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: September 30, 2009

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

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

FTS-HHS HCFA

Moderator: John Albert
September 30, 2009
12:00 pm CT

Coordinator: Welcome and thank you all for standing by. All participants will be in a listen-only mode until the question and answer session. If you would like to ask a question at that time you may do so by pressing star 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time. And now I would like to turn the call over to John Albert. Sir you may begin.

John Albert: All right thank you. And good afternoon or good morning depending on where you're calling in from. Today is Wednesday, September 30, 2009 and this is one of the continuing conference teleconference events that we have been hosting to implement the Section 111 provisions.

This call is specifically geared toward non-group health plan policy on the CMS Web page which I'm sure you're all familiar with. I won't bother repeating it. There is a complete listing of all future conferences as well.

With me is the usual cast and crew of Barbara Wright, Bill Decker, (Bill Zavonia) and several others who are offering support on this call.

I'm going to just make one brief announcement and I'm going to turn it over to Bill Decker who will then go into a couple of issues he wanted to bring up. And then Barbara Wright, since she's a policy person here for this call will begin with the presentation as well.

We don't expect the presentation to be too long. We'll be able to get right into question and answers fairly quickly.

One of the things I just wanted to mention for those on the phone is that we are aware that because of the large volume of enrollments coming into the Section 111 Web site that some registrants are receiving error messages when they're trying to register on the site.

We are aware of that and a fix is going in this week. What we would ask and for those that would like to register now is that if they could - if they want to try so they can - the best time to do it is either early in the morning or late in the day.

Mid afternoon is not a good time because it will more likely generate those errors. Or if you'd like you can just wait until next week.

So September 30 deadline. And I recognize that people are concerned about making that deadline. But for purposes of this process the registration deadline is not as critical as the - actually of the data submission window.

So you can register next week and you'll be fine or even the week after that. The main thing is, is planning towards implementation next year. So again if you would - if you haven't registered or have problems registering, by all means you can wait until next week when that fix should be implemented, you know, or try early in the morning or late in the day.

Barbara Wright: And to add on to what John was saying -- because we're still getting a number of questions from people who haven't registered because they're waiting to see final language on who is an RRE et cetera -- we want to emphasize that

we've said repeatedly on the calls that CMS will not fine an individual or entity out of compliance solely because they haven't registered prior to 10-1.

Our biggest concern is that you be registered soon enough that you're able to test during the entire quarter of January through March 2010 and that you're capable of going into production with the quarter starting April 2010.

John Albert: Okay. And I guess with that I'll also state as I do at every call and that is, you know, we try to provide as much information as accurately as possible. But again the official source of the requirements is the actual - are the actual User Guides and specific documents on the Section 111 Web page.

So if there's an instance where we contradict those materials which can happen sometimes, please refer to the documents of the official instruction from CMS, not anything said on these teleconference calls.

And with that I'll turn it over to Bill Decker who wants to make a couple of points and then we'll move on.

Bill Decker: Thanks John and good afternoon everybody. I am Bill Decker and I do have a couple of points to make.

First of all I want to go over with all of you on the call the main point that - which is that this is an NGHP call as John mentioned.

This is non-group health plan only. If you're a GHP person this is not a call for you. You don't need to stay on.

And today we are focusing policy questions, not technical questions. We'd like to have you make sure that you only ask us questions about the policy

implications of Section 111 reporting for you. And we will do our best to answer them.

In addition I want to go over with you a brief explanation once again of what we call our escalation process which is a description of what you need to do if you working with your EDI representative and you are not getting the answers you think you should be getting and you want to talk to somebody else.

In your User Guide, the NP - NGHP User Guide the escalation process is described on Page 104 which is in Section 18 of the User Guide. It's called Customer Service and Reporting Assistance for Section 111.

Specifically that is Section 18.2 starting on Page 104. And that's in the NGHP User Guide Version 2.0 dated July 31, 2009. That's the process to follow if you think you need to...if if you are a signed EDI rep to move a particular problem that you think you may be having further up in the hierarchy at our coordination of benefits contractor.

Secondly, we want to tell you that new information has been added to both the GHP and the NGHP pages on the Section 111 Web site. This new information is dated September 28, 2009.

It concerns what we refer to as the use of agents. And this particular new information reinforces something we've said on these calls a number of times that we want to go over again.

We want to reinforce for you that the agent simply works for the RRE. The agent is not responsible for the integrity of the data. It is the RRE that is responsible for the completeness and accuracy of the data being submitted on its behalf by their agent.

Thus if there are problems as a consequence of data issues that arise, it is not the agent that we will be talking to. It is you the RRE. You have to keep that in mind as you're going through this process.

Another announcement we want to give you today, it concerns the issue of foreign addresses. If you are a company that believes you will have to be a Responsible Reporting Entity and that you will have to register as an RRE but you do not have a US address or a US tax ID number, a TIN or EIN and as we call it both ways -- it's still the US tax ID number -- we're asking you to wait a little bit for further instructions from us before attempting to register.

We want to get this process for registering foreign companies without TINs in place before you try to register.

Our instructions for how to do that are currently under development. And when they're completed the instructions will be posted on the Section 111 Web site. And the publication alert will be emailed to all of you that the posting has occurred.

There aren't a lot of companies quite honestly, that are foreign based that may have to report to us that we are aware of yet. But there are a sufficient number that we do need to get a process in place to have them properly registered.

And then finally I'd want to remind everybody that the computer based training classes for the non-group health plan reporters are available to you. They are listed on the - or they're accessible to you through the computer based Training page on the Section 111 Web site.

Complete instructions for registering are on that page. And the NGHP course list, the course list available to non-group health plan reporters which is also available on that page was last updated on September the 15th. And that will give you all the most current information on courses that are currently available to you. That's what I had. Anybody else have something else? John does I believe.

I one thing I also wanted to mention that's come up that's causing some issues is that for folks that are registering we're getting word that whether intentional or not, a lot of the emails that we used to keep in communication with the RREs, agents, authorized reps et cetera are being tagged as spam.

Whether that's on purpose or not, you know, we don't know because it depends on, you know, your servers at your site. But again, that's very critical that you take those, you know, receives those emails especially the - we're concerned about, you know, kind of I guess you could say someone using an agent and essentially thinking they can turn the keys over to the agent and not have to deal with CMS.

Well again as (Bill) mentioned whether - if you use an agent it doesn't really matter. The RRE is ultimately responsible for implementation of the Section 111 reporting. And you do not want to turn, you know, turn those or cut off those emails that are needed to not only warn you of issues related to compliance or lack thereof, but also if there are issues with the data that affects, you know, essentially claims processing and payment as well as Medicare recovery, it's absolutely critical that you receive that information as email is the primary mode of transportation since there are so many RREs registered as kind of, you know, to get the message out to as many people as quickly as possible.

So please check to make sure that and work with your EDI rep. Make sure that, you know, your entities spam filters aren't cutting those out or if you've purposely label them as spam we strongly advise that you do not do that or, you know, allow those messages to come through.

Because they're absolutely critical to, you know, officially operating this process for both CMS and the RRE and its agents.

So there'll probably be more coming out on that. So other than that I guess I'll turn it over to Barbara who wanted to go over a few things.

Barbara Wright: Thanks John. The first thing I wanted to mention is the Web site because we've been getting some questions lately in terms of what's the most current documentation.

As again, as we've said on some of the prior calls, we have some limitations internally on how many documents we can post to each tab on the Web site.

So in addition to looking at the tab, that is the liability insurance, no-fault insurance and Workers Compensation insurance, if we run out of room there -- and I think we're at the limit right now -- normally we then try and post the document right on the What's New page.

So you should be looking at the What's New page for downloads. And occasionally it will be a subject matter that crosses both GHP and non-GHP so it will be posted on the overview page.

If you haven't been looking at the items where you scroll down on the What's New page, then you're missing some of the alerts and some of the most recent documents. So I just wanted to remind people of that.

Man: There's actually been a number of updates to the Web page that is forcing us to move stuff around on that overall - you know, under the tabs and what not. So we apologize for that but unfortunately it's beyond CMS's control. We have to work within the limitations we're given unfortunately.

Barbara Wright: Yes we do have people that are working on making the whole dedicated Web site a more dynamic Web page so that we shouldn't have that future that problem in the future. But we wanted to make sure everybody was aware of it for right now.

The second thing is clinical trials. We're still getting questions on that. That language is still in clearance here so that's forthcoming.

Write-offs. We have heard most loudly from hospitals in terms of hospital write-offs. But the question of write-offs, putting out exact language obviously includes physician and supplier write-offs. It can include other types of write-offs too.

We are continuing to meet on various associated issues on that so we don't have final language on that to give you yet. But it is under consideration.

The RRE language, the draft language that was put out, we're continuing still to review comments and make final tweaks to that. Let's see, mass torts and product liability, as we had said before, we were forming a workgroup. We did have a meeting yesterday. We're having another meeting probably next week.

To give you a flavor of where we're going is first of all whatever we do we want to be able to fit it into the current record format.

We don't want people to have to make major significant changes at this point. But we’re considering not just narrowing down that terminology but potentially replacing it.

For instance for product liability that term may end up being replaced for certain types of torts. It may be limited to simply ones where there’s ingestion, exposure and implantation.

That hasn't been decided for sure but that’s one of the items we talked at in the call, the same thing in terms of mass torts. To the extent we’re defining mass torts we’re defining it for purposes of this reporting.

So it won't necessarily be mass torts as certain people think of them right now. What we’re most concerned about is being able to define and deal with cases where by the very nature of the way they’re settled, the information that we require to be reported isn't necessarily in existence or available at the time the TPOC date would occur based on our rules.

For instance -- and I think we've mentioned this before -- some of the pharmaceutical cases for example Vioxx had I think it was approximately 24 months. But its settlement had a 24 month plan to have people apply to be part of the class and then to determine who would get paid and how much would be paid et cetera.

