TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: December 11, 2008

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
December 11, 2008
12:00 pm CT

((Crosstalk))

John Albert: And the (Bagnerian) ring to it there.

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question and answer session at which time you may press star 1 to ask a question. Today's conference is being recorded, if you have any objections you may disconnect at this time.

I would now like to turn the call over to John Albert. Thank you, sir, you may begin.

John Albert: Hi. My name is John Albert with the Centers for Medicare and Medicaid Services. I'd like to welcome you all to a continuing series of open door teleconference events hosted by CMS to essentially provide for an exchange of information regarding the new Section 111 mandatory insure reporting requirements.

First of all in terms of some house rules this call is specifically geared toward non-group health plan responsible reporting entities, which includes worker's

comp no fault liability insurance. We're going to go through some documentation here initially and once we get through that we're going to open up the floor to question and answers.

There will be future calls held addressing either general questions or, as we move toward implementation, some of the calls will become more technical in nature and we'll have the appropriate - coordination of benefits contractor staff here who are charged with implementing the actual data exchange itself on behalf of CMS.

With me I have Miss (Barbara Wright) and Mr. (William Decker) to assist answer the questions. For everyone - for people that are on the call if they don't know all official instructions and guidance regarding the implementation of Section 111 are being released at a dedicated CMS Web page. That Web page is cms.hhs.gov/mandatoryinsrep.

Some other documents are forthcoming. They're - right now we have a (post it) out as of December 5, a second interim user guide that includes record layouts for non-group health plan reporting; we encourage you to please take a look at that if you have not, there's a lot more information available that's been posted recently.

For those that have been asking about compliance issues CMS will soon release documentation regarding compliance standards that CMS is looking at implementing with this reporting requirement.

With that I would like to turn it over to Miss (Barbara Wright) who wants to go over some additional material that's been released.

(Barbara Wright): Okay, good afternoon. The first thing I'd like to talk about a little is exactly what we're using our mailbox for public comments for. There seems to be some misunderstanding; we've had questions that come in that say, I've asked you this question and you haven't specifically answered it.

And what we need everybody to understand is the questions that are coming in are not going to be answered on a one by one basis; we're using that information to update the information that we post on our Web page or make available as a download on the Web page.

So that's - as people keep up with that material they will see their questions answered but you are not going to be receiving individual one on one replies or we're not making a list of all the questions and posting those with answers. The answers are going to be subsumed in the other materials that we put out.

A second general question that came in was the PRA comment period. People want to know when the second comment period will be. In terms of that that will be announced when we publish our revisions to the PRA - or our updates to the PRA and it will run from that date. We will once again, when that notice is published in the federal register, we will put an alert on our Web page and we will make documents from the federal register available through our Web page.

John Albert: This is John. And just again for those that don't know there is a list service that you can subscribe to on that Web page, which will provide you with alerts every time a new document is put up on the Web page. So if you haven't subscribed to that please do so so that you will be informed as quickly as possible regarding additions to the CMS Web page.

(Barbara Wright): And that listserv function we realize there have been some problems with that and occasionally the notice of the updates is out before the actual document it's referring to so there's a slight lag. We are trying to fix that; we understand that can be frustrating to you but overall the listserv at least lets you know each time we're updating the Web page.

With respect to the questions we've gotten for liability insurance, no fault insurance and worker's compensation throughout this call we will probably be using the term NGHP just because it's shorter to say than all those words. So what we wanted you to know first before we go to straight Q&As is answers to some of the questions that have come in and December 5 of this year there was a new document for NGHP that's the record layout and has substantial additional text that answers a lot of policy-type questions that people have been asking.

Material in the document, which is available on the Web site and hopefully people have already looked it, it's now divided into an overview, a section on who's the basic - who's the responsible reporting entity, general rules for agents, high level file submission rules, general requirements for the reporting process and what triggers reporting and then the actual file layouts.

With respect to questions that have come in about when does reporting take place and what actually gets reported I'm going to briefly run over a list of the issues that we've addressed in that document in response to questions people had. You should not take the words that I'm giving you right now as being the complete answer, you do need to go to the actual document and read the full answer.

But the section on what triggers reporting has information that we expect the reporting only with respect to beneficiaries. There is a report only once there's

been a settlement judgment or award or other payments. If you give notice prior to that taking place that is not Section 111 compliant. Submissions need to be on a beneficiary by beneficiary basis by type of insurance, by policy number, by responsible reporting entity, etcetera. Therefore a single RRE could have multiple records for the same individual or there could be multiple records submitted by different insurers.

We answer information about joint settlements, judgments and awards, multiple settlements involving the same individual. We have a piece about reinsurance, stop/loss insurance, excess insurance, umbrella insurance, guarantee funds, patient compensation funds, which have responsibility beyond a certain limit, etcetera.

We give you information regarding file submission and exactly what needs to be submitted as of 7/01/09. We had a question about one-time payment for a defense evaluation; that's answered. We have information about payment pending investigations, reporting regardless of whether or not there's an admission or determination of liability.

There were questions about whether or not the RRE should be determining what portion of the settlement is medical. There were questions about de minimis or nuisance exceptions, questions about situations where allegedly there were no medical, questions about property damage only claims. And we want to make it clear there's a property damage only claim such as someone had a bent bumper etcetera. Reporting is not required if the claim did not claim medicals or have the effect of releasing medical.

There was a lot of concern that RREs would end up reporting every single automobile ding or accident and that certainly was never our intent. There were questions about property damage - I'm sorry - the amount of the

settlement when you give a flat settlement obligation, that's without regard to payment for ongoing medical. We have information about where the date of incident is prior to December 5, 1980.

Medicare has always been secondary to worker's compensation but there are different rules for liability and no fault if the date of incident is on or after December 5, 1980. We have information about - we had an allegation or statement that parties were assuming that they could issue policies that were supplemental to Medicare for liability or for worker's compensation or by no fault.

