

FTS HHS HCFA

**Moderator: John Albert
January 22, 2009
12:00 pm CT**

Coordinator: Good morning and thank you all for holding. I would like to remind parties that your lines are on a listen-only at this time. The conference is also being recorded, if anyone has any objections you may disconnect at this time. I will now turn the call over to Mr. (Decker); sir, you may begin.

(Bill Decker): Thank you very much. Hi, my name is (Bill Decker) and I'm with CMS in Baltimore, Maryland. With me on this call - working the call with me is (Barbara Wright) a colleague of mine here at CMS and for her expert opinion from the outside we have (Pat Ambrose), who's working with us on the implementation of the Section 111 Requirements for both the NGHP and GHP RREs that will be reporting to us.

This call today is a question only call; we are not going to be giving out a great deal of new information although at the beginning of the call (Barbara) will be giving some information about - on a couple of items. So if you have questions queued up that's fine, you may have more questions after (Barbara) speaks; you may not, that's fine with us.

We are not going to be taking any call - any questions at all from people who are GHP - that is Group Health Plan Responsible Reporting Entities. This is a

non-Group Health Plan call this afternoon. There will be Group Health Plan calls later on this month and into next month also.

With that I think that that's all the preliminaries. Most of you are, I'm sure that many of you have been on earlier calls, you know, what the format is; we will do some talking and then we will open up the lines to you and your questions. And we have - besides myself and (Barbara) and (Pat) there are a rather large number of other people in the room who will be able to answer a lot of the technical questions that we can't.

And so with that I think I will turn it over to (Barbara Wright) who will give us the introductory - her introductory remarks. Thanks, (Barbara).

(Barbara Wright): Hi, good afternoon. What I'd like to do first is I'm going to go through a number of items to either update you on where we stand or to provide a slight amount of information and then what we would do is we will address the query function, which I know everyone related to the NGHP reporting has been anxious to hear about and then we'll do the question and answer.

The first thing I'd like to mention is the NGHP user guide. That is still in process. We've had several questions about the dates. We are aiming to have it out sometime in February; we don't have an exact date at this point. In the mean time in terms of technical information you can use the GHP guide as somewhat of a reference.

For instance the query function we're talking about today when we go over that, they will tell you how much of that information is exactly what's in the GHP guide and where there are some differences. Also although the file layout is not the same to the extent the user - the GHP user guide gives

information about how the process works. That information is generally the same.

The second point is in terms of the timeline when it comes up time for you to register and test it's critical that you understand that you need to do this even if you haven't yet collected all your data, even if you don't have all the data. In order to keep this flowing smoothly we need to keep things on board in terms of progressing toward the actual production live date.

And you can register and test without having real data. The test - the data that you used during testing does not have to be accurate or true data in terms of what you will be reporting in your live production. So keep that in mind and don't delay registering or don't delay setting up testing solely based on where you are in your data collection process.

Third point is we wanted to let you know that there will be an alert out in a couple of days on the Web site that's asking about your interest in having CMS participate in a conference dealing with Section 111 reporting. We need to be able to plan both for budget and staffing purposes, where we're going to be going and how we're going to do any presentations.

So we're asking for anyone who's interested to supply detailed information regarding when they would be interested in having us participate, what the type of conference is, the target audience, etcetera. And the alert will specify all the information you need to provide.

We're not necessarily limiting ourselves to big conferences; obviously we'd be more likely to be able to do travel for a very large audience but we aren't ruling out the idea of doing some conferences possibly by Pictel or by telephone for instance if it's a relatively small audience we don't want to

exclude those but we might have to do slightly different arrangements. So as soon as that alert goes up we really need information as soon as possible if for no other reason then I'm sure we'll get conflicting date requests. And to a certain extent unless we have a lot of requests in the beginning it will end up being first come first serve.

Next thing is the data code sets. We haven't finished looking at all those; we were asked to consider whether or not we would use something other than the WCIO codes. And we haven't made any final decision on that. So we will let you know as soon as we do.

On the last call additionally there were some questions about Department of Labor issues, for any of you that are associated with the Department of Labor, we are in the process of setting up a call/meeting with the Department of Labor to discuss some of the issues you've raised.

Mass torts, right now they're an open issue in terms of exactly how those should be reported, whether we will have something slightly different than what's in the interim record layout there right now. We should be setting some meetings up on that shortly. We're taking a look at all the (BACA) requirements so that we don't run afoul of those when we try and convene people.

We've also had requests for separate worker's comp versus liability/no fault teleconferences or other meetings. And we are looking into that for the future; we probably will not do that until we at least have an initial version of the full user guide out there so that we've got a base document that we're working with and that everybody can comment on and explain why it either does or does not work for their particular area.

The next thing on my list is we've had several questions about what if an incident takes place overseas; are the - in other words outside the United States - it wouldn't necessarily have to be overseas, we'd count Canada too. But we're also looking at insurers that are outside the United States. And basically the reporting requirements still apply. If it's someone who's a Medicare beneficiary we should still be secondary.

Now how this will work out in practice is a slightly different issue. But they're not off the hook for reporting simply because they're not located in the United States.

Joint power authority was an issue brought up on the last call. And we're working on language to address that right now. So we don't have anything further to provide you on that at this moment.

We've had several questions come in since the last call that deal with what do you need to report in terms of cases where you have ongoing responsibility as of July 1, 2009 particularly if you have closed the case in your records even though you technically have responsibility for future medical if a new request comes in? Most entities have told us they handle those as re-openings.

The issue that's of concern to us is that we - as we indicated in the interim guide - we can't have records where you have technically ongoing responsibility closed for our purposes because we have to have a method to deny claims appropriately. So we are looking at the issue of how far back we will require you to go in terms of cases that are already closed as of 7/1/09. And we'll need to get back to you on that.

Remember that this is only for ones with ongoing responsibility. If there is a case that would've required the (TPOC) reporting, the Total Payment

Obligations to the Claimant, in other words, while I don't like to call it a lump sum payment it's essentially a one time obligation. Those cases, even if they were originally set up to be paid through an annuity or through a structured settlement, if that settlement took place before July 1, '09 those do not need to be reported.

We've had additional requests about a threshold for reporting purposes. We are meeting on that sometime next week I believe and we will get back to you as soon as we have further information.

Okay the next issue - and I'm going to ask (Pam Ambrose) to address - we had several questions come in where people are saying that X is the responsible reporting entity; they want to appoint Y as their agent but Y wants to use Z to do the actual physical submission. So you're really talking three entities involved instead of two.

And I believe we gave a tentative answer on the December 11 call but we now have information on how we have this set up to be done. The information will be in the next updated version of the GHP user guide and will be in the end GHP user guide. But (Pat Ambrose) will walk you through how it's going to work.

(Pat Ambrose): In order to explain this I need to define a couple of roles, individuals that will play a particular part for your Section 111 reporting. The first is your authorized representative. This is the person who's able to essentially legally bind the RRE to the requirements of Section 111 reporting. And so your authorized representative is actually associated or employed by the responsible reporting entity.

The authorized rep is again ultimately responsible for reporting and will sign off on information that you provide during registration. This person will also sign off on who you appoint to be your account manager. Each RRE will have one account manager; this is the person who's going to manage the overall day to date processing and account information related to your Section 111 reporting.

Your account manager can be an employee of the RRE or it could be an agent. Your account manager could in fact be a representative from your TPA. Lastly we have another role that will be played and this role is known as an account designee. These individuals will be people who are able to upload and transfer files, monitor file statistics and so on. They can be individuals from the RRE, the TPA or an agent.

In terms of the registration process what will happen - and this will again all be documented in the upcoming user guide. The RRE will come to the COB secure Web site and provide information - basic information about the responsible reporting entity and the authorized representative. Once that information is vetted by CMS or CMS's Coordination of Benefits contractor a letter will be mailed US Post to the authorized representative. That letter will contain a PIN, a personal identification number.

The authorized representative then provides that PIN to their account manager. The account manager then comes back to the Web site and performs the second step in the registration and account setup process by first providing some information about themselves, determining or developing their own personal login ID and password and then setting up the rest of the RRE's account information related to - information related to the agent that will be used in file transfer and other details of that nature.

