TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b)(8)

DATE OF CALL: March 24, 2009

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

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FTS HHS HCFA

Moderator: John Albert
March 24, 2009
11:30 am CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After the presentation we will conduct a question and answer session. To ask a question please press star 1. Today's conference is being recorded, if anyone has any objections you may disconnect at this time.

Now I will turn over the meeting over to Mr. John Albert, you may begin.

John Albert: Good afternoon everyone. I wanted to welcome everyone to yet another one of our open door teleconference events. This teleconference is specifically targeted toward non-group health plan, i.e. worker's comp, liability, no fault insurers that fall under the reporting requirements of the Section 111 MSP reporting requirements.

With me I have several people who will be providing some additional information before we actually get to the Q&A session. First is William Decker, the second is Barbara Wright, the third is Pat Ambrose and also (Bill Devonia) who chimes in from time to time.

As everyone knows or should have seen if they are subscribed to the list service on the Section 111 Web page, which again is www.cms.hhs.gov/mandatoryinsrep, the Centers for Medicare and Medicaid Services released its first formal complete user guide for the non-GHP reporting process recently. We also published an alert that essentially provided additional information that we needed to get out sooner rather than

later rather than try to hold off on or republish the user guide so immediately after we did the first one.

First Miss Barbara Wright is going to provide - kind of go over some of that information that new one (that's in) the works.

Barbara Wright: I'm going to go over some items that are in the user guide as well...

John Albert: Okay, okay.

Barbara Wright: ...as the alert.

John Albert: Okay. We receive - continue to receive a lot of questions obviously with the release of the user guide a lot more questions, the volume has picked up. And it's also probably seen in terms of how many people have signed on to this call today there's been an uptick obviously in the number of people participating probably as a result of us releasing that NGHP user guide.

So with that I'll keep it short and turn it over to Barbara who's going to go over a couple of things and then after that Pat Ambrose will provide some updates regarding more technical issues.

Barbara Wright: Good afternoon. To forestall some of your questions the first thing I was going to list is the items that we're working on right now that were not in the user guide. We're working on mass torts and product liability. We're working on bankruptcy and insolvency. We have been gathering examples out of the questions that came in and also from specific documents that were sent to me to add additional examples of who exactly is the RRE or responsible reporting entity in certain situations. Then we're working on the model form.

We were a little bit surprised to see that we're still getting questions concerning who Section 111 applies to; comments such as some believe this applies only to worker's compensation or they think somehow the only type of liability insurance it applies to is automobile insurance. So we'll reiterate that Section 111 applies to all liability insurance including self insurance, all no fault insurance and all workers' compensation.

It applies only when the injured party is a Medicare beneficiary. And the reporting takes place only after there's been a settlement, judgment award or other payment which would include assumption of responsibility for ongoing medicals.

First of all everyone needs to be using the CMS statutory definition if self insurance which is essentially if there's an entity that's engaged in a business trade or profession to the extent they bear any risk they are self insured whether or not they have a formal plan of self insurance.

That definition is in the statute, it's provided in the user guide as well. RREs must also use CMS's definition of no fault insurance. That definition is also in the user guide as well as the regulation cite to that. As I said before liability insurance is all liability insurance and that includes whether or not it's commercial, malpractice of any type etcetera.

However, you do need to keep in mind that we're - there's a situation that does not claim or release or have the effect of releasing medicals it doesn't have to be reported. For instance if there's an automobile that the sole claim is for damage to the car we don't need to know about any settlement, judgment award or payment for that.

We had a question about states that provide liability programs for their employees. The state asserted that it's not self insured; they don't believe it's engaged in a business, trade or profession and they don't believe they carry their own risk. MCS disagrees, if it's a state liability program we consider it to be liability insurance.

We had another question that asked about a state municipal risk management authority where the state law says that business is not insurance and their actions aren't the transaction of insurance. For purposes of this reporting it's CMS's definitions that control not state law. So we do consider that to be a situation that needs to be reported.

Another state made the comment that medicals remain open in their state and that they believe that this should preclude the need to report ongoing responsibility for medicals. We disagree and we've said in all the teleconferences and in the user guide that ongoing responsibility for medical does need to be reported.

In part this assists CMS in stopping inappropriate payments when there is an open, ongoing responsibility. Just because worker's compensation is agreeing to cover related care doesn't always ensure that a provider, physician or other supplier would immediately bill them. So having the information in our system helps us pay claims correctly.

We received another question about deceased beneficiaries, were they covered under the reporting; yes they are. If someone is a Medicare beneficiary or was a Medicare beneficiary at any of the time period issue the claim has to be reported if it meets the other criteria.

We continue to receive questions along the line of actions that entities wish to call goodwill gestures such as adjusting off a hospital bill as a goodwill gesture or assuming liability but then writing off the associated care. Do they have to report that? Those type of actions demonstrate a primary payment responsibility so yes they do need to be reported.

W received an additional question about a student accident program, were these covered? Depending on the specific facts that would normally be a no fault insurance situation under CMS's definition or else liability insurance and if anyone involved and covered under that program was a Medicare beneficiary then yes it would need reported.

Let's see, we also are continuing to receive some questions about states that have lifetime no fault and situations surrounding that. If you have a state that has lifetime no fault benefits but there is nonetheless a settlement that releases future medicals and there's a single payment obligation that goes along with that, yes, you would report the TPOC or total payment obligation to the claimant. And if that terminated responsibility for ongoing responsibility for medicals you would report that termination as well.

We received several questions about government; whether or why different levels of government should be included as a responsible reporting entity. They are engaged at minimum in the business of government; we consider them to be a responsible reporting entity if they don't hold separate policies.

Clinical trials, we received a specific question about that. That will be addressed in writing either in an alert or an update to the user guide.

And we received a couple of questions that said what about multiple incidents in the same claim specifically someone injured their arm in January and then

they tripped in June, there are two distinct accidents and the incoming indicated that those would be a single claim. Most of the experience we've had in talking to the industry indicates that those would normally be two separate claims.

But in either situation they clearly would have their own dates of incident and potentially associated payments so they would normally be reported separately.

The user guide that we've put out just for those of you that haven't had a chance to read it yet, the types of things that are covered in there is there's a complete file layout. It explains the query function in some detail for those of you who wish to use that to determine who is or is not a Medicare beneficiary.

It has detailed registration information. It expands the information regarding who is a responsible reporting entity or RRE. And as I said we're still working on additional examples to publish a more expanded list because we're getting a never ending variation from all of you on the various combinations.

There's also expanded information regarding what to report and when. This ties back to what was in the interim record layout what was labeled as what triggers reporting. So this is the new title you want to look under for that type of information.

We addressed a look-back period for ongoing responsibility for medicals where the responsibility existed before 7/01/09 and continues on or after 7/01/09. We limited that to situations which are open in your records or were open in your records as of 7/01/09 or later.

We understand the industry in general what we've heard is pleased with us considerably shortening what could be the look-back period but not necessarily as pleased with what we subsequently published as a threshold for overall reporting.

The user guide contains our final decision on what code set to use, the ICD9 which when the change takes place in the future to ICD10 will be changed to ICD10 at that point. The instructions provide for a limited use of text for a limited period if you do not have the two ICD9 types of codes we require.

After the limited time period is up then everyone must report the codes. The one thing the user guide does not say is that CMS is in the process of reviewing the codes to determine any that are prohibited and we'll put that list out. In general what we're looking for is you will not be permitted to use a code that essentially translates to unknown; we're not going to consider acceptable to use that type of code.

With respect to the alert that was published dated March 20 as all of you may know by now we've extended the permissible period for testing through the fourth quarter in 2009 so that the required date for go live production files is in the first quarter of 2010. We put an alert in there about the availability of the HEW software that that's not available until you've actually registered.

We had a couple minor points in there in terms of referencing a couple of field numbers that were mislabeled and the need for you to use the user guide if for example there's registration information from some earlier document on the Web site still at this point and it's contradictory to what's in the user guide. The user guide is the most current.

The other big item in the March 20 document was threshold. There are interim reporting thresholds and as we have pretty much said in any conferences with the industry all along is in terms of dollar thresholds we never anticipated that we would come up with a threshold as high as what's often been recommended to us.

We're still looking for data. We haven't ruled out raising the dollar threshold associated with the ongoing responsibility for medicals for worker's compensation. We haven't ruled out listening to further arguments if you have further data in terms of the overall reporting threshold.

The very limited information we have at this point indicates that the $5000 threshold that we picked as the first interim threshold would effectively eliminate roughly 80% or more of an RRE's situations or TPOC amounts that need to be reported. So from the information we have it's not as though we've excluded a minimal amount. From our perspective at this point we have excluded a very large percentage at least to start with.

Those are the two documents they've put out most recently. I want to go over a few questions that came in and then I'm going to turn it over to Pat to address some of the technical questions that came in. People are still asking about ongoing responsibility for medicals and what it means and when they assume ongoing responsibility for medicals.

There seems to be some confusion about whether or not paying a TPOC amount automatically means you've assumed ongoing responsibility for medicals at some point.

One of the questions was if there's a decision made to pay but the payment is essentially going to be in a single obligation and it's not being processed right

that minute does that decision to pay constitute ongoing responsibility for medicals? Does an annuity constitute ongoing responsibility for medicals?

Generally what we've been looking at for ORM is the concept that the entity is going to pay on an ongoing basis when claims for medicals are submitted. Often with worker's compensation, worker's compensation bills will be submitted from providers, physicians and other suppliers and simply paid on an ongoing basis or for no fault the same type of thing whether it's paid directly to the claimant as reimbursement or to a provider or physician.

If you're setting up a single payment obligation whether it's funded as a structured settlement or annuity etcetera it's simply reported as a TPOC, a total payment obligation to the claimant. Similarly if you've decided to pay but essentially for no fault you're going to pay a single flat sum to the beneficiary then report that as a TPOC; you're not paying bills on an ongoing basis.

