# 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 14, 2010**

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

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

**Centers for Medicare & Medicaid Services**

**Moderator: John Albert**
**October 14, 2010**
**12:00 p.m. CT**

Operator: Good afternoon, my name is (Jackie) and I will be your conference operator today. At this time, I would like to welcome everyone to the MMSEA Session 111 conference call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star and the number one on your telephone keypad.

If you would like to withdraw your question, press the pound key.

Thank you.

Mr. Albert, you may begin your conference.

Jon Albert: Thank you, operator, and good afternoon everyone.

Again for the record, today is Thursday, October 14th and this would be non-group health plan policy call on Section 111.

Also I need to just put for the record also a disclaimer that while we try to – to reflect accurately what is in the user guide, sometimes we do misspeak and get a few things wrong related to instructions in the official user guide that's in Mandatory Insurer Reporting website. And where we do contradict that information, we need to make sure that everyone is aware that the written guidance is final guidance until it is revised by CMS.

A couple of quick announcements, I just needed to let everyone know that the calls that were scheduled for November 30th and December 20th, these were

supposed to be technical calls, have been cancelled. We will not be available during those times for those calls.

So to make up for that, we are going to find that – or (basically) keep the November 10th and December 9th calls, they will be both technical and policy calls. So again, the calls for November 30th and 20th are cancelled. And the calls scheduled currently for November 10th and 9th will be combined technical and policy calls.

Also just because someone did ask, the call for October 28th, the technical NGHP call, is still on. So that's – that will still be taking place.

With that, because we have a lot of people on the line and probably have a lot of questions, I'm going to turn it over to Pat Ambrose followed by (Barbara Wright). And if anyone else has, we'll get to them. And then we'll get into the usual question-and-answer session.

We ask that folks identify who they are, who they represent. And if they could out of courtesy to the many people on the line, please limit your questions to one primary question and one follow-up and get back in the queue again so that other folks on the line can get their questions answered.

And with that, we'll jump right into it.

Pat?

Pat Ambrose: Thanks, John. This is Pat Ambrose.

I have a couple of comments to make. One is the transcript from the September 22nd NGHP technical town hall call is posted to the website at www.cms.gov/mandatoryinsrep. So please review the information that was provided during that call on September 22nd.

In the meantime between now and the next technical call, please make sure that you submit any of your technical questions to your EDI representative. You most likely – that's – that's the best way to get an answer as soon as

possible to your technical questions. And your EDI representative is – is the best source of that information.

I'm – I also want to remind you to sign up for the computer-based training modules. If you go to the Mandatory Insurer Reporting website that I just mentioned, you'll see on the left-hand side a tab or a link to a page for computer-based training modules. And I encourage you to sign up for those.

One new announcement that has a – a possible impact – a positive impact in fact on your reporting, Section 111 reporting, is that we are no longer going to drop ICD9 diagnosis codes that were at one time considered valid.

So as we incorporate the new versions of ICD9 codes into Section 111 processing each year – and again refer to the user guide for the specifics on that – but as we incorporate the new version of valid ICD9 codes that are posted to the CMS website, what we'll do is just add additional new codes and possibly update the description of any existing codes.

We will not be dropping old codes from the list.

So the – the positive impact that this has for you is that if you report a – if you make a claim report with an ICD9 diagnosis code, and that is accepted and considered valid, it will always be accepted and considered valid on – if you update – if you send a – a subsequent update for that claim transaction or claim record in the future.

So you don't have to worry about a – a – an ICD9 diagnosis code that was accepted at one time and then because of our incorporation of – of the new list of valid codes, it – it's falling off that list of valid codes. It will always remain.

Obviously for new claim reports, you should always be looking at the most current, valid ICD9 codes – or – or the lists that are considered valid by CMS for Section 111 reporting.

With that, I will turn it over to (Barbara Wright).

(Barbara Wright): Thanks, Pat.

What I'd like to do first is talk about a few alerts that we have in process. The first one is an alert having to do with the date of incidence for cumulative injury.

This alert is in queue. It should be posted no later than the end of next week. And essentially what it says is that for purposes of Section 111 reporting, the date of incident for a cumulative injury is the earlier of the date that treatment for any manifestation of the cumulative injury began when such treatment preceded formal diagnosis, or the first date that formal diagnosis was made by any medical practitioner.

We have to add various questions on that date of incident. So we wanted to let you know that alert is in the process of being posted.

The second alert that's in the process of being posted has to do with the timeliness of reporting when certain information isn't known as of the TPOC date. We've had questions about situations not necessarily a mass tort per se or a class action or multi-district litigation, but for whatever reason the settlement, at the time of the settlement when the TPOC date exists as we've defined it in the record layout, at that point in time there has been no determination of exactly who will be paid or how much each individual will be paid.

And consequently, there would be no way to report as of the TPOC date. So what this alert will say is that for timeliness of reporting for all non-group health plan TPOC settlements, judgments, awards, or other payments they're reportable once the following criteria are met.

First, the alleged injured or harmed individual to whom or on whose behalf payment will be made has been identified. And second, the TPOC amount for that individual has been identified. So you're – the time frame for reporting will run from when those two criteria are met.

This means that until we can make some further changes to the system, if you have that type of situation, you could be getting a compliance flag indicating

that your report was untimely. Until we can change that in that – in the system, when you receive that type of flag, you will simply need to ignore it. But we wanted to alert you to that possibility.

An example of when this type of situation would exist, let's say you have an allegedly defective drug. And the settlement contains or provides the process for subsequently determining who will be paid how much. It might even involve an application process for people to apply to be included.

So as – that means that as of the TPOC date, there isn't enough information for you to be able to report a particular beneficiary or particular amount. And the timeliness of the Section 111 reporting for a particular Medicare beneficiary will be based on the date that there's a determination both that payment will be made to, or on behalf of, that beneficiary and a determination of the amount of the settlement, judgment or award or other payment to or on behalf of that beneficiary.

So – so those two alerts are in process.

Another alert that is in – in process that isn't quite in queue yet of – we're going to aim for the next – end of next week for it as well, is having to do with lump sum payments for indemnity benefits.

In general if you have a situation where the worker's compensation or no-fault law requires the RRE to make a one-time lump sum payment pursuant to statue and it's for an obligation other than medical expenses, to or on behalf of the injured party, the RRE will not have to report that one-time payment as long as they have reported and there will be continuing reporting of ongoing responsibility for medical.

If it’s a – if it’s a TPOC that’s associated with or there is with determination of ORM or there is no ORM, then it will have to be reported.

Another alert that is in process that we're working on is – for ICD9's there have been concerns expressed that there are some situations where the RRE's are unable to determine an ICD9 code because there is no injury, no alleged injury.

We're looking at a – (various) limited exception to use the default ICD9 code, but only in those situations. First of all, it would have to be a situation where no medical or injury is alleged. If there's one alleged, then you should be able to associate an ICD9 code.

And secondly, this default ICD9 would most probably be limited to situations involving loss of consortium and most types of (D&O) or (E&O) insurance where medical typically aren't really a factor. Though just to let you know that we are working on that as well.

And last but not least, to forestall questions on this since we don't have a final answer, we are continuing to work on the issue of December 5th, 1980 continuing exposure and when medicals are released, but there is no actual exposure on or after 12-5-80.

We don't have any final language for you on that yet. But what we're doing is crafting a potential exception for reporting. As of right now, reporting is dependent on what is claimed or released or (as the effective) releasing medicals.

So know that we're looking to come up with language that will hopefully exempt a group of situations from being reported, but we don't have that final language yet.

One other thing that came in as we were asked in the context of clinical trials if there was a diagnostic test to investigate the cause of a complication that had arisen and is paid for directly. Would that count as something that had to be reported?

And if everyone will check Section 11.10.2 of the existing user guide, we've already said that when there's a one-time payment for defense evaluation that that is not reportable. And we believe the situation I just mentioned would fall within that category.

I think, John, with that we can take questions now?

Jon Albert: OK, operator, I guess we can jump right into questions and answers.

Operator: At this time, I would like to remind everyone, if you would like to ask a question, press star then the number one on your telephone keypad.

Your first question comes from the line of (Diane Phillips) with (ConocoPhillips). Your line is now open.

Again, (Ms. Phillips), your line is now open.

Jon Albert: I guess we can move on.

Operator: Your next question comes from the line of (Richard Schultz) with Fireman's Fund Insurance. Your line is now open.

(Richard Schultz): Yes, good morning, this is (Richard Schultz) with Fireman's Fund.

Referring back to your earlier comment that an alert is coming out stating that if ORM is continuing, but we are lump summing permanent disability, that it is not a TPOC event. Does that apply also if in case we're not lump summing it, we're settling permanent disability with a structure, does the same apply that it is not a TPOC event if ORM continues?

(Barbara Wright): Yes, it does. But we make sure we add that to the alert.

(Richard Schultz): Then as a follow-up question, your other statement was rather significant, especially for those of us with a lot of asbestos claims. So on occupational disease or continuous trauma-type losses, we no longer need to put the first date of exposure. We only need to put the first date of medical treatment.

(Barbara Wright): I – I wouldn't say that applies to all occupational-type situations. What we talked about was cumulative trauma. People had asked us about things like carpal tunnel syndrome, someone who has a knee condition that's cumulatively gotten worse.