And that type of situation, the information simply doesn't exist at the time of the so-called TPOC date the way our documents are defined right now.

So some people in the workgroup are working on submitting suggestions to CMS in ways we can redefine those terms and still fit the information on the record layout that we've got right now.

So we will keep you posted as we move forward. But we don't have definitive answers. We think the way we're moving will be more flexible for the industry than if we were to simply to say we need to live with what's in the record layout right now.

So our interest is in protecting the Medicare trust funds but also making it as flexible as possible for you when we're doing things.

And some truly policy issues that are sort of preliminary that we were surprised to see questions but we're still seeing them, there's still a number of questions that turn up that ask about reporting for someone who has Medicaid.

Section 111 reporting is for Medicare beneficiaries only. When you're asking us about Medicaid it's not part of this process. Some of the questions that have come in have been from entities who deal in large part with children.

And so children normally aren't going to be Medicare beneficiaries. In fact virtually the only time when you're under - until you've had a job and earn and have wages on your own as a child, virtually the only time you could have Medicare would be if you were ESRD and you had it on your parent's record. And that's not liability, no-fault or Workers Compensation. So need to be careful about Medicaid.

The second thing is we continue to get questions asking whether a certain type of liability insurance is covered, some of it in the context of medical malpractice or certain types of omissions insurance et cetera.

And what we've continued to say is that Medicare secondary payer provisions apply to all liability insurance. But we've also said is when you have a claim that is not for any type of medical and doesn't have the effect of releasing medical, so let’s say you’re in a car accident that’s strictly a fender bender and the only claim is being put in to repair that fender, no we don't want no about that.

So while it applies to all types of liability insurance, you have language in the User Guide to allow you to exclude situations that clearly don't include medicals.

A third one there we’re a little bit surprised about some of the questions coming in is about when to report. We - and these are after the most recent policy calls.

There was one question about basically how long after payment of TPOC do I have to submit the claim?

The User Guide sets out how you define TPOC dates. So first of all I don't want to just say payment of claim because if you look at the record layout it tells you how you arrive at the TPOC date?

And then you have reporting responsibilities that you should be reporting it on your next quarterly submission but there’s a 45 day grace period built-in. So that if you had a settlement or a - with a TPOC date that was say a week before your file submission dates so you didn't have time to process it, that’s 45 day grace period would then allow you to delay reporting to the following quarter.

So if you look at what's in the User Guide we believe it covers when you should report in that type of situation.

We also had a question from a large corporation that was talking about the fact that it was self-insured for general liability. And many of the cases were in litigation. They would settle at some point. But they're only in litigation and could be there for years so should they have a separate RRE ID for those cases et cetera?

And no, they don't need a separate RRE ID just because something is pending in litigation versus the fact that it's settled or a TPOC issue you're never going to report until the TPOC date.

And if it's ongoing responsibility for medicals you need to report it now. So as I said, we're a little bit surprised at some of the questions about when to report.

We also have one about it was asking about litigation situations and reporting it while it's pending litigation again.

So it's back to if you have ongoing responsibility for medicals that's been established either under law or by you voluntarily taking that, then you need to report even while further action is taking place.

But if you're not making any payments and the only result is potentially a TPOC issue, then that's not reportable unless and until there's a settlement judgment award or other payment.

So for those who are asking that type of question we would ask that you go back to the User Guide and take a more careful look at it.

We also had a question about information about representatives. And we have a place in the record layout both for the representative's name and the representative's firm.

And at one point on one of the calls I believe it was stated that we might give people the choice of reporting one or the other. And we did not include that in the updated manual. And we made a determination that we're not going to allow that because we need that particularly on the backend.

If we get both those pieces of information it will help us match up reporting that is done through Section 111 with situations where a beneficiary or their representative has self identified a case while it's still pending.

If they happen too report only under an attorney's name and not the firm, and you report only the firm name, then we're likely to have to come back to you for another piece of information.

If we get both those pieces of information to start with, it makes our matching process much more feasible and greatly lessens the possibility that we'll have to come back to you for information.

That's the driver behind part of the information that we're asking for. We really don't want to have to come back to you a second time.

So those are sort of the overview comments we had. And operator if you'd like to open it up for questions?

Coordinator: Yes. We will now begin the question and answer session. If you would like to ask a question please press star 1. Please unmute your phone and record your name clearly when prompted.

Once your line is open please state your organization. To withdraw your request you may press star 2. And once again to ask a question, please press star then 1. And one moment for our first responses.

John Albert: And operator we also would like or appreciate if folks could limit their question to one question and one follow-up, so that we can have as many people get their questions answered as possible.

Coordinator: Okay the first question will come from (Bert Anderson). Your line is open.

(Bert Anderson): Thank you. In our state in addition to paying indemnity benefits and medical bills, if an injured worker has a permanent loss of use or a scar, we issue a payment for loss of use and scarring.

Could be a few hundred dollars, could be $20,000, $30,000. Do you expect us to report those payments as TPOCs?

Barbara Wright: Can you hang on a second?

Bill Decker: If that included payment for the medical regarding the loss of the limb but there's going to be ongoing treatment then they...

(Bert Anderson): I'm sorry, I couldn't hear you. Could you repeat that?

John Albert: Oh, can you come over here (Bill) because h can't hear you?

Sorry, we have a few less mics than we used to have in here.

(Bert Anderson): Okay.

Bill Decker: If the payment includes medical items and services related to the removal of the limb and then ongoing treatment of the limb, then it would be reportable.

If it's merely, I don't know what to call it, damages if you will, because the limb was lost and does not include any medicals...

(Bert Anderson): Yes.

Bill Decker: ...then it would not be reportable.

(Bert Anderson): All right. Thank you. And do I get one more question?

John Albert: Sure. Just one more.

(Bert Anderson): Yes. I've got your model notice. My concern is what happens if the injured worker simply refuses to sign the model notice and we've called him and we've written to him and they just don't sign it as opposed to signing your forms saying they're not going to give us their Social Security number?

Bill Decker: Hang on just a second please.

All right. Hi. This is Bill Decker. Essentially what you need to tell us with that form is that someone didn't sign the form and refused or didn't - or basically refused to give you the information that was asked for on the form.

(Bert Anderson): Okay.

Bill Decker: What you can keep on file yourself and that will show that you did try to collect the information. What we need to have however, is that the person who refused to provide the necessary information does need to note on the form that they had seen the form and were simply refusing to comply with the - with what it was asking for. And...

(Bert Anderson): Yes.

Bill Decker: ...they need to sign it.

(Bert Anderson): Yes. That's - I anticipate that at least half of those people are just going to refuse to sign anything including their acknowledgment that they're refusing to provide the information and, you know, despite our, you know, informing them they have to or following-up with letters and phone calls.

And I didn't know if, you know, if we keep copies of our letters to them explaining everything and their enclosure and explain, they just simply refuse to sign anything.

Barbara Wright: You need to document what you're process is and what was followed.

Bill Decker: Yes I mean that, you know, that's there's no necessarily right or wrong way. But again it's just you just need to document...

(Bert Anderson): Okay.

Bill Decker: ...that you are making that attempt. I mean yes you're right, there is lots of people out there who will receive that and be like I'm not signing anything

even though we put that on there as an option, you know, I refused to sign but...

(Bert Anderson): Oh I. know.

Woman: If you also had everybody refuse to sign in your records we wouldn't find that...

(Bert Anderson): Yes.

Woman: ...doubtful.

(Bert Anderson): Yes.

Bill Decker: I was going to say practical matter, I would also suggest including some to the extent you can, proof of receipt...

(Bert Anderson): Yes.

Bill Decker: ...by the named individual.

(Bert Anderson): Sure, so certified mail or something.

Bill Decker: Yes.

(Bert Anderson): Okay, all right thank you. That's sort of what we plan on doing.

Bill Decker: Yes. I mean, you know, like we said before I mean if they're 65 or over chances are they have Medicare. So...

(Bert Anderson): Right.

Woman: Right. You can always...

(Bert Anderson): But that's going to be very few but I anticipate there will be a few.

Bill Decker: Okay.

(Bert Anderson): Thank you very much.

Coordinator: The next question is from (Jeff Hame). Please state your organization. Your line is open.

(Jeff Hame): Hi. Good afternoon. I'm with Sedgwick CMS. And the question that I'm going to pose today I'm actually posing on behalf of one of our clients who raised this question to us. And we weren't exactly certain how to answer the question.

It has to do with exposure on an asbestos case. Essentially the issue is this. Is it reportable if there was exposure to our client's asbestos product that ended before December of 1980 but the exposure to all the asbestos in his life extended after December 1980?

If for example if like he was exposed to asbestos that they are liable for the period of 1950 to 1975 but he was also exposed to asbestos that someone else is responsible for from '75 to '85, do they have to report that matter if they settle it?

Barbara Wright: Well only what their responsible - well first of all as someone in the background here was saying is are we talking Worker's Compensation or are

we talking liability? Because the 1980 date is irrelevant if its Worker's Compensation.

Because we have been secondary to Worker's Compensation for the existence of the Medicare program.

(Jeff Hame): We are talking Worker's Compensation.

Barbara Wright: Okay if it's Worker's Compensation if you read the User Guide that 12-5 '80 date is totally irrelevant when it's Worker's Compensation.

We have always been secondary so any settlement judgment award that's Worker's Compensation, yes you're going to have to report.

(Jeff Hame): Okay thank you.

Coordinator: Next question is from (Darryl Brown). Please state your organization. Your line is open.

(Darryl Brown): Good afternoon. I'm (Darryl Brown) with Sedgwick Claims Management Services and thank you for taking my call.

In the spirit of complying with MMSEA we've been doing a lot of analysis of our claims. And we find that a lot of our claims do close without proper follow-up with treatment on behalf of the claimant. They'll return to work. They'll stop treating. They won't go back to the doctor. And despite our best efforts we can't get a final letter from the doctor saying the person no longer needs treatment.

