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: October 22, 2009

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

CAVEAT: THIS TRANSCIPT 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.

FTS-HHS HCFA

Moderator: John Albert
October 22, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen only mode until the question and answer session of today's conference. At that time you may press star one if you'd like to ask a question.

I would like to inform all parties that this call is being recorded. If you have any objections please disconnect at this time. I would like to turn the call over to Mr. John Albert. You may begin.

John Albert: Thank you and good morning or good afternoon depending on where you're dialing in from. Just for the record today is Thursday, October 22, 2009 and this is a Nongroup Health Plan Policy Open Door teleconference.

With me I have Mr. (William Becker) and Miss (Barbara Wright) to present questions and issues and take questions and issues related to the nongroup health plan policy aspects of the Section 111 of the Medicare, Medicaid SCHIP Extension Act of 2007.

Just a couple of things you'll need to note for the record as well is that while we try to speak in - speak the same language that is in the user guide there are occasions where we might contradict each other or the user guides that are available on the Section 111 web page.

And for the record if there is anything that we say that contradicts guidance in the - on the Medicare insurer reporting web site that the materials on the web

site are the official record of CMS' policy and instructions for fulfilling reporting obligations under the Section 111 insurer reporting provision.

So again if we do contradict any of the information on there please refer to the information on the web site. We try to speak with one voice but occasionally with a lot of material out there we don't do that so again refer to the written materials.

The other thing is that we're asking that once we go through some opening presentations that you limit your questions to one primary question and one follow up so that we can have other people - give other people a chance to ask questions as well.

There are a lot of people on these calls and we want to make sure that everyone gets a chance to come to the microphone so we're going to start off with a brief opening introduction by (William Becker) who's going to go over some high level materials since the last call.

And then (Barbara Wright) I guess will go over some of the more specific questions that we received through the Section 111 resource mailbox. Again please continue to submit your questions, suggestions, comments, etc. through that resource mailbox.

We go through every single one of those. It's the most efficient way for CMS to process all of the information coming in to it regarding Section 111. And with that I'll turn it over to (Bill Becker).

(William Becker): Thanks John. Hi everybody. Good afternoon everybody or good morning. I am (Bill Becker) and I'm with CMS in Baltimore, Maryland as we all are.

This is an NGHP policy only call. I'm going to make some announcements that are both policy and technical related here.

At the beginning of this call just for everyone's interest and to get everybody caught up with some issues that have come up recently and even though this is a policy call some of these will be of a technical nature. And I'll remind everybody again at the end of my little presentation here that this is a policy call.

So I'm going to get started with first an announcement about attempts to register. If you are a foreign entity registering as an RRE, we have said before on these calls and we're saying it again today. If you are a foreign entity and you are considering registering, then what you should do is wait.

We don't have the process for a foreign RRE to register in place yet. We're working on it. We had yet another meeting on it this morning. And it'll be available to everyone soon. Those of you who are foreign RREs and should wait you do not need to worry about being out or compliance.

You can't register because there's no way for you to register so consequently there's no way for you to not register and be out of compliance. Just take our word for that we're not going to make anyone - we don't want anyone to be nervous about not complying if you are a foreign RRE and do believe you need to register.

Secondly I want to go over some Social Security number information one more time. Once again the - there is nothing in the Section 111 law that requires the collection of Social Security numbers by an entity. We suggest strongly in a couple of cases that Social Security numbers should be provided to CMS.

If a reporting entity has a question about whether an individual may or may not be a Medicare beneficiary and the entity does not have a Medicare I.D. number, Medicare HICN for the whether they're interested in knowing about. We can check based on a person's Social Security number and some basic other personal identifying information.

And if an entity wishes to have us check we can do that using the SSN. But there's nothing in the law itself that says you must provide, collect an SSN from anyone. And we've had some insurers claiming that it's the law that is requiring them to collect the SSNs and that's just frankly not the case.

And we wanted to make that clear at this point. Now a few other items four other items quickly. For all of you out there who are NGHP RREs there are new and updated CBTs now available for you on our web site which is once again www.cms.hhs.gov/mandatoryinsrep one word that's mandatoryinsrep as one word.

That's our official Section 111 web site address and there are on the CBT tab on the computer based training tab there are new NGHP CBTs available for you. I think they were posted yesterday. And another item we will be posting downloadable files for test beneficiary data including the inefficient ICD9 codes in Appendix H and the error codes for claim response files on the Section 111 web site next week.

Each file will be accompanied by a document that describes the files purpose, the purpose of the file and the layout of the file that's for all of those of you who are wondering if you could get a panel of test beneficiary data. We are making that available to you shortly.

Third we plan to update the NGHP user guide before the end of the year. (Barbara Wright) may or may not speak to this issue herself but basically there is an awful lot of new information being developed for the NGHP part of the Section 111 reporting process at this point.

And rather than make a series of small iterative changes to the NGHP user guide what we will probably do is make one change incorporating all of the information and make that later on this fall.

John Albert: I do want to say that an awful of information being developed for the NGHP user guide. We're - some of these are just minor tweaks. It's not a matter that we're going to be radically changing the file layout or anything like that. So I don't want (Bill's) comment about a lot of information to scare people in terms of anything they're developing for their systems right now.

(William Becker): It's certainly not our intention to be scaring people in these calls with this information. But we did want to let you know that that information was going to be out there. I'd also like to welcome (Pat Ambrose) who has joined us at this point.

And I'm actually going to ask (Pat) to go over this last point because I think that she understands it a little bit better than I do. So (Pat) if you want to take over Point 4 here and just run through that.

(Pat Ambrose): Sure thing thanks (Bill). I wanted to add some additional information about the versions of valid ICD9 diagnosis codes that we'll be using. The current use guide just lists that we'll use the latest version. And actually a decision has been made that we will actually accept any ICD9 diagnosis code that's on the last three versions that are published by CMS.

CMS publishes a new version each year of what they consider to be valid diagnosis ICD9 diagnosis codes. And Version 27 was posted and is effective as of 10/1/2009. Now in order to allow or ease an agent's time to incorporate the new file into their system.

The COBC will actually implement the new versions on the following January 1 of the year so or of that next year. So again these are the files that we are using to validate the alleged cause field, Field 15. And any Diagnosis Code Fields 1 through 19 that start in field 19 let's see and so in the user guide you're provided with a link to the CMS web site at www.cms.hhs.gov/icd9providerdiagnosticcode/06_codes.afp.

All of the versions that I'm referring to can be found on that same page. They are in zipped files. When you download the zip file and open it up you'll see several files in there. You want the ones that have the diagnosis codes and associated short description.

Version 27 is named CMS27_DEFC_SHORT_ZX.text that's Version 27 effective 10/1/2009. Again we'll accept or consider any diagnosis codes that you provide in those fields on a claim input file that matches exactly the first five bytes of that file as well as the file for Version 26 which is Z26I-9diagnosis.txt.

And then in addition to that Version 25 which is named I9diagnosesZ25.txt. So again you may use when you start testing claim input files in January 2010 all three of those files contain what we will consider valid diagnosis codes for Section 111 reporting valid ICD9 diagnosis codes for Section 111 reporting.

We'll update the user guide with this information. But if you go to that site and you download the zip files and open them up you'll see what I'm referring to I think without any undue difficulty.

(William Becker): Thanks (Pat). And just so everyone knows we will of course be going over that information again on our next technical call for NGHP. Remember now that we're done with this portion of the presentation and this is a policy call so please try to define your question to policy questions. And I'm going to turn it over now to (Barbara Wright). (Barbara).

(Barbara Wright): Thanks (Bill). As usual the first thing we'll go over the status of some of the outstanding issues, the language, the perceptual language for hospital (unintelligible) supplier risk management write off that's still under review as is the language regarding clinical trials.

The mass torques work group continues to meet as we said on the last call we're moving away potentially from the use of the terms mass torque product liability. We're trying to come up with rules that among other things will provide for reporting in situations where either the amount of the individual payments or the identity of the recipients is not known at the time of the settlement judgment award.

So we continue to have weekly meetings and we have some draft language that's under review for some of the issues. Our goal in changing any definitions, etc. is to make sure that we can simply slot those changes into the preexisting deals on the record lay out so there's not any significant coding change involved with it.

Interim periodic payment the revised language on that will make it more flexible for the industry that's one of the ones that's still under review for the

updated user guide. We continue to get questions about Medicare set aside and the Section 111 process including entities or individuals that send in questions and send in presentations they've seen by some outside entity.

Where they tell us the presentation talks about the fact that in order to be in compliance with Section 111 you must do set asides or you're going to be subject to penalties. What we will reiterate again is that Section 111 is a new and additional requirement for MFP.

It doesn't change any preexisting obligation. But it has to do solely with the reporting requirements that we are establishing the procedures for and placing the instructions on our dedicated web site. It has nothing to do with set asides. Set asides are a way to protect Medicare's future interests.

And in conjunction with that there are preexisting rules dealing with MFP of the need to protect Medicare's interests. So to the extent you hear or see any presentations that want to tie set asides to 111 that's not true to the extent they want to tie them to other preexisting obligations that you need to take into consideration.

