TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: October 28, 2010

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

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Centers for Medicare & Medicaid Services

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

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

John Albert: Thank you, Operator, and good afternoon to everyone. Just for the record, this is the Non-Group Health Plan technical call for Section 111. Today is Thursday, October 28, 2010. As I always do, I always mention the disclaimer at the front for the transcripts, which are posted through the Section 111 Web site, and that is that anything that we say is fine, but if it contradicts written materials and guidelines that on the Web site those always take precedence on what we say on the call.

With us we have the usual cast of characters and we're going to go through a couple of brief presentations and open this up to a general Q&A session. I wanted to remind everyone, in case they had not seen it – I mentioned it at the last call – and that is the call that was scheduled for November 30th and December 20th are canceled. The next call for Non-Group Health Plan will be November 10th, and then followed by that, which will be both a policy and technical call, and the December 9th call is still on, as well, and that will be a combined policy and technical call, as well.

When we get into the Q&A session, I ask that folks please present who they are and who they represent and please, in the interest of allowing others to

have time to get their questions answered, please limit your questions to one and one follow up and jump back in the queue so other people can get their – get their time on the microphone.

Bill Decker is going to present a couple of the questions and answers that came in through the resource mailbox on social security numbers, and then Pat Ambrose is going to present some additional material, and I think we'll probably go into – (Aubrey), did you have anything – we'll go right into the Q&A session. So, with that, I'll turn it over to Bill.

Bill Decker: Thank you, John. Hi, everybody, this is Bill Decker with CMS in Baltimore. Good afternoon or good morning, depending on where you are.

We got a number of questions in the mailbox. We always get a number of questions in the mailbox, actually, about the collection of social security numbers and their relationship to healthcare – health insurance claims number, Medicare HICN, the Medicare ID number. First of all, I remind everyone again that it is the Medicare HICN, the Medicare Health Insurance Claim number, the Medicare ID number that we need to have to process your reporting.

That's the personal identifier that is specific to Medicare and that's the one that we ask you for. That's the one we expect you to be able to send to us. As we've said before, if a Medicare HICN is not available, and you want to see if an individual is a Medicare beneficiary, you can send us the individual's social security number, plus a small quantity of other personal identifying information. We can check the social security number and the other personal ID against our database and get back to you with a HICN if the person is, in fact, a beneficiary.

And if the person you are querying on with a SSN is not a beneficiary we will simply tell you that the person – that we don't have any record of that person as a Medicare beneficiary. If you're having trouble collecting either the HICN or a social security number from someone, and you need it for Section 111 reporting, the individual is not being cooperative with you and doesn't want to give you that – those personal IDs, for any reason, there is language

on the Web site that you can give to the individual, who must then complete the language and return it to you. You don't need to send that language to us.

You just need to keep it in your files, so that if it ever comes to a point where we say how come you didn't report this individual to us you can say the individual would not tell me whether or not he or she was a Medicare beneficiary or was unwilling to give me his or her SSN. We don't require you to collect SSNs. We require you to give us Health Insurance Claim numbers.

And, finally, we did have one question actually that came in the most recent batch of questions to the mailbox from an individual who wanted to know if a person could be a Medicare beneficiary if that person did not have a social security number, and the answer, of course, is no. You must have a social security number in order to be a Medicare beneficiary, because you have to be in the social security system in order to be a Medicare beneficiary, and there's no two ways about that.

So that should take care of my presentation and thank you very much. I'll now turn it over to Pat Ambrose.

Pat Ambrose: OK. Thank, Bill.

A recent – a recent posting on the CNR Mandatory Insurer Reporting Web site, at www.cnr.gov/mandatoryinsrep, that, as you should know, is our home page or the main page for information concerning Section 111 Mandatory Insurer Reporting. On the non-GHP page or the NGHP page, specifically for liability, workers' compensation and non-fault RREs, you'll see an update regarding the Town Hall conference schedule. On November 10, 2010 there will be an NGHP Town Hall call that will cover both policy and technical concerns, the same as with December 9, 2010. That will also be a policy and technical Town Hall call. The calls that were originally scheduled on November 30 and December 20, 2010 have been canceled.

Secondly, on the Section 111 COB Secure Web site, or COBSW, at www.section111.cms.hhs.gov, we have posted the updated error code files, based on version 3.1 of the User Guide, so there's an updated Excel file and

an updated text file that contains the error codes and descriptions as documented in version 3.1 of the NGHP User Guide. These can be found under the reference materials menu option on the login page and the files are dated October 14, 2010.

We continue to work on creating computer-based training modules or CBTs for additional topics, including ICD9, diagnosis code reporting and direct data entry or DDE. Also note that we are still in the process of updating the existing CBTs to reflect the changes in version 3.1 of the User Guide, and those will be posted out there or released as soon as possible, very, very soon. They're almost complete.

If you have signed up for the CBTs you will be notified via e-mail automatically when courses are added or updated. In order to sign up for the CBTs go out to the Mandatory Ins Rep Web site that I mentioned earlier, look at the tabs or the links on the left-hand side of the page and you'll see one for computer-based training or CBTs, click on that, go to that page and follow the instructions for registering for the CBTs. I highly encourage you to sign up for the CBTs. You don't have to take all of them. You can go through the curriculum at your own pace and take whatever courses you desire and skip over courses that you might not need to review, but there's a lot of information out there that you might find helpful.

We are – as I announced on the last technical call, we are making changes to accept ORM termination dates that are less than 30 days, greater than the date of incident reported on a claim record. A modification then will be made to the CJ06 edit for this. I actually need to check on the implementation date for that change. Originally I had announced that it was going in by November 1st. I believe that's still true and it might have already been implemented, but unfortunately I didn't get a final answer on that before this call, so if you need to know exactly when that change will be implemented please follow up with your EDI representative.

Note that the other component about – or that is part of that CJ06 edit about an ORM termination date not being more than six months in the future that will remain the same, that no change will be made for the edit related to future

dated ORM termination dates. You may submit future ORM termination dates, but they cannot be more than six months in advance of the – or the date that the file is submitted.

Another change that has not been announced yet has to do with the edits involving the representative's claimant and representative's claimant, or claimant representative, rather, city field. The city field as part of the address for the claimant, the representatives and claimant representative addresses on will be claimant put file detail record and claim input file auxiliary record.

The change that we're making to the city – the edit for the city field is to not allow numerics in these fields. In other words, not allow a number or a numeral to be entered or submitted in any position of the city field. This change will be made prior to January. Unfortunately it needs to be made as soon as possible as it is causing us issues with other systems that we interface with, so other systems that we're collecting this Section 111 information for and passing it on to are not accepting and will not allow numerics or numbers in the city name of the component of the address.

And, obviously, it should be intuitive that a city does not contain a number anyway, unless I'm mistaken somehow. I know some strange things can happen, but, at any rate, that change will be made. Of course, the User Guide will be updated so please make a note in your internal systems for this.

Let's see, other upcoming alerts related to technical issues that will be posted very shortly, most of these we've talked about on previous calls. One has to do with allowing for a default ICD9 code for very limited specific circumstances where medicals are released but there actually may not be an actual medical injury. I'm not going to get into the specifics for that other than to say that that will be implemented in the January release and it'll be available with any files submitted after January 1, 2011, and that alert with the default value will be published very shortly. The default value will be the characters "NOINJ" or no injury (or short) for no injury, so "NOINJ" will be the default code that we will allow in field 15 and field 19. Pardon me?

Male: But not yet.

Pat Ambrose: But not yet, yes, that's as of January 1st. So, again, that alert will be posted shortly.

Male: And it will be, as we've said, for very limited circumstances.

Pat Ambrose: Yes, indeed.

Male: Very limited (circumstances).

Pat Ambrose: There is also an alert pending that will describe some changes to the way that we will edit the Tin reference file address field, so that's the RREs address submitted on Tin reference file detailed record. The actual editing will not change, but instead of rejecting the record with error codes the change will involve returning compliance flag codes instead of error codes for that, and that alert should be posted within a week, a week's timeframe, if not sooner. I think it's ready to go, at this point.

So, again, the edits for those fields will not be changing, but instead of rejecting records with error codes we will actually, under certain circumstances, accept the record but return a specific compliance flag so that the RRE can follow up and correct that information and resubmit it at a later date, but it does allow us to process the rest of the information related to claim reports, so that will be posted soon.

Also, as announced on previous Town Hall calls, is the fact that we will continue to retain any ICD9 diagnosis code that was – that has been considered valid, so we won't drop off old codes. Any code that was considered valid at any time will always be valid in the future for ICD9 diagnosis code reporting, so what that means is if you send us an (add) record for a claim report, and that (add) record is accepted, and the ICD9 diagnosis codes were considered valid if later you send an update to that record or for that claim report those same ICD9 diagnosis codes will continue to be considered valid, so, again, changes are being made for that and will be effective in January when we would implement the new version of ICD9 diagnosis codes anyway, so you don't have to worry about codes dropping off and no longer being considered valid if they once were.

