

**TRANSCRIPT
TOWN HALL TELECONFERENCE**

**SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
ACT OF 2007**

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

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FTS-HHS HCFA**Moderator: John Albert****February 25, 2009****12:00 pm CT**

Coordinator: Good afternoon and thank you for standing by. At this time, all participants are in a listen-only mode until the question and answer portion of the conference. During that time, if you would like to ask a question, please press star 1 on your phone.

I'd like to remind all parties, this conference is being recorded. If you have any objections you may disconnect at this time.

I would now like to turn the call over to your host today Mr. John Albert. Sir you may begin.

John Albert: Thank you. Good afternoon or good morning depending on where you're calling from. This is one of a series of open door teleconference events that CMS is hosting as it rolls out the requirements for the Section 111 mandatory insurer reporting.

This particular conference is focused on liability insurance, worker's comp and no-fault insurance or commonly referred to as non-Group Health Plan insurance.

Now if you are a Group Health Plan participant, you need to probably get off this phone call. We have other calls scheduled per the CMS Web site for GHP specific calls.

A couple of things I want to introduce first, some of the people who are here today. The first is (Barbara Wright). The second is (William Decker). And the third is (William Savona). They're here to answer your questions that you have today.

We continue to work towards full implementation of this. And so far we are basically on schedule.

The, a couple of points I wanted to bring up real quick was there's - we have put out requests for information regarding conferences that outside entities would like us to attend to discuss topics related to Section 111. We have received numerous requests.

In recognizing that we have a limited availability as well as limited ability to travel for considerable periods of time, we are going to set up some specific open door teleconference events that address specifically worker's comp and liability no-fault insurance. Those announcements will come out on the Section 111 Web site.

Again that Web site is cms.hhs.gov/mandatoryinsrep. There is a listserv service you can sign up for that will provide you with updates whenever we publish updates to the Web site which are pretty frequently as of late.

Please keep in mind also that on the CMS Web page there are specific sections for both GHP as well as non-GHP reporting responsibilities.

We are getting close to releasing the largely anticipated or much anticipated user guide for NGHP reporting. That should be coming out we're thinking, you know, maybe a couple of weeks at most. So please keep your eye...

(Barbara Wright): Within the first two weeks of March.

John Albert: Yes. Yes.

(Barbara Wright): It's clearly not going to make it this week.

John Albert: Yes. So with that, this is purely a Q&A session. (Barbara Wright) wanted to bring up some points as a result of the questions we've received through the resource mailbox that again no matter how many times people call or email or whatever that we still ask that everyone's follow-up anything with an official written comment through the CMS Resource Mailbox. But again there's information on the Web page telling you how to submit that information.

We can't provide individual responses necessarily but we try to address as many of those questions as possible through the materials we publish as well as through these continuing open door discussions.

Again your best bet for getting information to CMS is through the resource mailbox. I realize that, you know, and we know from experience that more and more people are attempting to reach us individually or email us directly - things like that.

But we cannot promise that we will necessarily get that information or be able to even look at it. As you can imagine with the looming go live date for the Web portal there's a lot of traffic coming in right now. So again, please follow-up with the Resource mailbox.

We do catalogue all of those and try to address all of those questions. So with that I'd like to turn it over to (Barbara Wright) who wanted to go over some of the questions we received since the last phone call.

(Barbara Wright): And some of it's also just status information. John was talking about some additional Town Hall or open door calls.

We post ahead of time ones that we planned. And we are adding more. When he said we'll have a separate one for worker's compensation and then one for liability and no-fault, we're planning on doing those in April. There's one date already posted. We're going to find a second date in April. And then we'll designate which is for worker's comp and which is for the liability no-fault.

This way the user guide should be out. You should have a chance to look at it before we have those calls. In fact, we expect to have the guide out before the call we have in March.

So we expect the call in March will probably be questions directed at the guide itself. And then we'll be able to focus more down on the two main areas in the calls in April.

We also expect to try and schedule a call near the very beginning of May just solely to deal with registration issues. Computer based training is being developed for the non-GHP.

And that should be available before the first of May. But we also want to have a session available just to talk about registration in case people are having difficulty in registering.

One of the items from prior calls as we told everyone that we hadn't made a final decision on the codes to be used.

We've made a decision now that will be in the user guide. And so that the information will be available to everybody within the next couple weeks.

We will also have a threshold. It's likely that it will be an interim threshold. But we will have a reporting threshold. Again, this would be solely for Section 111 reporting purposes. It doesn't change any other obligations under the Medicare secondary payer provision.

We were asked for a decision about how far back people needed to go, if there was a ongoing responsibility for medicals that was assumed prior to 7-1-09 and continued on or after 7-1-09.

We listened to concerns from the industry that many people would have internally closed cases even if the case would be open under the definition we'd given in the interim layout.

So we listened to those concerns. The manual will - I'm sorry, not manual. The user guide will also address that issue and explain how far back you need to go.

We also listened to concerns from the industry in terms of our definition of what would be quote, open, that in some instances it would result in situations such as minor hand sprain that had some medical treatment. And under state law that case would be open for life.

So we put language in to address that type of situation as well. And that's still clearing through the draft.

In the user guide we also are building in charts with examples of exactly when to report and what type of action it would be, whether it would be an add or update or delete.

Let's see, next issue. In terms of ones we've promised, fronting insurance. I did have a conversation with several different entities about this. And the final conclusion of those at the table was everybody's views technically fit with what we already have in the interim record layout.

And I'm waiting for the people that were in this meeting to send me in examples. We said we'd review those and if we agree to the examples then we'll make those examples available to everybody so you'll have something more concrete to look at.

The Joint Powers Authority question, we've got tentative language on that that's going through the clearance process. We said we needed to look at mass torts. We are lined up internally to meet with one group in early March. And I will be reaching out to some other entities as well for further discussion on the mass tort.

We still have the model form on our plate. We haven't completed that. But it is still there. It may or may not be available by the user guide.

One of the things we're doing for the user guide is we recognize that we still will have some issues that we can't get the final language in this version of the user guide. But we believe it's more important for you to have the document available to you for all the other issues.

So we will continue to address those issues. And as we resolve issues, if a revised version is not something that's - will be happening shortly, then we will put the additional information up on the Web site as an alert and incorporate it in a subsequent version of the user guide.

One of the questions we received has to do with the December 5, 1980 date tied to liability and no-fault insurance.

We continue to see questions, but does this apply to worker's compensation too? And the answer is no. Worker's compensation has been primary Medicare since the inception of the Medicare program. So regardless of what the date of incidence is for worker's comp, the date of incidence doesn't affect report ability. You have to report worker's comp.

We have language in clearance to deal with situations such as non-compliant employers for worker's compensation situations where state funds are responsible for medicals under state law. In other words, different provisions where it's not your typical policy and there's state laws in place to designate the state having a process for taking care of this.

And we're working our language for that. And hopefully that will be in the user guide. If not there, it should be up on an alert shortly.

We continue to get reports or questions having to deal essentially with the number of record. There still seems to be some confusion between what the considers a claim which may include more than one insurance type if they relate to the same policy or with some entities if that company holds say an automobile req, they hold the policy for both drivers whether they might have those all in the same claim.

And we need to emphasize again that when you're reporting you're going to report on a beneficiary by beneficiary basis. You also have to report based on type so that if for instance, you have within a single policy, you have someone who's a Medicare beneficiary that you will be paying liability insurance benefits as well as no-fault as CMS defined no-fault, then you will be sending two records for that. It won't just be one record because it's one person.

And we believe we have language that addresses this issue in the interim record layout. And if you're not familiar with this you need to go back and take a look at it.

Another question with the layout is there seems to be some confusion with the term claimant. Basically your reporting situations where the injured party is a Medicare beneficiary. The only time that you're going to use these so-called claimant field is when the beneficiary is actually deceased. Where the beneficiary is deceased, the claimant is either the beneficiary's estate or I think we listed family member or other.

But the point is, you're not typically going to be completing the claimant information. And let's see, defense verdicts. We had questions come in about situations. And we'll look at tweaking language we've put out before, situation where there was a judgment. But the judgment was actually that no money was owed, that there was no award. The person's claim was denied.

And the question came in and said well you said you have to report all judgments. We're talking about judgments that result in liability or payment et cetera.

So if you have a judgment for zero or if you have a defense verdict judgment where there is not going to be any payments, then that does not need to be reported.

The last thing that came up was a few questions again John is I don't think it even applies in this context. But it came up on the list of NGHP. They were asking about reporting by a pharmacy benefit manager.

And I don't think that's relevant to worker's compensation, no fault or liability insurance at all.

So John, do you have anything else before we go to Q&A?

John Albert: No I again, I just go back to the interest that we've had in attending conferences. And again, we've seen, we've had some requests from relatively smaller local organizations - things like that.

And I just want to stress again that it's very likely we wouldn't be able to attend those types of conferences just because it, you know, our time is limited in terms of how many of these we can attend.

But again, as we put out the, when we put out the specific dates for these what we call specialized conferences, we'll also solicit in advance, questions that we can have on hand to basically address at those conferences.

So again, depending on where - you know, there'll be technical conferences as well as specially address the unique types of non-Group Health plan insurance such as worker's comp and liability.

(Bill Decker): Hi everybody. This is (Bill Decker). I'm going to jump in with one statement here before we get rolling.

We got a number of questions that are concerned with issues that we have - we here traditionally think of as the technical reporting issues.

We've got a question for example about whether a railroad retiree of Medicare, a beneficiary who's a railroad retiree is a Medicare beneficiary.

We've got another question about how that should be reported. We've got a question about how - what's the proper sequences for an update versus the lead transaction.

We had questions like this with some frequency. And what I wanted to say before this call gets started is that almost all of those sorts of questions will be addressed in the user guide which will be up on the Web site in a couple of weeks.

We may not in fact in this call address questions like that, the technical administrative questions that come up all the time in these data exchange processes. But they will be addressed in the user guide.

And as John and Barbara pointed out, we're going to have a number of additional calls for the NGHPRREs. And at that point, if they see something in the user guide that does not make sense to them or that they wish to question they can.

At this point, without the user guide available to you, we would urge you to wait until the user guide comes out before you get to those questions again. Thanks.

(Barbara Wright): Operator, I think we're ready to take questions.

Coordinator: Thank you. At this time, if you would like to ask a question from the phone, please press star 1. You will be prompted to record your first and last name.