Once that process has been completed the system will generate a profile report and issue that profile report to your authorized representative via email; and that's the authorized representative. Your authorized representative will then review that information, essentially by virtue of doing that is approving the agent and the account manager assigned to the account, sign that - the last page of that profile report then return it.

Also once the account manager has set up his or her login ID and password for the COB secure Web site in the Section 111 application online they're able to invite other individuals to become account designees. And again these individuals may be from the RRE, people who want to monitor the file processing statistics and the like; they can also be individuals from a TPA or they could be individuals from the agents.

Those - the actual file transfer, if you're uploading and downloading files on the COB secure Web site a user must sign on with their login ID and password and - in order to perform that. For secure FTP to and from the Web site this will be an automated process however a user's login ID and password either the account managers or the account - an account designee must use a login ID and password to successfully transmit files via secure FTP.

So the specific question that arose in the past had to do with if an RRE is using a TPA but it actually is not the TPA - the TPA is contracting with another agent to do the physical file transmission the way that the RRE could set up their account is to again name an authorized representative from the RRE, the TPA could perform the account manager function and play the account manager role on the COB secure Web site.

And then the agent would be named by the account manager during account setup and the account manager could also invite representatives from the agent to become account designees and get login IDs and passwords.

(Bill Decker): Hi, this is (Bill Decker) again. That sounds complicated I know and it sounds hard, I know. And in fact other - this is the process that we set up for other applications. And it is complicated and hard but not that complicated or hard ultimately. We also will be offering computer-based training that will guide everyone who's involved in the process through these steps after they're developed and after they're fully mapped out so that you'll have a chance to actually work the process before you go live with it.

We highly recommend the computer-based training, which will be available to you at some point and in the relatively near future for you - so we'll take you through the process and everyone who is going to be involved on the data exchange with us should probably take the training and go through the process ahead of time. (Barbara)?

(Barbara Wright): To add on to what you said on the computer based training I believe we have a new sort of alert or language on the page about computer based training on our dedicated Web site. I want to make it clear that the training that's there now is really directed at GHP responsible reporting entities and the training would not be particularly helpful to those of you who are responsible reporting entities or agents for the non-GHP, the liability, no fault worker's compensation.

So there is information on the page that tells you how you can go in and sign up so that as soon as the NGHP training is available you will be automatically notified; you may wish to do that but really would not be particularly

productive for you to go in and take the actual existing computer-based training.

Let's see. What I'm going - continue going through the list I have right now is it's just several items that have come up repeatedly in question so that we can make sure that everybody's on board at the same place. We continue to get questions about whether or not a particular type of insurance is included and it's more what - from our purposes is the sub category.

People will ask whether or not homeowner's insurance is involved. And we've covered that in the policy document that's in the interim record layout. Or they'll ask whether or not - why don't you have a particular sub category of insurance listed. And for our purposes - for liability insurance it's any type of liability insurance at all including self insurance.

If for instance it's medical malpractice, if it's - even if it's legal malpractice, if it's an issue that involves claiming and releasing medicals then we potentially have a recovery claim and Medicare should be secondary for any ongoing payments and we need to know about it.

The other major category besides Worker's Compensation is no fault insurance as we've defined in the interim document. We realize that the industry's definition does not quite match ours but the three major categories under our statute and regulations are liability, no fault and Worker's Compensation. And if it falls in that category unless it's one of the exceptions we list it in the interim document.

For instance if there's something that is clearly a property damage claim, you're in a car and there's people locked bumpers and it's purely a claim for car damage; it doesn't release any medicals or anything else then there's no

reason to report that to us. But you do need to - you need to go back if you haven't already done so and read the December 5 document in terms of what it talks about for triggering reporting, when you're obligated to report for these purposes.

Along the same line, people have asked about when I'm determining whether or not an individual is a beneficiary; how do I tell if someone is going to be a beneficiary within 30 months? That determination is irrelevant for the Section 111 reporting. People are mixing it up with a workload threshold that CMS uses for purposes of a process that it has for approving proposed worker's compensation set aside amounts. For our purposes we're looking at reporting when someone has already become entitled to Medicare.

Along the same lines, tied into recovery issues, we received several questions where people are saying now that this reporting takes place do we have to wait to disburse funds until we're contacted by Medicare or Medicare approves our settlement? That has not been a requirement in the past; it's not a requirement now. The fact that we have different entities that are responsible reporting entities for Section 111 doesn't change any of the preexisting obligations. There's no reason if you weren't waiting to disburse funds before that you should now be waiting to disburse funds.

Someone asked about how they were supposed to report on the first payment collected with a TPOC or Total Payment Obligation to the Claimant's date. And if people are having those questions they're misconstruing how we're asking you to report or when we're asking you to report. If there's ongoing responsibility you're not reporting an amount you're just reporting your ongoing responsibility.

The TPOC or Total Payment Obligation to Claimant date comes into play when there is a settlement, judgment or award that, again, I won't call it definitely a lump sum payment but it's where there's a single payment obligation established whether that's actually paid all at once or paid through a structure settlement or paid through an annuity you're reporting the total amount and we go into some detail, again, on the layout explaining how you calculate the amount.

People have looked at that and said, what do we do if it's a structured settlement for life and we don't know when they're going to die? We will address that in the manual. And if anyone has any comments on that and wants to let us know - what we're considering right now is saying that when it's a structured settlement for life that you have to report whatever is the minimum payout or what the payout would be based on the person's life expectancy, whichever is the higher amount. But we will address that in the user guide itself.

Let's see, we are still looking at the joint powers authority questions that we received at the last call so we will update you when we have information on that. We are still receiving questions that seem to tie this reporting into Medicaid. Despite what you may have heard or read from other sources for purposes of reporting to us on Section 111 this is limited to Medicare; we are not taking our accepting or requesting reporting having to do with Medicaid.

We are also still getting questions about whether or not you should report all settlements, judgment, awards or other payments regardless of Medicare entitlement. And again as I think I said earlier in this call you're only supposed to be reporting for people who are beneficiaries or if someone's deceased if they were a beneficiary at the time of the date of incident.

Okay, we received at least three questions asking essentially the same thing: they wanted to know whether or not they had to report if the situation - and all three questions tied it to worker's comp - do we have to report if we've accepted the payment obligation with an ongoing responsibility versus whether or not we've settled and we have an ongoing responsibility. And in either situation it must be reported.

Again, when you look at the statute and you look at the instructions we've given the responsibility for reporting in an ongoing situation is established because although there may not be a settlement, judgment or award there is the lynchpin at the end that says or other payments. So regardless of whether it's just accepted or finally settled if you have the ongoing responsibility you need to report them.

Could you hang on just a minute please? Just correcting me on my phrasing on a last statement in terms of reporting when someone is a beneficiary, I said beneficiary as of the date of incident; they pointed out I should have said a beneficiary at any time from the date of incident until the date of death. So if I didn't convey the right impression I've just corrected it for you.

We had some questions about, for instance, admitted insurance, surplus lines, etcetera. And people are asking whether - again, whether particular types of insurance are covered by the 111 reporting. If you believe a particular type of insurance is not covered you need to tell us that; you need to tell us why. And if we agree we'll look at an exception. But basically insurance is covered.

In terms of reporting on ongoing, as I said, I think, we're going to be looking at situations where - could you hold on a second again? Another issue related to ongoing situations as of 7/1/09, again, I believe I covered specifically annuities but if you have annuities, structured, settlements, etcetera that were

set up before 7/1/09 and that's a single payment obligation, you do not have to report those.

John Albert, who has joined or (Bill Decker), one of the issues that's come up - I'm not sure they have a final answer yet - but we received several questions that have to do with what do you do if there's a change in RRE; for example if the RRE is Insurer 1 and is bought out by Insurer 2; how do you handle that? And secondly if you have a situation where you need to make a change in agents, etcetera; can either of you address that?

John Albert: I mean in terms of responsibility for - I guess it depends on when - general question's regarding bought out, it sort of depends I guess basically on corporate law in terms of how that merger or acquisition is handled and what that new company takes on. That's something that kind of is beyond even the scope of this regarding, you know, old information, old obligations. But, I mean, generally there would be no need - assuming there's no need to provide updated information that record would still exist.