There's also a couple of policy alerts that are ready for reporting. One has to do with providing you information on how to calculate or determine the date of incident in a situation where the injury represent a cumulative trauma, such as carpal tunnel, and then also a policy alert related to when claim information must be reported, as has been subscribed previously. That is related to when the RRE knows who the injured party and how much they will receive.

As you know, in certain class action suits and mass tort situations there might be a settlement made, but the money is not actually allocated to specific people and the specific amounts not identified until much later after the settlement. An RRE will not be required to report, obviously, until they know who the injured party is and how much the TOPC amount is related to that injured party.

We're also working on issuing an alert to document the information that we provided on previous calls related to Workers' Compensation indemnity payments involving claims that are still open with ongoing responsibility for medical. So, please be on the lookout for a number of alerts that are planned to be posted.

All that said, as always, please submit your specific technical questions to your EDI representative first. Specific technical issues related to your file submission can't always be addressed effectively if they are sent to the CMS resource mailbox or elsewhere. You will get a much faster response to your technical questions if you contact your EDI representative and then follow the escalation procedures in Section 18.2 of the User Guide, if necessary.

Now I'm going to get into some of the specific technical questions that were submitted to the mailbox and answers for those. The first one had to do with what value to put in the state – yes, the state of venue, field 17, in case of a Longshore Harborworker Act, Jones Act liability, and maritime maintenance and (cure) claims. And you should supply a value of (UF) in field 17, state of venue, for those types of claims, and I'll make sure the User Guide is updated appropriately to make that perfectly clear, since it must not be.

The next question was asking whether an RRE must go through a testing process in order to submit querying files, and the answer is no. An RRE ID must be in a test status in order for production query files to be submitted, so as soon as the RRE ID is switched to a test status you may start submitting production query files. You can submit test files and test the query process at your own discretion, but it is not required. In order for an RRE ID to obtain a test status the authorized representative for the RRE ID must sign the profile report and return that to the COBC, so please refer to the User Guide section under registration and under the query file section for more information on that.

The next question asked if there was a tentative date for the direct data entry or DDE option update to the User Guide. The COB – the Section 111 COB secure Web site User Guide will be updated by January 3, 2011 with information on how to use the screen for direct data entry or the Web pages, rather, for direct data entry. So that information on how to actually enter data, where to go, what information to supply and how to navigate through the direct data entry Web pages is going to be in the Section 111 COB secure Web site, or COBSW User Guide. Now, this is the User Guide that is on the Section 111 COB secure Web site.

It is not the reporting User Guide, where all the file layouts and requirements for reporting and so on can be found. So, you would go to the COB secure Web site, sign on with your login ID and user ID and download the COB secure Web site User Guide from the reference materials menu option. You have to be logged on to the site in order to see that as an option under reference materials and download the guide. Now that guide will not be updated again until – with the DDE information until January 3, 2011. However, in the meantime, we are issuing computer-based training modules that show you step by step exactly what to do when it comes to working with the direct data entry. Some of those CBTs have already been published and others are on the way, so I would recommend that you sign up for the CBTs in order to get information on the direct data entry option prior to January.

Bill Decker: Just as a – just a reminder, the CBTs – obviously CBTs are available 24/7 and are free. They're pretty easy to get to. They're real good and we highly recommend using them.

Pat Ambrose: OK, thanks Bill.

This question also went on to point out that there is no actual query function for the DDE option and, as we've talked about on these calls before, the direct data entry option, the application will obviously attempt to match the information that you provide for the injured party to a Medicare beneficiary in real time as they're doing the direct data entry for the claim report. And this question went on to ask does this mean that a social security number must be entered for all injured parties, even if they have indicated that they are not a Medicare beneficiary?

So that really doesn't apply – I guess I first need to state that the reporting requirements for direct data entry, what claims need to be report for what injured party is the same for direct data entry as it is for all other Section 111 reporters, so those that submit files have the same requirements as those who are submitting claims via direct data entry, so you need to review the User Guide on the Mandatory Insurer Reporting Web site in order to determine what you know is actually required for reporting. So that said, you're only required to report claims for Medicare beneficiaries. If you know the injured party is definitely not a Medicare beneficiary do not report the claim.

If you are unsure you may during direct data entry supply the social security number for the injured party, and as you're entering the claim via DDE you must supply either the HIC number or the SSN for the individual. The HIC number is preferred, as we've stated before, but you may supply the SSN if you do not have the HIC number. And no matter which you provide, the HIC number or the SSN, note that the system will always match the information supplied to the list of Medicare beneficiaries before proceeding to the subsequent data entry screen. So, I hope I've cleared up some of that confusion.

John Albert: But, again, even with – this is John. Even with the lack of a DDE User Guide, again you know there is no difference at all in what is required on DDE versus the regular file exchange process. All of the business rules for determining whether or not you need to report and what data elements you need to report are the same regardless, so don't expect to see like a totally companion full-blown User Guide for DDE because it just won't be there. It's just a different process for submitting the same data.

Pat Ambrose: Correct.

OK, so the next question had to do with – actually there were two questions submitted that were related to a Workers' Compensation claim where the injured party had injuries to multiple body parts, and then due to the state regulations for workers' compensation injury to one body part will not have an ORM termination date, however certain other injuries, such as to the wrist and the jaw, will actually – the ORM, the RREs ORM for certain other injuries for that – under that claim will have an ORM termination date.

And the person submitting the question was asking how they handled that situation. They essentially want you – the claim remains open for ORM, but only for some of the injuries that were initially reported. So they've reported multiple ICD9 diagnosis codes to describe all of the injuries, and then ORM terminates for some but not all. And I think the only solution is that you submit one claim report initially for all the related diagnosis codes, and then as ORM terminates for certain diagnosis codes or injuries, and not others, that you submit an update to that claim report and remove diagnosis codes, and then, obviously, submit a termination date only when ongoing responsibility for medicals for the entire claim and all injuries – all injuries actually end.

So, it won't work to submit two claim reports, since the (keys) will be the same and the two records will overlay each other anyway, so keep the ORM open and initially report with all diagnosis codes and then if ORM terminates for one diagnosis code and not another just send an update to remove that diagnosis code. In other words, send an update with all the diagnosis codes except for the ones for which ORM has terminated.

The next question went on to ask about – and this is something that we have actually covered before on the calls, but that's OK. We want to make sure that we get you know everything cleared up for people who are maybe just getting geared up to get ready for reporting in January. The question had to do with suppose that they submit a claim report and the COBC sends back a correction or an update to the HIC number.

Now, note that we will never send back a change to a social security number field. We will always just return the social security number that you sent us, but we're not ever going to send back a corrected, or updated or changed social security number, however we will send back the most recent HICN or HIC number, which is the Medicare identifier for the beneficiary. In the case of sending back a corrected HIC number, this individual was asking, "oh, then if I have to send an update to the claim report later because the HIC number and social security number are considered key fields do I have to send a (delete/add), rather than an update," and the answer is no.

The only time you would send a delete/add for a change in the HIC number or the FSN is if you sent the wrong individual to begin with. If we send you back the corrected or updated HIC number on your next update just send that next update with the new HIC number, and we do ask that you the HIC numbers going forward. Now, if per chance you send an update with the old HIC number or the SSN we will still be able to crosswalk that to the most current HIC number, but we do ask that you send your update with that new HIC number going forward and just an update transaction, not going through the delete/add process that you do to change a key field.

The next question had to do with suppose a claim with the ORM indicator equal to Y was initially reported, and on that same claim report a TPOC amount of $6000 was also reported. Later the RRE realizes that the TPOC date for the – that was previously submitted was incorrect and that actually the TPOC date is now prior to October 1, 2010. As you know, TPOC – we require the reporting of TPOC as of 10/1/2010 going forward, so this individual was asking what they should do in that circumstance, and basically you have two options.

You could send up update record to zero out the TPOC amount because it was prior – you've determined that it's prior to 10/1 and it technically does not have to be reported, or you could just send an update transaction to correct the TPOC date and leave it on the claim report. We will accept TPOCs that are prior to 10/1/2010. They do have to adhere to the specified thresholds in the User Guide, but we will accept TPOCs that have dates prior to 10/1/2010, so you don't have to zero it out, but you may.

In the next scenario it was the same circumstance except it was a claim that did not reflect ongoing responsibility for medicals or ORM. In other words, the ORM indicator was equal to no, and the claim was submitted with a TPOC date of 10/15/2010, and then the RRE realized that that date was incorrect and the TPOC date was actually 8/15/2010, and so they were asking "do I need to send a delete transaction for that claim report since I've now determined that the TPOC date was prior to the required TPOC reporting date of 10/1/2010," and the answer is you may send a delete transaction to remove that but you're not required to, because again we will accept reports of TPOC prior to 10/1/2010. It, again, must adhere to the threshold specified but it can have a date prior.