By law these types of policies are primary to Medicare. So an insurer cannot, by contract, supersede federal law. We had a question about an age threshold for NGHP reporting and there is no such threshold. Questions about the geographic location of the incident, whether or not, if there isn't any settlement judgment award or other payment does reporting need to be done.

Questions about when a file is closed or there's a return to work. And last we had some questions about mass torts or multi-district litigations. Except for the mass torts and multi-district litigation the document addresses all the issues I mentioned. The mass torts - what we're still looking for is we have asked entities that deal with liability insurance to send us to our mailbox what they see as issues or concerns with respect to their obligation to report those mass torts.

We know that there could be situations where the insurer or self insurer doesn't necessarily know the amount of the settlements for particular individuals at the time of the settlement. What we are trying to do is compile a list of the issues so that we can attack them in a group. WE are looking to potentially do some type of workgroup to deal with liability issues similarly

for worker's comp after the first of the year but we haven't made final plans for that yet.

The next issue I wanted to mention is the possibility of the query function for determining Medicare entitlements. We thought that we would have a final answer by today; we're still hopeful that we will be able to give the query function but we did not get an answer by today. As soon as we get an answer we can post a separate alert on the Web site so that people can know that just as a separate issue. And if we are able to offer the query function there will be specific instructions issued about how you manage that query function.

In general for NGHP we've had several questions where people are asking does it cover this type of liability insurance or that type and does it cover home owner's insurance if it's (Med/Pac). It covers all types of no-fault insurance; it covers all types of liability insurance. It doesn't matter whether it's medical, malpractice or some other type of liability insurance. So you're not going to see a detailed list of every type of insurance that's possible.

I'd like to turn it back over to John right now to address several questions we had that came in that are either somewhat technical or deal with the mechanics of reporting.

John Albert: Hi. Thanks, (Barbara). Just again as I mentioned earlier as we move closer toward the implementation dates for this reporting CMS will host technical-only conference calls as well to basically address the - the detailed technical questions that will certainly be coming in as we roll out these requirements.

For those on the call if they haven't looked at the group health plan pages associated with the CMS Web site you can get an idea because we're much further along with the group health plan document because of the six month

shorter start time for reporting for GHP coverage. You get an idea of the kind of materials that we'll be developing for non-group health plan reporting such as computer-based training, etcetera.

But I will answer a couple of quick questions that have come that are more technical in nature. One of them concerned the - when we send response records back there are disposition and error codes that can come back with every single record. And some of them are marked as internal CMS use only or COBC responsible.

In those cases the person was asking what do we do with those? Does that mean we have to do anything? And the answer is no, that basically you would just need to resubmit that record again without making any changes to it. There are issues with data that actually come up with the coordination of benefits contractor and CMS's systems that it has to resolve in order to post a record successfully.

Another question came up regarding how is CMS going to handle required data elements and when these elements are not available to the insurer. For example the date of birth (unintelligible) I'm not required to file or pay a worker's compensation claim in Los Angeles and we do not always have access to that information regardless of our efforts to obtain them for this reporting.

The ability to - the more technical question is if you don't have the particular data elements and they are required in most cases if that record was submitted without required data elements it will error out. There are a few - there will probably be a few exceptions we will allow a record to process just to build a skeletal record and expect an update with the missing information on subsequent files. But for the most part the record would error out so there's

probably no sense in submitting that record to begin with until you can build a complete coverage record.

(William Decker): That doesn't eliminate your responsibility...

John Albert: Yeah.

(William Decker): ...to comply with Section 111 requirements.

John Albert: Yeah, that's - yeah. Again, not having it does not, you know, mean you're in compliance wit the reporting requirements.

Question came up about the document control number and this is the number that we - every record that comes into CMS should have a unique document control number that we allow the submitter to formulate in any way they want. We - when we send a response record back every single record has our own DCN on it as well as the DCN that came in from the submitter. There was a question about trying - if we could expand it beyond the 10 characters that we allow; that's something that we think we can do.

Another question came in in terms of - is it 15 now? Oh I guess we already did it. Sorry, somebody pointed out that we've expanded to 15. Okay, we've already answered that question.

A question came in regarding the use of agents. And what happens if we register but don't have an agent at the time and would like to then have an agent submit data on our behalf. What do we do, do we have to reregister? Basically by the time - when you first register with the COB contractor you will be assigned a dedicated electronic data interchange representative. You

may only need to contact your assigned EDI rep and provide the updated information to them.

Another question came in, can you let us know how a responsible reporting entity can file for an extension and what criteria needs to be met for an extension to be approved. The first thing I wanted to address is that while there are issues with, you know, with some entities getting certain data (unintelligible) the one thing that CMS is pretty firm about is that when the registration period starts for non-group health plan entities that is when we expect everybody to sign up and register with CMS on the Web portal.

In terms of extensions there is no provision to provide extensions. But I want to stress that again CMS is in the process of developing a document that basically discusses compliance and what you as a responsible reporting entity need to do to remain compliant with the reporting provisions of Section 111.

I want to stress again, as I've stressed in many calls, is that CMS is much more interested in getting a good clean data exchange running than it is in terms of compliance in terms of the timeframe. More information will be forthcoming but in terms of the blanket extension that is not something that CMS is prepared to grant.

Obviously there may be issues that come up that would require extensions on a case by case basis. But, again, more of that information will be forthcoming from CMS.

(Barbara Wright): Along with your comment about the necessity of registering as soon as possible could you explain to them whether or not they can do testing without yet having all the data?

John Albert: Yes you can do testing without having all the data. The testing environment is kept separate from the production environment. And, again, the critical timeframe that we want to remind everyone is that registration and testing within the CMS timeframe is very critical to you all as responsible reporting entities to remain in compliance with the Section 111 reporting requirements.

As documentation has been released and you can see in the latest version of the interim user guide we are allowing considerable extra time based on comments we've received from industry to go out and pursue certain data elements. You know, that, again, will be covered in the user guide and any future updates to it as we move along.

But again I can't stress enough that it is very critical that people register on the portal when it goes up in April and begin testing as soon as possible.