But obviously if, for example, contact information, things like that need to be updated we would ask you to update that information accordingly with CMS. Because again we're basing our contact with the RRE and other affected parties by, you know, by the information that we've collected previously. And if that information is no longer valid we would ask people to update that information.

Do you have a...

Man: It was just the general procedure if there's a change in agents, etcetera.

Man: If we have - in terms of the contact or EDI...

(Barbara Wright): Yeah, right at the current time the plan will be that if you need to change agent information that you provided during registration you can do that through your EDI rep. However, your account manager will always be able to, right from the beginning, be able to invite account designees and also remove account designees from their - who are associated with their account.

So if an agent is named as an account designee for the purposes of file transfer you will be able to then name a new person at the agent - the new agent facility to become that - to become an account designee and at the same time disassociate the original account designee from your account.

John Albert: I guess the bottom line is if there are any questions that you can't get answered then you should reach out to your designated EDI representative for assistance.

(Barbara Wright): Okay I have another issue for John. We have had several questions come in either making the assumption that they should report for everybody even if they're not - not a beneficiary or asking if they can report for everyone even if they're not a beneficiary. As I said all that we're requesting that you report is someone who is a Medicare beneficiary and that's actually what the statute specifies is that you should report for people who are beneficiaries.

John Albert: So you're talking about basically sending us everybody...

(Barbara Wright): Yes.

John Albert: No...

((Crosstalk))

John Albert: ...where there's been a settlement, judgment or award...

(Barbara Wright): Or other payments.

John Albert: Yeah, I mean, that's - I can't answer that right now because it's nothing that we've discussed internally in terms of what that does in terms of volumes etcetera.

(Barbara Wright): But keep in mind...

John Albert: We haven't gotten to that point in terms of (unintelligible).

(Barbara Wright): And we will be looking at that issue in terms of our internal compliance discussions for rules...

John Albert: That's a good lead in for the query file.

(Barbara Wright): But also keep in mind that if that were to be permitted or allowed you would have to have complete records with all of the data for every one you were submitting. So it would presumably mean significantly more development for all of your cases as opposed to those that you identify as beneficiaries. And as John said when we get to talking about the query function that will help you sort out why you may simply want to go through the query function to help you identify the beneficiaries.

John Albert: I personally can't imagine why anyone would want to build that many records, you know, and submit every one not knowing whether they are a beneficiary or not. Then again, as we'll get to, we are going to provide the ability for all the non GHP insurers on this call and everywhere else to

basically perform a query function which will weed out all the people that don't have Medicare so that will save a lot of development effort on your part.

This is the same basic tool that we offer to our Group Health Plan submitters today. Do you want me to just go into that a little bit now; is that...

(Barbara Wright): Why don't I finish this...

John Albert: Okay.

(Barbara Wright): ...before we go into the query thing.

John Albert: Okay, okay.

(Barbara Wright): We have had several questions that are approaching a single issue from different angles. People are saying when they submit that there will be a max of two records for each injured party. And, no, that's not a guarantee; that's not a limit. As we've said before this reporting each record that comes in will be insurer or worker's comp specific, it will be insurance type specific, for instance, someone could have a no fault and liability if they had med pay and liability provision under a policy.

It will be beneficiary specific; it will be policy specific; it will be claim specific. So you could have multiple records even more than two for the same individual. Along the same line we received comments that we could expect to receive multiple duplicative reports from multiple agents because RREs would have multiple agents.

And no we wouldn't expect duplicative reports; when you break it down by insurer specific, type and everything else you might have one agent that's

responsible for reporting on say the (PIP) or med pay part and another one that's responsible for reporting on the liability.

Or if something involved both worker's comp and liability you could even had records on that. But there should be no agent that's reporting exactly the same thing as another agent. And it's up to the RRE to make sure that their agents are not reporting duplicatively.

Let's see. John or (Bill), if you'd like to talk about the query function now.

John Albert: This is John Albert. Requests have been made, now obviously CMS understand the difficulty of, you know, trying to collect all this information, bring it together etcetera. And in the past there have been requests for assistance regarding this kind of function.

And CMS - the reason why CMS couldn't provide an answer right away is because we basically had to run some of these by our Privacy office and others within CMS who were concerned regarding the legality of releasing Medicare data to entities that didn't have the traditional ongoing relationship with an insurer such as you would in a Group Health Plan situation.

But basically CMS was granted approval to allow query access by all non-GHP RREs to essentially confirm or attempt to confirm Medicare entitlement based on an input file. This file process is identical to the one that we use for the GHP except that it doesn't provide as much detailed information on the response file.

But in a sense RREs will be allowed to send a query file on a monthly basis to CMS. And they need to provide the same basic identifying information that allows us to match to a Medicare entitled individual and that is (unintelligible)

number or (HICN) if you have it, which is the Medicare number, which again most people aren't going to have; name, date of birth and gender of the individual.

If we can match that information to a Medicare beneficiary we will pass back on the response file the Medicare health insurance claim number identifying that person as the beneficiary.

In addition where some of the matching criteria don't meet 100% we can actually correct information - this information comes straight from the Social Security Administration's database, which is the official federal record of every person who has a social security number in the United States. So if three of the four personal characteristics match with an SSN to a Medicare health insurance claim number we will correct that fourth item.

So for example you submit first initial of the first name, first six characters of the last name, date of birth and gender and you for some reason had the gender incorrect but everything else was correct we will pass you back the corrected date of birth. Again, that is the official federal record of that beneficiaries' date of birth, gender and name.

If there is any type of dispute related to that that is nothing that CMS can attempt to fix; that is between the beneficiary and the Social Security Administration exclusively. We only recognize the data we receive from the Social Security Administration. But again because we, you know, we recognize that you don't want to be doing unnecessary development we wanted to give you all this tool that will allow you to filter out only those individuals who you have to report as those being Medicare beneficiaries.

So we will pass you back the most current health insurance claim number that we have and ask that you submit that on a reporting record if you determine that that needs to be submitted; pretty straightforward. Because standard queries and responses fall into a standard HIPAA format - I'll refer to it as the 270 input and 271 response file, we will also provide software that will allow you to transmit the query file in the required HIPAA format; this is the industry-wide required format by the federal government.

That software has been in existence for quite some time and it's very easy to use. And again this is a very powerful tool that will allow you to basically attempt to filter out those individuals that do not have Medicare entitlement. The only thing to keep in mind is that again the query is only as good as the data going into it.

So if you don't have a lot of confidence in either the SSN or the, you know, multiples of the personal identifying information, again being name, date of birth and gender, you're never going to get a match because you're just not going to have enough information for us to confirm a match. So the SSN will still be a required element to be able to do this so we're not going to be able to provide you with an SSN; you will still have to get that. But again to confirm entitlement this process will allow you to do so.

That's all I have on that.

(Bill Decker): Okay, this will be in the user guide when it's released.

(Barbara Wright): And again keep in mind that when we don't match on something we're not saying that individual is not a beneficiary we're saying based on the information you submitted we cannot identify that individual as a beneficiary.

Before we go to the Q&A lineup we have about four technical type questions; let's see whether or not we can answer for you.

John Albert: And one thing too and that is while the non-GHP user guide is not out there if they do want more information about the query only process they can actually go and look at the GHP user guide, which has information about that. Just again keep in mind that you will not receive all of the Medicare data elements in that layout but in terms of descriptions of the process and how it works you can consult the GHP user guide for now.

(Barbara Wright): Okay, for the few technical question we're going to do before the call in. The first one had to do and (Bill)'s going to address that for us; it had to do with data errors.

(Bill Decker): Yeah the question basically is - we've got a suggestion that we should rate the data elements themselves by criticality. And our response to that is that in the file layout where we list the data elements we actually do say whether a particular data element is - we give an indication of a data element's criticality.

Do you have to have this particular element? Is this element a required element? Is this element a not so much required as secondary element or can it be safely not provided on a particular file layout. All that is given in the file layout itself so we wouldn't have a hierarchy of critical data elements available to you ahead of time, the hierarchy is actually in the file layout.