If when any of you ask questions lately if you have any opinion over whether - what I've just said helps clarify it some please let us know so we can add further language to the user guide.

Another issue came in is who is reported as the representative. If there's an attorney and, for example, a guardian, this is when you have a living beneficiary. And we want the attorney reported. Our records should internally, someone who has a guardian or a conservator etcetera typically we will already have a representative payee set up on our records so we do need the attorney information.

Let's see, a question was raised because apparently someplace in the user guide we say something about no querying or potentially say something about

no queries after the TPOC date or after ORM terminates. What we have also said is you do need to know status as a Medicare beneficiary as of the TPOC date or as of the termination date for ORM.

So in that sense yes you might have to do a query the day of or the day after or your next query submission after a TPOC date or after ORM terminates so that you can have correct information.

And again you would have to query if you had a situation where you were permitted to terminate ORM either by state law or by one of the criteria we've set forth and the person was not yet a beneficiary and then you subsequently reopened, you're going to have to begin any query function again if you reopen.

The next scenario people were asking about is if you're required to pay a pending investigation or you have a policy of paying pending investigations and the investigation results in denial. Yes you need to report the ORM while you're paying and you report termination when you make the denial determination. You do not go back and zero out the previously reported ORM.

For TPOCs and ORM both we had a question about multiple TPOCs or multiple settlements. Are interim settlements reportable while medicals remain open? We haven't received that much information about situations where there would routinely be interim settlements, but yes we do need all TPOCs reported regardless of whether or not ORM remains open.

With respect to TPOCs we were asked whether or not if there's a situation where there's a settlement and they've also arranged for a Medicare set-aside regardless of whether or not it's been through CMS's approval process for worker's compensation is that MSA amount included as part of the TPOC?

If it's a single payment sum obligation yes, I mean, presumably all the - most of the situations we're seen or that I'm aware of is there will be X amount payable plus the set-aside amount or X amount including the set-aside amount. So it's clearly part - the funding for that is clearly part of the total payment obligation to the claimant.

Death benefits to dependents, are those reportable? Again you go back to what we've referenced in the manual where something that doesn't claim or release or have the effect of releasing medicals with respect to the beneficiary does not need to be reported. But if it does any other those things then yes it needs to be reported.

We were asked about the 12/5/80 date for liability and no fault and the date of incident. Yes we say that in general CMS is determined that it won't pursue recovery if the date of CMS defined date of incident is prior to 12/5/1980. But then we give an example of a situation with a continuing DOI specifically with respect to exposure.

If it's easier for you to think of it that way, if you have a situation with exposure and that exposure continues on or after 12/5/80 it's really like you've got a series of continuous multiple DOIs and we only require you to report the first DOI but yes we do have a recovery claim in that situation.

Errors and omission policies that exclude medicals; we were asked if those ever had to be reported since the policy technically excludes all medicals. If the exclusion is being done on the basis of not paying for things that are paid for by a collateral source know that CMS's position is that Medicare is not a collateral source, you must report in that situation.

If a policy simply excludes medicals to the extent medicals are claimed or released or any settlement has the effect of releasing medicals then yes it still has to be reported. There are arguably nuisance - what entities would call nuisance suits, they're paying them. Whether or not they believe that the policy would have paid for medicals nonetheless they are settling that issue and it must be reported.

Okay last one of the questions that came up more than once in different variations is an entity has come in through our resource mailbox and said we don't have any employees, everything's outsourced or we don't, as a county, we have no employees that can sign a contract etcetera therefore who can do the registration and who's the RRE?

In both of the situations described clearly someone has the authority for example to do the outsourcing, someone in county governments, state governments, federal governments at some level there they have the authority to contract. So you need to trace it back up the chain if necessary but you must have an entity that can do the authorization. Pat.

Pat Ambrose: First I'd like to remind everyone that we are developing computer-based training, the CBTs related to liability and worker's comp, no fault reporting. There'll be a set of CBTs based on the information that's in the user guide. There'll also be courses specifically geared toward registering on the COB secure Web site for Section 111.

And a set of CBTs that will focus on your ongoing use of the Section 111 application on the COB secure Web site. And an announcement will be made on the Web site when these training modules are available. I highly recommend that prior to registration that you go through these courses to

obtain additional information and reinforce the concepts that are in the user guide.

I am in the process of taking feedback that we've received on the user guide both errors that have been found to solve one alert that we've posted about an error in the user guide. And obviously there may be others or have been others found. And I'll address those errors in the next version of the user guide and we'll publish an update.

That user guide will have in Section 1 a complete list of the changes that were made. In addition to that when we published this new version of the user guide I'm going to include a document - a separate document sort of in a Q&A form that will address the questions that have come up specifically related to the user guide.

And then that same information will be in the user guide but maybe the Q&A form will be an easier document to spin through and see what we've changed and find the question that you've submitted.

Speaking of which, please continue to send your feedback to the Section 111 email address. To obtain that email address to out to the mandatory ins/rep Web page and see the download on that main page that says opportunity to comment and within that document is the email address.

Another question or pointed out that the current link to the old registration information, registration documents that was on that main Web page that link does not work however that document is not any longer very accurate so I encourage you to use the user guide information in Section 8 on the registration process as well as later on when the CBT becomes available.

Also note that once the Web site is up live there will be a how to menu option that will have information on how to register and similar information that specifically on using the site. And then once you log on to the Web site there'll be a complete user guide posted there.

However I am planning on working with CMS to create a new registration overview document that will essentially contain the information in the user guide and perhaps beefed up a bit to answer some of the questions and put that out there instead of the old document that we had before.

I'm going to cover a little bit of information on registration and then turn it over - open it up to questions. In the Section 8 of the user guide you'll see that there's a couple of steps recommended prior to launching into registration that you need to think about. And those steps include figuring out how you're going to submit your files.

And how you're going to submit your files will determine how many RRE IDs you need to obtain and therefore how many registrations you need to perform on the Web site.

You may need to submit more than one claim file per quarter for one particular RRE. Each of those claim files then must be submitted with a unique RRE ID. So we have the RRE as the highest level, there's no actual code in the system associated with the RRE instead we start out with a TIN associated with that RRE and then subsequent RRE IDs; so one RRE in other words may have multiple RRE IDs.

You could have 50 different RRE IDs if you decide that you must submit 50 different claim files each quarter. Now the submission of your claim files might depend on if you have different claim systems and it is not a practical

process to roll up all of the claim records for Section 111 reporting into one file so that you have for example three different claim systems you may decide that you want to submit three different claim input files each quarter.

And these would be different claim input files obviously. In that case you would need three separate RRE IDs, another reason for your separation. So the first reason might be that you might have more than one claim system. Another reason might be that you're contracting with different agents to submit on your behalf.

Perhaps you send all of your worker's comp claims to an agent for some other reporting purposes and that agent is offering a service to you to then also report for Section 111. However that agent is only going to report a subset of your claims not all of the claims required for Section 111.

So in that case you may contract with that agent and have them report one claim file for their share of the claims in a sense and then perhaps your own IT department is submitting a claim file for the remainder of your claims. Or maybe it's a different agent that's submitting the remainder of those claims.

Again the number of RRE IDs is dependant on how many separate claim input files you need to submit per quarter. And then one further example that I can think of in terms of determining how many RRE IDs and therefore how many claim files you may be submitting might be dependant on subsidiaries.

If your subsidiaries are acting, you know, are doing around claims processing independently and again it's not practical to roll up the claim input files into one file to submit on a quarterly basis then you may submit separate claim files based on subsidiaries, it really depends on your unique situation.

In addition to figuring out how you're going to submit your files and therefore how many RRE IDs you need then you need to think about the individuals that will be involved in the reporting process. However, reference the authorized representative earlier, the authorized representative is the person who will sign your profile report and who holds ultimate accountability for your adherence to the reporting requirements.

Now your authorized rep is not a user of the COB secure Web site it's thought to be, you know, in my mind someone higher up in the organization who's not involved on a day to day basis but is actually though that person who's ultimately accountable and overseeing at a high level the process.

If you have 30 different RRE IDs you may use the same authorized representative for each of those reports or you may use different ones depending on your unique situation.

The account manager is actually a role or a person who will be a user on the COB secure Web site. Your account manager may be an agent; your account manager may be an employee of the RRE themselves. That's your individual decision or organization's decision. The RRE is responsible for the overall day to day processing of these files and would be the main contact with the COBC when issues arise.

If you have multiple RRE IDs that you're submitting multiple files per quarter you may use the same person as your account manager or you may use different individuals, different account managers for each file.

After the account manager there's a second user role or second type of individual who works on the COB secure Web site who's associated with your account and that's known as an account designee. The account designee will

obtain a login ID and password for the site and may submit files and view information about file processing and download response files.

The account designee must be invited by the account manager to be associated with that account. An account designee with one - each user of the Web site has one login ID and password and an account designee with that one login ID may be associated with multiple RRE ID accounts. So after you've given some thought to this and you know how many RRE IDs you need you will come to the Web site and perform the new registration step which is also labeled step one on the Web site.

During that process you submit information for the - related to the RRE, the TIN, the tax identification number, for the RRE that will be associated with that RRE ID. If you are setting up multiple RRE IDs you may use the same TIN for each of those or you may use separate ones, again, your choice as to how your organization is set up. You must perform this step though for each RRE ID.

Also during that first step you're providing information on who will be the authorized representative for that RRE ID. You'll provide the name and address, telephone number, contact information for that individual and also an email address.

Some of the communication between the COBC and the RRE will be via email. So the email address that you provide in this new registration step is the email address for the authorized representative. And that is an important thing that I'll stress in future documentation.

