TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: December 9, 2010

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

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Centers for Medicare & Medicaid Services

Moderator: John Albert
December 9, 2010
12:00 p.m. CT

Operator: … everyone to the Section 111 of the MMSEA. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. And if you would like to withdraw your question, press the pound key.

Thank you. Mr. John Albert, you may begin your conference.

John Albert: Thank you, Operator. And good afternoon to everyone. Again, my name is John Albert with the Centers for Medicare and Medicaid Services. And for the record, this teleconference is a non-group health plan technical and policy call for purposes of implementing the Section 111 of the MMSEA.

Also, for the record, today is Thursday, December 9th. And finally, for the record, as we always state, while we try to be as consistent with the written materials on the Section 111 website -- meaning the cms.hhs.gov/mandatoryinsrep web page, which is where all official documentation instruction appears related to the implementation of the Section 111 reporting process instructions, policy, et cetera -- we occasionally do misspeak. So, again, if we do say something that contradicts the written materials, the written materials are the official answer. We do publish these transcripts as part of that web page, but, again, the user guide and alerts in particular which you should be following, in terms of official instruction from CMS.

As we have in the past, Ms. Pat Ambrose will provide a presentation to go over some latest developments, as well as to answer many of the questions

that we've received through the resource mailbox. I'm not sure. I assume -- Barb, are you going to -- Ms. Barbara Wright will also provide some material, Bill Decker, as well.

Again, as we've said in the past, while the NGHP reporting officially goes live in January, we actually have already stood the process up, and there are numerous entities out there already reporting data to us in a production environment. We would encourage folks to begin reporting as soon as possible, because there's no better test of your system than to actually submit a production file to CMS.

Other than that, I think I'm going to turn it over to Pat. Right now at this time, we don't have any future conference calls scheduled, but we will be scheduling more of these calls in the coming calendar year.

With that, Pat?

Pat Ambrose: OK, thanks, John. This is Pat Ambrose. And as John said, I have some -- a presentation to provide you, along with some answers to questions that were submitted to the CMS Section 111 mailbox. The e-mail address for that mailbox, by the way, is on the "What's New" page of the website that John provided earlier, www.cms.gov/mandatoryinsrep. Again, for the e-mail address, you can find that on the "What's New" page.

Some recent postings on the -- on that series of pages under mandatoryinsrep, on the NGHP alert page, you'll see an alert dated November 18, 2010, providing instruction about a special default ICD-9 code. You will also see an alert dated November 18, 2010, related to TIN reference file address validation and associated compliance flags.

And lastly, although not -- it was posted very shortly after our last call -- was the revised date for reporting liability TPOCs and extension of the interim dollar reporting threshold dated November 9, 2010. So all of those alerts are on the NGHP alert page and should be of special interest to you, especially as you prepare for production reporting coming up soon.

Other alerts that are being considered or in process, there's one related to guidance about workers' compensation and no-fault, non-medical, one-time lump sum payment or structured settlement with or without an associated annuity, indemnity payment reporting. Again, that's workers comp no-fault, non-medical TPOCs and whether they need to be reported or not reported. We discussed that on some previous town hall calls, and an alert is pending on that.

We also have an alert pending regarding guidance for foreign responsible reporting entities, or RREs. There's an alert -- or a user guide pending -- update pending related to how the COBC will retain all ICD-9 codes. Basically from version 25 going forward, we're no longer going to drop off ICD-9 codes that were once considered valid. If for some reason they do drop off the list on the CMS website, (CD ICD-9) section -- I think it's 11.2.5 of the user guide for more information -- but note that, as we announced on previous calls, we are not going to be dropping older versions, but rather just incorporating new versions as they're released.

There's also an alert I'm working on to provide you information about a new online query process that will be added to the Section 111 COB secure website or COBSW. Again, this is an online real-time query that will be available to all RREs, except for those using the direct data entry option. It's limited to 100 queries per month. A user would have to manually enter the matching criteria, and this query would then provide a -- basically, a yes-or-no answer -- a yes-or-no answer regarding the Medicare status of that individual.

The reason this is not going to be available for direct data entry RREs is that you basically already have this capability within the direct data entry process. So it's not necessary -- a necessary function for direct data entry, RREs.

So stay tuned for more information. That will actually be available after January 10, 2011. Hopefully I'll get the alert published by then. But if not, I think the query process will be very intuitive. Once you log on to the COB Secure Website, on your RRE listing page, you will see an action in the action dropdown box next to each of the RRE IDs you're associated with.

There also an upcoming alert to notify you of a TIN reference response file that we plan to implement in July 2011. So as you know, we only provide a response file for the query and a response file for the claim input file, the claim response file. There's no specific response file for this separate TIN reference file that accompanies your claim input file, and requirements and specifications for that is forthcoming. We have a goal of providing you this information at least six months prior to implementation, so the clock is ticking on that, and stay tuned.

I'd like to provide some further explanation -- oh, one more update for an alert on the website, has to do with updating the timeline that is published on the overview page of the Section 111 mandatory insurer reporting website to accommodate the latest extension for liability TPOC reporting, and that's TPOC, T-P-O-C, for the meeting transcript.

So now I'd like to provide a further explanation and some examples for the liability TPOC reporting extension. This applies to all RREs that have liability TPOCs to report, including those that are submitting their claim reports via the direct data entry option, or DDE. Now, this extension affects liability TPOCs only.

All that has changed is that only liability TPOCs with TPOC dates of 10/1/2011 are required to be reported. This was 10/1/2010, but is now 10/1/2011 for liability TPOCs only. Liability TPOCs with TPOC dates prior to 10/1/2011 will still be accepted, and, of course, with all TPOCs, the interim thresholds will apply.

Workers' compensation and no-fault TPOCs with TPOC dates of 10/1/2010 and subsequent must still be reported starting in first quarter 2011. The extension does not apply to workers' compensation and no-fault TPOCs.

The timeframe for ongoing responsibility for medicals, or ORM, the timeframe for reporting ORM has not changed. The extension does not apply to reporting ORM. Any claim, being liability, workers' compensation, or no-fault, with ORM, in effect 1/1/2010 and subsequent, must be reported starting in the first quarter 2011. And this is -- so for ORM reporting, the data is

exactly as it is published in the user guide. And note Section 11.9 for ORM that was assumed prior to 1/1/2010, there is an exception that has been published in the user guide for some time in Section 11.9.

So some examples. If a liability claim has both ORM and TPOC, then the ORM must be reported starting in January 1, 2011 -- or starting in first quarter 2011, during the RRE's assigned file submission timeframe or via direct data entry. The associated liability TPOC for that claim may be reported, but is only required to be reported if the TPOC date is October 1, 2011, and subsequent.

So, again, if you have assumed ORM and that ORM meets the conditions for reporting, otherwise specified in the user guide, the claim must be reported with ORM, but the associated TPOC amount does not have to be reported unless the TPOC date is 10/1/2011 and subsequent.

Suppose you have an auto claim that, for the same injured party, there is both a no-fault ORM component and a liability or bodily injury TPOC. The no-fault ORM is to be reported as per instructions in the current user guide. The liability TPOC does not have to be reported unless the TPOC date is 10/1/2011 or subsequent. Those two reports would be made on separate claim reports anyways, since the no-fault would be submitted with the no-fault insurance type and the bodily injury TPOC would be submitted with the liability insurance type.

If you have only liability TPOCs to report -- again, if you have only liability TPOCs to report, then you do not have to start production reporting until first quarter 2012. If you have anything else to report, you have to start reporting first quarter 2011.

So if you have any ORM to report, whether it be under workers' compensation, no-fault, or liability, you must start reporting in first quarter 2011. If you have workers' compensation or no-fault TPOCs to report, you must start reporting in first quarter 2011 for TPOC dates of 10/1/2010 and subsequent.

The only RREs that can delay production reporting to first quarter 2012 are those that have only liability TPOCs to report. All other RREs must commence production reporting in first quarter 2011.

All that said, CMS strongly encourages RREs to commence production reporting of liability TPOCs as soon as possible. There is no penalty or downside to reporting early. In fact, it is probably advantageous to the RRE for several reasons. It will allow the RRE to thoroughly validate and fine-tune production reporting prior to the required date, which in turn will assure compliance with reporting requirements later. It will allow the RRE to proceed with their original timeframe without having to reallocate IT testing and operational resources.

It will keep the Section 111 reporting requirements fresh in the mind of personnel involved in the reporting process, for example, claims adjusters and those other individuals responsible for entering claims and the information necessary for Section 111 reporting.

Also, it will keep your log-in IDs for users associated to the RRE ID on the COB secure website active. If you are an RRE that has only liability TPOCs to report, you might want to keep this in mind, and if you're planning on delaying your reporting. Unused log-in IDs end up getting deactivated after a certain period of time, and you must later then request reactivation through your (EDI representative).