On the last part of this question it had to do with a claim where the injured party beneficiary is deceased and the RRE is attempting to report claimants one through four. They have all the required information for claimant number one but they do not have all the required information, particularly social security numbers or EINs, for claimants two through four and they're asking what they should do in that situation and if its – essentially you must report the claim timely in order to be in compliance with Section 111 reporting requirements, so you need to get the required information.

However if you do not have complete information for claimants two through four it is certainly better to report the claim with claimant number one and not with claimants two through four to get that information reported in. This person was suggesting, "Well, maybe if I don't have all the required information I shouldn't report at all," and that is not a good option in this specific circumstance. So, I would leave off claimants two through four and report the claim with claimant number one information and get that accepted,

and then send an update transaction as soon as possible afterward when you've obtain information for claimants number two through four. And I don't want to confuse people. There's probably somebody already that I've confused. We've said it does not good to send a claim that you know is going to error out and that's not specifically the circumstance here.

You know there are, as we know, certain required fields. Claimants two through four are not required. Obviously we want you to report them, but you can get a claim report accepted without providing any claimants two through four information. Obviously if you report some of claimant number two and not all the required components you will get an error code, so I hope you see the distinction here, in terms of what we've talked about before.

OK, the next question, I'm going to read the question because I'm not entirely sure I understand it, so the question stated "when an insurer issued medical payment limits on automobile policy are the payments reportable if less than $5000 and do you insurers report payments issued as of January 1, 2010 or October 1, 2010?" And they went on to ask "are medical payments issued under automobile policies considered to be ORM regardless of whether the limits were exhausted?"

So, I'm a little confused about the way that the question is phrased. I assume this question refers to no-fault insurance. There are no thresholds for reporting no-fault insurance claims, no thresholds related to ORM or TPOC amounts. You'll see that in the User Guide in the section under interim reporting requirements. Generally speaking, medical payments under no-fault automobile policy – the no-fault component of an automobile policy are considered ongoing responsibility for medicals, so the ORM indicator is reported as a Y and no actual dollar amounts are submitted. No TPOC amount is submitted. ORM is reported as soon as it's assumed regardless of the policy limits.

ORM stays open until the no-fault policy limits are reached or other state laws and regulations allow for ORM to be terminated. Please review Section 11.8 of the User Guide and the (CDTs) for more information on that.

Barbara Wright: To add to what Pat was saying. This sounds like it might be someone who's not as familiar with all the requirements. You really need to go back and look at some of the basic things, and remember that claims are reported by insurance type. You need to look at the CMS definition for liability insurance, no-fault insurance and Workers' Compensation, and you need to specifically look at the threshold. And the way the question in there truly wasn't – I think Pat gave a very good explanation of all the various points, but the question didn't have enough information to just give you a yes/no answer. You needed to look at all the different areas in order to get your answer, so if you would be sure and look at the thresholds, as well as the insurance types, as well as the information on reporting dates.

Pat Ambrose: OK. Thanks, Barbara.

The next question had to do with the reporting thresholds and ongoing responsibility for medicals. You will see in the User Guide, under the section for the interim reporting threshold, that there are thresholds related to liability insurance and Workers' Compensation TPOC amounts. And the question went on to say "is it acceptable to report TPOCs below the threshold only for claims with ORM," and that is true.

In other words, the TPOC threshold for liability and Workers' Compensation does not apply to claims that are reported with an ORM indicator equal to Y, so if you're reporting, making a claim report with the ORM indicator equal to Y, you can report any TPOC, associated TPOC amount. It may be under the threshold in that case. Now, on the other hand, if the ORM indicator is equal to N then the threshold logic and requirements apply to that claim and the threshold must be exceeded in order for the claim report to be accepted. So then the question went on to say "we reported a liability claim with a TPOC date of October 6, 2010 and a TPOC amount of $5000 exactly.

Will this report reject due to the TPOC amount being below the threshold amount?" And, again, as I said, this depends on if the ORM indicator equals N then the record will reject with an error, since the total TPOC reported is under the threshold. The TPOC amount must be over $5000.

Now, this question also went on talking about chargeable errors and errors that would count again the RRE, and I'm not really sure where they were getting that terminology. Frankly, there is no need to worry about the error counting against you or being a chargeable error. I mean, obviously, we do keep track of records you know or we are calculating an error threshold, that 20 percent error threshold, but that's mainly to make sure that there isn't something drastically wrong with the input file, and obviously RREs who continue to have a lot of problems with you know a high error percentage the COBC and your EDI representative will be following up with you to help you improve your error rate, but, again, there's no need to worry about the error counting against you or being a chargeable error.

Just don't send the record again if you realize that it is under the threshold and you get that error returned. Don't send the record again unless subsequent TPOC amounts are incurred, and need to be reported, and send you over the threshold.

Bill Decker: Hi, Pat, this is Bill Decker. There are ways for people to (inaudible) compliance with Section 111 reporting and they're well known. We've published them and we make them well known to you. The mere fact that an RRE or an RREs agent sends us information that is not absolutely correct is almost always not going to be a non-compliance situation. It's going to be that you made an error in your reporting. People make errors in reporting all the time.

We help them correct them, and they correct them and they continue on and life goes on as usual. That's what – that's the distinction we need to have everybody understand here. Merely making an error won't be necessarily a non-compliant event. Fixing the error, working with us to fix errors, working with us to make sure you're doing the reporting correctly is our goal and we want you to be able to adhere to that, but we don't want you to worry terribly much about whether or not what you are reporting to us is going to put you out of compliance.

Pat Ambrose: OK, thanks Bill.

The next question has to do with there are multiple RREs involved in the settlement of a claim and should the TPOC amount reported by each individual RRE reflect the total settlement amount or the portion of the settlement paid by the RRE in question? This individual gave an example that RRE number one pays $50,000, and RRE pays $25,000, and it's settling one claim, does RRE number one report the TPOC amount as 50,000 or as 75,000? And it depends on the nature of the settlement. Generally RREs only report their share, but in the case of joint and (several liability) the entire amount is to be reported by each RRE and this is documented in Section 11.10.2 of the User Guide, and I'm sure Barbara has more to add to that.

Barbara Wright: Let me rephrase what Pat said a little, because she said generally they only report their share, so if it's joint in several liabilities they report the whole thing. Normally they wouldn't have a share unless they had joint in (several) liabilities. There seems to have been some confusion with the industry, in terms of how they're thinking about – or how they or you are thinking about the concept of joint in (several) liabilities.

We are not talking about general joint in (several liability) for purposes of the accident illness injury as a whole. We are specifically limiting our language to situations where there is joint and (several liability) for a particular settlement, judgment, award or other payment, and when we had some conversations within the last few weeks this type of clarification seemed to help most people. We will be tweaking the language in the manuals to make this clearer.

Pat Ambrose: OK, great.

The next question had to do with a parent company and with two subsidiaries, and the parent company registered, which is completely appropriate as the RRE, and now they're getting ready to report and they have a circumstance where some claims are paid by the parent company, other claims are paid by each individual subsidiary, and asking how they would go about reporting these claims on their one file. What you can do is put in field 72 the tax identification number or the Tin. Put the Tin number – for the claims paid by

the parent put the two numbers for the parent, for the claims paid by the subsidiaries put their Tin in.

I'm assuming that the subsidiaries have separate Tins in this example. And then on your Tin reference file you'll submit three separate Tin records, one record for the parent, with the parent's Tin in the Tin field, and one record for each subsidiary, so hopefully that clarifies the circumstance. You may actually report all of those claim reports using the parent Tin in field 72 if they are appropriate. Obviously for any recovery action the Tin that you submit in field 72 and, of course, on the Tin reference file detail record will be the one that is used in the recovery actions and so on.

So, again, you would submit each individual parent and subsidiary Tin in field 72 and then submit separate – you know a Tin reference file, detailed record for each Tin that you have used on your claim detailed record. And, again, with a question like this, I would refer you to the computer-based training modules, as well as your EDI representative, who can probably help you with that as well.

Let's see, the next question was asking about the submission of test files after an RRE ID is in a production status, and so what I want to make clear to everyone is that is certainly possible for a test file to be submitted even if the RRE ID is in a production status, so if you're RRE ID has been changed to a production status but you need to retract, or continue testing, or you've made a change in your system that you want to test, or whatever the circumstances are, you don't feel you're ready to submit your production file yet and you want to submit test files prior to your – you know the date that you are required to go live you may submit a test file if your RRE ID is in a production status.

And that is true on into the future, so suppose you've submitted production files and you've been submitting files for the last couple of year, you would then still be able to submit a test file if, again, you've made some kind of change to your system and would like to test it before you implement it in production and it affects your production Section 111 reporting.