To withdraw your request, press star 2. Once again, if you would like to ask a question, please press star 1 on the phone.

Your first question comes from (Shannon Sergeant) of State Auto Insurance.

(Shannon Sergeant): Hello?

Coordinator: Your line is open.

(Shannon Sergeant): (Barbara), you mentioned a reporting threshold. Was that related to how far claims go back prior to 7-1?

(Barbara Wright): No. We're talking about two different things. We will have a reporting threshold, at least an interim one that is a dollar threshold in terms of what you're required which settlement judgments awards or other payments you're required to report except all situations where there's ongoing responsibility for medicals will be reported.

And the other if you want to call them thresholds of a different type, I was talking about if you had responsibility for ongoing medicals before 7-1-09 and it continues, such as say a worker's compensation case in a state with lifetime medicals -- a number of people in the industry have said we have a standard internal practice that we for example close the case if we haven't paid any

medicals in two years, even though we recognize they can come back and reapply or reopen.

And our definition that's in the interim guide says that technically the ORM should not be terminated unless there's no further possibility of any payment period.

And taking into account the industry's concerns, we will have language that will set a limit of how far you have to go back to look for cases that you may have internally closed to report those.

On the flipside going forward, the industry again said we have concerns with having to keep a case open just because there's at least some report possibility of payment.

So we have language to allow closure under certain circumstances there as well.

(Shannon Sergeant): Okay, thank you. And I have a second question. You're mentioning a defense verdict that results in no payment. In that situation we would have sent that the add transaction for a claim. Do you know yet whether then we would send a delete transaction or we would just never send an update that we're not making a payment?

(Barbara Wright): Well we are still looking. And I may not have listed it on the list. I gave you four. We're still looking to address questions about when someone reports if the matter is still under appeal by the insurer or worker's compensation.

If you're talking about a situation that involves a single payment obligation as opposed to ongoing responsibility for medicals, then in most cases depending

on where we come out at appeals, you may not even have reported it. So I can't really give you a separate answer until we can resolve the part about appeals.

(Shannon Sergeant): Okay.

(Barbara Wright): But we'll take under - we'll note that we also need to think about what that means in terms of add or delete or just modify.

(Shannon Sergeant): Right. Because if we have a - if we've identified a Medicare claimant and the claim is open and it goes to litigation, then we would have sent you that add transaction without a payment.

(Barbara Wright): Well no you wouldn't necessarily. Remember that for liability, no-fault and worker's compensation, if you don't accept responsibility for ongoing Medicals regardless of whether it's by law or just by, you know, practice, normally if you're only money involved is a single payment obligation whether it's actually paid out through a structured settlement or annuity or whatever, you only report once you've reached that settlement judgment award or other payment.

So our answer on what to do when there's a situation, an appeal, will be determinative of whether you've actually even reported something until the appeal is done.

(Shannon Sergeant): Okay, thank you.

Coordinator: The next question comes from (Ron Brittan) of Auto Owners Insurance.

(Ron Brittan): Thank you. We've got two questions. One of them relates to our ability as an RRE to have two sub accounts, one primarily for administrative purposes regardless of any third party that's reporting on our behalf.

Man: We're not sure what you mean by sub accounts.

(Ron Brittan): Well last - in the last conference there was discussion about us being able to have multiple accounts.

Man: Yes.

(Ron Brittan): And our question is regarding the query function, can we have a - an account, a separate account - and I'll call it a sub account, for that query function alone?

(Barbara Wright): You can have as many accounts as you want in terms of RRE IDs. But once you establish an RRE ID, that entity has an obligation to report.

Each RRE ID will have the ability to do the query function. So no, we aren't granting RRE IDs solely for the query function.

(Ron Brittan): Thank you. Our second question relates to - and we know that in the guide that'll be coming - it may touch on the timeframes, but we'd like a little added benefit of your impression of what the reporting obligation is.

Where we do not feel we've identified any beneficiaries in the past, a claim file has been closed and it's reopened.

If we still believe they're non-beneficiary under that fact pattern, is it clear that regardless of how far back we need to go that we will not be reporting that to you?

(Barbara Wright): You're only supposed to be reporting if someone is or was a Medicare beneficiary.

So if you've determined they're not a beneficiary...

Man: If you determined they were not a beneficiary at one - you haven't determined that they were a beneficiary originally when you closed the case.

If you reopen the case say in August 2009 because the new claim has come in, you will need to determine whether or not the first is the beneficiary at that time.

(Ron Brittan): So what you're saying is we have no obligation to go back in time until or if that particular claim resurfaces on its own accord, correct?

Man: If it meets this reporting that the threshold or look back period that we will establish.

(Barbara Wright): You're going to have to look at the wording that comes back. Right now under what the literal language is in the interim record layout is if you technically have responsibility for ongoing medicals under our definition. Which would be like for instance if you were in a state where they have lifetime medicals, technically those cases, if you have previously assumed ongoing responsibility for medicals, you would still have that, you arguably would have to go all the way back in time as long as that ongoing responsibility exists.

What we said is in the user guide, we have come up with a set timeframe that we're going to make people go back and look.

(Ron Brittan): (Barbara), I think you've missed the point of the question. Where we have not identified a beneficiary, the question is when that claim arises, will we then be for the first time, obligated to consider that particular file for reporting?

(Barbara Wright): If you've got someone that wasn't reportable before because they weren't a Medicare beneficiary, but you've now got an open claim for them and you are taking responsibility for ongoing medicals now, then yes, you do have to report that.

If you have a new single payment obligation, yes you would have to report that. Whether you're calling it a reopening or not is they are now a beneficiary, yes.

(Ron Brittan): Okay. And to clarify, your comment is if they are now a beneficiary, and so to relieve the industry of concerns, is it fair to say that we aren't being asked to go back and proactively reopen files until or if that particular claim file is brought back to our attention on its own accord with a new...

(Barbara Wright): I...

(Ron Brittan): ...(cycle) bill?

(Barbara Wright): I don't know that we're quite in agreement. Again, we're talking about a situation. First thing is whether they're cases that you technically have responsibility for ongoing medicals.

If you have responsibility for ongoing medicals under our definition, then under the current record, interim record layout, you are obligated to go back as far as necessary in your history to identify all those people.

And what we're telling you is that when the user guide goes out, it will set a finite limit on that. But for the people that are within that limit, that timeframe, yes you need to go back and check whether or not they're Medicare beneficiaries.

You're not off the hook just because you didn't know it at the time.

(Ron Brittan): Well I think that's inconsistent with the law and the purpose is it not? And I know this is a rhetorical question. But you're overreaching if you say we must go back and find when we are not aware of any beneficiary to begin with.

(Barbara Wright): You are required to determine who is a Medicare beneficiary for claims that are reportable. And what we're saying is where you have under our definition, responsibility for ongoing medical, yes, technically you would have to go back and identify.

What we are also saying is taking the industry's concerns into account, we are going to put a distinct time limit on that so that you're not going back into the lions of history.

But we're not prepared to announce that date here and how. We need to announce it in the user guide.

(Ron Brittan): Okay, thank you. Will that tie into any safe harbor discussion that have been talked about in prior meetings or comments?

(Barbara Wright): Well if we give you an absolute time limit, then you're entitled to rely on that time limit.

(Ron Brittan): Will that tie into any alleged statute of limitations that CMS will not go beyond?

(Barbara Wright): If we're saying that you don't have to report something, then for purposes of Section 111, you don't have to report it.

(Ron Brittan): Will it be consistent with the law I guess is what I'm getting at where the law has that as you may know, a bit gray on how far back the CMS go.

In other words, is this a witch hunt or is it frankly a clear statement that we will not go beyond this timeframe?

(Barbara Wright): We will give you a clear statement of what you need to do for Section 111 reporting. What we've said all along is we're dealing with Section 111 reporting and any limits we set for this do not effect any other obligations that exist with respect to the Medicare secondary payer provision.

(Ron Brittan): Okay thank you. I apologize if I'm being too straight-forward, but we're trying to get clear priority and it's very...

(Barbara Wright): I know. And hopefully when the user guide comes out, things will be substantially clearer than they are just with the interim one. We're trying to build into examples and we're trying to build in charts. And we have been looking at very limitations.

But in fairness to the industry as a whole and consistent with our decision to put all official instructions on the Web site itself, we really can't announce

policy at a call like this. We need to have it on the, you know, in the user guide where it's available to everybody at the same time.

(Ron Brittan): Well there are billions of dollars at stakes to the industry. And we need to know now what is it that you're asking of us.

And frankly we're trying to do what you're requesting in very reasonable fashion. However, not having it for two weeks is problematic because it may take quarters upon quarters of months and priorities for IT to complete this process.

And I recognize, you know, we're frustrated, but we really need some clear directives. And we also need to know exactly what it is that you're asking of us.

And it appears - and correct me if I'm wrong - that CMS desires to go back and find issues. And rather than when the issues as far as money flow occur, you really want us to go back and reopen the...

(Barbara Wright): The only ones we're talking about potentially doing this look back on are ones where there was an ongoing responsibility for medicals which technically continued on or after 7-1-09.

For example, let's say it was a liability insurance policy and there was a single payment obligation established in a settlement for \$400,000. And that was based on the definition that we have in the layout. It's being called a TPOC or Total Payment Obligation of the Claimant.

Let's say that that was, the TPOC day for that was June 25 because it didn't require court approval and all the parties signed the agreement on June 25, that does not need reported. So I...

(Ron Brittan): Maybe (Barbara), talk about PIP, Personal Inter Protection, Michigan in particular for example, where there are lifetime benefits. But we have closed the file because they haven't pursued anything.

(Barbara Wright): And that's precisely the Type 1 that we are going to give you the time limitation and the user guide.

And I understand your frustration but unfortunately we're working under certain limitations as well.

(Ron Brittan): So it's fair to say that you will be asking us to do proactive work when our files are closed and in the warehouse and not on our system. Is that correct?

(Barbara Wright): Maybe and maybe not. It depends on how long you keep stuff on your system. I think we've come up with a very reasonable limit. But again, I can't give it to anyone on this call. I - I'm sorry.

(Ron Brittan): Okay, so it's not based on...

(Bill Decker): Now we're going to have to cut this questioning off and go on to the next caller please.

(Ron Brittan): Thank you.

Coordinator: Thank you. Your next question comes from (Carol Sheehan), Highpoint Insurance.