And, of course, even if you are delaying your reporting of liability TPOCs, it's a good idea to continue forward with your testing so that you're ready in first quarter 2012 and have resolved any issues that you might have.

The dates for the interim dollar reporting thresholds set forth in Section 11.4 of the user guide have all been extended by one calendar year. This information is provided in the same alert that gave the extension for liability TPOCs.

For example, the $5,000 liability and workers' compensation TPOC reporting threshold is in place until January 1, 2013, instead of 2012. So all the reporting thresholds documented in the current version of the user guide in

Section 11.4 have been extended by one calendar year, and, of course, the user guide will be updated.

I'd like to provide some cautionary notes regarding the use of the new default ICD-9 no-inj, or no-inj -- obviously, that stands for no-injury -- that default ICD-9 diagnosis code. Please carefully read the alert concerning the restricted use of this default code. It can only be used on liability claim reports, where a settlement, judgment, award, or other payment releases medicals or has the effect of releasing medicals, but the incident typically has no associated medical care and a medical beneficiary or injured party has not alleged a situation involving medical care or a physical or mental injury.

It cannot be used if an injury is claimed or alleged or if the claim could involve medical care. It cannot be used just because an RRE is having difficulty identifying the proper ICD-9 code to describe the injury. It cannot be used on claims affecting ORM. It cannot be used on workers' compensation or no-fault claims.

CMS will be closely monitoring the use of this default. Any misuse of this no-inj ICD-9 default code puts the RRE at risk of non-compliance.

So all that said, we did get some feedback about the alert and the "if and only if" language that's in the field description, and we'll take a look at that in the next user guide update to make sure that we're completely clear and we're not attempting to list -- provide an exhaustive list, but hopefully the guidance in the verbiage of the alert is clear enough as to when it's appropriate to use this default code.

I'd like to also -- given the changes in dates and some general confusion over dates -- I'd like to review the timeline for reporting for Section 111, for non-GHP RREs. These are the required timeframes. And, of course, earlier reporting is acceptable. And also, make sure that you're applying the interim reporting thresholds as applicable.

So in first quarter 2011, all claims with ORM liability, workers' compensation, and no-fault ORM that exist on or after 1/1/2010 must be reported. Claims with workers' compensation and no-fault TPOCs, with

TPOC dates of 10/1/2010 and subsequent, must be reported. So that's first quarter 2011 coming up in just a few weeks. That's all ORM and workers' compensation and no-fault TPOCs, with TPOC dates of October 1, 2010, and subsequent.

In first quarter 2012, a year from then, claims with only liability TPOCs, with TPOC dates of 10/1/2011 and subsequent, are reportable, and any other claims that you're reporting with ORM that also include liability TPOCs of TPOC dates of 10/1/2011 are reportable. So, again, you may only delay reporting of liability TPOCs. All other required reporting is as documented in the user guide.

As I mentioned on the last call, our January 2011 release date is actually January 7, 2011. Files submitted before January 7th will be processed under the old rules, so to speak. And files submitted on January 7th and subsequent will be processed under the new rule.

The direct data entry option will not be available until Monday, January 10, 2011. So those of you who've signed up for direct data entry, you may begin submitting -- entering and submitting claims on the COB Secure Website starting January 10, 2011.

Speaking of the January 2011 alert -- I mean, release -- I would like to provide a summary of the changes that are being implemented in that release and also some changes that have already gone into the production system. So this is a summary that affect the start of reporting in January 2011. Some are in our January release, and some were already implemented.

As announced previously, changes were already implemented to accept ORM termination dates that are less than 30 days greater than the date of incident. A modification was made to the (CJ06 edit) for this. No alert was created for this change, but it will be included in the next version of the user guide.

Please note that I misspoke on the September 22nd call when I said this change was to be implemented in 2011. I meant to say 2010. Also note that the requirement concerning ORM termination dates being more than six

months in the future will remain the same, and those ORM termination dates more than six months in the future will not be accepted.

Changes are also being made to the representative claimant and representative claimant address, city fields to not allow numerics in these fields. This change will be made either in the January release or sooner, as it is causing us issues with other systems we interface with, which will (not allow) numbers in the city field.

Also included in the January release is the default ICD-9 code that I spoke about earlier. Another change going in the January release is to retain all ICD-9s from version 25 going forward and adding version 28. Another January release change includes the compliance flags that you will be receiving in lieu of errors for TIN reference file address fields as published in the alert I mentioned earlier.

Also in the January release is the online real-time query option. And, of course, direct data entry will be available in the January release.

And one other note that was discussed previously on previous conference calls, but I just want to remind you of, is to remember that the only field for which we accept parentheses at this time are the description of illness injury, field 57, the policy number, field 74, the claim number, field 75, and the plan contact apartment name, field 76. This is not really a change, but the user guide needs to be updated with this information.

Speaking of the description of illness injury, another change that is in the January release that has been published in the user guide for quite some time is that the description of illness injury, field 57, is being discontinued as documented in the user guide. So as of January 2011, you should just move spaces to this field.

Now I'd like to cover some information about status of RRE IDs on the COB Secure Website. As we've said on previous calls, if you have abandoned an RRE ID -- in other words, if you have registered for an RRE ID that you no longer need and never intend to use for production reporting, then please contact an EDI representative or the main COBC EDI department number,

which is 646-458-6740, to have that RRE ID that you have abandoned deleted.

RREs that have registered for an RRE ID are to move the status of that RRE ID into a testing status as soon as possible. Even if you're planning on delaying your reporting because you have only liability TPOCs to report, you are still required to move your RRE ID into a testing status.

To move to a testing status, you must receive your PIN, complete the account set-up step on the COB Secure Website, receive your profile report, and then have your authorized representative sign and return your profile report to the COBC.

The profile report must be signed by the authorized representative for the RRE, not an account manager, not an account designee, and not by your agent. Again, the profile report needs to be signed by your authorized representative.

So those are the steps that you need to take to get your RRE ID into a testing status.

RREs that have elected the direct date entry option will automatically be moved to a production status once the profile report is returned and logged by your EDI representative. No testing is required for direct data entry.

RREs that are to begin reporting in first quarter 2011 should be in a production status now, but at the latest by the time your assigned file submission in first quarter 2011 rolls around.

RREs are expected to move to a production status within 180 days after initiating registration. Again, those that are delaying reporting obviously will be given an extension for moving their RRE ID into production, but are still required to move into a testing status.

To obtain a production status, testing requirements must be completed by you or your reporting agent, and your EDI representative must change that RRE ID status to a production status.

Starting in 2011, the COBC will begin a clean-up process of non-GHP RRE IDs. If an RRE stays too long in any one status or still hasn't made it to production within a required timeframe, they will get an e-mail concerning the status of their RRE ID asking them to move forward or contact their EDI representative. It's actually -- if your RRE ID has not moved to a testing status, you will get an e-mail concerning the status of your RRE ID, and this e-mail, again, will ask you to move forward or contact your EDI representative or run the risk of having the RRE ID deleted or inactivated, which you certainly don't want to have happen. If an RRE is actively testing or not required to report until first quarter 2012, then we won't, obviously, be inactivating or deleting the RRE ID.

I'd also like to make some announcements about account manager responsibilities, the account manager role on the Section 111 COB Secure Website. Account managers for RREs are reminded of their ongoing responsibilities for managing the reporting process and users on the COB Secure Website. Account managers must move access -- must remove access of account designees that no longer need access to their account.

For example, if an RRE changes reporting agents, not only must the account manager invite people from the new agent as users associated to the RRE ID, but the account manager must also delete the users from the former reporting agent. Please note that this is necessary in order to comply with the (data use agreement) on the profile report that was signed by your authorized representative, as well as agreed to by the account manager when they registered for their COB Secure Website log-in ID.

So, in other words, account managers are on the hook for managing the users associated to the RRE ID. And in order to comply with that (data use) agreement, you must add and remove users -- your account designees -- in a timely fashion.

Account managers must forward pertinent e-mails concerning file processing issued by the COBC to account designees as needed. We are considering

improvements to the e-mail process, but until that time, it's critical that the account manager directs e-mails to the appropriate resources.
You do not want to allow a file rejected for severe errors or suspended for threshold errors to sit around unattended. That puts the (R.E.) at risk of noncompliance, so account managers for the (RR EID) are responsible for forwarding any e-mail notifications as necessary to account designees.

(John): (Inaudible) this is (John) I wanted to add or emphasis what (Pat) said about account manager responsibilities. The data use agreements kind of go above and beyond the folks in this room at the agency level and I can't stress enough to the participants on the call and those who even aren't on the call that it's very critical that you maintain good control of your (I.D.s) and access because there have been reports received by the group here that oversees privacy protection and data security and we would hate to see somebody's access removed and not be able to get it restarted again.