We had at least one question from an Indian nation that it was having problems registering or at least its agent said it was having problems registering because it did not have a PIN. On the other hand they reported that this Indian nation ran a casino.

To the extent that they have employees they should in fact have an employer identification number. Employer identification numbers as you should all know are a type of PIN. If they do have any employees then do not absolutely have a PIN/DIN for some reason then they should follow the foreign entity process and they need to talk to CMS when we have those instructions out.

We're continuing to get questions asking about if payments made to an attorney on behalf of their client or it's made directly to the client do we report everything paid or only the medical. What we've said and we assume this question relates to TPOCs.

When you're reporting TPOCs you report full amount. You don't make the judgment or the allocation of what is medical. And to the extent this ties into periodic payments our prior alert was talking about reporting those that's all around so periodic payments we will talk about separately.

But in general a settlement TPOC you don't - you as the RRE do not make any allocation. You simply report total amount. We continue to get questions about the registration deadlines. And as we've said multiple times we're not looking to find an individual or entity in non compliance solely because they haven't registered before 10/1/09.

The idea, the concept is that we want everyone registered by the end of the calendar year so that they have three full quarters to test and can actually be in production the quarter starting April 1, 2010. A lot of the questions that came in the most recent couple of weeks do actually have to do with technical issues in terms of voiding payments or HUE software, etc.

Now those will all be covered at the next call. We did ask for an example of situations where you would expect to have more than four or five TPOCs and the only one that's one in so far is particular situations for bankruptcy. So we will take a look at that unless and until we have separate instructions though.

If you have a situation with more than the number of TPOCs that the record layout allows for you would have to contact your EI rep. The - had a couple of

questions that deal with situations where an entity that would otherwise expect to register as an RRE.

Because it's in the process of winding down and is only paying existing claims and they wanted to know if they had to register and report if they're not having any new TPOCs on or after January 1, 2010. And the only thing they were paying is TPOC then no they wouldn't need to register.

If - and its TPOC as the TPOC date as defined in the record layout. If on the other hand they have ongoing responsibility for medical for certain cases that they're continuing to pay on and those are reportable ORMs then yes they are going to need to register and test and produce files.

If it's somewhere in between they assume that they will have - they don't have ORM and they assume that they will have no reportable TPOC as we've said if you don't have a reasonable expectation of having anything to report you need to watch your situation and register in time so that you could fully test before you would have something to report.

We have a question that maybe is halfway between technical and policy. It's asking about whether or not it's permissible to send information on every single claim irrespective of Medicare status. And it's comparing this to query file. And when you're doing query file you can query on whoever you decide you need to query on.

When you're doing production files you need to submit those individuals who are in fact Medicare beneficiaries and where it is liability insurance including self insurance, no fault insurance, and worker's compensation since Medicare is always secondary to all three of those.

(Pat Ambrose): (Barbara) if I could just interject. So on a production query you may submit essentially any individual that you're that you need to find out a Medicare status on.

And then on the production claim input file it's expected that you're just submitting information for Medicare beneficiaries. I just wanted to make that distinction that the query, the production query can have any individual as well.

(William Becker): Yes right.

(Barbara Wright): We have several questions asking whether trust established and liability settlements are they RRE rather than the self insured or the actual insurance policy.

The instructions that are in the current user guide control unless or until we might - if we find some wiggle room there in terms of our discussion on the mass torque, etc. and would have any way to make a trust, an RRE then we would put that information out once we have our conclusion on that.

But right now technically either the insurer or the self insured is the RRE. We've had some questions about defense evaluation payments and them not being ORM. We've seen it praised in the terms of trying to tie it into hospital write offs and saying well we're writing this off.

Because it's really an evaluation on whether or not we're liable. Most of the questions that have been presented to us about hospital risk management those are situations where they're alleging there have been claims, no actions so they aren't formally evaluating that type of claim.

They are doing some type of risk mitigation management so we need to keep the lines clear on that. And as I said the write off for risk management mitigation or risk management is still under consideration. We're having some an increasing number of questions are coming in that are really dealing with the recovery process.

And I am not going to address any of those questions here. We just need to make it clear to everybody that this dedicated mailbox is for Section 111 issues. It's not for recovery issues in general. We are - the agency is looking at as we have the resources to do it to do further outreach about the recovery process in general.

But submitting questions to this mailbox isn't going to get you answers on that issue. We have had although I believe we've addressed it more than once we have at least one more question where they're talking about an insurance policy that has bodily injury coverage as well medical payments coverage.

They explain that this does constitute med pay. However no fault as CMS defines it as well as the liability plan and they want to know when they're reporting which plan type do they select no fault or liability. You need to select whichever is applicable to the particular payment.

Most instances you would be reporting the med pay as ORM for no fault and if and when you have any type of settlement judgment or award or other payment for the liability generally that ends up being a TPOC. But you would be submitting two separate records or one for each type of coverage.

And if you had two drivers involved and you had two policies with your company and they each had both types of coverage then you'd be submitting

four records. We're continuing to get questions that have to do with joint several liability type situations.

We are asked if there's a manufacturing company that settled a dispute and it has four insurers. And each insurer is paying a quarter of the amount with the total of $18,000 so a quarter is under $4500. They want to know whether each of the four has to report the $4500, whether they have to report nothing.

Because it's under the $5000 current limit or something else. Now in a situation where those insurers did not have separate settlements so that their complete liability is limited to $4500 they're each obligated to report the total amount which means they would clearly be above the $5000 threshold.

We've said in the past this type of situation is one that's going to have to be matched up on the back end by our recovery contractor. And certainly we cannot assert a claim that involves more than the total of $18,000 but our thresholds are purely for this reporting process.

The fact that you each have to report $18,000 doesn't mean that we're going to have a recovery claim that's equal to $72,000 four times that amount. We will be limited by the total amount but you do each have to report that total.

We're continuing to get questions about the 12-5 AD dates in terms of the effective date for liability insurance. We have modified the user guide once to make it clear that in the terms of that date we're looking at physical exposure not legal exposure.

So if someone owned property in 1979 a beneficiary was living on it. Let's say there's something toxic on the property the beneficiaries living on that

property continues to live on it through 1980. But the property is sold in 1979 to someone else.

If the first owner gets sued and is asked to pay anything at all the physical exposure continues. It's not an issue of what were the years for the actual policy. So yes reporting would be necessary in that situation. And some of the examples that have been provided to us there's actually examples where the person not only had continuing exposure beyond that.

But it was in fact found that there was harm after that an actual finding. Now in that type of situation there can't be a remote question but we've said what we're dealing with is physical exposure when we're looking at that date not your legal exposure.

So if the policy covered some period short of 1980 that doesn't exempt you from reporting once the settlement judgment award or other payments TPOC exists or if there's ORM. We continue to get some arguments that people would like us to use whatever the industry's date of incident is.

We have explained on previous calls why CMS needs the date of incident that's in the record layout and we're going to continue to require that. We have a couple of either two or three in the last batch of questions that came in that are specifically asking about requiring that ten or asset plans for a representative that's a non attorney.

And we're going to take a look at those questions but as of right now the instructions that are in the user guide still control you're asked in at least one of those whether we could limit the requests for the ten asset plan in that situation, these situations where the representative was in fact an attorney as opposed to a relative or friend.

There is still some misunderstanding of TPOC versus ORM. Some of the incoming questions have phrases such as situations where they're referring to ORM and talking about situations where they're ongoing payments such as the structured settlement.

If you look at the definitions or explanations that we've got for TPOC where a structured settlement you do report a single TPOC and there is explanation in that user guide in the record layout. ORM is typically limited to situations involving no fault or worker's compensation.

And when there's a function or responsibility there for the ORM it should not be reported as a series of TPOCs there you're reporting for example the assumption that a no fault coverage and as you pay individual bills you've reported a single ORM and when the exhaust limit is reached on that no fault insurance then you report a term date for it as well as reporting I believe the exhaust limit.

We had at least one question that seemed to be confusing the $750 threshold for worker's comp ORM as being some how a reporting threshold in total. It is a threshold just for ORM and if that the requirements for that threshold are not met then you're reporting ORM you're not reporting specific dollar amounts.

Someone asked about the TPOC and funding way beyond TPOC date and said they wanted to be sure that if the funding is delayed beyond the TPOC date then the TPOC date itself should not be too populated and that's not true. So if you have a situation where there's funding delayed beyond the TPOC date for some period.

Then you need to appropriately mark that box but you still need to provide the appropriate TPOC date. One other thing is that we're looking at in the context of the mass torques and product liability is it's possible that whatever arrangements we've reached for those attachment cases could eliminate the need for this field at all in which case it could be set up to have a default.

(Pat Ambrose): And just to reiterate if you're reporting a TPOC amount in any one of the five sets of TPOC fields you are always required to also submit the associated TPOC date. And then in some situations you may be reporting a funding delay date as well but not usually. And as (Barbara) said depending on a requirement for the amount before reporting that funding delayed field might not ever be necessary.

And like with any of the fields on the file layout you should always if you're not submitting anything you should always default them to the default value for that particular field type and being a numeric data it would be all - it should be plugged with all zeroes if you're not supplying information.