(Carol Sheehan): Yes my question is as - we are a liability carrier in New Jersey. If - once we determine a claimant's Medicare eligible which we might do within maybe six months of the claim being open, two years later when we pay and close it, what other obligation do we have about any potential lien?

Should we write to you, ask you, do something before we settle this claim?

(Barbara Wright): Our intent at this time is to follow the standard process that we're doing right now. And for liability insurance, we are routinely doing the recovery with the beneficiary against their settlement. So we normally do not come back to the insurer.

Now there are ways, that any obligation that you have as primary payer existed under the prior law prior to these reporting requirements.

Some insurers in order to protect themselves do a three party payment. Some insurers don't actually cut the check until they know what the recovery claim is and they'll cut two separate checks.

We've heard of insurers that routinely will issue a single check. And the attorney as soon as he gets the recovery demand letter, he'll give them a copy and say can you trade this single check for two checks, one to Medicare and one to me? So we've heard of all different combinations.

But in terms of your reporting obligation, you will have satisfied that reporting obligation through the reporting.

(Carol Sheehan): Can I just ask one other question about the query itself? When we do our query, are we only going to find out that they're Medicare eligible, or will that

also encompass whether they're SSDI or the other situations that occur? I think it's...

Man: Just - it's Medicare. They've have Medicare entitlement and have a Medicare health insurance claim number.

(Carol Sheehan): So that's it. So if they happen to be collecting SSDI, we wouldn't know, we wouldn't find that out from the query?

(Barbara Wright): No, except that you would know by age.

Man: Yes.

(Barbara Wright): If you're under 65 the only way they could be getting it is Social Security disability or ESRD.

(Carol Sheehan): So they go hand in hand.

Man: Yes.

(Carol Sheehan): If you have one, you have the other. Okay.

(Barbara Wright): I mean the only time you've got the aged benefit is if you're 65 or above.

(Carol Sheehan): Okay, thank you.

Coordinator: Thank you. Your next question comes from (Bill Thompson) of the Hartford.

(Bill Thompson): Hi. I have a few questions. The first one has to do with - it's an example. I think before we said that E&O claims will have to be reported if you're

paying out what could be considered medical payments on the underlying claim.

But what about a situation in which you have a type of E&O policy that excludes coverage for bodily injury? The claimant is seeking bodily injury as well as other damages. But we wouldn't pay BI because there's an exclusion on a policy.

I think in prior communications you said that even if we don't make payments for CI, if it's claims and we release it in the release, then we still have to report it. Is that the case?

(Barbara Wright): Hang on a minute.

We're going to ask that you send a couple of specific examples in if you don't mind through the (George) mailbox.

(Bill Thompson): Okay, I'll do that.

(Barbara Wright): Okay. And also I guess we would ask people for the rest of this call, if you don't mind, if you could avoid using acronyms. Our heads are spinning with every single acronym in the insurance industry.

Man: Not that we don't use them ourselves.

(Barbara Wright): But we have our own 300 acronyms.

(Bill Thompson): Okay. Another question is, I think you touched on this in the last call. But maybe you could put some more clarity on it, as far as using the query function and whether we would need to essentially use it for every single

claim that we have, are we - can we assume that anyone who's 65 or older can just be reported?

In other words, we wouldn't have to send those claims through the query function?

Man: Yes.

Man: If you've got...

John Albert: Yes. I mean if you don't have the health insurance claim number...

Man: That's the Medicare ID number.

John Albert: Yes. I mean well that doesn't matter. They can use the (other stuff).

(Barbara Wright): But you're still going to have...

John Albert: But yes, the answer is you've got to have the Social Security (at HICN) obviously, you know, but you're - you would have to have the (SSNME) to use the query. So yes, you can make that assumption.

(Bill Thompson): All right.

John Albert: Most do.

(Bill Thompson): Okay. And then also just I know you've touched on this, but if you could just clarify. I think there's a little confusion about some of the terminology about whether someone's a Medicare beneficiary or a recipient or entitled.

John Albert: Yes.

(Bill Thompson): And what is - what specifically is the trigger?

John Albert: Well the trigger for the query is that they actually have a Medicare health insurance claim number. There are some cases where people for example are in, you know, in the disability period they apply for Medicare. But then for some reason they, you know, are off disability and - but they still have a health insurance claim number.

In most cases, once they're entitled they're entitled, you know, till death, you know. But, you know, there are a few instances.

But basically where we find the health insurance claim number, there's a high likelihood that they do in fact have current Medicare entitlement meaning they are able to get benefits as of today.

(Barbara Wright): Or coverage during the period effected by your claim.

John Albert: Right.

(Bill Thompson): All right. But do we have any obligation to report, say for example someone has a HICN in their beneficiary for some unrelated reason unrelated to the claim...

(Barbara Wright): Yes.

(Bill Thompson): ...do we need to report that person even if we're not getting meds on that claim?

(Barbara Wright): Yes. I mean the issue is not whether you believe you're paying meds related to the claim. It's whether or not they are in fact a Medicare beneficiary. And then we determine whether or not we paid anything related to the claim that should have fallen under your purview.

(Bill Thompson): Okay, thank you.

(Barbara Wright): So that's why if there's for instance, a single payment obligation for liability insurance, what we're looking at is did we pay something in the interim?

Under our statutory provisions, we have what's called promptly period. And it differs depending on the type of insurance or worker's comp.

But nonetheless, what the statute allows us to do is pay conditionally while claims are pending so that people can get a continuous line of care so they aren't deprive of medical care because for instance, their liability claim is in dispute.

And so once that claim is resolved, then we assert our recovery right against those conditional payments.

So no, it's not tied at all to whether or not you believe you paid medical. You need to look just at the beneficiary status.

(Bill Thompson): Thank you.

Coordinator: Thank you. The next question comes from (Lori Neilson).

(Lori Neilson): Yes. What's the turnaround time on a query?

John Albert: A couple of days.

(Lori Neilson): Okay and...

John Albert: At most.

(Lori Neilson): At most?

John Albert: A lot of times - at most.

(Barbara Wright): But remember, you can only submit one query file a month. So you want to load it up, put your whole list of queries.

(Lori Neilson): Right. And so what would be the best time? We do like liability generally only. So what would be the best time to query someone in terms of making a settlement? Would it be just before I'm settling?

John Albert: I - that's what I would, yes.

Man: Well that's kind of like a six point tossup.

John Albert: Yes.

Man: It's up to you to really decide when it is you want to know whether or not they're a Medicare beneficiary. It's hard for us to decide for you when that might be most useful to you.

John Albert: I mean you definitely would want to know to provide enough time to essentially meet your reporting obligations.

Man: Right.

John Albert: But again that query, I mean the monthly query function, you know, it allows you three queries per a reporting quarter. You know, should be adequate for, you know, (monthly) reporting record.

(Barbara Wright): We also have the 45 day window.

John Albert: Yes.

(Barbara Wright): So that you should always have enough to do a query within that. Now you do have to know whether or not someone is a Medicare beneficiary at the time there's a settlement judgment award or other payment.

So if for instance you got in the habit or you've took the practice that you were going to do an initial query on everybody when the claim is filed, ones that you found out were a Medicare beneficiary at that point, then fine. Whenever they settle, I would presume you're going to report those.

But ones that didn't show up as a Medicare beneficiary at that time, you really need to do, even if it's a single payment obligation, you need to do one last query as of the date of settlement, judgment or award so that you can find out if they were a beneficiary there.

And of course with the ones where you assume ongoing responsibilities for medicals we've talked on prior calls, that you do need to query them on a routine basis until you're able to terminate the ongoing responsibility for medicals.

(Lori Neilson): Okay. And we can the whole - like a whole batch of queries like say the 15th of every month or whatever date that is chosen...

John Albert: Yes. I mean...

(Lori Neilson): ...correct?

John Albert: Well actually of the...

(Lori Neilson): Assign us a date?

John Albert: The COBC will assign you basically a production schedule that we ask everyone to follow.

(Lori Neilson): Okay.

John Albert: Because otherwise, because we don't want anyone getting backed up so to speak. But...

Man: They assign it to you with your cooperation of course.

John Albert: Yes.

Man: So you need to be thinking about when you actually want to - what your own internal schedule is and then tell your EVI rep when your schedule is getting set up.

(Lori Neilson): Right. Okay, thank you.

Coordinator: The next question comes from (Kevin Moriarty).

(Kevin Moriarty): Hello?

John Albert: Yes?

(Kevin Moriarty): Oh hi. My name's (Kevin Moriarty). I'm an attorney in Burlington, Vermont. And I work with a lot of captive insurance companies.

And could I just ask as a preliminary question, I submitted my questions to that PL 110. I never got a response and it didn't - well I mean it didn't sound like you reviewed every email at the start of the call. But it didn't sound like you got it. Was I supposed to get a response back?

(Barbara Wright): I know that there were several there with captive ones. We do not do individual replies.

(Kevin Moriarty): No, I wasn't expecting individual replies. I thought the Web site said there'd be an acknowledgment that you got in the email, that's all.

(Barbara Wright): You should have gotten an acknowledgement, an electronic one. If you didn't, we found a few instances where people, instead of sending it in to the mailbox that's designated, there's a downloadable document on the overview page that says opportunity for public comment. You need to send it to that mailbox which it sounds like you did.

But a few people have scrolled down to the bottom of the page where it says Submit Feedback. And that Submit Feedback is the technical Feedback to our systems. We never see that.

(Kevin Moriarty): Okay. All right. Well anyway, I did use that right address. But actually, bear with me. I think I have - I have four questions I think I can go through quickly.

But actually can I just ask one other clarification? So am I understanding that the only thing that's - the reportable claims are ones that result in getting back an HICN after you do the query function and that's it?

(Barbara Wright): You have an obligation to determine whether or not someone's a Medicare beneficiary. If they're not a Medicare beneficiary, you don't need to report them. And in fact, we can't take a report on them because we must have either an SSN or an HICN.

(Kevin Moriarty): Okay, but question was if we get a report and it shows, and let's say we do it a second before we're required to report for the quarterly report and it doesn't show an HICN and we've done - assuming we've done the query properly, that person's not reportable?

(Barbara Wright): If - it goes back to what I said before. If there's ongoing responsibility for medical that hasn't terminated, you have an obligation to query that on an ongoing basis and report when and if they become a Medicare beneficiary unless the responsibility for ongoing medicals has terminated before that point.

If it's what we were calling a TPOC or the single payment obligation, it's just like the example I gave where that took place before 7-1-09.