(Barbara Wright): Additionally we had two or three questions come in that asked what do they in a situation where the responsible reporting entity has the TPA that processes claims and they want to use their TPA but then the TPA for whatever reason wants to use yet another entity to submit the actual files. They were asking who should they register as the agent.

And I believe based on discussions we've had here internally we see that as a situation where the TPA is sub-contracting with someone else and you would still register the TPA as your agent.

The last one was - we had a question about when an entity has assumed ongoing responsibility for medical. When do they have to update that record? And we've said they do not have to report any time they have a claim submission or payment for a particular medical item or service. But if there is

a situation where the information on the basic record needs updated that they should submit that as an update. Correct, John?

John Albert: Yeah, I mean, the most common, again, would be an update that would now include a termination of responsibility if that ongoing responsibility recently ceased to exist.

(Barbara Wright): But I believe one of the examples was for instance if there was originally attorney X associated with the file and it switched to attorney Y, yes we would like you to update the attorney information. Okay.

John Albert: I think we got them all.

(Barbara Wright): Okay, before we go to the strict question and answer I wanted to go to a couple of areas where we had several questions and just make sure everybody has basic understanding as well as one problem that someone saw with the record layouts.

We received at least one question or comment that the WCIO codes that are listed in the record layout that the individual could not access them on their server. (Frank Johnson) here went in and checked today. He was able to access them all and I think he also has an alternative method of you accessing the WCIO codes. (Frank).

(Frank Johnson): All right if you go into the record layout and you're unable to click on the link that had the WCIO codes come up you can always either copy and paste that link and put it in your browser. Another method - a little bit longer that can be done is to just - in your search window just type in WCIO.

Once you come up to the WCIO home page - that is the Worker's Comp Insurance Organization's homepage - you will want to go down to where it says Products. And if you click on the link that says Products that'll take you to another Web page. And then towards the bottom of that Web page you will see the three links that take you to the nature of injury, cause of injury and body part codes for the WCIO.

(Barbara Wright): Thanks (Frank). A couple more points and then we'll go to queuing up for questions and answers. Several questions that came in similar to prior questions seem to assume that the Section 111 reporting is dependent on or intertwined with other preexisting responsibilities. And we want to emphasize that the Section 111 reporting is separate and it doesn't affect preexisting responsibilities and obligations.

If, for instance, an attorney is representing a beneficiary we still expect that they will be doing self-identification in order to obtain condition payment amounts, which they may wish to use in their settlement negotiations. Similarly in the context of the worker's comp Medicare set aside approval process for proposed amounts. The standards for when CMS will review and won't review a proposed submission includes certain situations where the individual is within 30 months of entitlement.

That's not an issue for the Section 111 reporting. For ongoing responsibility you report when someone is a beneficiary and when there's a flat or single payment obligation whether it's actually paid out as a structured settlement or annuity you only report those when the settlement, judgment or award takes place.

This means that if you have a structured settlement that took place and the actual settlement was in 2005 and you're still making payments on that

structured settlement you're not required to report that structured settlement for the 7/01/09 date is used for any settlements, judgments, awards or other payments that take place after that for flat sum payments or for ongoing responsibility; if any new ongoing responsibility or if you had ongoing responsibility as of 7 - prior to 7/01 and it continued as of at least 7/01 you have to report those individuals.

And I guess at this point, Operator, could you queue people up for questions?

Coordinator: Absolutely. As a reminder if you do have a question please press star 1, again that's star 1 for a question. One moment while we wait for the first question please.

Our first question is going to come from (Douglas Holmes), your line is open.

(Douglas Holmes): Thank you. My question is about the - there's information on Page 13 of the December 5 information that's on the Web site having to do with when a file is closed. Just reading through this language I'm wondering when would CMS conclude that anything was ever closed with respect to a worker's comp case?

There's one sentence that says, if the responsibility for ongoing medical is subject to reopening or otherwise subject to a further request for payment the record submitted - it would be open. So what would terminate? Wouldn't an entry from a worker's comp agency that the case was closed and no further medical obligations on the part of the parties, wouldn't that close the case for purposes of reporting under Section 111?

(Barbara Wright): Potentially yes or no based on the type of question we had come in. There are situations where people who submitted questions said, well, if someone hasn't

treated in a while we automatically close that record. But then their question would go on to indicate but if someone requires further treatment then they come in and, you know, send in a request for that and we re-open the record.

That's a - they described a situation where the worker's comp entity still had an obligation to pay but it wanted to close the record simply because it hadn't had any specific claims submitted. For CMS purposes we use these open records to make sure we don't pay inappropriately. And beneficiaries are required to apply for any worker's compensation to which they may be entitled. So we want that open record until there's no possibility of further payments.

(Douglas Holmes): Okay so I guess the question would be - this is a follow up - would be - so it would be case by case basis is what you're saying; that you'd look at the entry and if it doesn't...

(Barbara Wright): Yeah just for example if under state law if there's been no treatment for five years it's absolutely closed and they can't subsequently reapply to have additional benefits paid then yes. Give us the termination date as of that point. But there are going to be some states, for instance, Michigan, right now that has unlimited medical. The fact that the person hasn't been requesting any payment for treatment for awhile doesn't mean that record should be closed.

If they have anything related to that, you know, their claim for the accident for the rest of their life then, yes, we should be secondary for that. So we want that open record on our common working file.

(Douglas Holmes): So just to follow that. So the reporting obligation would continue every quarter it'd just be a report that has nothing on it or...

(Barbara Wright): No, remember that we say where ongoing responsibility has been reported you don't have to report anything at all further until your reporting a termination date unless, as John mentioned a little while ago, you had to update some basic information on the record.

John Albert: So you send us a coverage record and we accept it and put it on our system and basically there's no change to that record and ongoing responsibility continues for five years, there's no need to provide any additional information. Now at the end of the fifth year and if, you know, in that case the responsibility ends then you would send an update record essentially which would include a termination date essentially and that ongoing responsibility to CMS's system.