That was one question we had. The next one...

((Crosstalk))

(Bill Decker): ...it's question 152, John?

John Albert: (Unintelligible).

(Barbara Wright): Okay we may not have...

((Crosstalk))

(Barbara Wright): We have a couple more here.

(Bill Decker): We have this one here, 207, which is are the limits on the size of a company where Section 111 is required for non-GHPs? Limits on the size of a company...

(Barbara Wright): And right now there are no limits on the size of the company or the number of reports that you have to make per quarter or per year. So the question goes on to ask is there an easy way to address this; should a parent company - when it registers should it list all of its subsidiaries; should it just list some or what?

(Bill Decker): It should list the subsidiaries that are - that are logically - are going to be logically involved in its reporting responsibility to us.

(Barbara Wright): And if at a later date it was one that it had not listed, John or (Bill), can you confirm...

(Bill Decker): It could be added.

(Barbara Wright): That would - you would simply add that...

(Bill Decker): Sure.

(Barbara Wright): ...through your EDI rep.

((Crosstalk))

(Pat Ambrose): Actually your account manager will have the...

(Bill Decker): Right.

(Pat Ambrose): ...to maintain some of your account information online - (unintelligible) information, sure.

(Barbara Wright): Okay, the last one we have right now that was purely technical has to do with a request that we consider changes in the timeframe for correcting rejected records.

(Bill Decker): The individual or the company that sent this particular question in asks - suggest that the 45 day response time from the (GOBC) back to the RRE doesn't give the company enough time to actually correct any errors and get them back to (GOBC). I've had a great deal of experience with error reporting back to companies that send us data and a couple of things that I can mention right away is that we say it's 45 day turnaround time for a response on an error; often time, in fact most of the time it's considerably shorter than that.

The second thing is that there hasn't been any - this is essentially a non complaint item from all of the firms that have been doing data exchange with us over the last 10 years. If it becomes an issue in the future we'll certainly be monitoring it but I don't think that it's something that most RREs need to concern themselves about. The time you receive information from us about an error on a data submission will be relatively short and you will have adequate

time and almost all cases to respond adequately to the error; that's been our experience.

(Barbara Wright): Okay, operator?

Coordinator: Yes, sir.

(Barbara Wright): Could we start the questions and answers now?

Coordinator: Thank you. At this time if anyone would like to ask a question please press star 1 on your touchtone phone. You may withdraw your request by pressing star 2. Once again to ask a question at this time please press star 1 on your touchtone phone. The first question I show is from (William Thompson), you may ask your question and please state your affiliation.

(William Thompson), your line is open, sir please check your mute button.

(William Thompson): Hi, this is (William Thompson) from the Hartford. There's a recent article in the New York (Bar) Journal about a query function that's available to claimants on mymedicare.gov which will show a claimant the amount of the conditional payment. Would a feature like that be available to an RRE so that an RRE can independently verify what the conditional payment is?

(Barbara Wright): At this time that function is a sub-function of a page that belongs to individual beneficiaries. And so what's happening there is beneficiaries who have self identified when we determine an interim conditional payment amount they can actually see what claims we've associated with their record at that time. That is in no way a final amount. And the final amount doesn't necessarily get updated on that page.

So in short right now we don't have any plans to adapt that. In the first place we don't have any system to do it on.

John Albert: Not to say that that wouldn't happen in the future but right now that's not something that is under consideration just, you know...

(Bill Decker): And that certainly wouldn't be the process we would use...

John Albert: Right, it would be a totally different process. It wouldn't be through this process.

(Barbara Wright): I mean the only one who has access to a particular mymedicare.gov record is that beneficiary; the only way their attorney has access is if the beneficiary gave the attorney their password for that purpose. And the beneficiary then has the ability to go in and obtain a new password to take that ability away from the attorney so they can limit when it's being done.

(William Thompson): Okay, thank you.

Coordinator: Our next question comes from (Jennifer Lake); your line is open, please state your affiliation.

(Jennifer Lake): Hi, my name is (Jennifer Lake) and I'm with Wells Fargo Disability Management. And my question relates to the testing phase; we will be an agent for multiple self insured companies, will we be required to send a test file for each RRE?

(Barbara Wright): Yes you will.

(Jennifer Lake): Okay. And just quickly, when you mentioned the query function you stated that we had granted approval for the RRE but will the agent be able to submit files?

John Albert: On behalf of the RRE yes.

(Jennifer Lake): Okay.

John Albert: But the RRE is still ultimately responsible for the conditions of the use of that data.

(Barbara Wright): I mean, I believe the expectation is, and John can confirm, that when you sign up for the 111 reporting if you're using an agent for that submission it's your agent that can specifically do the query file. They are not granting dual access; they're not granting the RRE access for the query function and the agent access for file submission; it's one access.

(Jennifer Lake): Okay.

(Barbara Wright): So if the agent is submitting the file it's the one that would do the query access.

(Jennifer Lake): Okay. Thank you.

(Pat Ambrose): What I'm wondering is do we have...

Coordinator: Our next question comes from (Scott Huber), your line is open; please state your affiliation.

(Scott Huber): Yes, this is (Scott Huber) with Golden Lamb. I have a question regarding the document control number and how it's supposed to be used; is it unique to the claim for the life of the claim or is it just unique to the claim in that quarterly input file?

(Barbara Wright): It's just in that quarterly input file. The purpose is to make it easier for you and your EDI rep to match the input record on that particularly quarterly submission with the response record that the (GOBC) will return.

(Scott Huber): Okay.

(Barbara Wright): So very often a reporter might - a submitter might use some sort of date and just a record counter for their DCN.

(Scott Huber): Okay. That being said what is the unique identifier that CMS will be using to uniquely identify each of these claims for the life of the claim, like a RRE ID and a claim number or a policy number?

(Barbara Wright): Well it's a little more complicated than that. It is, yes by the RRE ID and also by the beneficiary so their health insurance claim number of pick number and then by the date of incident and the type of insurance...

(Bill Decker): Yeah, the DCN is only used for basically tracking submissions and responses of files; the record is the record that'll cover it, it's all that other information that's used to...

John Albert: Right.

(Bill Decker): ...determine, you know, to track that basically claim.

(Scott Huber): Is it fair to say the DCN is record-specific rather than claim-specific?

(Barbara Wright): Yeah.

(Bill Decker): Yeah.

(Scott Huber): Okay.

(Bill Decker): Yeah.

(Scott Huber): Okay. And one last thing, just a follow up to your comment about the Medicare query function; will the RRE ID be a required field in that input file...

(Barbara Wright): Yes.

(Scott Huber): ...so that we can differentiate?

(Barbara Wright): Yes.

(Scott Huber): Okay. Okay, thank you.

(Bill Decker): Operator.

Coordinator: Yes, our next question comes from (Jill Breard), your line is open.

(Jill Breard): Yes, (unintelligible)...

(Barbara Wright): Operator, we're unable to hear anything.

Coordinator: (Jill)? We'll go to the next question; (Doug Holmes), your line is open.

(Doug Holmes): Hi, (Doug Holmes) with UWC. I wanted to - I know we had a question before about how to handle undocumented aliens or aliens that might be covered under a worker's comp and what the duty is to report them if any. And I wondered if you had the date of birth, gender and name of an undocumented alien or someone there was a question about and submitted that, would you - would that prompt a review of whether or not there was an SSN for them? How should we handle undocumented aliens?

(Bill Decker): The answer generally is that an undocumented alien is undocumented and doesn't have a social security number under ordinary circumstances; if they had a social security number we would consider them to be documented.

(Doug Holmes): Okay.

(Bill Decker): As a consequence you don't have any documentation to send to us that would help us to identify whether the documented alien is a Medicare beneficiary. If an individual does not have an SSN we can't do a match if he doesn't - if he or she doesn't have an SSN and a (HICN) we can't do a match. If the individual doesn't have an SSN the individual won't have a (HICN).

(Doug Holmes): Well...

(Bill Decker): If the individual doesn't have an SSN the individual is undocumented.

(Doug Holmes): Okay - what - this is a follow up...

((Crosstalk))

(Bill Decker): That's as much as we can say on that subject.

