now your ORM termination date needs to be 31 days from the date of incident because it can't be - we can't have the ORM termination dates to be less than 30 days from the date of incident for another technical issue.

But you would plug the date that you reached the $1000 limit for the no fault med pay in that particular no fault field for reaching that threshold amount -- I forget the name of it off the top of my head -- and then put the no fault limit in their of $1000. And you're done. You would have zeroes in your TPOC amount. So you would basically be making one claim report and you're finished.

(Susan Wilhite): Great, thank you.

Barbara Wright: Now know if you're paying out $1000 because that’s your limit and you're not paying for specific medical services you may get questions back in terms of who you paid that to.

If you pay out a no fault limit to a beneficiary and it's not exhausted for specific medicals, then, you know, the agency may need further information.

If it's already been exhausted for specific medicals then there will not be - the agency will not be trying to pursue further recovery against that no fault amount.

(Susan Wilhite): Typically an attorney presents us with was several thousand in bills knowing the 1000 limit, we pay the 1000 to the insured and the attorney.

Bill Decker: We don't have any further comments on that I guess.

Coordinator: Your next question comes from (Diane Phillips), Conoco Phillips. Your line is open.

(Diane Philips): Hi, thanks. I've got a question concerning liens. This is for general liability self insured. When oftentimes when we get a general liability claim for an injury as the claim progresses we receive liens from the medical providers.

But the liens are negotiated until the claim is actually settled. So we had a question as to whether the lien is considered an ORM or if it would be simply considered part of the TPOC?

Barbara Wright: Can you hang on a second?

(Diane Philips): Sure.

Barbara Wright: Let us repeat back what you said to make sure we're understanding the same thing.

You have a pending liability insurance situation. And you have hospitals A, B and C submitting their bills and they've, under state lien law they filed a lien

against any potential settlement. And you need and you want to know if you need to report that pending lean when it's filed?

(Diane Philips): Correct.

Barbara Wright: No. First of all you haven't accepted responsibility for that. It's simply a pending lean. And they even before the time you finished they may in fact decide to withdraw that lien if they're faced with a choice between CMS's timely filing limits running out before you settle.

(Diane Philips): True.

Barbara Wright: So...

(Diane Philips): So at the time we settle with the claimant we would issue a check to her. And when we would negotiate the liens separately. Would those negotiated liens be the additional TPOCs?

Barbara Wright: Your...

Bill Decker: They'd be payments on behalf of.

Barbara Wright: But this is an amount outside of the TPOC amount?

(Diane Philips): Just yes. Because typically what we do is we negotiate this settlement with the claimant to pay her personal injury and her pain and suffering et cetera. And then we negotiate the liens separately and make payments to the providers directly.

Barbara Wright: Okay can you hang on a second?

(Diane Philips): Sure.

Barbara Wright: Those are additional TPOC amounts that technically should be reported if they're above, you know, if they total above our threshold that we've set.

(Diane Philips): Okay.

Barbara Wright: And also your initial negotiation that's allegedly for pain and suffering, if CMS has other claims that it has in fact paid it will assert a recovery right against that TPOC amount.

(Diane Philips): Correct right, yes. And there could be providers who went through Medicare. But in some instances they come to you with us with liens directly. So yes we understand there could be conditional payments.

Barbara Wright: Yes. We have seen settlements for instance that will say we're settling with you beneficiary for X amount and we are assuming responsibility for any Medicare lien.

In that particular situation typically what happens is the beneficiary/beneficiary's attorney if they report their cash settlement to us they would at that time or certainly when they got a demand letter come back and say no the settlement said that the insurer is going to pay you directly for that in which case we would then issue a demand to the insurer.

(Diane Philips): Right. Yes we would handle the conditional payments that, you know, and make sure that we're aware of any Medicare liens.

Barbara Wright: Yes I mean you've phrased it in terms of negotiating individual liens.

(Diane Philips): Provider liens.

Barbara Wright: If your actual settlement says we are assuming responsibility for any Medicare lien then what happens in the recovery process is we end up being funneled back to you to assert our recovery demand.

(Diane Philips): Right. Yes we understand that.

Barbara Wright: Okay.