And they said for that, how do we know a date of incident? And what we're saying in that case – let me go back and look at the actual words so I'm not

misquoting it. That would be the date that – that you first have treatment or the first date that formal diagnosis was made.

So I didn't intend to say and I don't – I don't think we said that it's all occupational situations.

(Richard Schultz): Well then that as I would understand it puts us in the realm of three potential dates of injury. A specific date like when I drop a hammer on my foot, a continuous trauma which would be the first date of treatment, and an occupational disease which would be the first date of exposure.

Is that the intent?

(Barbara Wright): You're talking about defining date of incident in different situations. And when it's exposure, it is date of first exposure. When it's ingestion, it's normally date of first ingestion. When it's an implant, it's the date of the implant, and if – if you have a trauma-based incident, yes, it's the – the date of the trauma.

But both times I think you said that it's the date when treatment begins. And I want to emphasize that we said it's either of two things. Either the date treatment begins and that's when treatment precedes formal diagnosis. But if you have a – a formal diagnosis, before you started treatment, then it's the date of the formal diagnosis.

(Richard Schultz): Well often times in a continuous trauma, treatment will begin before the policy period.

(Barbara Wright): OK, well then the date of incident is still the date when treatment first began.

(Richard Schultz): All right, thank you.

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

(Diane Phillips): OK, I'm going to try this again. Am I on?

Jon Albert: Yes, yes.

(Diane Phillips): OK, sorry. I don't know what happened earlier.

It's (Diane Phillips) of (ConocoPhillips) company. I've got a question coming down from our litigation group for – for general liability claims. They're advising me that they have often times situations with a specific injury being litigated. The settlement is done on – for maybe three or four people. For example, if it's a family incident.

And apparently they're telling me that practices that they settle that claim for a lump sum, and the settlement agreement does not specify what amount is specific to each person. Now for Medicare reporting purposes, their question is – and – and I've given them one answer and they want me to confirm it with you, that if all of those persons happen to be Medicare beneficiaries then if it's a single defendant claim, then there is an amount that has to be reported for each individual. Is that correct?

(Barbara Wright): If they're all beneficiaries, let's make it liability insurance and they're all beneficiaries...

(Diane Phillips): Yes.

(Barbara Wright): ... and there's a single settlement, you're going to end up reporting the entire settlement amount for each of those individuals. And then in the recovery process, it will – it will be clarified (and four) separate claim reports...

(Diane Phillips): Yes.

(Barbara Wright): ... one for each Medicare beneficiary as...

(CROSSTALK)

(Diane Phillips): We settle for a total of $50,000 and that check as usual is given to the plaintiff's trust account.

(Barbara Wright): Right. And you're going to report $50,000 for each of those...

(Diane Phillips): For each...

(Barbara Wright): ... individuals...

(Diane Phillips): ... person.

(Barbara Wright): And – and to the extent we make any recovery demand, it will be clarified in that process. But also keep in mind even if the settlement says – a) it's $10,000 for Jim and $20,000 for Sue and – I don't know. One person gets nothing and someone else gets the balance, CMS is not bound by that allocation of the parties beyond...

(Diane Phillips): Right.

(Barbara Wright): ... we do defer if there's a hearing on the merit by a court of competent jurisdiction. But otherwise, we wouldn't be bound by it.

(Diane Phillips): So in that instance, Barbara, would – would the preferable practice be to go ahead and report the entire settlement for all of those persons even though individual amounts are set out in the settlement agreement?

(Barbara Wright): That is not preferable practice...

(CROSSTALK)

(Diane Phillips): OK...

(Barbara Wright): ... required practice actually. You do have to report the entire amount.

(Diane Phillips): The entire amount …

(CROSSTALK)

(Barbara Wright): Unless – unless you have completely separate settlements...

(Diane Phillips): Right.

(Barbara Wright): ... because we're not bound by the allocation, you need...

(Diane Phillips): Right.

(Barbara Wright): ... report the entire amount.

(Diane Phillips): The entire amount on each person's record.

(Barbara Wright): Right.

(Diane Phillips): Unless they have individual settlement agreements?

(Barbara Wright): Yes.

(Diane Phillips): OK. OK. That's – that answers the question. Thank you.

Operator: Your next question comes from the line of (Kathy Ballard) with Marathon Oil Company. Your line is now open.

(Kathy Ballard): Yes. We have a litigation that involves usually a toxic tort exposure. We can't – I'm trying to determine how to – how to put an ICD9 code on it. It says – the releases will say that they're settling – plaintiff alleged exposure to NORM, asbestos, benzene or whatever the – the matter may be about.

And there's not usually specific illnesses that are listed. So I don't know what ICD9 code to use in that instance.

(Barbara Wright): Well there are routine allegations made in terms of asbestosis and – and – you know, I just believe you should...

(CROSSTALK)

(Kathy Ballard): In – in one of the cases I'm looking at now, I've got their medical history. And there's nothing like that. Their medical history includes a broken arm.

(Barbara Wright): But remember it's not what injury is proven, it's what they're claiming and releasing. We're not – if – if they haven't yet received treatment for asbestos that you happen to know about, that doesn't mean you don't have to report that code.

You're not limited to determining ICD9 codes from medical records that you happen to receive. You should be developing your own expertise to the extent

it's not available to you on record for what ICD9 codes should be associated with what's being alleged – what's being claimed or released in any type of situation.

(Kathy Ballard): OK. So if – if none of their – if I can't find anywhere in their medical history evidence of – take asbestosis for – or AML or anything that maybe connected to asbestos exposure, I just go ahead and put asbestos code down anyway?

(Barbara Wright): That's claimed – that's – that's what...

(CROSSTALK)

(Barbara Wright): If that's what's being claimed and it's alleged and released, yes.

(Kathy Ballard): OK. I guess the science is still out as far as what exposure to these various toxic chemicals can cause. We have experts that say they can cause – exposure to NORM can cause cancer. And other experts that say, no it can't.

So if they are claiming cancer...

(Barbara Wright): Let me repeat something I think we've said on other calls, but just to make it clear again, is CMS's (touchdown) with respect to recovery is related to what's claimed or released and the MSP statute does not require that CMS prove causation.

What we have is a situation where a settlement judgment award or other payment constitutes proof of primary payment responsibility for whatever is claimed or released.

So that’s what you're reporting is tied to.

Does that help you some?

I – I know you're used to (as the temp) probably thinking in terms of did they prove this? But for purposes of your reporting responsibility it doesn’t have to be proven.

Just like the statue makes a settlement or judgment or, you know, other such situations proof of primary payment regardless of whether or not there's the determination of liability.

(Kathy Ballard): So if they're claiming fear of cancer, there's not an ICD code, I don't think, that has – that's fear of cancer. And the state of Louisiana allows them to be paid – to sue us for that and to be paid for it.

(Barbara Wright): But it seems that you could find one that's at least close. You seem to be stating some type of mental anguish there.

(Kathy Ballard): OK.

Male: Anxiety.

(Kathy Ballard): OK. All right. We'll see what we can do. Thank you.

(Barbara Wright): Thanks.

Operator: Your next question comes from the line of (Rulyn Allen) with (Morgan, Lewis). Your line is now open.

(Rulyn Allen): Hi, this is just an easy question. I find on – just as you were talking about the rescheduling and cancellation of future calls, can you – would you mind repeating those dates?

Jon Albert: Yes, the call for November – November 30th and December 20th have been cancelled. We're going to combine the technical and policy on the existing November, December calls which is November 10th and December 9th. Those calls are still on. And they will be both policy and technical NGHP calls.

And to add also to that, the October 28th call is – is still on and it is an NGHP technical call.

(Barbara Wright): And there should – there should be updated information codes on the website. It just hasn't been posted yet.

Jon Albert: Yes.

(Rulyn Allen): Thanks a bunch.

Operator: Your next question comes from the line of (Nicky Lahan) with (LWCC). Your line is now open.

(Nicky Lahan): Hi. At the last call, we got a little confused. We thought we understood, you know, the whole TPOC thing and when to report. And at the last call it was indicated that if we have ORM on a claim, then we shouldn't be reporting a TPOC. So you know, we took that and we're thinking, does this mean that we only need to report claims in which we're saying we don't have ORM.

(CROSSTALK)

(Nicky Lahan): That we're denying worker's comp benefit for, but we make a TPOC payment to them?

(Barbara Wright): Let's stop before you go further. Our – our comments earlier in this call were very specific. When you're making an indemnity payment that is separately provided for by statute. If you're making any lump sum payment that's related to medicals et cetera, those are fully subject to the TPOC requirements.

(Nicky Lahan): OK. So if we just did one lump sum indemnity payment, but we weren't saying that we're releasing any type of medical, then we wouldn't report that TPOC. But if I made a payment to a claimant where I'm releasing indemnity and medical, then I would report that TPOC.

(Barbara Wright): If you – yes, as long as you had ongoing responsibility for medical. You can't have a situation where you're – you have a lump sum indemnity and at the same time you have never reported ongoing responsibility for medical or you're terminating the ongoing responsibility for medical.

If either of those situations exist, then you do have to report the indemnity TPOC.

(Nicky Lahan): OK. And also the term non-reportable TPOC was mentioned in the last call. And that was our first time hearing it.

