FTS-HHS HCFA

Moderator: John Albert
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12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the question and answer session, you may press star 1 on your touchtone phone.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. I'll turn the meeting over to your host for today's conference, Mr. Bill Decker. Sir, you may begin.

Bill Decker: All right, thank you very much. My name is Bill Decker and I'm with CMS in Baltimore, Maryland. I'm here with a couple of other folks who are also going to be participating on this call. One of them is Barbara Wright, who will be leading most of the discussion this afternoon. Assisting both Barbara and me is Ms. Pat Ambrose, who will also be chipping in from time to time with questions and some answers.

We also have a couple of other experts in the room who are available for those questions that are - that we would like to have them involved in.

I would remind the audience this afternoon that this is an MMSEA Section 111 MSP Mandatory Reporting Teleconference Call. This call today concerns itself with liability insurance, workers compensation and no-fault insurance only. It does not concern itself with group health plan coverage. We will have a call in fact tomorrow for all the GHP folks who might be on this call.

But this would be a good time for anybody who is not either a liability, workman's comp or no-fault and that will be impacted by Section 111 to get off the call because it's actually not direct to you.

So with that, I would say this. If you have a copy of any of the materials that are up on our Web site and available for you to be - to using in reference, please have them handy. It's useful for us if you can direct your questions to specific documents if they are related to specific documents.

And I think that first - the first order of business for us this afternoon will be Barbara who will - Barbara Wright who will be discussing for you for about half an hour or 45 minutes or so a variety of issues that have come up based on the questions that you have sent to us over time.

And once again, we say to you, please send us your questions. We do read every single one of them and we try to answer as many of them as we can in calls like that or calls like this or with the new documents that we will put up on the Web site.

So with that, (unintelligible) preliminaries are all over and I'll turn this call over to Barbara Wright. Barbara?

Barbara Wright: Hi, good afternoon. I realize that many of you were probably on the call last week. So I don't want to go over exactly the same points in the same depth but I will reiterate a few of them.

We are still working on Department of Labor issues. In fact, we have a meeting set up with the Department of Labor tomorrow. We are working on mass tort issues, we are working on joint power authority issues. The User Guide for NGHP is in process and we hope to have it out some time in February.

Let's see - these other main ones. The last time on the call, we briefly went over the query functions which although it's not yet on the Web site other than to reference it in one of the agendas, we are providing a query function for NGHP, we will briefly go over the mechanics of that today, it is available.

In the GHP User Guide, the submission process is the same, the information as returned I believe is slightly different. But we will go over that and it will be included in the NGHP User Guide when that's updated.

We've also had a number of questions for situations where Entity A is the responsible reporting entity. They want to use Entity B as their agent but Entity B for whatever reason wants to have Entity C do the physical submission. And Pat Ambrose will briefly go over how this will be done. There is a way to set it up in our system for this to be accomplished.

Those were the major areas where we've got ongoing work. And if we get questions or something as I'm going, we will certainly let you know. I think the first thing real quick, just to get it out of the way is Pat, you want to go over the query function real quick?

Pat Ambrose: Sure. The query function will be made available to Section 111, liability, no-fault, workers comp responsible reporting entities. It will be done in the form of a file exchange, an input file that the RRE or that their agent will submit and a response file that will be transmitted back in the same manner to the RRE or its agent giving you results of the query process.

The file transfer is in the form of the ANCX12 270271 transaction set. However, the COBC will provide software called the HIPAA eligibility wrappers software that will take simple flat files, formatted files as input. You would take this HIPAA eligibility wrapper software or the HEW - HEW software, install it on your system, provide it a flat file input. It would then sit out the X12 format for transmission.

Likewise, it will take the response - the 271 response - back from the COBC and translate it into a flat file format that would be easier for you to use. So you may either use your own X12 translator and your EDI rep will provide you with the mapping information necessary or you may request a copy of the HUE software and that is available in a mainframe or a PC server-based version.

Bill Decker: Is there any cost to that to...

Pat Ambrose: No, there is no cost to that HEW software. So as I said, you will - any - you may want to use this software as a query process in order to determine whether someone, an injured party for which you have a claim from is entitled to Medicare. It's a simple process where you do need to provide the SSN on the input query records and the COBC will - and other criteria about that injured party - their name, date of birth, gender. And the COBC will match up that information.

If it does match to a Medicare beneficiary, it will pass a disposition code indicating that or a disposition code indicating that the information that you supplied could not be matched to a Medicare beneficiary.

No reason for entitlement or dates of entitlement will actually be provided due to privacy concerns. You may submit a query file on as frequent as a monthly basis. It is submitted by your RRE ID and I think that's pretty much all. And if you have further questions about that, you can ask them when we open it up to questions.

In addition, of course, this process and the file formats will be thoroughly documented in the User Guide that Barbara mentioned. In the meantime, you could refer to the query only file in the GHP User Guide for Section 111 since that is using essentially the same process.

The only difference is on your response file, you will not receive back the reason for entitlement and those dates about the individuals Medicare entitlement and involvement.

Barbara Wright: Thank you, Pat. One of the other issues that is coming up again in questions we've received since the call last week is how to deal with situations again where we have an agent versus another entity that the RRE - I'm sorry - an agent versus another entity that the agent would use for actual physical submission of a file.

I was just flipping through the questions from this week and we have at least three or four this week even though we answered that on the last call. So I'm going to ask Pat to go over than next.

Pat Ambrose: Okay. What I have to do first is back up and talk a little bit about how you will register for Section 111 and set up your account for reporting purposes. You will register on the COBC secure Web site. The COBC is creating a new Section 111 application for this purpose. Registration for liability, workers comp and no-fault RREs begins May 1, 2009.

Prior to registering, you have to decide how you're going to submit your files. That will dictate how many accounts you need to set up. And these accounts are key buyers or each account is set - is assigned a responsible reporting entity ID or an RRE ID.

You're only allowed to submit one claim file per quarter. Therefore, if you need to submit two claim files because you have two different systems that process - one processes your auto claims and another processes your work comp claims and you're not going to roll up all those claims into one file, you may register twice and obtain two RRE IDs.

In a similar situation, you might have one agent who process a certain set of claims for you and another agent that processes a certain set of claims. If those agents will be submitting directly to the COBC on your behalf - and again, because of the limitation of one claim filed per quarter - you'll have to set up two RRE IDs, one for each agent submission.

But those are just some examples. You might also decide that you want to send multiple files per quarter due to the organization of your subsidiary. So there's also been the flexibility for you to roll up all those files together and submit one file.

So after you've decided how many RRE IDs you need or how many Section 111 accounts, you will determine who will be your authorized representative

for each of those accounts. You authorized representative is a person employed by the responsible reporting entity who has the authority to agree to the requirement and will ultimately be held accountable for the responsible reporting entity adherence to the Section 111 reporting requirements.

The authorized representative is not going to be a user of the COBC Web site. But they will have certain tasks, such as finding a profile report that will produce after registration an account set up. And essentially so doing, they are assigning the data use agreement and also authorizing their other users associated with their account - specifically the account manager.

The account manager is the person who is going to manage the day-to-day administration of your Section 111 reporting. This person is a user of the COBC secure Web site, they will be able to - they could be an employee of the responsible reporting entity, they could be an employee of your TPA. They could be also an agent.

It certainly - it’s up to you as to who you assign to be your account manager. Now the account manager is an important role not only because they’re controlling these day-to-day processing but they also managed the other users that you invite to work on your account on your behalf of the COBC secure Web site.

These other users are known as account designees. So once the authorized representative at the RRE as assigned a profile report and certified that the account manager is - has their approval, then the account manager can come to the site and invite other designee.

Other designees could be again, employees of the responsible reporting entity, they could be associated with the TPA or they could be associated with an

agent that you're using for reporting purposes. You may use one agent entity to submit your query file and a different agent entity to submit your claim files or you can use the same agent for that purpose.

Again, if you have one agent - if you have two agents submitting different claim files, you're going to need two different RRE IDs. You could use the same people, the same account manager for that purpose for both accounts.

So the specific question that Barbara brought up was again, that the RRE has a TPA processing claim and the TPA, rather than creating the files for Section 111, is actually delegating the file transfer for Section 111 to another agent. And in that scenario, you might have your authorized rep again is going to be an entity or a person associated with your RRE. Your account manager could be someone at the TPA location and the account manager can then invite the agent as an account designee.

Barbara Wright: And what I'd like to add in all the scenarios that Pat did, regardless of whether an RRE reports directly, uses simply an agent that takes care of all of their functions or has one entity who uses someone else to physically submit the files. In all cases, the RRE is ultimately responsible for compliance with the Section 111 requirements.

We've also received additional questions again in terms of compliance. And we wanted to let you know that we're still working on compliance issues and again reiterate that the agencies highest concern is getting complete and correct data. Our aim in not have to do anything with penalties.

So you know, we're looking for cooperation and compliance for that. And along those same lines, it's important to keep repeating that even if you don't have all the data we're requiring or haven't assembled it yet, it's important

that when the date for registration comes up on the timeline, that the RREs register and get busy with testing so that we have that completed. You do not need to have real data do the testing. Use dummy data for the testing is to determine whether or not the submissions and response files will work. Bill?