(Barbara Wright): We also received another question about the representative information. It appears to related largely to ongoing responsibility for medical. It's very old cases. It was asking about whether or not a representative still needed to be reported in these cases if there had been no contacts with the representative.

For example an ongoing responsibility for medical where that responsibility was assumed 20 years ago and there's been no real contact on the case and as far as you know there's no active attorney. And from our perspective if you don't know the current attorney there's no need to report a current attorney.

But if you've got a relatively new claim you've got a situation where you've just assumed ORM or you have a situation where there's a TPOC and there's

been an attorney or other representative involved then you do need to report that. Operator, we can open it up for questions.

John Albert: Operator.

Coordinator: Thank you. We'll now begin the question and answer session. If you'd like to ask a question please press star one. Please unmute your phone and record your name clearly when prompt.

Your name and your company is required to introduce your question. To withdraw your question you can press star two. One moment while we wait for the first question. I currently have no questions in the queue.

(Barbara Wright): Hold on.

Coordinator: Go ahead and press star one if you'd like to submit your question. Okay that takes a while for it to come in. First question is from Catherine Dickenson of Husch Blackwell Sanders. Your mike is open ma'am.

Catherine Dickenson: Hi yes we've had some confusion with some of our clients with respect to the language in the user guide. On the 1988 exposure date it talks and gives an example of exposures that happened after 1988 but in the actual paragraph itself it talks about releasing injuries after 1988.

And typically speaking if we settle a lawsuit we're going to release all injuries up until the date of the settlement even if they only allege exposure before 1988 because obviously we don't want to leave ourselves open to getting sued again. And I was hoping we could get some clarification on that.

(Barbara Wright): As we discussed this somewhat at the most recent mass torque issues CMS the way the Medicare secondary payer statute is written CMS does not have to establish causation. A settlement, judgment, award and other payment whether it's through compromise or otherwise establishes primary payment responsibility.

And we're entitled to recover for what's claimed or released. The industry has expressed the same question you just raised and we invited the industry if they could come up with language that would allow Medicare to protect it's interests and still cover what it was concerned about we were fine.

We haven't come up with any way to do that. For example we could not abide a situation where someone simply oh well I'll amend my complaint since I'm not able to prove exposure after 1980 I'm going to change my complaint to just 1978 and it doesn't matter that I'm releasing everybody for those other years.

We have the opposite concern the insurance industry does. If it's what's actually being claimed then, you know, therefore it was a consideration in a settlement, judgment award or other payment then we need to recover for services that we've paid that are related to that so.

Catherine Dickenson: But then practically speaking you're just going to get everything reported then because no defense attorney in their right minds is only going to partially release a mass torque claim.

(Barbara Wright): Well we're waiting to see whether some of - there was a strong interest expressed by several of the insurers that have been involved in the mass torques group to work on language that could help with this. And we're waiting to see whether we get any comments on that.

Catherine Dickenson: Because certainly I know I represent a lot of clients, corporations that are sued in mass torques. And I think we would be interested in submitting proposed language too if you guys would be amendable to that.

(Barbara Wright): Any one who would like to submit language can submit it to the resource mailbox you submit questions to. It helps if you identify what you're addressing in subject line.

Catherine Dickenson: With respect to the mass torque group is it mostly insurers or do you have any representation from corporate America?

(Barbara Wright): There are some corporations in it. There's various groups which have members that are both corporations and industry. There are some entities that are purely agents for reporting purposes. There are more than one law firm. There's about 50 some people on the call normally.

Catherine Dickenson: Okay. All right well we may submit some language then thank you.

Coordinator: Our next question comes from (Richard Schultz). Your line is open.

(Richard Schultz): Yes (Richard Schultz) with Fireman's Fund Insurance. Relative to the partial settlement of ongoing responsibility for medical so assume we have a claim and we're paying medical but we're settling part of it like perhaps a claim for attendant care.

Do we fill in an ORM termination date without partial settlement or do we leave ORM termination date open because we're still paying for some parts of medical?

(Barbara Wright): You would leave the ORM termination date open ended meaning with zeroes until your ORM for that claim is entirely ended or terminated. And you may send an update record to report a settlement amount in a TPOC field when you send that update you would still be reporting the record with the ORM indicator equal to Y. And the ORM termination date zeroes and then the TPOC amount and the TPOC date.

(Richard Schultz): And as a follow up question if we're also settling indemnity you want to know the full amount of the indemnity and the partial medical settlement as the TPOC amount.

(Barbara Wright): In terms of indemnity I hesitate to say anything right now till we look at where we're going with the current language about any periodic indemnity payments. I don't want to say something that's wrong in context of our current thought on language.

(Richard Schultz): When do you expect to have more on that? Because we're trying to put training together for something that's effective in two months.

(Barbara Wright): We're trying to wrap up the current policy issues within the next few weeks.

(Richard Schultz): All right thank you.

Coordinator: Our next question comes from (Cathy Stroegle). Your line is open from Montana State Fund.

(Cathy Stroegle): Hi this is (Cathy Stroegle). We're a worker's compensation insurance carrier for the State of Montana. I just have a question about delayed funding dates. Many times when we do a settlement we settle the medical with the medical aside but many times at the time that it has been proved either by the court or

the Department of Labor we do not have the approved set aside from Social Security.

And that may come down a couple of months later. Is that an example of a delayed funding? Because we wouldn't pay the settlement amount until we get the approved set aside.

(Barbara Wright): You've got a definite delay in the funding there so yes I do think that's an example of delayed funding.

(Cathy Stroegle): Okay great that's what we needed to know. Thank you very much.

(Barbara Wright): Although I would say if you're looking for an approval of a Medicare set aside you're not getting it from Social Security that is a process that CMS has a review process for proposed worker's comp set aside amounts. Social Security does not.

(Cathy Stroegle): Yes you're exactly right. I misspoke I'm sorry.

Coordinator: Our next question comes from (Shenko Reaja), (Airwea) Travelers. Your line is open.

(Shenko Reaja): Yes thanks. Actually we have got registered RIE some time back, you know, even before we'd received a latest user guide. So when I do the best (unintelligible) I got a bounce back saying that I have to follow the naming convention (unintelligible) not as per the user guide. So if that the case now will that be any correction of should happen on the profile? And if so what is the process?

(Barbara Wright): I'm not sure if I understand the question so you're trying to upload a file and you've got an error that your file was not - what was - did you receive an error while you were uploading the file?

(Shenko Reaja): Right the error says that I need to follow the naming convention as per the profile not as per for user guide. And that - basically when (unintelligible) file name which is given to us looks like it's for the GHP and basically we are a non GHP.

(Barbara Wright): Are you sure that you registered your our EID under - it sounds to me like when you registered you might have registered as a GHP rather than a liability no fault or worker's compensation RRE. I think that's your problem. What I'd recommend you do is contact your EDI representative who's assigned to you and the contact information should be on your profile report.

And they'll provide you with instructions on fixing your RIE I.D. Remember there are at least a limited number of entities that will be RREs for GHP and also be RREs for non GHP. If that's the situation they do have to have separate RRE I.D.s for GHP versus non GHP.

(William Becker): And they have to send query files, you know, separately as well for GHP versus non GHP.

(Shenko Reaja): Right. So (unintelligible) before we get the latest user guide it looks like we have got registered the earliest and we got GHP (unintelligible). It should be a non GHP then. So basically what I understand is I need to talk to an ADA to get that changed right.

(Barbara Wright): Yes.

(Shenko Reaja): Okay thanks.

Coordinator: Our next question comes from (Donna Bushard) of Farm Bureau Insurance and your line is open.

(Donna Bushard): Good afternoon. As long as there weren't a lot of questions I was wondering if you had discussed the termination date, exhaust date issue that I sent a follow up email on from our 10/6 call?

(Barbara Wright): If it's not one of the ones I went over at the beginning of the call then it's one that's still being discussed internally here.

(Donna Bushard): Okay. I'm really bumping into this one really bad.

(Barbara Wright): What is the question that you have?

(Donna Bushard): Okay so right now when we've talked about this at several calls where if the injured becomes deceased the termination date is set to the deceased date or 30 days from the date of incident if the deceased date is within 30 days.

We talked about setting the exhaust date to the deceased date. And then we talked about it again where I pointed out that if the injured becomes deceased we can subsequently exhaust benefits and what to do with those dates. So I sent an email and what I was...

(Barbara Wright): I think this is one that we maybe considered more technical as opposed to a policy one. I do now that you're describing...

(Donna Bushard): Well I would disagree because as a policy do I send you an exhaust date when I'm deceased?

(Barbara Wright): No whether its policy or technical the reason I gave the answer I did was if you had had one that was truly a policy one I didn't address them because those are still under discussion.

I don't know the complete status on the one you're brining up for tax benefit my understanding of your question was we don't want to put in a term date of the beneficiary's.

You were concerned whether a term date of the beneficiary's date of death would cause problems with claims that were processed subsequent to that date. Correct or not.

(Donna Bushard): No it was if I have to send an update after I have terminated and told you that where the exhaust date is now we've actually exhausted.