And it's something that isn't necessarily always in this groups purview or scope of control so again I can't stress enough that the government takes privacy and protection of data much as does private industry. Very seriously so again I can't stress enough to make sure that you have all of your requirements (set) on your end regarding data security and access, etcetera so that's all.

Male: OK thanks (John), another reminder about the computer based training modules we continue to create and roll out additional CBTs for new topics. Including (inaudible) we have three courses available now for ICD-9 and I highly recommend that you take a look at those, they're very informative and available to anyone for free of charge, of course.

And you sign up for those CBTs on the mandatory (INS REP) website, use the tab on the left hand side for computer based training and follow the instructions to sign up. Whenever we roll out new courses or updated courses, you'll be automatically notified.

We're also still in the process of updating the CBTs for version 3.1. So again new courses that are being added or have been added include ICD-9 and direct

data entry and then updates related to the existing courses to keep pace with the user guide.

A question was asked previously related to Worker's Compensation claim, where the RRE assumes ORM for one injury however another injury was claimed by the injured party and the RRE denies responsibility but settles for a sum over the Work Comp TPOC reporting threshold of 5,000 dollars for that alleged injury.

So the RRE does not assume ORM for the second injury but settles this for the second injury basically to avoid litigation. So there is a reportable TPOC. For example, a neck injury is accepted as a compensable injury caused by work. A shoulder injury is also claimed by the injured worker that it should be part of the same claim and injury but there is evidence it is not work related.

The RRE enters into a settlement mutually acceptable by both parties to keep the condition in a denied or denied status or not admitting liability, the settlement is not mandated by law it is a decision by both parties rather than litigating.

In this situation you should report the neck injury that you accepted ORM for on a claim report with the ORM indicator equal Y and include only the diagnosis codes related to the ORM and in this example, the neck injury. And no TPOC or other information related to the shoulder injury.

Secondly, report a second separate record with the ORM indicator equal to N, the diagnosis codes related to the alleged shoulder injury and the associated TPOC. The TPOC is reportable even though the RRE does not admit liability as documented in the user guide section 11.10.2.

Both claim reports would have the same policy number, claim number and so on. This will allow CMS to track the ORM for the neck injury while separately considering the TPOC for the shoulder injury as necessary for recovery purposes.

The user guide will be updated with this scenario. So this is different from what we have talked about in the past and what's documented in the user

guide. This is a case where ORM is assumed for one injury and ORM is not assumed for a second injury but a TPOC has been established for that second injury.

As always, please submit your specific technical questions to your EDI representative first. Specific technical issues related to your file submission can't be addressed effectively if they are sent to the CMS resource mailbox or elsewhere, you'll get a much faster response to your specific technical issues if you contact your EDI representative and follow the escalation procedures in section 18.2 of the user guide as necessary.

I'm going to go through some of the questions that were submitted to the mailbox. Obviously this is the last call prior to production reporting being required for most RREs starting on January 2011, I'm sorry for taking up so much time, we do want to get to your live question and answers so I'll go through them as quickly as possible but we feel it's important to address the questions coming into the mailbox and try to get answers out to you.

Male: For the folks that do submit the written questions, again it really is the best way you know because it gives us a good set of documentation to work with. And so we really try to make those a priority on these calls. So we apologize again if we're going to be presenting a lot of material but we've also just received a lot of questions and we want to give those folks who took the time to actually type in the questions to get their answers as soon as possible.

Male: Yes and please note when you send those questions you'll get an automated reply that says you won't get a response and that's not completely true, you don't get a direct response back to your e-mail address but we do read each and every e-mail that comes into this mailbox and try to address it either on the call on in alerts or in some other fashion and updates to the user guide and so on.

One question that came in stated that we are resubmitting this question to clarify that it is a section 111 reporting question, not a billing question. If a provider is writing off an entire patient bill for risk management purposes, such that Medicare is not billed at all for the service. Does the provider need

to submit a section 111 report. The provider has not assumed ORM but just wants to write off the single bill for services provided.

CMSs answer for this is that it is not a yes or no answer. This question says nothing, says it has nothing to do with billing but that avoids what is said in the alert on write-offs and risk management.

If a no paid bill should otherwise be submitted under CMS billing rules and the provider or supplier must submit a bill and show the write-off amount as a primary payment amount. If a no paid bill does not need to be submitted and no ORM is assumed, the provider supplier does not need to submit a section 111 claim report.

Another question came in asking some questions about direct data entry and whether an RRE can start entering claims prior to January 10? And the answer is no. Direct data entry will not be available on the (COB) secure website until January 10, 2011.

This same question was asking about how they would report multiple TPOCs when they're submitting a claim via direct data entry on the (COB) secure website? The direct data entry application provides five boxes so to speak for you to enter your TPOC information. Just like the file format does, so you will enter separate TPOCs for the claim report via direct data entry again up to five are listed.

If you incur an additional TPOC after you submit your first report you will go back into the direct data entry process, select that claim for update and update the original claim to add the second TPOC. I advise you also to read carefully the definition of TPOCs. We continue to get a lot of questions about reporting multiple TPOCs and particularly what to do with you have more than five to report. And that should be an extremely rare situation, making multiple payments for a single settlement does not constitute multiple TPOCs. One settlement equals one TPOC in general terms.

The next question about DDE, was asking about the user guide for — that will include direct data entry, the section 111 (COB) secure website user guide

will be updated with instructions for direct data entry and that will be available after you log onto the (COB) secure website on January 10, 2011.

Please see the computer based training modules in the meantime, and also note that each page of direct data entry will have a quick help link with all the information that you should need to fill out that page as you're going through the application. The application, I've seen it is very intuitive and if you are familiar with the requirements in the (NGHP) reporting user guide as you should be, then you should not really run into any questions.

Questions about data elements and how they should be defined are all specified in the existing reporter user guide. Even though it only addresses files the same requirements for those fields in reporting are, hold true for direct data entry as well.

Another question asked about once an RRE has started submitting via direct data entry, is it possible to then test the secure file transfer process. And in an eventual plan to eventually convert to SSTP instead of direct data entry you can submit, I mean you can change your submission process. And quite frankly I'm not exactly sure how the submission of FTP files will work and so I encourage you to submit that question to your EDI representative and I'll follow up on it later.

But obviously you would need to test your file submission prior to converting from direct data entry to file submissions and I at this point don't have all the answers, believe it or not.

Another question asked us to address changes to the user guide and system updates that we're making other than what I've announced previously for the January release and for the (ten) reference response file coming up in July 2011. I don't know of any changes that are in the works of course we'll have an eventual conversion from (ICD-9) to (ICD-10) and I realize that we've had a lot of changes and alerts coming out in the last six months, that's the nature of the beast when your implementing a new application of this magnitude.

But we are committed to giving our RREs at least six months lead time for any significant changes, obviously we'll likely come across some things that

we have to fix but there should be no requirement changes coming up that you haven't already been alerted to. And again we're committed to giving our RREs at least six months lead time so we do understand that you have to rally you resources to react to those changes.

Another question reads, if a (MedPay) policy limitation runs out prior to January 1, 2010 but do to an administrative error the ORM file remained open or the claim remained open on or after 1/1/2010 despite they're no longer being any funds available, is the claim reportable?

So this is an RRE who the no fault policy limitation has been reached but they have not yet actually closed the claim as of 1/1/2010 which is the effective date for reporting ORM. Note that ORM is terminated when the no fault policy limit is reached, so the RRE does not have ORM on 1/1/2010 in this particular example and therefore the claim is not reportable. Even though it might still be open for administrative reasons, ORM has already terminated (essentially) so that claim is not reportable.

Another individual asked if we expand on an example that's given in the user guide. And this is an example that's in the section that talks about initial file submission and in particular example 2B on, and in that example it reads a Medicare beneficiary is injured in the job on February 15, 2009 and files a worker's compensation claim.

Worker's compensation assumes responsibility including a requirement to pay pending investigation for the association medical. The claim is still open, worker's compensation continues to have responsibility for the medicals on and after January 1, 2010.

There was a judgment or award of 50,000 by the worker's compensation court issued on June 23, 2010. In the current example 2B this judgment or award left the medicals open and this individual was asking well what if this judgment or award closed the medical?

ORM is to be reported with an ORM termination date which was probably the TPOC date in this example and the TPOC date, the TPOC rather does not have to be reported because again in this example it's prior to 10/1/2011.

So the only difference there as far as what you would submit is a claim report with the ORM indicator of why in an ORM termination date rather than zeros in the ORM termination date. I hope that answers that question, if not please follow up with your (EDI) representative.

Another question came in about ICD-9 codes and reporting of a claim that for an individual that might not have initially been a Medicare beneficiary but then many years down the road does become a Medicare beneficiary and the RRE still has ongoing responsibility for medicals and they now need to send in a claim transaction for this claim.