In these cases say you have someone that's 16 years of age, do we have a requirement where we accepted ORM to continue querying this person or the CMS to determine if they're a Medicare beneficiary?

Barbara Wright: Well first thing would be the plan that you're paying this under, does it have lifetime benefits? Does it...

(Darryl Brown): Yes.

Barbara Wright: ...time-limited benefits?

(Darryl Brown): It's a lifetime medical state.

Barbara Wright: I mean technically you have an obligation to check. So therefore if, you know, you want to be able to close it, we need something that essentially treatment has ended.

That's part of the reason what we put in place was at least for the initial year a threshold of $750 for Worker's Compensation for ongoing responsibility for medicals. And the specific criteria are spelled out in the User Guide.

If it's for medicals only if there's essentially no lost time we spell it out more specifically. And if you're making the payments direct to the provider with the hope that small ones like sprained ankles arms et cetera where it's a very limited amount you won't have to report that because of that threshold.

(Darryl Brown): Right. But when the thresholds go away and we have these situations where, you know, there is no compliance on their behalf, we try really hard to get that letter from the doctor and the person's 16 or 17-years-old, then technically we would have to query and query and query till they're probably 65 when they

become Medicare beneficiary to report acceptance or as it happened 40 years ago.

Barbara Wright: And you're right technically. One of the things that we've invited people to do and we continue to invite particularly during the first year is if you can show us industry data in terms of what claims fall under and stuff like this, we aren't - we haven't ruled out extending the thresholds or even increasing them if we see sufficient reason to do so.

So we would - we realize you feel in sort of a quandary right now, but at minimum help us get data so that we can work on your behalf for future years.

(Darryl Brown): Thank you.

Bill Decker: You have to understand that we feel your pain on this one. And the law requires that you have to continue to check with us and check with your - with the individual you're making the payments to.

And in the scenario you laid out the law seems...

Barbara Wright: Capricious?

Bill Decker: Capricious, yes that's a good word. And we understand that and we're trying to address that the best way we can so that we get our own compliance with the law to work best with your practical needs regarding the law.

John Albert: I've said on a few other calls that, you know, we are not out to make everyone jump through hoops for very little return on investment so to speak.

And the thing is though that we need to be able to have a justification that we can provide to CMS leadership that hey, this is a threshold that's probably the best one to go with.

And unfortunately we still have - we've got lots of people say, you know, why do we have to do this, that or whatever. But we don't have any data to say why we shouldn't do it either.

So again this is why we're - and, you know, we've been, you know, hopefully people agree on the phone we've been working very much with, you know, different partnerships out there to, you know, as these processes are being developed to make sure they do the most for everyone at the least amount of convenience.

But again, we can't stress enough that we need hard data from industry to help us support these positions. Because otherwise if we can't justify it and we say we're not going it, we're going to be told go get it. So, you know, help us help you.

(Darryl Brown): Absolutely. I'm glad you do see the significance of this issue and the backlog and the bottleneck that this could cause insurance companies and employers. I mean it's a big, big issue.

Barbara Wright: The big thing for us too is remember that we're charged with implementing this with respect to pre-pay issues as well as post-pay. It's not just setting up information so that we can do recovery. It's setting up information so that we don't pay when we shouldn't pay.

Pay and chase is expensive for everybody. And if we have records set up, I think actually the bulk of the known savings for Worker's Compensation are

the ones where we've actually denied payment and sent it back to Worker's Comp because we have an open record.

So it is critical to us that we know about the ongoing responsibilities and medical situations.

(Darryl Brown): Okay. Can I just ask one related question please?

Bill Decker: Sure.

(Darryl Brown): In some states the employers have the ability to hand over First Aid claims without reporting these cases to the insurance carrier or without having their third party administrator handle these claims?

And they pay these claims, First Aid claims. They're not defined by the state statute as an injury. They pay them in-house.

So let's say we have a situation where the person is a Medicare beneficiary. Is there an obligation to report ORM?

Barbara Wright: I'm not sure that we understand exactly what you're talking about. But if it's like an employer for instance and they're paying and they're not paying under Worker's Compensation, then they're paying under self-insurance unless they're paying it under an existing GHP plan. But take your pick.

It sounds like it's either self-insurance as MSP defines it. It's under an existing group health plan where they would take - if they were Medicare beneficiary they would fall under the reporting for that or as Worker's Compensation.

(Darryl Brown): Even though the state does not define a first in some cases First Aid claims as injury?

Barbara Wright: Is not how the state defines it. It's under the federal rules and regulations. And under the statute for MSP if there's an individual entity that's engaged in a business trade or profession, and they bear any part of the risk, they are self-insured to the extent they bear that risk.

So if it doesn't technically fall under the state's Worker's Compensation definition the way you've described it, it appears to fall under liability self-insurance which does not require a plan saying I am self-insured. It is just the definition that I gave you.

(Darryl Brown): Thank you.

Coordinator: The next question is from (Bill Tominga). Please state your organization Your line is open.

(Bill Tominga): Hi. I'm with Global Aerospace in Short Hills, New Jersey. And we're curious about the applicability of Medicare set asides to liability claims?

Barbara Wright: If you've read transcripts from prior calls that is not a Section 111 issue. And we are limiting these calls to Section 111 issues. There is not - the same formal process for liability set asides that there is for Worker's Compensation set asides. However the underlying statutory obligation is the same.

For liability set asides if you - for Worker's Comp the process is technically not required to have a CMS blessed set aside.

For liability situations as I said, the underlying obligation is the same if you wish to pursue CMS approval of a liability set aside, your avenue approach is through the applicable regional office.

Whether or not they agree to review it does not provide - if they decline to review it that doesn't provide any type of safe harbor. And the regions are making their determinations based on their workload.

If their workload permits and they believe there are significant dollars at issue, regional offices are reviewing proposed set aside amounts but certainly not typically at the same small level that it’s being reviewed through our Worker’s Compensation review contractor or Worker’s Comp set asides.

(Bill Tominga): Not sure, so is that a yes or a no? I'm not sure?

Barbara Wright: Well I don't know what you mean by yes or no. There is not the same formal process. You have the same legal obligations. This has nothing to do with Section 111.

111 did not change any pre-existing obligations. It that added a separate reporting requirement.

(Bill Tominga): Okay. Thank you.

Coordinator: (Marcia Nigra), your line is open. Please state your organization.

(Marcia Nigra): Hello. My name is (Marcia Nigra) and I'm with Sedgwick CMS. And I do have a quick question. And forgive me if it was answered in one of your prior calls. I didn't see it in the manual.

But on reporting TPOC for auto claims, when we have a claimant where we're repaying a property damage claim and two years later a BI claim, is a TPOC the combination of both the property and the BI claim or it's just the BI claim?

Barbara Wright: If you previously had a TPOC situation that was solely tied to the example I gave earlier in this call, a damaged fender, and that's all the claim was for and it didn't have the effect of releasing medicals, it didn't include any claim for medicals, then that claim is exempt from the reporting.

(Marcia Nigra): Okay, so just so I'm clear on this.

Barbara Wright: Some things exempt from reporting you don't need to add it to other TPOCs that are...

(Marcia Nigra): That's exactly what I wanted to hear. Okay thank you.

Barbara Wright: We'll get it on the second or third try.

(Marcia Nigra): Yes I know. Well it takes me a while, you know. But thank you. That's exactly what I wanted to hear. Thanks.

Coordinator: (Jeremy Kilgore), your line is open.

(Jeremy Kilgore): Hi. I'm (Jeremy Kilgore) with Sedgwick CMS. The question I have relates to a program in Ohio regarding $15,000 deductible program.

Employer can pay up to $15,000 of the medical on their own while also participating in the state fund.

Then once they reach the $15,000 it's transferred to the Bureau of Worker's Comp which will then take over the RRE portion.

Is it possible for these employers to query when they initially have the claims and once they get a hit on them and prior to the 15,000 send them over to the bureau for reporting?

Barbara Wright: It would be a matter of state law of, you know, whether or not the bureau was going to be the one responsible for in making payment. I don't think we're going to entrenched in that to the extent that you are - as an employer in Ohio if you're paying the first $15,000 then you're basically self-insured for that. And it would fall in whatever rules we put out for RREs when we get the final language out there to the extent we make a distinction on who's actually cutting the check. Then that's the rule that you would follow.

(Jeremy Kilgore): Okay but once - we can refer those claims over to the bureau at any time. Would that then put the responsibility on the bureau, not on the employer?

Bill Decker: It would be on the employer to the extent that the employer has maintained it assuming that that's the criteria we use. And then once the bureau starts making payments, it would need to report as well.

(Jeremy Kilgore): Okay thank you.

Coordinator: (Frank Sourlin), your line is open.

(Frank Sourlin): Yes I have a question just going back to the - on the file layout, the attorney fields. In New York State generally we only capture an attorney name firm, not an actual first name and last name.

And on the July 31 layout if we - it indicates if that you put down yes for representative the first name and last name fields are required. And we don't have that.

But - so we want to - we’re trying to figure out how to report when we give you guys a yes with attorney when we only have a firm name?

Barbara Wright: No am I hearing that you maybe have a concern with some of your ones where you have existing ongoing responsibility or you have a concern for one’s where you’re going to be reporting TPOC?

(Frank Sourlin): The - both.

Barbara Wright: Well I mean to the extent that you’re going to reporting TPOC, TPOCs don't have to be reported until the date of 1-1 2010. So if you’re not collecting that information you need to collect it in the future.

If you have an issue in terms of how to report for an ongoing responsibility for medical ones, then we can take that issue under consideration where you may not have had that information and you’ve had the case for some time.

(Frank Sourlin): Well generally in New York the people aren’t really represented by firms. When they go to hearings, the firm sends different attorneys to the hearings. They’re not necessarily represented by one particular attorney.

Barbara Wright: Well you'll need to get a name from them of who they want to be considered the Attorney of Record for you because we need both those fields.

(Frank Sourlin): Okay thank you.

Coordinator: (Celia Winchell), your line is open.