If that takes place before the person becomes a beneficiary, then no, you have no reporting obligation with respect to that individual.

(Kevin Moriarty): Well I'm sorry, I think my question's simpler. I just want to know if you look and there's no HICN and assuming we're at the (keep) times we're supposed to be looking or we've done our repeated look, if they don't have an HICN, are they not reportable?

(Barbara Wright): No. I mean, you know, we...

(Kevin Moriarty): All right that's - thank you. All right. So the self - have you changed anything? Now the self-insureds have to register right, if they are self-insured under the definition.

But what if - and maybe this goes back to the errors and omissions question. I mean aren't you going to have millions of records for people who are never going to have anything to report potentially for these self-insureds?

(Barbara Wright): John can give you a little bit more detail. But the registration is fairly open. If you don't expect to have anybody to report, then you don't need to register.

But once you get some type of claim where you believe there's a possibility that you're going to have to report, then there's an obligation on you to register early enough that you can follow through and do any necessary testing before you actually have a reporting obligation.

(Kevin Moriarty): Okay but - but okay, as I read the guidance to date -- and I understand it's a moving target somewhat -- it sounded like anyone who is self-insured had to register by, you know, within the established timeline. And so I'm hearing that's no the case for self-insureds unless they expect to have a claim.

(Barbara Wright): Yes well, I mean you're basically correct. What we were talking about people who are paying on a routine basis, have claims on a routine basis so that they

have something that's clearly reportable as of 7- 1-09 then yes. They need to register within the timeline we put out.

But for entities that don't expect to have anything, they need to adjust their registration so they can get testing done before they would have any reporting obligation.

(Kevin Moriarty): Okay that's very helpful. Thank you. And real quick, oh, if you - as I understand it too, if you are an insurer that provides reimburse through according to your definition and your example, reimbursement only coverage of the insured is not a responsible reporting entity right?

(Barbara Wright): Hang on just a minute.

Basically we believe this is covered in the interim record layout where we said whether it's called stop loss insurance or reinsurance or excess insurance, if that is purchased by entity A and the reinsurance or stop loss insurance et cetera, is entity B, if what they do is pay A and A is the one that's making any payment out to the injured party, then no the stop loss insurance does not need to report.

(Kevin Moriarty): Okay, thank you. But my question then is, suppose you have an (ex) that wants to - that is right now - and I'm talking about license insurer that is a responsible reporting entity but it converts its coverage to that type of reimbursement only, how do they deregister or whatever so that they don't have to keep submitting reports?

(Barbara Wright): At the point that they would no longer have anything to submit, then they need to speak to their EDI rep and will arrange to take care of it.

(Kevin Moriarty): Okay and then real quickly thank you. Last question. Is there any thought, you know, I have a lot of clients that if they have any reportable claims, there's going to be just a couple every year at most.

And, you know, they're talking about a considerable amount of time and expense to set up this upload type thing.

Is there any possibility of having just a secure page on the COBC Web site where they can actually go in and input data for the three or four claims we might have rather than have to go through this whole process of doing the file, you know, this electronic file layout, et cetera?

I mean because that's going to be a lot of - I mean I'm thinking of captive insurers. But maybe other single line insurance companies would be in the same situation where, or even self-insurers where there's very, very few every once in a while. It just seems like it's a lot of time and expense to set up this uploading electronic reporting.

John Albert: At this time that is what is available. It's not to say that that's, you know, we're very well aware of that. And, you know, at the same time, we also while we can't recommend, also recognize that there are a lot of entities out there that are offering services to assist folks as well. But at this time we do not have that functionality available. And it's something that we are - would consider. But that's nothing we can commit to at this time based on, you know, the funding for the program as of this date.

I did want to go back quickly though to revisit your issue regarding the query. And I want to make sure that everyone understood that not receiving a HICN on the response file does not in and of itself mean the person is not a beneficiary.

I know that you did mention assuming the query was perfect, what we interpret that as, is that assuming that you do have in fact, the valid SSN, name, date of birth and gender of the person and meaning you have a clean input record, in that case that would be true.

But again, the query file will not be able to identify a person if you for example, have the wrong SSN. And, you know, so we just need to make sure that this, you know, a query in and of itself doesn't, you know, basically provide a path or whatever, a safe harbor regarding reporting obligations.

So if you think the person is a beneficiary and you submit them and they - and we don't find them, the chances are you may want to develop further to make sure you're providing good input information into that file. But we just wanted to make sure everybody understood that.

It's a tool out there that will help you validate hopefully all the people that have Medicare and don't have Medicare. But it's not, you know, the end all of it.

(Barbara Wright): And the query...

(Kevin Moriarty): And, you know, okay thank you. But just on that last point about the de minimis, you know, if there were any way to - or small number of claims reporting, I mean I guess I appreciate your limited budget. But the fact is just, you know, what I'm hearing is they have to go and introduce.

It's not so much whether they have the technical expertise on staff. It's the expense and time of dealing with others to do it.

And if you come up with a small reporting option later, it's not going to help people who have to do it now to comply with the upcoming deadlines.

So it's, you know, it's not, you know, it just doesn't seem like a particularly helpful way to look at how this is going to go. Because these people are still going to be caught up in the current plan.

It's just, you know, for them, it's just a huge headache for a very small benefit. I know what Medicare intends to do but this is just, well to be honest with you, a lot of comments. But this just sounds like a whole lot of administrative household for very little results.

(Barbara Wright): Could you hold for just a minute please?

You also mentioned the concept of captive insurance companies. What we want to make clear is that for purposes of registration, you can treat that the same way as a parent and subsidiary even if it's not technically a subsidiary.

So if you have one entity that has let's say like 25 captive insurers that the entity that has those captive insurers can be the RRE for all of them.

(Kevin Moriarty): Oh okay. Thank you. That's helpful.

(Barbara Wright): So does that help some?

(Kevin Moriarty): It may. But I'm thinking also of the self insured guys who, you know, I have other clients who don't have captives. It's just - because they - many - I think it's normal, especially small businesses. Everyone's got a self-insured retention these days.

(Barbara Wright): Right. Now what we've heard some is that some of the most active signups to go out and find an agent. And we don't vet or endorse particular agents. But a lot of that has been for the self-insured.

And we don't have details on what they're doing. But I would assume that the agents may be making accommodations for the people that want to sign up that don't have a lot of systems. They may have some type of interface to get the information to them. That might be something you want to explore.

(Kevin Moriarty): Right. Okay. And I promise, last quick question. Are there going to be good faith, any exception to the penalties for good faith efforts to do the reporting even if you might not do it perfectly?

John Albert: At this time we don't have any of that defined. But again, as I've said on every single call, our primary interest is getting data, not assessing CMPs.

You know, the first thing that everyone can do that would go a long way towards settling any future good faith issues would be to register during that open registration timeline and do the testing with CMS.

We recognize that you know, the hunger for the final user guide obviously, you know, is of great concern to us as well. And we recognize in our many years of experience of doing similar data exchanges with many different entities with the COB contract, that it can take a while for people to get this moving. And we are very accommodating in that sense.

Do we have something written in terms of a definitive, what is a pass and what is a fail? No we do not.

But again, the best thing everyone can do is register when the Web portal goes live and engage with CMS. That's what we're looking for.

(Kevin Moriarty): Okay, thank you very much.

John Albert: Next question.

Coordinator: Your next question comes from (Andrea Kerry).

(Andrea Kerry): Hi. I actually have two questions. The first one is for the field that is referring to products, could a product be a food, a traction, property or medicine?

(Barbara Wright): You're talking down in the product liability field?

(Andrea Kerry): Yes.

(Barbara Wright): That's one we should have mentioned that we're still working on language for. As we've said on other calls, we don't want to set that up to require product liability information on every single situation that involves some product because virtually everything dose.

In other words, if (John Smith) has a toaster that's bad because his wire is frayed, we don't want to turn that into a product liability situation. We're looking more for what people traditionally refer to as mass torts, et cetera. So we haven't completely refined the language.

(Andrea Kerry): Okay. And my second question would be about the RR - excuse me, must report to events. Is - we're trying to figure out what you mean by the date.

Is responsibility assumed referring to an incident date or a date reported?

(Barbara Wright): When you're talking about ongoing responsibility for medicals, we're simply asking you to report yes or no when you assume - until you assume it. If you were otherwise reporting the case for instance, because you had a single payment obligation, then you would report no in that field.

If you're assuming ongoing responsibility for medicals which is what happens with many workers compensation cases, you would report Y for yes when you'd made the decision or by law you add it, you would report it within your next file submission.

And then when your responsibility terminated, you would report the termination date. You would continue to leave a Y in the ongoing - in the assumption of ongoing responsibility.

What that does is tell us that yes, there was open ongoing responsibility and gives us the termination date.

(Andrea Kerry): But just for clarification, no actual date is needed. It's a yes or no?

(Barbara Wright): Yes.

(Andrea Kerry): Okay.

(Barbara Wright): Except for the termination. You do need to give us the specific dates.

(Andrea Kerry): Right. Okay, thank you.

Coordinator: Your next question comes from (Patricia Lambrecht).

(Patricia Lambrecht): Yes, this is (Pat Lambrecht) at Chubb. We have about three questions here. The first one you may have just addressed. But we were interested in product liability field for workman's compensation. It sounds like you haven't defined whether or not we need to report those.

(Barbara Wright): Our expectation right now is that whatever we define within the context of...

John Albert: Excuse me, do you have a speakerphone on in the background? It's causing feedback here or...

(Patricia Lambrecht): No.

John Albert: Okay.

(Barbara Wright): Okay. We expect that whatever we define for product liability will be required to be reported if there is a worker's compensation situation that also involves product liability.

(Patricia Lambrecht): So we would have to report the product liability. So we would - for work comp claims, we do have to report the product liability?

(Barbara Wright): Yes. Once we further define those fields down, yes.

(Patricia Lambrecht): Okay. Would it be possible for us to get a copy of the HEW software before the registration process?

John Albert: No.

(Patricia Lambrecht): Can we pick our submission date if we register early?

John Albert: There is no early registration.

(Patricia Lambrecht): Well let's say if we register May 1 as opposed to June 30?

John Albert: We would encourage you to register, yes. I mean we will work with you to set up those dates. But you will have to go through the regular registration process.

(Patricia Lambrecht): Right. But if we get - if we're one of the first ones that get in there we have - we could possibly say that we would like this window for our submission timeframe?