The last question that I'm going to go over, and I can hear the cheering in the background, has to do with Workers' Compensation claims that are denied and the RRE is not accepting the ongoing responsibility for medicals, and/or the claim is under dispute, should we still filed disputed Workers' Compensation claims as ORM or should these be – not be filed as ORM? What if the Workers' Compensation claim starts out as compensable and we file as ORM, and then we controvert the claim later, if that's still an ORM, or should we be changing that indicator? I think we've covered this before, Barbara, but if a – if a Workers' Compensation claim is being contested is the – RRE is required to pay medicals during that period of time?

Barbara Wright: If they are RRE, either voluntarily or are based by state laws required to pay medicals during that time then they need to report it. Similarly, we want to clear that the fact that you are denying liability is not controlling for purposes of reporting. When there is a settlement judgment payment, the settlement, judgment, award or other payment Medicare is secondary if there's an established primary payment responsibility, and that can be demonstrated by a payment.

It does not require a determination or admission of liability, so the fact that you're – if you reach a settlement and you continue to deny liability that doesn't mean that you don't have to report, so we want to make that clear that we're not accepting any statements or any – if there's any hidden intent or unintentional part of this question that is meant to imply that if you don't accept liability that you don't have to report. That's not true. You do have reporting responsibilities as long as there's a settlement, judgment, award or other payment, and that includes payments made while something is pending (inaudible) required by law or you voluntarily do it.

Pat Ambrose: OK, so I hope that answers the question that you know in the case that you are making those medical payments that you would submit the record with the ORM indicator equal to Y. When ORM terminates you would send an update record with the termination date. If it was determined that ORM never existed, and the claim never should have been submitted in the first place, then you would submit a delete transaction to remove it entirely, like – most likely you'll be sending an update with a ORM termination date and not

switching – remember, if you ever had ORM on a claim that ORM indicator remains Y.

It doesn't switch on and off. It's not an on-and-off switch, and if you need to change the ORM indicator on a claim because you erroneously submitted it as Y or submitted it as an N you have to go through the delete/add process, because we consider that a key field.

OK, with that, we can open it up to questions, John.

John Albert: Yes, this is John. I just wanted to re mention something I mentioned a couple of weeks ago, and that is while reporting is not due to begin or required until January, I do strongly encourage those that are ready to submit production data to do so early, because, as we've said and some of our data partners have said, there's no better final test of the process with each RRE as actually you know doing a full production run or limited production run of live data.

We have had numerous RREs move into production status and we actually have received some you know live files containing data, and we always encourage folks to not be afraid to start a little early because it will – it will leave you hopefully better prepared coming January. And from CMS' perspective, we've also found this very useful, as well, so we want to – you know we've already identified a few minor issues to production and have made corrections accordingly. So, again, I strongly encourage folks to not be afraid to start production early, as a kind of a final test for both you and CMS.

So, with that, Operator, we can open up to the first question.

Operator: At this time, I'd like to remind everyone in order to ask a question, please free star, followed by the number one on your telephone keypad.

Your first question comes from (Juanita Radar) of State Compensation. Your line is now open.

(Juanita Radar): Hi, I have a question. I'm not really sure if this is a tech question or not, but if we have – let's say we settled the claim 30 years ago and we've been paying the treatment bills all this time, and they had an attorney when the case was

settled 30 years ago, but we've heard nothing from that attorney since, should we be sending you that attorney information?

Male: You're talking about one where you're continuing to report ORM. If you have no information that the individual is still an attorney of record and wouldn't be (inaudible).

(Juanita Radar): Pardon me, I didn't hear that.

Male: You're talking about a situation where you're continuing to report ORM because you're continuing to make payments, correct?

(Juanita Radar): Well, basically these are our legacy cases and will affect (mainly) this first transmission where we have you know old cases that we've been paying the bills on but the settlement was 30 years ago and that's the last we heard from the attorney.

Male: Right, but you are reporting them as ORM, correct?

(Juanita Radar): Right, right.

Male: OK. If you have no information that this individual is still the attorney of record, I would assume they're not (inaudible).

(Juanita Radar): OK, and then also let's say the individual has become their own representative. We call that in pro per. Do you want any reports of the individual as their own representative?

Male: No.

(Juanita Radar): OK. OK, that's it for me.

Male: (Inaudible) (default), right?

Male: Yes, I mean essentially without attorney information the default is the individual.

Pat Ambrose: Well, and we have indicators, representative indicators, and you know you'll see that there is not one (related to self) or the injured (parties themselves).

Operator: Your next question comes from (Suzanne Cornwah), New York State Insurance Fund. You line is now open.

(Suzanne Cornwah): Hi, I have a few questions. The first one is I just wanted to confirm, the fields that you look for the match on the claim input file are those the same fields and sizes as in the query file, so that means are you still only matching on the first letter of the first name, the first (inaudible) of the last name?

Pat Ambrose: That's correct.

(Suzanne Cornwah): OK, so let's say we put the full last name in, as long as those first six match it'll get a match?

Pat Ambrose: Yes.

(Suzanne Cornwah): OK.

Pat Ambrose: Yes, yes.

(Suzanne Cornwah): And my other question was the 45-day window does that apply – you know that it has to come within the 45 days prior to submission. Does that only apply to TPOC?

Pat Ambrose: Well, there is no ORM start date.

(Suzanne Cornwah): Right.

Pat Ambrose: You know we don't know when – you know by your claim report we don't know when the RRE assumed ORM however it does apply, so if you have assumed ORM more than 45 days prior to your file submission then that claim is reportable. If you assumed ORM within 45 days prior to your file submission you may apply the greatest period and report that – make that claim report on your next quarterly file if you're not prepared to include it.

(Suzanne Cornwah): We're not so concerned about really when we assume it. It's a matter of you know have trouble in finding out if they're actually Medicare eligible. I mean we've gotten – we've sent questionnaires out and it's amazing the discrepancies we're finding is that some of these claimants – it looks like we've gotten ('01s) in the query response and the claimants are saying that they're not Medicare eligible, or we've gotten totally different claimant names, totally different HICNs back from the claimants.

Pat Ambrose: Well, any discrepancies in your query process should be reported in a secure fashion to your EDI representative so we can investigate.

(Suzanne Cornwah): I mean I don't know if it's if these claimants are not aware of what they're current – you know their claim numbers are the health insurance claim numbers.

Male: That's most likely because, again, the information we get comes straight from Social Security Administration, which handles enrollment for Medicare, and that is – that is the official government record until it's changed, and really the only time it can be changed is really through the beneficiary reporting some errors themselves. Even we can't make changes to that information. So, we've seen you know numerous cases in the past where people have alleged that this is not my number, or this isn't me, but you know until it's corrected at the Social Security Administration it is them, so …

(Suzanne Cornwah): Well that's why (inaudible) …

Male: Yes.

(Suzanne Cornwah): … was more of you know by the time we find out that they're eligible.

Pat Ambrose: OK.

Male: Yes.

Barbara Wright: I mean that's also the (inaudible) (here experience). One of the reasons why the model language we put out we have a picture of the Medicare card.

(Suzanne Cornwah): Right.

Barbara Wright: (Inaudible).

(Suzanne Cornwah): We have it on our questionnaire. We use that ...

Male: OK.

(Suzanne Cornwah): … but still we're getting certain HICNs back as like start with two letters and then numbers and I'm not really sure where those came from.

Barbara Wright: There are a few railroads, for instance …

Male: Yes.

Barbara Wright: … that has a couple of letters at the beginning. I'm thinking one of them is usually a W.

(Suzanne Cornwah): I don't know if they were necessarily railroad. Were there different numbers used if they were social security disability beneficiaries? I don't know.

Barbara Wright: If they were what, please?

(Suzanne Cornwah): Social security disability beneficiaries that were subsequently Medicare eligible.

Barbara Wright: No, when you get Medicare based on having social security entitlement …

(Suzanne Cornwah): Right.

Barbara Wright: … you still use your social security number …

(Suzanne Cornwah): OK.

Barbara Wright: … as the basis for your HICN, or if you're getting it based on age and you're getting Medicare through your spouse's social security number, so the base is always the social security number.

(Suzanne Cornwah): All right. OK, thank you very much.

Male: And we'll take it as an action item on part. There may be some publicly available documentation that kind of explains how the numbers are assigned, which …

Male: Well, there is. It's on the Social Security Web site.

Male: Yes, but (inaudible) getting the actual site, though.

Barbara Wright: I mean they …

Operator: Your next …

Barbara Wright: Social Security also assigns numbers in part based on where a person lives at the time the …

Male: Yes.