The new or add claim will have to be reported with diagnosis codes that are deemed valid for reporting at that time. Currently as I said earlier we are never removing any ICD-9 codes that are considered valid. However, you know many years down the road we'll be converting from ICD-9 to ICD-10 codes and we haven't finalized the requirements for that but the expectation is that new or add transaction, new claims or add transactions will have to be submitted with ICD-9, I mean ICD-10 at that point in time.

We have stated that for updates to old records that we would continue to include the old ICD-9 codes. Again we haven't determined the exact process, we do understand the difficulties it's likely that the RRE will be required to cross walk old codes to new ICD-9 codes, I mean ICD-10 codes at some point in the future.

Again we're working on the requirements for that and we'll provide them as soon as possible and we are trying to keep the difficulties that we understand you'll have under consideration.

What I would do if I were you is also consider a you know what your, how your going to handle essentially possibly a cross walk of ICD-9 to 10 but more on that later.

Another question came in about something that was said in a previous call, saying that we would be providing an alert about indemnity payments that should be considered TPOC or not. And that as I said alert is pending, I do

want to make sure that you understand that individual medical payments made to reimburse providers for medical services are not TPOC, they constitute ORM so the claim is just reported with an ORM indicator equal to Y. The user guide currently has information on period indemnity payments and the alert is pending on these so called lump sum indemnity payment.

The next question asked can we send a termination date on an ORM or no fault claim if the statute of limitations date has been reached. The answer to that is if ORM is terminated or closed by virtue of state law, then ORM has ended and a termination date can be submitted.

Another question came in asking about ICD-9 codes and some confusion over what I said on the last call. This individual noted that on the downloads of ICD-9 codes that there are three digit codes on that file and they're certainly are valid three-digit codes that may be submitted for section 111 reporting. They're either three, four or five digits. So, on the last call when I was talking about (ICD9s) being four or five digits, I was talking about a specific range of (ICD9s) as an example for why people were getting the (CIO5) error. If your (ICD9) is in a range for which the diagnosis codes are only four or five digits, then you must submit four or five digits. So, I was trying to say that in some cases, you must submit four or five-digit code and not just the first three digits. However, there are valid (ICD9) codes that are three digits. If a three-digit code is used and submitted, you should fill the remaining digits with spaces – not zeroes – spaces.

Another question came in stating that they have a person who died in 2007. His daughter now wants reimbursement for nursing services which she supplied to her father. They go on to say that they know they don't have (O) or (M) as he is deceased. So, you know would we report this claim or wait until they have reached a settlement?

First of all, you might have (O) or (M) to report on a deceased person depending on when that – how long that (O) or (M) was effective. Again, check the dates for (O) or (M). If it was effective as of 1/1/2010, then the (O) or (M) is reportable. This person died in 2007, so obviously it sounds as though no (O) or (M) is in existence as of 1/1/2010. And so, then the claim

would only be reported after settlement judgment award or other payment is made for the reimbursement of nursing services claimed.

My next question has to do with multiple (tepox) and the reporting of multiple (tepox). Again, this has to do with reporting more than five (tepox) and what to do. If you have five – more than five (tepox) to report as documented in the user guide, you are to add the sixth and subsequent (tepoc) amount to the fifth (tepoc) amount and update the fifth (tepoc) date to the most recent (tepoc) date and submit an update for that record.

All that said, I just want to caution you about the definition of (tepoc) and making sure that you truly have more than five (tepox). Multiple payments for one settlement does not constitute multiple (tepox), so please read the field definition for the (tepoc) amount in the user guide carefully and make sure that that's the case. But if you are meeting the requirements for more than five (tepox), add the sixth and subsequent, put it in the fifth (tepoc) amount field and put the most recent (tepoc) date in the fifth (tepoc) date, as well.

Another question was asking about handling mandatory reporting requirements for writeoffs or providing property of value and whether these writeoffs or property of value are considered (O) or (M) or reportable as (tepoc). These are (tepox) and follow the rules as such. Obviously they have to meet the threshold and so on for reporting. There's information about writeoffs and risk management of this sort at the end of section 11.10.2 that I think is pretty clear.

Another question was submitted about a – one settlement on October 1, 2010, but the settlement stipulates two separate payments – one lump sum of $1,000 and a second payment of $50,000 to fund a structured settlement. And this (RRE) is indicating that they planned to report this as two separate (tepoc) amounts, and that's not correct. The key here is – at least for this question that was submitted – is that they said there is one settlement. So this, regardless of how the payments are split up, this is one (tepoc) with one (tepoc) date. And of course, depending on whether it's liability, workers comp, no-fault, and the (tepoc) date that will help you determine – and the threshold that will help you determine whether that is reportable or not. But

again, just because there are two separate payments, it does not constitute two separate (tepox).

Let's see, next question – someone was asking about the compliance codes and how we have 10 possible compliance flag fields on the response file, but we don't have that many compliance codes defined. In the current version 3.1 of the user guide, we have three compliance flag values defined and then in that new address – (tin) address validation alert, we now are up to nine possible compliance (flag) values that can be returned in those 10 possible positions on the claim. The tenth position is just simply for future use, so it is true that we only have up to nine compliance flags now, but we do have room on the record to post 10 different compliance flags. And obviously you'll be notified of any new compliance flags that might be added.

The next question is kind of long, but we felt that it was important to cover. This question reads that if we have a wrongful death claimant who generally alleged emotional distress and mental anguish with regard to the death of a family member in an accident for which they are suing, in their original pleading but who is – they are not alleging any injury as we get near settlement of the case, so originally they might have been alleging emotional distress, mental anguish, some sort of injury and now as they're approaching settlement, they are not alleging any injury for that claim and the decedent is not a Medicare beneficiary, do we need to check the Medicare status of this injured party or wrongful death claimant.

You would only need to check the Medicare status of the surviving claimant. The claim is reportable if the settlement judgment award or other payment releases or has the effective releasing medicals. And again, I'm assuming that the deceased is not a beneficiary and that the surviving family member ((inaudible)) is the injured party for your claim and they are the individual for whom you need to check on Medicare status and potentially report a claim report if medicals are released or the claim has the effect of releasing medical.

The next question was asking about if the payout of the settlement is through an annuity, how do they report that. And please see field description – the field description for field 101, the (tepoc) amount, which in part says that if a

settlement provides for the purchase of an annuity, it is the total payout from the annuity and so on from there.

Let's see, next question that I have on my list – what do we do from a reporting standpoint when the person (is) no longer entitled? This individual indicated that they have seen instances where individuals appear to be entitled for a period of time and then no longer entitled. And they went on to ask in that circumstance should they submit a delete report when we receive notification that they are no longer entitled. I'm not sure if the exact circumstances of how this (RRE) is determining that the person is no longer entitled.

It is possible for a beneficiary's entitlement to end and start up again later. However, you should never get a positive response on one query and a negative response for the same individual on the query the next month. Once the person – once the person's initial entitlement date is reached, we should always send back a positive response on the query even if that entitlement has ended. When you submit the claim, it might be returned with an (03) disposition code. You, as the (RRE), do not need to do anything other than the report on a claim-by-claim basis and send updates as specified in the event table in the user guide. Do not send deletes for what you – when you think there might be a change in entitlement.

Now, all of that said, any discrepancies with the query results should be reported to your (EDI) representative in a secure fashion to be researched. Just briefly, I should note that we were experiencing some difficulties where, as we've said on previous calls, we do get Medicare entitlement information for Medicare beneficiaries prior to their actual entitlement date and so we may have future entitlement dates on our file that we'd use for the query responses. And we have some difficulties. When we were in that case, we were sending back a positive response to the query saying that this person is entitled to Medicare, albeit it being in the future. But then, when the claim was submitted we ran into some problems.

We made some changes internally to correct this issue, and so essentially now – and those changes were just made in the last month or so. So, going

forward, it is a true statement that you should never get a different answer on your query. And if you do, report that to your (EDI) rep. But this particular circumstance could be a result of a change that we made to the query process. When you submit a query for an individual, if we see that at the time that you're submitting that query that the individual's Medicare entitlement date is in the future, we will return a 51 or a negative response to Medicare entitlement and we will not return a positive response or an (01) until their entitlement date has actually been reached.

Other things can happen with the Medicare entitlement files, social security could send us information about someone's entitlement and then retract it and so on.

It's not a perfect world. And again, I encourage you to report discrepancies in a secure fashion through your EDI representative.

But hopefully that explains that situation.

We also had an e-mail submitted about, someone who has changed their last name. That actually appears to be their -- well they changed their first and last name. And their last name appears to be a website URL, or a website address.

And so as such it has a period in it. It's kind of an unusual circumstance obviously. And they're asking how should they handle are -- are name -- are only alphabetic and we don't accept periods in them or we're not expecting them.