Man: That would be entirely up to the EDI rep you were talking with once you - after you registered.

(Barbara Wright): They're going to attempt to accommodate people. But ultimately they have to accommodate the entire universe.

(Patricia Lambrecht): Right. That's why I want to get in first.

Man: We understand.

John Albert: Yes.

(Patricia Lambrecht): I have one last question. And I don't know if you are prepared to answer it or not.

We've had a lot of discussions about situations where we just cannot get the Social Security number from the claimant.

And at what point - I mean are we ever resolved of our responsibility? We're just trying to understand if - how long do we have to keep trying to get the social to be compliant?

(Barbara Wright): That's what we're trying to work out in terms of the model form or model sample form that we're working on. So do we have an answer for you today, no.

(Patricia Lambrecht): Okay, but you're aware of the (issue)?

John Albert: Yes, very much so.

Man: We're very aware of it. Remember it - we want the Social Security number or we want the Medicare ID number. We prefer the Medicare ID number. The only cases where you can't get it that you need to be (fretting) about getting the Social.

(Patricia Lambrecht): Right. Well we want - we're assuming we need the Social so we can - when we need to do the query, we have the Social to do the query. We won't have the Medicare number unless we get it from you.

John Albert: And we were trying to address the obvious, you know, those - obviously, you know, everyone's told don't share your SSN. And we are...

(Patricia Lambrecht): Yes.

John Albert: ...working with our other internal CMS partners to try to educate the public regarding that hey, this is a legitimate request and you should provide the SSN to anyone that essentially is paying benefits on your behalf. That would

include not just Group Health Plans, but also liability, worker's comp no-fault insurers. So...

(Patricia Lambrecht): Right.

John Albert: ...I guess we're very - we've been battling this forever. Because, you know, the process we have for validating information has been the same for ten years. And as, you know, HIPAA came along, it's made it difficult for us as well to make sure - because we're just trying to, you know, make sure everybody can get the data they need, not only internally at CMS, but also our many data sharing partners.

And we are very well aware of that and want to provide...

(Patricia Lambrecht): Right.

John Albert: ...that kind of information to you.

(Patricia Lambrecht): Okay, one more question and we did touch upon it a little bit earlier.

We're having a lot of discussion here about the penalties. And is it \$1000 per claim, \$1000 per claim per day?

And I know you're not in the business of penalizing people who cooperate with you, but we have a lot of questions about how big a problem is this? And how much time do we have to submit people that aren't considered beneficiaries?

Do we have three quarters to do it? Do we have a year to do it to get it right in terms of all the data?

(Barbara Wright): Well it's technically under the statutory language, \$1000 a day per individual...

(Patricia Lambrecht): Yikes.

(Barbara Wright): ...that you aren't (worrying). I mean that's - if you go read the statute, that's what it says.

Now what we've tried to do is build in, you know, timelines. So you're supposed to have a quarterly submission but we added a 45 day window knowing that you might not know about something till within a week or two of your file submission date, then we've added an extra 45 days. So you can do a query or whatever you need to do.

(Patricia Lambrecht): I guess what we're thinking is if we submitted someone and we get an error on that record, we understand our obligation is to correct it and submit in the following quarter.

What if it's still a problem? We just - how long are we allowed to get it right?

(Barbara Wright): We have not worked out any bright lines at this point. As John said it's, you know, it's important that people...

(Patricia Lambrecht): Make the effort.

(Barbara Wright): Yes.

John Albert: Engage with us. That's all that we're looking for.

(Patricia Lambrecht): Yes, okay. Well we'll be doing that.

Man: We've been doing this now for a little over ten years with the electronic data exchanges. And this is not actually the first time we've ever had that question.

(Patricia Lambrecht): Ah, okay. All right, thank you very much.

John Albert: Sure.

Coordinator: Thank you. Your next question comes from (Yvette Lynch).

(Barbara Wright): Hello?

Coordinator: Ms. (Lynch), please check your mute button.

(Rebecca Justice), your line is open.

(Rebecca Justice): Yes, I actually have four very short questions. The first one is going back to the (Hugh) Technical Requirements.

IT folks need to try to get this technical requirements, not necessarily the software, such as what platform that exists on so that they can make sure that we meet the technical requirements to install it, put it on their server - that type of thing.

John Albert: I would refer you to the GHP user guide.

(Rebecca Justice): Yes...

John Albert: That has a lot more information about it. The only difference between the two is that in the non-GHP version you will only receive the Medicare Health insurance claim number - none of the additional information.

But it's the same format, same process. So you - I would use that.

(Rebecca Justice): Okay. And there's no more - and more in-depth technical information on that is there available (sic)? Because I have read that and it just doesn't seem to be really in-depth.

John Albert: If you want to send a question, you can send it to - please send it to the CMS Resource mailbox with your contact information. And we can hopefully get someone to return your call directly. It's a contractor.

(Rebecca Justice): Okay, great.

John Albert: Okay?

(Rebecca Justice): Next question I have is what is meant by partial resolution? One of the statements in the interim guide states that we must report settlement judgment awards, reports are required with either partial or full resolution of a claim. What's meant by partial?

(Barbara Wright): Okay. What we're trying to do is figure out words that will suit everybody. It's not necessarily even resolution as much as addressing.

For instance, if you have a worker's comp claim but you don't consider it quote, resolved, but you addressed it in part by assuming responsibility for ongoing medicals because state law says you have to, then you've partially resolved or partially addressed that claim and you have to report.

And similarly if you have a case where you for whatever reason, the determination has been that there is a single payment obligation or what ends up being called a TPOC in our layout and you've assumed responsibility for ongoing medicals, that's either a full or partial resolution - whatever you want to call it.

Don't read too much into the term resolved. The point is, if you've got what qualifies as the assumption of ongoing responsibility for medicals or you've got a single payment obligation whether it's by settlement, judgment award or otherwise, then you have to report.

(Rebecca Justice): Okay, very good. Thank you. Next one is no medicals. There's a statement in it that reads no medicals. If no medicals are claimed and/or released, the settlement doesn't award or other payment must be reported regardless of any allocation made by the party or determination by the court. What is meant by no medical?

(Barbara Wright): Do you know what page that was on so I can look at the actual wording?

I mean what we're talking about is we've had situations where people come in and say well, I don't think I should have to report because I didn't quote, pay any medical.

And what we're saying is it's not up to the insurer or worker's compensation to determine whether or not we have any medicals that were entitled to be released for.

If it's a claim where medicals were claimed or released or the settlement judgment award has the effect of releasing medicals, then that ongoing responsibility or single payment obligation has to be reported to us.

What we tried to make clear with the language about no medicals is for instance, if you have an automobile fender bender and no one's claiming any medicals, there's no release signed about medicals or anything, then no, you don't have to report that.

(Rebecca Justice): Oh okay. That's on Page 12.

(Barbara Wright): Yes. And there - another - but we're not bound by the allocation of the parties. So let's say there's a settlement for policy limits for \$100,000. The fact that the claimant and the insurer agree this is all for pain and suffering doesn't control what we do.

You still have to report it and we make a determination of whether or not we have a recovery claim.

(Rebecca Justice): Oh okay. Okay.

(Barbara Wright): And in tying in with that, one of the questions that came in, I think it was a firm that dealt with accounting malpractice and was asking whether they had to report their settlements, judgments or awards.

And it would fit under this type of language. If medicals aren't being claimed or released, then no, we don't want to know about it. And it doesn't have - if they're not claimed released and there's no effect of releasing those, then we don't need to know about it. It'll apply to all of ours.

(Rebecca Justice): Okay so the relief is what determines whether or not we need the report. Is that what...

(Barbara Wright): The claim and/or the release. If they've claimed the release and it's not like for - and we see all variations of this. Someone comes in and claims every injury known to man. But the release says this is just for pain and suffering and it doesn't - I'm sorry, that still needs reported. It was either claimed or released.

(Rebecca Justice): Okay, okay. And then the last question that I had is in regards to the Federal Tax Identification Number. That basically states a Federal Tax Identification Number reference file must be submitted with the initial claim file containing records for each (claimant) submitted in Field 50 of the claim file detail record.

Is that referring to each individual claim? Does that TIN need to be submitted for each individual claim?

Man: We're thinking.

John Albert: Yes, we're thinking.

(Rebecca Justice): Okay.

(Barbara Wright): If you can point us where you are on the record layout I can - John and (Bill) can look at it.

(Rebecca Justice): Oh one second.

(Barbara Wright): Excuse me, do you know, what part of the record layout you were pointing to so I can show that particular section to John and (Bill)?

(Rebecca Justice): Well I actually have my notes here so I'm not in the document itself. I'd have to find it. I'm just quickly looking to see if I can find it in the document.

(Barbara Wright): Maybe if John could give you a brief recap of the TIN reference file versus what goes on the record.

(Rebecca Justice): Yes that specific statement's on Page 8 of the interim guide.

(Barbara Wright): Okay, eight.

(Rebecca Justice): Second paragraph.

(Barbara Wright): Now our page is not printing.

John Albert: No. Oh wait, I'm sorry.

Man: Yes (David), I'm sorry.

(Barbara Wright): Hang on for just a minute.

John Albert: Yes.

John Albert: Hi this - I mean so - I mean basically anywhere that it's - for that applicable plan which would be the insurer essentially, the worker's comp plan, I mean they all have to have a unique address.

We use the TIN reference file to basically allow addresses to be coded on the individual record with just that TIN number rather than having to code an entire address for every single record you submit.

So basically every unique applicable plan must have a unique TIN ID and therefore a unique address submitted as part of that record, individual record.

(Rebecca Justice): Okay.

John Albert: Is that...

(Rebecca Justice): Yes. So it has to be with each record.

John Albert: Yes, yes. I mean but obviously you could have the same - if it's the same plan from record to record for example, then you would have the same TIN for those records.

But basically if it is a unique entity, then that has to have a unique address.

(Rebecca Justice): Okay.

Man: Most of the times it'll be the same TIN coming in from the same reporter most of the time, particularly if the reporter is an RRE itself.

Where this gets to be more important is when the agent is reporting for multiple entities. The TIN is actually one of the key identifiers for us to know which entity is involved.

John Albert: But every file that comes into us under each RRE, you can only have one address associated with that - with one particular TIN.

If you try to load a TIN reference file that repeats the same TIN number with different addresses, we're only going to pick up the first one we read essentially.