Barbara Wright: … number is given to them and they keep that number once they have it. Once they (inaudible) about the 45 days before we go into the next question is it's to your advantage to report as soon as possible because part of the reporting is to ensure that we pay correctly, and if we pay incorrectly because it's taken you a while to report then you're increasing the potential for you to get a recovery claim and have to do more processing, so if you have responsibility to ORM the sooner you get us that information the sooner we will have it posted, and if we are erroneously billed we can redirect – you know we can essentially say, no, you have to go back and bill the primary insurance.

Operator: Your next question comes from (Jo Ellen Davis), Zurich Insurance. Your line is now open.

(Jo Ellen Davis): Good afternoon. I have a question and it's basically clarification about all the ICD9 codes. And so after reviewing the previous transcripts and looking at the User Guides, here are my questions. In the first ICD9 code when you report let's say an add obviously it has to be a valid CMS acceptable ICD9 code. Does that first code always have to remain the same is my first question? So let's say I reported ICD9 code 7932, a valid one that's accepted

by Medicare, any subsequent reporting must always have that one in the first ICD9 code position?

Female: No.

Pat Ambrose: I don't – I don't think necessarily, no. I mean if you – if you removed that one and – or wanted to replace it with something else, I mean you could – you could change the code that's in there. They're not really positional as much like the TPOC fields we've talked about being positional to make sure that we get you know zero out of the right one and so on. So …

(Jo Ellen Davis): OK.

Pat Ambrose: … the answer is no.

(Jo Ellen Davis): That's what my follow-up question was going to be. Are they positional, because when I was reading a transcript from the September, I think it was the 22nd phone call, where a gentleman asked – he had – he had sent three ICD9 codes and then they blanked out second one, but one and three would remain the same? That's where I got that they had to be positional, so …

Pat Ambrose: Yes, they – they just wanted to do that and we said that was OK, but that is not required. He could have blanked out number two and moved number three to number two …

(Jo Ellen Davis): OK.

Pat Ambrose: … and reported that way.

(Jo Ellen Davis): So they don't have to remain positional, and the first one, obviously, always has to contain a value? It can never be blank?

Pat Ambrose: That's absolutely correct, as of January 1, 2011.

(Jo Ellen Davis): OK, thank you very much for your time. That's all I have.

Pat Ambrose: You're welcome.

Operator: Your next question comes from (Theresa Folino) of AAA Auto Club Group. You line is now open.

(Theresa Folino): Hi, in talking with other insurers among the industry, I understand it's that taking a little bit longer than 14 days to get a response file when they're submitting a production report right now, and our concern is is what would happen if we didn't get a response file prior to the next reporting date and we sent everything again, because, unfortunately, we didn't build into our system anything to show pending.

Pat Ambrose: Well, are you talking about query response files or the claim – the claim response file?

(Theresa Folino): The claim response file.

Pat Ambrose: OK, those – the turnaround is 45 days, not 14 days …

(Theresa Folino): OK.

Pat Ambrose: … so – and you will get a response file within 45 days, but you know if for some reason you didn't and you sent all the claims again they would just be reprocessed. It's not really – I don't see any harm really being done by that. If we've already taken an add transaction, and added the claim report and you sent another add transaction we'll actually treat that second add transaction as an update, and so you know if it's the same record it'll just get processed again with the same result.

Male: But – and this is for everybody – if you're getting close to the point where you want to send in your second report and you haven't gotten the results of your first yet, you really want to talk to your EDI rep right away. That's where you want to start with here. What Pat said is true, but the first step is really to find out why you haven't gotten your first response yet.

Pat Ambrose: Yes, absolutely. That should be escalated to your EDI representative straight away. And you know of course there's processing that you need to – to perform, based on the results of that response file that affects the next file that

you're going to send, so, at any rate, I don't know currently of any circumstance where someone is not getting a response file within 45 days.

Male: (Inaudible) (cut it off).

Pat Ambrose: Yes, I mean truly.

Male: I mean, yes, the system is set to cut that file, response file, even if it's not completed processing, right …

Pat Ambrose: So, right. So right after 45 days is up and you don't see a response file available you need to e-mail or get on the phone with your EDI representative straight away.

Male: Yes.

(Theresa Folino): OK. Then earlier in the call you were talking about the settlement amount that had to be submitted, and my understanding was is if various carriers were all paying a portion of claim that we had to submit the entire amount of the settlement and not just our portion. Am I misinformed?

Barbara Wright: Yes.

(Theresa Folino): Yes. OK.

Barbara Wright: Again, what we've heard from the industry is that generally when they're talking about joint (inaudible) liability they're talking about (inaudible) of joint overall liability for the settlement accident incidents. When we're referring to joint and (several) liability we're very specifically limiting it to joint and (several) liability for a specific settlement, judgment, award or other payment. Assuming you're in a settlement situation, if there's three defendants and they each have a separate settlement they only report their own amount. If there's a single settlement which by law or by the terms of the settlement itself makes them jointly a severally liable, meaning that if, for instance, they're all responsible for 10,000, but if one of them doesn't pay that 10,000 the other two have to pick it up. Then in that situation that type of joint and (several) liability each of them has to report the total amount.

Male: (Is that all)?

(Theresa Folino): Yes, that did very much. Thank you.

Operator: Your next question comes from Edward Eisenman of Berkshire Hathaway. Your line is now open.

Edward Eisenman: Hi, I have a question regarding reporting of ICD9 codes and specifically it's for ORM. And my question is if an RRE is disputing a specific diagnosis do we report only the ICD9 codes that we decide to accept and we pay for?

Pat Ambrose: Are you talking about ORM or are you talking about a TPOC situation?

Edward Eisenman: ORM.

Barbara Wright: If it's ORM you should be reporting what you've assumed responsibility for, but in connection with a TPOC, where, as we said earlier in this call, there doesn't have to be an acceptance or a determination of liability. When you have settlement (side) situation you should be reporting codes for everything that has been alleged.

Edward Eisenman: OK, so everything for TPOC and for ORM only what we are going to accept and pay for?

Barbara Wright: Yes.

Edward Eisenman: OK. And my follow-up question then is if we were to – if an RRE accidentally reports an ICD9 code that they don't intent to pay for does that in the eyes of Medicare make them liable for that code down the line if they don't remove it?

Pat Ambrose: (Inaudible) (and) update record to remove it and that should take care of your situation.

Edward Eisenman: OK. OK, thank you very much.

Operator: Your next question comes from David Piatt of Piatt Consulting. Your line is now open.

David Piatt: Hello, (Barb), Pat. I thought I withdrew my question, but I'll it anyway now. A different type of – way of reporting ORM in the clinical trials when you have an adverse event that comes and goes over time, the way I thought we would report that was essentially since we have a different date of incident for each one that we would report in separate ORM or separate IC9 code (inaudible) close them out.

Female: I don't understand.

Barbara Wright: David, I don't understand …

David Piatt: Yes.

Barbara Wright: … why you would have a different date of incident. If you have a particular complication, the fact that it may clear up and go down, et cetera, would be about responsibility for that complication. We should have that ORM open for that complication continuously. And …

David Piatt: Yes, I was going to do that, but what I'm saying is that you know they're different – different complications under one test scenario, so you know you might have you know report all kinds of things, right, so at one point they report you know my leg aches and so you report that, and then you know when that goes away you close that one, and the next time you know the top of their head hurts and you report that one then you close that one out. Because my fear is if you aggregate them all over time on an ORM from you know when they start – you can't even tell when it starts, right?

You can't say I took ORM at the beginning if the clinical trial all the way to the end of the clinical trial because you haven't, so you're saying I've accepted responsibility for this injury that occurred at this time in the course of the clinical trial, and that over time you know it went away and you know have the ORM closure thing, I realize, but I'm not addressing that right now, but these are specific instances of a particular injury at a particular time, and so (that these) not be aggregated over the whole period of the clinical trial period because then you know it might confuse the process of what I'm actually responsible for.

Barbara Wright: If you believe you have different incidents then report them as different incidents, but …

David Piatt: OK, thank you Barb.

Barbara Wright: … a flare up or an up and down in a particular complication the ORM record should stay open.

David Piatt: Yes, I agree with you. I understand. Thank you.

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

(Ellen Ecell): Hi, you stated earlier that you're going to be making a change so that ICD9 codes submitted with a claim will always be valid going forward for that claim, I guess.

Pat Ambrose: Correct.

(Ellen Ecell): Now, the documentation, when I was looking at it, you provide those yearly files of valid codes and the last three years were supposed to be valid, so we were planning to – if we were sending an update to a claim and the ICD9 was no longer considered valid we were going to have our users change it, so we don't have to do that now?

Pat Ambrose: That's right. It was supposed to help you you know in that circumstance, yes. So, in other words, we're going to use the versions that are out on the CMS Web site. We'll use version 25 and subsequent indefinitely for as long as we're using ICD9 codes.

(Ellen Ecell): OK, so the ICD9 codes, all the ones that have been valid are going to be valid?