So that and any other changes to information provided then, you know, typically for ongoing records you're going to have an initial record that puts it on our system and then only a second record that eventually closes that ongoing responsibility if that so occurs.

(Barbara Wright): And we had another question somewhat along the line for ongoing responsibility. They said does the fact that we reported ongoing responsibility guarantee that we're going to make payment? Does it bind us to something?

What we see the ongoing responsibility report as you've assumed responsibility whether it's for very short term or long term; you're simply reporting that and if an exhaust limit is reached then you're reporting the termination date based on that exhaust limit or if you have a situation like worker's comp where under state law there's no further possibility of payment - or reopening you're reporting a termination date, yes, it will be case by case but you do need to understand the general rules.

(Douglas Holmes): Okay.

Coordinator: Our next question is going to come from Anthony Filiato, your line is open.

Anthony Filiato: Thank you. I represent a mono line long shore carrier and I'd asked this question before and I've not received a response yet is whether or not you have contacted the United States Department of Labor to whom - who regulates us and who receives every bit of the information that you're asking from us and has it in their files and in their computer systems as to whether or not you've spoken to them about receiving the information from them rather than having to duplicate the process?

(Barbara Wright): We haven't made contact yet. We do plan to contact them but strictly under the terms of the statute it is the responsible reporting entity that must submit information to CMS.

Anthony Filiato: Well then I have the follow-up question that, so, okay, so you're going to make us do this again but in a different format probably. The other part is have you dealt with the situation of the United States Department of Labor's special fund where they are paying the compensation payments to the injured employee and the private employers may or may not be paying medical to that individual and - who is supposed to be responsible for reporting each of those items?

(Barbara Wright): Could you repeat your name and would you mind sending us a more specific email about the special fund?

Anthony Filiato: I can do that. I can give you the individual at the United States Department of Labor who runs it who would love to talk to you about it. It's - I will happily send you an email because the United States special fund has $125 million in

liabilities each year and I would assume that you would want to know whether they're paying someone. And how am I, as the representative of the employer, supposed to know, you know, report on behalf of the federal government?

(Barbara Wright): It may be a matter of who exactly is the responsible reporting entity and the particular situation. But if you wouldn't mind, if you could repeat your name so we can be sure and look for your specific email.

Anthony Filiato: Sure it's Anthony Filiato – F-I-L-I-A-T-O with Signal Mutual.

(Barbara Wright): Okay, thank you.

Anthony Filiato: Okay.

John Albert: Anthony, you could include your - give us your phone number or include it in the email as well.

Coordinator: His line is now closed.

John Albert: Oh.

Coordinator: Our next question comes from (Deanna Fisher), your line is open.

(Deanna Fisher): Hi this is (Deanna Fisher) with Med (Insights) of (GAB) Robins North America Company and (Mark) Supporter. It is more likely than not that an entity may be self insured and insured for the same line of business depending on the state in which it is conducting business. However, if the administrator of claims - this entity may be an administrator of claims in all states.

Does CMS expect this entity to register as a self insured for all states or is it the intent of CMS that in those states where it is insured it is named as an agent by the insurance carrier?

(Barbara Wright): Not quite either of those. If in the states where they are self insured they need to register as a responsible entity to report for those - the coverage in those states and any settlements, judgments, awards or other payments. In states where they have insurance they may or may not be the agent. We don't designate who has to be the agent. If there is an insurer it's the insurer that designates the agent and we're not going to step into that particular decision.

They may do it exactly as you said but that's not our requirement terms (unintelligible) the agent.

(Deanna Fisher): Does the answer change if the policies of insurance are merely fronting policies purchased by the entity?

(Barbara Wright): Without looking in my insurance dictionary, which I'm turning to more frequently now, my memory is that the fronting insurance is somewhat akin to reinsurance or that type of situation. And again what we - if you look at the document we've got out if it's a situation where the insurer is paying the self insured that they're not actually paying individual claims to claimants then any reporting responsibility is going to rest with that self insured.

And let me give you an example: there's a situation where it's - and we'll assume it's a Medicare beneficiary since that's what we're most concerned about. There's a Medicare beneficiary that's in a wreck. The individual or the entity is self insured for the first $100,000 and has reinsurance for the rest and there's a supportable claim for $200,000.

If the self insured individual pays out the $200,000 and gets the extra $100,000 from their reinsurance only the self insured entity reports and it reports the full $200,000; the reinsurance does not have to separately report. Does that help?

(Deanna Fisher): It does, thank you.

Coordinator: Our next question is going to come from (James Kennedy), your line is open.

(James Kennedy): Yes I have a question concerning, you know, MSA situations and how they ducktail into the reporting requirements under Section 111. Let's say you have an individual who is not a beneficiary, they're involved in an accident and you anticipate paying that person let's say above the $250,000 threshold amount that would require the institution of an MSA under those circumstances but you don't do that.

Is the fact that the person is not yet a beneficiary mean that you do not have to report that settlement?

(Barbara Wright): You are not reporting that settlement for purposes of Section 111 reporting if the person is not yet a beneficiary. It doesn't change, as I said earlier in the call, it doesn't change any other preexisting obligation and an individual is still at risk if they don't establish a set-aside and follow appropriate procedures for that.

But the reporting is not triggered by a set-aside; it's triggered by the criteria we've set forth in the documents we've put out.

(James Kennedy): And I understand that so a beneficiary means literally a beneficiary at that time?

(Barbara Wright): Yes.

John Albert: Yeah.

(James Kennedy): Okay, thank you.

(Barbara Wright): Or if they're deceased if they were a beneficiary at the time they died.

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

(Roy Franco): Thank you very much. (Roy Franco) with (Safeway) as well as a (Mark) supporter. I want to talk about - a little bit earlier on the RRE question involving self insureds, you know, for us here at (Safeway) we are insured in some states with the (strunning) policies which are not like - I think what you said they were reinsurance policies, they're just simply paper that we put out there - that insurance carriers put out there that allow us to do business. We pay and process all the claims.