(Rebecca Justice): So one record, one TIN.

John Albert: Yes, right.

(Rebecca Justice): Okay. Okay, very good. All right, thank you.

John Albert: Okay.

Coordinator: The next question from the phone comes from (Jim McMorrell).

(Barbara Wright): (Jim)?

Coordinator: (Jim), please check your mute button please.

Okay, (Keith Bateman).

(Keith Bateman): Hi. A follow-up on the form comment. When are we going to see the form? What's the latest ETA on that?

(Barbara Wright): After we get the user guide out. I mean it's not going to be in the first user guide. We're trying to get the bulk of this document out which once you include the record layout as you know, the interim one is 77 pages. The actual guide is about 160 I think.

And we need - we feel we need to get that out to you with as much information as possible. So that's our priority over some other things.

But as I named earlier in the call, we have some other things that are top priority once we do that.

(Keith Bateman): A follow-up on the last discussion on the TIN number. If you have a company that has chosen to have multiple RREs but they only have one TIN number, is that a problem?

John Albert: No, because the reference file is tied to each RRE ID.

(Keith Bateman): Okay. Next question. A worker's comp large deductible program where there is a policy but the policy holder administers the claim below a certain threshold and then turns it over to the work comp carrier to administer once it goes above that threshold.

Each of them have RR - their own RREs. How does that transfer - is that transfer to be handled?

(Barbara Wright): What do you mean transfer? I mean...

(Keith Bateman): It's the same claim, but the payer changes.

(Barbara Wright): Okay.

(Keith Bateman): Okay, at some point in time.

(Barbara Wright): You're each going to report your individual obligations. The worker's comp carrier wouldn't report until it actually assumes?

(Keith Bateman): Right. So the self - the policyholder would send a note - would they indicate it's some sort of termination of their obligation?

(Barbara Wright): If they're doing ongoing responsibility for medicals, they'd indicate with the yes and then they'd report with the termination date when their responsibility ended. And the worker's comp carrier would be reporting when it had assumed responsibility.

And if it was a different situation where there was a single payment obligation and you both had a single payment obligation, you'd both report it.

So it depends on the specific facts. But you don't need to like write us a note that you're transferring responsibility. You would just each perform your own reporting responsibilities.

(Keith Bateman): Okay.

(Barbara Wright): One of the things that we will need to do on the backend is fold some of these things back together where we can't avoid the fact that we have two entities or two records for a particular...

(Keith Bateman): Okay, so you're going to handle that yourselves?

(Barbara Wright): Yes.

(Keith Bateman): Okay. Next question. Let's say a company has five RRE numbers but uses one vendor to report. When you get to the testing with your vendor during the testing period, are they going to have to test for each RRE record individually

or will they just do it once, does the vendor do it once to test their end of the process since they're the ones that are going to be interfacing with you?

John Albert: I mean right now the way it's set up that every RRE would be expected to do a test. Obviously if you have one vendor who's submitting on behalf of TINs if not hundreds of other RREs, the testing I would imagine would be very limited. But we do have to make sure that for example, connectivity and things like that are taken care of.

But I would expect any tests that took place, once a particular vendor tested one RRE should be pretty simple and straight-forward. I'm going to assume that they learn from the first test and get any future ones correct.

(Keith Bateman): Okay. Then I was asked to raise another question about illegal aliens. Here's the question. Worker's comp has been second - has been primary to Medicare since 1965.

There was an amnesty sometime in the 80s for illegal aliens. For those claims that were prior to that date when they were illegal aliens but they filed the worker's comp claim, are we supposed to somehow check on their status to see whether they have now become a citizen and now are (entitled to it)?

(Barbara Wright): Are you talking about one where you have current ongoing responsibility or it ended ten years ago?

(Keith Bateman): Yes.

(Barbara Wright): If you have current ongoing...

(Keith Bateman): Your look back provision may solve this.

John Albert: Yes.

(Barbara Wright): The look back provision will address this. And it's, like I said, we believe we've given a very reasonable limitation so...

(Keith Bateman): Okay. Is that limitation subject to further discussion once it's out?

(Barbara Wright): We always listen to your concerns. But we do truly think we've come up with a very, very, very reasonable...

John Albert: Very reasonable.

(Barbara Wright): So hopefully the industry to the extent it understands that we're doing, any look back at all we'll be very happy with the one we will be providing.

(Keith Bateman): Okay, thank you (Barbara). Okay that's my - that's the end of my questions.

John Albert: Thank you.

Coordinator: The next question will go to (Yvette Lynch).

(Yvette Lynch): Hi. This is (Yvette Lynch) from Brown & Brown Insurance. We are an agent that will be reporting for many RREs within our own organization. And you've touched a lot today on the registration process.

And our question is during registration, can we somehow get the same EDI rep or will we be dealing, me as the tech, will I be dealing with multiple EDI reps and multiple testing dates and so on and so forth or during registration can we somehow funnel that down to a manageable amount?

John Albert: We would like to be able to assign you one EDI rep for all of those. We just can't guarantee that at this time only because it's a capacity planning issue.

Once we have - you know, that's why we're saying the thing we're most interested is getting everybody registered as quickly as possible. That will allow us to work with all of the submitters to basically get them what they need.

And obviously, you know, it makes total sense for one EDI rep to work with, you know, all of that agent's, you know, partners so...

(Yvette Lynch): Right. Let me ask...

John Albert: That's something that, you know, when you do register and you do get assigned an EDI rep, I don't know if we modified any of the registration process that asked for questions like that.

But essentially when you do get that EDI rep you can work with them directly to accommodate. And the contractor will do that.

(Yvette Lynch): Okay, so one thing I'm doing right now is devising a planning tool to submit to all of our agents to kind of help them with this EDI process. And maybe the answer in this case is to be involved or listen in on one of those registrations so that we can then coach our other agents to try to get, you know, to conform somehow with that EDI rep or those testing dates. Is that reasonable?

(Barbara Wright): You've also used terms a couple of different ways. When you were talking in the beginning, you said that you were going to be the agent for all the RREs in our organization.

(Yvette Lynch): Yes.

(Barbara Wright): Now you're talking about multiple agents.

(Yvette Lynch): I'm sorry. I misspoke.

(Barbara Wright): If you are for example, if you're a parent company and you have subsidiaries or we said if you're a company and you have captive insurers, you can choose to just have one RRE ID in which case you would have one submission date and you would have one rep et cetera.

So you don't have to break things up. And we've also heard of situations where people are internally even if they have various locations around the country, if they're doing data development anyway, they are internally rolling information up and sending it in on one RRE.

We're not saying what you need to do or should do. But just consider your possibilities before you decide to have multiple RREs.

(Yvette Lynch): Well we are the agents within Brown & Brown Insurance. But the - but along with our piece of the organization, our multiple insurers which we understood would be have to be their own RREs.

(Barbara Wright): We're - I'm a little bit mixed up by you saying you're an agent within Brown & Brown. Is Brown & Brown an insurer? Is it an RRE itself?

(Yvette Lynch): No.

(Barbara Wright): Okay, so you're not an agent within Brown & Brown. Brown & Brown is an agent is what you're saying.

(Yvette Lynch): No.

(Barbara Wright): Okay, so you're not an agent within Brown & Brown. Brown & Brown is an agent is what you're saying.

(Yvette Lynch): We...

(Barbara Wright): It doesn't - you're telling us it doesn't have independent responsibility as - to be an RRE...

(Yvette Lynch): No. But we - but within Brown & Brown are multiple insurers.

(Barbara Wright): I don't - we don't know what you mean by within. If you have contractual relationships with multiple insurers who are RREs, then yes, they are going to independently have to have separate RRE IDs.

But if - I guess it was just your phrasing.

(Yvette Lynch): Yes.

(Barbara Wright): It sounds like you are purely an agent for various insurers. And yes, the insurers will have to have their individual RRE IDs.

(Yvette Lynch): Okay. And then somehow can we - somehow can we try to be involved in one of those registrations so that we can get the other ones too? Because the insurers are part of Brown & Brown as are we. So we'll be doing...

Man: The...

(Yvette Lynch): the reporting.

Man: ...registers. Not the agent.

(Barbara Wright): You need to back up a little because it is the RRE that does the actual registration.

(Yvette Lynch): Right.

(Barbara Wright): So if you are the agent, they will be giving us that information when they register.

(Yvette Lynch): Right.

Man: And then you will report on their behalf because you are their agent. If you are reporting on behalf of say 20 RREs...

(Yvette Lynch): Right.

Man: ...at that point and you wish to be working with one EDI rep, that may be possible. We can't tell you whether it would be possible or not at this point.

(Yvette Lynch): Okay. And you mentioned like dates, you know, that the EDI rep would set those dates with our cooperation. If we knew that, you know, one of the RREs dates and EDI rep could be, then those others could request similar dates or...

John Albert: Yes. Yes. I mean we definitely want to work...

(Yvette Lynch): Okay.

John Albert: ...to accommodate.

(Barbara Wright): The first time you're in contact with any EDI rep, make sure they know how many people, how many entities you're the registered agent for, and then they'll work with you to the extent they can.

(Yvette Lynch): Perfect. Thank you.

John Albert: Yes provide them, you know, provide, whoever contacts the EDI department first, provide them with a list of all those other IDs that you're - you know, are representing as RREs and they can, you know, work with you to set up the production schedules and all that.

(Yvette Lynch): Thank you. That's exactly what I needed. Thank you.

Coordinator: Your next question from the phone comes from (Scott Blankenship).

(Scott Blankenship): There it is. Hello. I had a question about the EDI rep. It sounds like - I used your advice and looked over the Group Health Plan user's guide. And it talks about the query function file needing to be within wrapped within an EDI envelope. But I don't see any language about the info claim file or the other file, the TIN reference file having to be put within EDI.

Man: It doesn't have to be.

(Scott Blankenship): Excellent, great. The HEW software, I'm wondering if that's something that we are going to end up downloading or can we get that in CD form?

The reason I ask is because I - I'd have to take - I'm going to have to work to get our file (rules) pretty strict. And I have to go and - if we had to download it make sure I take measures to get that worked out.

John Albert: I don't see why that'd be a problem sending to your (CD). But unfortunately there's no one here to answer that question at this time.

(Barbara Wright): Can you send that specific question to the resource mailbox and be as specific as possible in the subject line?

(Scott Blankenship): I will do it.

John Albert: Thanks.