(Doug Holmes): Okay so let's say that someone is a guest worker or has an alien number but it may not be an SSN what's the process if they become injured and there's some sort of a payment?

(Bill Decker): They have a guest worker number but not an SSN?

(Doug Holmes): Right. They have an A number but that's through INS but they may not have an SSN.

(Bill Decker): I don't believe that we match guest worker numbers or other sorts of identification - temporary identification for individuals. I don't believe the Social Security Administration matches that - takes that number and issues a Medicare ID number based on a number that is not a social security number.

How you handle payment reimbursement for individuals in that situation are not as a consequence or anything that I think the Medicare program has any control over. That's be a fair statement?

(Doug Holmes): Well, I mean, they may if they are in a guest worker status they may become citizens at a future point.

(Barbara Wright): But that goes back to your obligation to report; if they are a covered (life) for GHP at the time they become a citizen, have an SSN they would get reported for that. If they are someone that you have ongoing payment responsibility for and they become a Medicare beneficiary then that person needs to be reported when they become a Medicare beneficiary. And that would apply whether or not they start out as an undocumented alien or not.

So just as you will have some monitoring responsibility for people that you have ongoing payment responsibility for that would include undocumented aliens who might later also become beneficiaries.

(Doug Holmes): Okay just one...

(Bill Decker): We can't, I mean, you know, without the critical information we can't, you know, we can't find them on our system. I mean, that matching process that we have is pretty rigorous because we want to make sure that we truly are building records for Medicare beneficiaries...

(Doug Holmes): Yeah.

(Bill Decker): ...and without an SSN we're not going to be able to find them so don't send them to us until you can get that because, again, if they don't have it yet then there's no obligation anyway. But as (Barbara) pointed out once they - that obligation, you know, starts - is established then yes you would need to send that information to CMS where there's like these ongoing responsibility instances.

(Barbara Wright): But to give you further example again, if you had ongoing responsibility once - that's someone you should have been monitoring and once they became a beneficiary you would submit that. But if the same person was in a situation where you were only required to report the total payment obligation of the claimant that you didn't have ongoing responsibility we don't care if he becomes a beneficiary a month later; that's not someone you're going to report.

(Doug Holmes): Okay.

(Barbara Wright): Does that help?

(Doug Holmes): Well I guess it helps for now, I mean, yes. It's still sort of a - more of an operational administrative question but - if you have anything in writing on that that would be even more helpful.

(Bill Decker): We'll definitely provide information, you know, written documentation regarding this very question which will come up any time.

(Doug Holmes): Oh, I have one other question if I could - on a bankruptcy, this question about - you said something about corporate law if there was a successorship or one entity acquired another that corporate law would make the determination - I just want to be clear on that; if a company went bankrupt, went into debtor in possession or there was a series of successorships are you saying that the bankruptcy law or the law of the particular state that was involved in the successorship would determine who the RRE is?

(Barbara Wright): I think we haven't reached a final determination specifically on bankruptcy situations. If you're referring to what John said earlier today we were specifically talking about examples where there's for example a buyout or something...

John Albert: A merger...

(Barbara Wright): And he was saying that the contract that's controlling that buyout would have an impact. If there was a contract where they took over everything as it was that would be different from one where essentially everybody's coverage technically terminated and restarted the next day and so you'd have to look at that on a case by case basis.

(Doug Holmes): So we could put in our contract if we acquired something, we'd put in our contract that we are or are not the RRE; are we acquiring the responsibility...

(Barbara Wright): No, no. Once you've got responsibility for a covered life you've got the reporting responsibility if you qualify as an RRE under our rules.

(Doug Holmes): Okay so I...

(Barbara Wright): You can't by contract eliminate your responsibilities.

(Doug Holmes): Okay well that's - I was - it sounded like that's what you were saying and it didn't sound like that was - that's not what I expected. So what does that mean that you determine your - the reporting based on the applicable law - governing...

(Barbara Wright): It's really going to be who has the responsibility as of the settlement, judgment, award or other payment.

John Albert: And there's no one answer for these. You know, we're talking about bankruptcy, we're talking about mergers and - but I mean, you know, those processed can't be used just, you know, arbitrarily remove responsibility; those responsibilities remain and, you know, it's situational so we can't really answer that question...

(Doug Holmes): Okay.

John Albert: ...you know, directly in that sense so.

(Doug Holmes): Thanks.

Coordinator: Our next question comes from (Kevin Moriarty), your line is open.

(Kevin Moriarty): Thank you. I had a question about settlements in that - or reporting settlements; what's the position on confidentiality that a lot of settlements would have and I guess that would apply to both settlements that are after June 1, 2009 and ones that may be in effect as of June 1 - excuse me July 1 where there's an ongoing payment obligation?

(Barbara Wright): In effect for a Medicare beneficiary confidentiality to the extent you're talking about doesn't exist. We've mentioned it on some other calls. There are two regulations, 42 CFR 411.23 and 411.24, first of all the point 23 requires beneficiaries to cooperate for purposes of coordination of benefit efforts. And 411.24A deals with the release of information. And it says essentially by being a beneficiary and having had claims submitted on your behalf you have by virtue of that regulation granted any entity that has information necessary for coordination of benefits a release to give that information to us.

So in terms of like a liability settlement our routine posture, and this regulation covers, if you sign a confidentiality agreement that may be confidentiality as opposed to releasing it to the outside world in general but we're still entitled to that information.

(Kevin Moriarty): Okay, thank you.

Coordinator: Our next question comes from (John Karp), your line is open.

(John Karp): Thank you. This is (John Karp) with (Pemco) Insurance out in Washington state. We're a small property and casualty company that operates in just one state that's been relatively free of regulation and virtually totally free of

federal regulation. And this situation is representing a lot of new challenges for us.

And I'm wondering if you could point me towards some resources that would be useful for smaller companies like us or if you're going to post say a resource page of agents that have experience dealing with these kinds of data interfaces with the federal government?

And also I guess would you be posting a place where smaller companies like ours or that are similarly situated could find each other and pool our resources or create user groups? A lot of compound questions there but we need help.

(Barbara Wright): Can you hang on a second? We're back and what we've said in past calls and I think we have to stand behind that is we really can't get involved in the contractual relationship for agents so we cannot make recommendations in terms of agents; who's good, who's bad, who we've dealt with, what we know about them. And this process is new for - except for people that may have had existing voluntary data sharing arrangements.

What we would recommend smaller entities do is they might want to consider trade associations in their area, contacting them, see whether or not they have anybody that they can recommend. We know that there are various entities out there that are positioning themselves to be agents.

What we would say is in terms of what people have or haven't done the only data sharing that we've had in terms of voluntary agreements was specially with GHP to the extent anyone has quote been supplying us with data they haven't been supplying us - other than these voluntary agreements - they have not been supplying us with data under this process.

So that's just everybody should be aware of that. And I realize that doesn't get you quite where you want to go...

(John Karp): Right.

(Barbara Wright): ...as far as any type of putting entities in touch with each other I would assume - or we would hope that trade organizations etcetera in addition to possibly a recommendation different trade organizations would be the entities that could facilitate communication between like entities.

(John Karp): Yeah, we're not seeing that yet. But apart from recommending people positioning or companies positioning themselves to be agents couldn't you provide a page where those that were - were positioning - without recommending - just those companies that are doing this work where they could post a reference so we could contact them?

(Barbara Wright): CMS can't do that because it would - it would be a tacit endorsement of a particular entity. I mean, we have no way of knowing - we are not in a position to vet or to determine whether or not someone can even remotely do what they're advertising. And so we are simply staying out of that process completely.

John Albert: I mean I can tell you that, you know, again all of the major trade organizations, you know, are aware of this legislation and we've actually - early in the process we had - held listening sessions with, you know, large trade groups and things like that just to get their initial feedback on this process. So I mean there's, I mean, you know, there's plenty of - there should be plenty of information out there.

But again I would go through your trade organizations and associations and your state wide organizations, your state insurance commissioner for example. Other resources are available to you I'm sure are out there and other resources I'm sure after this call are going to make themselves known to you.

(Bill Decker): Yeah.