And so they're asking should they just space it out and leave a space where the period was, or should they (smunch) it together?

As it turns out in this particular case that was submitted, it won't matter because we only -- whether it's a query or a claim record, we're only using the first initial of the first name and the first six bytes of the last name for matching purposes.

But you know, going forward if you run into this it -- it really is going to depend on what social security does. And hopefully not a lot of people are going to change their names to website addresses.

But --.

Male: Yes, you heard correct.

Female: But what I would do is try to query, you know, in -- in different ways to make sure that if -- if you can't get a hold of their social security card or verification of what their card looks like on their social security card or their Medicare card, then try it with just spacing the period out and leaving a space there, and if you get a negative response try it again (smunching) it together.

And you know just to be sure that you've covered your bases.

Male: And actually that -- that name -- the new name is probably cross walked to the (SSM) -- and the -- the old name, I mean, would still probably show up as the match.

Female: I -- I can't …

Male: But we don't know for sure, so.

Female: The next question goes on saying that they -- their question applies to (ORM) and TPOCS in auto liability situation for property and casualty carrier.

When they're looking at deriving ICD-9 codes for a -- to report on a particular claim in -- one possible way of deriving those ICD-9 codes is to look at the actual medical bills that are submitted to the carrier.

Now often times providers, doctors, (inaudible), other suppliers will include diagnosis codes on medical claims that are not related directly to the injury. And this individual is asking which ICD-9 code should I include?

And so you should only report ICD-9's that relate to the injury. Those caused or alleged by, in this case, an auto accident.

So if the provider had for some reason included hypertension and that is not related to the auto accident that should not be included.

Your ICD-9 codes that you're submitting are to describe the injury so that -- then we can go back and identify applicable claims to, you know, take care to -- to make sure that the ICD-9's that you're submitting actually describe the illness or injury and aren't just every single ICD-9 that might have been included on a medical bill submitted to the carrier.

Additionally, remember that we told you that if you're reporting ORM, report codes for what you've accepted responsibility for. If you're reporting (T-pox) you should be reporting all the codes associated with what's being alleged.

It should not be limited to what you believe you're liable for. If you've got a settlement judgment -- if you've got a settlement, it's everything that's claimed and released. So, that includes what's alleged, not just what you believe you're liable for.

Yes. And please see section 11.2.5 and the new ICD-9 CBT. I've covered that information as well. And, the last thing on those to reiterate again what we've said on other calls. You're not limited to what is on a medical bill. If you've got treatment for a particular injury or part of the treatment and it includes two diagnosis codes but you know in their complaint or their claim, they've alleged injuries to four different body parts and you're reporting a (T-pox) then the fact that you don't have a medical bill that includes a particular claim does not limit you from reporting those codes. You should be reporting the codes that are related to everything that is alleged.

OK. Our next question had to do with reporting claims that settled prior to the required reporting dates for Section 111 where there was a Medicare set aside that was approved by (CMS). Basically, the (T-pox) reporting date for workers' compensation is the same regardless of whether there was a Medicare set aside or not.

So, it's a settlement that led to the (MSA) is 10-1-2010 and subsequent and as workers' compensation, then at other -- and it otherwise meets the recording requirements then it must be reported. So, the fact that there is a Medicare set

aside has no bearing on whether it's reportable under section 111, just follow the same rules that are in the user guide for (T-pox) related and associated dates.

Skip this one.

Another question was about ORM and when a (RRE) can determine when ORM is terminated and I believe the question is referring to a exception that is documented, a special exception that's documented in Section 11.8. And this person is asking can it only be a written doctor's statement or can we rely on verbal communication with either the insured or provider and I think that wording in that exception is perfectly clear that it must be a signed statement from the injured individual's treating physician that he or she will require no further medical items or services, et cetera.

So, a signed statement is certainly not a verbal communication. So, to invoke that special exception, now, of course, that's not the only reason ORMs can terminate, but to invoke that special exception documented at the end of a -- of section 11.8, it must be a signed statement.

Next question goes on. When reporting a claim where my company paid a portion of the settlement to a claimant and the insurance company, for the contractor hired by my company paid a portion of the settlement, do I report only the (T-pox) amount paid by my company? Or the entire settlement amount?

You report only your portion unless the settlement reflects the legally defined term joint and (several) liability. So, generally speaking, you're most likely reporting only your portion unless the settlement reflects joint and (several) liability.

The next question was asking about what codes to use for field 15, the alleged cause of injury. In the case of asbestos exposure -- and this is covered in the ICD-9 but I'll give you those E-codes that we recommend right now. Possible E-codes for asbestos exposure could include E-0008 or E-0009. External cause status NEC and external cause status NOS respectively. Again, I refer you to the (CBT).

Another question came in about the 272 71, the X-12 270, 271 transaction set and the 50 10 version, 50 10 format and conversion to that and whether testing will be required whether our X-12 270 271 or (Hew) software would change for the 50 10 version.

So, here is my understanding and I encourage you to follow up with your EDI representative. But, I've been told that the 50 10 version does not apply to the 270 271 transaction sets. In any event, there is no plan to change the versions of the X 12 270 271 or the HEW or H E W software used for the query purposes for section 111 any time in the next year at least.

If and when we do change those formats our REs will be given ample notice of that change in plenty of time to test.

The next question was asking about ICD-9 codes again and reporting body parts that they had ORM responsibility for as of 01-01-2010 or are they -- are they basically, you know, what exactly to report here. In the case of a deceased individual, ORM generally ended when they died. If they died before January first, 2010, then the RRE did not have ORM on January first, 2010 and reflectly, you would not report that claim.

This question went on to ask some questions about asbestos exposure in 1980. The individual dies in 1995 from the sepsis related to cancer, et cetera, et cetera. You must report ICD-9 codes for the body parts that you have ORM for. You may still have ORM even if you are not receiving claims for old injuries. If there is any possibility that treatment could start up again and you would assume ORM for those old injuries then report the associated ICD-9 codes.

You should report those injuries for which if a medical claim was submitted to you, (two) would be required to pay it or reimburse for it.

On previous calls, we talked about ORM officially ending for one injury due to state work comp law but continuing for another. And in those cases, you only need to report the ICD-9 for the injury for which ORM continues, essentially.

I hope I got to the jist of that question. I'm sorry, I just don't want to take up any more time and with that, (John) I will turn it back over to you.

(John): Thank you. And again, we apologize. We're not going to have a lot of time for open mic Q and A because there's a lot of stuff that came in through the resource mail box that we wanted to address.

And now I want to turn it over to (Barbara Wright) who has a few more things.

(Barbara Wright): Actually, I just have one short announcement. We have gotten several questions that are asking whether we're still looking at the December 1980 issue, particularly in terms of exposure cases and whether or not we're going to have any more work group meetings. And the answer is yes to both of those.

We are still looking at those issues. We want to resolve that as soon as possible and we will be having at least one more meeting, if not more, after the beginning of the year.

(John): OK. Thank you, (Barbara).

And, (Phil Decker) also had one thing.

(Phil Decker): Hi everybody, this is (Phil Decker).

Just quickly, again to reinforce what (John) mentioned very early in the call. We will be having more of these calls next year. We haven't scheduled any yet. When we have scheduled them, when we intend to schedule them very quickly, now, they will be posted on the website as they always are. Please be on the look out for those coming up.

The questions that came in that I want to specifically address related, as they always do when I have to answer questions to Social Security and other issues, basically, they're pretty easy this time. There were a couple of questions related to do we require the reporting of Social Security numbers.

And the answer to those questions as always, is no. We do not require any section 111 RRE to use Social Security numbers to do section 111 reporting.

We require section 111 RREs to use Medicare health insurance claim numbers, the Medicare I.D. number to do reporting. If you don't have a (Higgin), a Medicare health insurance claim number for an individual and you wish to find out if the individual may be a Medicare beneficiary, you in that case, can use an SSN and send that to us with a bit of other personally identifying information and we can confirm or deny that the individual is or is not a Medicare beneficiary.

Based on the information -- based on the information you have submitted, that's right.

If we find the beneficiary -- the individual is a beneficiary, we will tell you that and return the individual's Medicare health insurance claim number to you which you will then use in the future. if we do not find a match on our databases, we tell you we have not found a match on our databases and that is all.

The other half of that question, or the other half of the implied questions here that we're getting, is what happens if someone tells me, that is you, the RRE, that you have to give them Social Security numbers because there is a requirement that they report them.

Again, we state only that we have no such requirement, that anyone report Social Security numbers to us for section 111 reporting. It may be that one of your clients and sure, someone else out there in the real world would like to get Social Security numbers for folks with and whether or not you supply them is not a decision that we can make for you. We can only tell you that we do not require them for section 111 reporting.

Male: When we receive quotes, we have received a number of questions from individuals where they say an insurer has told them that the (amounts are) Medicare is requiring them to gather the Social Security numbers.