(Scott Blankenship): During the testing phase I'm assuming you will be allowing multiple submissions more than once a month during the testing phase.

John Albert: Yes.

(Scott Blankenship): Okay. And...

John Albert: The average testing is from start to when you're probably ready to submit a second test file. It's probably about two weeks.

(Barbara Wright): And they will specifically have you test different functions such as add, delete, et cetera.

John Albert: And then again, we will be offering much more material on that. We're in the final process of basically building the portal and getting it certified here by CMS internal powers that be that have responsibility for data security protocol

and all that. But we will provide certainly more information as we get near the rollout period which for GHP is April and for non-GHP is May.

(Scott Blankenship): Thank you. I think you addressed this earlier. And do you have any idea what the dollar threshold will be?

(Barbara Wright): For reporting purposes?

(Scott Blankenship): Yes, yes.

(Barbara Wright): Unfortunately as I said, we have an idea but we can't release it until we release the user guide.

(Scott Blankenship): Okay, thanks.

(Barbara Wright): We do expect to have the threshold in there. At this point the expectation is it will be an interim threshold.

Woman: (Unintelligible).

(Scott Blankenship): Okay, thank you so much. That's all I had. Thank you.

John Albert: All right.

Coordinator: The next question is from (Cindy Holly). Your line is open.

(Cindy Holly): Oh, my question was answered earlier by someone else (unintelligible). I have no further questions at this time.

Coordinator: Our next question is from (Matt Burt). Your line is open.

(Matt Burt): Yes, good afternoon. I have a quick question regarding - actually I've got two questions. The first one is regarding, you addressed this earlier regarding worker's compensation.

But in the event that we are paying claims and we're just paying the wage loss piece of it and no medicals, I would assume that that would be something that we would not to query for to determine beneficiary eligibility.

(Barbara Wright): We're still looking at language to address various parts of the worker's compensation because our concerns with allocation, et cetera. And that's one of the reasons even after the user guide comes out that we want a specific all with the worker's comp entities.

But I don't have an answer for you right now.

(Matt Burt): Yes and that makes sense too because we have our own internal policies as to, you know, if we get a settlement, how we would break that settlement out into medical expenses or legal expenses or wage loss expenses.

A next question for you is regarding more on the liability side. A question on some of the fields in your file layout. The first question is if the insured party's a minor and is represented by a parent or family member who is designated as the next friend in Michigan or a conservator, would that next friend or conservator be claimant number one or other representatives?

(Barbara Wright): Okay. I have to look back at the field again. The only I believe -- and we will go back and double check again -- the only time you're going to have to fill in the claimant file is when the beneficiary is actually deceased.

In terms of representatives -- and I've got to go back and look at the actual field -- you don't remember what field number that was do you?

(Matt Burt): Yes I do. The claimant is Field 82 through 94. And the other representative is Field 62 through 73.

(Barbara Wright): The injured party, attorney or other representative information, if you have a minor who the one is the next friend, you would - and there's an attorney, you would list both of those representatives, but nobody would get filled in in the claimant field.

Again, the claimant that's further on is solely for when the beneficiary is deceased. Does that help you?

(Matt Burt): I think so. Let me ask this next question. Maybe that will solidify it. If there's an attorney representing the child via this next friend, which session would this be - would this attorney be found in?

(Barbara Wright): It would be in the ones that start at 62.

(Matt Burt): Sixty-two. Okay, yes, that's very helpful.

(Barbara Wright): Like if you look on Page 43, right before it talks about claimant one, it says this section is not used when the injured party/Medicare beneficiary is alive and someone else is pursuing a claim on behalf of the beneficiary, in other words your next friend/attorney or whatever. This is solely for situations where the beneficiary is deceased.

(Matt Burt): Okay. Is this the same for - so the next friend would be the same for legally incapacitated people?

(Barbara Wright): Yes, that's why we've got down there that it - let me go back and find that page again. If you notice, we've got you can give values of attorney guardian conservator power-of-attorney when you're talking about the representatives so...

(Matt Burt): Okay, and one final question on this matter. If the injured party died and the personal representative is appointed for the state, is that personal representative information found in Fields 82 through 94 or 62 through 73?

(Barbara Wright): The exact situation you named. It might be in both. Because if they were the representative before but then they are, you know, on behalf of the claimant on behalf of the estate that's fine.

But if it's - if they are representing the estate, then in your claimant field it would actually say - let me find it here. I keep losing.

In your claimant field for 82 it would actually say the estate is the claimant. And then the representative of the claimant would be listed starting in Number 96.

(Matt Burt): Okay.

(Barbara Wright): Looking at Pages 43 and 46. Do you follow?

(Matt Burt): Yes.

(Barbara Wright): Okay.

(Matt Burt): Thank you. That's all I have.

Coordinator: Thank you. Your next question comes from (Doug Holmes):

(Doug Holmes): Hi. (Doug Holmes) with EWC. One item I didn't hear you mention was the - whether there was anything new on any accommodation for the long shore or other - or the other Department of Labor programs or if that will be addressed at all in the user guide?

(Barbara Wright): We are still waiting for some information back from Department of Labor. So I mean timing will dictate whether or not we get certain things in the user guide that we released first. But it's still on our list obviously.

(Doug Holmes): Okay. One other thing that - well actually two quick questions. One is looking at the stimulus bill that just passed, there's quite a bit of language in there about systems and health information being maintained with new electronic health record standards.

Are we likely to see modifications from these formats as a result of the changes that were in the stimulus bill?

John Albert: Personally I would doubt it but, you know, that's something we really can't count on.

(Doug Holmes): Okay.

Man: We don't have enough information at this point to comment on it. And that's I think where we would want to go with that.

The stimulus bill language doesn't have any direct relationship to what we're doing here but as far as we know at least at this point. But we just can't go there.

(Barbara Wright): It's also not clear one way or the other without us having further information whether or not the type of file we're talking about here would even constitute a quote, health record.

Man: Right.

(Doug Holmes): Well yes. And that was my next question just on, you know, my first scanning of the definition of health information, makes me wonder whether it might in fact be so.

That would be good to know as soon as you're able to say something about it obviously. And then if that does come up, then obviously it has some other confidentiality and/or notice things would have to be hoops to jump through I'm assuming.

Man: As I say, we can't tell at this point. No we can't. I don't want to go any further than that.

(Doug Holmes): Okay. And my last question is, I know we had the discussion before about - and I assume it's still on the plate somewhere, how much information could be provided back as part of the query function whether it was - whether you could also disclose the reason for the entitlement and the date of entitlement?

John Albert: Basically a decision was made that we could only provide a Medicare health insurance claim number as a minimum necessary. Part of the issue is related to

ongoing responsibility versus non-ongoing responsibility for reporting purposes, the minimum necessary, the confirmed Medicare entitlement.

So at this time we have no plans on providing more than that. If you have - if you want to further comment on that of course, we are very interested to hear like why and how and things like that. And if you could document that for us...

(Doug Holmes): Okay.

John Albert: ...through the resource mailbox that would be extremely helpful because we have a few questions, but for the most part, not much other than, you know, we're glad you're giving us, but just, you know.

(Doug Holmes): So what - and the other - then the other pieces of what you described before which was if we submitted the date of birth and name and, well I forget what the fourth item is...

John Albert: The gender.

(Doug Holmes): And gender, that the response would give us corrections to that information so that we wouldn't make the same mistake again I guess would be the...

Man: We're going to put you on hold just for a second.

(Doug Holmes): Okay.

Man: Yes for the reporting that you're - that you'll be doing and when you send us a response file, in return you will get a Medicare benefit - this person is a Medicare beneficiary yes or no. And if the - if it is a Medicare beneficiary it

will be provided with a Medicare ID number, the HICN. That is the response you will get.

You won't get any updated changed or additional information otherwise.

(Doug Holmes): Wow. So we'll just keep making the same mistakes all the time?

Man: Well it would get a...

(Barbara Wright): Can you hang on just a second?

Man: Yes let me - let's we can maybe make a couple of clarifications and then tell you that we're going to have to...

(Barbara Wright): Go back and look it up documents.

Man: If you're just sending a query file, that is a file inquiring about a beneficiary status independent of any other reporting, what I just said was true.

If you're sending...

(Doug Holmes): You mean...

Man: If you're sending queries in with your regular reporting to us, you will get additional information back, information beyond yes or no this person is a Medicare beneficiary. And if yes, then here is the person's health identification claim.

(Doug Holmes): Okay.

Man: Okay?

(Doug Holmes): Okay, that's helpful.

Man: So that's - I mean it's two separate. It really is two separate issues going on here. And what the purpose of the query is for, that's where (John) that's what (John) was getting at when he was saying - when he was talking about minimum necessary reporting.

We get a lot of people who just want to know if somebody's a beneficiary. And there are other - but in our regular processes more information is provided. And so that's the way we keep that separate.

(Doug Holmes): Okay thank you. That's it for me.

Coordinator: Thank you. The next question comes from (Clair Bellow).

(Clair Bellow): Yes. Hi. I am with (Vertical) Claims Management. We're a TPA. And we work mainly with medical malpractice captive and self-insurance program. And a couple of the questions - I have like two questions.

One is regarding the ongoing responsibility of medical. That's historically a term that is used with regard to worker's compensation claims. But there are often times in medical malpractice claims where we are making - well the insured or the insurer we represent has agreed to pay for follow-up treatments for a patient. And it may include one or two physician visits. It may include some additional surgery. But historically those are not considered ongoing responsibility from a legal standpoint.

Would they be considered ongoing responsibility from a reporting standpoint?

(Barbara Wright): As you describe them, yes. If you have a situation where you had a settlement for say a flat \$500,000 or something and part of that was expected to cover certain things like you just named, then that would fall under the single payment obligation, the what we're calling the TPOC.

But if you have a situation where the insurer will continue to specifically pay out only if and when certain medicals occur, then they've assumed ongoing responsibility for those medicals and they need to report it as such.

(Clair Bellow): Okay.

(Barbara Wright): We do realize that that's going to occur. The ongoing responsibility for medicals is probably going to be most often with worker's comp followed by no-fault as we've defined no-fault.

(Clair Bellow): Right. And once the reporting begins for the program, is the EDI representative the resource that might be available for us to touch base about what should or should not be reported?

(Barbara Wright): Hopefully all the issues that you're going to find the user guide clear enough. We intend to keep the resource mailbox available for the foreseeable future. And if there are continuing issues we need to know about it.