(John Karp): I hope so. Thank you.

John Albert: State who you're with again and everyone on the phone can listen.

(John Karp): Yeah, well, this is (John Karp) with (Pemco) Insurance in Seattle. Can I give my phone number?

(Barbara Wright): Fine with us.

(John Karp): Two zero six, six two eight, seven nine four nine.

John Albert: I'm sure there's a lot of pens out there scribing as we - as you said that.

(John Karp): Terrific. Thank you.

(Barbara Wright): Before we go to another question we want to clarify what I said before in terms of whether or not the entity that physically submits the files must be the same one that does the query file. It has to do with the access.

(Pat Ambrose): When you register and set up your account on the COB secure Web site for Section 111 you will indicate your file transmission method for each file you plan to exchange. So for the liability worker's comp and no fault reporting there's the claim input file and then there's the query file. You can actually set

up two different transmission methods for those two files. For example you might want to transmit the claim file using (Connect Direct) over the AG&S network, the AT&T Global Services Network and then transmit your query via secure FTP and that will be possible.

Or you may decide that you want to transmit all your files by secure FTP or up and download using HTTPS, using an active user session on the Web site. Regardless of that all your - your account manager and all your account designees, users of the Web site, will have the ability to up and download files; it's up to the account manager and of course the RRE to manage this process. So if you select the HTTPS file up and download process all users would be able to perform that function. There'll be more information about the actual mailboxes and this process that goes on.

Likewise if you select secure FTP on the COB secure Web site all users will have the ability to up and download files accordingly. If you're using (Connect Direct) over (Agnes) that obviously is a file exchange over (Agnes) that goes to a specific account so you can have - you can only exchange files between two physical locations so that's kind of the limitation there. However you could use one (Agnes) account for the query and another (Agnes) account for the claim input file exchange.

So in theory an RRE could perform all these function themselves, the exchange of both files, or they could have two different agents under one RRE ID who are transmitting files back and forth for them. This will be detailed in the upcoming user guide.

John Albert: Okay Operator, thanks.

Coordinator: (Katherine Segal), your line is open.

(Katherine Segal): Hi this is (Katherine Segal) with Lumberman's Underwriting. We have a couple questions; one is on the product liability. As a worker's compensation carrier there may be the possibility of a product liability, however, are we required to report yes before any litigation has determined that there is definitely product liability and an amount recoverable?

(Barbara Wright): If the claim involves a product liability claim then we need to know that. I mean, it's not whether or not there's been a judicial determination or a settlement. If - let's give it two different situations of worker's comp. If it's worker's compensation and you're reporting ongoing responsibility and it's an asbestos related claim then you should be reporting the product liability fields.

If it's one where there's the total payment obligation of the claimant that that's all you're reporting then by virtue of having had a settlement involving that claim or having had a judgment you reported at that time. So it's not really any different than liability; you don't report - reporting is not dependant on a judicial finding, it depends whether you're dealing with ongoing or the so called (TPOC) or Total Payment Obligation to the Claimant.

Does that answer or are you asking something slightly different?

(Katherine Segal): Well let's just say like a machinery and later it turns out that it's not the machinery that malfunctioned you would then - can you then come back later and report now?

(Barbara Wright): I think when we're talking about the mass tortes we will be looking at some of the issues in terms of product liability. If you want to detail your question a little bit more about where you'd like to see the difference (slide) in we'd appreciate an email to our...

((Crosstalk))

(Katherine Segal): All right, I'll email that in. We'll detail it even further. Thank you.

(Barbara Wright): Okay.

(Katherine Segal): And just one other one; as a work comp claim office we have both internal and external claims handlers. When we report the tax ID number and the office code site ID for the claims handlers do we have to report both the internal and external tax ID or just the one for the carrier?

John Albert: (Unintelligible) to go.

(Barbara Wright): Could you hang on for just a minute? Okay we're back. If you've got a situation involving worker's comp, liability, no fault CMS's standard procedure is to pursue recovery from the beneficiaries when there's been a settlement, judgment or award with the beneficiary. And all that's involved is that single payment obligation whether it's done through structured settlements or otherwise.

When there's a situation where there's been ongoing responsibility particularly if there is no settlement those are the instances where we may be pursuing recovery directly from the insurer. And basically in terms of address if the address we have is the one off that record then that's where demands that go to the insurer or the worker's comp carrier would go. So that's what we would use that address for and whichever one you give us.

(Katherine Segal): So then since we as Lumbermen's Underwriting Alliance are the carrier regardless of where the claim is handled that's what tax ID number you'd like to see reported?

(Barbara Wright): If that's where your processes would best be served by having the demand go to that point if we need to do any type of demand then yes.

(Katherine Segal): Okay, thank you very much.

Coordinator: (Tom Kennedy), your may ask your question.

(Tom Kennedy): Hi this is (Tom Kennedy) with (ACE), I have a couple of questions so bear with me; I'll try to keep them general because I think they impact more than just us. One is around the eligibility process; the biggest problem we have right now is trying to expect or determine what kind of volume we're going to have once we send the file to you and you come back tagging (E) claimants as eligible or not eligible. Is there any thought to allowing companies to send a file before we start getting into the production mode so we can kind of determine what our current population is of Medicare beneficiaries because that drives our staffing and our reject process and...

(Barbara Wright): I think we'll have to get back to you on that because we're still looking at the final language on our data use agreements and privacy agreements.

(Tom Kennedy): Okay.

(Barbara Wright): But we will take your comment under consideration.

(Tom Kennedy): Okay. The other with that - with eligibility is did you say - I'm a little confused there - once we send somebody in that file, say we send it in

September of whatever year; it comes back as - that person comes back as not eligible. Do we have to keep sending them or we're okay; we're off the hook?

(Barbara Wright): Again that goes back to whether it's a situation where you've got ongoing responsibility or it's the single payment obligation. If you've got ongoing responsibility as we indicated in the December 5 interim document those have to be monitored in some form so that you can report to us when they become Medicare beneficiaries. But if the only thing that ever existed was the single payment obligation, again, whether it was done through structured settlement or otherwise if they're not a beneficiary as of the date of that settlement then you don't ever need to report them.

(Tom Kennedy): Okay but...

John Albert: We would expect people to use the query files to make that determination...

(Tom Kennedy): You do or you don't?

John Albert: ...first - first just because it would be easier and that's a, you know, rather than having to build a complete reporting record, I mean, you can do that if you want and that's how a lot our GHP people do it but, you know, you kind of have that option but basically if they haven't attained Medicare entitlement the first time you send them and there's still ongoing responsibility you do need to monitor for Medicare entitlement whether it's by sending a complete record as an add or just querying every month until, you know, such time they become Medicare entitled then you would send a production record...

(Tom Kennedy): Yeah, we were going to keep - we were going to keep querying every month.

John Albert: Yeah.

(Tom Kennedy): Okay. The other question I have involves the 7/1 date and what you send in the first - when we go live between October and December of this year. What does that 7/1 date represent? Can we consider that to be cases or claims that we've opened from 7/1 forward or is that everything we have open as of 7/1 or what do I make of that date?

(Barbara Wright): Okay, again I believe this is addressed in the 12/5 document. But...

(Tom Kennedy): It's in there but it's not really clear to be honest with you.

(Barbara Wright): Okay.

(Tom Kennedy): It's not in worker's comp terminology.

(Barbara Wright): Okay. And if you want to send us a further note on that page in detail fine but the general answer is it's not driven by the date the claim is filed, it's driven by when the action on the claim takes place. If you've accepted ongoing responsibility prior to 7/1/09 and it still exists as of 7/1/09 you have to report that. If it's one...

(Tom Kennedy): Okay.

(Barbara Wright): If it's one that has a single payment obligation, the total payment obligation to the claimant then if that settlement, judgment or award or their payment took place prior to 7/1/09 you don't need to report it. If it was 7/01/09 or later you have to report it regardless of when the case or claim was actually filed or opened.

(Tom Kennedy): Okay so to me it's everything open as of 7/1/09. And if it's closed then - there's a medical payment after 7/1/09 we would have to send it in.