Is there any way that you all could explain that or – or and/or, I should say, tell us exactly where non-reportable TPOC's are located in the user guide?

(Barbara Wright): I guess I would have to know the context where we used that – (inaudible) in the same discussion.

(Nicky Lahan): It was in the same discussion. That's where our confusion started.

(Pat Ambrose): We – I – I – I think it was stated that, you know, while those are settlement judgment, award or other payments, constituting a total payment obligation to the claimant, (they), you know, just – were not related to medical and therefore not a reportable...

(Barbara Wright): We were giving you a specific exception to – in other words, a particular TPOC situation that you did not have to report. Do we have a separate listing of those? No.

(Nicky Lahan): OK. That was it. Thank you all.

(Female): OK.

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

(Diane Duffy): Thank you. My question – and I apologize if it's been answered on previous calls. But clarification about Jones Act claims. Are those reportable under the – under the Section 111?

(Pat Ambrose): The Jones Act is liability. Those – it's liability insurance. And yes, it's reportable like any other liability insurance.

(Diane Duffy): There's also medical in there because they cover everything from if you're out on a boat and your appendix burst. Or you just have a toothache because you don't have good dental hygiene. They cover things like that.

(CROSSTALK)

(Diane Duffy): So those would also then be reportable?

(Pat Ambrose): If it's under the Jones Act, it's reportable. You'll have to make an individualized determination, whether there's some situations under the Jones Act where you would actually have ORM for liability insurance.

(Diane Duffy): OK. Thank you.

Operator: Your next question comes from the line of (Yvette Griffith) with (Brown & Brown Insurance). Your line is now open.

(Yvette Griffith): Hi. My name is (Yvette). And we – I – I apologize. I know this question has been asked before. And – but my concern comes from the fact that I've recently asked it of my EDI rep. We're an agent, so we have – we are working with multiple reps.

And I'm getting different answers when I ask the question. So the question is – if we were to submit a record and it is – and we submit it timely, but it's rejected because of say, a mismatch on the name or – or some reason to cause that record to be rejected.

We then re-file it at the next submission period. Is that record considered late and subject to penalty?

Jon Albert: Well if the record didn't match because the original information that you sent was erroneous, it wasn't in fact, you know, (John Smith) born in 1938 or whatever. I mean that would be flagged as a late submission (as if you say) – found out the guy's name was (John Smyth) instead. And – and it did match this time, that would be flagged as a late submission.

(CROSSTALK)

(Pat Ambrose): There's no – while we return a compliance flag indicting the record might have been reported late, there's no automatic...

Jon Albert: Right.

(Pat Ambrose): ... (compilation) or imposition of a – a fine by the system or anything like that.

Jon Albert: Yes, we're...

(Pat Ambrose): It's a – it's a warning flag to you that, you know, this record was technically reported late. But there's, you know, no calculation of a fine taking place as a result of receiving that compliance flag.

Jon Albert: At this point in time, we're trying to provide these kind of – you know, flags or whatever. Because basically, make you aware that you may be considered not in compliance with the requirements.

But at – at this time also, there is nothing – no formal guidance regarding (CMP)'s or any of that. None of that has been published. So – but to answer the – the core of your question, that – that would be considered a – a late submission.

(Yvette Griffith): OK. Is it – are the – the problem that we – what we ran into was the claimant had supplied as a first name, (JW). And we were returned a – an error that – that wasn't the – that – that was not the first name that – on record with – in your database.

Jon Albert: We recommend that, you know, as a – in terms of any outreach that – that you may need to do, just like we do as well, to have them use the name as it appears on their social security or Medicare card.

(Yvette Griffith): Yes. I think we're going to have to implement some type of system at intake to either gather that – you know, somehow get an image of that card, or make sure that they're supplying it as it is on their card.

(CROSSTALK)

Jon Albert: We highly recommend that approach. We highly recommend that approach. And – you know, again it helps you, you know, (budget your) records as well as everyone else.

(Barbara Wright): Alternatively, some individuals or entities when they're collecting that type of information, whether or not they can get the card, they get the card if they can.

But even if they can't, they have an alternative question where they specifically ask for any other names the person has used.

(Yvette Griffith): That's a (good point)...

(Barbara Wright): And I – one thing John didn't say is that for first names, we match on just the first character...

Jon Albert: First (character) – yes, first initial of the first name and – and first six characters of the last name.

All right and we do have ways of (cross-walking), like, you know, people are married or whatever, remarried, et cetera. That's, you know, those numbers are (cross-walked) back to older versions of their name as well on our system. So...

(Yvette Griffith): Fantastic. So just like in the query and the claim file as well, you're going to match on the same amount of characters. The first character for the first name and – and the first six of the last.

Jon Albert: Yes.

(Yvette Griffith): Fantastic. Thank you very much.

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

(Debra Daniels): Hi, thank you. I would like clarification please, because I get different answers.

Say for example on an automobile policy, you have medical payment. And say the limit is $5,000. And we pay the limit to the hospitals. Is that reportable?

Jon Albert: Yes.

(CROSSTALK)

(Debra Daniels): Do we report it this time or as of October the first, or do we go back to January the first?

(Barbara Wright): You should be reporting that as a no-fault policy. And you would essentially be able to report the ORM start date and termination date on one submission.

(Pat Ambrose): Yes, there's no actual ORM – I mean effective date. But you would report that as insurance type for no-fault, an ORM indicator equal to (Y).

(Debra Daniels): Yes.

(Pat Ambrose): And – and then the date that the limit was reached, your $5,000 no-fault policy limit was reached, would be your ORM termination date. So you'd report that as well.

And then there are a couple of other fields, I think, 82 and 83 related to the no-fault policy limit and – and date when that was reached. And so you'd put that date in there too.

(Debra Daniels): OK...

(Pat Ambrose): ... and – and the $5,000 that you referred to is not...

(Debra Daniels): Yes (ma'am)...

(Pat Ambrose): ... a TPOC – that is not a TPOC. That is – you know, you paid that out due to individual medical claims.

(Debra Daniels): Yes.

(Pat Ambrose): And you're – you're putting (back) that no-fault limit in the – in the no-fault policy from its field but not reporting it as a TPOC.

And so you'd make a one-time claim report, as I said, with the ORM indicator to (Y) and you would also – with – and the date of (event) then would be auto accident.

(Debra Daniels): Yes.

(Pat Ambrose): And then you may also submit the – the ORM termination date.

(Debra Daniels): OK. If that amount is less than $5,000, say the limit is $1,000, do we still report that?

And our report appeared in March.

(Pat Ambrose): Yes. In that case, you most likely have not terminated your ongoing responsibility for medical.

(Debra Daniels): Well the claim is closed and the limit was $1,000. That's all we paid. We paid it to the hospital and we sent letters out saying the limits were exhausted.

(Pat Ambrose): What you're really asking is whether or not there's a threshold for reporting for ORM? For no-fault insurance, no, there isn't a threshold.

(Debra Daniels): OK.

(Barbara Wright): Right.

(Pat Ambrose): So whether it’s $1,000 or $5,000 or $50,000, you need to report it.

(Barbara Wright): Right.

(Debra Daniels): OK. And one more question, please, if I may ask – our liability, like bodily injury, so there is a threshold on that, correct?

(Pat Ambrose): Yes, that’s liability insurance.

(CROSSTALK)

But yes, check out the section in the user guide that discusses those interim reporting thresholds.

(Debra Daniels): Yes. I read all of that and then I got confused because I would go to these different webinars and people say stuff different ways. And that would get...

(Pat Ambrose): You know would I -- my best recommendation for you to – to get – to clear that up would be to register for the computer-based training modules.

(Debra Daniels): OK.

(Pat Ambrose): And you don't have to take them all. But there is a computer-based training module that covers the reporting threshold when...

(Debra Daniels): OK.

(Pat Ambrose): ... to report, when not to report, and what to report. And I think that's probably – that – I think you would find that very helpful.

(Debra Daniels): OK. I'll do that. Thank you very much.

(Barbara Wright): And I – I would note that computer-based training we offer is free.

(Debra Daniels): (Right).

Operator: Your next question comes from the line of (Ann Chandler) with (Forman Perry). Your line is now open.

(Ann Chandler): Hey, I am one of the people who submitted the question about, you know, having the TPOC date. And, you know, not having the information about the amount of settlement to report. So I appreciate that you all have alert coming out about that.

I just had two follow-up questions. In the – in this scenario where you've got like a qualified settlement (tried) so the – the court approved a max settlement of let's say 100 different claims with 100 different cases, for a couple of million dollars. It's going to be the total amount paid out.

And then the – that money will be paid out over the course of five years with, you know, special master allocating funds to each person. I – I understand how the alert that you have coming out is going to cover when to report, but let's say there is a situation where let's say it's $20,000 – excuse me, $20 million that we're paying out over five years. And we're going to pay out $4 million each year and everybody's going to kind of take a cut of that each time.

So there will be, you know, five rounds of that going out. Would that be a structured settlement, or multiple TPOC situation?

Jon Albert: Generally that would be a multiple TPOC situation...

(Ann Chandler): OK.

Jon Albert: ... a (structured) settlement has no payment that are coming out of it. What you described is there are some product liability situations that we've been involved with where it – it really in order to not inappropriately exhaust the fund to allow everybody to get something, it does it more in rounds. As they're sure that additional funds are available.