(Clair Bellow): Okay. And on a more technical line, when we are working with our client programs as new RREs, for - I guess beginning in July with the query testing and then going forward through the October 1 deadline. For programs that are writing liability claims, it seems to me we need to be running queries on all open files as of July 1 of '09, correct?

(Barbara Wright): Again, the timing of when you want to do queries is up to you. If you choose not to do it until you've actually had a settlement judgment award or assumed ongoing responsibility that, you know, that is up to you.

But you do as I said I think earlier in this call, you need to be careful not to query too soon unless you have it set up in your regular query file to do it again.

If you determine on day one that the person's a Medicare beneficiary then you know you're going to report them. But if your day one query says this person is not a Medicare beneficiary and you know, you've got the first initial, last name, date of birth et cetera is correct, then you're still going to have to double check that as of the date of any settlement judgment or award.

(Clair Bellow): So if I - if we have a case where we have a settlement, you know, we're contemplating the settlement with a claimant and we do a query and the case settles the next week we report it...

(Barbara Wright): Yes, if they're a Medicare beneficiary, then yes you're going to go ahead and report it.

(Clair Bellow): Okay.

(Barbara Wright): But if you don't know, if your initial query's say a month ago or two months ago or whatever, didn't show them to do a - be a beneficiary, you should do a follow-up query just to make sure they haven't attained Medicare entitlement in the meantime. And that 45 day window gives you the opportunity to do that and still make sure it's in your next file submission.

(Clair Bellow): But I thought I understood from the interim statement that part of the reporting requirements under 111 is to help protect the Medicare position with regard to medicals that are being paid.

How will I as an insurer or the representative of an insurer know that if I wait to run a query until the time of settlement?

I mean aren't I inherently defeating...

(Barbara Wright): Well no. If you take into account two different situations, if you've got a situation where you're going to have ongoing responsibility for medicals then yes you need to know as soon as you've made that assumption whether or not someone is a beneficiary.

Our assumption is that many entities will query as soon as they get the claim. And if they've got a beneficiary, then that settled it for them.

What I'm saying is you can't rely solely on that early query if the response is in the negative, that they can't - that the person is not identified as a beneficiary.

Then you have to at least, no, you need to double-check as of the date of the settlement judgment award or other payment.

(Clair Bellow): Okay. So all right. That's helpful. Thank you very much. That's all I have.

Coordinator: Your next question comes from (Bonnie Muster).

(Bonnie Muster): Yes. Thank you. I actually have a question that doesn't seem to relate to others that have been asked.

If a company is making a good faith effort to secure the mandatory data and we only have the basic information to report, let's say for example we have the name, date of birth, HIC and number and gender, you know, maybe there's some pieces of what would be called the mandatory information that's not available.

Is that going to be considered a good faith effort to - in the reporting process?

(Barbara Wright): As we said, we will have more details later. But most of the data is, yes, you obviously have to get the Social Security number or HICN or whatever from the individual on some of the things like that. But an awful lot of the data is data that's based on your processing of the claim.

(Bonnie Muster): Right. I think there's just - you know, there's some concern that there may be some pieces that it records as mandatory that we don't - you know, that we may not normally today capture and we're working to build it into our capture (plan).

(Barbara Wright): The industry has indicated that there are a number of fields that on some of the reports to us they've said are unavailable. And when we talked to them further, it's not - for most of it, it's not that it's technically unavailable, it's that it's not currently captured or tracked in any meaningful form.

(Bonnie Muster): Right.

(Barbara Wright): And...

John Albert: Yes. And I can say that in terms of submitting individual records that if there are mandatory fields and they are not populated, that record will reject from,

you know, from our process. And therefore you will not have been able to successfully submit that record.

Things that we will...

Man: And you'll be asked to resubmit.

John Albert: Yes, you'll be asked to resubmit. And, you know, things that we've talked about internally is that, you know, we want to provide plenty of flexibility for people to come up to speed and report the data to us.

And again, I stress as I do every time, they're interested in good quality data first, not CMP.

(Barbara Wright): Right.

John Albert: At the same time, if people continue to give us essentially junk files that we can't process, that may raise the specter of compliance with Section 111. So just keep that in mind.

(Bonnie Muster): Okay. And I have a couple of other questions. One, if a file is closed where the recipient was not a Medicare beneficiary, let's say for example a Med (Tip) and literally all that happens is a supplemental request for payment is received. A bill comes in from a...

(Barbara Wright): If you...

(Bonnie Muster): ...hospital. And this individual was not a Medicare beneficiary at the time that we thought our file was closed. So all we now have is a bill from a hospital.

And we look at it and we say oh yes, that's, you know, that would be applicable we can see. Do we have to go back in and open that claim file and reevaluate that individual to see if at that point in time they are in fact a Medicare beneficiary?

(Barbara Wright): If you have a situation where you're dealing with what we defined as no-fault which is I assume what you're talking about with...

(Bonnie Muster): Yes.

(Barbara Wright): ...with a (Tip) payment, if the first time around you exhausted that limit, then obviously there's nothing further to report. The limit's already been exhausted before they became a beneficiary.

If they apply for supplemental benefits and it's related, you have an obligation to pay, then essentially you're going to have assumed ongoing responsibility for medicals again even though your record was terminated.

Again, you'll have to look at the language we have out there as to when you can terminate records for no-fault and worker's comp et cetera for ongoing responsibility of medicals.

But when that's been done, if you reassume or have that responsibility again, we're looking at how to phrase, how to describe what we want you to do.

But in lay language we will probably be calling it a reopening.

(Bonnie Muster): Okay. And I think the concern from the feedback that I'm getting is that in most cases today, if the individual's not a Medicare beneficiary, in most cases today under our system, that bill comes in, we look at it, we say, oh yes, this is

a justified bill that needs to pay, we pay it and we move on. So we're talking about a, you know, a short time period of handling.

(Barbara Wright): Well it is a new settlement judgment payment, settlement judgment award or other payment. So if they're a beneficiary at that time that takes place, yes, then that is reportable.

Now again to the extent we have any dollar reporting threshold, if it's a lump payment obligation that's one thing. But if it's a situation for PIP or something where you've got ongoing responsibility, yes you are going to have to report that to us again. And you're potentially going to have an open ORM record for some period of time again.

(Bonnie Muster): I want to also clarify one other thing. I think I understood that - or it's been mentioned that we're expected to report on every death claim. Is that correct?

(Barbara Wright): I don't - we would be interested to know if you found language in a transcript that indicated that because we don't believe that's been our position.

(Bonnie Muster): Okay.

(Barbara Wright): I mean if someone wasn't a beneficiary at the time - had never been and was not a beneficiary at the time they died, then it falls under the same category as anything else. You can't report them.

(Bonnie Muster): Okay.

(Barbara Wright): But if someone is for example, a beneficiary and then dies sometime before you have a settlement judgment award, yes, you do have to report that because

we could have paid claims while they were still alive after the date of incidence.

(Bonnie Muster): Another question. If we identify an individual we believe to be a Medicare beneficiary, but they refused to give us a Social Security number or HICN number, what action does CMS expect a company to take?

(Barbara Wright): Well again, that's what we're working on the model form for. But you also to the extent if you have the sufficient information that they're a beneficiary, you can certainly remind them of their obligations that exist under the regulations.

Someone who is a beneficiary has a legal obligation to cooperate in terms of cooperate in terms of providing coordination of benefit information.

(Bonnie Muster): And in conjunction with that then, that model form that you're working on, is - that's going to be something that we can give to that individual that will help explain in plain English why we're asking for more information.

(Barbara Wright): That's part of it. There is if you haven't seen it, there is an alert on the overview tab that explains why insurer's worker's compensation will be collecting this information.

I think the date on the document is June 2008. But it's a download on the overview page.

(Bonnie Muster): Oh no, I think we all understand it quite well.

(Barbara Wright): No, no, no. But in terms of giving something to the beneficiary, we purposely put that on CMS letterhead.

(Bonnie Muster): Okay.

(Barbara Wright): If you want to use that as a tool. We've had some insurers that said they found that quite helpful.

And as (John) said earlier during this call, we're working with some of our internal partners to try and get the word out on this 111 reporting through potentially some other publications that we do.

(Bonnie Muster): Okay, okay. All right. Okay. And then in terms of oh gosh there - I do have one more question. I know we're nearing the end of time.

With regard to the individual who is - who's claim has never been reported before, let's say we get a notice from an attorney, here's all our medical bills, here's - they've completed their medical, it's a no-fault and please make payment, normally under our current basis, we open, review and pay all pretty much at the same time.

In handling of that claim, let's say we identify their Medicare beneficiary. We have all the sufficient information to report, what we're looking at is do we use that - do we do an add, okay this is a file that we're paying everything on at one time even though it normally would be a no-fault and we have an open and then a notice of a close. Do we do - how do we do those at the same time?

(Barbara Wright): If you're doing it as a single payment obligation and you're not assuming ongoing responsibility for medical, it's a settlement with the sense being you're getting releases, et cetera, then you handle it as what we've listed at TPOC.

But if you're assuming ongoing responsibility for medicals, you have to fall into that reporting realm, you may want to consider whether you wish to pay directly to the insured or whether you want to pay the provider supplier in a situation where you know it's no-fault. I mean we hear both ways from the industry.

(Bonnie Muster): Okay. Okay.

John Albert: Operator, this is John Albert. We're run out of time. We've actually run over a little bit. And we needed to stop the call for now and thank everyone for participating. Keep your eyes on the Section 111 reporting, the mandatory insurer reporting Web site for future calls. Especially as I mentioned before, we'll have some specific to worker's comp liability and mostly some technically calls related to registration on the Web site - things like that.

I'd like to thank everyone for calling in. Your questions have been very good. We have literally hundreds of questions through the CMS resource mailbox. Please continue to submit those questions, especially, you know, there's a few people here we spoke to we asked for some specific examples or write-ups and provide your contact information as well.

Before we end the call, I wanted to get a final count of the number of participants and how many people were still in the queue?

Coordinator: There were 36 parties still in queue and total just now there was 528 online and 450 have already disconnected. So...

(Barbara Wright): Okay.

John Albert: Did you have any final?

Man: Okay, with that...

Coordinator: Grand total of almost 1000.

Man: All right, we're done then. Thank you.

Coordinator: All right, thank you.

Thanks for joining today's call. You may disconnect at this time.

END