Once the first step, that new registration step, which is really pretty short - once you've completed that the COBC will validate that information and then

send a letter via US Postal Service to the authorized rep named in that step. And that letter will contain - actually at the end of the first step you'll be assigned your RRE ID and your EDI representative but the letter will also contain your RRE ID and then a personal identification number or PIN that you will need to give to your account manager for the second step.

The second step of registration is called account setup and it's performed on the COB secure Web site. It must be done by your account manager. It's absolutely critical that that second step of account setup is done by your account manager. That's when your account manager becomes associated with the RRE ID and obtains their - the first time they go through the process they get their login ID and password.

Obviously as you're doing account setup for second and third and subsequent RRE IDs you'll use the same login ID; we won't need to develop a new one each time. After account setup is completed by the account manager the profile report will be sent with all of that information that's been provided during these two steps of registration and account setup, the profile report will go to the authorized representative for signature.

It'll be sent via email, a copy will go to the account manager but it is the authorized representative that must sign it and return that as instructed to the COBC. At that point you can start the testing process once that profile report has been received back and logged at the COBC.

After the account manager has obtained their login ID and set up the RRE ID account the account manager can then launch into associating or inviting other users to the RRE account - RRE ID account. And those other users are known as account designees and again can perform all the functions that an account manager can however they may not invite other users.

So as you can see the account manager is that person who's to control the users associated with the RRE ID account on the COB secure Web site. The authorized representative must - is in essence by delegating that authority to the account manager they are approving then those people as well.

So the account designee, the way that that works is the account manager, and again more information will be forthcoming on this process, but the account manager will log into the site and there's an action under each RRE ID that he's associated with to select to manage his designees.

He'll select that option and then invite designees. He will need the email address for those individual people who will be account designees associated with that RRE ID. So they will provide the email address and information about that person.

The first time as an account designee you're invited to the site by an account manager you'll receive an email with a token - secure token link that you must follow back to the site and use that to register for your login ID and password.

Once you've established your login ID and password subsequent invitations - maybe you'll be associated with 1500 different RRE IDs, if possible. The subsequent invitations will just be an email informing you that your account manager has invited your or associated you with this RRE ID. And the next time you log into the COB secure Web site on your main page, we call it the RRE listing page, you'll see all of those RRE IDs that you're associated with listed there.

So that's all I'm going to cover specifically today and I guess, John.

John Albert: Yeah, this is John. I had a couple things that have, just again in looking over some of the questions and just pointing people again to, you know, hopefully they've had a chance to look over the guide since it was put out. But again in terms of some of the sections of the guide to address a lot of what we see as common questions coming in, for example, one of the questions comes in concerns - or a lot of the questions concern when to - to use the delete function versus update function.

And I would refer everyone to Section 11.5 and even more specifically 11.5.4 which is an event table which basically describes scenarios - examples of scenarios of when to use either an update transaction or in the case of where you're actually updating key matching information you would delete and then re-add a new record to essentially change a key field.

Also Section 9.2 contains the data format - there's a lot of questions regarding, you know, like, you know, is it less justified, would you use spaces or zeros, things like that. And there's a table in 9.2 which goes into great detail regarding the record level format.

The other thing Pat mentioned about the computer-based training modules, those will be rolled out gradually as they're completed. And of course the first pieces will concern the registration process and those should be coming out very soon.

Also some questions have come in as they have in the past under the GHP reporting about changing information related to a TIN number. Basically anytime somebody needs to update information associated with a particular TIN ID they would need to also resubmit that record to allow that new address to overlay the old address at the individual record level.

Again that information, a lot of it is in the user guide but keep in mind that when you're updating address information that means you need to not only update the reference file but also the individual records associated with that particular TIN otherwise it will not necessarily trigger a mass update on our part. We need to know which records have the new address etcetera so keep in mind that you have to update the record as well as the TIN reference file as well.

In Section 12.3.2 there are what we refer to as threshold errors. These are still under fine-tuning so to speak in terms of these are ways that we look at an overall file coming in and it's an attempt to identify essentially anomalies in submissions to identify potential errors on the part of the submitter regarding the types of records, timing, etcetera.

So those, again, for non-GHP we don't expect to receive very many delete transactions so we have a delete threshold where if, you know, a certain percent of the records coming in are in fact delete transactions that would trigger us to essentially suspend the file and go back to the submitter to confirm whether or not that's really what they want to do with that particular file.

Other than that's all the other information I had. Barbara, did you mention anything about the - there was a lot of questions about the liability set-aside and worker's comp set-aside and, I mean, we're not request a, you know, I don't know if you wanted to - just because it keeps coming up.

Barbara Wright: Two things...

John Albert: I didn't mean to put you on the spot.

Barbara Wright: ...first I was going to mention that we've had several questions in the past what if I don't think I have anything to report; do I have to register now? If you'll check out Page 53 in the guide we've addressed that. It essentially said if you're not expecting - reasonably not expecting to have anything to report you don't need to register immediately.

But you do need to register in time to allow three full months or a full calendar quarter for testing at the point where you have a pending claim or that you have a reasonable expectation that it can result in a need to report.

John's question about worker's comp set-asides and liability set-asides, we'll repeat what we said over and over is that the worker's compensation set-aside process first of all that is not a required process; it's a voluntary process that's highly recommended.

Secondly CMS for liability set-asides does not have the same formal review process although our regional offices will consider review of proposed liability set-aside amounts depending on their particular work load and whether or not they believe significant dollars are at issue.

Last but not least...

John Albert: But again none of them are required.

Barbara Wright: Well the point is the set-aside process is totally separate from the Section 111 reporting process. As we've said in more than one call we don't anticipate changing our routine recovery processes. When there is a TPOC amount typically what we're doing is pursuing recovery against the beneficiary's settlement, judgment award or other payment; we are not - the fact that you're

reporting to us doesn't change any other obligations or eliminate any other obligations.

Bill Decker: Yeah, hi, this is Bill Decker. I just have a couple of points to make quickly and then I guess we can go into questions. The only two that I want to re-steer or reinforce is on the alert that we published on March 20 we told you that we extended the permissible testing period. I want to reiterate though to everybody, I mean, of course for everybody that doesn't mean that we have extended the first reporting period to January 1 as a requirement.

If you can register and test and begin to do production reporting before that date please do so.

Barbara Wright: October 1 of 2009...

Bill Decker: October...

Barbara Wright: ...is the first date that we'll be ready to accept production files.

Bill Decker: Right but you could start testing after registration.

Barbara Wright: Yes.

Bill Decker: Right. And if you're ready...

Barbara Wright: Well actually let me clarify - I'm sorry - July 1, 2009 is the current start date for testing.

Bill Decker: So first testing July 1, first production October 1.

Barbara Wright: Right and production requires start in January 1.

Bill Decker: January 1, 2010. Okay, make that clear. The second thing is the - when you're sending us questions and you are referring to information - hard information what I generally think of as hard data if you can let us know where we can see that information also to be really useful. We get a lot of questions saying we have data that says - and then you make a statement and we can't - we have no way of knowing what the data is because we don't have the same access to it that you do.

If you could just - if you have data and can give us the data sources we would really appreciate it. It would be very useful for us as we're doing our own examination of these issues to have the same access to the same information that you do. And that's it for me.

John Albert: And finally before Q&A, again, the resource mailbox is the most efficient way to get your questions to CMS and also to the broadest audience within CMS especially now that we have the full-blown user guide out there and other materials forthcoming we want to hear your suggestions, comments, etcetera about the materials or anything that we could provide regarding additional educational materials, whatever.

So please continue to submit those with specific information in the subject line which helps us categorize it. Those are all catalogued and as Barbara went over a lot of the questions and so did Pat and myself and Bill, we try to answer those on these calls but we more specifically try to answer those types of questions as continue to refine that materials that are out on the Web site.

So with hat I'd like to turn it back over to the operator and we can get into the Q&A session.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question please press star 1; you will be prompted to record your name. To withdraw your question press star 2. Once again to ask a question please press star 1. One moment please for the first question.

Our first question comes from (Frank), your line is open.

Barbara Wright: Yes, (Frank). (Frank).

(Frank): A question on the bulletin that came out the other day, the alert, on the second page, number three regarding the thresholds. Date of December 1, 2010 just curious to know why that's there. Are these thresholds likely to change after that date?

Barbara Wright: As we've said right now we have relatively minimal data. We're trying to gather more data. The plans right now, the legislation doesn't include minimum thresholds. If we have the capacity to take in all the data and it's productive for us to do so that's under consideration. But at the same time if you can give us data that helps show why we shouldn't collect information we're most interested in that.

Number three, under the interim reporting thresholds, which is worker's compensation, ongoing responsibility for medicals and it lists certain criteria. We're not interested in ongoing records for worker's compensation for the medical responsibility if it's not likely to result in situations where Medicare may have made an inappropriate conditional payment.

So if we can define a situation tightly enough as one where that's unlikely to have happened then we're not interested in receiving those records at all. The

data we have at this point we felt comfortable testing this threshold. But again the more you can reinforce what we've got or give us information that lets us do higher thresholds we haven't ruled that out.

But we also can't rule out the possibility of some lower situation if the data doesn't pan out.

(Frank): Thank you.

Coordinator: Our next question comes from (Cindy Sage), your line is open.

(Cindy Sage): Yes good afternoon. Thank you for giving us this opportunity. I had a couple questions, the first one dealing with Page 52 of the users guide. We had some questions regarding the qualified exceptions to get a better understanding of how that works. It indicates here that when ORM is assumed prior to July 1 of 2009 and our medically active case was closed prior to January 1 that we will not be required to report those. Is that correct?

Barbara Wright: Right, except that you will be required to report if it's subsequently reopened.

(Cindy Sage): Okay how about in our instance sometimes we have cases that we have ongoing medical responsibility. However we have them in a closed status yet we may pay a medical bill here and there. So internally we consider them closed. How would CMS...

Barbara Wright: If you're paying a medical bill here and there then you're really continuing to pay.