(Diane Philips): Okay very good. Thank you.

Coordinator: Your next question comes from (Sakir Filpato), (Krum) Insurance. Your line is open.

(Sakir Filpato): Hi this is (Sakir) from (Krum) Insurance. We are having a sister company for or five sister companies. And we were told to be able to use multiple RRE IDs.

But we do not have a definition of RRE IDs still working under progress. We are having difficulty in defending our application and we're getting some challenges to meet those criteria. I would like to know when your RRE ID definition will be finalized?

Barbara Wright: We said that we hope to have everything final out early in December. But I would ask you, you said you had a number of sister companies. As we mentioned earlier in this call do you have an entity in a corporate structure that is above all of those sister entities?

(Sakir Filpato): Yes we have. But our legal department is telling us not to do that. They want us to report on the different RRE IDs. But when I talk to the EDI representative they are saying that we can report all of our sister companies in one RRE ID.

But our sister companies are the same level. So really...that we cannot - if the sister companies are on the same level we cannot do that. And we are...

Barbara Wright: Can you stop a second? This goes back to a question that we had earlier in the call. If your internal legal counsel is telling you you can't do something for whatever reason, that's not something we will interfere in.

What we're telling you is that if you have a sister companies and you have an entity that is above all of them in the corporate structure from our perspective it is permissible for you to have a single RRE ID from that entity that is above all of them. And that entity can report for all the sister companies or if there's five sister companies that entity can get five RRE IDs and report for all of them.

But what you cannot do is have a sister company register as the authorized representative for another sister company and assume that it can be the RRE. That's what's prohibited under our rules.

(Sakir Filpato): Okay.

Barbara Wright: And that's - we've said that before and that's not going to change in the final draft.

(Sakir Filpato): It's not going to change okay. Thank you.

Coordinator: Your next question comes from (Tonya Goff), (Kindred) Healthcare. Your line is open.

(Tonya Goff): Yes I have a question about the product liability indicator Field Number 58. We're a healthcare company that handles professional liability claims. And occasionally we may have a claim a negligence claim or a product that didn't perform as expected and its performance is one of the contributing factors to the claim being made.

And then sometimes we'll bring in the manufacture product to investigate the failure of the product involved in one of our claims.

We've gotten advice from another company we're working with that product liability indicator Field 58 was designed particularly for a product liability claim and shouldn't apply to us because the claim against our company would be of negligence rather than product liability. So I'm just calling to confirm your intent for the product liability?

Barbara Wright: Were you on at the beginning of the call?

(Tonya Goff): I was but I didn't really think it still answered my question in particular.

Barbara Wright: Well it does and it doesn't. What we said is we're completely revising the description for Fields 58 through 62.

(Tonya Goff): Yes.

Barbara Wright: So there is no longer going to be a field that's labeled Product Liability Indicator.

(Tonya Goff): Okay.

Barbara Wright: It's going to be labeled group one or group two, group one claim or group two claim indicator. And if you meet the definitions that we have there you will report that you're either group one or group two.

And depending on which of the two you would be, you may or may not be required to report to specific manufacture et cetera.

But if you don't - if the answer to whether or not your group one claim or group two claim, if you're neither one of those you won't have to report Fields 59, 60, 61, and 62. So you need to wait for the final language on that.

(Tonya Goff): Okay. But it won't be as - you're saying it could be definitive if we're not handling a product liability claim specifically or do we know that?

Barbara Wright: We are using terminology of product liability. I mean that's not the terminology that's going to end up in the manual. If are - are you saying you're - I missed or forgot what you said at the beginning.

Are you in a situation where - if it's a medical malpractice situation that's based on something that you did with the device so there's a device involved, if it fits in our group one claim then you'll report that information.

It may or may not be a situation. I think a lot of medical malpractice situations many of them wouldn't involve a group one claim or a group two. But you really need to wait and see the language that we put in.

(Tonya Goff): Okay well for us it would be mostly it's the negligence part of the claim or failure to monitor or something specifically medically.

But then a separate and aside from that we have we know of a product that didn't work right. But it wasn't us doing anything that made that work incorrectly.

Barbara Wright: I understand. But you're still going to have to wait to we have language out.