(Barbara Wright): Yes that's not a problem. If you have reported a record with ORM subsequently reported an ORM termination date you may still send an update to that record. On that update record you may fill in the exhaust date if it's a - now the exhaust date only refers to no fault claims.

(Donna Bushard): Yes.

(Barbara Wright): You may change your ORM termination date if you deemed that that needs to be changed. And in fact if ORM, you know, not for example in the case of the injured party's death but you may send an update to change the ORM termination date back to all zeroes to indicate that, you know, actually I should not have terminated it and it's reopened.

(Donna Bushard): Okay. So I think what I heard was if I originally send a termination date if I send another record with a different termination date you're not going to have a problem with that.

(Barbara Wright): No we will not.

(Donna Bushard): Sweet now so the only other outstanding question I have is from two conference calls ago we had discussed putting the actually deceased date into the exhaust date field when they were deceased within 30 days of the date of incident. And I'm hoping that that has been retracted where we said no I don't need to value the exhaust date with the real deceased date.

(Barbara Wright): I don't recall the deceased date being a part of that conversation. But there is currently an edit in the system that we're struggling to work around because we have to post this information on other Medicare databases. And so there is an edit that says that we can't accept a termination date that is less than 30 days from the date of incident.

And so we did instruct you to be sure in a case where ORM terminated within 30 days to actually plug your ORM termination date to 31 days subsequent to the date of incident. And if it is a no fault claim when you're submitting that update record or it could be all on this first add record for that matter.

What we wanted in the no fault the date the no fault policy limits were reached was the actual date. There's no such edits about the 30 days and so on and so forth with the no fault the date that the no fault policy limits were reached. So you can put in an accurate date there.

(William Becker): I think part of her concern was someone who was deceased is do they have to submit as long as the no fault was still open and was paying through the day of death do they have to submit a termination date at all.

(Donna Bushard): I think yes.

(Barbara Wright): Well that would be the most accurate reporting but I mean then the concern became if you run into a situation where that date of death is less than 30 days from when it was assumed what can they put there since the date of death, you know, violates your 30 day rule.

(Donna Bushard): And do you need the date of death now.

(Barbara Wright): No.

(Donna Bushard): You don't need the date of death then I think I'm good.

(Barbara Wright): No we know - we are notified by Social Security Administration at some point in time subsequent to a Medicare beneficiary's death. And date of death is not a field on the claim input file nor are we anticipating that you would routinely use that date.

It really is a matter of reporting when ORM terminates. However in the case that it terminates within 30 days you have to plug it at 31 days subsequent in order to get around this issue right at this time.

(Donna Bushard): Okay well thank you (Pat) and then the web site that you gave to the ICD9 codes. Is that in the user guide?

(Barbara Wright): Yes it is.

(Donna Bushard): Okay thank you. You guys have a great day.

(Barbara Wright): And (Pat) could you list this issue for the technical call because I thought we were going to address all the update issues then so there might be people that want to know about this.

(Pat Ambrose): Yes absolutely I saw the question come in and I'll make sure we rehash it in the technical call.

(Barbara Wright): Operator.

Coordinator: Our next question comes from the line of (William Thompson), The Hartford. Your line is open. (William Thompson), are you on the line?

(William Thompson): Yes I'm here. So my question is having to do with the topic of some sort of non traditional lines like ENO and DNO and point of practices. And I think we've discussed those before.

But I am going to submit some proposed language about whether those may or may not need to be reported if there's no injury. But I'm wondering if you want us to focus on suggest the changes to the user guide or to the CFR or both or how you want us to kind of approach it.

(Barbara Wright): The only thing we can affect right now is the user guide. Changes to the CFR have to go through the whole rule making process and what's in the user guide is not considered a regulation. It is a CMS user guide so I think for the time being right now you should be focusing if you have a concern on the language we have there with what we have.

Where that's based on statute and regulation then it's likely we won't be able to change it unless, you know, there's some tweak. But no don't routinely submit comments on existing regulations right now.

(William Thompson): Okay all right. Okay I see your point and I guess a part of the problem is if you put something in the user guide it's inconsistent with the CFR then I suppose it's not all that effective.

(Barbara Wright): We have to be our own regulations.

(William Becker): Yes we can't - we're not making things up through the Section 111 so if there's something in the user guide that you think, you know, contradicts existing regulation then we of course want to know about it.

(William Thompson): Yes. Okay thank you very much.

Coordinator: Our next caller is from (Scott Huber). Your line is open sir.

(Scott Huber): Thank you. I submitted an email to everyone earlier. I just wanted to follow up to see if you had made a decision on (unintelligible) health insurance claims if they are GHP or non GHP.

(Barbara Wright): The person who was working on addressing that is not here today.

(Scott Huber): Okay. That was my only question thank you.

Coordinator: I apologize (Scott) was from Gould & Lamb. Our next question is from (Paul Schaffer) of Captive Management. Your line is open.

(Paul Schaffer): Hi just a quick question. This is related to the RREs with a foreign address. What's the expected date for the registration web site to be fixed so that we can register?

John Albert: We're actually considering some possible alternate methodologies for registering but I would imagine that would be fairly soon. Again we're looking for the next couple of weeks to get the last of this stuff wrapped up so.

(William Becker): Right we want to move as quickly as possible with the foreign registration issue. It's as John pointed out we may not be going through the electronic registration process on this one that we are using for everyone else. We don't know for sure yet but that depends. And until we know for sure we're not going to give you much more information.

(Paul Schaffer): Okay.

(William Becker): They're telling us right now that we shouldn't be saying anything about - I suspect we shouldn't be saying anything more than we already have.

(Paul Schaffer): Okay. Thank you very much.

John Albert: We are very aware of the issue and trying to resolve it as quickly as possible though.

Coordinator: Our next question comes from (Scott Omstead). And your line is open.

(Scott Omstead): Hi. Yes I have a question about permanent partial impairment payments on worker's comp claims. Are those reportable as a TPOC or do they just fall under regular ORM reporting?

(Barbara Wright): Again the person who is working on that particular issue is not here today.

(Scott Omstead): Okay. I didn't have any other questions other than that.

John Albert: We're sorry we can't help you today.

(Scott Omstead): All right.

Coordinator: Next caller is from (Misa Koo) from Commerce Insurance.

(Misa Koo): Hi thank you. I was calling because we have - we're working on updating some of our historical data just the 2009 ORM claims just to make sure that we have the socials and that we can get the HICNs from the customers.

When is the appropriate timeframe for us to or when are we allowed to use the template that was provided by CMS before after we've done all the routes to try to obtain the HICNs from the customer? Is there a timeframe for when we can start using the form?

(Barbara Wright): You mean as opposed to waiting until next year...

(Misa Koo): Right.

(Barbara Wright): So you can use it now as we said we do expect that to be, you know, like your final line not your first question to the person not just routinely sending it out but you've said you've got a process. Yes go ahead and use it.

(Misa Koo): Okay that was my only question. Thank you.

Coordinator: Next question is from (Mith Lunam) from (John Manville). Go ahead.

(Mith Lunam): Hi I need some clarification on Field Number 15 on the claim input form where you're asking for the E Code for the cause of the injury or accident. We have a large group of claims to report that were caused by asbestos exposure. And I don't see anything in those E Codes that covers that.

(Barbara Wright): We'll have to take a look at that. I saw that was one of the questions on the incoming I think. I don't know whether it came from you.

(Mith Lunam): It did.

(Barbara Wright): So it is on the list to be looked at.

(Pat Ambrose): Yes we'll try to address that at the next technical call.

(Mith Lunam): Okay how do I follow up when you come up with an answer to get the answer?

(Barbara Wright): It's on our list so it's going to be discussed at the next call if we have an answer. And it would - if there's some reason there isn't any viable code then we would have to address that in some type of an alert.

(Pat Ambrose): Alert or the user guide update.

(Mith Lunam): Okay. In the mean time should I put it into 924.9 which is like another miscellaneous?

(Pat Ambrose): Well that Field 15 has to begin with a letter E. It has to...

(Mith Lunam): Right it would be E924.9.

(Pat Ambrose): Right. As long as that is not on the list of insufficient codes that is in Appendix H I assume that would work.

(Mith Lunam): Okay.

(Pat Ambrose): But you have to check Appendix H because - yes okay.

(Mith Lunam): Okay.

(Barbara Wright): Your description sounds like it might be one of the ones that's in the insufficient.

(Pat Ambrose): Yes it does. I don't know for sure.

(Mith Lunam): Okay I'll check that. Can you clarify for me also when you receive a response code, an error code which is Code No. 51 does that indicate that you could not find the individual in your system or that you found them and that they are not Medicare eligible?

(Pat Ambrose): It means that we did not match them to or match the data that you sent to a Medicare beneficiary on our file. So, you know, as long as the data that you sent was completely accurate the assumption you can make is that that person is not and won't soon be a Medicare beneficiary.

Now you want to make sure that you continue to monitor those individuals after if ORM continues because they might become a Medicare beneficiary in the future.

And also make sure that your query or your, you know, that you're submitting your information subsequent to assumption of ORM and subsequent to TPOC date. So, you know, if anything new happens or if ORM continues you need to check their Medicare status again.