When we receive those inquiries, we tell them a response along the lines that (Bill Decker) just reported. That we do not require collection of the Social Security number. So, you need to be aware of that and insurers should not be quoting (CMS) as saying…

Male: Or the government. Or other, you know, if the government says I have to collect. The government, as far as we know is not saying that.

Male: OK. With that, Operator, we are now ready to go to Q and A session. If you hear any background noises, another very large conference letting out in a room next door consisting of hundreds of people and so we apologize if you hear any interference from that.

Operator?

Operator: If you would like to ask a question, please press star then the number one on your telephone keypad.

And your first question comes from the line of (Rebecca Justice) from Walt Disney Company.

Your line is open.

(Rebecca Justice); Yes. HI.

I know this is a non-technical call, but as this is the last one before we go into production, it's really imperative that we get an answer.

We, based on the multiple changes that CMS has proposed, all good, of course, from a technical aspect, we are still testing. Our go live date is on March first. Because of that, we have to request a production Medicare beneficiary file on January 15th so we have the 45 days to prepare them within that grace period.

We've had multiple delays in receiving a claims input response file for Medicare. So, we've gone back to our (EDI) rep as the user guide states and asked for statuses. And we continue to be told that the Medicare servers are having issues. And we've also seen that with a production file for one of our

other business units at Disney. So, it is, of course, very frustrating but our main concern is that we have not finished testing and it is unlikely that we'll finish testing prior to our go live date because we simply (had to had) adequate time.

What is Medicare doing to respond to those types of issues and ensure that the RREs that are expected to go live expected to be in production status, how to finish testing due to the technical issues that Medicare's having?

Female: I can speak to of the changes that are going on behind the scenes to improve the process. One is that on November 23rd, we implemented a -- some changes to our secure file transfer infrastructure that has shown a marked improvement. So, those that were having trouble transferring files, you know, were getting timed out during (FLTT). You should not be seeing those issues any longer. Of course, you need to try it again since November 23rd.

Secondly, we have a change to business process behind the scenes of the (FFTP) that have to do with moving files from the (FFTP) server to our other servers for processing. That's going in on December 15th. That's already looking very good in testing and we'll get to the bottom of, I believe, the -- one of the issues that possibly your (EDI) rep was alluding to of some files not successfully being picked up timely and processed timely.

So, I do apologize for the struggle that you've had. Now, all that said, I think CMS will back me up on saying that our interest is to get people tested and (inaudible) and work with you as soon as possible. If an RRE is struggling to complete testing but is obviously demonstrating that they are working actively toward a production reporting status, there is -- we understand that there are going to be some folks that might miss their initial date and again, if you demonstrate that you're working actively toward testing, there's not going to be some adverse action taken against the RRE.

Male: Particularly if it's CMS's responsibility.

Female: Right.

Male: To lay in the testing.

Female: Right. So, I hope that, you know, we -- I, you know, addressed your concerns particularly as far as getting files returned in a timely fashion.

(Bill Decker): And I -- this is (Bill Decker), I'd like to ask you a question, or, when was the last -- how are we most -- what was the most recent time you were told there were still issues with the -- with the servers or with the computer programs or whatever it was that your EDI rep was telling you about?

(Rebecca Justice): So, essentially, just a quick time line is that we had tried to submit our claims input file, middle of October. When week two, sent an e-mail to our EDI rep having issues. We sent an e-mail a couple weeks later. Still having issues. I sent an e-mail on Monday to the EDI rep and the supervisor, according to the user guide, and within two days we had no response.

So, I don't know what happened. Why it took an e-mail to the supervisor to get a response? You know, I don't necessarily put any blame on any particular person, of course. It's just it seems to be a gap in processes that it took escalation to make that happen.

Female: Well, and, you know, again, I just refer you back to the escalation procedures in chapter 18 of the user guide. And you know, don't hesitate to use that if you need to. That's what it's there for.

(Rebecca Justice): OK. And so one of our other business units actually went into production early. They were able to -- they were able to make that happen. But they sent a claims input file in -- how long -- On October 22nd and have not yet received a response. So, we know that we have the 45 days -- up to 45 days. Is that still expected with these issues or these process improvements? That we will receive a claims input response in production 45 days later?

Female: Yes. And you know, hopefully sooner, but you know, the 45 days stand. But -- and I believe that you will see these issues cleared up after that change goes in December 15th that I was talking about.

(Rebecca Justice): OK. Well, we did get our claims input response, actually yesterday so we were very pleased and so that does help in knowing that we have our -- that

we have some processes that are going into place to help prevent these types of issues. That's help as well. So, I appreciate it.

Male: And you're -- and your sending in production files early again, helps us identify, you know, these types of issues so…

(Rebecca Justice): Right, it's a -- we have multiple RREs, so one RRE is not -- is a production in the -- others are still testing. I'm just very concerned about the fact that we haven't had adequate time to go through all of our testing areas to ensure that our system is working properly.

Male and Female: Thank you.

Female: For everyone on this call, just so there's no misunderstanding since this is the only call this month, technical questions as well as policy questions are welcome. It's not just a policy call.

Male: Operator?

Operator: Your next question -- your next question comes from the line of (Brigit Grady) from Benderson Developments. Your line is open.

(Ed King): I'm actually (Ed King) and I'm going to ask the question on (inaudible) behalf. (Inaudible) to the November 12th alert concerning the use of the no injury code for certain categories of claims. The question is, if a property damage claim, (A), with a general release has the effect of releasing potential medical claims, is the no injury code appropriate to be used in that category? And then should it be reported? And then also, if something of value is given in response to a claim, but no release is taken, is it reportable?

Female: We've said from the beginning if it's purely a property claim, that that's not something we really want reported. So if it's simply a broad general release and it is clearly only a property claim, we have never really asked for that to be reported and when you say something of value is given and there's no release, there's nothing in our definition of what's reportable that actually requires a release. We say when there's a settlement judgment award or other payment and that other payment can include something of value, so the fact

that you don't get a release doesn't relieve you of reporting obligation. In fact, a number of insurers have reported that particularly with low dollar claims, they often issue a check with the expectation that the issue may go away and there is no formal written settlement and there is no signed release.

(Ed King): It's going back to the first question that it is property damage, but a general release is taken. Are you saying that because it is property damage, you know a general release is taken, there is no requirements to report?

Female: Yes, if it's purely a property claim, we are saying a broad general release alone is not going to require you to report.

(Ed King): And on the second part of the question, if an item of value is given because there is a suspected or a claim of injury could be reportable. Again, if it's property damage, it's not reportable.

Female: (Inaudible) all our rules together. If it falls under a purely property damage claim, then that's what you're dealing with. When you're talking about items of value being given, then that's not determined – you know it's a completely separate issue and it seems to me you're trying to make a – or asking us, I'm not saying you're trying to make us do anything, you're asking us to come up with different combinations and a rule for each combination. What you need to do is apply the rules for each you know specific issue. I'm afraid I can't give you anything more specific than that.

(Ed King): But on the key issue of property damage, that is not reportable.

Female: I'm not sure what you meant by your last statement I'm afraid.

(Ed King): A payment for property damage is not reportable.

Female: If it's purely a property damage claim, there's clearly no medicals and the claim is solely for property damage, again, what we've – and there's – it's a broad general release, then we've said no, you don't need to report it. We could certainly come up with scenarios where it's allegedly for property damage, but it's specifically releasing medicals, et cetera. We could come up with any number of combinations, but what we've said a couple of times right

now is when it's clearly only a property claim and it's only a broad general release, no, we don't expect you to report it.

(Ed King): OK.

Operator: Your next question …

Male: Operator?

Operator: Your next question comes from the line of (Rebecca Gayle) from MSA. Your line is open.

(Rebecca Gayle): Hi, good afternoon. My question deals directly with mass torte and toxic torte claims, which I understand with the new notices put out on the site, the first reporting date for those type of claims will be first quarter 2012. Is that correct?

Male: No.

(Rebecca Gayle): No, that's not correct.

Male: The alert was specific to liability insurance (inaudible) reports. It was not based at all on what the underlying alleged injury was. The delay is specific to whether or not it's (inaudible) and whether or not it's liability insurance. It's not whether it's something you all a mass torte. It's not whether or not it's something that involves exposure. It is all liability (inaudible) reporting and that's it.

(Rebecca Gayle): OK. So basically you have to base this on the (inaudible) as opposed to what type of claim it is.

Male: Correct.

(Rebecca Gayle): OK. Thank you.

Operator: Your next question comes from the line of (Wendy Rader) from State Compensation Insurance Fund. Your line is open.

(Wendy Rader): Hi. I'm asking a question on worker's compensation and this is in California and we have death claims where the dependents on the death claim are specifically defined by the labor code and those are what we think will be reporting as claimants. But we want to know if we haven't verified that they actually qualify as a dependent, should we report them anyway?