And it reassesses claims each time et cetera.

(Ann Chandler): OK, thank you. And then, I thought I was clear on this and I think someone asked a question earlier using the (title) paid to four Medicare beneficiaries – being $50,000 example, if you could all remember that.

But that would be – would that be a situation where you had four beneficiaries who are in the same case? And this is my question for it.

Let's say the qualified settlement – that would be say 100 different cases where they're – they're all separately filed claims. Everybody's in a different case, but they're all from the same plaintiff's counsel.

And an (RRE) wants to resolve all those at one time. Do they need to do a separate settlement document for each of those people in order to be able to report just the individual allocated amount?

Jon Albert: Generally there's one settlement document that requires, you know, individual releases, et cetera with respect to (dismissing) beneficiaries.

(Ann Chandler): OK. So – so we would want – we could do one settlement document, but individual releases in order to – let's say – so for – what I'm trying to avoid is the situation where, you know, $20 million is the total payout and they all – and you know, poor (Mrs. Smith) over here, may have just only received $4,000. But we're going to tell you all that she got $20 million.

So – so as long as (Ms. Smith) has her own release –.

(Barbara Wright): We – we can't give you legal advice, but certainly I would expect that – that settlement document to make it clear that these are individual settlements with individual claimants, et cetera.

(Ann chandler): OK, great. Thank you.

Operator: Your next question comes from the line of (Suzanne Stratham) with (Grandis Felter). Your line is now open.

(Suzanne Stratham): Hi, my name is (Suzanne Stratham) and I'm an attorney in St. Louis with (Greenspa, Hempler and Gayle).

First, I wanted to thank you for hosting these town hall meetings. They've been extremely helpful. I mean, I appreciate your patience with our myriad of questions.

I am calling about risk management write-offs, specifically the May 26th, 2010 alert. My question is this. if a hospital writes off part of a beneficiary's claim for risk management purposes, I understand that alert to say that the hospital is not required to report but it must submit a claim to Medicare reflecting the unreduced charge and the amount of the write off.

So does this mean that if the hospital writes off the entire amount of a claim for risk management purposes, that the hospital – a) does not have to report, and b) does not have to submit a claim to Medicare?

(Barbara Wright): (I hear) the person on this end, or do we need to speak up louder?

(Suzanne Stratham): I'm sorry. Can you hear me?

(Barbara Wright): Yes. We had someone who started to answer. And I wasn't sure you could hear him.

(Suzanne Stratham): I – I did not. Sorry.

Jon Albert: You need to report it, but you – it could affect (inaudible) in one date. And you would be – the claim in the full amount in a liability payment for the full amount of charges.

(Suzanne Stratham): Could you say that again? I – I understood the alert to say that you did not have to report.

Jon Albert: No. You would have to – if the risk management decision, correct?

(Barbara Wright): She's asking whether she has to make a separate 111 report or if it's covered – by the billing.

Jon Albert: It's covered by the billing. I'm sorry. You would have to bill but you don't have to do a Section 111 report.

(Suzanne Stratham): That's the case if we write off the entire amount of the claim as well?

Jon Albert: Correct. Don't forget about your (1831J) requirements. (Dealing with) providers are supposed to be submitting no pay bills.

(Suzanne Stratham): If it's a partial write off or full write off?

Jon Albert: Correct.

(Suzanne Stratham): OK, thank you. That answers my question. I appreciate it.

Operator: Your next question comes from the line of (Theresa Barrio) with (Pitney and Bowes). Your line is now open.

(Theresa Barrio): Hi, good afternoon. My question involves employment practice liability claims where the plaintiff is suing us for wrongful termination or discrimination. Sometimes they also include a claim for emotional distress or mental anguish.

If they do, would these claims be reportable?

(Barbara Wright): As – as we said at the beginning of the call, it's any time medicals are claimed and/or released. So even if they don't claim medicals, if they release medicals it is technically reportable.

We are considering whether or not we can give some type of exception on reporting in situations where there are no medical claims. There's no, you know, no injury at all and reporting is only implicated because of the release.

But we don't have any final language on that. So you know – but certainly where it's alleged. Yes.

(Theresa Barrio): And I'm sorry, when you said any time medicals are released. What – what exactly do you mean by that?

(Barbara Wright): As we said earlier in the call, and we've said on other calls, Medicare is a touchstone for recovery and MSP situations is related to what is claimed or released. And the existence of a settlement judgment, or to other payment, or in certain cases, other factors demonstrate primary payment responsibility.

And we are entitled to recover for what we've paid for that's related to what's claimed or released. And the MSP statue does not require us to separately prove causation.

(Theresa Barrio): OK. And then I think you were saying that you're considering an exception when there are no medicals, but there is a release?

(Barbara Wright): If the only issue – if the only thing that implicates reporting is the release, and we're considering a very narrow exception, probably limited to loss of consortium and we're also looking at (D&O) and (E&O) in connection with that. That – but that's probably the broadest it would extend to.

(Theresa Barrio): OK, that was actually (going to be) one of my other questions about (D&O) and (E&O) related claims.

I guess it would go to the same thing if there was a medicals release then it would be reportable.

(Barbara Wright): Yes.

(Theresa Barrio): OK. OK and if I may, just one more question about short-term disability or long-term disability benefits being denied to employees.

Would that follow the same...

(Barbara Wright): Could you speak up a little please?

(Theresa Barrio): I'm sorry. Is that better?

(Barbara Wright): Yes.

(Theresa Barrio): And I guess it follows the same route for short-term disability or long-term disability benefits being denied to an employee if there's emotional distress factor it would go along the same lines then?

Jon Albert: Usually short-term and long-term disability includes both medical and (mental).

(Theresa Barrio): OK, so those would be reportable.

(Barbara Wright): I mean, remember that we're talking about all types of liability insurance and all types of no-fault insurance as defined by regulations.

So it's not – is it liability insurance for this or liability insurance for that? It's the whole spectrum of liability insurance. And we look at what's been claimed or released.

(Theresa Barrio): I just want to be clear. I was working with my EDI rep and it was mentioned to me that those were not reportable. So I just wanted to double check.

(Barbara Wright): I – I don't know what to say.

(Theresa Barrio): Yes. All right. All right, well thank you very much.

Operator: Your next question comes from the line of (Karen Stellar) with the (Ohio Bureau of Work). Your line is now open.

Again, (Ms. Karen Stellar), your line is now open.

(Karen Stellar): Yes, we know earlier you talked about the valid and invalid ICD codes. We had a question regarding the excluded ones.

Are you planning on adding excluded ICD9's in the future? And if so, how long do we have before we remove those from our report?

(Pat Ambrose): There is no plan currently to change that list of exclusions. And we would most certainly allow – you know, we're trying to allow six months for changes like that. But you would – you would get plenty of notice.

(Karen Stellar): OK. OK. That's it, thank you.

Operator: Your next question comes from the line of (Tracey Leader) with (Fresno County). Your line is now open.

(Tracey Leader): Yes. We've signed up as a – for the (DDE), the direct reporting – direct data reporting. And since there's no query process, I wanted to know that if we have them complete this form that you've provided, the one that has the little sample Medicare card on it, and they say that they do not have Medicare, will that protect us?

Jon Albert: I mean, well...

Male: That might be a yes and a no.

Jon Albert: ... yes and – I mean – if – if you– if you – I mean the main thing we want to tell you is the document, your attempts to get that information. But again, the – to go back to your original question regarding query, direct data entry does in fact function as kind of a default query mechanism as well.

You can begin the process of entering – of that record, essentially the first think it does when you enter the first person identifiable information is it essentially tells you whether the person – based on the information you've submitted, is – is or is not a Medicare beneficiary.

I mean that information is accurate.

(Karen Stellar): Right. But I can't do that until January 1st. And I have to report on settlements made as of October 1st.

So right now I don't know how I can tell if someone's telling me the truth or not.

Jon Albert: But you're not physically reporting until the first quarter of January. And you will be able to – the...

(CROSSTALK)

Male: ...first week...

(CROSSTALK)

(Barbara Wright): ... data entry (inaudible).

(CROSSTALK)

Bill Decker: Yes, yes, the – hi, this is Bill Decker. The – you're– you're going to start reporting on everything beginning in January...

(Karen Stellar): Right.

Bill Decker: The fact that you've got something to report on that's happening now, we're still going to be reported in January. And that's when it becomes in effect in – you know, in play, (in valid).

So you don't need to worry too much about querying on – on information you're gathering to be reported later at this point.

The form you talked about – it's one of the things that I wanted to address for you, that we provide that – or that language is out there for you to give to folks who are reluctant to provide you with personal identifying information.

When you – when you asked about that in the beginning, both Jon Albert and I said, well, yes and no, does it protect you? It – it shows us good faith effort

on your part to collect information that you could not collect and that you needed.

That's what it does and that's why we developed it for – for folks out there and situations where they tried to get identifying information from individuals and the individuals were not giving it to them or were reluctant to give to them.

It's something that you need to keep with you in case we ever need to check with you on why you didn't report on something that we now know about. That's essentially how that would work for you.

(Karen Stellar): OK, but we – we're – our policy is going to be that we're not going to settle any claims with Medicare beneficiaries. We are going to make those go to trial.