Pat Ambrose: Correct.

(Ellen Ecell): There'll never be one that falls off the list, correct?

Pat Ambrose: I mean, I guess it's conceivable, but highly, highly unlikely that we would change the list of excluded codes, but there is no plan to do that and I don't see us doing that. As you know, eventually we need to make the transition to ICD10 and I don't – I just don't see a code suddenly being added to the list of excluded codes.

Male: I mean you can …

Female: (Inaudible).

Male: … (inaudible) back and use a 20-year-old code book and it's still …

Male: The excluded codes, those are ones that we exclude from (only reporting). They don't go away in the ICD9 index, however. We would just (inaudible) and say don't send them to us.

Pat Ambrose: Right.

Male: But that's different. I mean they'd still be valid, in the sense that they haven't been erased from either the ICD9 index or our own index.

Pat Ambrose: Yes.

Male: They'll still be valid for you for reporting. It really was, as Pat said, a way for us to make it easier for you guys to cope with the ongoing increasing number of codes that really come through in all these revisions. The old codes pretty much stay the same. There are just new codes and new extensions on old codes basically, and we didn't want to have you people having to go through taking off all the old codes from ICD9, putting on all the codes from ICD10 and doing it again the next time that happened.

(Ellen Ecell): Oh, no, I appreciate that because that's what we were struggling with that …

Male: Right.

(Ellen Ecell): … codes were going to fall off the list and we're going to have to deal with that, but (for) now we won't have to deal with that. Just one other thing, I was looking at the – the User Guide, the one on the – where you login to look at it.

Pat Ambrose: Yes.

(Ellen Ecell): (Inaudible) call it – the Secure Web site User Manual.

Pat Ambrose: Yes.

(Ellen Ecell): And I think – I think it's missing some – the NGHP information, as far as the response folders and the response dataset names.

Pat Ambrose: OK.

(Ellen Ecell): I don't see – what I see in the regular User Guide there's a response folder for claim and query only …

Pat Ambrose: Yes.

(Ellen Ecell): ... and this is referencing like (NFP), non (NFP). I think it's only showing the GHP information …

Pat Ambrose: OK.

(Ellen Ecell): … under the (STP).

Pat Ambrose: OK.

(Ellen Ecell): (So, you) might want to look at that and just – I'm assuming that what's in the regular User Guide is correct?

Pat Ambrose: Yes.

(Ellen Ecell): OK, so just so they know that there's stuff missing.

Pat Ambrose: OK. It would be great if you could shoot an e-mail to your EDI representative, when you get a chance, with that but I'll – I'll make a note of it, as well.

(Ellen Ecell): OK, and just one other little thing, you said about submitting you know as soon as you can, if it's possible. There's a statement in the User Guide that

says "RRE submitting production files prior to January 1st must adhere to their assigned file submission timeframe for the applicable quarter." That's true?

Pat Ambrose: You know if you send it outside your assigned file submission the file will suspend with a threshold error and your EDI representative will need to intervene to release it. So, I think we're – the message is if you would like to send a file, a production file prior to January we'd be perfectly happy to take it, and even take it outside your file submission period, but you need to give your EDI representative a heads up that that's what you're going to do.

(Ellen Ecell): OK, but then we also have that 45-day window consideration, as well. I was going to submit it later than my window …

Pat Ambrose: (Inaudible) and you know …

(Ellen Ecell): … and I'm running into that.

Pat Ambrose: … (inaudible).

(Ellen Ecell): (Inaudible) my (back rate).

Pat Ambrose: That's OK, you can – you know technically you shouldn't get any compliance flags if you're sending a file prior to …

Male: January.

Pat Ambrose: … January, but if you do you can ignore them.

Male: Yes.

Pat Ambrose: And if you do, well, I guess it would be good to report that to your EDI representative, as well.

Male: (Inaudible).

Pat Ambrose: Yes.

Barbara Wright: I mean the point is …

Male: And I can tell you right now you know if you report data to us and you get some kind of compliance flag for lateness or whatever we're not going to be doing anything with them, because, again, requirements aren't you know due to kickoff until January, so …

(Ellen Ecell): Oh, no, I was just saying that if I submitted say towards the end of December and my normal window I'm going to be submitting in mid February I may not get the response file back from my first submission in December and that's going to cause me a problem.

Pat Ambrose: Yes, you're – you're right about that.

Male: Yes, but you (probably) will. You probably will.

Pat Ambrose: You know – I mean you should – you should not submit it so late such that you can't allow for not only the 45 days for the response and your ability to process that prior to your file submission in first quarter.

(Ellen Ecell): (All right), well, OK, that's just more ammunition I can push back to my business people then.

Pat Ambrose: Well, I (inaudible) on that but …

Male: (Inaudible) and even you know if there's issues with like the start date and things like that. I mean you know again if you don't feel comfortable submitting a full file you know by all means submit some records that you want to submit now versus when they're actually due in January (inaudible) you know.

(Ellen Ecell): It was really more about them trying to get us to submit so that they wouldn't have to enter ICD9 codes.

Male: Oh, OK.

Male: OK, fine (inaudible).

(Ellen Ecell): OK, that's it.

Male: OK.

Male: (Inaudible).

Male: Yes.

Male: Next question.

Operator: Your next question comes from (Norman Reese) (inaudible) Insurance. Your line is now open.

(Norman Reese): OK, thanks. On a contaminated drug case, let's say you have 500 claimants and some are Medicare beneficiaries, you've got two defendants which each would be an RRE, and there's an agreement for each defendant to pay $5 million or a total of 10 million to settle these cases. (It's our) understanding each RRE would have to determine who the Medicare beneficiaries are, and each RRE would have to report on each, would they report the five million they paid on each or the total 10 million, since there's no allocation in the release of what claimant gets what?

Barbara Wright: Well, I don't really have enough information (for what you do). If the settlement is structured such that they're (joint) – essentially (joint) (inaudible) (rivalry) for the whole settlement fund then they're both going to end up having to report the total amount for each (client) (inaudible) who is a Medicare beneficiary and who is reportable, et cetera.

(Norman Reese): Right, so each RRE has to report on each claimant?

Barbara Wright: I don't – I don't have a simpler answer for you in that situation. I realize it sounds redundant, but it will be straightened out on the back end of the recovery. We can't simply arbitrarily say RRE one has to report but not RRE two.

(Norman Reese): I understand that, but you'd be showing 20 million per claimant with each RRE reporting.

Barbara Wright: No, no, no, you have to report – it's not the entire settlement for 3000, or 100, or whatever. You have to report the amount each person who is a Medicare beneficiary is going to get. You're reporting (is not) a beneficiary-by-beneficiary basis.

(Norman Reese): Well, at times, (where) that is not specified in the release. That is (said) later between the plaintiff attorneys, and the claimants and the court.

Barbara Wright: We've been saying for two years now that there is this reporting obligation. If people were not (obtaining) this the way they were structuring their settlements prior to MMSEA Section 111 they need to be doing that now because they have the obligation to report.

(Norman Reese): OK.

Barbara Wright: From a reporting standpoint, it is not sufficient for defendants to simply get money, put it in the fund and say that's it for me because I don't know who's getting the money. They have an obligation to determine who the beneficiary and how much of those beneficiaries is going to receive.

(Norman Reese): OK, then if you know the allocation made to a particular claimant, say John Doe gets $10,000, and there are two RREs you would show – report him as $5000 per RRE? Is that correct?

Barbara Wright: No, you would each report – each RRE would need to report the 10,000, where you only have (inaudible).

(Norman Reese): OK.

Operator: Your next question comes from (Bonnie Mustid) of Farmers Insurance. Your line is now open.

(Bonnie Mustid): Thank you. I have a question regarding HICN numbers just if you have any thoughts on this. One of the things we found, as we tried to send our query, is that we had received some (inaudible) HICN numbers that begin with HO, and the query process was reading that as a header, and so our query file would not go through. We did remove those from our first query file and has

– we're pursuing trying to figure out how those came about having the HO in it, but the strange thing was is as we prepared to look at what we would like – what we would set up for our next query file.

We have additional clients who also have given us HICN numbers that start with HO and it's not allowing it to go through the query process, so I'm just wondering – you know we actually want to verify before we report them (and we had a recent collect) and that's why we're attempting to query even though we have the HICN. But are there any thoughts on where this HO could be coming from?

Male: Yes, hang on a second. We're going to go off line just for a second. Don't go away. Don't anybody go away.

(Bonnie Mustid): (I'll wait).

Operator: Your next question comes from (Brenda Smith), (PMSI). Your line is now open.

Male: No, no, no, Operator. Operator (inaudible).

Male: No, no, no. No, we're still – we're still answering the previous question. Don't go to the next one yet.

Operator: I'm sorry.