(Cindy Sage): Right.

Barbara Wright: You've got ongoing responsibility and no you really shouldn't terminate those. We said elsewhere in the draft and elsewhere here that if it's - we don't consider it closed for purposes of this reporting unless either it's closed under the state statutory provisions which would - well actually our broad umbrella is that it's closed when you can guarantee that you're not going to be making any further payments and there's no possibility of reopening which could either be an expiration under state law or other statutory limitations.

What we said in order to aid people so they didn't have to keep the records open indefinitely we've offered you the opportunity to close it or term it for purposes of this reporting if you have evidence through a treating physician that there won't be ongoing treatment etcetera.

But the situation you've just described seems to be a typical situation where the person needs ongoing care on an intermittent basis in which case there should be an open record so that we can, as appropriate, determine not to pay claims if they're billed to us in error.

(Cindy Sage): Okay, thank you Barbara, I appreciate that. We're trying to get our system in a place that we can provide this information and that helps me to explain that to our IS department.

Barbara Wright: I mean part of what we're trying to do is make sure you have the ability, you the RREs have the ability that you don't have to hold a record open for 40 years because someone had a sprained wrist and they're in a state with lifetime medicals. We wanted to give you some way to have that closed.

But, you know, again where there is an expectation of making payment etcetera clearly those are the ones we would want to be open.

(Cindy Sage): Okay. And then on Page 47 on your event table when you're talking about changed information in the bottom left hand corner of this block it lists ICD9 codes so am I correct that every time a person who's receiving ongoing medical treatment say their condition worsens and they develop new conditions so there's new ICD9s assigned to that individual that we will need to file an update record?

Barbara Wright: If you're adding new ICD9s to your record, yes, that would help CMS in terms of appropriately processing claims as well.

(Cindy Sage): Okay and then last question I had from our IS people is that it appears that in the old format regarding P&C claims you had a column for ICD9 and also body parts but am I correct

((Crosstalk))

(Cindy Sage): ...no longer body parts?

Barbara Wright: That was before we made a final decision on the code sets. We got information from various part of the industry some didn't use any codes at all, some used WCIO codes, some used Department of Labor. And we ruled out various code sets for various reasons. The ICD9 is universally available. And since it does have an external cause of injury code that's available as well we've settled on using solely the ICD9 codes.

(Cindy Sage): Okay thank you very much for your time today, I appreciate it.

Barbara Wright: Okay.

Coordinator: Our next question comes from (Arlene Arenstein), your line is open.

(Arlene Arenstein): Good afternoon. I'd like to ask if it has been contemplated the additional cost that this law will have various participants incur as a result of it?

John Albert: I mean in terms of costs I mean we had to file a package under the Paperwork Reduction Act that provided for several comment periods related to the proposed, you know, what the proposed impact of the legislation would be on both government as well as the private sector.

(Arlene Arenstein): And how was that dispersed between the private sector and legislators so that people were made aware of this act?

John Albert: It's through the Federal Register. That notice - and actually there's a link on the mandatory insurer reporting page to that information.

(Arlene Arenstein): And what methodology was used to inform the general public who does not use IT computer technology to provide this information?

John Albert: Well I mean that information is in the actual Paperwork Reduction Act and we would refer you to the package that's out there - we would refer you to that which includes the methodology used to determine that information.

(Arlene Arenstein): Okay. And then I have a final question: How do you know that everybody can readily get ICD codes and that those are readily being used by every participant in this reporting mandate?

Barbara Wright: We didn't say that everyone is currently using them. The statutory provisions give us the authority to require information we need for coordination of benefit purposes including recoveries where appropriate and certainly including claims processing.

The determination was made that the ICD9 codes are our best methodology for doing that across the board. If you don't currently get that information you will need to get it. If you use different codes right now such as WCIO you may decide you need to change. You may do some type of mapping between WCIO or the DOL codes if you use those and ICD9.

But the requirements...

(Arlene Arenstein): All add expense to the participating providers that have to live up to this mandate. It's just a general comment about the incurred costs that this mandate will put upon agencies that are already stretched to the limit.

John Albert: Okay thank you.

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

(John Miano): Yes hi good afternoon. My questions - actually I have two of them - concern updates. With regard to Page 43 what should happen if there are updates to fields which are not present on the bulleted list that's on the update section, i.e. things like plan contact address, no fault insurance limits, which are not present?

Pat Ambrose: We do not require that you send an update record in the case of those - changes to those fields.

(John Miano): Okay so we're not required to send a record there. Okay. Also having to do with Section 11.5.3 under updates; you provide some scenarios for updating existing TPOC values and for providing additional TPOC amounts. This implies that a claim can have multiple TPOC dates and amounts; however it's

not clearly specified how to send updates to additional TPOC amounts or dates.

For example if you have a claim that has an original TPOC amount of T1 and an additional TPOC amount 2 was sent with a code of 03 on the action type on a later date. If we send another update to a TPOC amount how can we specify if that update is for the original TPOC T1 or the subsequent TPOC 2?

Pat Ambrose: I don't have an answer for that. Is that a likely occurrence?

(John Miano): It is. Yeah.

Barbara Wright: We'll have to take it in...

(John Miano): Let's take an example such as a worker's compensation claim where you may have an initial settlement of indemnity and then you're going back and you're also settling medical. If you have updates with regard to those - to the information with regard to TPOC 1 say for instance that the date that was initially provided was accidentally provided as the date that the funds were released rather than the date that the judicial order came in approving the settlement, you know, something of that nature.

And you've already reported your second settlement which is your medical settlement. If you send in an update on the TPOC date which one, you know, how you going to know which one did that apply to?

Barbara Wright: Well we appreciate you asking the question. We'll go back and look at it again.

(John Miano): Okay. I have one last question. And this is in regard to the HEW software. If we're an agent and we're not a registering RRE how do we obtain a copy of the Q software? Do we have to wait until one of our RRE registers?

Bill Decker: Yes.

(John Miano): Okay. Thank you.

Coordinator: Our next question comes from (Nikki Lahan), your line is open.

(Nikki Lahan): Hi. I had a question about if you all could possibly provide an example for the claimant 1-5 like for worker's comp scenario in reference to - like when would we have to necessarily report a dependant?

Barbara Wright: Well first of all remember as long as the beneficiary, the injured party, is alive you're not going to be using that file all, the auxiliary file. This is solely for situations where the beneficiary is deceased where the claimant by default if nothing else becomes the beneficiary's estate or maybe a dependant or something like that.

So we imagine that in most situations you aren't even going to be using that. Not even a claimant 1 let along having to do the full auxiliary file.

(Nikki Lahan): Now okay so if we have a claimant that dies, okay, and then we later settle the file with his widow and we're not paying her any medical benefits because it's a worker's comp claim, we'd be settling out the death portion of the claim. Would that be something - would that be a scenario in which we could possibly have a claimant 1?

Barbara Wright: If medicals for the beneficiary were claimed released or having the affect of being released then you need to report to us.

(Nikki Lahan): Okay that was it. Thank you.

Coordinator: (Pat Lambrick), your line is open.

(Pat Lambrick): Hi yes, this is (Pat). We have four or five questions for you from (Sub) Insurance. The first question has to do with - we've discovered that we have to tie the query results back to the claim that necessitated the query and we were wondering if it would be possible for you to include the document control number on the query response file?

Barbara Wright: You won't - unless I'm misunderstanding the question you will have the results of your query before you actually submit a record to us. So we won't have any DCN to tie to anything. You're only - for non group health plans you're only reporting once there is a settlement, judgment or award or other payment.

And you're only reporting for those people who are beneficiaries. So basically once you find out someone is a beneficiary then you report them if and when you have the settlement, judgment or award or other payment. You aren't going to have reported something and then get a HIC number and then tie them together. You can only report it if you already have...

(Pat Lambrick): Right. I think I did not include the correct file - the question is can we send you the DCN number on the query...

(Fred Cluso): The question is - this is (Fred Cluso), I also work at (CHUB). The question is, is it possible to have a DCN number added to the query file that we sent to

you? I know that there's a DCN number coming back on the query file but there's none going on the query file.

Barbara Wright: Yeah, at this time we would assume that you're going to use the SSN - you have to submit your query with the SSN...

(Fred Cluso): Right.

Barbara Wright: ...of the injured party or the HIC number if you happen to have it why you would query then I don't know. But all our assumption is that you are matching your query record back to the SSN of the injured party for any applicable claim that might need to be reported.

And at this time we don't have a DCN. We've been using this format in the GHP - the group health plan - for awhile. We don't have a DCN on the incoming record, you know, we can take it as a note. But I mean, there's no projected date. You really need to set up your system to do the matching on SSNs.

(Fred Cluso): Thank you.

(Pat Lambrick): Our second question has to do with when we have agents reporting for us are they obligated to send their files in during the same timeframe as the RRE has been set up to send theirs in?

Barbara Wright: That's the only time they can send it.

(Pat Lambrick): Okay.

Barbara Wright: They're acting on behalf of the RRE.

Pat Ambrose: Yeah, I mean your agent is - I'm not sure I fully understand the question. Maybe if you give me a little bit more background on...

(Pat Lambrick): Our (TPA).

Pat Ambrose: You know, each - you will register and then an RRE ID for each file submission. So if for example you have an agent who will be submitting one set of claims or, you know, one claim file for you per quarter and then you and your own IT staff is creating another set...

(Pat Lambrick): Right.

Pat Ambrose: ...then what you want to do in that circumstance is register for two RRE IDs...

(Pat Lambrick): Correct.

Pat Ambrose: ...and the agents will use one and you'll use the other. Each RRE ID will get a separate file transmission timeframe of time so RRE ID number 1 will have to submit during the - say the first week of the second month of each quarter. And RRE ID number 2 might be the third week of the third month of each quarter.

(Pat Lambrick): So there's a separate window for each RRE ID?