(Celia Winchell): Oh yes. Thank you. This is (Celia Winchell) with (Forest Fire). Thank you for taking my question.

I was following up on an additional question on using the letter to obtain the HICN and SSN numbers.

What are your expectations to continue if any after settlement? So if we have sent the letter to the claimant and they have - let's say they've even (acknowledged it) and signed it that they won't provide their SSN.

We then settle the claim but we don't know, you know if they're a Medicare beneficiary so we can't report at this point. Do we have an obligation to continue to try to get it or at that point do we not?

John Albert: Well let me refresh everyone's memory on this so that we're all starting from the same point here. Remember that the primary identifier we require is not the SSN. It's the Medicare ID number.

Beneficiaries if they have received medical services that will be paid for by Medicare have to provide their Medicare ID number. They can refuse to provide it but they're under obligation to provide that.

The Social Security number (limitations) are a number that we can use to see if we can find the Medicare beneficiary. If you know an individual is a Medicare beneficiary, if you're certain of that because they have told you that or they have supplied you with Medicare ID number, then you don't need to worry about getting the SSN.

(Celia Winchell): Right.

John Albert: So only in cases where you need to get the SSN that we have an issue. And now I'll turn it back over to Barb.

Barbara Wright: Part of what you're talking about is a timing issue. When someone comes in and files a claim from you, if you're sending this to them at that point and they're not giving you the information to query, that's not good enough.

Because when you have to know whether or not they're a beneficiary is that - is you need to know as of the date of settlement whether they are or ever have been a Medicare beneficiary.

So you are going to have to make at least one further attempt at the time of the settlement if it's someone that refused or simply didn't sign. So that's from a timing issue.

The other thing that we would mention, I know or at least we've been told that in many situations you may not ask for actual copies of Medical bills. But typically if a bill - if a provider physician or other supplier submits a bill, it's going to have the Medicare number on there whether it's primary or secondary.

So if you're asking for medical bill think about whether or not you should be asking for a copy of the doctor's bill, not just the statement that's sent to the beneficiary.

John Albert: And by bill you should indicate that it's the universally used claim form, not just some letter that says you owe X dollars.

There's a universal claim form that's used to bill Medicare and other insurance companies.

I would also note that if your settlement judgment et cetera provides for ongoing medicals, then you would need to continue to query this periodically so that you would know when the individual did become eligible or enrolled in Medicare.

(Celia Winchell): Great. Okay thank you. Can you also - do have an idea of when you'll have your RRE language published?

Barbara Wright: At this point we don't have an exact date. We're working through stuff as fast as possible. But when we get certain things we think settled, someone raises a new angle on it. And we have to meld that in before we can get final clearance on it.

(Celia Winchell): Okay thank you.

Coordinator: (Jim Price), your line is open.

(Jim Price): Yes, (Jim Price) with the On Global Risk Consulting. Thank you for taking my call.

We have sort of a unique situation with some of our clients who have divested themselves of some subsidiary organizations.

However, part of the divestiture was an agreement to continue to pay either the Worker's Compensation claims for those divested companies.

So they're in a situation where the divested subsidiary is no longer their subsidiary, yet they are technically the, you know, the primary payer for those ORM. How should they be registering for that situation?

Bill Decker: I would assume that they would register as themselves since they're the ones that have the primary payment responsibility. The subsidiary is no longer theirs.

John Albert: But they still maintain the primary payment responsibility?

Bill Decker: But they - no the subsidiary doesn't.

John Albert: No but they...

Bill Decker: Right. It's the party that has the primary payment responsibility is the RRE right?

(Jim Price): Yes, you know, the divesting company, you know, because of the, you know, the divestiture agreement have agreed to continue, you know, the payment for those ORM.

Bill Decker: (That's a) primary claim...

(Jim Price): Okay.

Bill Decker: ...that divesting company, the RRE.

(Jim Price): Okay so they do not - okay so they would not list the divested company as a subsidiary?

Bill Decker: The divested company number one at the time of the registration from what you're saying is not a subsidiary. And number two, that divested subsidiary is no longer legally responsible for payment.

(Jim Price): That's correct.

Bill Decker: Therefore I believe the only thing that seems logical to me is that it would be the divesting company.

Barbara Wright: I mean you've said this is a situation where the subsidiary that they divested themselves of that - I want to make sure I get this right.

You're saying they had a subsidiary. They got rid of the subsidiary, but the subsidiary continued to be responsible for the claim?

(Jim Price): Well the subsidiary still has Worker's Compensation claims. And the divesting company has agreed to continue to be responsible for the resolution of those Worker's Compensation claims.

Bill Decker: Well you're describing a situation where basically the parent sold the assets and perhaps some of the liabilities of a subsidiary to another entity but as part of the sales agreement retained the liability for - the responsibility for certain other liabilities?

(Jim Price): Correct.

Barbara Wright: Then they - the parent company is the one that's the RRE. I just wanted to make sure you weren't talking about they retained TPA responsibility.

If they actually have the financial responsibility then they are the RRE.

(Jim Price): Not withstanding the fact that the employee, you know, the employee of the subsidiary is obviously, you know, not their employee?

Bill Decker: But they had - it doesn't necessarily have to be their employee if they have the legal responsibility.

(Jim Price): Okay so as long as a parent company who has accepted responsibility registers as the RRE, they don't need to register and probably could not register that divested subsidiary company?

Bill Decker: Right.

(Jim Price): Okay.

Bill Decker: Because their divested subsidiary does no longer legally exist.

(Jim Price): Yes, that makes sense. In follow-up, we do have some clients who have Canadian parent companies and have subsidiary companies in US. And it would make sense for the parent company to register as the RRE yet, you know, we're still experiencing some difficulties in getting through to the number that you have provided for assistance. And I'm just wondering if you could provide some guidance for those...

Barbara Wright: Can you hang on for just a second?

(Jim Price): Sure.

John Albert: Yes, you can register using the subsidiary name address and EIN but each subsidiary...

Bill Decker: Yes.

John Albert: ...would need to register because you can remember, and RREs shouldn't be anything higher on the food chain but a - one subsidiary cannot register for a sibling subsidiary.

Barbara Wright: And what I was asking John Albert while we we're off line and I guess I'll ask it again to be absolutely clear, (have we) said that if they want to register at the parent level and that's all they want to register...

John Albert: They can do that, yes.

Barbara Wright: They can register at the parent level and use the mailing address of one of their subsidiaries here in the United States. That's what I'm asking. And we may not have a final answer on that.

John Albert: We don't have a final answer.

(Jim Price): Because there's still the issue with regards to the TIN number, you know which...

John Albert: Right. We're validating that information as well.

Bill Decker: That's why we don't have a final answer.

Barbara Wright: And so you can either register at the subsidiary level or we don't have a final answer for you yet.

John Albert: Right.

(Jim Price): Okay very good. I do appreciate your answers. Thank you.

Barbara Wright: Can you hang on for just a second again?

(Jim Price): Sure.

Barbara Wright: But we need some further information from you. Hopefully you're still on the line.

(Jim Price): Yes I'm still here.

Woman: What number are you calling that you're having trouble getting through on...

(Jim Price): It is at the 646-458-6740. And we have had a number of clients who have expressed some frustration with this line in that many times they're nonresponsive. So if you could look into that, that would be greatly appreciated.

Man: So does that mean that calls are not being answered or they're being answerer but then the answerer is not giving information...

(Jim Price): The answerer is not getting information and, you know, there's no follow-up. So that's that is what I'm hearing.

Woman: You do know about the elevation process if you're not getting an answer right?

Barbara Wright: There is an escalation process in the User Guide. Are you familiar with that?

(Jim Price): I think it'd be helpful to review it if you would.

John Albert: It's Section 18.2 on page 104 I think it is.

Barbara Wright: Let me check.

John Albert: That basically if you can't get, you know, what you need at those levels, it basically provides alternate numbers to bump it up.

Barbara Wright: And John's exactly correct, Section 18.2. It's on Page 104. I think it has one line that leads over to Page 105.

John Albert: About customer service and reporting the systems for Section 111.

(Jim Price): Okay yes, I have that beginning on Page 105.

Barbara Wright: If you look down under 18.2 there's an escalation process. And that's what John's referring to.

(Jim Price): Okay.

John Albert: They though, you know, apologize in advance if there were some problems with that. But we still ask that people please, you know, start at the low and work their way up only when they have to because you're, you know, the folks that are higher up. And they only want to know about the real problems. So but that sounds like one that you can escalate.

(Jim Price): Yes we very much appreciate it. Thank you.

John Albert: Okay.

Coordinator: (Dennis Quinn), your line is now open.

(Dennis Quinn): Hi. This is (Dennis Quinn) from (Barter & Mullin). I was hoping to follow-up on a couple of the earlier questions dealing with the safe harbor issue.

It seems from reading the notice that the only time the safe harbor applies is when the claimant actually returns the form.

One of the prior questions they asked how many times you have to follow-up or when during the process would you have to follow-up.

And I am inferring from one of the responses that if you send out the CMS model notice at the time the claim is opened you'd have to make at least one more attempt to obtain that I guess, at that time that the TPOC is paid or shortly thereafter. Is that...

Barbara Wright: That's partially it. First of all we said you need to document your process. And Mr. Decker, Bill Decker recommends that at least at some point there be there be something that shows - like certified mail or something that shows a clear attempt to deliver.

But the other thing is the timing. What I said was you have to know as of when any TPOC situation occurs or when the ORM occurs and particularly if something's in litigation if they filed a claim in 2002 you might not have a TPOC till 2005.

Having inquired in 2002, even if you got an answer of no it's not good enough because they could have become a beneficiary in the ensuing two or three

years. We're saying that you've got a timing issue separate from whether or not it' signed. And you have to address both aspects of it.

(Dennis Quinn): Right. Is there going to be any additional written guidance on the safe harbor or is it or is it - because there seems to be some ambiguity as to assuming, you know, we do as you say, is that going to be sufficient?