Male: (Inaudible) a brief discussion off line, Operator. We'll be right back.

Operator: OK, sorry.

Male: OK. Thank you.

John Albert: All right, we're back. We're going have to take this issue under advisement. We apologize to the caller who was just cut off, but if they could send – if they're still listening, if they could send their question into the resource mailbox and denote the – I guess the subject of HO …

Male: The HO HIC number or something like that, or you know …

Pat Ambrose: There are some very old assignments of HIC numbers that are Railroad Board numbers that began with H0, and you know we dealt with this situation before and I can't remember …

Male: About two years ago.

Pat Ambrose: … what the result was and we'll just have to get back, as John said.

(Bonnie Mustid): OK, thank you.

Male: OK.

Pat Ambrose: Oh.

Male: Good, you're still here.

Male: Yes, we're aware of it now again and if you're still having problems with it yes. The issue is, of course, that you're going to – never going to be able to include those – those numbers without confusing us and thinking that – into thinking it's a header record you're sending. If you don't have a lot of them, you might want to talk to your RRE ID about sending them in – I mean your EDI rep about sending them in some other way, just to see if we could trace them.

Female: But please send a note to the mailbox so we can get back in touch with (you).

Male: Right.

Male: Yes. Yes, include your contact information. OK, thanks. Operator, next question.

Operator: Your next question comes from (Brenda Smith). Your line is now open.

(Brenda Smith): Hi, thank you. I have a clarification question for something Pat said earlier. I think you said that there were going to be some edit change for particular fields, where instead of having the record rejected a compliance flag would be returned. Did you say what particular fields that would apply to?

Pat Ambrose: Yes, I don't know if I …

Male: Hang on a second.

Female: OK.

Male: Hold on, everyone.

Pat Ambrose: We're back. I just wanted to validate that I could actually provide that information. The fields are on the Tin reference file and they are the Tin office code mailing address line one, the Tin office code mailing address line two, the Tin office code city, the Tin office code state, the Tin office code zip and the foreign RRE address lines one through four and it affects – the following error codes will no longer be returned and will essentially be replaced by compliance flag. These error codes include CT14, CT15, CT16, CT17, CT18, CT19, CT20, CT21, CT22 and CT 23.

(Brenda Smith): Thank you very much.

Pat Ambrose: You are welcome.

Operator: Your next question comes from the (Jim McEnroe) of PG&E. Your line is now open.

(Jim McEnroe): Yes, hi. I did send – I was asked to send in an e-mail on credit rights for Workers' Compensation. I sent that on October 1st. But my next question has to do with resources for ICD9 codes. We have claims open from the '40s where we're paying future medical, and I'm concerned about our ability to identify the appropriate ICD9 code when we're reporting our legacy ORM files. Is there a resource available to help us determine what is the appropriate ICD9 code for the settlement that we entered into 50, 60, 70 years ago?

Pat Ambrose: Well, the – the options that you have are to translate the information you have about the claim and the specific injury to an ICD9 code. There is software out on the Internet available for – that you know if you do a search on ICD9 diagnosis code you might find software that can help you with that translation or mapping. You know basically put in the injury – broken arm – and it will

provide you with a potential ICD9 codes that could be used for that. We can't recommend a specific software product or package, but I believe some of it is actually available at no cost.

(Jim McEnroe): OK.

Pat Ambrose: You can you know search through the files that are on the CMS Web site of valid ICD9 codes and you know look for a particular injury, but that's basically how you would have to go about mapping the description of the injury to ICD9 codes for submission.

Male: Or the one more plug for early submission, if you submit the data prior to January you don't have to use the ICD codes. You can use the – use the (scripture), so …

Male: And you just have to hope that you're not going to be finding an old diagnosis that doesn't exist in the real world anymore as a (diagnosis) …

(Jim McEnroe): Well, for a lot of these when it's pre computer we may only have five or six data elements …

Male: Yes.

(Jim McEnroe): … the person's name, obviously we'd have their address, but we might – like one I saw for a tooth and it wasn't only in talking to the person that we knew that they broke their tooth digging a hole, but – OK.

Male: I'm sure an old one for a witch exists, as well.

(Jim McEnroe): Yes, and to be clear, we have to go back beyond 1962 or five, whenever Medicare was created and report those or is 1965 the cutoff date?

Male: I thought it was '65. I mean …

Pat Ambrose: Unfortunately, Barbara Wright has left the conference call and I don't have an answer for that, as far as the date of incident. I think that you know maybe you can find it in Medicare regulations, or this question has been covered in previous Town Hall calls or …

Male: Well, it was covered but it was moving – it was a moving target, so I'm just trying to remember where it landed.

Pat Ambrose: Yes, and I'm afraid I …

Male: At first it was '84, and then it was '65 and then I thought it just said it didn't matter what the date was.

Pat Ambrose: I think for Workers' Compensation it has always been primary to Medicare since …

Male: Yes.

Pat Ambrose: … Medicare inception, and I don't think the date of incident for Workers' Compensation matters, but I can't say …

Male: OK.

Pat Ambrose: … definitively. Now, it's not the case for no fault and liability, since that has that 12/5/1980 date. Oh, Barbara has just returned, so would you mind repeating your question for her benefit and …

(Jim McEnroe): For Workers' Compensation do we report ORM regardless of the date of injury, even if it's 1940?

Barbara Wright: Yes.

(Jim McEnroe): OK.

Barbara Wright: Workers' Compensation has always been primary to …

(Jim McEnroe): OK.

Barbara Wright: … Medicare. It's been primary since the inception of the program. The 12/5/80 date is only relevant with respect to liability or no fault.

(Jim McEnroe): And can you embellish on what you indicated earlier in this question? I was on vacation, so I missed a couple of conference calls, but you're saying if we report ORM on claims before January we don't have to use the ICD9 codes?

Pat Ambrose: Yes, if you look at the requirements in the User Guide, prior to January there's a field 57 that you can use in lieu of field 15 and 19, the alleged cause and an ICD9 diagnosis code in field 19. You can submit a description of the illness/injury in field 57. However, if later you need to send an update transaction, and that update transaction is being sent after January 1, 2011, you will need to submit it with valid – a valid E code in field 15 and a valid ICD9 diagnosis code in field 19, so eventually you have to (derive) the valid ICD9 codes for fields 15 and 19 anyway.

(Jim McEnroe): OK. I also thought the ICD9 codes weren't just for causation, but for the body parts that we've accepted ORM on.

Pat Ambrose: Correct, so field 15 is the alleged cause and field – the ICD9 diagnosis codes 1 through 19 that start in field 19 are for the injury, a description of the injury, and would be body part. And that actually to your question earlier, if you have body part codes associated to Workers' Comp claims I would think that you could map those to ICD9 diagnosis codes, as well, for …

(Jim McEnroe): OK.

Pat Ambrose: … those reporting purposes.

Male: And, Pat, maybe you'll be able to verify this or not. I think with ICD10, which you obviously don't have yet, I think the codes get more refined so that there is a left versus a right, et cetera. And if having reported simply where it would be for like knee is causing a problem to you internally, for any reason, once ICD9 – I mean once ICD10 comes in if you wish to update to the appropriate left, right, whatever you would be able to do so.

Pat Ambrose: Yes, I don't think we're there yet on the ICD10s, but …

Male: ICD10 is still three years off, isn't it?

Male: Yes.

Pat Ambrose: So does that answer your question, sir?

(Jim McEnroe): Yes, that answers that question. Did you receive the – I mean I know I got the kickback e-mail, on the e-mail I was asked to send in regarding credit rights when (we entered) into ORM, but we have $400,000 credit, so until the employee spends that – demonstrates through canceled checks, et cetera, that they've spent that 400,000 on valid medical Workers' Comp benefits that we would have paid we don't have to pay ORM until that credit has been exhausted. So, I was asked to write in an e-mail about how we're going to deal with that when it comes to reporting.

Pat Ambrose: We did receive it. We did receive it. I did not include it in my presentation on this call, since I – it's more a policy-related question.

(Jim McEnroe): OK, that's what I thought. OK.

Barbara Wright: I'm not sure that we have a final answer for you yet, but …

(Jim McEnroe): I can wait for the policy call. I wasn't sure if that was policy or technical.

Barbara Wright: But, I mean, in terms of what we may be leaning toward is toward having the ORM reported, because this, for some reason, we have no other record. The Workers' Compensation is still primary to (inaudible) and we would at least have to have proof of denial by Workers' Compensation before we could pay it.

(Jim McEnroe): Right, I see.

Barbara Wright: So you know I'm not sure what the final answer will be, but at this point it's at least equally likely that it would still need to be reported.

(Jim McEnroe): OK, thank you.

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

Keith Bateman: Hi. Pat, I sent you an e-mail regarding the server issue. Can you shed any light on what's going on there?