Pat Ambrose: Correct.

(Pat Lambrick): Got you. Okay we had a question about the ICD9 codes. Could you tell us when you would expect to ever get 19 ICD9 codes in?

Pat Ambrose: What we did was the CMS internal files have up to 20 diagnosis codes which does seem like a large amount. And so what we did was in order to not have to impose changes on you later we decided we might as well put them on the record now. And, you know, you'll note that we had reserved some filler space for it.

So the 19 - there's 19 ICD9 diagnosis codes on the record as well as one cause code that's also using an ICD and that is considered a diagnosis code, the internal CMS database as well. So it's unlikely I suppose that you would have that many but we wanted to make sure that we didn't have to come back to you with changes to the file layout later. So...

Barbara Wright: Also note that I think we specifically asked for that we didn't expect it to be unusual necessarily to get up to four or five particularly if there were multiple body parts involved.

(Pat Lambrick): Right. Right, okay. Thank you. Two more questions. Do we have to send updates to what you're calling pertinent information after we have determined that ongoing responsibility has been settled with a payment?

Barbara Wright: Two separate questions really; if you're terminating ORM and it's been terminated then no in general you're not doing anything with that record, you're not going to be submitting updates. For the TPOC information typically you won't have updates, once again, you will have closed it unless you have reason to be, you know, paying multiple TPOCs etcetera.

We are not expecting you to continue to monitor files where you have terminated ORM under our criteria or where you've closed the record after you've had a single TPOC and that was all that was pending.

(Pat Lambrick): Okay. And the last question if we - if the attorney changes or any of the other representative information changes do we need to send you an update for that?

Pat Ambrose: I'd have to refer to you to the event table and there's a concise list of the data elements that if those change we expect an update otherwise we do not.

(Pat Lambrick): And that event table is in the user guide?

Pat Ambrose: Yes, ma'am.

(Pat Lambrick): All right thank you very much; you've been very helpful.

John Albert: It's Section 11.5 in the user guide.

(Pat Lambrick): Thank you.

Coordinator: Our next question comes from (Linda Leathers), your line is open.

(Linda Leathers): Thank you. I have a couple of questions. Ours relates to - we are a cost containment company not an insurance company and many of our companies that we do business with have high dollar deductibles that don't reach those major thresholds a lot of times so we would be reporting for them.

In those cases would we be the RRE, or would we be an agent?

Barbara Wright: Wait, you said, yeah, but you have clients who would - in their relationship with you they have a high deductible?

(Linda Leathers): Right.

Barbara Wright: And they take care of the amount below the high deductible?

(Linda Leathers): Yes.

Barbara Wright: Then they're the RRE for that which is considered self insured.

(Linda Leathers): So they are the RRE or we are the RRE?

Barbara Wright: They are the RRE for the high deductible or low deductible if they're paying that directly to the claimant. If they always pay it to the insurer, to the policy that the deductible is part of and the insurer pays out both the deductible amount and the amount above the deductible then the insurer is the RRE.

(Linda Leathers): And in these cases the employer pays the provider not the employee.

Barbara Wright: You're talking - the employer is the holder of the policy?

(Linda Leathers): Well yes.

Barbara Wright: And when you say provider you mean the physician or supplier or who do you mean?

(Linda Leathers): Yes, the physician.

Barbara Wright: So you're talking basically worker's compensation type benefits?

(Linda Leathers): For non subscriber.

Barbara Wright: Okay. If the...

(Linda Leathers): So in all of those cases would the employer be the RRE?

Barbara Wright: Yes.

(Linda Leathers): Okay so would we have to submit a separate - like you were talking about two RREs for ID numbers so that we could be an agent and submit that information for them?

Barbara Wright: If they wish to use an agent then they need to register and name you or anyone else as their agent.

(Linda Leathers): Okay and we would have to do a separate one for each individual client then?

John Albert: Each RRE, yeah.

Barbara Wright: Each RRE.

John Albert: They would have to designate you as their agent.

Bill Decker: They wouldn't do the registration though.

John Albert: The RRE would.

((Crosstalk))

John Albert: Yeah, make that clear.

(Linda Leathers): We would not be responsible for registering on any of these we'd have to make sure that all of our clients knew...

Barbara Wright: Right.

John Albert: Yes.

(Linda Leathers): They have to register as an RRE?

John Albert: Yes.

Barbara Wright: Yes.

(Linda Leathers): Okay.

Barbara Wright: Do make sure everyone who hasn't made it through the guide yet some of the other sections we added was language about appeals, we added language about joint power authorities. We added a very detailed list that tried to walk through the various scenarios for worker's compensation. So make sure you've looked at all of those in determining who's an RRE.

As I said we are adding additional examples and we are working on one particular situation where there's an allegation that non-subscribers in that particular state do not furnish any type of worker's compensation that what they furnish is actually liability insurance.

(Linda Leathers): Right. And those are the people that we're talking about.

Barbara Wright: Well we are looking into that issue and we'll address it specifically. If you're from the state of Texas we're talking about you.

(Linda Leathers): Okay because my question is we would be reporting only on the medical claims and then they would probably have someone else reporting on the lost time wages or whatever. So...

Barbara Wright: Well if you're lucky it'll fall under all the thresholds and nobody will report.

(Linda Leathers): I doubt that but it would be nice. So will the - they will need to register for two RRE IDs so that they can have two separate dates?

Barbara Wright: If they want to do two separate reports then two separate RRE IDs.

(Linda Leathers): So because that way they would have the opportunity to send the data at different times, correct?

Barbara Wright: You can't - and Pat correct me if I'm wrong - you cannot get two separate RRE IDs just so you can based on your convenience switch your reporting time quarter to quarter.

(Linda Leathers): Right, no I didn't mean it so that the times would be easier; since there's two separate companies reporting...

Barbara Wright: Yes.

(Linda Leathers): ...two parts of the information.

Barbara Wright: They would have their own RRE and their own assigned submission window.

(Linda Leathers): Okay thank you.

Coordinator: Our next question comes from (Debbie Mitchell), your line is open.

(Debbie Mitchell): Thanks, hi. This is (Debbie Mitchell) from (Simmons Stipper) Law Firm and I've got a couple questions I'd like to ask you. The first one is we're talking about the ICD9 codes that are on the conditional payments and the final demands. And we are expected to review those to make sure they're accurate. But we find in our firm that they are not complete.

If we would send in and say that they're not related and then we will in turn get a new conditional or final demand back that states that yes it is correct and they will not remove them...

Barbara Wright: I don't mean to be rude but we are not discussing the recovery process right now. We are discussing Section 111 reporting. And your discussion relates specifically to the recovery process.

(Debbie Mitchell): Okay so who should we discuss this with because we cannot get any answers from anyone? How do I get these questions answered? Because these are important also.

Barbara Wright: If you have a question to submit you should submit it through your regional office to the MSP coordinator in that regional office.

(Debbie Mitchell): Okay that's what I'll do then.

Coordinator: Our next question comes from (Robert Real), your line is open.

(Robert Real): Yeah hi. With regard to a TPOC situation RREs are required to report once there's been a settlement or award. So for example on an auto/liability claim if the RRE report to you is not made until after the claim is settled who is responsible for any - and I know you didn't want to talk about recoveries but

who then does the responsibility lie as far as any recovery that you have? Who's responsible for that recovery to pay that back?

Barbara Wright: Nothing has changed in any of our recovery processes or the underlying statute or regulations for that. As we've said our standard process is to pursue recovery against the beneficiary's settlement, judgment or award or other payment.

Insurers who wish to protect themselves may do it in a variety of ways; we've heard of situations where if the attorney holds on to the check until he has the demand amount and goes back to the insurer the insurer will trade it in or replace it with two checks, one specifically to Medicare for the correct amount and one to the beneficiary and their attorney in place of what started out as a three-party check.

Or they may simply only do a three-party check. Or, you know, however they wish to handle it. But I mean that hasn't changed and it's not part of the Section 111 reporting process.

(Robert Real): Okay thank you.

Coordinator: Our next question comes from (Tony Krako), your line is open.

(Tony Krako): Yes I just wonder again, we've raised this example before and it's never been really clarified or else it wasn't clarified to me where we have someone who's not a Medicare recipient; we have a state where the ongoing responsibility is lifetime.

And I guess I want to know or we want to know basically do we have to query this person every quarter for 25 years, or can we just not query him because he

wasn't a Medicare recipient at the time our payments ended when he stopped getting care? And then if he resumes care in 10 years that's compensable, we then query him and find out if he's or not a recipient?

Barbara Wright: If he's open in your records you need to leave him in your query file. But we gave you parameters in the interim layout and again in the user guide to say that if you have for example lifetime medicals or the statutory timeline for responsibility hasn't expired and you still have some possibility of payment or reopening that from our standard that should not be terminated.

However what we put in the user guide is that at least one way for you to avoid that if you have a statement from the treating physician that further care is not expected we are fine with you sending in a termination on that record and then you would not need...

(Tony Krako): Well I - it's not a record. This is not a Medicare recipient; it's someone we've accepted a lifetime responsibility for theoretically.

Barbara Wright: And what I'm saying is we're fine with you not querying that individual...

(Tony Krako): Okay.

Barbara Wright: ...once you have that statement. And then, you know, you would consider it closed unless and until there was a reopening type action. And then you would have to monitor it for possible Medicare status unless and until you termed it again.

(Tony Krako): Okay thank you very much.

Barbara Wright: Okay.

Coordinator: Our next question is from (April Johnson), your line is open.

(April Johnson): Hi thank you. I have a question regarding Page 19 of the user guide where it references RRE for liability self insurance pools. I had previously submitted a question regarding whether joint powers authorities would be considered RREs. And it looks like the user guide addresses this issue but now I'm confused about a couple of definitions.

So could you clarify for me the meaning of full responsibility to resolve and pay claims and without involvement of the participating entity?