(Barbara Wright): As I said earlier on this call we're looking at how far back people need to go in situations where you technically under the law have ongoing responsibility but under your current existing procedures have already quote closed it.

(Tom Kennedy): Okay. And then last question tied in with that is this grace period, this one year grace period for the information before 7/1/09 I'm a little confused, are we supposed to determine eligibility in that first file that send for that and the new have a year to clean it up or you don't want to know about it...

(Barbara Wright): No this is the idea, the ones where you have ongoing responsibility but that was established prior to 7/1/09...

(Tom Kennedy): Yeah.

(Barbara Wright): ...we're giving you a year to do your initial reporting for those people. But let's say you had ongoing responsibility as of 7/1/09 and it terminated June 1 of '09 that doesn't mean you don't have to report them by the end of that year; you'd still have to report the responsibility through - from it's start date through June '09 when you eventually reported it. That grace period is really to allow you to go back and do your file checking for the ones where you've had the responsibility for some time.

(Tom Kennedy): But the eligibility is done in the fourth quarter of this year for that stuff, right or now? That's where I'm a little confused.

(Barbara Wright): Okay, remind us again what's the date we said you had to supply it by?

(Tom Kennedy): Supply...

((Crosstalk))

(Bill Decker): They have to do the first report the last quarter of the calendar year.

(Tom Kennedy): It was the third quarter of 2010 I thought.

(Barbara Wright): Yeah and I'm trying to look in the file layout when we said you had to submit that information.

(Pat Ambrose): Third calendar quarter July through October 2010.

(Tom Kennedy): Okay.

(Barbara Wright): What field is it?

(Pat Ambrose): I mean it's a matter of going back and it's just the issue of you have ongoing responsibility, the claim is open as of 7/1/09, the date of incident...

(Barbara Wright): Right.

(Pat Ambrose): ...and the claim opening happened prior to that and you're basically giving them until their third quarter 2010, July through October of 2010 to obtain the (SFN) and determine whether that individual is a Medicare beneficiary or not and...

((Crosstalk))

(Barbara Wright): Right, did everyone - could everyone hear that or not?

(Tom Kennedy): Not fully.

(Barbara Wright): Okay well we'll have that repeated louder.

(Pat Ambrose): Okay, we're - ongoing responsibility for medical was assumed prior to July 1k, 2009 and it continues as of July 1, 2009. In other words the claim - if it's worker's comp the claim is still open for ongoing responsibility for medicals as of July 1, 2009 and it occurred or opened prior to that you're - CMS is permitting RREs to delay reporting for these individuals until the RRE is (assigned submission) in the third calendar quarter, which is July through October, of 2010.

So this extension is intended to allow RREs time to go back and determine the Medicare status of individuals of the injured parties on those claims. Basically allow you time to go back, determine their status and obtain their SSNs for individuals for whom there's a preexisting ongoing payment responsibility which continues as of July 1, 2009.

(Tom Kennedy): Okay.

(Barbara Wright): If you look in the document that was issued on December 5 in the section What Triggers Reporting - three, four - it's the fourth major bullet, the second sub paragraph under that contains the information that (Pat) was reading.

(Tom Kennedy): Page number?

(Barbara Wright): It's the page - page number 11 in the copy that I'm printing out.

(Pat Ambrose): It's important also to note that we're only talking about claims with ongoing responsibility for medical that are subject to further payment as of 7/1/09.

(Tom Kennedy): Okay.

(Pat Ambrose): And again you have until the third quarter 2010 to obtain the information on those individuals, determine whether they're a Medicare beneficiary, get their SSNs and all the other required information and report that claim record.

(Tom Kennedy): Okay.

(Barbara Wright): And I believe I may have inadvertently used the year 2009 in a comment a few minutes ago. Do go by the dates (Pat) just read you from the 12/5 document.

(Tom Kennedy): Okay. And the when will the applied error code listing be done, is that part of the user guide or is there going to be something released before that?

(Pat Ambrose): I'm sorry, could you repeat that?

(Tom Kennedy): The basically the reject error code definitions, when will they be released?

(Pat Ambrose): Yes those are coming out - those will be defined in the liability worker's comp, no fault user guide that's coming out in February.

(Tom Kennedy): Okay.

(Pat Ambrose): There'll be disposition codes provided back on each response record and if the record is in error specific error codes telling you what the error in question was.

(Tom Kennedy): Thanks.

Coordinator: Thank you, (Yvette Lynch), your line is open.

(Yvette Lynch): Hi my name is (Yvette Lynch) and I'm with (Brown & Brown) Insurance. Our question is if a third party is acting as an agent for multiple RREs assuming that the RREs that we are submitting for have completed their - did their registration can we somehow get on a cycle for all of those RREs that we can test and then during the production submit at the same time?

(Pat Ambrose): When it comes to test files you can submit those, there's no assigned timeframe for submitting your test files. Basically once the RRE has signed and returned the profile report the agent can start sending in test files. Those test files go to different locations by RRE and each RRE is assigned a file submission timeframe and the agent has to adhere to the specific file submission timeframe for each RRE.

So in other words no you can't change the submission timeframe for the RREs so that you can send everybody at one time.

(Yvette Lynch): So there's no way that we could - there's no way we can coordinate that at all even during - even during that registration and the time that they're assigning the submission period?

(Pat Ambrose): No not at this time.

(Yvette Lynch): Okay.

(Pat Ambrose): You'll basically have to program your internal system to know when to report for each RRE.

(Yvette Lynch): Okay.

John Albert: We're not saying that that won't happen in the future but right now because it becomes a workload planning issue on our end that, you know, depending on how many entities are out there and when they want to submit we don't know if we'd ever be able to please everybody. So for now we're doing it by RRE.

(Yvette Lynch): Okay.

John Albert: Okay?

(Yvette Lynch): All right. Thank you very much.

John Albert: Sure.

Coordinator: (Mark Steckbeck), your line is open.

(Mark Steckbeck): Thank you. My name is (Mark Steckbeck); I'm with the National Conference of Insurance Guarantee Funds. Very briefly guarantee funds are statutory entities that are responsible for paying certain policy claims of insolvent insurers. And as an RRE a guarantee fund will normally work with (C) files that are given them by the insolvent insurer and they generally have no way to compel a claimant to provide their social security numbers should they fail or refuse to provide that information.

My question is this: Will CMS establish a Safe Harbor defining what efforts it will accept as evidence of a reasonable effort to obtain social security numbers from claimants who fail or refuse to provide it?

(Barbara Wright): As we've said in past calls, that is one of the issues that we're looking at and we're looking at a potential model form. We haven't reached any final conclusion on it at this point.

(Mark Steckbeck): Do you think...

John Albert: We're definitely very aware of the issue and, you know, want to do what we can to provide that assistance but we haven't made a final decision in terms of how that process would work if, you know...

(Mark Steckbeck): Okay. Thank you.

John Albert: ...aware of that issue and understand that.

(Barbara Wright): And we understand what you're asking and I believe others have asked too is can there be a Safe Harbor if a defined level of effort is met, correct?

(Mark Steckbeck): Yes.

John Albert: Okay.

Coordinator: Were you ready for the next question?

(Barbara Wright): Yes please.

Coordinator: Great, thank you. (Susan Cornbluth), your line is open.

((Crosstalk))

(Susan Cornbluth): This is (Frank).

(Frank Sarroway): Hi, this is (Frank Sarroway), I'm from New York State Insurance Fund; we're a worker's compensation carrier. Actually several of our questions were already answered but we still have I guess one or two we can ask. When the process starts and there is a match how far back is Medicare going to go as far as looking for treatment dates that may be related to a worker's compensation claim?

(Barbara Wright): Medicare recovery claim is driven by the date of incident which is one of the reasons we've explained on numerous other calls why we have to have the date of incident as defined by CMS reported. We agree - our understanding with the industry is that the date of incident we use will typically be the same as what worker's compensation uses if it's like a car wreck or an accident or a trip or whatever.

But where there will be a difference in many states and some federal programs is where the incident involves like exposure, for example. We understand that under some federal law and I'm not sure about different state laws, that the date that's used as date of incidence by those entities is the date for example of last exposure because a responsibility is essentially assigned to the last employer.