And the question I have is - it's fairly straightforward, you know, from year to year we keep changing these programs; we change these insurance carriers, you know, you know, today we might use (Zurich), tomorrow we might use Safeco. Do we have to reregister or have these insurance carriers reregister us as agents every year we change these policies around?

(Barbara Wright): If they want to use you to do the actual reporting they are going to have to keep current on who they're using as an agent.

(Roy Franco): But - but...

(Barbara Wright): Let me finish.

(Roy Franco): Okay, cool.

(Barbara Wright): If they want to do the reporting directly that's another option or if the or you and they together determine that there's some other entity out there that you're reporting to for whatever other purpose that can do more of a continuous report that's fine too. But, yes, someone is going to have to essentially track who is the current RRE and current agent.

(Roy Franco): So if we have, I mean, obviously if we handle the claims and we're processing the claims, you know, in an insured state, self insured state, then we would - as an entity we would obviously have to work with these carriers each and every year to make sure that, you know, someone has the appropriate torch to report those claims; is that...

(Barbara Wright): Yes.

(Roy Franco): Okay, all right. That's going to create, you know, some interesting issues down the road but workable I suspect. In regards to the multiple defendants that you can have in a tort claims, if we take a simple slip and fall accident and it happens in a grocery store from a leaking product that occurs on the floor you could have the product supplier, you could have the premises owner, you could have the property manager, you could have the retailer all be involved in a claim.

And all could potentially be paying on this claim involving this one plaintiff. How does - how do we coordinate the reporting of all of these individual defendants so that they have all of the same payment - the body part code, ICD 9 code, injury type codes?

(Barbara Wright): You as the...

(Roy Franco): The common working file doesn't sort of get, you know, corrupt as a result of this multiple reporting?

(Barbara Wright): Okay, it's not incumbent upon a particular RRE to coordinate with another RRE. You each have your own individual reporting responsibilities. If you each report exactly the same codes fine, if you report a variety of codes because there are more than one code that can apply to a situation. If anything it might give us a fuller picture. We have the ability to take at least five body part code and ICD9 codes and I think we've - we're expanding it so we potentially can take more IDC9 codes, John, correct?

John Albert: Yeah.

(Roy Franco): Yeah, is that per RRE or is that...

(Barbara Wright): That's per record that's submitted. So if you're self insured and you're submitting something on a liability record for someone and you put in five codes, if you have to submit a no-fault record for that same person even if it's on the same policy, you've got the potential to put in different or the same codes.

But we will look at them cumulatively and one of the things that we have to do internally is with the information we get we are developing a process where we will make sure that we do not institute a duplicate recovery when new already have a pending recovery case in our other system.

(Roy Franco): Okay. That's very interesting because as we're going through the claims process we're initially reporting because we have an expectation of payment to the COBC for getting an interim payment statement, we're working with them in terms of, you know, correcting the errors on that statement and we get a particular number from the government that says this is what, you know, our demand is. We resolve the case then get a final demand from the government or what looks like to be a final demand.

We then pay that final demand off and then we report again yet what does this reporting do at that point? You know, you have all of these multiple new ICD9 codes that are coming in. Is the government's intention to then come back and say, well, we forgot these and we need to get these extra dollars back?

(Barbara Wright): Our intention is in part to look at the quality of the reporting we're already getting. We may use it for certain validation things. We do not believe in the NGHP arena that we have anywhere near full reporting. So while you're particular company may be very conscientious about doing some self identification and be involved earlier there are other entities that are not similarly involved and the cases aren't even necessarily being reported by the beneficiary's attorney.

So, I mean, we don't have a completely set program. We will look at the best ways to use this data.

John Albert: And there are, I mean, there are new tools being developed that, you know ,the reason why, I mean, there are a lot of data elements on this record layout is that will help us do that sorting so that we can avoid those duplications of efforts.

That, I mean, you know, from the point of view of the group health plan world, which there's been these similar types of data exchanges going on for a long time, those complete timely records they essentially result in less work long term in terms of resolving claims between Medicare and other payers and coordinating future benefits because it gives us the more complete picture of what's out there so that's what we're hoping through this.

And again tools are being developed through the process on the recovery side of the house here that will hopefully help us eliminate some of those problems that have occurred in the past.

(Roy Franco): You know, this is the final question because I thought it would be helpful for the data field if there was one added that said you had previously contacted the COBC or presented that information. And when I look through the fields I don't see anything which provides a - some kind of document control number of anything about a prior report that was already made so they can be all tied together.

(Barbara Wright): Well one of the reasons we don't have that there besides concern by a lot of the industry in terms of not wanting that but a lot of our self identification is not by the insurer or by the worker's compensation entity it's by the private attorney. And therefore to checkmark yes or no there wouldn't necessarily tell us whether or not we had a record.

We're going to have to have a more detailed matching or duplication - a process to eliminate duplicates based on additional data elements including, in some instances, down as far as policy numbers etcetera because we will have multiple reports for the same individual and the information will be cumulative.

(Roy Franco): Okay, I see. You know, I think with the (MMSCA) reporting and that regulation you have, 42 CFR 411.24 for (unintelligible) and (paren) which requires, you know, insurance carriers, self insurers to be responsible if after 60 days the claimant does pay. I suspect a lot of insurance carriers and self insureds like myself is just - are not going to be giving the money to the claimant right off the bat and we're going to be doing a lot of coordination with the COBC.

So it might be helpful to have that data field put in place.

(Barbara Wright): Yes thank you for the suggestion.

John Albert: Yeah, thank you.

Coordinator: Our next question is going to come from (Carmela Clarity), your line is open.

(Carmela Clarity): Hello, my name is (Carmela Clarity) calling from (Keenan) and Associations. And actually I was - I just wanted to get clarification of a couple of items. Number one is in the record layout it says that - well my question is if the employer is self insured yet the reinsurer is paying the money to the claimant who is considered the RRE, is it still the self insured employer or the reinsurance program? That's question number one.

And then I also wanted to clarify on the data elements for nature of injury and body parts are those fields required to be in liability records? Thank you.