Male: We're not going to get involved in your state law questions. If they are Medicare beneficiaries and would be reportable on that basis, then you need to do appropriate reporting.

Female: These are claimants by our definition in the case of a deceased beneficiary and the other claimants, (inaudible) referring to, but …

(Wendy Rader): Right. Because your examples don't cover our dependents at all, so you know there is no definition of the word claimant other than your examples.

Female: I mean is it fair to say, (Barbara), that if they consider these individuals claimants, then they report them as such? If they don't consider them as claimants then they don't?

Female: Settlement judgment award or other payment, if you're paying them and they otherwise meet our criteria as being beneficiaries, et cetera, then you have a reporting obligation.

(Wendy Rader): OK. So if we are paying them, then we report them. If we're not paying them we won't report them.

Female: Yes.

Female: Sounds fair.

Female: Yes, I mean I know that the insurance (inaudible) worker's compensation industry would like us to do so, but we can't generally go in and investigate your questions of state law. We're dealing with whether or not you pay primary does and if you did, then we need to have it reported appropriately.

(Wendy Rader): Right. Well, we would report the claim of the Medicare beneficiary as a death claim regardless of whether there's any claimants, but if there is no claimants,

you know there wouldn't be any information for those. It would simply be a report and you wouldn't be able to tell that it was a death claim.

Female: Right. Correct.

(Wendy Rader): OK.

Female: (Inaudible) Medicare becomes aware of beneficiaries of you know date of death at a certain point in time of course.

(Wendy Rader): OK.

Female: So does that answer your question, though?

(Wendy Rader): Well, it gives me a little more direction.

Female: OK.

(Wendy Rader): And the other part of the – the additional question I have has to do with your alert about periodic payments on May 27th of 2010. And now in the case of a death claim where the ORM termination date, as we understand it, would be the date of death and cannot be extended for any reason. And yet, the alert uses the phrase that as long as RE separately assumes slash continues to assume ORM and reports this ORM appropriately, we don't have to report because we're making periodic payments. But we are making periodic death payments to their dependents after the date of death, so this phrase continues to assume ORM is what's throwing me.

I mean is it true that for a person who has died, the ORM termination date can never be later than that?

Female: That …

Male: I mean …

Female: … that's our understanding. That you're – on the date of death, your ongoing responsibility for medicals end.

(Wendy Rader): OK. Thank you.

Operator: Your next question comes from the line of (Susan Carter) from Employers Insurance. Your line is open.

(Susan Carter): Hi. I have a couple of questions. The first one, when you refer to representative reporting, the applicant's representative, does that have to be the work comp claim or the Medicare attorney? Sometimes they have both a Medicare attorney and a work comp attorney. Which one are you interested in? Does it matter?

Female: The injured party's representative you're asking about?

(Susan Carter): Yes, sometimes they have multiple representatives and there's – is there – if they have a Medicare attorney, is that the one you prefer over the attorney on their other claim?

Female: Could you give us an example of what they would have a separate quote Medicare attorney for? Because they've got a – normally, people have an attorney that' representing them in the underlying action or claim, they don't have a separate attorney client relationship with a different entity to be their Medicare attorney. Sometimes their attorney will hire another attorney or another firm to assist in the Medicare recovery claim or pursuing matters with Medicare, but we don't typically see a separate Medicare attorney.

Male: I guess it would be you know the person who would be expected to work with Medicare to resolve a claim if any would be who we'd want to know about.

(Susan Carter): OK.

Male: And again, any recovery action that CMS takes you know the recovery contractor would be working with that appropriate beneficiary's attorney. Now who that is, I mean we can't say, but again that's the entity that you would want CMS to go to or person you'd want that – you know especially the recovery contractor and/or the CMB contractors to go to for follow up as the case is resolved and all that, so.

(Susan Carter): OK.

Male: I don't know if we can provide specific recommendations and other than to say as we say with everything else, it's like the contact information you provide us is information that we use to either coordinate benefits to begin with or pursue recovery actions.

(Susan Carter): OK. That answers it. Thank you. I have one more quick question, can you elaborate a little bit more on what you mean by the delayed funding field and examples of how that would be used?

Female: I believe that we indicated earlier and I'll have to turn to (Pat) to ask her whether or not it's been done. I thought we gave instructions for that currently to be filled with spaces.

(Pat): Yes. We can't come up with a reason any longer why you would need to use that funding delayed field. For the most part, you would just report (inaudible) and a (inaudible) date. There is also guidance out on – an alert on the Website about when you're required to report in those certain liability situations you – it's not until you know who the injured party is and how much they are being paid. Originally, the field was put out there due to delays in the settlement might be today, but the actual allocation of money would not be made for years down the road. But with that change in guidance and you know the other reporting requirements, we don't really have a good example of when you would ever need to use that funding delayed field.

Female: I mean we've said spaces for now, correct?

(Pat): Zeroes, yes.

Female: We may, in the future, consider whether or not we would have you fill that in in situations where and we've talked about Vioxx as an example in the past where there was a settlement, but then there was a whole one or two year process to identify which beneficiaries would be paid and how much they'd be paid. When those are eventually reported, we may decide to use that field to allow you to report when you know that identification was made so that you don't receive unnecessary alerts.

(Pat): Right. So you would put the actual you know prior settlement date in the (inaudible) date and then put the date when you finally know who is getting paid and how much they're getting paid in that funding delayed field. But we haven't …

Female: And it's when you know that a particular individual is not being – is being paid not necessarily every one in the settlement has been identified as being paid.

(Pat): Right. Right.

Female: So but for the time being, as (Pat) said, if the field is not being used.

(Susan Carter): All right. Thank you.

Operator: Your next question comes from the line of (John Miano) from Gould and Lamb. Your line is open.

(John Miano): Hello, good afternoon, everyone. (John Miano) with Gould and Lamb and this question is one that actually I'd asked (Pat) before, but now that we have (Barbara) and (John) in the room. Can you please provide us some directive with regard to document retention specific to those claims that are submitted to CMS for mandatory insurer reporting for the quarterly claim report? How long should TPA or the RE be holding on to claim records pursuant to those claims?

Female: What I believe we said during some earlier calls way, way in the beginning is that CMS does not have any specific section 111 document retention requirements. You basically need to take into account all statutory provisions that might be out there that affect document retention. One document retention date we've mentioned in the past just to give you and idea how long things can go on is that under the Federal False Claims Act, I believe, those claims can routinely go back 10 years. So you know that's just an example, that in no way says that we're telling you you have to keep your documents 10 years, but you need to keep them long enough that you believe you've taken

care of any issues that may arise and as I said, I just gave you an example of a statute that I know goes at least 10 years.

(John Miano): Thank you. One other question, if I may, we often hear from colleagues that are submitting data to us that the date of birth field is one that's difficult to them to obtain and they've asked us if there is perhaps a default or filler data that could be provided in order to allow the claim to be accepted. Is there say for instance a situation where filling the date of birth field with all ones or all nines or all zeroes or anything of that nature would be recommended? Or is there a recommended default value for date of birth?

Male: There is not, but again the matching criteria does allow enough flexibility in that if the date of birth is incorrect and the other information is correct, it will still be considered a match. So I mean we know people lie about their age, things like that, but the first initial, the first name, six characters of the last, gender date of birth and SSN or (inaudible) is enough to allow a match and we do allow that in addition you know the (inaudible) or SSN, if provided, has to match to three of the four of those other characteristics, so if you get the first and last name and gender correct, that would be considered a match.

(John Miano): Well, I understand that in regard to the Medicare query input file, however …

Male: It's the same for production files, the same matching criteria is used.

(John Miano): But the claim input file, so …

Male: It's the same …

(John Miano): … all right.

Male: … same process.

(John Miano): Thank you.

(Pat): And in fact, just a reminder that on the query response, we should be returning the date of birth that Medicare has on file for that person in the case of a match.

(John Miano): I see. Very good. Thank you.

Female: Welcome. Great.

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

(Debra Daniels): Hi. I wanted to comment on this caller who asked about server issues through the SFPP process. We submitted a corrected test claim file that has been sitting on your server ever since November 30th. Our EDI rep she's been helping us with these issues and she's really good, I'm not complaining about her. But I understood that she put it on a spreadsheet for the programmers to push it through.

(Pat): Yes. And that relates back to that correction that we're putting in December 15th. If you want, I could take your EID to follow up on, but it sounds like your EDI rep is you know proceeding. I know it's a delay in your testing and that you're anxious to get it done. As we said, we understand that some folks might be late reporting, but as long as you're working closely with your EDI rep, they're – you will suffer no consequences as a result of that.