Barbara Wright: Sure, can you hang on for a second?

(April Johnson): Sure.

Bill Decker: Generally speaking that would mean that the joint powers authority adjudicates the claim and has the authority to adjudicate and pay the claim without additional concurrence by the member of the joint power authority.

(April Johnson): Well for example under our contract with our members of our joint powers authority they do have the right to consent to a payment of, for example, a medical malpractice case. So in the scenario where they are providing consent does that mean they become the registered reporting entity?

Barbara Wright: What do you mean by power - they can't object but they can consent? I'm not...

(April Johnson): No they can - they can refuse to consent in which case we wouldn't settle. So we would only be settling if they provided written consent.

Barbara Wright: Okay can you hang on a second?

(April Johnson): Sure.

Barbara Wright: Could you send your specific example into us and note that you brought it up at this call?

(April Johnson): Sure, I'd be happy to do that.

John Albert: Provide us with your, you know, name and telephone and all that kind of information.

(April Johnson): I will do that. Thank you so much.

John Albert: Thank you very much.

Coordinator: Our next question comes from (William Thompson), your line is open.

(William Thompson): Hi. I've got a question about the edits. And it looks like in your Appendix E, Page 157 you've got a list of various different codes. If we wanted to build an internal edit system should we find all the error codes in this section?

Pat Ambrose: Yes.

(William Thompson): Okay. Thank you.

Coordinator: Our next question comes from (Doug Holmes), your line is open.

(Doug Holmes): Hi, thank you. One - I know that this question was asked before but I think it's important. On Page 52 of the user guide there is the language and the qualified exception that begins with, "However, for ORM assume prior to July 1, 2009 if the claim was," and then there's this phrase actively closed or removed from current claims records.

And I think, Barbara, you gave some examples of things that had been addressed before but this language seems to be a little less specific as long as there's no later claims activity that needs to be reported. Can you, I mean, is it - am I right, this is a little broader than just the statutory provisions or some of the things that we've talked about before?

Barbara Wright: The concern we had from the industry was several. You know, that while there may be a statutory provision that relieved a particular entity absolutely of any responsibility in some situations if a case was inactive for a particular period of time under their rules right now without regard to Section 111 they considered that case closed. And it was either archived or it wasn't readily accessible or this.

Our intent was that we not make you go back and search for all those cases. But if you have a situation that's basically in your open records and it was there as of 1/01/09 unless you meet our other criteria for terminating then those should be reported.

John Albert: It's not so much what you call it it's what's actually happening with that particular case. So if it's - if you say it's closed but you're still making payment that's not closed.

(Doug Holmes): Okay no I understand that. But the reasons that it's - I mean if it's actively closed and not in your current claims records and there's no additional activity

then the way I read this is that you wouldn't have to report it. But if you did get some activity then you would.

Barbara Wright: Then you - yeah, you would add it, you know, when you took action to effectively what would be reopen it...

(Doug Holmes): Yeah.

Barbara Wright: ...you would have to report it at that time and/or monitor it at that time...

(Doug Holmes): Right.

((Crosstalk))

Barbara Wright: ...beneficiary.

(Doug Holmes): But it's not specifically tied to whether there's a statute or some other process?

Barbara Wright: No it was intended to be broader than that.

(Doug Holmes): Okay.

Barbara Wright: If we had said the statutory you'd have been right back where we started before.

(Doug Holmes): Right. Yeah, I appreciate it. That is a good change. Good work. A second - I have two other questions. And this is - on the question of appeals on Page 59 if - and the negotiations - and in that second - there's a second dotted paragraph if there's a - if there's an appeal or further negotiating the judgment

award and/or other payment and if payment is not being made pending the results of the appeals or negotiations the TPOC is not reported until the appeal/negotiation is resolved.

And I just - do you anticipate having any further definition of what negotiation or appeal - I think the statute even talks about appeals without addressing the reason for the appeal. I mean it could be an appeal based on procedural issues totally unrelated to...

Barbara Wright: Well but again this ties back to whether it's being paid while its appeal or negotiation is going on.

(Doug Holmes): Okay.

Barbara Wright: If it's being paid then we need to know about it but if it's not being paid at that point then routinely we would - and continue any conditional payments etcetera and we don't want to jeopardize beneficiaries'...

(Doug Holmes): Good.

Barbara Wright: ...ongoing health care. But we didn't include the word settlement in that phrasing because if you've settled you've settled. There really shouldn't be continuing negotiation there.

(Doug Holmes): Okay. All right thank you. And my last question is on the data use agreement language on Page 79 it's Section 16. And you mention at the top that you were still working on a - what did you call it, is it a memo or a draft that we could get the individual to sign permitting use of their Social Security...

Barbara Wright: We're still working a model form...

(Doug Holmes): Okay.

Barbara Wright: ...that has nothing to do with the data use agreement which is signed by the RREs and which applies to agents etcetera.

(Doug Holmes): Okay well then here's my question: At the very end of that long safeguarding and limiting access to exchange data there's the phrase that the administrative civil and criminal penalties for noncompliance contained in applicable federal laws. And I'm just wondering if there's a conflict of laws question where there might be some information that is subject to state law that, you know, shouldn't that also be draft in a safeguarding statement?

Barbara Wright: I lost you at some point at the very end there. I mean are you saying that if a state law is more restrictive then...

(Doug Holmes): Right.

Barbara Wright: If you want to send us in a particular issue but generally if it's information that we need for this process then it's authorized under the federal statute then...

John Albert: That would always trump any state law naturally.

(Doug Holmes): Well I guess that's the question.

John Albert: Yeah, I mean...

(Doug Holmes): I'm aware of somewhere where the trumping isn't necessarily, you know, there can be a conflict of laws that - where this doesn't trump something else.

John Albert: No I mean so far, I mean, in terms of, I mean, only because we've been, you know, dealing with this type of data exchange in the group health plan world for a long time that there have been many cases where people have brought up similar, you know, supposed conflicts with state law etcetera.

And but the thing is, once investigated, I mean, in every case there has essentially been no state law that essentially somehow overrode or attempted to override the federal authorities related to these types of processes. So - but again we would always be willing to take a look at...

(Doug Holmes): Okay.

John Albert: ...information and provide, you know, guidance accordingly because we're obviously we know that there's a lot of information out there but in most of these cases, at least from what we've seen so far, none of it really actually has interfered with these types of coordination of benefits processes with the data.

(Doug Holmes): No I understand. But if there were some then the very last sentence there, would you have a problem with making (an) applicable state and federal laws?

Barbara Wright: Well...

John Albert: We can't, I mean, the federal government can't require enforcement of particular state laws. This was - as it pertains to this data exchange with this agency as protected under the Privacy Act.

Barbara Wright: If you have an agent that you wish to impose further restrictions on based on state law we are not involved in that discussion or process. This is...

John Albert: Yeah, kind of outside our authority.

Barbara Wright: Yeah, this is for...

(Doug Holmes): Okay.

Barbara Wright: ...purposes of the exchange with us.

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

Pat Ambrose: Could I, operator, interrupt and go back to the prior question that was asked about the error codes. I just want to make sure that I'm clear on my answer that those are the only error codes that are, you know, are currently - you could currently receive in file processing.

But when you're building your system we really need you to read the entire guide and pay particular attention to the field description in the Appendix A as well as the - all the disposition error codes and compliance codes listed in Appendix B. So I might have been a little hasty there in not understanding exactly what the question was.

But when you're designing your system you are of course responsible for everything that's in that user guide.

Barbara Wright: Next question.

Coordinator: Our next question comes from (Roy Franco), your line is open.

(Roy Franco): Thank you. This is (Roy Franco) from (Safeway) and Medicare Advocacy Recovery Coalition otherwise known as MARC. I have a few questions for the group and I'm hoping I can get it - some help here.

On the authorized representative email could we use generic email addresses like for example cmsrepresentative@ - no, cmsauthorizedrepresentative@safeway.com so we're not continually changing the email addresses as people move from job position to job position?

Pat Ambrose: Actually at this point in time it must be the email address for that specific individual. It's a CMS security issue and part of our security design, you know, we can take that comment under consideration. But that email address is to reflect a particular individual.

(Roy Franco): Okay so what happens if that particular individual is out of the office or away on sick leave, that type of situation? How do we - how do we get access to that box or how would we get access to that box because, you know, of email privacy issues on so forth?

Pat Ambrose: There's not going to be that many emails that actually get sent to the authorized rep, it really is going to be mainly the profile report. The account manager does get a copy of the email that goes to the authorized rep for the profile report.

(Roy Franco): All right I guess my same question for the account manager; can we use generic email boxes for the account manager because that position could change as well?

Pat Ambrose: Yeah, absolutely not. I mean that email address is reflective of an individual is how we keep our users unique within the system in fact.

(Roy Franco): Okay.

Pat Ambrose: So the account manager email address...

(Roy Franco): All right well that's good to know. I just - thank you so much for that. With regard to document control number once the RRE, you know, establishes a document control number for a record that particular document control number will be set in stone so to speak and not change correct?

Pat Ambrose: It's only on one particular file and corresponding response file submission, - and, you know, submission and response. The document control number does not have to be maintained throughout in the sense the history of that claim record reporting.

(Roy Franco): All right, so if we add or update or delete or have further additions to TPOC amounts we would not be using the same document control number, we would be using a different document control number?

Pat Ambrose: Yeah, basically. Its only use, I mean, it's up to you how you design this document control number; it has to be unique within the particular file for that particular quarter and then we will return it to you. And it's strictly only so that to make it easier to match up your incoming records to then the response record that we send back. But there's no tracking of it ongoing on the part of the COBC.

Barbara Wright: So to clarify if they had a record they submitted with the DCN the response would have that DCN. If they submitted an update to that record it would be there choice whether or not to use the same DCN or a new one, correct?