(Tonya Goff): Okay will do. Okay thanks.

Coordinator: Your next question comes from (Hillary Lewis) CNA Insurance Company. Your line is open.

(Hillary Lewis): Good afternoon. I'm asking a question, the company issues a professional liability policy with a self insured retention. We do have agreements whereby the insurance company handles the claims within the SAR and makes the claim payments. And I'm wondering under this construct would the insurer then be the RRE for purposes of the claim payments made within the SAR?

Barbara Wright: You need to look at the July 31 draft. To put it at its simplest, generally when the insurer is making all payments to the claimant regardless of whether it's a deductible or the amount of the deductible they end up being responsible to report both of them. But you do need to look at the specific examples that are in that draft.

(Hillary Lewis): Right yes. We were looking at the statement and the reason scenarios where you stated that the insurer is the RRE for purposes of the deductible amounts if payment of the deductible is by the insurer.

And then you had said in statement one that deductible amounts are self insurance for MSP purposes. So we were extrapolating from that as well.

Barbara Wright: But you believe that the draft says that when the insurer actually pays both the claimant that the insurer is the RRE?

(Hillary Lewis): Yes.

Barbara Wright: What we really need on some of these questions is not somebody restating what's in the July 31 one. If you think there is some language that's unclear that calls your interpretation into question then please let us know.

But if you have questions where you're simply repeating what we've got as a fact scenario our answer's not going to differ.

(Hillary Lewis): Thank you.

Coordinator: Your next question comes from (Bonnie Mathardy) of Farmers Insurance. Your line is open.

(Bonnie Mathardy): Yes, thank you. My question relates to TPOC situation. We have let's say for example we get a signed release and we issue a check with an agreement that we will pay the hospital bill that has already been incurred and the doctor bill has already been incurred as soon as the individual gets it.

But we have the release. And the release basically says that we're paying him those two bills plus the money that - the money amount and they're releasing all claims.

Now then the first payment does not go above the TPOC threshold. At the second payment or the third payment is when it goes above the TPOC threshold.

Of course the threshold's high right now but understanding that at future point it's going to be lowered.

So when we get to the point - we know that we don't report prior to hitting that threshold.

When we get to the point with those payments that we go above the threshold do we report that as multiple TPOCs or because it was underneath the dollar amount can we add all of those money amounts together to report as the first TPOC?

Barbara Wright: Could you repeat what your basic premise was it's that you're going to pay a cash amount of X plus what?

(Bonnie Mathardy): We're - we offer let's say for example we offer to pay general damages and the individual has been to - went to the emergency room and saw their doctor once.

And so we say we'll pay your emergency room bills and your doctor bill and give you $1000 for your general damages. And...

Barbara Wright: But not - your - the agreement does not state that you will pay their related medical bills? It's specific to two particular claims?

(Bonnie Mathardy): It's specific to what has already been incurred. It's not any future payments at all. It's not an ongoing...

Barbara Wright: That wasn't quite what I asked.

(Bonnie Mathardy): Okay.

Barbara Wright: Because even if it’s already been incurred are you saying it's specific to particular bills that are named in the settlement or it's that you will pay for medical costs already incurred?

(Bonnie Mathardy): Well let's use both examples and I'd like your feedback on both.

Barbara Wright: Well the one example we've already talked about. If what you have is the cash settlement plus that you will pay any Medicare bills, then in that case whether or not you have to report it under the TPOC since there is an obligation to repay Medicare once there’s been a settlement judgment award in that case you would have at least an independent obligation under the existing rules that you would need - whether the beneficiary or the provider - beneficiary or the rep did or not, you need to make sure that the COBC knows about that case and that settlement so that the MSPRC could issue a recovery demand for any claims that we've already paid.

If you're working with an attorney and he shows you he’s already self identified, when he reports his settlement judgment award to the MSPRC he would be telling them hey, don't send the demand to me and my client. This is what the settlement says. It says that this entity or this insurer will pay Medicare's liens. So send the demand to them. And in those instances we do.

(Bonnie Mathardy): No I don't - that's not the question. I'm so sorry. Let me try again.

Here's the situation. Simple they get in an accident they go to the emergency room and they have one follow-up visit with their doctor.