Bill Decker: Yeah, Barbara, I just wanted to jump in here just quickly to let everybody on the call know that we've been joined by John Albert who also will be available to provide comments and to take questions from you later on in the call. Thanks.

Pat Ambrose: And if I could - this is Pat Ambrose - if I could just follow up with one last comment. I know I provide a lot of information about the use of the COBC secure Web site registration and setting up your accounts. All of this will be detailed in the upcoming User Guide. And after that User Guide is published, we'll have subsequent calls where we review this information. We'll also have computer-based training courses available that will cover that in detail. So don't sweat it just yet.

Barbara Wright: Okay, a few other issues that are coming up repeatedly is we're continuing to see a number of comments that come in that really have to do with Medicare's recovery function. Those will not be answered through this forum. The process for recoveries has not changed. These calls and the instructions we're putting on the Web page are aimed specifically about how to perform the required Section 111 reporting.

We're also, along that same line, there's questions about whether or not an entity has to report if liability hasn't been established. And from our perspective, that's not a relevant issue. Reporting is required regardless of whether or not there's been a determination of liability as long as there's been a settlement, judgment award or other payment.

Similarly, we're continuing to get questions about whether there's a dollar limit connected with reporting. At this time, there's not. The agency is looking at whether or not we can include some type of threshold for the Section 111 reporting purposes if we come up with the threshold, we want to emphasize now and want to continue to emphasize that this would be a threshold solely for purposes of compliance with Section 111.

It doesn't change any other existing responsibilities for any entity with respect to the Medicare secondary payer provision. So it's not a threshold in terms of being a safe harbor from any other type of obligation.

We are still getting questions asking about situations where an entity says they're already reporting or they've already given information to the COBC. This doesn't effect their obligations under Section 111. Information that's self-identified by, for example, the plaintiff's attorney or even if it's self-identified by an insurer. If it's not done within the Section 111 process, they're not compliant with the Section 111 provision. If they have other reasons for doing that self-identification, that's fine. But it doesn't eliminate the Section 111 requirements.

The date of incident issue continues to surface. The Department of Labor and some entities - mainly dealing with workers compensation - are continuing to ask whether they can use their own definition of data incidence, whether it's date of last exposure, whether it's simply a reported data that they never check or whatever. They want to know if they must use CMSs date of incidence definition.

And our position continue to be yes, we have to use our definition. As we pointed out in the file layout, we would expect that definition to differ only in

a case that involves exposure, ingestion, implant. So for the typical incident that - a car wreck, someone falling or any type of trauma based situation generally, the date of incident is going to be the same regardless of whether it's the one that insurance industry or workers compensation is using or CMS.

But in the situations I mentioned, the amount needs the DOI under its definition because that's what's tied into our recovery process. I believe there was an alert that made it out this week. If it hasn't, it should be up within the next day or two. It invites entities that wish for CMS to participate in an outside conference to send us certain information so that we can begin planning.

The only thing that I would add that might not be on the alert itself is if you have flexibility, please specify what that is. If you're mainly asking us for a topic, particularly if it's a small conference which might end up being through one of our regional offices of through some type of pic-tel or teleconference, if you have an option of doing it by April or May, let us know that that's not with both. The more flexibility we have, the more requests we can accommodate.

Truly the main issues that were on list right now, unless someone else here has something they'd like to address right now, we'll open it up for questions. Operator?

Coordinator: Thank you. If you would like to ask a question, you may press star 1. Please record your first and your last name clearly when prompted. To withdraw your request, you may press star 2. One moment please.

Our first question is from Teresa Lynn. Your line is open.

Teresa Lynn: Thank you. I'm with CorVel Corporation and I have three questions. The first is, if there is an excess carrier involved, would the self-insured have to report in the first section of that period of time until they've met the amount for the excess carrier? And would the excess carrier then have to come and also report the same injured party? That's question one.

Barbara Wright: The answer to that is going to impart depending on how payment is being made. I believe it's a draft in the interim record layout. But in situations where a deductible or other smaller amount is self-insured but it's actually paid out through the insurer for the amount beyond that, we've said that the reporting should all be done in situations where it's self insurance and there's an excess policy that kicks in after that where the self-insured is making the initial payment to the claimant.

And then when the self - I'm sorry - when the excess insurance kicks in, that access insurance is actually paying the self-insured entity who pays the claimant?

Teresa Lynn: Correct.

Barbara Wright: Then the self-insured entity is the one that does the reporting.

Teresa Lynn: So the excess carrier would never have to report.

Barbara Wright: If the excess carrier was making payments directly to the claimant, then the excess carriers are going to be involved in reporting. I believe this is covered in the interim records that's out there right now. Let me see if I can find a page for you.

In the section on, What Triggers Reporting, starting on Page 9...

Teresa Lynn: Correct.

Barbara Wright: Let's see, Page 10, the third sub-bullet talks about reinsurance stop laws, excess, umbrella, etcetera. The key in determining whether or not reporting for purposes of the Section 111 provisions is required is whether or not the payment is to the injured claimant/representative of the injured claimant versus payment being made to the self-insured entity to reimburse the self-insured entity.

Teresa Lynn: Okay.

Barbara Wright: So I think if you go through what we've got in this What Triggers Reporting carefully, we did not try and name every possible type of insurance arrangement. What we tried to do is put things down conceptually. So go back through, if you still have a question after that, we'll consider it.

Teresa Lynn: Thank you. The second question is, in a judgment, settlement or award, if CMS believes that the settlement amount is not considering CMS's concerns for future medical, what will CMS be doing if you disagree with the settlement amount?

Barbara Wright: Well, first of all, that's not really Section 111 reporting. And secondly, situations vary for workers comp versus, for instance, liability. Liability policies have caps...

Teresa Lynn: Correct.

Barbara Wright: On that basis, clearly they are not necessarily going to be big enough. If you have a catastrophic accident and the policy limits are $50.000, obviously it's

not going to cover everything where you have a workers comp situation where by state laws essentially, if they take responsibility for the accident, they're talking responsibility for those medical arguably for a lifetime.

If they pay only $20,000 in a catastrophic incident, then there's an issue whether or not they've taken our interests into consideration. But that's not really a topic for this call.

Teresa Lynn: Okay. And the last is - and I believe you've answered this but I just want a clarification - on the query mode, will you not be telling us what the SSDI status is if someone has applied for SSDI?

Bill Decker: No.

Teresa Lynn: Okay. Thank you.

Coordinator: Our next question is from (William Thompson). Your line is open.

(William Thompson): Hi, it's (William Thompson) from the (Harper). I also have a few questions. I just wanted to get some further clarification on the registration for the RREs. And I guess the most basic question, one of them would be, is there any limit to the number of RREs?

In other words, we have a scenario, we're a large insurer, we're going to have quite a number of PPAs that will probably self-report on behalf of parts of our business. And then we also have various different lines of business that may also report separately.

Barbara Wright: Could you stop a second. You said you're going to have someone who's going to self-report. What do you mean by that? A report through the 111 process, something outside the process, what?

(William Thompson): What I mean is that we would plan to ask the TPA to report and we'd assign them as one of our agents.

Barbara Wright: To answer the first part of your question, there is no limit to the number of RRE IDs that you set up. You know, you will have to map it out ahead of time. But even if you miss one, let's say you set up 25 RRE IDs and then you just cover that you need another one, you may continue to register and request additional RRE IDs.

(William Thompson): Okay, so in other words, for each separate report that we - as a company-wide enterprise sends to you, we need to have a separate RRE ID?

Barbara Wright: Yeah. And it mainly is because of a system requirement that we are only accepting one claim file - one claim input file per quarter per RRE ID.

(William Thompson): Okay.

Barbara Wright: It also allows you to be able to transmit files that are for one particular responsible reporting entity from different locations, you know, from in two different locations.

(William Thompson): And if you - if there's an error file with respect to one particular RRE ID, say for example, from one of our TPAs, would the error report come back to the RRE or would it come back to the TPA that submitted the report?

Barbara Wright: It'll go back to the entity that submitted the report, it'll go back to the agent that submitted the report. It kind of depends on your file transmission method.

Now the statistics related to each file transmission will be available to users, all users associated with your accounts on this too via secure Web site. So the RRE would still be able to see the files submitted by Agent X had 15 records in error and so on.

(William Thompson): Okay. And sort of along those same lines - and this has partly to do with the query function - but if you could just clarify the issue, for example, say a claimant is 67 years old so we would assume that they're a Medicare eligible. But I guess the point of clarification I'm looking for is say we settle a case that - where we're paying medical bill damages.

Would we just assume that that person is reportable or is there some scenario which if that person who is 67 has private insurance and, you know, Medicare never paid any of the medical bills, we'd have to also send the query function to determine whether we need to report it?

Barbara Wright: It's possible to be 67 and not be covered by Medicare, if you have not elected to sign up for Medicare benefits.

(William Thompson): So in other words, we can't assume that just on all our files where people are 65 and older, that we just automatically report all those?