(Mith Lunam): Okay is there some way that we're going to know if, you know, we've transposed two numbers in their social security number and that's the reason you can't find them.

(Pat Ambrose): No unfortunately there's no way for us to provide you with that information.

(Mith Lunam): Okay so but in both of those instances the code we would get back is 51.

(Pat Ambrose): Yes if you sent incorrect information.

(Mith Lunam): Right.

(Pat Ambrose): And we didn't match you would get a 51. If you sent correct information and the person is not a Medicare beneficiary then you would get a 51.

(Mith Lunam): Okay so if we get that code back obviously we want to double check and make absolutely sure that the information we sent was correct.

(Pat Ambrose): I'm glad you said it.

John Albert: Yes especially if they're over 65.

(Mith Lunam): Right.

John Albert: Because, you know...

(Barbara Wright): And two of the most common errors that we've seen in internal runs that we've done for other purposes is an error in the first name because (Elizabeth) has been called (Betty) her entire life but Social Security has her as (Elizabeth) so...

(Mith Lunam): Right.

(Barbara Wright): And also for some reason we see more errors in terms of the day of the month for birthday as opposed to like the month and year itself.

(Mith Lunam): Okay. So if the person - if I know that they're over 65 and I get a 51 clearly I want to do something to verify that information and not just assume that they're not Medicare eligible.

(Barbara Wright): Right and...

(Mith Lunam): Okay.

John Albert: And the makers would say yes.

(Mith Lunam): Okay.

(Barbara Wright): And if you're for example worker's compensation and you know that the person has been - if someone's been - had a claim that's like 10% disability they're probably not someone that's eligible for Social Security disability because that requires 100% disability.

(Mith Lunam): Right.

(Barbara Wright): But severity of the injury can also help you make some gauge too. Is it someone who could be expected to be totally disabled? And if they're under 65 even if they're totally disabled right now there's a two year waiting period from when they become eligible.

(Mith Lunam): Okay. Okay great. Thank you.

Coordinator: Our next question comes from (Michael Gardner) from CorVel Corp. Go ahead.

(Michael Gardner): Yes it's (Mike Gardner) from CorVel. I had a question about RRE registration. I've got a company with multiple NAIC code subsidiaries. And they are owned actually duly owned by two sort of roll up companies. And I was curious how that - how those subsidiaries could be assigned if you had two split owning companies?

(Pat Ambrose): The most important thing is that you register according to, you know, who is the RRE and then how you will submit files. You can use the same NAIC company code for multiple RRE I.D.s.

And when it comes to the subsidiary information on that second page of the new registration step you do not have to supply all of that information if it is causing you difficulty. You may, you know, essentially skip that entirely.

(Michael Gardner): And I should add a clarification that our goal is to try and consolidate it into as few RREs as possible.

(Pat Ambrose): Yes as you should. So let's suppose that you've consolidated it into two reporting entities RRE I.D.s. You just need to for each of those RRE I.D.s you

just need to submit an NAIC company code for one of the subsidiaries that is reflected by that particular registration and subsequent file submission.

We're just using that NAIC information for validation in trying to make sure that everyone who has - who should be registered has registered. And of course a lot of entities don't even have an NAIC company code.

(Michael Gardner): So if one of those subsidiaries I did not list on the registration specifically is writing a claim is covering a claim and I report that tax I.D. in my report even though you don't have it on the registration it'll go through okay.

(Pat Ambrose): Yes absolutely. And I'm glad you brought up the tax I.D. because that is also collected of course at registration. You may use one tax I.D. when you register and again do not have to provide all of your tax I.D.s on the subsidiary page of registration.

However when you go to report your claim input file and of course the reference file the TENs that you use on those files are really the ones that we care about as far as working with your data subsequently.

(Michael Gardner): Okay good to know. I do have one follow up comment if that's okay. The - you guys have brought up the difference between SSN and HICN on many of these calls. And you brought it up specifically today. And I want to point out and correct me if I'm wrong.

But the HICN is typically an SSN with a letter code determining type of Medicare claimant. So the problem still remains there with the industry of no matter what you have to collect the SSN of somebody in some format and supply it along or the system won't work without it.

(Pat Ambrose): Well it might be a matter of semantics but you are correct that most frequently the HIC number is derived by the Social Security Administration and making use of an SSN followed by a suffix. So however it is actually a HIC number and separate from the SSN.

(William Becker): Yes there's a couple of other things too but (Pat's) absolutely right. Remember too that there are about 25 different suffixes that can be used. And so you've got to be very clear about that. It's not just the SSN if you're reporting HICN.

John Albert: The other thing is that for just in general terms for everybody to understand is that the CMS Medicare Program doesn't actually invent the HIC numbers. Those are supplied to us by the Social Security Administration. And those are the numbers that they give us to use so that we can identify our Medicare beneficiaries. We don't have any control over that process. And there's nothing we can do about that process.

Absolutely correct all of you who understand that there's a relationship between the SSN and the health insurance claim number and that's why there's that relationship. It's not a relationship that we have ourselves constructed. It comes to us because of our relationship with the Social Security Administration.

(Michael Gardner): Yes I absolutely understand. My point is just that the issue of, you know, difficult of collection of SSN or the HICN still exists even though the SSN is not a required field. Because you're still dealing with that data privacy. You know, people that don't want to give up their SSN are also not going to want to give up a HICN for the same reason (unintelligible).

(Barbara Wright): We understand your concern. The one thing we'd reiterate in terms of anyone who's not as clear on the use of SSNs with suffixes for HICNs is when you do your query file the only thing that's going to be matched on if you submit an SSN is the SSn.

If it's - if someone has benefits based on their spouse's record so that the HICN is that let's say a wife has it based on her husband's record. The HICN would be the husband's social security number with a B. If you submit just the husband's SSN it's not going to match to that woman because the SSN belongs to him.

The only way that's going to match on her is if you submit the HICN or you submit her own SSN. So, you know, don't arbitrarily lock off any letters at the end of these and assume it's still going to match to the correct person.

(Michael Gardner): Absolutely I hope I didn't confuse that issue for anyone else but thank you.

Coordinator: Our next question comes from (Joel Rogers) from State Farm. Go ahead.

(Joel Rogers): Well I was just wanted (Bill) to restate that web site that he mentioned at the beginning of the call.

(Pat Ambrose): Is this a web site with the ICD9 codes.

(Joel Rogers): I think that's the one.

(Pat Ambrose): Yes I'll try to read it off slowly. It is www.cms.hhs.gov/icd9providerdiagnosticcodes/06_codes.asp. What might be

easier for you is to look in the user guide for liability Section 111 liability no fault and worker's compensation reporting.

The user guide can be found on the end GHP page or tab of www.cms.hhs.gov/mandatoryinsrep. And in that user guide it lists that web site that I tried to read off with the diagnosis codes.

(Joel Rogers): Thank you.

Coordinator: Our next caller is (Robert Isler) from Aon Global Risk. Go ahead.

(Robert Isler): Thank you for taking my call. We have a client who has already registered part of the program but they've had a very unusual situation. They have an auto liability program and a general liability program both with a large deductible.

And the claims are handled by a third party administrator. Their first named insured who has a contract with BPA and also have funds all the claims. But they have over 100 named insureds, 100 of these two policies and none of these named insurers are subsidiaries.

And trying to avoid registering over 100 named insureds that are not subsidiaries we've told them right now to just name the first named insured who also has a contract with their carrier in the TPA. Are we on the right track?

(Pat Ambrose): Could you hold on a moment?

(Barbara Wright): We're not sure we understand what you're referring to. If you're talking of property casualty...

(Robert Isler): Yes.

(Barbara Wright): And your named insured so your policy holders.

(Robert Isler): Right. They've insured - well we're not the carrier. We're their broker.

(Barbara Wright): You don't register the policy holder.

(Robert Isler): Well the reason I said the policy holder was because they are the RRE. They're funding all the claims and I'm just using some terminology interchangeably here. You know, we've got one company...

(Barbara Wright): Are you talking more like a fronting situation?

(Robert Isler): No they're all - no there's no fronting going on. It's not a captive or anything of that nature.

(Barbara Wright): You're saying that a company is routinely buying insurance but doesn't use that insurance.

(Robert Isler): No they have the insurance. They just - it's a very unique situation with for lack of a better word say is a family situation where you have a bunch of other companies which we've got the carriers to agree to consolidate all of these named insureds under one policy, one policy would be auto and one policy would be a general liability instead of issuing, you know, 200 policies.

And the first I'm using the word the first named insured, the first company who has contracted with a third party administrator to handle all these claims, you know, is also the first named insured on the insurance policies. But each

policy does have a listing of these over 100 additional named insureds that are no subsidiaries. They don't all roll up to one holding company.

(Pat Ambrose): But in this scenario do you have a property casualty insurer carrier who is writing these - underwriting these policies?

(Robert Isler): Yes.

(Pat Ambrose): They are the RRE mostly likely.

(Robert Isler): They don't fund the claims. They got a very large deductible.

(Barbara Wright): If we're dealing with the deductible situation when the final RRE rules come out however the deductible needs to be handled that's going to drive who's the RRE. So yes there may be situations where you may have multiple ones that have to register separately.