Pat Ambrose: Well, issues – we did have some issues with secure STP server. I was actually out of the office, so I'm not that well versed on the details, but those issues have been addressed, and continue to be addressed and I believe that as of this call performance is much improved. And I'm looking for some notes that I had on it, which I am not finding in front of me.

Keith Bateman: I'm not trying to – it would be helpful if for people to know what's going on. And, again, the thing our Company has raised, and obviously sometimes you can – you'll know your server is going to be down for a length and other times who knows, but where you know it's going to be down it would be helpful if there was some way to notify folks don't send anything right now.

Bill Decker: Yes, this is Bill Decker. The server issues, there were three separate ones, actually, were all unrelated to each other and all unexpected. We couldn't have notified you ahead of time because we didn't know it was going to happen. The longest outage we had I think was six hours. The other two were within like an hour or even 45 minutes out. It happens sometimes with machinery that the machinery breaks down and that's basically what happened with a couple of the servers that we were using. We were notified pretty much instantaneously by our own staff up at the COBC and we monitored the situation here closely. Unfortunately there's just times when that will happen with complex systems and there's not much we can do to report to you. We would certainly let our audience know if the servers or any of the hardware was coming down for any length of time and was planned. We wouldn't ever not tell you about planned takedowns.

Keith Bateman: OK. One other question and this is a follow up to something I'd asked Barbara. On federal employees, the Railroad employees are the only ones that have a different set of numbers that were used other than the HICN number system that was being used by Social Security.

Barbara Wright: As far as I know that's true. And everybody keep in mind, though, once the (tags) are – the (BIC) letter that you see at the end is usually an A, or a B, or a

D because you're talking (to) either the person them self, their spouse or their widow or widower, but there are times when you see, for instance a C for a child, and you may see an additional digit after the letter you know in some instances if there's multiple wives, et cetera.

Male: But those are on suffixes. The prefixes …

Barbara Wright: Yes.

Male: … were only railroad, railroad workers.

Barbara Wright: I think so, yes.

Male: Yes.

Keith Bateman: Thank you.

Operator: Your next question comes from (Cindy Hall), (ALN) Solutions. Your line is now open.

(Cindy Hall): Hello. Pat, at the beginning of the call, right after you announced the canceled calls that had been combined with the policy/technical, you gave an update of some documents that were being posted and you gave a very long URL, some Excel files and code files that we could obtain, and I'm asking you to please repeat that file location for me.

Pat Ambrose: Sure, no problem. That was the URL for the Section 111 COB secure Web site, where you would go to upload and download files if you're using the (HGTP((inaudible) method, and you can see it's where you registered for Section 111, and also where you can see the you know file statistics, so the URL is www.section111.cms.hhs.gov. Did you get that?

(Cindy Hall): I did. I think I may have misunderstood. I thought you'd indicated there was like an update of some code lists that we could look at …

Pat Ambrose: (No), yes.

(Cindy Hall): … that you were (inaudible).

Pat Ambrose: Now, what is updated there, once you go to that site it'll first display a login warning, and after you've reviewed that click on "I accept." That's not actually logging you in yet, but – and then the actual home page will display for the (COBC) Section – or the Section 111 COB secure Web site, and on that home page there is our menu options across the top, and there is a reference materials menu option, and if you click on that it will drop down a list of available reference materials and one of them are error codes, and so the updated files that are out there are – it's an Excel and a text file that have the list of error codes that are in the User Guide, along with a description.

And we put those out there because some folks found it convenient to be able to download that, because the User Guide is in a PDF format and not so friendly for you know use in your systems, and so they're downloading those error code files to use in their systems to present to users. So they'll get a response file back with a particular error code and be able to display not only the error code to the use, but also the description that's in the User Guide that corresponds to it, but they're not – it's the exact same information that's in the error code table in the User Guide.

(Cindy Hall): Thank you.

Pat Ambrose: OK.

Operator: Your next question comes from (Emil Dammel) of (Tempco) Insurance. Your line is now open.

(Emil Dammel): Hi, this is (Emil Dammel) from PEMCO in Seattle and I have two questions, if I could. The first one is for Pat. And, Pat, I would just like to clarify something I think I heard you say at the beginning related to ORM termination date can be no more than six months after the date the file was posted. Pat, can you give me where in the User's Guide I can find out about that more so I understand it better?

Pat Ambrose: Yes, the error code table in the User Guide is error code CJ06 is where that it is documented in part. I think it's also documented in section 11.8, where we talk about ORM and the submission of ORM termination.

Barbara Wright: (But) what you were talking about, please clarify. If you were talking about when they wanted to post the termination date at the same time they were posting the (start) (inaudible) same time they were opening the ORM (posting), otherwise the determination date for ORMs certainly would be six – more than six months.

Pat Ambrose: Actually, no. The system – and it's because of another system that we interface with will not allow us to take in an ORM termination date that is six months in advance.

Barbara Wright: No, that's what I meant. It's for advance posting. If you open and ORM record 12 months down the road, 18 months down the road, whatever, you can (inaudible) at that point.

Male: Yes (inaudible) you can't – you can't post a future termination date six months from today or more.

Barbara Wright: So that limitation is only when you're trying to post the ORM termination date in advance.

Pat Ambrose: Right.

Male: Right.

Pat Ambrose: Right, you – and it is only that today you are telling me that this ORM is going to terminate six months from – or more than six months from today and …

(Emil Dammel): So, from a practical standpoint, if one of my policyholders is involved in an auto accident on January 1, 2010, and they have PIP coverage that expires on January 1, 2013, which is three years after the accident, you're saying we should not be putting into the termination field January 1, 2013 because it's more than six months after we initially post the file?

Pat Ambrose: No.

(Emil Dammel): No.

Pat Ambrose: What I'm saying is you would report that ORM with the January 1 – I think you said 2010 …

(Emil Dammel): Correct.

Pat Ambrose: … or January 13, 2010, and an open ended or all zeros in the ORM termination date, and then leave it open until six months prior to January 1, 2013, and then you may send an update transaction with the ORM termination date that is future dated ...

(Emil Dammel): OK. OK.

Pat Ambrose: … you know. And so what we're saying is that when you make initial report you cannot report the ORM termination date. You certainly must report the actual ORM, but you wouldn't report the termination date until you get closer to the actual termination date …

(Emil Dammel): OK.

Pat Ambrose: … within six months of it.

Barbara Wright: We've also – you need to be very careful about posting future termination dates because there could be intervening dates. Some people ask that if they were in a state where if the person doesn't get care for two years it terminates and they go ahead and put in the date when they get close to that two years, and we've said no because you don't know at that point whether there will be further care that will require you to keep the record open. So, not only can't you put in a termination date too far in advance, but you need to be extremely care about putting one in in advance if there's any possibility that you're going to be needing to make payment. The other …

(Emil Dammel): OK.

Barbara Wright: … (inaudible) I believe, on the last call, was someone asked about a situation where there was a dollar cap per year on the ORM, and they wanted to know whether to terminate it at the end of the year and open it up again the next year, or terminate it when it was exhausted for that particular year and open it

up again and we said no. In a situation like that, where there's just the dollar limit per year, your ORM hasn't expired, it hasn't gone away, it's just exhausted a limit for a particular year, so in that case you need to leave the record open.

(Emil Dammel): OK. And then I had one more question, if I could please, and I don't know if you folks can respond to this or not, but last night I was – it must have been during the Giants/Rangers game, I actually paid attention to a commercial and it was I think a Medicare public information type of commercial, and …

Male: (Inaudible).

Male: You don't have to go any further, we all saw it.

Male: We know it, yes.

(Emil Dammel): My ears perked up when I heard them give advice to Medicare beneficiaries to not give out their HICN number and my adjuster is going to be asking all of them for their HICN numbers.

Male: Yes.

Male: Yes, that's true. That's a – from our perspective it's unfortunate, but certainly we understand why in general it's not a good idea to give out personal identifiers. When you're dealing, however, with insurance claims you do need to submit your insurance claim number to whoever is going to be paying for you or who is your insurer and that's the situation that we find ourselves in.

(Emil Dammel): OK, gang, thanks for your help.

Male: Sure, thank you.

Male: All right, Operator, we've run out of time. I'd like to thank everyone for their great questions. Again, please stay tuned to the Mandatory Insurer Reporting Web site for future alerts. As Pat alluded to, there are a number of them coming out in the near future concerning a lot of different topics. Also, more information will be forthcoming about direct data entry, as well.

Keep your questions coming in to the resource mailbox. As you could tell by Pat's always fun presentation, there's always a lot of questions that we try to answer on these calls that come directly from the resource mailbox and we use that to update our materials, as well, so we hope you find these calls useful and entertaining, at least, and we'll talk to you again on November 10th, if I remember correctly.

Operator, if you could stay on the line after disconnecting everyone, we have a few questions for you.

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

END