(Debra Daniels): OK. And another question I have was once this does get processed, how long would it take before we get a response for the file? Would it be 45 days? Or would they rush it through? Because …

(Pat): Test files should be turned around just after I think it's two weeks. Production files, there's a 45 day turn around, if not sooner. I mean basically as soon as the file is completed processing, in both cases – test and production – we'll send it back. So once the file starts processing in test, you should get it back – a response back in two weeks. I believe, the (check) I use to (write on) that, I don't have it sitting in front of me.

Female: OK. Because I was concerned because we're supposed to report like March 22.

Female: Yes. I understand.

Female: I worry if you have enough time if we have issued with our files that our programs can fix it so we won't miss that deadline.

Female: Yes. Absolutely. And, as we said before, if you're working closely with your EDI rep, which it sounds like you are, and they know your status, just keep plugging away and all will be good.

Female: OK. Thank you.

Operator: Your next question comes from the line of (Taffy McGlouphlin) from (Work Med) Benefits Services. Your line is open.

(Taffy McGlouphlin): I'm having difficulty understanding how or whether to report a (tea pack) amount on worker compensation award for permanent, total disability where we're making life-time payments. The May 27, 2010 alert talks about what I think they're referring to probably as temporary, total disability but I'm not sure if that applies to the permanent total disability payments because there's no set amount that we pay. It's just ongoing.

Female: Are you still talking periodic payments or …

(Taffy McGlouphlin): They are periodic. Yes. But it's not wage replacement, it's an award.

Female: But is it an award for indemnity or …

(Taffy McGlouphlin): Yes. It's an award for permanent, total disability.

Female: I don't think the language we have in the user guide right now differentiates between whether it's partial or permanent in total. I thought it was phrased in terms of whether or not it was indemnity.

(Taffy McGlouphlin): Well, it is. It does say indemnity. But I guess what I'm having trouble distinguishing would be a permanent – if we got an award for a permanent, partial disability award, we pay those out periodically also. But there is a total amount that's paid. So it would be my understanding that we report the total amount on those. But if you're saying that we can say we can just consider it the same …

Female: If it's what qualifies under other instructions in the user guide as being a (tea pack) for indemnity, that's what (Pat) said earlier in the call. We're still working on trying to clarify language on that for a separate alert.

(Taffy McGlouphlin): OK. All right. OK. Thank you very much.

Operator: Your next question comes from the line of (Jeffery Brown Hems) from (Cedric) Claims Management Services. Your line is open.

(Jeffery Brown Hems): Thank you very much. I think my question is geared toward, (Pat). (Pat), you'd mentioned some of the improvements that you're looking at implementing as far as the FSTP transmission processed, what are the challenges our organization has experienced has been delays in having files that we have actually – production (quarry) files that we've submitted to the FSTP server not getting picked up and not getting processed timely.

Then when we follow up with our EDI rep to get those processed, what ten happens – when we submit the files in subsequent month, the (semi-professional) automated emails get generated and of course those then get sent to the account managers for the (RREIDs) that we as a reporting agent for. Unfortunately what happens is because the failures in the processing of these files is not really an error on our end but was an error on the COBC side, there's no way to actually turn off those automated email messages. And they give the mistaken impression to some of our RREs that we're generating errors when in fact the process really had to do with failures of the COBC to address that.

So the question really pertains to is there a way or are you looking at situations where these types of errors occur that some of those messages could get suppressed so it's not giving false information to account managers that the queries thresholds have been exceeded when they really in fact have not?

(Pat): Well, I'm hoping with the changes going in later this month these issues will be cleared up, first of all. Secondly we have made a change to put bulletin board announcements out on the COD secure website when we're experiencing particular difficulties. And third, I guess I will take your comment under advisement and, you know, we'll see what might be able to be

done about that. I do understand and sympathize with your situation and like I said I'm hoping with these changes going in later this month, it's going to become a non-issues for you. But I can't speak to – we weren't looking at anything right now about suppressing emails and suppressing that threshold errors of too many queries submitted in one month and so on. But I hear you.

(Jeffery Brown Hems): OK. And then so a follow up to that then. Would you mention the bulletins that would go out if you guys are experiencing difficulties – would there ever be a way that you might be able to send an automated email to reporting agents to advise them. So at least then we could be proactive and advise our RREs that you're experiencing that problem?

(Pat): Yes. I mean, I think as a matter of fact we are looking at some sort of broadcast email capability to, for something of this nature. And again I will note that and take your feedback back and see what we can do about it.

(Jeffery Brown Hems): OK. Thank you.

Operator: Your next question comes from the line of (Susan Cornblues) from New York State Insurance Fund. Your line is open.

(Susan Cornblues): Hi. I have like just one statement first and then a question. When we sent, you know, claims out and we got the (clearer) response file back, we found that there were quite a few discrepancies in the date of birth and we've contacted the claimants on a bunch of these cases and they insist that we have the correct date of birth in our system. There are other instances where we submit the query production file and get the response back and we found also in gender that claimants like a name of (Maria Alvarez), we submitted as a female and the response that we got back from CMS was it said it was a male. And we have quite a few cases like that.

(John): Yes. I mean, these kind of things occur all the time but I can state – this is (John) – that the data that we use comes right from the Social Security Administration, that is the official record as far as the federal government of who that entity is. You know the – if the official record of who the entity is based on the SSN, there have been cases reported that individual A will be

using individual B's SSN for example. That may account for some the things that have happened with this sort of unusual responses that you're getting.

(Susan Cornblues): But with the gender, I mean, would it help to send our EDI reps some examples of specifically the gender or not bother?

(John): I mean the gender isn't such a critical one in that it's – there's only two choices basically. But I mean, if you seem to be getting a lot of discrepancies by all means …

(Susan Cornblues): Right, some of dates of birth …

(John): But again I can assure you the reason why we have a matching criteria that requires three of the (fours) that again often times people provide incorrect date of birth just through normal key stroke error. They might …

(Susan Cornblues): Right. I know …

(John): … female and all that kind of stuff.

(Susan Cornblues): We're trying to get our records updated and we submit a discrepancy report to our district offices and they've gone to the claimants – they spoke to a claimant's mother who insists this is her son's date of birth. So some of our reps are telling these people to contact Medicare …

Female: If they disagree with the information, you know, first off all, if you can at all see a copy of the actual Social Security card or Medicare card, et cetera. But if someone believes that Social Security has their wrong date of birth, et cetera, they can contact Social Security and ask – first of all they can tell them, they understand they have incorrect information and Social Security has the ability to go back and look at the actual application that was filled out for the Social Security number and verify they've got it in their system correctly but second to correct it if it needs corrected. We can't change that information …

(John): That's the important thing. CMS cannot change the information we get from Social Security.

(Susan Cornblues): So we should tell them to contact Social Security?

(John): The beneficiary is the, are the only ones that can actually try to do that, so to speak. I mean, we as an agency receive information through another component here, not just related to COB stuff but across all benefit coordination that, you know, with these kinds of questions that come in. And you know, again, a lot of it's just simply mistakes. I mean a lot of stuff is done manually and it's just wrong and it's on the system.

But only the beneficiary can go to the Social Security Administration and get that information corrected. Once that information is corrected at Social Security Administration, that information flows to CMS and we update our records accordingly as well. So if it's a change of male/female or a change of date of birth or they have the last name is just totally goofed, which is probably more rare thing, that will flow to us and then we would provide that information to anyone who we do data exchange with so.

(Susan Cornblues): OK. Thank you. Now, my next question is when you talked about ICD codes, I think months ago, and you'd mentioned if we send – let's say we report certain ICD codes in the first five fields and let's say we submit an update record and we remove the code in field one, even, or any of the other fields, do we have to (collect) those codes or can we leave it in the original location?

Female: No. You don't have to (collapse) them.

(Susan Cornblues): And it doesn't matter even if there's nothing in field one – for the initial it has to be …

Female: Yes. Yes. Yes. I'm sorry. Field one, I mean, obviously is required. So …

(Susan Cornblues): But on any other …

Female: … error …

(Susan Cornblues): … on an update records also?

Female: Yes.

(Susan Cornblues): Field one is always required in an update record.

Female: Yes.

(Susan Cornblues): OK.

Female: Yes. Sorry about that I wasn't thinking clearly.

(Susan Cornblues): OK. And would it be possible – I know you've had other, those CBTs you've put them into pdfs so we can like print them, would it be possible to do that with the ICB codes?

Male: It's downloadable from the …

Female: Yes. They're downloadable into a text file. But, I don't know. I'll look at it.

(Susan Cornblues): OK. All right. That's all I had. Thank you.

Female: OK.

Male: Operator, it's past 3:00 Eastern time and we have to end this call to – oh, yes – end this call and we appreciate everyone's participation. Again, we had hoped to have more time for some of the direction Q&A but again because of all the very well written questions that we received through the resource mail box, we as always try to give them priority. Please, keep a look at on the CMS website for future teleconference events …

END