Their bills are - they have no more bills anticipated whatsoever for that. They say we're done. It’s a simple liability case, a car accident for example.

And so we say we will give you $1000 - basically what we're going to do is we're going to pay their hospital bill for the emergency room. And we're going to pay their doctor visit.

And we're going to offer them some money for general damages. Rather than waiting for that individual to get their hospital bill and their doctor visit bill in order for us to pay those and the general damages all it once we say give us a release for those three things.

And we will go ahead and pay your general damages. And then as soon as you get your ER bill forward it to us and we’ll pay it. As soon as you get your bill for a doctor visit forward it to us and we’ll pay for it.

Barbara Wright: Hang on a minute.

(Bonnie Mathardy): Thanks.

Patty Ambrose: Hi this is (Patty Ambrose). I'm going to try to answer that. It sounds really like it's a one lump sum settlement and would technically be one TPOC amount that you would report except that you don't know the amount, the total amount of the TPOC initially because you haven't received the provider bills, the doctor and/or emergency room bills. Is that...

(Bonnie Mathardy): That's correct. So...

Patty Ambrose: Okay.

(Bonnie Mathardy): So an example I mean obviously if, obviously if the first amount was $5001 then we would report that...

Patty Ambrose: Right, right.

(Bonnie Mathardy): ...and then we would report the others separately as additional TPOC amounts.

Patty Ambrose: Right.

(Bonnie Mathardy): But in this situation the issue we have is that that first payment may only be let's say for example $1000. And now we're waiting to see...

Patty Ambrose: Okay. Well basically you have, if you do have enough information to report the entire TPOC amount at the start you may do so. And, you know, and one TPOC amount, one TPOC date reflecting that settlement date.

And if, you know, and if it's over the threshold. Now perhaps it's not a completely accurate figure. And later on when you get the actual bill from the doctor or the hospital you are -you could send an update record and adjust your TPOC amount. That's one option.

But if you have no idea and it's - and you're still under the threshold, then you would not report until you had adequate information to make the report.

And when you make it you still could report that in one TPOC amount. You can report it in three separate. But in my opinion it’s still only one TPOC even though you're making three separate payments.

(Bonnie Mathardy): Okay, okay.

Patty Ambrose: So now when you reported later it's possible that that settlement date or TPOC date might trigger a late submission flag. Because you, you know, you settled but you didn't know the exact amount of the settlement on that date.

(Bonnie Mathardy): Right, right.

Patty Ambrose: And there's really nothing you can do but just report it as soon as it makes sense or as soon as you have enough information to do so.

Just because you get a late submission compliance flag that does not mean that we're automatically charging some kind of fine or penalty. It's really just a warning.

And of course you would have documentation in your system if anyone followed-up and says this was a late report, why? Okay?

(Bonnie Mathardy): Okay. May I ask just one last question? And it's just related to this because I would love to have this documented. And I know we have not seen any updated notes from the last two calls on the Web site. And I know that you have problems with the space on the Web site.

Is there any opportunity in the future to get these calls, the documentation of these calls on the Web site?

Barbara Wright: Hang on a second let me check what the status is.

(Bonnie Mathardy): Thank you.

Patty Ambrose: We - just say that you're working on it and will get there soon as possible. What else can we say.

Barbara Wright: You're on open mic. We were just talking and it's our understanding that all of them are on the Web site except October. But they may not be on the page that you expect.

So if you - we do have people working on the Web site. So I mean we are trying to get them up there. But I know that I was told that some of them if you can't find NGH there's at least four places you need to check -- the transcript page itself, the liability no fault Worker's Compensation page, the What's New page, and the Overview page. Because we've had to insert downloads on all those pages even if that wouldn't have been your first choice. So I would check all those.

(Bonnie Mathardy): I think some got updated since this morning actually.

Barbara Wright: Okay.

(Bonnie Mathardy): There - some of them are there now. Thank you.

Barbara Wright: Okay. But for everybody on the call be sure to check those various pages when you get alerted to a new item because that's what we're forced to right now.

(Bonnie Mathardy): Thank you. I appreciate your time.

Coordinator: Your next question comes from (Benita Batia) of State Compensation Insurance Fund. Your line is open.