You can't - if there's an insurance policy and there are three different entities that are insured and they each have separate payment obligations then potentially you've got three separate RREs. One RRE can't assume the reporting obligation of another RRE.

(Robert Isler): Yes. Now well most of these companies don't have any claims so we know the user guide there's not need for them to register at this time.

(Pat Ambrose): True.

(Robert Isler): So when will the final rules about the deductibles come out?

(Barbara Wright): Again we said we're trying to wrap all that up within the next couple of weeks.

(Robert Isler): Okay. All right.

Coordinator: Our next question comes from (Elaine Harding) of Sisters of Mercy Health. Go ahead.

(Elaine Harding): Yes you may have already covered this one discussing the query. We submitted a query and we came back with a person who did not show up with a HICN number. We being a healthcare organization were able to say okay she's of age look at the record.

Does she have a HICN number that she was admitted with and yes she did? So - and it is her spouses. We've verified all this information so how can we identify people if we're not a healthcare organization?

I mean I have to step in. But how are we going to be able to know for sure if they come back they're age eligible. But the benefits are not under their SSN. How are we going to know for sure whether someone's a Medicare beneficiary?

(Barbara Wright): If you have the correct SSN and the correct data for the other elements then even though she has benefits under her spouse's record when you submitted her SSN it should have returned the correct HICN. If you actually have a situation where you know that all four of those elements were correct I think we'd like to see that example to know that it's not showing the HICN.

(Elaine Harding): All right. I will - I did verify it once. I will verify it again and if not I will send it to you.

(Barbara Wright): Another one that's not an uncommon mistake particularly for women who are 65 now or were 65 several years ago is that they never change their last name with Social Security.

(Elaine Harding): Right.

(Barbara Wright): But, you know, generally we have a tie through so.

(Pat Ambrose): I want to interject about sending your issue. Please contact your EDI representative. We don't want anyone sending...

(Elaine Harding): Right.

(Pat Ambrose): Social security numbers and other, you know, HIC numbers and private information to the research mailbox.

(Elaine Harding): Yes I understand that. And we have talked to the EDI rep who said he wasn't quite sure what was going on but I will get back in touch with him.

(William Becker): Yes just give the information to the rep that's him and the rep will be able to give it to us through a closed system.

(Elaine Harding): Okay.

(Barbara Wright): And if you would make sure to tell him (Pat Ambrose's) name.

(Pat Ambrose): Oh sure I can help out.

(Elaine Harding): All right.

(Pat Ambrose): But just to clarify when you send or we have this person stored on the Medicare beneficiary database with their own social security number and their own HIC number. Now that HIC number might be based on their spouse's SSN but it has a different suffix than their spouse's HIC number.

So if you send in a query with the individual's social security number and all the other - and you get a match on three out of four of the other remaining fields you should get a hit and should get the most current HIC number we have on record.

(Elaine Harding): Okay. And if I can one more quick question about transcripts. Do we know when we'll be able to get the August/September transcripts?

(William Becker): Are they posting the transcripts?

(Elaine Harding): I've not found them.

(Pat Ambrose): There's been a delay. And I...

(Barbara Wright): We will go back and check again. The last I had heard was that they should - that they were supposed to be up within two weeks. I thought I heard that about a week ago. As we've said on some of the calls we have an issue with how CMS sets up its web sites.

We are - it's not controlled by our group. There's a limited number of documents that can be placed on the sites for download, etc. And the person who works on this web site has been working on getting what's called I guess a dynamic listing that will allow us to post all of them without running into this over crowding issue. So we are trying to make sure everything's up there.

(Elaine Harding): All right. Thank you very much.

Coordinator: Next is Fireman's Fund Insurance (Barbara Whitfield) go ahead.

(Barbara Whitfield): Hi (Barbara). I'm calling because of a reference you made in your preliminary statements which I assume alluded to what's going on in the Wayne County Courthouse in Michigan where there is a law firm up there that's trying to intercede as an RRE for all the asbestos claims as opposed to us.

And my question to you is, are you planning on doing something about this? Are you planning on being actively involved in trying to stop this aberration of RRE rights?

(Barbara Wright): Well first of all I wasn't making any reference to anything that's going on and I think you said Wayne, Michigan.

(Barbara Whitfield): Wayne County Court, Wayne County, Michigan.

(Barbara Wright): I know but what I want to make clear is I was not making any reference to any specific case whatsoever. If there's something going - I mean...

(Barbara Whitfield): I will send you the documents related to this because it's been published.

(Barbara Wright): Well no but let me finish what I was going to say. CMS does not endorse or advocate any particular entity or company as an RRE. If the parties to a particular case agree in a settlement or otherwise that they're going to use a particular entity as their agent I mean that doesn't control the RRE.

The RRE is the insurer or the self insured entity. It's not someone else that's being used for reporting purposes. That is - that per our current instructions. So we have no instructions that say that Joe Blow or anyone else is an RRE just because there is a court case.

(Barbara Whitfield): Okay and I understand what an RRE is and what the reporting responsibility is. But this particular law firm that's trying to super impose themselves on the court system and wants to become the RRE for all of these claims that settle. And it sounds to us at least that the court is going along with this proposal.

(Barbara Wright): Well the RRE is defined by our user guide and right now the RRE is the insured or the self insured. We've had proposals from a number of individuals, insurance companies around the country that want to say in what they're calling towards a court action that any time money is put into a trust that that trustee is the RRE or that the trust is the RRE. We have not agreed to that position.

We are listening to the industry's concerns or suggestion in this area. But I need to keep reiterating that we have not found a way legally to say that the trust is the RRE at this point. We're still - we're willing to explore anything to cut down the number of RREs, etc.

But ultimately we're bound by the statutory language. And if there's any misunderstanding out there that I or anyone else on behalf of CMS has said that trusts in this type of litigation or settlement funds or anything else are the RRE at this point I'm asking everybody to remove that concept from their mind. Because we have not endorsed that.

(Barbara Whitfield): Thank you very much because we don't want you to endorse that. So I'm glad to hear that. That that's not your position it's just that I think we're going to have some problems and you won't have them but we will in trying to stop this kind of idea from going forward. Anyway thanks for your time.

(Barbara Wright): You need - you also need to distinguish between who's the RRE and who is the agent of the RRE the self insured or insurer can appoint whomever or whatever entity they want as an agent.

(Barbara Whitfield): A self insured yes but not an insured party who we are paying the claim on behalf of right.

(Barbara Wright): Not disagreeing.

(Barbara Whitfield): All right.

(Barbara Wright): It's the RRE that makes the choice.

(Barbara Whitfield): That's right okay thank you very much.

Coordinator: Next is (Dan Ounmatt) from (Cunningham & Butler) claim. Go ahead.

(Dan Ounmatt): Thank you. I have a question regarding the social security number collection and this was alluded to at the start of the call. And I just need additional clarification. I understand (unintelligible) but in live situation we're relying on the social security number to run through the query process.

I don't know if you have any other thoughts on that. I know there was another alert form that was provided. Any other thoughts you might have in regard to

social security numbers collection there of and running those through the query process would be appreciated.

(William Becker): No. Yes and no I mean you need to run through the query process. You can use a Medicare I.D. number that's the preferred number.

(Dan Ounmatt): Yes.

(William Becker): I you don't have a Medicare I.D. number you can use a social security number that's a secondary number. If you provide the SSN or the HICN with other personal identifying information and we match on a person on our database we'll let you know.

The requirement for Medicare is the HICN. The secondary number we can use to match, to find beneficiaries through the query process is the SSN. As we've talked about here on this call there are a variety of issues around using the SSN what will happen if it's not a correct SSN, etc.

Basically what I said in the beginning of the call was that there isn't anything in the language of the Section 111 law that requires anyone to collect social security numbers for the purposes of reporting them to us through Section 111.

You do need under the law because it's a part of MST law to tell us about anybody who you know is a Medicare beneficiary or who you should know is a Medicare beneficiary. The collection and use of SSNs gets you help with the or should know part of that. But as I said before strictly speaking there's nothing in Section 111 law that insists on it.

(Dan Ounmatt): Yes (unintelligible) as far as the HICN number I mean if somebody gives us a HICN number then we can pretty much assume that they're a Medicare beneficiary. But the predominant amount of claims we have is we don't have individuals with HICN numbers. We have a need to collect a social security number to run through the process.

John Albert: If you are, you know, in terms of your outreach efforts I mean one of the things that we're trying to do in addition to the, you know, we have the model language out there that actually has a copy of the Medicare card on it. But again we encourage people to point folks to the Section 111 web site first of all.

And we are in the process of developing more materials that will be directed toward, you know, the average citizen who just wants to know more about this process such as possibly a beneficiary tab on the web site, etc. that again should give more plain language information about what this is. Why am I being asked by this liability insurer for my SSN? You know, that kind of stuff.

(William Becker): We encourage individuals to cooperate with insurers who are attempting to see if these individuals are Medicare beneficiaries. We can't insist that they provide SSNs to insurers but we encourage their cooperation. That's as much as we can do at this point.