(Barbara Wright): The nature of injury and body part, if you look at the 12.5 issuance what it says is until - let me find the right place. I think we gave a certain date, yeah, it's January 1, 2011. Up until that date if the RRE cannot furnish the WCIO code for alleged cause of injury the WCIO code for nature of injury as well as

either at least one ICD9 or one WCIO body part code you have the alternative of providing text. There's a separate field for that.

But as of January 1, 2011 everyone must furnish the WCIO code for alleged cause of injury, the one for nature of injury and either the ICD9 or body part code.

(Carmela Clarity): Okay, thanks.

(Barbara Wright): And your second question that had to do with a reinsurer paying directly I think I want to take that back and discuss it with a couple people further. All reports that we'd had so far from people everyone was fairly insistent that the reinsurer's responsibility is traditionally to pay the, you know, the self insured entity.

And that self insured entity is the one that makes the actual payout in which case we left the reporting responsibility with the self insured. Your - the hypothetical or the example you gave, does that happen frequently or can you give us more information on that?

(Carmela Clarity): Yes it does happen frequently, in fact, that's a lot of our business where our employers are - it's part of our program where as our customers - they're considered self insured by the state of California however as far as funding the account - the accounts are funded either by a pool or a reinsurers program and they - those funds are - the payments to the claimants are coming from the reinsurers not directly from the self insured employers.

(Barbara Wright): Okay, I do want to take that back and talk to a couple of people. I also want to make sure because we've seen a little bit of confusion, that you are talking about NGHP. We've had a couple people come in with questions and say well

if I'm self insured, and they're talking about group health plans, they're saying do I need to follow the rules for liability insurance including self insurance, no fault and worker's compensation. You are talking about a situation that's not...

(Carmela Clarity): Specifically worker's - yes, it's specifically worker's compensation and liability.

(Barbara Wright): Okay.

(Carmela Clarity): Specifically.

(Barbara Wright): Thank you.

(Carmela Clarity): Thank you.

John Albert: Yeah, thank you.

Coordinator: Our next question is going to come from (Susan Cornblooth), your line is open.

(Susan Cornblooth): Hi, this is (Susan Cornblooth) from the State Insurance Fund. I have - in New York. I have a few questions. On the prior conference I believe you said that if there are any other national codes that are used you would be open to that. And currently we use NCCI codes for body part, nature of injury and cause of injury. The only codes we're allowed to use as of 2011 will be the WCIO codes?

(Barbara Wright): That's our intent right now. You are the first one that has suggested a different national system for us to look at.

John Albert: (Unintelligible).

(Susan Cornblooth): All right because we believe that a lot of the carriers if not most of them are using the NCCI codes.

John Albert: Yeah, we would strongly encourage anyone who is on this call that if, again, they are using those to please submit comments through the resource mailbox that is on the mandatory insurer reporting Web page because this is the kind of information that we want to know about.

(Susan Cornblooth): Okay. And another question: I just - certain things I just want to clarify. If the claimant is eligible under a family member or a spouse do we need to report that family member or spouse's information?

(Barbara Wright): I want to make sure again we're talking about the...

(Susan Cornblooth): Worker's comp.

(Barbara Wright): Yeah, okay. And they're eligible in what way?

(Susan Cornblooth): For Medicare.

(Barbara Wright): If you're paying a Medicare individual...

(Susan Cornblooth): Right.

(Barbara Wright): ...and is a situation that involves any bodily injury then yes.

(Susan Cornblooth): No, no but let's say we have a claimant; our claimant is Medicare eligible but not under their own account, under a family member. Do you need - you need our claimant's information and the family members, you know, like Medicare claim numbers for both?

(Barbara Wright): We need the Medicare information for the person that - for the injured party when that's the beneficiary.

(Susan Cornblooth): Okay, and that's it? Okay. Also, how do we report when liability is transferred to another carrier or agency? And also how do we report liability when a case is apportioned?

(Barbara Wright): First could you explain what you mean by a responsibility is transferred because if you had ongoing responsibility and it was terminated because you transferred it to another entity...

(Susan Cornblooth): Right.

(Barbara Wright): ...you should be submitting termination information and they should be submitting a new record showing they have ongoing responsibility.

(Susan Cornblooth): Okay.

(Barbara Wright): And if there's a flat settlement, again, that wouldn't apply because whether it's being paid as annuity or a structured it would have just been reported once.

(Susan Cornblooth): Okay. What about apportioned cases? Is there any place - we didn't see anything on the layout where it talks about percentage of liability.

(Barbara Wright): Are you talking like comparative negligence or are you talking...

(Susan Cornblooth): No worker's comp. On a worker's comp case a claimant can possibly have two or three cases. We would possibly have maybe a total of 70% of the liability and another carrier would have 30%.

(Barbara Wright): You would report the portion that you have responsibility for including dollar amounts if, again, it's a flat obligation and they would be responsible for reporting theirs.

(Susan Cornblooth): Okay and - because I didn't see any field in there for percentage.

(Barbara Wright): Well but we don't care what your - because we have a priority right or recovery we don't care what percentage you have of the whole, we have a potential recovery rate up to that settlement amount if we've paid enough. How that relates to the total claim isn't particularly relevant for our purposes.

(Susan Cornblooth): All right because a lot f times it's not a settlement amount it's ongoing payments.

(Barbara Wright): And if - well, okay, I guess our question is what you mean by ongoing payments. If you've assumed responsibility to pay medicals on an ongoing basis then you need to report that to us as ongoing responsibility and we set that up in our common working file that helps when we process claims that come into Medicare on behalf of the beneficiaries. But if you're saying for ongoing payments if you're talking about a situation where you're responsible for a $500,000 settlement that's going to be paying out...

(Susan Cornblooth): No...

(Barbara Wright): ...on annuities then...

John Albert: Let me try.

(Susan Cornblooth): Okay. Another question. What do you consider as late submission?