(Benita Batia): Hi, good morning. This is (Benita) from State Compensation Insurance Fund. And I had a question on Field Number 12 which is CMS date of incident.

In Worker's Compensation and we have a lot of claims which are pertaining to cumulative trauma due to orthopedic injuries. And we needed to know if these are reportable under this particular field?

Bill Decker: We're checking, hang on.

Barbara Wright: If it's something for which Worker's Compensation is paying or accepting claims then it does have to be reported.

I think what you're asking for and I'm not sure where we are on the right now is you would like to see a better - you would like to see an example of date of incident when it's a cumulative injury, correct?

(Benita Batia): Correct.

Barbara Wright: Okay we'll look further at that.

(Benita Batia): Right our concern also is that our discovery period sometimes does not extend retroactively beyond a year from the date of incident that is reported to us.

So if you're asking us for the date of first exposure we may not have that information with our dates on the current rules for California.

Barbara Wright: Well if it's simply that you're not currently tracking it if it's an exposure claim you're required to get that information for us. Data that you did not previously collect if it's something we require, you do have to collect it now.

(Benita Batia): Can it be updated if we can provide you what we have but we can update if we receive additional more clarification on that date?

Barbara Wright: Certainly when you got an ORM yes. But you should have a date of incident when you're talking about a situation where you're reporting a TPOC.

Because we would be calculating our claim incorrectly if we relied upon an incorrect date of incident. The ORM is to make sure that we're paying correctly as we go along et cetera.

Patty Ambrose: I mean from a technical perspective you can change it. Being a key field you have to go through that delete add process to change the date, the CMS date of incident that you've originally reported.

(Benita Batia): Yes well our concern is that suppose we get an injury reported today. And the person now has say a carpal tunnel. And he or she has been working for a year with our employer who we ensure.

We would go back and say well one year from you were still working on this so we would report that date.

Barbara Wright: And...

(Benita Batia): In order for us to go back and dig into the history of how far along she worked with other employers which would actually be the date of first exposure might be ten years before we may not have access to that information right away because it's not part of our policy.

Barbara Wright: We will take a look, further look at things like where you're talking about carpal tunnel or you're talking about bad knees et cetera that may be for either plumbers or electricians or something like that.

But that's different. That's not usually what we refer to as exposure. Typically when we're talking about exposure we're talking about environmental type claims whether it's an indoor environment or an outdoor environment. We're not talking about the fact that you worked so you used your wrists.

(Benita Batia): So would that kind of injury be reported under 12 or?

Barbara Wright: You have to have a date of incident always. You know, the issue is we will take a closer look at what we consider to be the date of incident for situations like carpal tunnel or cumulative bad knees because you're an electrician or a carpet layer or something that you're always on your knees.

That's different then situations where you've got like asbestos exposure. We need the date of first exposure relative, you know, to the claim.

If someone's worked in a plant for 40 years we need to know the - and it's that plant where they were supposedly exposed, we need to know their data first employment even if that's outside your typical range. So I think we need to distinguish between date of incident for group one type and group two type claims as well as trauma induced ones as opposed to some of the ones that you're naming that are more cumulative like carpal tunnel. And we will have to get back to you.

(Benita Batia): Okay. I have a follow-up question. And this relates to TPOC. Basically my question is that if we reported TPOC and then we have a third party recovery

a subrogation credit or by cash, can we update that or are we required to update that TPOC that has already been reported?

Barbara Wright: That's a TPOC that you've already made. So, you know, it needs to stay reported.

(Benita Batia): So we do not need to update that with the recovery that you received after we made that settlement?

Barbara Wright: No.

(Benita Batia): Okay. All right thank you.

Bill Decker: Operator this is Bill Decker.

Coordinator: Yes sir?

Bill Decker: We're going to have to cut this call off now.

Coordinator: Okay.

Bill Decker: Unfortunately as I announced at the beginning of the call we have other things that are now pressing on us. And we need to stop this call.

So operator if you can close it off and then when you're finished with that come back to us and let us know how many people were on it.

Coordinator: Yes sir, one moment. This does conclude today's conference. Thank you for attending. You may disconnect at this time.

END