Or, you know, do you have to show you attempted, you know, monthly or a certain number of times to try to keep them...

Barbara Wright: We will consider people's request to have something more specific. We may or may not have that. We can't possibly nail down every single, you know, situation in terms of what will always constitute enough effort.

We as we said, you know, you need to show us you really had a process and not just you dropped something in the mailbox and didn't really follow-up and that's it. And you have a timing issue.

And one of the things we suggested is that you have, you know, documentation that certified mail or something at some point, not necessarily your first attempt but...

Bill Decker: Right. And we're going to put you on hold for just a second. Please don't go off the line yet questioner. We'll be right back to you.

(Dennis Quinn): Sure.

Bill Decker: Check one thing here.

Yes hi. This is Bill Decker. We just want to make it clear to you and to everybody else that the model language that we've provided for your use is to be used in the following sequence. You approach an individual for identifying information.

The individual declines to give you the information that you need, either a Medicare ID number or a Social Security number. It is at that point you provide that individual with the model language.

It is not designed, the model language is not designed to be simply given to anyone for whom you have an interest in collecting information from, whom you have an interesting in collecting information.

It’s only to be used in cases where the individual has first - it should only be used in cases where the individual has first declined to give you the information that you need. And then you provide the model language.

We just wanted to make that clear to you and to everyone else on the call that has issues with that. Because that’s the way it was designed to be used. It’s not a form to be used routinely to collect information.

Barbara Wright: And that’s the context the issue was presented to us to too. People said we’re having difficulty getting information. We've asked they don't want to give it to us. In that situation what do we do?

And we said when you have that situation, then we'll work on language for you to use. We didn't say this is the form that you use and go out and collect information and you just wait and see whether or not you get an answer.

It’s really your second approach when someone is not cooperating with you.

(Dennis Quinn): Okay. Right. Thank you very much.

Coordinator: (Sarah Fulkerson), your line is open.

(Sarah Fulkerson): Thank you. I'm (Sarah Fulkerson) from Healthcare Services Group. And I have a question about who the correct RRE is in our situation?

We - HSG is a business management company. And there are two insurance companies, Missouri Hospital Plan and Medical Liability Alliance that contract with HSG. And HSG manages the business of these two insurance companies.

Neither of the insurance companies has any employees. And HSG handles all the aspects of the businesses including managing the claims and lawsuits and can contractually bind MHP and emulate it to third parties.

So when we originally registered back in May we registered HSG as the RRE and MHP and MLA as the subsidiaries even though strictly speaking they're not subsidiaries of HSG .

So when the July 31 alert came out about corporate structures and RREs that got me thinking well maybe we need to redo this and make MHP an RRE and MLA an RRE.

That's not really the most convenient way for us to do this. We handle all the claims together and it would be more convenient to report all the claims through HSG as the RRE. But I want to make sure that we're doing it the right way. So I'd like some feedback on that if I could have some.

Barbara Wright: Could you hang on a second?

(Sarah Fulkerson): Sure.

Barbara Wright: It’s our position that HSG is basically a TPA. There’s someone at those two other companies that is contracting with you even if they don't typically have a employee structure per se. And they need to register as RREs. They can use you as an agent. They can use you as the account manager -- however they deem to do it.

But everything that you've described makes you a TPA.

(Sarah Fulkerson): Okay I appreciate that. I just wanted to make sure that we were doing it the right way.

Barbara Wright: Okay.

Bill Decker: You also don't want to be identified as the RRE because then you'll be considered the primary plan as the legal responsibility for paying all those claims and repaying Medicare if there’s a problem.

(Sarah Fulkerson): And paying the $1000 a day penalty. Yes.

Bill Decker: That’s correct.

(Sarah Fulkerson): Exactly. So I appreciate your feedback and wanted to get this done the right way. We'll get that changed.

Bill Decker: And for everyone out there, this is more of a technical issue. But again if you have made a determination that you may have registered incorrectly or the

incorrect entity has registered, please contact your EDI representative to basically cancel out that previous registration.

It's important that, you know, for management of the workload that for everyone that, you know, if you determine that you've made a mistake in registering that, you try to as quickly as possible contact your EDI rep directly and unregistered or de-register so that we're not bombarding you with emails and we're not maintaining accounts that don't matter. So we appreciate that.

(Sarah Fulkerson): And can I register these two new entities as RREs before I cancel the registration for...

Bill Decker: Yes.

(Sarah Fulkerson): ...the first one. Okay.

Bill Decker: Yes.

(Sarah Fulkerson): Great. Thank you so much.

Coordinator: The next question is from (Fasriba Terisami). Your line is open.

(Fasriba Terisami): Hi. I'm at (Hospital Insurance) Group. This is in reference to the event table provided in the User Guide. It's mentioned that we need to send our major (cards) RREs TIN information changes which is one of the non-key field change.

So my question is say we've ordered for like two, three or five years and then after that for some reason RREs TIN changes.

So are we expected to send updates for all of our prior transmissions? If you could just give some examples to understand this scenario.

Barbara Wright: Well first of all you're talking just NGHP and not group health plan situations right?

(Fasriba Terisami): Yes.

Barbara Wright: So if you're talking a TPOC that's been reported that's only ever being reported once then no, there's nothing further for you to report. But if you have an open ROM, ORM record then yes you need to do appropriate updates.

(Fasriba Terisami): So I mean say my example say we send like ten or 20 quarters, we send 20 files and after that then it changes. So does that mean we have to send updates for all of our records represent, you know, previous transmissions?

John Albert: Again I think it depends on what type of records you're sending. If you're sending like a Worker's Comp where there's ongoing responsible for medicals, you know, and...

Barbara Wright: And it's still open.

John Albert: And it's still open, then yes you need to provide updates to that information. But if it's essentially a TPOC amount that was settled case closed, you don't need to update that information.

It depends on the record type.

Woman: I think she's asking you if she has to update more than one...is that correct?

John Albert: Well if yes. I mean if someone has, you know, a lifetime of Worker's Comp and that record remains open and, you know, claims are being paid then, you know, updates would have to occur when...

Barbara Wright: As appropriate.

John Albert: As appropriate.

Woman: But not to every quarter, just once for that.

(Fasriba Terisami): If...

Barbara Wright: You have nothing to update if there's been no change. If you have a change it depends on the type of record. If it's an ORM record you know that you're not reporting individual dollar payments.

It's just typically you're reporting when it's established and when it's terminated. And if you have fields to update in the interim you need to do that. And if it's...

(Fasriba Terisami): No I'm specifically talking about the RREs TIN information, that's field 74 I think. Field, yes field 72.

Barbara Wright: But we're still talking the same thing. If it's a record that needs updated you need to give it...

John Albert: Well she's talking about the RRE. If you're - are you talking about at the RRE level or the individual record?

(Fasriba Terisami): RRE level.

John Albert: Oh okay. Well that you can update any time.

Woman: When it changes.

John Albert: Yes.

Woman: But not - you only change it once.

Barbara Wright: When you change an RRE number you don't go back and resubmit all the records that you're submitted...

John Albert: Right.

Barbara Wright: ...in prior quarters if that's what you're asking.

(Fasriba Terisami): Yes that's what I'm asking.

John Albert: Yes you don't need to resubmit that those.

(Fasriba Terisami): Okay so what does an update record mean?

John Albert: An update record is update to information on an individual reporting record. So you're telling us about, you know, (James Smith) who has Worker's Compensation and we've - and its ongoing responsibility for medicals.

And something on that record needs to be updated, you would send an update transaction that would update that original record you sent to us some time ago.

Woman: And that's one transaction.

John Albert: Yes.

(Fasriba Terisami): Okay so for example in our thing we have only Tin information. So we'd be sending thousands of records based on our volume. So we are thinking it would be a huge bulk update if it happens...

John Albert: No, no, no you're mixing up the individual coverage records versus the RREs identifying information. I thought you're talking about the RRE TIN that you submit when you register. That's different. That's not an individual reporting record.

(Fasriba Terisami): Okay so if RRE (still) information changes, then we are not expected to send update for each of our individual records?

John Albert: Can you hold on just a second?

Barbara Wright: Let's try one other approach. If you're talking about you have an RRE ABC company and that RRE somehow changes TINs and you need to update that TIN then you update your TIN information in your registration and that's what you need to do.

If you're talking about a situation where the RRE was ABC and all of a sudden that responsibility shifts to company DEF. Then ABC is going to have to issue termination for any open records.

John Albert: Which is an update transaction.

Barbara Wright: And DEF has its responsibility to now report add records.

(Fasriba Terisami): Okay.

Barbara Wright: So we're not sure which of these different situations you're talking about but we've given, you know, what all of them are. If you're - if it's an update to an individual beneficiary's record and it's an open record like ORM you have to update that individual record in your transmissions.

(Fasriba Terisami): Okay.

Barbara Wright: If it's something that's a TPOC for (Johnny Smith), a single beneficiary and there's no, you know, it's not something that you have to re- report, you're not going to have to update anything.

(Fasriba Terisami): Okay.

Barbara Wright: If you're dealing with the RRE, then it depends on whether it's really an update to that RRE or it's a change of RRE.

(Fasriba Terisami): Okay so we reported ORM and we terminated it, that means we don't need to send update for those, only open ORMs?

Barbara Wright: Yes.

(Fasriba Terisami): Okay.

Woman: If that - if something like that happens, why don't you call the EDI rep and they'll walk you through it.

(Fasriba Terisami): Okay. Okay, thank you.

Coordinator: The next question is from (Joe Keeper). Your line is open.

(Joe Keeper): Hi. (Joe Keeper) from (Benderson) Development, question regarding a liability claim.

We are a national retail strip center developer. We have hundreds of properties all of which are subject to a self-insured retention. Each of the properties is owned by a separate entity or group of entities all of which are overseen by one entity. It's not a parent child subsidiary relationship. It's a sister, you know, sibling relationship as described in your July 31 alert.