Pat Ambrose: Right.

(Roy Franco): Oh okay. So that's actually very helpful. So if an RRE wanted for audit purposes to keep, you know, the, you know, one particular record's updates, deletions, so on and so forth they could use the same DCN number from quarter to quarter for that particular record?

Pat Ambrose: Yeah, now there is a case where, you know, an unusual case where you have to send a - let me think - a delete for something you sent erroneously before and then add it back because you're changing what we refer to as one of the key fields. So that delete transaction and the add transaction will have to have different DCNs. But...

(Roy Franco): Because it occurs in the same quarter?

Pat Ambrose: Yeah.

John Albert: Right.

(Roy Franco): All right, okay.

Barbara Wright: Keep in mind though we hope that for NGHPs that there isn't going to be a lot of updates or deletes except for reporting termination of ORM or if you already have ORM reporting the TPOC. I mean in general if all you have is ongoing responsibility for medicals that will either be once or twice; it won't be on a quarter by quarter basis.

And for TPOCs in most instances we would anticipate you've got a single report and that's it.

(Roy Franco): Sometimes what happens is in the liability arena settlements fall apart. I mean, everyone has the best of intentions to conclude a settlement and everyone's very excited about that. But when they go back to their respective offices they can't exactly agree on certain terms and they may have gotten, you know, a little ahead of themselves and reported something that needed to be deleted so...

Barbara Wright: Yeah, well if you look at the TPOC date we would advise you or hope that you don't get overly excited and do it, I mean...

(Roy Franco): Exactly.

Barbara Wright: We don't have to have to do deletions etcetera. In looking at the way we set up the TPOC it was designed to take that into account. If you have something that's signed but it requires court approval you don't report it until you've got the court approval.

If you, you know, we tried to set out different parameters there so that you would be reporting it only when it's really done. The same thing with if it's under appeal - formal appeal or negotiation settlements should be done, period because you've gotten it signed, sealed, delivered.

(Roy Franco): Okay.

Barbara Wright: But if it's an award or judgment you're continuing further negotiation as long as you're not paying we don't want you to report it.

(Roy Franco): Yeah, yeah. I'm just concerned where you get that situation where there's no settlement agreement, there's no court approval. You issue the check and the, you know, the plaintiff then says no that's not what I wanted, you know, has

second thoughts. And all of a sudden you're deleting a record because, you know, you added it because you made the payment. So it happens quite a lot unfortunately on the liability side when you think you have something you don't.

Barbara Wright: Can you hang on for a second?

(Roy Franco): Thank you.

Barbara Wright: (Roy)?

(Roy Franco): Yes.

Barbara Wright: A couple people here were saying think about the fact that you've got only a quarterly submission. So that in most instances if it's no not really what I want unless somehow your reporting is like pretty much 24 hour in most instances you should have the ability to catch that before the report is submitted.

(Roy Franco): All right. Now I'm just glad to understand the process so that it helps with setting it up. I do have a follow-up question on TPOC. You know, the - with regard to annuity settlements if the expected payment amount, can we get some clarification what that means? Is that the guaranteed amount to be paid to claimants?

Because usually when you purchase an annuity it's substantially or significantly less I guess when we had higher interest rates - significantly less than the actual payout amount so just trying to determine if that's the guaranteed payout amount.

Barbara Wright: Do you have a page number?

(Roy Franco): Actually I have other places marked. I...

Barbara Wright: Okay I think it's on Page 111. And it says if it provides for the purchase of an annuity it's the total payout for the annuity for annuities - we left off a D - for annuities based - oh, I'm sorry, for annuities base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payment amount if there's a minimum payout whichever calculation results in the larger amount.

So if you paid based on a life expectancy of 10 years you've got an annuity for $100,000 based on a $50,000 payment you're going to report the $100,000…

(Roy Franco): Right.

Barbara Wright: At the same time if it had a guaranteed payout even based on 10 years or let's - it had a guaranteed payout of $100,000 or $120,000 even if the person died sooner if that's higher than the $100,000 you're going to report the higher amount.

(Roy Franco): And so I - that's getting to my point that if it has a guaranteed amount then we would report the guaranteed amount.

Barbara Wright: Whichever is higher.

(Roy Franco): Okay.

Barbara Wright: I mean if you've got a calculation that it was based on the expectation the person would live 10 years and so it was expected to be $100,000 but if they die in the first year they're still guaranteed $80,000 you report the $100,000.

(Roy Franco): Well let's take the flip of that. Let's say that the guarantee is less than the life expectancy so, you know, the guarantee is for four years but the life expectancy is five. Through some odd, you know...

Barbara Wright: Whichever calculation results in the higher amount; that's basically...

(Roy Franco): Okay fine.

Barbara Wright: ...but...

(Roy Franco): So it could be greater than the guaranteed amount, all right. Okay I understand that. Thank you so much. I have one more question here. And that's, you know, Barbara, you know, raised the liability MSA question again. And I was wondering if you could repeat because it just sort of changed up a little bit in my mind what was happening with MSAs, the liability take. I didn't even think that MSAs had any applicability in the liability arena because it's a voluntary process in worker's comp.

And, you know, we were getting a lot of push back from regional offices, you know, they're very inconsistent about reviewing and not reviewing them. So if you could repeat that and just kind of straighten me out I'd appreciate it.

Barbara Wright: Is this called once more with feeling?

(Roy Franco): Yeah, once more with feeling.

Barbara Wright: Liability set-asides; both of them, worker's comp and liability neither one of them has ever been required to participate in a CMS review process.

(Roy Franco): Okay.

Barbara Wright: Nonetheless they're based on the same underlying statutory language which is that Medicare is not supposed to pay if payment has been made. And to the extent a settlement, judgment award or other payment takes into consideration future medicals then that settlement, judgment or award should be appropriately expended for those future medicals.

The fact that we don't have a formal review process never did and does not create any type of safe harbor if it's not reviewed by CMS. The threshold for review for worker's compensation, Medicare set-asides is just that. It's a workload threshold that doesn't create any type of substantive safe harbor for instances where the worker's compensation settlement is below that threshold.

(Roy Franco): All right. Well thank you. I did have one more question and that's on the appeal on Page 59. And this is actually following up on what (Doug Holmes) mentioned a little bit earlier. From time to time we in the liability side have to post appeal bonds in order to proceed with an appeal. Would the posting of an appeal bond constitute an other payment so that we would have to report?

Barbara Wright: Can you send that question in to us? I have a tentative answer but we don't want to give a tentative answer on the line.

(Roy Franco): Will do. Thank you Barbara. Okay, that's all I have.

Coordinator: Our next question is from (Tony Renarro), your line is open.

(Tony Renarro): Hi. First I just want to say thanks for hosting these teleconferences. I think most of them have been pretty helpful. The first question I have is with respect to the alert that was just posted and the specifically the threshold. Is it a problem if we did report everything even if so it would have been exempt under these interim thresholds; if it's easier for us to implement a solution that provides reporting for everything that's Medicare eligible?

Barbara Wright: Hang on for a second. CMS really wants people to adhere to the thresholds we're using. I mean, right now we want to be able to ensure that everybody's reporting accurately and that we as well as you can handle the size of the data flow etcetera. And you may have heard some of the others in the industry are objecting just the opposite way; they don't want to report anything except what is above any thresholds. But, yes, we would prefer that you stick with the thresholds.

(Tony Renarro): Okay. I mean, for us, I mean, I think we would prefer to see something much higher and that something would have been, you know, more amenable for us. So I just...

((Crosstalk))

Barbara Wright: Well as I said if we can get more data we haven't ruled out considering more but and again it's very limited but it's been fairly consistent that at $5000 it was wiping out roughly 80% or more of the claims universe.

(Tony Renarro): Right.

Barbara Wright: And at $10,000 it was wiping out about up to 92% of the claims universe. So we do need to even - to even if this were only a test and not live you need some data to see what's happening with the data.

(Tony Renarro): Okay.

Pat Ambrose: To that point about thresholds essentially adhering to them being required we'll have to update the user guide to add error messages and those we'll be adding to the appendix and in other places in the guide where we talk about editing.

(Tony Renarro): Meaning if you report something that's outside the threshold?

Pat Ambrose: Yeah. Yeah, I would anticipate that what we're hearing from CMS today is that if you submit a record that is outside the threshold or below the threshold that we will actually return it with an error message.

John Albert: We haven't...

Pat Ambrose: Okay.

John Albert: We haven't gotten that far yet.

Pat Ambrose: Okay.

John Albert: We just...

((Crosstalk))

Pat Ambrose: Sorry, sorry.

(Tony Renarro): Okay. And the next question is it possible to post the record layout in an Excel format out on the site? I just think we'd find this very helpful format in our

own documentation and communicating with our technology partners. Is that...

((Crosstalk))

Pat Ambrose: We can check but I think we have an issue with 508 compliance in that it has to be published in the PDF format. But I can take that as an action item, go back and look.

Barbara Wright: Yeah, we can check whether as long as we also have it in PDF whether we can give an alternative format as well.

(Tony Renarro): Okay. And the last question and previously this is something you thought you've gone over quite a bit...

John Albert: If you want to send again that specific question with your contact information to the mailbox that would help too.

(Tony Renarro): The Excel question?

John Albert: Yes.

(Tony Renarro): Okay. And the last one, and again sorry if this is something you feel you've gone over sufficiently already, but I find the Section 111 reporting requirements this doesn't change our obligation to protect the Medicare - potential Medicare lien on a liability settlement? Is that something you've been pretty clear about; can you confirm that?

Barbara Wright: Yes.

(Tony Renarro): Okay. Thank you.

Coordinator: Our next question comes from (Ken O'Harra), your line is open.

(Ken O'Harra): Thank you. I had specific questions about verifying eligibility specifically the 270-271 transaction. Is there going to be a separate implementation guide for this legislation? And will there be sample 270-271 transactions that we could look at?