And I won't know that between October 1st and January 1st. So if I settle someone and they tell me they're not, then I'm going to have them fill out that form just so that I have it in writing that they're telling me, "No, I'm not."

(Bill Decker): That's OK, I mean, I – you know, I'm not sure what you're asking or looking for from a...

(Karen Stellar): OK. All right, thank you.

(Bill Decker): OK.

Operator: Your next question comes from the line of (Sabrina Moscowitz) with (Hughey and Lebeuf). Your line is now open.

(Sabrina Moscowitz): Hi, this is (Sabrina Moscowitz) from (Hughey and Lebeuf). I think you covered this on the last call, but I just wanted to make sure – for the DDE option, you are going to be issuing a user guide. Is that correct?

(Pat Ambrose): No we're actually adding information about DDE in all the screens to the existing Section 111, so it'll be a secure website user guide.

So that user guide will be available once you log on to the Section 111 COB secure website and – and you'll be able to download it if – if you need...

(Sabrina Moscowitz): OK.

(CROSSTALK)

So there won't be a separate user guide posted, like in the same place that the regular user guide is.

Pat Ambrose: No. No. It'll be a chapter included in the COB secure website user guide.

Yes, we also – each of the web pages will have a help page that you can go to. And then there will also be computer-based training modules available.

(Barbara Wright): And this user guide you're talking about Pat, you're talking about it for the mechanics...

Pat Ambrose: Right.

(Barbara Wright): ... of DDE. You still need to go to the full user guide to look for policy regarding who's in RRE, what must be reported, when it must be reported, et cetera. So having that user guide doesn't mean you can abandon the existing user guide for policies and overall procedures.

(Sabrina Moscowitz): OK, thank you.

Operator: Your next question comes from the line of (Vicky Rogers) with Wells Fargo Disability Management. Your line is now open.

(Vicky Rogers): Thank you. I – I think I have more clarification now on the TPOC. I just had one other question.

If we have a worker's compensation claim that – that we have already filed ORM, the claimant then dies. And we have indemnity benefits that are payable to a dependent. Do we report that as a TPOC?

(Pat Ambrose): You're going to be reporting to the ORM termination date as of the beneficiary's date of death. And then if you have a separate indemnity slash survivor only benefit, no you aren't going to be reporting that.

(Vicky Rogers): OK, great, thank you very much.

Operator: Your next question comes from the line of (Joellen David) of (Zurich Insurance). Your line is now open.

(Joellen David): Hi, good afternoon. My question is – is kind of the opposite of a previous question. It's in regards to valid ICD9 codes.

If we would load the October 2010 ICD9 codes from the CMS website, would that encompass all the valid ones, or do we have to load 2010, 2009, and 2008?

(Pat Ambrose): You – you should be fine using the most recent version. But what we are capturing are basically all the versions back to 2005, I believe it would be.

And – and then building our – our – our table of valid diagnoses based on version 25, 26, 27 and as of January we'll add any additional ones that are found in 2008.

(Joellen David): So basically what you're telling me is they were all mutually exclusive files and we should really – so a best practice type of situation take all of them and load them, eliminating all the duplicate codes that could appear on all of them?

(Pat Ambrose): That’s what I would do.

(Joellen David): OK. Thank you very much and have a great afternoon.

(Pat Ambrose): Thanks.

Operator: Our next question comes from the line of (Katherine Goldhaprin) with (Segal and McCambridge). Your line is now open.

(Katherine Goldhaprin): Thank you. I have a question about – I'll give a hypothetical and ask if I'm interpreting this right as to how it should be reported.

A settlement for a $10,000, the husband has (one cancer received) medical treatment. The wife only have a loss of consortium claim. There was no medical allegations regarding her.

This would be reportable only with the man's social security number and information to Medicare. That's correct?

(Bill Decker): The amount you're actually going to report?

(Katherine Goldhaprin): We would report the full $10,000 regardless of how it is distributed between the two.

Jon Albert: And – and the husband is the beneficiary, the wife is a beneficiary too, but she didn't either claim or release any medical in connection with her claim, correct?

(Katherine Goldhaprin): Correct.

Jon Albert: OK.

(Katherine Goldhaprin): But – and so that would be 1 percent that's correct, because the man gets reported. But if she claims any emotional disturbance and related medical care, then her claim would also need to be reported, correct?

(Bill Decker): If she's also a beneficiary, you would be – this would be another – like the family situation that...

(Katherine Goldhaprin): Right.

(Bill Decker): ... someone asked about earlier, you would be reporting the full $10,000 for each.

(Katherine Goldhaprin): OK.

(CROSSTALK)

Jon Albert: Even if she didn't claim (medical) or mental but you – you had a release and released it.

(Katherine Goldhaprin): Then her full information would need to be reported. And they would each be reported separately at $10,000 each.

(Bill Decker): Yes.

(Katherine Goldhaprin): OK, thank you.

Operator: Your next question comes from the line of (Suzanne Vic) with (Malaby and Bradley). Your line is now open.

(Suzanne Vic): Thank you. I – I would just like some clarification if it's possible with regard to the (E code and asbestos). It seems as if asbestos falls under poisoning and the choices are either accidental, or purposeful.

Pat Ambrose: You know, we answered this in our ICD9 (CBT) which I think is available now. And I don't have the answer off the top of my head. But there was a not otherwise classified code that I thought was recommended for that circumstance.

(Suzanne Vic): And I'm sorry, where is this again?

Pat Ambrose: Oh, the ICD9 (CBT) is not posted yet?

Well it will be in that ICD9...

Jon Albert: The computer-based training module.

Pat Ambrose: Yes...

Jon Albert: CBT.

Pat Ambrose: CBT, computer-based training module.

If – if we go on to another caller, I'll see if I can find the answer to that while you're – you know, as – as we go through answer other questions, and – and come back to you.

(Suzanne Vic): OK, thank you.

Pat Ambrose: Otherwise, submit it to your EDI representative and – and tell them to pass it on to Pat Ambrose and I can answer it for you that way too.

(Suzanne Vic): Terrific. Thank you very much.

Operator: Your next question comes from the line of (Katherine Dickinson) with (Fish Blackwell). Your line is now open.

(Katherine Dickinson): Good afternoon. I just had a quick clarification and then a question.

Clarification, just want to be absolutely 100 percent sure on this, if we are paying a one-time settlement to a plaintiff firm for them to allocate among their clients, if I don't know how much each individual client is getting, and I don't have individual settlement with them, I report the full amount per claimant, is that correct?

(Bill Decker): No. You cannot simply do that and not get the information. You have a responsibility to get the information in – in – in terms of how it's allocated and do appropriate reporting.

(Katherine Dickinson): OK.

(Bill Decker): But what we talked about earlier was when the time frame begins to run in situations – for example, like Viox when that settlement was signed, it was set up to have an application process and a whole – I don't remember how many steps. At least three or four steps before anyone even determined who would be paid and how much.

And what we said is until a determination was made of who was paid and how much, the time frame for timely reporting doesn't begin to run. But it doesn't excuse the actual reporting once a determination is made, who – who gets the money and how much.

(Katherine Dickinson): OK. So we'll just have to push that issue then.

And then my second question which might be kind of an odd one is there ever a circumstance where Medicare would pay for VA benefits?

(Bill Decker): We don't pay for VA benefits per se. People can be a Medicare beneficiary and also be entitled to get care at a VA facility.

But where the care is provided by a VA facility, or ordered by them, then VA is supposed to pay for it and Medicare is not. So it's paid for.

Jon Albert: There's a very, very limited inception that is in the case of certain emergency services, that the VA facility is the only available facility that performs the services under certain requirements, Medicare will make a payment but it will use government determined rates to VA facility.

(Bill Decker): Yes, that's - that's really for individuals that aren't otherwise entitled to VA services.

Jon Albert: Right.

(Katherine Dickinson): I got you. So if I asked someone that is a VA being treated strictly at VA facilities and – and, you know there's no evidence that they've been treated outside of the VA, there's a very good...

Male: No.

(Katherine Dickinson): You don't have a lien.

(Bill Decker): We'll – we'll stop you right there. You can't make that assumption.

(Katherine Dickinson): OK.

(Bill Decker): You know, the person could be coming to us for other – other care. You may not know of all their medical care.

(Katherine Dickinson): Right.

(Bill Decker): That's one of the issues with all of this reporting is if we had some way to guarantee that all bills were directed to you and that you knew about all of

them and that you'd actually paid them, we wouldn't need reporting in the way we need it.

But there is no way that you can know exactly what Medicare has been billed for.

(Katherine Dickinson): All right. So if I client who try to telling me there's no lien because they were treated only at the VA, I should still report it if I know that they're...

(Bill Decker): Yes. You still need to report it.

(Katherine Dickinson): All right, thank you.

Operator: Your next question comes from the line of (Leo Simard) with (Patrons Oxford Insurance). Your line is now open.

(Leo Simard): I'm sorry. The lady, a few calls ahead, asked a question regarding consortium claims. But just to clarify, if on a release you pay a husband and wife for a lump sum amount, both are Medicare recipients, there is no need to report for the party that was not injured in the accident if they are claiming only consortium, but are not claiming anxiety or emotional distress, correct?