But for CMS's purposes we have to have date of incident as defined in the 12/5/09 document, which relates to for exposure it's date of first exposure, for ingestion it's date of first ingestion, for implants it's when the implant actually took place.

(Frank Sarroway): Okay so in other words if we were to report to you say in 1990 - an incident in 1995 the incident date you would look back to 1995 to see if there was any treatment that Medicare felt may be related to that worker's compensation claim?

(Barbara Wright): What I'm saying is technically we're allowed to but certainly we take into account certain operational considerations when we're doing our recovery process.

(Frank Sarroway): Okay.

(Barbara Wright): So I mean I can't give you a flat assurance we're not going to go back to a certain date and certainly worker's comp is slightly different also than liability since in certainly liability situations no one even determines that they're going to file suit until 10 years later or something. Liability claims routinely go all the way back.

(Frank Sarroway): Okay. And the second question was more of a general question just as far as I know as a worker's compensation carrier, you know, I think we all - we want to be billed by the provider when the treatment occurs so we don't have to deal with the, you know, reimbursement situations. And I just wanted to know what is Medicare doing when you find that you have like particular providers that are billing Medicare, that - when they should be billing the worker's compensation carrier, you know, because it's related to a worker's compensation claim?

(Barbara Wright): The point is that's why we need this better information on ongoing records that we don't believe we've had in the past because if we have this in what's called our common working file our expectations, hope - is that we will be

able to deny payments when such claims then - until we have proof that it has, you know, that it's one that doesn't fit within the worker's compensation claim, which would essentially force providers, physicians and other suppliers to bill the worker's compensation carrier.

John Albert: So if we have an MSP record on our file in most cases we will not accept a bill from a provider for primary payment; we will reject that claim. So that's the whole point of this whole data exchange is so that everybody pays it right the first time, so.

(Frank Sarroway): Right but I think in some way shape or form I think even that - I mean obviously, you know, it's going to take carriers time to determine that a claimant is Medicare so there's going to be that time lag and, you know, I think - I guess the problem as a carrier we have because we have the same thing with the health insurers that nobody's involving the medical provider in this process or kind of like twisting their arm to make sure that they bill the proper party.

John Albert: Well again it won't matter because if we have an MSP record the provider will not be able to bill Medicare for primary payment so...

(Frank Sarroway): Right, okay.

John Albert: I mean, you know, initially when, you know, this will surely mirror the GHP process that initially when these data exchanges start flowing there's a lot of like retroactive correction of mistaken payments, things like that. But once reporting is up and running for a while essentially all of the parties involved should have fairly accurate and up to date coverage information on each other's files and therefore that'll facilitate proper billing to begin with, which

again the overall stated goal of this process is so that everybody pays right the first time because recovery is expensive for all involved.

(Frank Sarroway): Okay thanks.

Coordinator: (Rebecca Justice), your line is open.

John Albert: (Unintelligible).

(Rebecca Justice): Yes I've just got a couple questions in regards to the query process. When will that query process - the function be available?

(Barbara Wright): You'll be able to start testing it after July 1, 2009. The non-GHP or the liability, no fault, worker's compensation RREs will register for Section 111 reporting between - or starting May 1, 2009 ending June 30, 2009 and as long as you've returned your signed profile report you can start testing the query process as of July 1.

(Rebecca Justice): So the new can use our production data once we've registered to determine if our claimants are a Medicare beneficiary?

(Barbara Wright): Yes.

(Rebecca Justice): Okay.

(Barbara Wright): Now the test files are limited to 100 records so just so you know that. And, you know, there's other limitations; the testing process will be defined in the user guide but, you know, you won't be able to send in an unlimited number of test queries.

(Rebecca Justice): And that was my next question; in the user - in the interim user guide it basically says that it's 200 per month so how does that work when we have subsidiaries registered under an umbrella is that...

(Barbara Wright): I think the 200 per month you might have gotten out of the GHP user guide and there's an online query process called (Basis) that is not actually being made available to non-GHP RREs; you will have only the (X-12 270/271) transaction set that file exchange for queries. And there's no limit per - you can only send one file per month but there's no limit on the production file size.

(Rebecca Justice): Okay so the 100 limit is for testing?

(Barbara Wright): Yes ma'am.

(Rebecca Justice): Okay so we can send one file per month but there's no limit in that one file that we send?

(Barbara Wright): That's correct.

(Rebecca Justice): Will there be a timeframe that's designated to us that we can send that file or will...

(Barbara Wright): No actually any time during the calendar month is completely fine.

(Rebecca Justice): Okay but once we've sent it that's all we can send for the month?

(Barbara Wright): Yes.

(Rebecca Justice): Okay, would that be all of our questions? The one other question that I had in regards to that; is there a charge for that service?

(Bill Decker): Nope.

(Rebecca Justice): Okay.

(Barbara Wright): And also know that being able to send it monthly should put you safely within reporting guidelines because remember there's a 45 day window in terms of when something has to be submitted if you're within 45 days of the end of a particular quarter - quarter submission then you have until the next submission to include that record. So you should always be able to do the query within a timeframe that would allow you to report timely.

(Rebecca Justice): Oh so it's 45 days prior. We do have one more question and that's in regards to the errors that are sent back to us, so for instance if we send a file that doesn't contain all of the data it needs to contain or maybe contains the incorrect data are there penalties or fines that would then be charged back to us if the data is incorrect or do we simply have until the next quarter - next quarterly report to correct the data?

John Albert: One of the things we're looking at in terms of compliance is that we definitely want to discourage people dumping junk data on us. You know, but at the same time if you do send a record that errors out, you know, because of a format or whatever, missing data, whatever, I mean, we would expect you to correct that data on your next submission.

But there's no, I mean, and again people keep bringing this up and again I'll just say it, you know, as best I can is that at this point in time CMS is much

more interested in getting good quality data than it is, you know, assessing any CMPs.

So, you know, again if - we probably will set some standards regarding overall quality of data. I mean, if we're getting just basically files that have nothing but junk on them that - that would most likely put someone at risk for non compliance but at the same time we also recognize that things happen and we do allow you that extra quarter to correct that record that didn't pass through the first .

(Barbara Wright): And again for issues where there's considerations like having to go back and check your prior records, the ongoing prior to 7/1/09, we're trying to build in an extension for certain types of issues.

(Bill Decker): And finally remember that you're not operating in a vacuum here; any time you send data into our contractor you'll be - you will have access to a human being at the contractor's site who can help you with any issues you're having. That human being is called the EDI representative and you'll be assigned your own real live human being to talk to on - whenever you do have issues that come up with your data submission whether it's an input file or correction file.

(Rebecca Justice): Will we have an online site that we could check any errors or it's just simply through that EDI representative?

(Barbara Wright): Well the user guide will detail what the errors are and essentially provide information on what would need to be corrected. The online - the Section 111 application on the COB secure Web site will have a - online documentation mostly related to use of that. And it'll give information on statistics related to your file processing like how many records were in error and so on. But it's

really the response file and then the user guide that defines the data elements in the response file that you would use to figure out - figure it out.

(Rebecca Justice): Okay. And I'm sorry, we have one more question and that would be it.

(Barbara Wright): Okay.

(Rebecca Justice): On the claims where we have ongoing payment issues that we had done the research initially and Medicare had come back and said that the person was not eligible how long or how often should we then go back to see if the person has become Medicare eligible? And the other issue is - the release forms that they currently sign are good for a year so we would then have to continue to get a new release each year?

(Barbara Wright): You don't need a release form to submit that social security number to us.

(Rebecca Justice): We don't need a release?

(Barbara Wright): I mean once you've got the social security number you can continue to do the query function on it. And as John was saying earlier our expectation is you would probably be building a file of ones that you have ongoing responsibility for and just querying them once a month so that you would catch anyone who had become a beneficiary.

(Rebecca Justice): Thanks. Okay. Thank you.

(Barbara Wright): Operator, since we're coming in on 3:00 we'd like to end the call but then we would like to speak with you briefly.

Coordinator: Sure it'll just be a moment. This does conclude the conference call, you may disconnect at this time. Please hold Mr. (Decker).

END