But for a given property I could have six entities that own the land. They then lease it to three or four different entities that own the improvements that own - then lease them to the tenants.

And all seven entities or nine entities I think they use, would probably be sued or put on notice of a claim.

Barbara Wright: And they might each have individual reporting responsibilities.

(Joe Keeper): Well that's my fear.

Barbara Wright: If they do individual settlements, then they potentially...

(Joe Keeper): Well they're all related companies that are - where they're insurance program's overseen by one company, say call it company A.

Company A would investigate, it, defend it, make the decision whether to settle it. But all those individual entities would have the - would be charged back for the settlement.

Woman: But the overseeing entity is not a parent so...

(Joe Keeper): No it is not.

Woman: So then that's your answer.

Bill Decker: What you've indicated is who's making the payment? Is it the self-insured retention people that are making the payment or is it the insurer that's making the payment?

(Joe Keeper): It would be the self-insured - we control our self-insured retention program. So if it settles within the self-insured retention, we make the payment.

Barbara Wright: Hand on a second.

(Joe Keeper): I could have one further point too by the way that might be beneficial.

John Albert: Hold on just a moment.

(Joe Keeper): Thank you.

Barbara Wright: Some of us heard various things from you before. So we want to know whether you in fact said that you have an insurer that's paying the claim and then individual sub entities or sister entities or whatever are being charged back for that amount.

(Joe Keeper): It's not an insurer. It's company A is a sister company to several hundred other companies, so say companies one through 300. Company A oversees a self-insured retention program for companies one through 300.

Bill Decker: So company A is acting as an agent for the other companies to the extent that those other companies are siblings?

(Joe Keeper): Correct.

Barbara Wright: And therefore they each have their own individual reporting responsibilities.

(Joe Keeper): Just to make sure, I mean that's how I read what the CMS guide says. But the realities and the efficiencies are not there.

It's becoming a burdensome, you know, process in order to comply because some of those entities that own, the example where I said six own the land and three own the improvements, you know, the buildings, one or more of them could be like a 1% or less owner.

Woman: But they could still use the same agent. All of them could.

(Joe Keeper): Well they all use the same agent to run the self-insured program.

Woman: Right, and the agents who report to us.

Bill Decker: Yes, that company could be designated as the agent for all of those companies.

(Joe Keeper): Well it can't be designated as the RRE though.

Bill Decker: No.

(Joe Keeper): Yes that's - I'm trying to see if I can - how - what - how small a number I can boil the - our e-group down to.

Woman: But the really important part is is who's sending the report. So I mean that's the main workload associated with it. The RRE takes a financial responsibility, but the agent can do all the work for them.

(Joe Keeper): Right, but I'd have to potentially register several hundred RREs. And then six or more, in the example I gave you, nine of them would report the same claim.

Barbara Wright: We understand your concern with having to report for multiple RREs that can be boiled down. Please -- and it sounds like you may have already -- but take a look in the July 31 alert whether any of the comments or proposed language that we have in terms of if payment is made by one entity versus the actual self-insured entity, if those can help you out at all.

(Joe Keeper): Well - I'm sorry to interrupt, but if you could maybe elaborate on that a little bit. Because when I read the July 31 alert, it led me to believe that regardless who- you can't just designate one person to pay, one RRE to pay on behalf of multiple RREs.

Barbara Wright: No, no, you can't. You're right. And that language may in fact not help you given your particular corporate structure.

But absent that, we're constrained by the statutory language that the RRE has to be the applicable plan.

We're trying to do what we can and tried to do what we can in that alert where we could say X can report because it doesn't add to its reporting burden and it doesn't really add to its risk for a penalty because it - it's charged with knowledge and reporting anyway.

But to place for instance to say that the entity that you're talking about who appears to us to basically be asking - acting as a TPA to all of a sudden say it has the financial burden and risk for the - for any potential civil money penalty no matter how much we don't want to impose CMPs -- and that's not our goal -- that somehow it has the risk for those civil money (unintelligible) for every other corporate structure that you're talking about. That's not something that we have the ability to say or to shift.

(Joe Keeper): Okay. You know, I mean I'm just trying to figure out, it seems that the system was being set up to try and make it usable in the most efficient manner possible.

Barbara Wright: We would like it to be efficient as possible, but we are constrained by the statutory language. If we have our total druthers, it'd be nice to just say if you want to appoint a single TPA for 50 companies, that that TPA could report for everybody, but that's not the way the statute is structured.

I mean the statute is structured to make the RRE also the one who is potentially responsible for any civil money penalty. And that's not the TPA.

(Joe Keeper): Well to the extent those nine entities, if there's indemnification agreements between them where one gets indemnified so it does not actually have to pay to the claimant does that...

Barbara Wright: No we've said you can't shift the reporting responsibility by contract or otherwise. We've tried to be as flexible as we can and say if there's two subsidiaries and they have a holding company that that holding company could report for both of them because it's got ultimate responsibility up the line.

But the situation you identified is not that you've got essentially parallel entities who don't have responsibility for each other.

(Joe Keeper): No I guess what I'm saying is, you know, you have property owners that lease land to the improvement owners. The improvement owners maintain the land are the ones that typically should be liable to the third party that got injured.

They get sued and, you know, they go to a judgment. Judgment's held against the property of the improvement owners. And they're also recorded to indemnify the landowners.

So the improvement owners make the payment. Is it the improvement owners that are the only RRE in that situation?

Barbara Wright: If the only one that was - as you described it...

Bill Decker: Who was legally liable?

Barbara Wright: Yes. If there's a judgment against the tenant of the land, then it's the tenant that's really the RRE. It's not - if you have a judgment that's against the tenant and the landowner, then you've got potentially two RREs.

(Joe Keeper): Right, if the landowner also has to pay and doesn't make the payments.

Bill Decker: No, no, no. We're talking legal liability here.

Barbara Wright: If two situations. You've got a landowner and you've got a tenant. And in one - and it goes to trial. And the court says you tenant need to pay 50% and you landowner need to pay 50%, you've got two RREs.

You've got another situation it same thing, goes to trial. Or for whatever reason, a claim was only filed against the tenant, then the tenant is the RRE.

If that tenant subsequently seeks indemnification from the landowner, we don't care about that.

(Joe Keeper): Okay. What about - and I know I'm only supposed to have two questions but I apologize. In a situation like the tenant landlord situation -- it's the easiest example I guess to use -- you know, individuals injured inside the tenant space, the tenant and the landlord are both sued, the landlord tenders its defense to the tenant.

The tenant accepts it and defends it, that tenant pays any judgment or settlement, is the landlord still an RRE?

Barbara Wright: Who is the landlord settling with? I mean if the landlord was sued and the landlord has an executed settlement with the entity that's filing suit, then whatever the landlord settled for, the landlord has responsibility for.

(Joe Keeper): But if it's the - but no, but the landlord at that point would not be making any decisions. The decisions would be controlled by the tenant or the tenant's insurance carriers.

Barbara Wright: That's up to you who you have as an agent et cetera. We're talking about who ultimately has the settlement judgment award against them that - and that settlement judgment award involves the Medicare beneficiary.

Bill Decker: When you're talking, you're saying all of these entities are self-insured.

(Joe Keeper): Right, but what happens - what oftentimes happens in that type of - in the real estate context is that you lease land to a third party. They run a store.

Bill Decker: Right.

Woman: You know, this hasn't - this situation hasn't happened yet and - but if something like this does, we would be happy to talk to you at that point in time. But I think we probably should give somebody else a chance to ask a question.

Is that all right?

(Joe Keeper): Well I guess I don't understand how it hasn't happened yet because it's how it happens and...

Woman: No I mean at this point in time it's like there's - this is like a hypothetical situation for you. And...

(Joe Keeper): No, it's an everyday occurrence for us. When we get a claim...

Bill Decker: I think you need to read what guidance we put in the RRE guidance that - when we publish it. And I think that should answer your questions.

(Joe Keeper): Is that something that's already published or something that's going to be published?

Barbara Wright: Well it's - you - the alert is the current language, proposed draft language. But I get a sense and I'm - that we're not necessarily talking at odds here but we're not communicating with the right language.

So if you could write something in to the resource mailbox and specifically reference this call, it sounds like you may be making it more complicated than it needs to be in some of the situations.

(Joe Keeper): Well okay. That might be true. I'm just trying to understand it because, you know, we want to report and we want to report correctly.

But, you know, my understanding when I was reading that is if you don't pay anything directly for the claimant...

Bill Decker: Okay.

(Joe Keeper): ...that you don't ever - you're not reporting...

Bill Decker: We're going to have to go on to the next questioner now.

Barbara Wright: So if you would please write in to the mailbox.

Bill Decker: Right.

(Joe Keeper): How do I reference the call? Like what do I say to reference the call?

Barbara Wright: Put tenant landlord property - I mean whatever the tiers of it where, say this is where we talked about these multiple tiers and them all being self-insured.

Bill Decker: Right.

Woman: We'll recognize it.

(Joe Keeper): Okay, thank you.

Barbara Wright: Thanks.

Coordinator: The next question will come from (Rebecca Mitchell). Your line is open.

(Rebecca Mitchell): I'm with the Southwest Ohio Regional Transit Authority. We are self-insured for third party liability claims. We typically issue a one-time payment for full and final release of all claims unless we are on notice (really). And we don't usually include amounts paid by Medicare in the settlement amount.

From my understanding, after the payment is issued, that's the point where we need to report the claim and the payment to Medicare.

Now after we report the claim to Medicare, is Medicare going to come after us for the amount of bills paid by Medicare?

Barbara Wright: What type of insurance are you? Are you worker's compensation or...

(Rebecca Mitchell): No, third party liability claims.

Barbara Wright: If it's liability insurance, our preferred method and what we typically do is issue a demand to the beneficiary for against their settlement judgment award or other payment.

We have the legal right to come back against an insurer if we don't receive satisfaction through the beneficiary. As a practical matter is that what we normally do? No.