(Barbara Wright): If they're not claiming or releasing any type of medical.

(Leo Simard): OK, correct. All right, thank you very much.

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

(Wendy Raider): Hi, the question I have is another one having to do with the new alert on – well you said lump sum payments of indemnity. But then I think you also said that would cover periodic payments of indemnity as well.

But the question has to do with a death claim and this would be a claim where the person – I mean, OK, the – the dependents are getting the death benefit which is indemnity. Then we have a settlement. The ORM was terminated at the date of death.

So – but as I understand you, you're saying that we're – we don't have to report the death benefit being paid to the beneficiaries because it's indemnity. Is that correct?

Jon Albert: Don't have to report indemnities survivor benefits. No.

(Wendy Raider): Yes, but we don't call it survivor benefits. That's why I'm asking, because it's worker's comp.

I mean it's just indemnity. That's what we call it.

(Bill Decker): But is the indemnity supposed to be covered?

(Wendy Raider): It's – the payment to the dependents of the – of the person who was killed – you know, it's just basically indemnity, just regular payments for them as specified by law.

(Bill Decker): It sounds like survivor benefits, but you're saying it's not survivor benefits.

(Wendy Raider): Well that's not what we all it. So I – I don't really know what survivor benefits is because I just know worker's comp.

(Bill Decker): (This question) should be appropriate location from your (state law) where they describe what this is.

(Barbara Wright): Yes, I mean, the issue is in some situation the survivors receive a payment that was a – a payment that was otherwise due and payable to the injured party, that could include more than indemnity.

And – and those clearly do need to be recorded.

(Wendy Raider): Yes.

(Barbara Wright): So when it's – when it's clearly you know, paid fully because of the survivor type situation, then you're essentially into non-reporting. But we need to know which it is. We can't just say – I know you said, "We call it indemnity." But we need to know what it actually is.

(Wendy Raider): OK, so – well in this case I'm talking about money that does not include any money that could have been paid to the injured worker. Because the injured worker is already decreased and these benefits are based on the fact that he died.

So there's no other money included in that.

Male: Again, your description is what we would call survivor benefit. But to play it safe sent it – it could be appropriate definition of those payments of your state statue. It's in the mailbox and you could – you could ask for anything.

(Wendy Raider): OK. OK. And the fact that it's a lump – I mean, it's like ongoing payments doesn't make any difference. It's just whether or not it's...

Male: And what the nature of the payment is.

(Wendy Raider): Yes. OK.

Male: But we want to see exactly how your state law describes it.

(Wendy Raider): Yes, OK. Thank you.

Operator: Your next question comes from the line of (Mike Carney) with (American Mining). Your line is now open.

(Mike Carney): Hello. Our question is – it goes back to the (OD), date of incident. And for example, we had a claim alleging, let's say, black lung disease. And this person was a coal miner for 35 years. And we were – we are not able to determine what his first date of exposure was.

How would we proceed from there?

(Barbara Wright): When you say you're not able to (determine) what his date of first exposure is, certainly there should be some recollection of the approximate date, et cetera.

If – if you have some type of affidavit or statement from him that he first worked in the mines in 1940 and that's – and the claim is a result of that, then fine. Use that date.

(Mike Carney): We can estimate to our best then? If he began working in the coal mines and he said 1940, we could – we could basically work – or use 1940 then?

(Barbara Wright): That's fine.

(Mike Carney): OK.

(Barbara Wright): Be sure and include a month and day. Whether it's January 1st...

(Mike Carney): OK.

(Barbara Wright): ... you know. But – I mean – but, document how you arrived at that date so you've got information.

It shouldn't just be a unilateral guess on your part.

(Mike Carney): OK.

OK, thank you.

Operator: Your next question comes from the line of (Deanne Muncie) with the (Education District). Your line is now open.

(Deanne Muncie): This is (Deanne Muncie) with (ESE 112) in Vancouver, Washington. And I need some clarification on the permanent impairment that is an indemnity payment.

We have a claim where ORM is reported. The worker is then determined to be medically fixed or stable without the need for further ongoing treatment. So ORM would terminate.

But they are entitled to a lump sum indemnity payment for permanent disability. Is that something that would be reported as a TPOC?

(Barbara Wright): No. If – if the ORM is terminating you have to report the TPOC payment.

(Deanne Muncie): OK. And so then would that be the same situation with the pension benefit?

Male: What benefit?

Female: Pension.

(Deanne Muncie): If a worker is unable to return to their job of injury or they have multiple injuries that preclude them from returning to work, they could be entitled to pension benefits.

(Barbara Wright): Is that pension under worker's compensation? Or is that –.

(Deanne Muncie): It's under worker's compensation, yes – indemnity payment.

(Barbara Wright): Well, you just said it was an indemnity payment. Again what we've said is indemnity or other – if ORM is terminating, then yes, you have to report those TPOC's.

(Deanne Muncie): OK. Thank you.

Operator: Your next question comes from the line of (Suzanne Cornglick) with New York State Insurance. Your line is now open.,

(Suzanne Cornglick): Hi, I just need clarification on what was said before about the ICD codes, the fact that you will not drop old codes from the list.

Does that mean if we send in valid codes, and the file is accepted by – by Medicare, right? And if we have to do a subsequent update record, if those codes have subsequently become invalid that means it's not going to error out?

(Pat Ambrose): Yes. I – in – in – in essence, yes. Those – if those codes were expected as valid at one time, they will always be accepted as valid on subsequent updates.

(Suzanne Cornglick): OK, because that’s a big change. I think we have a program to like delete those codes. But what do you call it? OK, so that means then that if we do send it, it's not going to – so it's not going to be rejected.

Because the current guide has – that if any of those codes are invalid currently, it'll be rejected. So that’s not going to happen anymore?

(Bill Decker): Not – you have to distinguish between this update and a new record.

(Suzanne Cornglick): No, I don't mean a new record. I mean an update record.

(Bill Decker): You sent one record in with ICD9, ICD codes using revision 9.

(Suzanne Cornglick): Right.

(Bill Decker): You're now sending an update to that record using ICD9 codes, revision 10. You're going to send us codes from the tenth revision of the ICD9 coding scheme. What we're telling you is that the codes you sent originally, they're from the ninth revision are still going to be valid.

If you're sending us codes that are the same as the old revision 9 codes, fine. If you're sending us codes that are from revision 10, we will accept that as valid also.

(Suzanne Cornglick): That's not what I'm saying. I was – I'm just talking about ICD9 codes.

(Bill Decker): Yes.

(Suzanne Cornglick): Send a record to CMS. And the record is accepted. We have to do an update record because we added additional codes, or because something else changed. And if we submit an update record that record might have codes that have subsequently become invalid. Would that be accepted?

(Barbara Wright): Yes, you do not need to change...

(Suzanne Cornglick): OK.

(Barbara Wright): ... the codes that you had on the records the first time.

(Suzanne Cornglick): OK.

(Barbara Wright): If – if you need to add additional codes, use the most recent codes.

(Suzanne Cornglick): Right.

(Barbara Wright): If you're letting codes remain, you can keep the ones that are no longer on a current list.

(Suzanne Cornglick): OK, thank you very much.

Operator: Your next question comes from the line of (Gladys Drigins) with (Comp Services). Your line is now open.

(Gladys Drigins): Hi, I'm calling because we are a third-party administrator acting as an agent for the (state auto cash fund). (Night cash) pays medical and rehabilitation benefits up to $50,000 annually with $1 million and (lifetime) aggregate.

Once that $50,000 has been exhausted for the year, our plan is to enter a termination date for ORM and once it renews the next year, do we submit it as an update or do we do a new add record, or how is that to be done?

(Pat Ambrose): Can you hang on just a second. OK. When you have the situation you named, you should leave the ORM record open. The policy itself is still active. You just aren't paying any additional benefits that year.

You know, if you receive a claim directly that you need to deny because you've exhausted the amount payable for that year, fine. But for our purposes your ORM responsibilities overall still exist.

(Gladys Drigins): OK, well how would that alert Medicare if you say, well they're no longer paying? Now we have to be responsible whatever other party is responsible and needs to be paid wait. That's where we're a little confused at I believe.

(Pat Ambrose): Medicare's billing processes allow for situations where the primary payer denies a particular claim. Providers and suppliers should know how to bill when they get proof that it's not going to be paid for by another entity.

(Gladys Drigins): OK, so it should remain open. OK, thank you.

Operator: Your next question comes from the line (Jeanine Barrow) with Doctors Company. Your line is now open.

(Jeanine Barrow): Yes, hi, I have a question again regarding this family injured parties. This is the case of birth trauma.

When a claim is made on behalf of the mother, do we have to report the baby as well? At that time, we have not yet sent our query, so we have not yet identified if anyone of them is (MMR) beneficiary.

(Barbara Wright): Remember, you're only reporting Medicare beneficiaries. Our guess would be you are going to have a limited number of birth mothers who are Medicare beneficiaries. Although certainly we cover people who are disabled and they're not necessarily that old.

Similarly, the only way an infant would typically be a beneficiary is if they were also (DSRD) eligible. So...

Male: (Inaudible).

(Barbara Wright): ... you're not going to know...

(CROSSTALK)

... well I don't know quite how to say it except that basically you shouldn't have too many immediately born babies that are Medicare beneficiaries.