John Albert: Well I mean right now in terms of what we've set up for - the group health plan world is that essentially if an event - a reportable event - a record would need to be established within 45 or fewer days of the beginning of the next reporting quarter. You would essentially be able to report that on the following quarter's submission.

(Susan Cornblooth): Okay.

(William Decker): But that's for GHP...

John Albert: Yeah.

(William Decker): This is NGHP.

(Susan Cornblooth): Right.

(William Decker): And if a single reportable event that will never occur again what would - what would we consider to be a late report?

John Albert: It's the same thing.

(Barbara Wright): If you don't report it within the prescribed submission window then it's late.

John Albert: Yeah.

(William Decker): You've got a submission window and how do you know that - what the submission window is?

(Barbara Wright): You will have an assigned submission window. And again, you'll have a submission window for each quarter.

John Albert: Right.

(Susan Cornblooth): Okay. On - I didn't understand what it talked about with a death case? As far as worker's comp is concerned is it sufficient for us to report termination when a claimant dies?

(Barbara Wright): If you're talking about responsibility for ongoing medical?

(Susan Cornblooth): Right.

(Barbara Wright): Okay, yes, I think their death would terminate your responsibility for ongoing medical...

(Susan Cornblooth): Because there was questions in there about claimant one and additional information...

(Barbara Wright): Okay - keep in mind that - what - I think the section - do you have the page number hand?

John Albert: Forty three.

(Barbara Wright): Forty three. What you're looking at there is slightly different; we're talking about if you read the thing under claimant information, that's the situation where you've had a pending claim...

(Susan Cornblooth): Right.

(Barbara Wright): ...and the beneficiary is already deceased. And there's like, you're not really talking the ongoing medical part, you're talking about there's a claim for some type of settlement or judgment that's going to be more of a flat - I hesitate to call it a lump sum but the point is it's going to be a single payment obligation, it's not going to be the ongoing medical issue.

(Susan Cornblooth): Okay.

(Barbara Wright): And in that case we need to know who's pursuing that claim and that's what the claimant information is.

Woman: So I think - this is another person in the room. You asked that question earlier that if there was the injured party versus the claimant party that's why (82) is there, that's why we're looking for that; we need to know who the insured party is as well.

(Susan Cornblooth): Okay. And another thing, if, let's say we voluntarily pick up payments and report certain body parts if, as litigation goes on, there's hearings at the worker's comp board and body - not al those body parts are established, some - maybe some are added, some are not established. We report that as a change, right?

John Albert: Yeah.

(Barbara Wright): In connection with ongoing responsibility, yes.

(Susan Cornblooth): Okay so, you know, because we - when we get a claim filed, you know, we review the case and if we feel there's - well see we - worker's comp liability we pick up payments and then they have hearings at the board so we report all the injuries and all the body parts that are reported to us and then any changes we'll do later on, right?

John Albert: Yes, I mean, as needed.

(Susan Cornblooth): Right, okay. Do you have other questions? Can we have one more - another question?

John Albert: All right, this is it though; we have five hundred people on the line...

(Susan Cornblooth): Okay.

John Albert: ...who want to get through.

(Frank Saraland): This is (Frank Saraland). Just a question on this ongoing responsibility because somebody had asked a question before about a closed case. In New York State unless a case is closed on what we call Section 32 settlement as far as whether or not responsibility continues is kind of a gray area and it's really handled on a claim by claim basis.

So, you know, somebody mentioned before there may be a five year gap; we don't have any like timeframes or dollar amounts where medical is cut off. But that issue - it's not clear and it's litigated in a lot of cases...

(Barbara Wright): Well what we're saying is we're not saying you're reporting to us as ongoing guarantees that you're going to pay every claim. What we're really getting that information for is to set up information on our common working file for claims processing so if we have a claim come in that's related to the alleged injury we will deny payment at least until someone shows us that worker's comp has looked at that claim and made its determination.

It's not - you're reporting the ongoing responsibility isn't an absolute guarantee that you're going to pay all claims until there's a termination date.

(Frank Saraland): Okay, thank you.

(Susan Cornblooth): Can we ask one more question?

John Albert: We really have to let - open up the line to some other questions. A lot of people that are in the queue right now and if you want to get back in the queue please do so but for the sake of all the other people participating we'd appreciate if...

(Susan Cornblooth): Okay.

John Albert: ...you could try back later. Thank you.

Coordinator: Our next question is going to come from (Priscilla Linkowski), your line is open.

(Priscilla Linkowski): Thank you. Appreciate the responsiveness from the CMS folks in addressing the concerns that were raised at the town hall meeting back in November 20. And this current layout seems to be very receptive to those recommendations made at that meeting.

Two things: one, in terms of the thresholds that you're considering have you received much data from carriers and/or self insureds to begin thinking more towards an actual threshold? And second I believe it was (George Mills) who indicated at that meeting that there would be consideration at the starting of the reporting on a requirement only on those beneficiaries who are 65 or older. Are you any further on either one of those tasks?

(Barbara Wright): To the best of my knowledge we've only received two emails with data about percentage of settlements showing the payment range like X percent under this, etcetera. In terms of an age threshold we are still, you know, talking about that but that's much less likely to be implemented because the arena of liability and no fault and worker's compensation is precisely the arena where we're likely to see a greater percentage of beneficiaries actually being under 65 because they were harmed in a car wreck and that resulted in them being a beneficiary or otherwise.

(Priscilla Linkowski): All right. Thank you.

(Barbara Wright): And as you'll note in the document on 12/5 it does state that at least for right now there is no age threshold.

(Priscilla Linkowski): Thank you.

Coordinator: Our next question comes from (Mike Simpson), your line is open.

(Mike Simpson): Hi, this is (Mike Simpson) from the (PIAA). I just wanted to follow up on the discussion you've had in previous meetings regarding the trigger for what would cause a report to actually be filed. The current plan is that it's a verdict

or settlement or other payment and if you can just explain again what the rationale is for using that rather than using a - just a payment?

We have situations in the third party liability insurer where a verdict doesn't necessarily close a claim there could be additional negotiations after the verdict or maybe even an appeal which would drag it out substantially beyond that. And it's kind of hard at this point for us to know when we would have to report if we do negotiate after a verdict or appeal.