Barbara Wright: Well, the other advantage of using the query function - although you may not be happy with part of it - if you submit someone who's 67 and it gets reject, you may want to check whether you've got correct information since there is an overwhelming likelihood that they're Medicare.

If you get a negative report on that, you may not have sufficient information to make the correct match. So you know, that's kind of a - sort of an alert to you, that you possibly don't have all the information you need.

Bill Decker: Personally I would assume that anyone 65 and over have Medicare. But again, like Barbara said, you know, if some reason they aren't found on our system, odds are that you probably don't have enough accurate information regarding that particular beneficiary for us to match that individual to a Medicare health insurance claim number which would - which should trigger development on your part with that particular person to make sure that you have enough of the either the SSN and the personal identifying information to - for us to be able to confidently identify their Medicare health insurance claim number.

(William Thompson): Okay. And with respect to the query function, did I understand it that we can only submit once file per month? Because my concern there is for each claim handler on every particular case, we probably want them to verify independently whether the person is Medicare eligible. So I think it would be very difficult if we can only send in one file per month.

Barbara Wright: It'll actually be by the same RRE ID that you're using for your claim input file. So each of your agents or TPAs or whatever the entities are that are transmitting these files for you, if they have a separate RRE ID, they can send in a separate query.

(William Thompson): Then it's just once a month per RRE ID?

Barbara Wright: Yes.

Bill Decker: Yes.

(William Thompson): Okay, is there any thought in the future to being - to be able to send in, you know, daily requests, you know, so each claim handler can do it independently?

Barbara Wright: Think about that on a national basis.

Pat Ambrose: Well, you know, we can certainly take that under consideration. But for obviously the initial implementation, it's a file exchange on a monthly basis.

Barbara Wright: And keep in mind that in terms of when something has to be reported, because we have the 45 - for want of a better term I'll call it sort of the grace period - submitting one file a month does give you the opportunity to make sure you've reported everybody timely in terms of being able to use the query function.

(William Thompson): Okay. Well, I just want to clarify something from another call. I think you answered this but we have a question about, you know, entities that may want to settle a slip-and-fall case but for example, by issuing a gift card. Does something like that need to be reported as a settlement of a potential DI claim?

Barbara Wright: I mean, if it's a settlement, judgment, award or other payment, I'm not going to dictate whether you do it.

(William Thompson): Okay. And just - I guess my last question is, if this isn't the right form, maybe you can direct me to the correct form. But I'm still concerned that in trying to protect an RRE's interest and making sure that Medicare gets the money that RREs are required to protect, I think you mentioned that CMS would endorse the dual payee method of settlement check?

We're hearing a lot of pushback on that theory from the plaintiff community and is there any thoughts that you might put some language on your - in your guidance statements endorsing that principle so that we don't get sued for bad faith if we want to utilize that methodology?

Barbara Wright: Hold on a second, please. Sorry, we're back. What we've said in the past is, you know, that we've heard a number of ways that different entities are protecting their interests. We've heard situations where we know there are situations where they do multi-party checks. We know there are situations where they put a certain percentage of the settlement in a multi-party check and the balance of it directly to the beneficiary.

There's different ways that can be handled but CMS cannot tell an insurer which way to do their checks nor can we say that if you do it X way in terms of a percentage of it, that that's always going to be complete protection. In most situations, you should have some idea of the medicals that are involved.

(William Thompson): Right. But what I'm saying is that apparently there's a lot of pushback in the plaintiff community about using any form of dual pay checks. So...

Barbara Wright: I understand what you're saying. But that's not really -and I know people get tired of hearing this - but that's not a Section 111 issue. The idea or concept that Medicare's interests need to be protected has existed since the inception of the Medicare program.

In terms of workers compensation, Medicare has always been secondary to that. And when the so-called MSP provision started being passed in the 80s, it added group health plan insurance, liability insurance, no fault insurance. But those provisions have been there now over a quarter of a century. So the fact that we've instituted these reporting requirements doesn't change those

obligations and it, you know, that's - sorry, but that's not really the subject of this call.

(William Thompson): Right. I just - in my last comment, I just - I think RREs are willing to try to comply with the reporting but - and we'd also like to make sure that we don't have to pay twice for these settlements. And you know, if you - if CMS thinks it's undisputed that you have this super lien, then I think it would be helpful if the RREs could be helped in the process of trying to get your money if you had language on your site saying you endorse that methodology in a settlement.

Barbara Wright: We'll take your comment under consideration.

(William Thompson): Thank you.

Coordinator: Our next question is from (John Higgins). Your line is open.

(John Higgins): Good morning, I'm with CorVel Corporation. I have a question concerning sort of the gap in the timeline of the data. Let's say, for example, we have a case where we announce a settlement of $10 million but that's the first payment we've made. So we've never reported them in the past and what happens is, is there's a 45-day gap between when we figure out we have a settlement and we send you the query file.

What happens if a person falls off of Medicare during that 45-day period and no one is aware of it? We in good faith sent you the data, said is this person eligible, you say no, they're not. What's the safe harbor in that scenario for us?

Bill Decker: They'll still get a (HIKN). They'll get a (HIKN). If they had Medicare entitlement, they'll get a (HIKN).

Barbara Wright: Operator, can you hear the response or was it too soft. (John), could you hear?

(John Higgins): I could barely hear the response.

Coordinator: If you could speak up a little bit, that'd be great.

Bill Decker: If the person had Medicare entitlement and they have a health insurance claim number, we will pass back that health insurance claim number which should be triggered to know that the person had entitlement at one time.

(John Higgins): Okay, so the rule is going to be if they had entitlement at any time, we send it in to you?

Pat Ambrose: On the query process anyway, we will return a response saying, this person was found with match to a Medicare beneficiary if that person every was or is a Medicare beneficiary.

(John Higgins): And then what we would do is send in the initial report to you folks and then you would either come back in saying whether or not it's valid with the time or not.

Pat Ambrose: Yeah. There are different disposition codes dependent on we might accept the records and say yes, you know, we accept this record, there are no errors on it. We matched this person to the Medicare beneficiary.

However, the timeframe reported on the claim, like for example, between the date of incident and the settlement date, during that time frame this person

was not entitled or covered by Medicare. So thanks for reporting but, you know, we're not actually going to attempt to recover on that or anything of that nature. So you will get a separate disposition code as opposed to, you know, yes, they were a Medicare beneficiary during that time period.

(John Higgins): That's perfect, thank you very much.

Barbara Wright: Before we go to the next call, operator, one thing we should reiterate again is CMS has no intention to change its current recovery process. For the most part, what CMS does is that if there's a settlement, judgment or award, it pursues recovery directly against that settlement, judgment award whether it's ongoing benefits under, for example, workers compensation, then there may be a demand against the workers compensation entity.

But the Section 111 reporting is not seen as a vehicle that we have any particular intention of saying, hey, we're not going to pursue recoveries against beneficiary settlements anymore. We're always going to go directly to the insurer.

We're not looking at reporting that way. We're looking at the reporting to get information to assist in our other ongoing procedures. And one semi - not really a real technical question before we go on, operator - we got a question that came in about Field 77 in the layout.

And Field 77 - let me read you this section - it has to do with the ongoing responsibility termination dates. And the question came in and said, the direction says this only applies for the ORM indicator is Y for yes. And they think it ought to be just the opposite. Wouldn't it be applicable if the ongoing responsibility for medicals is no. In other words, there's no longer any ongoing responsibility for medicals.

And what I'd like Pat to do is walk through when you use both those indicators.

Pat Ambrose: Okay, if you are reporting a claim for which the RRE has responsibility for ongoing medical, generally speaking, there are two reports required. An initial report that will provide information about the injured party as a Medicare beneficiary. And the ORM indicator will equal Y.

So this claim then can be opened and the insurer is paying ongoing medicals for a number of months or even years. During that period of time, we do not need to report on the claim again unless something material has changed and the User Guide will indicate what those material changes are that you would need to send an update.

But again, generally speaking, you would then - when ongoing responsibility ends, either due to a settlement or due to the injured party being healed and going back to work or whatever the case may be, you would then send an update record, the second report or final report for that ongoing record.

On that second report, the ORM indicator should still equal a Y. And it should also include the ORM termination date, the date that the ongoing responsibility that the RRE had has ended.

Also, there are other fields related to no-fault - the no-fault policy limits and the date that those were reach. But, you know, strictly talking about the ORM indicator on both those reports when you're reporting on ongoing responsibilities. The ORM indicator should still be a Y.

Even though it has ended, you report the second record with a Y but provide us with the ORM termination dates to indicate the responsibility has ended and the claim has closed.

Barbara Wright: So you have two typical situations. One, you're reporting ongoing responsibility for medical, say in the first quarter of the year. And then some quarter in the following year, you're reporting a termination date, you leave the original indicator as yes and you add the termination date in the Field 77.

The other situation you can have is due to the timing or reporting, you could have a situation where you're reporting both the ongoing responsibility for medicals and the termination date in the same file. So you could have either one of those.

Next question please.

Coordinator: Your next question is from Keith Bateman. Your line is open.