Also beneficiaries have appeal rights including a separate right to request waiver of recovery depending on their particular situation. And if we waive it under that we don't come back against anyone else.

The particular regulation I'm referring to is in 42CFR 41124.

Man: I.

Barbara Wright: I, subsection I. But keep in mind as we've been saying all along, we're not trying to change all the pre-existing processes. We have not made it a practice to routinely go back against insurers in these type of situations.

Section 111 is just new reporting. It's not changing any underlying obligation you already had.

Now that having been said, keep in mind we've also said that for ongoing responsibility for medicals, particularly Worker's Compensation and no-fault, those are situations because there's ongoing responsibility, we already routinely contact those entities when they still have responsibility and it hasn't been exhausted and there's bills that we pay to get repaid.

(Rebecca Mitchell): Right, right. But ours is just a one-time payment for full and final release. So after we cut them the check, we don't have any kind of ongoing responsibility with them.

Barbara Wright: No.

(Rebecca Mitchell): So I guess we're just trying to figure out for our reporting concerns, I guess what's going on in the background at Medicare because we're telling you about everything after the fact. So it's not like you even have time to send us out the lien notice saying, you know, Medicare's lien right now is...

Barbara Wright: Okay, but back up to what I said. We don't typically send our recovery notice when there's a TPOC type situation.

We normally recover against the beneficiary once they receive that settlement judgment award. And there's some benefit to the beneficiary that we do that.

Because if the beneficiary has paid attorney costs and other procurement costs, we do a pro-rata reduction in our conditional payment amount in determining how much we will actual - actually recover. And so that is the normal avenue.

But in all fairness, I did have to point out the regulation that's a 42CFR41124I that legally when we can't recover from the beneficiary we do have the right to come back against the insurer or Worker's Compensation entity even though it would mean they would pay twice.

(Rebecca Mitchell): Well actually we're not paying twice because the amount that we would be issuing the check for would just be for pain and suffering. It doesn't include any Medicare, any Medicare amount.

We're not - if we're talking about somebody who's got Medicare...

Barbara Wright: We do not - we're not bound by the allocation of the parties. The fact that you label something simply as pain and suffering does not bind us. And we have first priority rights against any money that's paid.

Bill Decker: I would strongly suggest that you review the statute, that 42CFR - pardon me, 42USC1394YE and the...

Barbara Wright: 1395...

Bill Decker: 1395YB.

Barbara Wright: YB.

Woman: That's a statute.

Bill Decker: That - and the corresponding regulations at 42CFR subpart 411. They make clear your obligations as a primary plan to Medicare and what Medicare's rights are.

And just from the way you're phrasing things, it appears to me anyway that you may not be fully aware of your statutory and regulatory obligations.

Woman: However, Barbara has said that what we typically do, what we have done is bill the beneficiary.

Barbara Wright: But from the information you're giving us, can we say you're off the hook? No.

(Rebecca Mitchell): Okay, so just my final follow-up on this. A lot of times we have claims where we settle the claim say for less than the bills that are actually paid because there is pre-existing condition issues and there's a lot of other issues that maybe the treatment that they were receiving wasn't exactly related to our accident.

So is that something that we can challenge after the fact with Medicare?

Barbara Wright: That's not how we figure our recovery claim. What we do - first of all, we have rules that limit the amount we actually include in our recovery claim. There's a regulation that's 411.37. And we never, let's say we paid $100,000 in conditional payments and the policy limit was $20,000.

The absolute most our recovery claim could be for is $20,000, plus we would reduce it by net of fees and cost.

And in that situation if we were taking everything that was left as I said, the beneficiary has the right to request full or partial waiver of recovery when certain conditions are met.

So our normal practice would be - and we'd be going to the beneficiary first and either recover from them, potentially do a partial waiver or possibly reach a compromise with their attorney. But we would be bound by the limits of that liability settlement unless we want to take separate distinct action and pursue you for some reason for amounts above $20,000.

So I mean but this is way out of the scope of this call. This has to do with our recovery process. It doesn't have anything to do with Section 111.

(Rebecca Mitchell): Okay, and that's all my questions. Thank you.

Coordinator: The next question will come from (Keith Thurston). Your line is open.

(Keith Thurston): Hi. This is (Keith) from Deseret Mutual. And I have a, what I think is a unique question regarding to reporting obligation.

We administer a program for a religious organization that pays out of pocket costs for anyone who's injured in an activity sponsored by the religious organization. And this program has always been considered secondary to any insurance coverage and of course is funded by a gratuitous contributions.

And so what we're looking to clarify is to whether or not this organization is obligated to report under Section...

Bill Decker: Under the Medicare secondary payer provisions, that is considered liability insurance. And they're reporting obligation that goes to the liability insurance.

It sounds to me like they would be considered self-insured for liability purposes from your description.

(Keith Thurston): Okay.

Bill Decker: It needs to be reported if the injured party was a Medicare beneficiary.

(Keith Thurston): Okay, very good. Thank you.

Coordinator: And the next question is from (Jane Shop). Your line is open.

(Jane Shop): Hi. I'm from (Sun Bank). And I actually have a question about when to report ongoing responsibilities for medicals when we have a claim that does not open or close within the same quarter.

And by that I mean we're part of that 15K program that another caller alluded to. And there's many times that is within that threshold. But if I accept ongoing medicals today not knowing the full extent of that injury, I don't know whether or not it's truly going to bypass that $750 threshold.

Barbara Wright: Well remember, that $750 threshold is not a threshold that stands out there by itself. In the first place, it's got to be a claim that's only for medical.

(Jane Shop): Yes it is because it's a 15 - by just being in the 15K program I already meet the other three objectives.

Barbara Wright: If it's in the 15K program it can never include lost wages or lost time.

(Jane Shop): Exactly.

Barbara Wright: And that all your payments are made to the provider.

(Jane Shop): Right.

Barbara Wright: Well in that case, you've said this is ongoing responsibility for medicals. Hang on a second.

We agree that this is a timing issue on this one. If it clearly meets all the requirements and your only issue is whether or not it's going to exceed that $750 threshold, then you need to report it as soon as it's exceeding that threshold.

(Jane Shop): So wait to report it until I bypass that 750.

Barbara Wright: That's fine. You can report it ahead of that. But we're saying you must report it when it bypasses that.

If for ease of reporting you want to just do it with the others, then go ahead and do it because it means that payments are more likely to be done correctly.

But what we're saying is for those where it's not going to bypass that, we're - it's acceptable for us for you not to report the ORM until it bypasses.

Bill Decker: I guess it depends on the expectation. You know, if they would expect it to bypass, that they should probably report it now that we're not worrying about recovery.

Barbara Wright: But remember, this is ORM and you're not reporting individual dollar amounts so...

(Jane Shop): Right. It just says on Page 44 as soon as it's assume, I mean Page 66. But then on Page 43 it outlines those thresholds that you don't want to know about it. And...

Barbara Wright: Well now wait a second. The threshold for ORM we put in there for the convenience of the industry.

And if you want to report ORM from the get go, that is fine with us.

(Jane Shop): Okay.

Barbara Wright: That ORM threshold was for the industry's convenience. And if the 750, if it's easier for you to just go ahead and report ORM from the beginning, do that and then report a term date.

But if you've got the wherewithal where it's easier for you to wait and do a timing issue for those that are the medicals only, then that's fine with us too.

(Jane Shop): So I won't ever if I do wait, because again, most of our claims are pretty small -- sprained ankles and everything -- if I do wait and because it opened in one quarter but yet I didn't bypass that 750 until let's just say two quarters later, I won't be somehow penalized or fined because I'm reporting late?

Barbara Wright: Well first of all, if we questioned you on it, you would have the specific factual circumstances and you - and, you know, we - it's up to you which way you want to do it.

(Jane Shop): Okay. All right, thank you.

Bill Decker: But you're correct that you would see that flagged for late submission, you know. But again, if it's within that...

Barbara Wright: A flag doesn't mean we are automatically in the next mail going to mail you a notice of a civil money penalty.

Bill Decker: Right.

Barbara Wright: A flag is a caution and means that we could have further questions.

(Jane Shop): And if you would question me, as long as I have documentation to say well, it's because of the way the invoices came in?

Bill Decker: Yes.

(Jane Shop): Okay. All right, thank you.

Bill Decker: Again, we're not out to assess CMPs. We're out to collect data timely, accurately.

(Jane Shop): Well and I think everybody on this call would agree we're all trying to do it right.

Bill Decker: Yes.

(Jane Shop): You know, that's why we're on the call and that's why we're putting forth such an effort.

And I guess that leads me to my second question. Does - do you guys have any plans to implement, you know, some type of call center or something so that way we could ask these policy questions once these Town Halls are completed?

Barbara Wright: At this point we don't have any date when these calls are going to definitely terminate. We've got at least two per month for the rest of this year. We have at least one per month for the next quarter or two. We will keep them going as long as they need to keep going and the Web sites up there indefinitely. Because it's the place that's going to contain all our final policy and directions.

(Jane Shop): All right, thank you.

Coordinator: (Robbie Downing), your line is open.

(Robbie Downing): Hi. This is (Robbie Downing) from (Mastacont). I think you've pretty clearly answered a couple of my questions. But I wanted to go through just a couple of things real quick.

Attorney info for liability and product liability -- that type of thing -- if - for most cases we're going to have that information, but occasionally on product liability, we may not have it because there's a hold harmless clause or something of that nature.

Does that...

Barbara Wright: You've got to have some attorney that you're dealing with for that beneficiary if there's an attorney involved. You aren't going to be sending it to no name mailbox.

(Robbie Downing): Right, got you. And the other question though is the date of incident that you're using on occupational, you know, repetitive trauma, exposure -- that type of thing -- what if our dates do not actually - what if our dates don't qualify for what you have as a date of accident? How do we deal with that or date of incident?