(Jeanine Barrow): Correct. So in this case which record do we send? I mean the mother or the baby, or –?

(Barbara Wright): Well you're not sending anything until there's a settlement judgment or award.

(Jeanine Barrow): Yes, there is a – there is a settlement judgment award. But at this time, we have not yet identified either one of them as Medicare beneficiary. So...

(Barbara Wright): But you don't report unless they are in fact a Medicare beneficiary.

Male: They have to...

(Jeanine Barrow): OK.

Male: ... first find out if you have a Medicare beneficiary to report about...

(Jeanine Barrow): OK.

Male: ... and then make the report if you need to, and if you have a Medicare beneficiary to report about.

(Jeanine Barrow): All right. But...

Male: Not necessarily send us anything about anybody who's not a beneficiary unless you believe that that person – that there's a high likelihood that the person is the beneficiary and you simply don't know.

(Jeanine Barrow): OK. So in this case, if on the next (second) reporting we decided that both mom and baby are Medicare beneficiaries, we have to send two separate records with the same TPOC amount, one for the mother and one for the baby?

(Barbara Wright): Yes.

Male: Yes.

(Jeanine Barrow): OK. And the father too, sometimes the father is included. And they're all Medicare beneficiaries and they're all going to be reported. This is on beneficiary by beneficiary basis.

(Barbara Wright): Who is the injured party? And who is (inaudible)? If it's only – if the claim is on behalf of the mother and she's the only one where they're alleging – alleging or releasing medicals, then you're only going to be releasing her.

The fact that there's a father who's a Medicare beneficiary doesn't by itself make him reportable.

(Jeanine Barrow): OK. So it's always – so OK, so we're only going to send only the claim who's against. And then as far as the baby...

(Barbara Wright): You're looking for who the injured party is. Who's receiving – you know, the settlement on their own behalf. When people have been talking about lost

consortium plans or family plans, in each case we've said that it hinges on whether or not that person is claiming and/or releasing medicals.

So if this – if mother is somehow harmed during birth and there's – even if the – even if the baby had (ESRD) and they got him or her a social security number on the day they were born, et cetera. If there is no claim or release of injury with respect to the – the baby, there would be no reason to report them.

Similarly if father was in the waiting room and isn't claiming mental distress or anything else and even if he's the beneficiary, he's not going to be reported.

(Jeanine Barrow): OK, thank you very much.

Operator: Your next question comes from the line of (Jamie Schultz) with Methodist Le Bonheur Healthcare. Your line is now open.

(Jamie Schultz): Hi, thank you. Again, I'm (Jamie Schultz) from Methodist Le Bonheur Healthcare. And I just wanted to clarify about the reporting which begins in 2011.

Anything that we have settled that would be reportable from October 1 for this year will be reported in 2011. But only on the time period we required to report. Is that correct?

In other words, my reporting period begins February 8, so I wouldn't be reporting until February 8. Is that correct?

Male: Yes.

(Barbara Wright): You always report during your assigned submission window, yes.

(Jamie Schultz): All right, thank you very much.

Operator: Your next question comes from the line of (Peter Foley) with American Insurance. Your line is now open.

(Peter Foley): Hi, you all, just an observation. The – the Medicare should consider having an internal discussion between those who are trying to fight fraud and your

group that is trying to set up a – appropriate reporting mechanism. Because it is not helpful to be running TV ads saying do not give your social security number or Medicare number to anyone, especially somebody calling you over the phone.

Because the way most insurance companies are going to solicit this information is through phone and letter. And this is going to make it all the more harder by having an ad campaign out there – just an observation.

(Bill Decker): Yes, thanks, (Peter). We're aware of that. I mean that's an ongoing issue with a lot of beneficiary outreaches. The concern over privacy or you know, use of social security numbers in particular.

We have tried to get some of that information updated or modified as we've run across it. But...

(Peter Foley): Yes, but, your running TV ads against it.

You know, a pamphlet is not as powerful as a TV ad.

(Bill Decker): Yes.

If you – if you have any ideas about this and you want to submit them to me directly – this is Bill Decker.

(Peter Foley): Hi, Bill.

(Bill Decker): You can please do so. And that's for anyone who is on this call.

This is an ongoing, as John says, it's an ongoing issue. The entire (gestalt) identity and identity theft and identity protection is something that is in the forefront of every federal agency, not just this one.

And we are all trying to do our best to do our jobs, while at the same time getting the information we need to do the job. So anybody has any ideas, please get them into us.

Appreciate it. Thank you.

Operator: Your next question comes from the Line of (Maria Krose) with (Elam Fire). Your line is now open.

(Maria Krose): Good afternoon. From previous calls, it appears that CMS is going to distribute some additional RRE definition information. Is that still the case?

(Pat Ambrose): We're still looking at putting out some additional examples. But none of the examples will change the definitions that are out there right now.

(Maria Krose): OK. Do you know when those might be distributed?

Jon Albert: We're aiming to wrap up a lot of the ones we've got within the next couple of weeks.

(Maria Krose): Perfect. Thank you very much.

Operator: Your next question comes from the line of (Michelle Cox) with Knoxville Utilities. Your line is now open.

(Michelle Cox): Good afternoon, thank you. We're a municipal provider for utilities in the city. We run our own claims department and process all customer damages and injury claims.

I understand the release wording and it's been our business practice to have a standard one that includes everything known and unknown.

Whereas we – we don't fulfill payments on property damage, it sounds to me like now where I had been thinking I'm just worried about injuries, if I want to keep the same working we've always had, I'm going to have to start blanketing my claims paperwork to claimants, even if it's a property damage just to cover myself to find out if they're a Medicare person or not. If I want to keep the same language that – you know, known and unknown at this point.

Am I correct?

Male: I mean, you know, the – the requirements under Section 111 are the requirements under Section 111 in terms of reporting...

Male: ... judgments, awards, et cetera that are – that Medicare should be secondary to.

We can't advise you on your business practices. But that is the requirement though.

(Michelle Cox): So if the property damage that I may detain from October 1st of this year on, and I know it's going to be at that TPOC $5,000 and higher, I best be getting your model language form to those people so I can make sure I'll be ready for reporting, even though it's a property damage and it's a $5,000 or more.

And I'm also going to need a special code because it won't even be injury related, so I can report. Right?

Male: But what – in just saying property damage, how is that medically related?

(Michelle Cox): Well, if they're signing a release, one of our standard releases if we do may a payment, it's – it's a kind of release that includes everything known and unknown, which includes, you know, any release of any personal injury or death and so on and so forth and so on and so forth.

So there may not have been any injury, but we have a standard release form that has that language in it.

Male: Yes, – we're – we're not really sure how to – how to answer you on that. I mean, again it comes down to whether medicals were claims released or not. And then – but it sounds like if the property – why would there be medicals associated with property damage?

(Michelle Cox): And there wouldn't be...

Male: No – we – we really can't – I mean, we – we can't be put in the position of answering questions about a business model that we don't know or have first hand knowledge of.

(Michelle Cox): Of course. So if it's a property damage and the claimant never said anything about injury, but if they– we –we present them a settlement and we have them

sign a release where we use standard language that includes everything known and unknown which often includes any personal injury and death and so forth, just them signing that – even though they never said anything about injury, I'm still going to have to report it if it's $5,000 and up next quarter, right?

Male: I – I can't answer that because again, if it's – if it's a property insurance, then it's property damage. That's – you know, on the surface doesn't sound like medical. It's not just a purely property...

(Barbara Wright): And if it's a property damage policy...

Male: Yes.

(Barbara Wright): ... and it can only pay property damage, we – and we've (said in) the guide that RRE's are not required to report liability insurance, property damage only claims...

Male: Yes.

(Barbara Wright): ... did not claim and/or release medicals or have the affect of releasing medicals, what you're telling us is that on a standard practice, you're going to have them...

Male: Yes.

(Barbara Wright): ... release medicals.

(CROSSTALK)

That's – that's a business decision on your part.

Male: Yes.

(Michelle Cox): No, if it's our standard practice even on property damage. And they get a settlement amount and they're a Medicare beneficiary, if I had a TPOC of $5,000 or more, next quarter I'm going to have to report it because even though they never me told they had an injury, the paperwork that they signed

says we're releasing any future medicals, even though there never was one. I'm going to have to report that, am I right?

Male: I – I don't think we can necessarily advise you on that. I mean...

(Michelle Cox): Well I don't want to be at risk of your penalty of $1,000 a day, you know.

(Barbara Wright): And – and – I would make a distinction. If it's a – if it's a policy that only covers property damage, and it can only pay property damage, that's a different issue.

(Michelle Cox): Well we're self-insured. We're self-insured. And that budget line item pays out property and injury.

So those dollars are paying property and injury.

Male: Can you hang on just for a second please?

(Michelle Cox): Thank you.

Male: We have language in the user guide. I'm sorry, we're back again.

We have language in the user guide that touches on this, and that's about as much as we can provide to you on your immediate question at this time.

And if you want to...

(Michelle Cox): Can you tell me that ID number or page, or anything for reference?