Keith Bateman: Hi, this is Keith Bateman with PCI. Pat, would you just - I'm sorry to ask you to walk through this again but I've gotten several questions from members about whether both the RRE and its agent can use the query system to check on Medicare eligibility.

Pat Ambrose: It all depends on how you're set up in terms of RRE ID. We will accept one query file per month per RRE ID. Now as far as who may submit that file, if you're using the mailboxes on the COBC secure Web site, there'll be a file upload and download process and there'll also be a secure FTP process.

Any user associated with that RRE ID account on the COBC secure Web site will be able to up and download files to those mailboxes using either the

HTTPS where you're using a - you'll be logged on as a user of the Web site and selecting an action and saying I want to upload this file or I want to download this file. The secure FTP is obviously more behind the scenes in an automated fashion.

But again, so what, you know, what you have to do is coordinate among - your account manager would have to coordinate amongst those users because again, we're only going to process one query file per month. So if someone has uploaded a query file from say, a user who's an employee at the RRE but then the agent's attempt to upload a query file, we're not going to accept that second file.

Does that answer your question?

Keith Bateman: I think that does. Thank you. Another question is regarding the model form. Where does that stand? When can we expect that?

Barbara Wright: It's not done yet. We're trying to tie that together with when we issue the NGHP manual.

Keith Bateman: Okay. Next question - real - last week, you got - last call you got a question on the product liability field as to whether it had to - we had to fill it out if there wasn't litigation. Let me rephrase it; if there isn't a product liability claim, do you have to fill out that field? I would assume not because there is no potential other liable party at that time.

Barbara Wright: I guess I didn't understand the question - the phrase put at the end in terms there is no other responsible party. I'm not sure...

Keith Bateman: Well, I mean, the idea for the product liability field is to help you identify other potential responsible primary payers.

Barbara Wright: Not necessarily.

Keith Bateman: Okay, well...

Barbara Wright: The product liability field has...

Keith Bateman: From a comp point of view, that ‘s how it would be used and that’s how the question came up.

Barbara Wright: Okay. Part of what we need product liability information for is in terms of making sure we are not doing duplicate recovery claims in an ability to be able to process them faster and more efficiently. There will be certain situations where particularly with respect to recoveries, we will be able to essentially filter claims we’ve paid through one set of parameters as opposed to having to do it thousands of times on an individual basis.

So there’s a lot of reasons for us to use the product liability information that doesn’t go to, hey, there’s somebody else out there. Should we try and go out there and get money from them.

Keith Bateman: Okay. But the question is, you aren’t expecting the reporting entity to make a determination of whether there is a potential product liability exposure, are you? You’re saying if there’s something else out there.

Bill Decker: Right, I mean, if it hasn’t happened, it hasn’t happened.

Keith Bateman: Right, that’s what I wanted...

Barbara Wright: Oh, okay, I wasn't understanding. No, we're not asking you to determine whether there's a claim against somebody else, we're asking you to determine whether the claim - for instance, the workers compensation claim, it could be based on asbestos exposure. We want to know that. I mean, that's the type of product there but that's not to say that you have to tell us - that's not to say you're identifying someone else for us to recover from or sue. It's for us to be able to use that information for they type of purposes I just mentioned.

Keith Bateman: Okay, then let's get away from an easy example. What if we're talking about an auto accident and there's a potential suit against the auto manufacturer but nothing's been - no claim has been made?

Barbara Wright: Well, I think that's refining this part is part of why we are still in the process of set up some calls or meetings about mass torts. Because our intent is not necessarily to have every time there is a product literally involved, have that be considered a product liability claim.

But for instance, let's take - I think it was Firestone - if it's not, I apologize to Firestone. But there was a situation a while ago that was tires specifically related to Firestone. And if it's that type of situation where you know that, then that needs to be reported.

I think as we said way early in one of the calls, we're not looking for every time someone has a defective wiring on a toaster for that to be reported as a product liability claim. But we're really looking for the types of things that are - we're trying to refine it so it would be more along the line of situations where there's mass torts and then we would use that information for the type of situation that I referenced. Not to go out and find someone else to sue. Does that help some?

Keith Bateman: I can give you other examples but let me move on. You were looking into how far back you might go pre-July 1, 2009 cases where there is potential ongoing responsibility but not necessarily payments actually being made?

Barbara Wright: That's still under discussion. We haven't made a decision on that yet.

Keith Bateman: Okay. If there is a statute of limitations for reopening a claim, if that period passes, now, there are states that I will call hard statute of limitation states and other ones that are soft statute of limitation states where even though there's a statute of limitations, the court might grant and exception. When that statute of limitations is passed, can we reconsider that no liability - no ongoing responsibility exists and report that as claim closure?

Barbara Wright: That's one of the areas some other people have asked us to look into to try and give more specific guidance. I would say, you know, in general what you're saying should be true but it is another - unfortunately, another issue that we are looking at. People have specifically requested - they would certainly prefer to operate as they do now.

For instance, if they don't have a claim within two years, even if they technically remain responsible for the individual's lifetime, they would like to be able to close that out where continue to get statements like isn't that correct, isn't that what we should be doing. And of course, that is contradictory to what's in the guide right now.

So we're considering that whole question and trying to look at being able to give definitive guidelines.

Keith Bateman: Okay. Two more quick questions. On the last call, there was a question that was raised about the entities that are expected to report. As I understand what you have said in the past - and they seem to waffle a little bit - was any entity that falls within the definition of NGHP that is making payments to a claimant has the potential to report. Is that correct or are you looking to exempt some entities?

Barbara Wright: I don't believe we're looking to exempt some entities. What we said in the Attachment A of the supporting statement of the PRA package. And as we've said, our decision is to go along with what was we proposed in that is we're looking for a way to not require multiple entities to report in clearly defined situations such as a situation for instance for workers compensation.

If the insurer not only is paying a bulk of the claim but they actually make the physical payout of the deductible or co-insurance or whatever it's called in a particular situation, then the reporting responsibility all falls to the insurer rather than having the self-insured entities for the deductible report as well as the insurer.

So if there's a particular situation that we can lay out that reduces reporting, we're trying to do that. But we aren't - no, we're looking to exempt any particular entity from their reporting responsibilities.

Keith Bateman: My last question is, on your December 11 call, you made it pretty clear that you would look with disfavor on anybody that tried to report - throw all your claims in without checking to whether they were Medicare enrolled. But there seemed to be a little waffling in response to a question on the January 22 call.

Barbara Wright: Well I think we have a concern with what some would call dumping.

Keith Bateman: Yes.

Barbara Wright: Among other things, the statute says you're supposed to identify beneficiaries and report on those. So that's what the statute says. In addition to that, if all you do is report everybody, you're never going to have a heads up where you might have inaccurate information. At least if you use the query function, in cases where you have a strong likelihood that the person is the beneficiary and the reason to know that, you've got a heads up to get your correct information.

So if you're just dumping and you're not submitting full and complete information, the answer you get back, it's going to say we can't identify that as a beneficiary. It's not going to say the person is not a beneficiary.

So the query function gives you an opportunity to be the most prepared you can to submit accurate file.

John Albert: This is John Albert. In terms of, you know, at the time we were still unsure if we were going to be allowed to offer that query functionality. And again, the reason why everybody wants the query file so they don't have to try to build complete records for all these individuals who never had Medicare to begin with. And I don't, you know, I can't, you know, personally understand why, you know, someone would want to build a record with this much information on so many people that most likely don't have Medicare.

And that, you know, in terms of the issue with dumping is, like, what's going to happen is if those files aren't complete information and we can't process them because they're all skeletal records or whatever, that's potentially going to be a compliance issue as well.

So we strongly encourage people to make use of the query file so the can focus development for reporting purposes on just those entities where Medicare would be involved.

Keith Bateman: Okay.

John Albert: This is a tool that will greatly reduce hopefully the amount of work that everyone has to do.

Keith Bateman: Okay, thank you.

Coordinator: Your next question is from (Karen Houlk). Your line is open.

(Karen Houlk): Yes, we're a TPA and we have a self-insured RRE who has two TPAs for GL currently as well as another TPA for workers comp and a self-insured carrier that also handles workers comp. And they're claims get distributed based on the location, they type of loss and the date of loss.

Is RRE going to be able to list all of those entities as agents and how are we going to handle the one query file per month if they can only make one submission and they have all these different entities doing their work for them.

Barbara Wright: I think what we're recommending in a situation like that, if I'm understanding it, is that the RRE would register and set up more than one RRE ID. So you might have Company X being the self-insured responsible reporting entity and they have, say, three TPAs that will be reporting three different claim files and possibly doing three different queries on, you know, related to those claims.

They would be - RRE would come to the Web site three times and go through the registration process and receive three RRE IDs and provide those IDs to each of its TPAs and/or really agents that are doing the reporting.

Man: And then each RRE ID would be able to submit one query file per month.

(Karen Houlk): Okay. Because there was no clarification that they could have multiple IDs. But if that's been taken care of, that answers my question.

Barbara Wright: Yep.

(Karen Houlk): I do have another question. We planned as best efforts to ID Medicare claimants to send out in informational form that they're to complete and return under penalty of perjury. If they give incorrect information and/or refuse to give information, is this CMS going to establish any best effort policies so that they can say we have met our burden?