Barbara Wright: You need to be making your best attempt to obtain information on when they're claiming the harm, et cetera, and if it involves implantation, exposure, ingestion. Then it's date of first ingestion, date of first exposure, date of implantation.

I know or we know that that's not what the industry always currently collects. But we do need that information.

(Robbie Downing): Okay. And again, that was why I was asking because we have case law that tells you certain times that you use certain things and...

Barbara Wright: We have certain things that are required under state law for Worker's Compensation for example. There's some federal statutes that have responsibility for employers at certain times. And we have our own statutes or when we have to develop information. And we need that date of incident for our purposes.

If you - if for instance it were a Worker's Compensation claim case and we had for our purposes, an earlier date of incident than you were legally responsible for under state law and we asked for payment for a medical service that was prior to that date, then you would present your law as a defense to your obligation to pay for services prior to that date.

That doesn't change what recovery rights we might have against the beneficiary in terms of their entire claim et cetera.

(Robbie Downing): Okay.

Barbara Wright: So we need it for our purposes.

(Robbie Downing): Okay, that's my question. How do we report...

Barbara Wright: Her layout has two dates of incidence fields, one for the date that CMS defined date of incident and one for whatever yours would be under the industry definition in your particular case.

(Robbie Downing): Okay. All right that's fine. Thank you.

Coordinator: The next question is from (Carol Dambi). Your line is open.

(Carol Dambi): Hi. This is (Carol Dambi) with (Banner) Health.

If we have a Worker's Comp claim which was administratively closed before 1-1-09 and so we don't have to report it and then it gets reopened later and we do report it, what kind of documentation do we need to have so that we don't get dinged for late reporting?

Barbara Wright: Well again, the late reporting is a flag. And if we were questioning you on something, then you would essentially have whatever documentation, what it wasn't open to start with.

(Carol Dambi): Okay. And also we have an occupational health department which sometimes treats Worker's Comp employees have been injured. But it's not something that we, you know, pay out or keep track of.

Does that amount that they might spend have to be included in the $750?

Barbara Wright: I'm not sure what you mean by you don't pay and don't keep track.

(Carol Dambi): Well we pay - you know, were the Worker's Comp fund to pay, you know, that we have in our company pays for the providers who provide care for an employee who's injured.

We don't have to pay anything for services provided by our own occupational health department.

So do we need to try to find out what those amounts are and add them up if we need to try to get the, you know, the $750 threshold?

Barbara Wright: Hang on a second.

The situation you're naming, there's no billing to anyone or any entity. Is that true?

(Carol Dambi): Yes.

Barbara Wright: In that case you don't need to include that value.

(Carol Dambi): Okay, thank you.

Barbara Wright: And we hasten to say that that's not the same thing as a hospital provider, physician or supplier that decides they don't want to charge, they quote, want to write-off...

(Carol Dambi): Okay.

Barbara Wright: ...for someone who falls or trips. This is a specific situation where the whole context is essentially an onsite or on location self internal services being provided that are never billed for to anyone.

(Carol Dambi): Okay.

Coordinator: The next question will come from (Clair Bellow). Your line is open.

(Clair Bellow): Good afternoon. I'd like to follow-up on this on the prior question. And the internal process that would not be reportable, in the situation where the hospital is providing a - an internal service and doesn't bill anyone...

Barbara Wright: We just said that's not the situation. If you've got a hospital that bills anybody for anything, that doesn't fit the situation as we heard this lady described it.

She talked about an internal service to their company that is never billed to, that that service never bills anyone for any purpose. She didn't say we just don't bill these people but we're an occupational health and we bill other people that come into our shop.

If this is a completely internal service to them that's never billed to anyone, anywhere and they don't have other clients, that's what we were talking about and that's why we were saying that's completely different than a hospital that may chose not to bill for particular services.

(Clair Bellow): All right. My original question was as we've been talking today and as we have been working with our clients going through the process, one of the questions that keeps coming up is we know that the CMS response files that will be coming back may have the compliance flags.

We know that the compliance flags are a warning in nature. But is there a formal process or administrative hearing process or complaint process that will be put into place where you do question reporting prior to the imposition of penalties for the RREs to understand, you know, how they're going to hear from you if there are questions and how they response to those questions?

Bill Decker: You know, we basically do not have any formal process surrounding CMPs. But obviously if you have questions about particular response files, you can

work with your EDI rep to help you understand what those might be in relation to.

But in terms of again, the flags in and of themselves do not mean that, you know, a CMP is to be assessed. But at this time we don't have a response in terms of future plans for CMPs.

Barbara Wright: But they will be subject to appeal.

Bill Decker: No, that's not (unintelligible). That's not been decided. I mean none of...

Barbara Wright: There has been no final process for CMPs developed yet. When it is developed, it will be made public and everyone will have the opportunity to see what it is.

But at this point we have no final decisions on the process.

(Clair Bellow): Great. Thank you.

Coordinator: The next question will come from (Ann Zyker). Your line is open.

(Ann Zyker): Yes, hi. I was also curious about the hospital write-offs and obviously you've answered that.

Do you have any idea when you'll come out with the final decision on that? I know it's been months since we've been inquiring.

Barbara Wright: Excuse me. We're on a sidebar right now for a second. We're going to have to have you repeat that question if you can hold on for a minute.

Could you repeat your question please?

(Ann Zyker): I was just saying that my question initially had to with hospital write-offs as well. Do you have any idea when you'll finalize that decision? We've been inquiring for months with respect to...

Barbara Wright: Yes, we're aware that you've been inquiring. And I actually spent part of yesterday once again compiling every single email that I've - that has come in on the hospital write-off.

And we actually have another - a higher level meeting scheduled on that this week. So, you know, we are trying to get final language and get some type of final clearance here. But I can't give you an assurance on the date because I'm not and the people in this room are not in control of that final decision.

But rest assured to the extent that it makes you feel any better that it is something that we're actively working on. And we are trying to take into consideration everybody's concerns and looking at write-offs from various angles so that by us saying one thing, when we're saying it in the context of Section 111 we're not inadvertently effecting some other area of the Medicare program where write-offs are a routine part and don't impact MSP.

We need to make sure that we're like addressing all those angles. And that's part of what's taking so long.

(Ann Zyker): I see. Okay. Well in light of that, what - I know in the beginning of the call you said no one's interested in signing with respect to not being registered on time.

There - is there a publication that states what the fine is with respect to not being registered timely?

Barbara Wright: No, no, no. CMPs are $1000 a day, you know, per person for people (that are done). And what we've said is one way you keep yourself in compliance when we don't have finely tuned procedures right now as we've said, you make sure you're ready. You make sure that you follow the steps we've outlined to register when we say you should, to test when you say you should. And you submit data when you - we say you should.

And what - the point we were making at the beginning is that we're never going to find someone non-compliant solely because they failed to register by 9-30. Because our ultimate concern is that you register soon enough, that you can perform the full quarter of testing before you have to go live with any - your - whatever your file submission window ultimately is when it occurs in the second quarter of 2010.

The reason we wanted people to register by 9-30 was two-fold. One, if you're registered, you can at least start looking at the query process, particularly if you have open ORM records you have to deal with.

And two, so that we have some idea of what's going to be tunneling our way in terms of capacity and the numbers that are going to be reporting.

And so I don't know how many other ways we can say it. Maybe we need to put out a separate alert with just that paragraph. But we don't intend to find anybody non-compliant solely because of the, you know, failure to register by 9-30.

(Ann Zyker): Okay. I mean and I understand. I think the concern obviously is given what you've just stated and not knowing yet about hospitals folks...

Barbara Wright: Yes. And I understand for that reason you may be non-reporting. But part of that depends on is that the only reason you would be self-insured and self-reporting is because the write-off.

Think about whether or not - let's take a hospital because I guess that's the context you're in. But say you're some other provider or supplier and you're looking for that type of medical write-off. If for instance your hospital does not have a liability policy, I guess I would have to assume that every single case where some falls or slips or maybe there's malpractice or something like that is not always going to go away by a write-off.

You have at least some instances where you - probably there is some type of lawsuit or claim.

If you're self-insured for that, then you would be setting yourself up as an RRE potentially for those types of situations anyway.

So just make sure you're not assuming that your write-off or planned write-off situation is the only time you might be an RRE. Be sure you've assessed other times when you could be an RRE.

(Ann Zyker): Right. I appreciate that. I thought for some of the smaller places it may be that they're fully insured on the other coverages. And so it is only the hospital write-offs that would make them and RRE.

Barbara Wright: And also look at what's in the July 31 alert in terms of being self-insured for deductibles et cetera if you're in a situation where you would routinely have

to be the RRE because of that anyway. That's yet another reason to think about it.

(Ann Zyker): Right. But if you are routinely, the deductible is covered through - you don't have a deductible and that's through the insurance.

Barbara Wright: Yes. If the write-off issue is the only time you think you'd be self-insured, then yes I'd probably wait until we have our final word before you register. You don't want to completely unnecessarily register.

(Ann Zyker): Okay.

John Albert: Yes, and the registration deadlines are primarily geared towards the larger entities. And this is - I mean the whole point of registering timely is so that everyone can get ready to go when it's time to go.

But again, you know, don't take those quite so literally. It's more about again when ultimately the data is due to CMS.

(Ann Zyker): Sure. Okay, thank you.

John Albert: Operator, could you let me know how much - how many people are still in queue because it's actually a little bit - a couple minutes past 3:00 and we have to end the call.

Coordinator: As of now there are 40 people still in queue.

John Albert: Oh wow. Okay. Well unfortunately we've run out of time today. And I'd like to thank everyone for their participation on this call.

Please keep in touch with the Section 111 Web site. The next call will be a more of a technical call related to the (fiscal) issues with registration and implementation on reporting.

We will continue to have these calls. As Barbara mentioned, our plans are to remain accessible as long as need be through the implementation and production phase of this process. And with that I'd like to thank everyone for their participation.

And operator if you could hang on for just a minute and also let us know how many people ultimately were on the call.

Coordinator: I sure will.

END