(Barbara Wright): Also make sure that you're making full use of any materials that are submitted with the claim to the extent in a no fault situation. You get a bill from a provider some times the claim will have the Medicare number there as well.

I know that people have said depending on the type of situation they don't necessarily see actual bills they're resolving without going to that depth of research.

But hospitals won't - hospitals or medical providers who are RREs won't necessarily be the only one's that are seeing some of the claims that are supporting or seeing some of the medical bills that are supporting the claims. And if you have them please be sure to look at those to see whether or not there is any HICN information.

(Dan Ounmatt): Thanks.

Coordinator: Our next question comes from (Keith Bateman) of TCI go ahead.

(Keith Bateman): Hi this is (Keith). I want to follow up again on HICN social security number issue. Obviously Section 111 places a obligation, affirmative obligation to determine whether someone is a Medicare beneficiary.

But assuming that someone is and you (Barbara) had said that under the law that the person has an obligation - they're applying for Social Security has - I mean for Medicare has an obligation to cooperate.

However most of the people that we're dealing with are not going to be people that have applied for Medicare. What legal basis is there for us asking for either a HICN or a social security number from them?

(William Becker): For you to comply with MST law you can ask for a HICN and if an individual you're asking for that HICN is a Medicare beneficiary they have to give it to you. If they are not a Medicare beneficiary you can ask for their SSN.

(Keith Bateman): And they have no obligation to provide it.

(William Becker): Correct.

John Albert: If they're not a Medicare beneficiary then no they don't have to provide the SSN.

(William Becker): Right.

(Keith Bateman): And so that means for those cases that are long term ongoing responsibility for medical and if they say we don't have a HICN then we have no legal basis for continuing to do queries.

(Barbara Wright): If you have the SSN you can query. If you don't have it you can't.

(Keith Bateman): We don't have any basis for continuing to ask them for that information.

((Cross talk))

(Keith Bateman): I'm just trying to get clear as...

(William Becker): Come back from another perspective view if you - you are obligated under MST to tell us about folks that you should know are Medicare beneficiaries.

(Keith Bateman): Section 111 we have an affirmative duty to...

(William Becker): Right.

(Keith Bateman): Make a determination.

(William Becker): Right. As - we really can't go any further down this road because, you know, there isn't anything else that we can probably tell you about this. You need to tell us about folks who are beneficiaries or you should know are beneficiaries.

You need to ask folks that you're servicing or providing coverage to if they're beneficiaries or know that they're beneficiaries.

And if they are they have to tell you. There's a variety of ways for you to ask us if they're beneficiaries based on supplying SSN and other information. But that's as much as we can tell you on this issue I'm pretty sure. Everyone here is nodding their heads yes so.

(Keith Bateman): Follow up question on that. If I am a small claims volume company but I have the option that instead of doing a query sending a letter on a regular basis every two years assuming we're talking about somebody young enough that they wouldn't qualify on the basis of age to see whether they'd become - they're on Social Security, disability now or enrolled in Medicare by sending them a letter asking them for a HICN number every two years or every year rather than trying to set up a query using the query system.

John Albert: I mean there's nothing preventing you from doing that. You know, we would encourage folks to use electronic process. We recognize that there are going to be some very small entities out there registering for Section 111 and that as I think I've said on some previous calls we're exploring alternate reporting methodologies for those very small occasional reporters. But right now the process we have is the process we have.

(William Becker): Yes and you've got that's a very worthwhile thing to do is to ask individuals if they have - if they've become Medicare beneficiaries that's certainly something I would recommend anybody who's going to have to report on Medicare beneficiaries to do.

(Keith Bateman): Okay thank you.

Coordinator: Our next question comes from (Laurie Dusharm). Your line is open.

(Laurie Dusharm): Hi thanks for taking these questions. I'm patiently waiting for the RRE guidelines because I have a number of work comp deductible policy holders that want me to take a final position or temper to take a final position on who is the RRE. And what I've informed them is I need to wait for the finalized guidelines.

The problem that I'm having is there are some brokers who are apparently part of the mark coalition who are telling these clients and myself that I am way behind the market place because CMS already has communicated to them what some of the final guidelines are. And if that's the case I would appreciate if you'd give those to the rest of us.

(Barbara Wright): No let me correct the statement on that we - the last time we met - we meet with various groups and we appear at various conferences. And Mr. Albert, John Albert was at the last time we spoke to (Mark). And we made it very clear that we were not giving any final advice.

We discussed things the same way that we discuss with you. There have been times where we've said this is where CMS is leaning, etc. But we've made it clear to everybody that what's on the web site is the only guidance. And we have no other final guidance.

And you've heard us say over and over on these calls we want to wrap it up as soon as we can but our whole intent with this dedicated web site and one of our strong goals is to make sure everybody gets the same advice at the same time. So no we have not given - if they say they have final information we would say that's not true.

John Albert: That's not true at all.

(Laurie Dusharm): That's all I need to hear and when the transcripts out there it'll be helpful because we are being challenged on that so.

John Albert: Yes well I'll say it right now for the transcripts again all official communication regarding Section 111 reporting requirements appear first and only on the CMS mandatory insurer reporting web site end of story. Anyone who claims to have privy to final decisions before they're published is not telling the truth.

(Laurie Dusharm): Okay thank you.

Coordinator: Our next question is from Scott Sasjack with Nixon Peabody law firm. Go ahead your line is open.

Scott Sasjack: Hi thanks. My question relates to the model language for soliciting a claimant's HICN and social security numbers. I was wondering can insurers edit the language in any way.

Can they add anything to the form? Can they change the format? Or do they need to use on the exact document from the web site exactly as it appears on the web site in order to take advantage of the safe harbor?

(Barbara Wright): Can you hang on...

(William Becker): Hang on just a second. Okay we're back. I guess the answer is that the - if you use the model language that we provide that is an implied safe harbor. But if you don't that's not an implied safe harbor so you can use other language but

there's no implied safe harbor if it's not the language in that model language that CMS provided on the web site.

Scott Sasjack: Okay so they should use the model language exactly as it appears there. And if they have their own form they should submit their own form first and then use the model language which to follow up.

John Albert: That would be - I mean everyone has, you know, a different customer base and, you know, obviously one size doesn't fit all. We would recommend that folks try to gather the information using their own methodology if they think it would be better than what's on the CMS model language. But for terms of safe harbor the CMS model language is recommended as the last resort I guess.

(Barbara Wright): Well what we said in the prior call I think we mentioned briefly on this call is we're not saying or recommending that someone should take what's on that web site, send it to an individual and if it comes back with no answer that they automatically have a safe harbor.

What we're saying is they should have a process to collect that information using whatever forms or methodology they deem applicable. And if their method is unsuccessful then we're saying if they want to use this model language we will, you know, it's for an implied safe harbor if that's their final resolution.

Scott Sasjack: Is there any disadvantage to sending the CMS form first or is it better to use that as the last resort?

(William Becker): Well again I guess I would defer to your customer base and, you know, you know them and what they respond to and don't respond to we would hope.

And that you're probably more likely to get, you know, I'm hoping more hits using your own process. But again that model language is there for your use and you can use if as often as you need to.

(Barbara Wright): And one possible disadvantage of using it first is that obviously as the place to say no I'm not going to give it to you and by default you may get more people that are saying no than would have said yes and given you what you needed to query if you'd submitted your own form or request first.

Scott Sasjack: I see that was one of our concerns actually. Okay thank you that answers my question.

Coordinator: Our next question comes from (Martin Schwartz) of Sonenshine.

(Martin Schwartz): Thank you. We have a question about the application of the pre December 5, 1980 exposure exception to the reporting obligation in the context of asbestos product liability litigation.

The user guide states that where multiple manufacturers and sellers are sued which is just about always the case in asbestos litigation the reporting obligation for Defendant X is based solely on whether the plaintiff was exposed to Xs products after December 5, 1980 not products of other named defendants.

Our client is a defendant on a success reliability theory in tens of thousands of asbestos cases and has been for about 20 years. But has been held by numerous courts to have no liability for any asbestos products sold after June 1967.

The client therefore very rarely settles a case and has never been found liable without evidence that the plaintiff was exposed to the predecessor company's asbestos products prior to 1968.

The reason for this as you can imagine is that there's seldom is any evidence that a plaintiff was exposed after 1968 much less after 1980 to a product that was made or sold by the client's predecessor prior to 1967.

Now the plaintiffs in asbestos cases they always name dozens and dozens of defendants in their complaints and they don't distinguish among them in the complaint. But they broadly allege that the plaintiff was exposed to defendant's collectively asbestos products over the plaintiff's entire work life which could typically be say 1955 to 1985.

Now the true facts of exposure to any particular defendant's product is not developed until there have been depositions and responses to interrogatories and document requests. Now our concern is that although the language that I quoted above relates to the objective facts as to when a plaintiff was exposed to a particular defendant's product.

There's also language in the user guide which suggests that if there's been any exposure for post December 5, 1980 with claim then the RRE must report for Section 111 purposes.