Barbara Wright: This is what we're looking at in the context of the model form we're working on. That's the exact issue we're looking at here.

(Karen Houlk): Okay. All right, that's all I had.

Coordinator: Our next question is from (Gwen Hanson). Your line is open.

(Gwen Hanson): Thank you - excuse me - I believe my question was already addressed regarding reopenings and I guess I would ask that you continue to look into what happens when a claim is closed. And whichever state agency or insurer issues an order on that claim, saying that further medical is no longer payable while reopening under the statute still applies.

For instance, you know, some states have up to ten years to reopen or apply to reopening. But after that time, you have no idea who is going to reopen in this future and who is not. So if you can continue to research that and provide guidance, I appreciate it. Thank you.

Barbara Wright: Okay, before we go to the next question, I want to clarify that at least from what we've heard so far, there's two takes on that - or at least two. There's situations where entities - whether it's workers compensation and that's who it generally is or someone else where they automatically close it if they haven't had a medical claim for X amount of time.

There are other situations where there's a formal order to close it and the only way it's reopened is if there's a formal finding of a worsening of conditions. And if there's other specific variations on that that are widespread, I would like to know about those because our conclusion in those two situations might be different.

Right now, the interim record lay out basically says that you cannot submit a term date until there's no possibility of further payment.

So if anyone has any comments along that line, send them in.

Bill Decker: Send them to us - yes.

Coordinator: Your next questions is from (Doug Holmes). Your line is open.

(Doug Holmes): Hi, this is (Doug Holmes) with EWC. I just wanted a clarification on the one item that involves Field 12. Let's see, date of incident field. And I think earlier today when talking about the inquiry function, the query function, you made the point that the - what was coming back would not include the data

entitlement or enrollment - I'm not sure what the term is - and will also not include the reasons for Medicare entitlement.

And I'm just wondering, I think a few phone calls ago when we talked about this, I think initially and raised the concern that we would not have the information or we would be in a difficult position trying to report something particularly on an initial exposure case.

That I think someone - at least I wrote it down this way - that we would only be obligated to report going back to the first date of entitlement - Medicare entitlement. So that would give us at least some relief from trying to speculate when that first exposure might have happened.

But if the query function doesn't give us that date, then kind of reconcile those two comments, at least the way I remember them. And that's a question. And then I guess the follow us then is, if for - there's some legal reason, confidentiality reason why that information can't be sent back, is there, you know, is there a legal memo or is there something that's being based on. Those are the questions.

Barbara Wright: Can you hang on a second?

(Doug Holmes): Sure.

Barbara Wright: Okay. The response information right now has been justified through our privacy staff on the basis of minimal information necessary to accomplish the functions that we need to have completed. We will look at the issue that you just raised in terms of whether or not we can justify to the privacy staff that we should be able to release the data's entitlement.

One of the things it would be helpful for us to know is that I'm assuming based on what you've said is that this is primarily an issue in situations involving exposure, implantation, adjustment, etcetera, where the date of incidence is a substantial period in the past. So is that a fair statement or do you see other times when the date of entitlement would routinely be needed?

(Doug Holmes): I guess I could probably think of others but the ones are the most difficult are where we're not capturing the information at all and there's some speculation involved about, you know, when did someone first become exposed. That's the - I think those are the - other may have other examples I'm not thinking of off the top of my head. But the ones addressed in Field 12 certainly are ones that would be at issue.

Barbara Wright: Hold on a minute please.

(Doug Holmes): Sure.

Barbara Wright: One of the individuals in the room here was suggesting, we will look at this in terms of whether or not we can release the entitlement date. But one of the points that someone here in the room was making internally is that if you get query information back showing someone is a beneficiary and it's a case that involved suggestion implantation and exposure - whatever.

Under the regulations that I believe we sited in the last call - 42CFR411.23 and 411.24 - beneficiaries are required to cooperate in terms of coordination of benefit issues and assist you with information that they could readily provide a copy of their Medicare card which would give you the entitlement dates.

Now that's not a full solution, we'll, you know, we'll still address internally whether or not we can release the entitlement date. But that is at least something you could consider.

(Doug Holmes): Thank you. I appreciate it. That's it for me.

Coordinator: Our next question is from (Nancy Riley). Your line is open.

(Nancy Riley): Thank you, this is (Nancy Riley) with (John Jason and Company). I just have a clarification question. On the query, in order to register for that, you have to have the RRE ID. So therefore, since we're not able to register as the RRE until May, then the query will not be available until May. Is that correct?

Barbara Wright: Yeah, we're not actually anticipating accepting any files from liability, no-fault and workers compensation RREs until July 2009. The system will not be ready to process either claim or query files until then. And in fact, at that point we'll be testing files. We had a question last - on the last call sort of about the timing of when an RRE would then - or their agent be able to start a production query process. And that question is still pending.

(Nancy Riley): Okay. The only other thing that I would like to ask you to do is to run through those - the HEW and the - I tried to write it down as you were talking and I couldn't quite get it all. You were - I know that there's HIPAA eligibility wrappers.

Barbara Wright: Yeah, let me refer you to the easiest thing is probably to refer to the GHP page on...

(Nancy Riley): okay.

Barbara Wright: Mandatory (ends rep) Web pages. And there is a GHP User Guide and in that there's a query only file. And that is in almost the same format as the one that we'll use for the non-GHPs.

(Nancy Riley): And it'll give me all those NTC CDOC or whatever software information?

Barbara Wright: Yeah, I mean, the final file format that's transmitted back and forth is the NCS12270271 transaction set. However, if the COBC will provide free software to translate files - flat files into the S12270270 and then from the S12270271 that we returned. And that software is called the HIPAA Eligibility Wrapper. And we made up another acronym and are calling it the HEW.

(Nancy Riley): Okay. All right, thank you.

Barbara Wright: If you're looking for the - if anyone is looking for the GHP User Guide, when you go to our Web site there is separate GHP page. And Bill Decker can give us the date of the most recent version of the GHP User Guide, I believe.

Bill Decker: I can give you the date to the degree that it was in late December. I'm not exactly sure the - of the date.

Barbara Wright: I think it was the 17th.

Bill Decker: The 17th.

Barbara Wright: You should always make sure you're looking at the most recent version of...

Bill Decker: It's labeled Version 2, V2. And it's the December edition of the GHP User Guide.

Barbara Wright: And right now for non-GHP, the most recent version is the interim layout that's dated December 5. We just the other day had a situation where someone was commenting on an earlier version and said it was the latest one. So make sure that you've got the current one.

Bill Decker: Indeed for all of the data, all of the information, all of the materials that are up on the Web site, always try to be sure you're working with the most current version of any of these items. We do try to pull out old items if they're no longer applicable. But sometimes we'll leave them up for reference.

However, in the case of the user guides, file layouts or notices or any of the kind of instructional materials that we're putting up, please make sure you're using the most recent version.

Barbara Wright: And I have to add one more thing and caution you not to use anything else in that GHP User Guide for your liability workers comp no fault reporting. None of the rest of it applies. Operator?

Coordinator: Our next question is from (Jim Price). Your line is open.

(Jim Price): Thank you for taking my call. My name is (Jim Price), I'm with (AON), we are a risk consulting service and we're also a founding member of (MARC).

The question I have has to do with many of our clients who have what's knows as a self-directed deductible program where the insurance policy is actually written on the paper of an insurance company. However, through practice, the insured manages the deductible and usually through a TPA.

So in that circumstances, would, you know, who would be considered the RRE?

Barbara Wright: As we said, if there's deductible that's been paid to the claimant directly by the party that's considered self-insured for purposes that deductible, then they're the RRE. If the deductible is being paid our through the insurer, then the insurer will be the RRE.

Unless we're missing something, we're not sure why this doesn't fit within the language we've given in the interim guide.

(Jim Price): Well it's because, okay, it's because, you know, we have a fronting policy, you know, that is actually the, you know, the insurance carrier, you know, for these losses. However, through agreement, the carrier has agreed to feed the responsibility for those losses to the insured and their TPA.

Barbara Wright: You said your name was again - I'm sorry.

(Jim Price): (Jim Price).

Barbara Wright: And you're with (MARC)?

(Jim Price): I am with (MARC), yes.

Barbara Wright: Okay, I know that (Roy Franco) has raised this issue before. Obviously we may have to have some additional conversations to pin down language or make sure it's in the User Guide.

(Jim Price): Okay, that would be great. The other thing is in listening to these calls, it is apparent that the MMA is going to be a real issue, especially with liability

carriers and I understand that these calls really have to do with the reporting requirements.

However, where the real issues are going to occur here are going to be in having, you know, the insurance companies and the RREs and their agents trying to figure out how they resolve these cases once they get settled. Is there some possibility that we could have some conference call that deals with the MMA issues?

Barbara Wright: When you say MMA issues, I'm not sure what issues you mean.

(Jim Price): I guess what I'm talking about are the statues that have been acted, you know, with regards to the MSP in terms of how MSPs are actually resolved.