The reason I'm asking that question is CMS indicates they do real time transactions and it appears that you're going to be doing batch transactions. Also I was wondering about the NPI - the National Provider Identifier - what would we submit payment insurance company in place of the NPI?

Pat Ambrose: You need to refer to the Section 111 user guide for the query process that we're implementing for Section 111. There are other processes at CMS however they are not prepared to take queries from this particular community for Section 111 reporting.

So again the query for Section 111 for liability, worker's comp and no fault is via a batch process. And the file layouts - the file layouts that are provided in the user guide are the input and output to some (wrapper) software that HEW or Queue software that the COBC will provide you. Alternatively you may send us 270, you know, you can use the 270-271 format, your own translator for that.

(Ken O'Harra): Yeah.

John Albert: That's what we were...

Pat Ambrose: But, you know, you're sending it to - these files that you're exchanging for Section 111 query either come directly to the COBC data center or they're exchanged via the COB secure Web site. The other process that you're referring to is at the CMS data center and completely unrelated to this. So does that kind of clarify the situation or...

(Ken O'Harra): Well I just want to create a compliance 270-271 transaction because we have our own translator so we'll be generating that transaction.

Pat Ambrose: Right, right. And so in order to do that you may contact - after registration contact your EDI representative who will send you the necessary (X12) mapping documents...

(Ken O'Harra): Okay.

Pat Ambrose: ...for the 270 and 271 transactions that we use for Section 111. And it will be, you know, essentially a batch process not a live, real time, online process. It's send me a file, we'll process it and send you a response back.

(Ken O'Harra): Okay see I was looking at the CMS Web site and looking specifically at your guides for 270-271 and there's some, you know, contradictions between that guide and this user guide.

Pat Ambrose: Yes, yes, yes it's a completely and entirely separate process maintained by different, you know, developers and systems and, yeah. And again the CMS process in the CMS data center is not prepared to handle the queries necessary for Section 111 so we're doing it through the COB contractor instead.

(Ken O'Harra): Okay so basically wait for the registration process and talk to the EDI rep?

Pat Ambrose: Yeah.

(Ken O'Harra): If we have specific questions.

Pat Ambrose: Yeah.

(Ken O'Harra): Okay great. Thank you, I appreciate it.

Coordinator: Our next question comes from (Michelle Letter), your line is open.

(Michelle Letter): Along those same lines actually my question is about the query process. You guys had mentioned that quarterly or monthly querying is acceptable for all open claims; that's what you suggested for all of your open claims to determine Medicare status.

My question is we have clients who have not paid into the Social Security Disability in any way. These are not people that are necessarily going to be eligible for Medicare unless they have kidney disease until they're 65. Do you suggest run those query files monthly as well?

Barbara Wright: If you can assure yourself through other means that the person absolutely is not a Medicare beneficiary we don't demand that you run a query process at all. But there are people that if they're paying into Social Security in any way shape or form or paying, you know, that may be entitled to Medicare before they're 65 on a basis other than ESRD so.

(Michelle Letter): Okay that answers my question. Thank you.

John Albert: The query is merely a tool that you can use at your discretion. And, you know, again, I mean, if there is a chance that they would be a Medicare beneficiary then we would say you should probably use that query function in those cases.

Barbara Wright: Yeah, as we said even with the query function we give you a response based on the quality of your data; based on the information you submit. A negative reply does not absolutely ensure that the person is not a Medicare beneficiary. To the extent you don't do it it's helpful to know any other names the person has gone by. If they come in with the name of Betty and their name is really Elizabeth they're not going to match on the first name.

So even rejects you need to at least think about whether there's a reason to do further development to determine if any fields were in error. Operator.

(Michelle Letter): Okay.

Coordinator: Our next question comes from (Scott Umstead), your line is open.

(Scott Umstead): Hi. Thank you. I have two sets of questions. The first two questions have to do with file - the record submission and the error processing. If we were to say submit a input claim record with the TPOC date and amount on it but for whatever reason it comes back with a disposition of (SP), an error, and then we fix it and submit it on the next quarter could we expect to get a compliance error back on that submission - that second submission?

Pat Ambrose: Yeah, essentially you would see - potentially the compliance flag set. It, you know, remember that the compliance flag doesn't mean that we have an accepted and processed it it's just an alert to you that record was received and accepted late. We don't save what you've sent the last time and in essence if it was sent in error it doesn't count for timely submission.

(Scott Umstead): Okay. So it would be no benefit to us to knowingly submit something where we're having difficulty collecting a value but say for example we know the TPOC amount but...

Pat Ambrose: No I - no if you think that, you know, if you don't have enough to submit it for whatever reason to pass all...

(Scott Umstead): Okay.

Pat Ambrose: ...of those edits there's no point. You know, and we will take it the next quarter you will get - have that...

(Scott Umstead): Okay.

Pat Ambrose: ...compliance flag but, you know, there's...

Barbara Wright: In other words you can't just submit the SSN or HICN and the TPOC amount and expect to add everything else later.

(Scott Umstead): Well, okay. Thanks.

Pat Ambrose: And there's...

(Scott Umstead): Go ahead.

Pat Ambrose: Oh that's okay. It's not - please...

(Scott Umstead): Okay then say you had - say we got a disposition code back of 50, okay on a claim that we had submitted and so we're expected to resubmit that the next

quarter. But between the time we received the 50 and the second quarter something changed on that claim. Do we submit two records for that claim on the next quarter or do we just submit the updated one?

Pat Ambrose: I'm going to have to go back and check on that. I hesitate to...

(Scott Umstead): Okay.

Pat Ambrose: ...answer it off the top of my head.

(Scott Umstead): Okay.

Bill Decker: I think it would depend on the situation. I mean if you're talking about - an essentially a change that that affects - that, you know, basically that prior period was a unique period versus what your submitting now then it would potentially be two records.

But otherwise if you're merely updating an existing reportable event then you would just normally send the current event - the current data that you have on that individual. It just depends on, again, what data element etcetera.

(Scott Umstead): Right. Well the 50 really, I mean, the way I read it is the 50 means that for whatever reason COBC could not process it or didn't get to it or something along those lines. So I just wondered would they even know about it?

Pat Ambrose: That's correct. That's why I need to go back and see. You know, I - let me just get back to you on that.

(Scott Umstead): Okay I'll send it on email. And then the last thing is - and it gets back to a discussion we had on the January 28 call about RREs being able to designate a

person to perform the query - or an agent to perform the query versus an agent who does the actual reporting. And I believe on that call we mentioned that here was - that you could do that and it sounded like through - you could designate different account designees to do different things.

And I was wondering if you could clarify that a little bit. The users guide didn't really talk to that other than to say that an account designee could submit files but it didn't say which file types.

Pat Ambrose: For one RRE ID you may have multiple users who can upload files using HTTPS and download files to the COB secure Web site. You may also have multiple users who may secure FTP. So - and your file transmission is by file type so every user that the RRE associates with that RRE ID it is allowed to use that ID for file transmission.

(Scott Umstead): Okay.

Pat Ambrose: And then, you know, I'm skipping over the connect (write-over), the (AG&S) network. But so, you know, in theory what you're saying is true. I think CMS wants to put a caveat on it but you could have your account manager in place. One person from one agent company to become an account designee and transmit query files via the secure FTP for example.

Know that, you know, all users will have access to those mailboxes.

(Scott Umstead): Okay.

Pat Ambrose: And then you could have them invite another person from a separate agency submitting your claim file and transmitting it. All of the, you know, they have

to be invited your account manager and then, you know, that's all being approved by the...

John Albert: Authorized...

Pat Ambrose: ...authorized rep. And that could all be done under the same RRE ID.

(Scott Umstead): Okay perfect. Thank you for - thanks.

Barbara Wright: Operator?

Coordinator: Yes.

Barbara Wright: We have someone here that wants to make an announcement with the Web site for our MSP RC for anyone who has questions about the recovery process. I thought that we had provided that in the user guide but I can't locate it right this second. So (Nathan Crawford) is going to give everyone the information.

Coordinator: Go ahead.

(Nathan Crawford): If anybody is having either issues with recovery or just new to the process you can go to the MSP RC Web site which is msprc.info and that'll have information on the process and contact information and documents and anything that you need to know to get through the recovery process, so.

Barbara Wright: And actually if you go to - we just had someone that found it - it's Page 82. Okay let me double check with 82 in my printout one. Yeah it actually starts on Page 81, it's Section 19 under training and education. It not only mentions our dedicated Web site for Section 111 it also mentions the Web sites for the

COBC which is general overall information. It gives the Web site for the MSP RC and it also gives the specific Web site for worker's compensation set-aside information. So that's Page 82 in the guide.

And...

John Albert: The very end of Section 19.

Barbara Wright: Right. And Operator I think that's all the time we have for questions. Before you sign off we would like to know how many people were on and if there are any questions still queued up?

John Albert: Operator?

Coordinator: Yes.

John Albert: Oh we wanted to know how many callers were still on and also how many questions were in the queue. We have to close this conference because we've run out of time.

Coordinator: There were 1045 people on the call. And you had 37 questions still in queue.

John Albert: All right.

Barbara Wright: Great, thank you very much for your participation and please note that we've added extra calls in the coming months. In April there are two separate calls for NGHP. There's one that's specifically designated for worker's compensation and one that's specifically designated for liability and no fault. There are also two NGHP calls in May; one in the first half of the month is specifically designated for registration issues for both liability and no fault as

well as worker's compensation. And then there's a regular joint call later in that month.

So please check the Web site for all those calls, some of them were just recently posted.

John Albert: Thank you very much.

Barbara Wright: Thank you operator.

Coordinator: Thank you.

Barbara Wright: Good bye.

Coordinator: Good bye. Thank you, this does conclude our call for the day. You may disconnect at this time.

END