(Pat Ambrose): Yes, in Section 11.10.2, there's certainly information about claiming and/or releasing medicals. But that paragraph – subparagraph that Barbara referred to is on or about page 95 and it starts out saying, "RRE's are not required to report liability insurance including self-insurance settlements, judgments, awards, or other payments for property damage only claims, which did not claim and/or release medicals or have the affect of releasing medicals."

(Michelle Cox): So I may have the affect of releasing medicals...

(Pat Ambrose): Yes, we understand the point that you're making...

(Michelle Cox): OK.

Pat Ambrose: And – and right now, CMS is saying that all they can advise you or you know, our only answer is what information has been provided in the user guide to date.

(Michelle Cox): So if I keep my release form as it is today, that covers all or everything...

Pat Ambrose: And there's a lot of stuff that we're – we're looking for – we – you know, the fact is, we don't want property damage only claims reported. Since it's not helpful to anyone.

But...

(Barbara Wright): We can't simply exempt people from the MSP requirements based on their own personal business practices and things that they've chosen to include in their releases.

Male: I mean, the important distinction is that goes beyond the Second 111 reporting requirements. That's part of the general MSP statue. So –.

(Michelle Cox): I do appreciate everyone's time and – and these conferences are very valuable. Thank you.

Male: All right, thank you.

Operator: Your next question comes from the line of (Nancy Lock) with (Fulbright and Jaris). Your line is now open.

(Nancy Lock): All right, thank you.

We have some questions from some clients. Especially when Medicare Advantage is the insurer, so to speak, but our understanding is that still going to be reportable to Medicare in the usual method, correct?

Male: Yes. As...

(Nancy Lock): And then – so the question is that if – does Medicare Advantage then have a right to reimbursement, or does – will that be handled directly through Medicare?

Male: No, as we've said in the past, both Medicare Advantage and the Part D drug plan have their own direct recovery rate.

(Nancy Lock): Right.

Male: So any resolution needs to be done with them directly. But the issue is among other things, that the fact that someone's in a Medicare advantage plan doesn't mean that fees for service didn't pay one or more services.

(Nancy Lock): Right.

Male: It – it also – people can go in and out of the Medicare advantage plan...

(Nancy Lock): Right.

Male: ... (inaudible).

(Nancy Lock): And so there'll be information passed between regular Medicare and the Medicare advantage programs and who's getting what or are we going to be (whip side) a little bit?

Male: Well the data that we collect on Section 111 is going to be provided to the fee plans through normal data dissemination processes, a common working file and (MBD).

(Nancy Lock): Oh, excellent. OK.

And...

Male: But the point is the recovery – the responsibilities regarding recovery and repaying Medicare, beneficiaries have an obligation to repay PDP plans or Medicare Advantage plans as appropriate already.

(Nancy Lock): Right.

Male: ... (inaudible) the pool. It's not something that is replacing or adding to general recovery responsibilities. It is simply an additional reporting requirement for certain entities.

(Nancy Lock): I think the concern that some of our clients raised were they were concerned that they were going to kind of get (whip sawed) between the two. But it sounds like you two are talking so that answers the question.

And – and just to the previous caller, one question that came to my mind is if you have something like she's describing with a general release, and I understand we're reporting those, but what do we put for an ICD9 code?

I think that's our biggest issue with those kinds of cases.

Pat Ambrose: Hold on one minute please.

(Nancy Lock): OK.

Pat Ambrose: We don't really have an answer for you at this time. And – and recommend that you – you know, pick the best code that – that you can to describe the – the alleged clause and the injury. And I realize that you don't have a – a lot of choices there, but we just don't have anything else to advise you.

Female: Yes, because it – like she was saying, it would be one where there's nothing really plain. But we would include it in a general release. So I guess we're just – pick something.

(Nancy Lock): OK, thank you very much for your help.

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

(Susan Kline): Hi everybody. I guess I just need just a little bit more clarification about these permanent partial disability awards that are after claim closure.

When I – when the question came up early in the teleconference today, I wrote, "lump sump payments for indemnity benefits which are permanent

partial disability here, the RRE does not report if ORM has already been accepted. If no ORM then it must be reported."

Then later if – if ORM is terminated, then you must report the TPOC.

(Barbara Wright): When we were talking about ORM being accepted, whether it was your shorthand or our shorthand that's speaking, the – the concept is if – if there's already been ORM established and it's continuing, that you don't have to report the indemnity TPOC payment.

But if there hasn't been ORM established at all, or it's been established but it's being terminated, then you do have to report the TPOC indemnity.

(Susan Kline): OK. And in the case of the liability, because we're self-insured, self-administered here, when the liability folk get ready to do a settlement on a medical issue they have to – they're responsible to find out whether there are any conditional payments made.

Because this is a statutory permanent partial disability award, is there any obligation on our part to find out if there are conditional payments made for this individual when we terminate ORM, which is typically somebody has a knee injury, they have surgery. Part of their meniscus is removed. They're released back to regular work and they get $2,500 permanent partial disability award for the body part that's, you know, been cut into.

Their – is that...

(Barbara Wright): That's arguably any entity that has primary payment responsibility is supposed to know about that primary payment responsibility and pay appropriately.

If nothing else from a – a standard business practice, if you're looking to close the whole thing and you don't want to be surprised at a later date, you may wish to notify us that you – that you're looking at closing the record and you want to know whether there are any existing bills prior to this – whatever your termination date is for ORM, so that you can close your files entirely.

We can't tell you how to set up a whole business practice for what you want to do. But yes we could be coming after you for money that was owed for services prior to when ORM was terminated.

(Susan Kline): OK. Even though we accepted the ORM, we made all the payments, da, da, da, da, da.

(Barbara Wright): Well if...

(Susan Kline): No I'm just worried about the – the injured worker. That they're – you know, that – that CMS is going to say, "Oh, well, you know, the City of Portland is saying that no longer is your knee injury the major contributing cause of your need for treatment. The doctor released you and said you don't need anymore treatment."

And they go in because they bumped their knee and you know, then CMS is going to say, well you got $2,500 for your conditional payment, so you have to use that money to pay instead of Medicare paying.

When it's a statutory – it's – it's – we have to pay them that money. It doesn't cover future medicals. It doesn't cover – it doesn't cover future medicals period.

(Barbara Wright): Beneficiaries with – with whom we make or against whom we assert a recovery demand do have protections built into the process in terms of challenging the existence of the overpayment, asking whether or not they're entitled to a waiver of partial or full recovery.

If there's a situation where the – the claims that we would assert against them should actually be being paid by their worker's compensation contract, then they should be notifying us of that.

And also in many cases where we do demands for recovery of worker's compensation or no-fault, the actual demand does go to the insurance entity rather than the beneficiary. It's liability settlements that we (inaudible) send the recovery demand to the beneficiary.

(Susan Kline): OK, so we report the (TP), the claim closed, ORM terminates and then we put in the $2,500 and we just wait and see what happens, I guess.

If there's – I mean, we have lifetime medical here. If he goes back to the doctor we'll reopen it. If it's an aggravation of (perpalitive) care, and we'll go in and we'll say, ORM yes again, you know, and then pick it up from there.

(CROSSTALK)

(Barbara Wright): If you have lifetime medical, we're not clear exactly why you're terminating ORM. Because what we've said is that you cannot terminate ORM if there's lifetime medicals, unless you have essentially a statement from the treating physician that there will be no further care required.

It's not just a matter of inactivity on the record.

(Susan Kline): No, no, that's it. We – we can't even close a claim without a doctor saying that. But they do have five-year aggravation rights.

(Barbara Wright): OK.

(Susan Kline): You know? They could have something twisted at home and the doctor says, "Oh, oh it's an aggravation claim." And then we'd have to reopen it.

(Barbara Wright): (Fine).

(Susan Kline): OK? All right, well, thank you.

Operator: Your next question comes from the line of (Peter Gunn) with Applied Underwriters. Your line is now open.

(Peter Gunn): Hi, I was just wondering if you could define what you mean by indemnity benefits. Because usually with worker's comp indemnity benefits are for wage replacement or something that has nothing to do with medicals. It's about – it's a financial benefit to the claimant to restore them to approximately where they were at the time of their injury.

So I don't – I guess I'm really struggling to understand...

... indemnity payment required by statue and for things like lost wages, et cetera. And ORM remained open, it's going to be – (the) reports.

Female: Right.

(Peter Gunn): So why does it need to be reported once ORM closes, since it's still not claiming or releasing medicals?

(Barbara Wright): We – we are entitled under Section 111 to collect information that we need for proper coordination of benefits including any recovery actions. One of the things we do, and this is just an example, but one of the things we do when we do a recovery action is if the matter is in dispute, and the – any attorney fees and costs are actually borne by the beneficiary, we do a pro rata reduction in determining the amount of our actual recovery claim.

We would need to know the total amount that's involve din any settlement including indemnity et cetera in order to properly calculate our procurement cost reduction, so that's one reason we would need the information.

Whereas in an – continuing ORM situation, we would most likely be pursuing recovery directly against the worker's compensation entity. And it wouldn't be the same issue.

So that going into a lot of detail on recovery, that's just an example of why we need it.

Again, we need or were requiring, reflecting information under Section 111 to serve different facets of our whole coordination of benefits process.

Prepay, post pay, recovery, so it may not always be apparent exactly how we'll use that information.

(Peter Gunn): I understand that party, I guess I don't – it...

END