Barbara Wright: Your just talking about recovery process in general?

(Jim Price): Well, I guess so, yes. Because certainly the statues have left some huge questions with regards to that.

Barbara Wright: Can you hang on a second? One of the things that we're going to be reviewing here is whether or not we need to put additional information up on our site for the Medicare secondary pair recovery contractor which is where information about thee recovery process is.

So if you haven't taken a look at that site, you should do so and see whether it answers any or all of your questions. And if you still have issues, please let us know. But I don't see that becoming part of the general 111 presentation. It's not part of that process and we won't be addressing that on the Section 111 Web site because there are other avenues for that information.

(Jim Price): So the question - I mean, I - we have reviewed those and they're still are a lot about standing questions there. So I guess the question then becomes, how do we begin to address those questions?

Barbara Wright: Well I would like to see a list of what the issues are, if you agree, if you or whoever you're working with agree on what the issues are. But I would reemphasize that from the agency's perspective, nothing has changed with respect to recoveries. We intend to continue to, particularly for liability and with very few exceptions, we do a recovery claim against a beneficiary settlement judgment or award once there is a settlement judgment or award.

(Jim Price): Yeah, we understand that and I think what I'm trying to relate and I understand that it is not the appropriate forum here but I think most people who are in our industry, you know, the claims adjusters in the field, you know, who are responsible for this don't have a clue, you know, that, you know, that they have this responsibility.

And certainly Section 111 has been (unintelligible) a call, you know, that there is this thing that's out there and needs to be addressed. And I would say that the practical experience of most adjusters who are trying to adjust these claims is that the recovery system that has been set up is broken and doesn't work.

So having said that, I think that it would - anyway that we can facilitate some discussion with regards to the process itself I think would be very beneficial to both Medicare and to the industry.

Barbara Wright: Okay, thank you.

(Jim Price): Thank you.

Coordinator: Our next question is from (Anthony Crackle). Your line is open.

(Anthony Crackle): Yeah, hi, (Anthony Crackle) for (Warren Beacon Insurance). Just a little more clarification. It was brought up in different formats in the last call and I believe in the call before that, it's our understanding that if we accept claim, you know, we have theoretical ongoing responsibility. In other words, the state jurisdiction requires us to pay medical lifetime if applicable to the injury in medical care.

In a case where we have someone who's not Medicare eligible and he files a claim and we're paying medical benefits on it, it's our understanding that we have to have some kind of continuing process or continuing query to see if he ever becomes Medicare eligible. Is that correct?

Bill Decker: Yes.

(Anthony Crackle): Now my question is to be in a real - not even an outlandish example, in a real example, if I have a 25 year old who's sprained his wrist in New York State, let's say, and I have a continuing responsibility for lifetime medical to that wrist. He's not Medicare eligible, he has three or four months worth of medical care, he stops medical treatment easily within a year. Do I have to follow him for 40 years until he turns 65?

Barbara Wright: Under the current instructions, the answer would technically be yes. If you can give us information on how something like that could be managed and still protect our interests, we're willing to listen. And as we've said on prior calls, our problem is that we cannot afford to have records routinely closed just because someone hasn't treated. Because that then leaves us open to exposure.

We don't have anything in our claims process (unintelligible) so that if the person treats for something related that we reject that claim.

We also understand that on your part, your heaviest interest is not keeping situations open indefinitely. So if anyone in the industry has a suggestion in terms of how to manage that, whether that deals with a certain level of injury, this may be something that could be tied to potential thresholds.

If there's some way that we can manage that and still protect our interests with respect to our claims processing system, we're very interested in hearing that.

(Anthony Crackle): Yeah, I think that'd be a - for all the worker comps carriers on the line, that would be a primary concern of ours because see, the bulk of claims filed are medical only so we'll be doing medical care claims. So whether we can work something out with you guys on types of injury and/or dollar threshold or some other maybe timeframe thing.

We realize that we don't want you to pay for something you shouldn't be paying but we have to match up the reality of the cost to the industry to have to follow claims for decades upon decades.

Barbara Wright: Okay.

John Albert: We agree with that in many ways. You know, the purpose of this again is to keep Medicare whole. At the same time not so much to overburden...

Barbara Wright: I mean, if it's a situation where clearly it is only a sprained on the wrist and if it doesn't treat within X amount of time, it's never really going to need treated. If there's some clear way to distinguish those or be able to grapple

with those versus the situation where someone's in a car wreck and they had some severe injuries so they may not treat for a couple years.

But because of the severity of their injuries and everything, down the line they are going to treat. I'm interested in hearing about someway to manage that.

(Anthony Crackle): Okay, thank you very much.

Coordinator: Our next question is from (Mark Smith). Your line is open.

(Mark Smith): Yes, hi, this is (Mark Smith) from (Insurance Services Office); a couple questions regarding the query process. And it was mentioned earlier that one individual said it should be assumed or could be assumed with reasonable certainty that a claimant over the age of 65 is probably Medicare eligible beneficiary.

And in an automated process, wouldn't it be easy to just assume that and submit all those over 65 claims in the reporting process? And if an individual came back as not being in the records, then pursue additional information or would there be some compliance problem if they - RRE decided to submit all over 65s assuming they're Medicare eligible rather than running them all through the query process.

Barbara Wright: Your main advantage in the query thing that we mentioned is potentially timing. Because if you do it in the query file and have to do any development, you can still report that person timely as opposed if you don't. If you're going to be submitting a query file anyway, why not put that person in it and that way if you have to do any development, you can still report them timely.

Whereas as you simply include them in your final file without the query function, there's some possibility of lack of timeliness for error.

(Mark Smith): Well I think it's an issue of volume because the majority of claimants are going to be under 65 and you're talking about, you know, tens of thousands of claimants that are going to go through the query process. So we want to try to weed out as many going through the query process as we could.

But really the question is, would there be a compliance issue if we submitted the all over 65s in the reporting process without running them through the query.

Barbara Wright: Hang on just a minute.

Man: Yeah, we just wanted to make sure we, you know, understood your question clearly. I mean, the answer is is that yeah, it's okay to submit everybody over age 65. But of course, you have to make sure that you are submitting those individuals who are under 65 and Medicare entitled as well. But there's no problem with submitting a full pile of 65 and over as, you know, reportable incidents.

(Mark Smith): Great, that's what I wanted to know. And my second question, now that there's a query function available and I understand that we've been saying for quite sometime that the statues have been on the books regarding Medicare secondary physician.

But now that this query function is available, there will be thousands more individuals who are identified early in the claims process as being Medicare eligible beneficiaries that the RREs were not aware of in the past and really had no way of finding out other than asking.

So I know you said the recovery process is not changing, you're still going to got after the Medicare beneficiary after payment or settlement. But now that the RRE is going to know early on, probably as soon as the claim is filed, perhaps, or within 30 days, that they're dealing with a Medicare eligible beneficiary.

Does this create an expectation on your part, on CMSs part that the RRE is going to be coordinating payment with CMS or set aside money in the non-workers comp claim situation?

Barbara Wright: I think you asked a very compound question.

(Mark Smith): Okay, I'll simplify. The fact that the RRE is now going to know about the...

Barbara Wright: Yeah, I understand. Let me break down what I heard the two different areas is that is one is to the extent that we're going to know about ongoing situations, in ongoing situations and those will largely be workers comps or no fault...

Man: Right.

Barbara Wright: Those are the situations where we've said, while you have ongoing responsibility and either cap has been met for no-fault or there's plain ongoing responsibility for workers compensation, those are the situations were recovery demand may come directly to the insurer.

Man: Right.

Barbara Wright: Now, having said that, if it's a situation where you've got ongoing responsibility by us knowing about that sooner, hopefully, you know, the

expectation is that in claims processing we will be able to deny such claims that come in so that the physician provider or other supplier will bill workers comp, for example, appropriately so we'll never get into a paying shape.

(Mark Smith): Right. I'm really concerned more with the single payment settlement situation.

Barbara Wright: And the single payment settlement, that we do expect to continue the recovery against the beneficiary settlement (unintelligible) award. It has not ever been our intent to routinely proceed against the insurer. There are benefits to both the insurer and the beneficiary by doing it that way because a good example is the liability.

If we recover from the beneficiary, then we will do a pro rata reduction in our determining the amount of our recovery claim to take into account fees and other costs associated with obtaining that settlement judgment award where those fees and costs are actually born by the beneficiary.

So in effect, we sort of support that recovery effort when we recover directly from an insurer the beneficiary has no such procurement costs and we recover full conditional payment. So we see an advantage to the beneficiaries to continue the way we are right now.

(Mark Smith): Okay, thank you. And one last question regarding that. Is there a - I know you're working on a form that would provide for a safe harbor. But in the situation where there is a single payment, the RRE did make the due diligence at both perhaps claim file and also at payment to query and find out they're not Medicare eligible.

But for some reason, it turns out they were and you're unable to recover any moneys from the beneficiary. Is there ever an instance where you would go

back against the insurer who's already settled and closed the claim and paid and recover monies?