We would think that - we believe and I guess we're requesting your guidance and clarification as to whether the user guide names or should be - should not be construed to impose to reporting obligation by an entity like our client a particular manufacturer that there should be no such reporting obligation unless the evidentiary record developed during the case or a trial or in

settlement negotiations show some objective evidence of exposure to that defendant's asbestos products on or after December 5, 1980.

(Barbara Wright): I understand your concern. I understand your position but that is contrary to what we said earlier in this call. The - we as I said we don't need CMS under the statue doesn't need to prove causation or it would be relitigating everything.

Its issue is primary payment responsibility and that is demonstrated by any type of settlement, judgment award or other payment. If as you said you have a situation where your client always wins and doesn't pay anything and rarely settles anything where they win obviously they aren't going to be reporting.

If they have a settlement judgment award or other payment then they will need to report based on the fact that it's what's claimed or released. As we've said earlier in the call we've invited the industry if they can give us some way to frame language that gets rid of this release issue and doesn't put CMSs/Medicare's interests in jeopardy.

(Martin Schwartz): Well as a follow up to that the client does settle cases but there's always evidence of pre 1968 exposure when they settle.

(Barbara Wright): And that's precisely the concern that we several of the participants from the mass torque work group have brought up and that we mentioned earlier in the call.

And we've invited the industry if they can come up with some way that CMSs interests are protected and it's not something that's wide open for gaming on the part of those involved in these types of settlements or releases CMS is

willing to look at it. But legally we're allowed to recover for what's claimed or released.

(Martin Schwartz): Would CMS be open to a modification a new language that was based upon the objective discovery record that's created or trial record that's created in the case of the test?

(Barbara Wright): I don't believe that CMS is going to be willing to be put in a position where it would have to essentially do the equivalent of relitigate or defend whether or not they're actually you're getting into the causation issue which is what we do not have to establish.

So more than that at this point I can't give you any more. We've said if there's a way to protect Medicare's interests then people are, you know, insures can come up with suggested language we're willing to look at it.

(Martin Schwartz): Thank you.

Coordinator: The next question comes from (Rhonda Brooker) of New York Central Mutual. Your line's open.

(Rhonda Brooker): Hello my name's (Rhonda Brooker). I'm from New York Central Mutual. We have a test query that we received back and we have some Code 01s that had some updated information.

And we were told back at the 8/11/09 teleconference to not include any suffixes or periods in the query or claim input. But when this query came back we had removed the suffix but it had suffix Jr. put back in it. Are we supposed to now put the Jr. back in?

(Pat Ambrose): So Jr. in part of the surname, last name field.

(Rhonda Brooker): Yes.

(Pat Ambrose): Well that's interesting. I didn't realize that we stored that information. So it really is not going to matter because we still only match on the first six characters.

John Albert: Is it a short last name like B?

(Rhonda Brooker): Day, D-a-y yes.

John Albert: So probably what's happening, you know, SSA probably captured that as part of their last name.

(Pat Ambrose): I'll take a look at it. I am surprised and I'm glad that you've educated me today. And we'll go back and take a look at basically what I can say is the name that we have is the name as it appears on the individual's Medicare insurance card or on their SSA card on their Social Security card. Now again I didn't realize that it would include suffixes like that, titles.

John Albert: Short names. Which RRE I.D. are you? Do you know your RRE I.D.?

(William Becker): We can go back and take a look and see if it is that, you know, rather than make a hypothetical off.

(Pat Ambrose): Yes I'm definitely want to investigate to see what - if we need to update that information.

(Rhonda Brooker): I don't have our RRE I.D. in the conference room.

John Albert: But it's New York. What was the whole name?

(Rhonda Brooker): Well.

(Pat Ambrose): Actually do this send the example to your EDI rep and tell them that (Pat Ambrose), you know, to forward it to (Pat Ambrose) that I wanted to take a look at it rather than - I'd rather not give out my email address on this call.

(Rhonda Brooker): Okay.

(Pat Ambrose): All right thanks.

(Rhonda Brooker): And along with that now our transmission records when we do get these updated information for example the first initial is different than the name we have on our records or the date of birth, you know, what this person is giving us but your updated record is showing a different date of birth. Are we supposed to change our information and put it in the transmission file the way you have it or the way that our person is giving it to us?

(Pat Ambrose): Well let me say this if you've got that corrected information back then you've matched for us to feel comfortable that we've matched it to the correct Medicare beneficiary. It's really your choice. And we can't tell you what to do with your own internal system.

I mean it is possible that SSA has an incorrect update for the person and it'll get corrected there and then subsequently get corrected on our files and that you were right all along.

I mean it's not as likely I think but so it's really informational and there is no requirement on your part to update your systems with a different birth date that we might provide back. What I do encourage you to do is take the HIC number that we provide back and store that and try to use that going forward.

(Rhonda Brooker): Okay thank you.

Coordinator: Our next...

(Barbara Wright): Operator, could you tell us how many people we have in queue because we are going to have to stop at 3:00.

Coordinator: Okay we have 23 at this time.

John Albert: Okay.

Coordinator: Our next one is from (Ryan Proser) of HR - I'm sorry, HCR ManorCare. And your mike is open.

(Ryan Proser): Yes I'm legal counsel for a self insured in the liability context. And my question is relative to set asides. Twelve months ago the American Association of Justice released a clarification statement or memo about the MMSEA and essentially they concluded that Section 111 does not require set asides in liability cases in order to account for future medical costs.

And I agree with that analysis. But what they seem to be advising their members is that when they're settling liability cases for a Medicare beneficiary they can simply ignore the MSP statute aside from repaying Medicare conditional payments made prior to the settlement.

And from my perspective Medicare's interests can't possibly have been reasonably considered under that approach. So because CMS hasn't officially stated that set asides or a claim settlement allocations are recommended in liability settlements and they haven't published any procedures as such.

I was wondering if you could advise me as to the best way a party settling a liability case especially a self insured like my company to ensure that Medicare's interests are being quote/unquote reasonably considered.

(Barbara Wright): Actually I saw your question come in and I meant to address it in the ones at the beginning. If you go back on some of the earlier transcripts we've done short points on liability set asides. The AAJ is correct in that Section 111 does not require liability set asides as we said at the beginning of this call 111 is a new and separate reporting requirement.

And all it is a reporting requirement but we also said Section 111 doesn't change any preexisting obligations. The idea of set asides is based on the fact that Medicare is prohibited from making payment where payment has already been made.

So that if you have a settlement judgment or other payment that takes into account in any way future medicals that settlement judgment award or other payment should be exhausted or appropriately before Medicare is billed for the associated services.

We do not have the same formal process for liability set asides that we have for worker's comp set asides. The worker's comp one is a recommended process. It's not a required process and keep in mind we're talking about a recommended process not the fact of whether or not you should or shouldn't have a set aside in a particular case.

For liability we don't have the staffing or resources right now to do that type of program for every single liability settlement or even with certain dollar thresholds what we've told our regional offices is if they believe there are significant dollars at issue in a particular case and the workload of that particular regional office permits.

They may review a proposed set aside amount for liability. The fact that they declined to review in a particular case does not create any type of safe harbor. So you're back to an obligation that has existed essentially since 1980.

And if an entity has not been taking this into consideration and taking steps whether it's to do a set aside or some how else take care of it. It's something they now need to be documenting and taking care of. Simply it is a - it's an obligation that existed far in advance of Section 111.

(Ryan Proser): Okay and just as a follow up. So should the regional office not have the resources to formally review a set aside or a claims settlement allocation that I would want to put together in one of my releases and I go out to a third, independent third party an agent or an independent physician or whomever.

They do an independent analysis. And either a zero dollar amount or some small portion of the total settlement award is dedicated as a set aside and plaintiff's counsel is agreeable to that. We attach that as an exhibit or an amendment to the assigned release upon settlement. In CMS' eyes is that going to be sufficient?

(Barbara Wright): We as I said we don't have any formal process. I can't give you an answer on that. It does sound like one way to appropriately document what you've gone

through and that you've made a reasonable consideration. Can we say more than that? No.

(Ryan Proser): Okay thanks.

(Barbara Wright): I mean I can't give you any bright line rule to help you out here.

(Ryan Proser): All right well, you know, I guess we'll just adopt those steps and, you know, see how things turn out. But we just wanted to create a paper trail to show CMS that we're, you know, taking the necessary steps in case they, you know.

Some times subsequent to our settlement come back and try to, you know, seek an over payment from us because we're the primary payer of the self insured. So we're just trying to come up with ways to insulate ourself in case that happened.

(Barbara Wright): But that's what I - goes back to what I just said. You need to at least think about having a process in place where you're documenting why or why not there are future medicals and how you took care of that. And our anecdotal experience is a lot of entities were simply not even considering the possibility of future medical.

(Ryan Proser): Okay I think you've answered my question. I appreciate it.

(Barbara Wright): Okay.

John Albert: Operator, its 3:00. I think we're going to have to go. We most of us here have additional meetings.

Coordinator: Okay well at this time we thank you for your participation. And you may go ahead and disconnect your line as this concludes today's conference.

John Albert: Operator, could you stay on the line for a second?

Coordinator: I sure will.

John Albert: We just wanted to know how many had attended the call.

Coordinator: Just a moment.

END