Barbara Wright: Well, I mean, first of all, the fact that you reported, that's a separate issue. And like we said, compliance with that doesn't really leave any other obligations. Secondly, as we've said several times during this call, it's not our intent to pursue that process. Have we ever pursued that process? Yes, we have. But those have been unusual situations, sometimes where an entity was simply purposefully ignoring Medicare which is a different situation.

And last, in terms of having gone through the whole process and done query, if you had incorrect information again, the query process can't take care of that situation because what we do is that query process responds with we can't identify this individual as a beneficiary based on the information you submitted. It's not a finding or a statement that the person is not a beneficiary.

(Mark Smith): Right. Thank you, I really appreciate that clarification. Thank you very much.

Coordinator: Our next question is from (Regina Eldridge). Your line is open.

(Regina Eldridge): Hi, this is (Regina Eldridge) for (Area Insurance). I believe this has already been answered but I'll go ahead and ask. If the RRE is an agent for reporting, will the response file be returned to the agent or the RRE?

Barbara Wright: It's returned essentially whom ever submitted it. Like, as far as the file transmission message, if you're using a mailbox on the COBC secure Web site, any user of the COBC secure Web site will have access to that mailbox and - but essentially we transmit the file back in the same method or way that it was transmitted to us.

If you're using (Connect Direct) over the (Agnus) network, it would go back to the same location that it was sent to us from actually.

(Regina Eldridge): All right, thank you.

Coordinator: Our next question is from (Roy Franco). Your line is open.

(Roy Franco): Yeah, thank you very much. The question I have is I heard earlier in the conference call that the registration process for the RRE will remain open. Is that and indefinite period that the - that it will remain open to add additional entities?

Barbara Wright: Yes. You know, obviously things can change, new RREs can come into an existence, account information, you know, and so on. So yes, it will remain open as a function ongoing.

(Roy Franco): Okay. And with regard to RREs that we have registered entities 1 through 7 and now the opportunity has come where they're perhaps adding a new TPA that will b taking over the business from a particular date forward. What's the - what would be the expected time frame to get that particular RRE - registered RRE up to speak.

Barbara Wright: This would be for new - a new entity, a new line of business or something of that nature or are you just talking about changing information because an RRE is replacing one agent with another?

(Roy Franco): Well, what would happen in a TPA situation is if there was a decision to change a TPA, the old TPA could continue with the ongoing claims that have existed up to that point and still have responsibility to report. But now the new TPA will be taking on - will be going forward at a new date.

Barbara Wright: So the RRE wants to add an additional agent.

(Roy Franco): That's correct.

Pat Ambrose: Yeah, I mean, I think in that circumstance since the original TPA will continue potentially submitting claim files you need to then register for a new RRE ID for the new TPA/agent and they would then start submitting as soon as they got the account set up and they've tested.

Man: What drives this is again, what - when is that incident reportable? So if there's a new entity that is - has responsibility for reporting new reportable incidence, then the time frame set out in the guidance regarding when does that have to be reported is what really drives it.

Man: But I think you said, (Roy), that basically the underlying RRE is the same. You simply want to use the different agent for part of that work. In which case, as Pat said, you'd register a new additional agent if you had a situation where for whatever reason, an agent was being - an RRE wanted to replace one agent with another. Then I - Pat can explain but I think it's a matter or updating the registration.

Pat Ambrose: Yes, I mean, if you're switching agents completely and the new agent will submit all your claims or will completely replace another you can use the same RRE ID. So if you have a cut over date when that will happen...

(Roy Franco): Okay.

Pat Ambrose: You did a new RRE ID. But you know, you haven't necessarily thought through all the details about that. But you've given me good food for thought to take back.

Barbara Wright: Back to the developer.

(Roy Franco): Okay. Well that's very helpful information because the situation could very well happen where you'd have, you know, TPA wants to continue to report on the old losses that they developed. And then TPA, number two, taking forward, you know, on the new dates, you know, going forward. So I appreciate, you know, you all listening into that.

I think earlier (Keith)'s statement made a comment that should have triggered something in my mind. And that's where, you know, you are a registered RRE and you have ongoing, you know, you have responsibility to report. But because of liability assumed under the contract, whether it be another self-assured and assume that liability or another insurance carrier has assumed that liability.

The claim is being processed by this other entity. So in name only for example, this other entity is handling the claim on behalf of my company. Do I have to worry about reporting those losses if that other company is the one that's responsible for making the payment and responsible for settling loss?

Barbara Wright: As I said, I think it was (Jim Price)'s call, that we need to make sure we're covering all your issues with fronting policies and that what we set out conceptually in the interim guide right now covers that.

I don't feel comfortable trying to give you a yes or no.

(Roy Franco): Yeah, I appreciate that. And actually, this is beyond the fronting policy issue. This is for example, you know, my company is selling Campbell's soup. And the Campbell's soup product is defective. As the result of the defective nature of that product, Campbell's soup has agreed to pick up my defense under the terms of t he purchase agreement and defend the claim and pay the claim on our behalf.

And my question is, do I have to worry about Campbell's soup representing us or taking care of that claim on our behalf? It's slightly different from the fronting issue. And we can probably chat with that, you know, throughout the process. But I just wanted to put that as one of the issues that have come up.

Barbara Wright: Okay.

(Roy Franco): And Barbara, one last question. I know you mentioned 42CFR411.23 and 411.24 and maybe my read of it is wrong but I do believe that the cooperation in there is related to when you're involved in a workers comp loss. And the question has come up whether that would be possibly broadened...

Barbara Wright: No.

(Roy Franco): Through the liability...

Barbara Wright: That section of the regulations is not specific to liability or to no-fault or to workers compensation 411.23 and 24 I think - and someone just looked it up in the regs - that is in the general part in the MSB, it covers all of them.

(Roy Franco): Okay. So it is not limited simply to just workers comp?

Barbara Wright: No, it's not.

(Roy Franco): Okay, thank you very much. Those are the questions I had, I really appreciate the time.

Coordinator: Our next question is from (Scott Hibner). Your line is open.

(Scott Hibner): Yes, I have a question regarding the action type field. How do we know what constitutes a successful load of a record? Is there something comes back and response file for disposition code for that?

Barbara Wright: Yes.

(Scott Hibner): So that we know that it's an add that time and any subsequences would be an update?

Pat Ambrose: Yes. You will receive a disposition code and depending on the disposition code received back, know that it's been accepted and then any subsequent record would be an update. There's a disposition that comes back that says, you know, this record was rejected because it was an error. And in that case, you could use the action type of add again once you've fixed it and resent it.

(Scott Hibner): Okay.

Pat Ambrose: And yes, that will be detailed in the User Guide.

(Scott Hibner): Okay. And then follow up to that; when - if you can give an example when we might use the delete action?

Pat Ambrose: That's only in very rate circumstance. One case would be you sent us a claim completely in error. Maybe you have a claim system problem and, you know,

I do struggle to find examples so let's suppose that you reported a claim and a settlement amount and that claim was not settled. So it's still pending, something along those lines.

So it's really generally speaking, only used when you've sent something completely in error.

Barbara Wright: Delete is more frequent with the GHP situations because Medicare is not always secondary to GHP. But for liability, no fault and workers compensation, we're always secondary so you really shouldn't be reporting unless there's a situation that in GHP, much as we don't like it, we have the situation, for example, where someone potentially has submitted information on a group of retirees where we're not in fact secondary.

So it's not a function that we would expect to see utilized vey often for the liability, no fault or workers compensation situation.

Man: These delete functions used to delete records from our files. And I just wanted everybody to know that it's a very useful function in a very limited set of circumstances and we do keep track of it.

(Scott Hibner): Okay, that's good know.

Barbara Wright: I do have to mention that there are other cases and what we're developing for these User Guides is soft of trying to create sort of an event table to say under these circumstances that this changes or if this happens, send a delete, send an add, send an update to help you with that field.

(Scott Hibner): Okay. Thank you very much.

Coordinator: Your next question comes from (Tom Kennedy). Your line is open.

(Tom Kennedy): Hi, this is (Tom Kennedy) from (Ace Insurance). I just have a couple quick questions. The eligibility file, is that determination, does that mean the person is eligible? I know this might have been answered in the past, I asked it a few months ago but it sounds like it might have changed. Does it mean that that person, if it comes back yes, that person is currently receiving Medicare benefits or it just means that they are eligible to get them?

Man: It basically means that they at one time were eligible and enrolled in Medicare and received a health insurance claim number.

(Tom Kennedy): Okay. So there's a higher likelihood that there was a claim under that person that Medicare may have paid on?

Man: There's a high likelihood but not 100% all the time is there a claim paid for a person who's Medicare eligible, okay?

Pat Ambrose: The query will return a positive response as we've matched this to a Medicare beneficiary whether - even in circumstances where the entitlement and enrollment in Medicare, the coverage in Medicare has actually ended.

(Tom Kennedy): Okay.

Pat Ambrose: And that happens in cases of disability for example.

(Tom Kennedy): Okay.

Barbara Wright: And an example of someone we may not have seen anything for is some veterans exclusively use veterans facilities. But they may still be Medicare beneficiaries.

(Tom Kennedy): Okay.

Barbara Wright: But that doesn't mean that just because you know someone's a veteran that you don't report. We still need the check whether or not we paid claims.

(Tom Kennedy): All right, that helps. The other question I have is, is there any sort of a metric or relationship between how many hits we've had coming back for Medicare eligibility and then the following month file trying to match up that same hit ratio or those - that count of people that came back as eligible.

So if we submitted 1,000 claims for eligibility, 400 came back as yes. Are you looking to see that in the following month we submit 400 claims?

Barbara Wright: No.

Man: No.

(Tom Kennedy): Okay, just checking. And the User Guide, when that comes out, does that mean we are done with changes to the data layout because I can't have developers working on a moving target so I need to know when...

Barbara Wright: We will make sure people know if there are still open issues. One of the issues that we're still getting questions, comments from all sides is what set of codes should it be. And obviously there's some people that want to argue strongly for WCIO, there are other people arguing no for that, there are people that are arguing for Department of Labor and they're - and I'll probably mix up the

initials - but I think it's NCII codes. And I'm trying to remember if there's another set of codes too.

So as long as we've got an open issue on that...

Pat Ambrose: I think the layout is reasonably stables and also realize we have developers on our end that are equally as anxious for its finality.

(Tom Kennedy): Okay. And then last question is, the response file for the -what do I call the big file which is the full data set - is that only going back to the RRE directly or is that also going back to the agent as well. I just wanted to make sure. I always assumed it went back to the person who sent it.

Barbara Wright: Yes.

Man: Yes.

(Tom Kennedy): Okay.

Barbara Wright: I mean, but you know, again, some of our files transmission methods involve a mail box on the COBC secure Web site. And any user that has access to that RRE ID account has the ability to download files from that mailbox, response files from that mailbox.

(Tom Kennedy): Okay.

Man: Just to be - try to be utterly clear, whoever sent us the file gets the file back, people -there are other entities that may have access to the same file but they're not the primary recipient of the response file. They simply have access to it in certain cases.

(Tom Kennedy): Okay, thank you.

Barbara Wright: Operator, could you give us an idea of how many questions are queued up?

Coordinator: At this time, I show 15.

Barbara Wright: Okay, let's see if we can do a couple more.

Coordinator: Our next question is from (Donald Vickery). Your line is open.

(Donald Vickery): Hi, (Don Vickery) with (Main Municipal Association). And my question had to do with statues of limitations and ongoing payment obligations and that has already been answered. So thank you.

Coordinator: Our next question is from (Mike Stenson). Your line is now open.

(Mike Stenson): Hi, this is (Mike Stenson) from (Unintelligible) Insurer's Association of America. And the question that's (unintelligible) my membership is a case of a derivative claim such as loss of consortium. Are we expected to report if we have a situation where the underlying claim, let's say for a male, is a medical liability claim but that person is not Medicare eligible. If there's a associated loss of consortium claim made by the spouse who is Medicare eligible?

Pat Ambrose: Let's here about whether the injured party is the medical - I mean, you know, has - you're paying medical...

Man: Well, I know but loss of consortium is defining about injured in some way.

(Mike Stenson): Well we'll acknowledge them but there's a (unintelligible) there. But the person filing the real medical file to the claim is not Medicare eligible but their spouse is and they're filing a secondary claim.

Barbara Wright: In general, no, you're probably not going to have to report. But what I think we need to get more specific instructions to you out on or make sure it's in the guide is what we expect to be reported in situations where there's wrongful death.

(Mike Stenson): (Unintelligible) wrongful death or any kind of injury.

Barbara Wright: What?

(Mike Stenson): This could easily extend into cases that are not wrongful death.

Barbara Wright: Oh, yeah, I understand so...

(Mike Stenson): Okay.

Barbara Wright: So let us make sure we address it.

(Mike Stenson): Okay, thank you.

Coordinator: Our next question is from (Angela Barnes). Your line is open.

(Angela Barnes): Hi, this question may be addressed on Page 12 but I'm seeking clarification. Does Section 111 contemplate that in applicable plan, we report on Medicare eligible claimants who file claims under professional liability policies? So for instance, if we settle an accountant's malpractice claim under a professional

liability policy and we make a payment to a claimant who's also Medicare eligible, are we required to report that settlement?

Barbara Wright: I think that that's one that we hadn't thought of all aspects on. All Medicare has recovery rights with respect to all liability situations. But part of what you're looking at is what is claimed and/or released. And as we've said in the document, we made it clear for instance, if it's a car wreck that's purely a property damage situation where no medicals are claimed and/or released that that didn't have to be reported.

It would be helpful to us to the extent that the situation you're talking about fits under that which is on Page 12, no medicals, if medicals or claimed and/or released the settlement must be reported regardless of any allocation.

So you know, professional malpractice in general is included. But if it fits under the absolute medical situation then it doesn't need to be reported.

(Angela Barnes): Okay, thank you.

Coordinator: Our next question is from (Scott Onstead). Your line is open.

(Scott Onstead): Hi, thanks for taking my call. I'm with (Sedgewick CMS) and (unintelligible). So quickly, regarding the RRE registration process, can we assume that September registration document is still applicable and accurate, all of that required information is accurate?

Barbara Wright: Generally speaking, the process will - online will work different than what you see there. But for the most part, we are collecting that information and have similar requirements.

(Scott Onstead): Great. There was one question in there about the number of paid claims resulting in an insurance payout over the last year. Is that just limited to the claims of those who we - who might potentially be beneficiaries or is that all claims?

Pat Ambrose: I think we were looking for all claims.

(Scott Onstead): Okay.

Pat Ambrose: Since we figured you wouldn't know necessarily about the Medicare beneficiaries. And it's just a volume estimate, truly just an estimate to help us with our own capacity planning.

(Scott Onstead): Okay.

Barbara Wright: If you report all claims and we make an assumption that like, 10% of them are involved beneficiaries or something then we'll derive all our volume that way as long as everybody's reporting on the same basis, then we can make some estimate off of it.

(Scott Onstead): Perfect. And a couple or more questions you might not know because this might be something for the COBC. Is there anyway we can get - we're trying to prepare our clients for the registration process. Is there anyway we can get screen shots of the CB - of the secure Web site, the registration process?

Pat Ambrose: It's not available yet but there will be instructions provided. The user manuals will have a brief kind of overview on how to get started with the process and what you need to do.

(Scott Onstead): Okay.

Pat Ambrose: Secondly, once the Web site is up, there will be how tos on the home page of that Web site to essentially help you through the process. And then lastly, there will be computer based training courses specifically for the applicant - the Section 111 application on the COBC secure Web site. And those will show screen shots and step-by-step click here enter this type of information.

(Scott Onstead): Okay.

Pat Ambrose: You know, obviously we're working on the underlying system so the training will be somewhat subsequent to that. But hopefully prior to when your registration has to begin. I mean, not hopefully, it will be -the CBTs will be available prior to your registration.

Barbara Wright: And with respect to the CBTs, I believe there's now an announcement out that makes it clear to everyone that the current CBTs are GHP-directed and would not be particularly helpful but it also gives you information on how, if you haven't yet registered so you don't have your personal EDI rep, how you can register so that you'll be inline for the training.

And that once the NGHP CBT training is available, you will receive an automatic announcement. So Bill, do you know if that announcement made it up under the Web page?

Bill Decker: I think it has already.

Barbara Wright: Yeah. So if you go onto the page with the CBT trainings, you can find out how to pre-sign up for training so that you'll be contacted as soon as the NGHP CBT is available.

(Scott Onstead): Okay.

Bill Decker: One further note on the computer based training is that we just want to be sure that everyone out there knows that that's no cost to you.

(Scott Onstead): That's always good.

Bill Decker: You should take it because it's useful and it won't cost you any money.

Barbara Wright: And you can have multiple individuals from your entity sign up for it, you're not limited to one person per entity.

(Scott Onstead): And one last question - I'll be quick - for those agents that may support a larger number of RREs like a third party administrator, is there any effort being made to designate a single EDI contact at the COBC that we can work with instead of having to support a different contact for each RRE?

Pat Ambrose: Yes. However, you know, as far as the system assignment of EDI rep, it will be by the RRE ID. But yes, we do recognize and some accommodations can be made for that.

(Scott Onstead): Perfect, thanks.

Barbara Wright: Operator, how many calls do we have inline.

Coordinator: At this time we're showing nine.

Barbara Wright: I don't believe we're going to be able to stay on for that. We all have other meetings that have actually started. So we appreciate everyone's participation. For those of you who might be a reporting entity both for GHP as well as non-

GHP, there is a call tomorrow and we are having at least call for NGHP and GHP per month for the foreseeable future.

Bill Decker: Probably more than one as it will turn out.

Barbara Wright: So again, we appreciate your questions and comments and anything that you can send us on the issues we've raised today. As we've said, we are reading everything that's in the mailbox. Thank you very much for your participation.

Bill Decker: Operator?

Coordinator: Yes, sir?

Bill Decker: I just want to know real quick how many people had signed on.

Coordinator: One moment please.

Woman: 591 according to this, what I'm looking at.

(Elizabeth): This is (Elizabeth), hello.

END