(Barbara Wright): Okay, we are still looking at how to phrase anything tied to appeals, etcetera. But one of the reasons we cut it off as of the settlement date whether that's established by the check being issued if there's no written agreement or by a court order ,etcetera, is because that's the date that we cut off what's included in our recovery claim.

And if we extended that time range to get reported only when payment was actually being made we would be disadvantaging both the beneficiary and the insurer in terms of what we could include in our recovery claim. It would allow us to include much more.

(Mike Simpson): Okay, thank you.

Coordinator: Our next question comes from (Barbara Taylor), your line is open.

(Todd Edwards): Actually this is (Todd Edwards) from State Farm Insurance Company. In regards to the response file that you folks will be sending back to us when we have data discrepancy can you folks provide us with what the current thought is regarding how those data discrepancies will be resolved especially if it resolves around date of birth, address, those kinds of personal information?

(William Decker): At this time, I mean, we're not correcting this - the data on this. Are we correcting the data? I mean if - forgive me for not keeping up with some of the changes but basically if there are discrepancies and if we are making a modification to name, date of birth and gender of the individual that information that we use - it comes straight from the Social Security Administration enrollment files and it's considered the official government record of that individual.

If you are - or should I say the beneficiary disputes that information the only way that can be updated is if the beneficiary themselves goes to the Social Security Administration. We - and that, you know, if that record is somehow updated we would know about it. But for purposes of identifying who is or who not a Medicare beneficiary the information that we have on file is the official federal record of that beneficiary.

(Todd Edwards): Okay, thanks.

(William Decker): And just as an FYI we have never seen in all the years of GHP data exchange information that was inaccurate from the Social Security Administration. In most cases, you know, basically the information submitted by the reporter was incorrect and it's very common to, you know, transpose digits on dates of birth and things like that, so.

(Todd Edwards): Thank you.

Coordinator: Our next question comes from Joyce Shulman, your line is open.

Joyce Shulman: Hi, I'm Joyce Shulman with Employers Direct and this is worker's comp related. And I have a couple of questions. I have been recently receiving conditional notices of payment on closed medical only files. And the person is

53 years old, was obviously working at the time of the medical only so, one, I'd like to understand how you even found out we had a closed medical only file. And then, two, is it your intention to then tell those people to reopen their worker's comp claims so that Medicare doesn't have to pay benefits?

(Barbara Wright): I'm not sure that I fully understand what you've got. But if you have a situation where you've received some type of conditional payment notice as the insurer that indicates that we have, in one of our systems, a record that there's a pending claim.

So that...

Joyce Shulman: And how would you have that record...

((Crosstalk))

Joyce Shulman: Where would you get that from?

(Barbara Wright): That's what I was going to...

(William Decker): That information can come from any number of sources developed by the coordination of benefits contractor. You know, it could be beneficiaries, insurers, employers, etcetera. And, again, the point, you know, one of the purposes of this type of reporting that we're implementing is to hopefully reduce a lot of that erroneous reporting to begin with.

In many cases information comes from beneficiaries, which historically has been the least reliable source of other coverage information.

(Barbara Wright): Another source where we get information if the provider, physician or other supplier elicits information when they're treating an individual and gets information that this is related to a worker's compensation claim, etcetera. There is information that they include upon their claims submission.

Joyce Shulman: And so then your goal is to delay their payment so that they would pursue reopening a closed claim when they were discharged as cured?

(Barbara Wright): I'm not, yeah, I mean what you're asking seems to be outside the scope of what we're doing. We don't have any goal of delaying payment. We do have a goal of having accurate records regarding who has worker's compensation and to the extent people may have in the past simply not reported or neglected to pursue their worker's compensation. If there's ongoing responsibility and we have an open record hopefully that will allow our claims processors to essentially in the notice that would go back say there's associated worker's compensation, you should be billing them first and us second.

We're not trying to drive anyone to pay anything beyond their current obligations; we're simply trying to make sure that we're paying in the proper order. And at least where there's ongoing responsibility that we eliminate pay and chase when possible.

Joyce Shulman: Okay so that would lead me to my next question: It's not uncommon for a worker's compensation claimant to have five different back injuries with five different employers. Who you would be sending a conditional payment notice to in that case?

(Barbara Wright): The information about conditional payments and recovery is outside the scope of this call. If you want to submit a question we will try and forward it to the appropriate staff to answer it.

Woman: What you're asking is about the recovery process, right now that's not what this call is about. The call is about the reporting process. But we'd like to answer your call about recovery. So if you want to share your name and the phone number now...

(Barbara Wright): We would prefer to get an actual email so...

Woman: All right.

(Barbara Wright): ...we can forward it to the right staff.

Woman: Okay.

Joyce Shulman: Okay.

Coordinator: Our next question comes from (Keith Dateman), your line is open.

(Keith Dateman): Thank you. First question: When do you expect to have the user guide finalized? It's very difficult for people to deal with a moving target.

(Barbara Wright): We appreciate that but we've also - because GHP has been our priority of necessity we've been trying to get as much information out as we can. We believe what we've got is much more solidified than I was before so as soon as we get the answer on the query access we'll be able to build certain parts of the manual as well as there have been some improvements that have been made to GHP file submission and processing that will carry over.

So that is our next step to have a fuller guide. If you look at the 12/5 document you'll note that both at the beginning and specifically with the file layouts

we're trying to give you information that you can track exactly what changes have been made since the prior version.

(Keith Dateman): All right, I appreciate that just from a company point of view it takes time to change systems and timeframes are getting awful short.

John Albert: Yeah, we totally understand and our goal is not to spring this on you at the last minute. And, you know, we will adjust schedules as necessary but in the meantime we are working to get this finalized as quickly as possible because we do understand, you know, that you have work to do on your end as well, so.

(Keith Dateman): Okay. Next question: You have sort of changed your position since October 29 on being bound by court approved allocation.

(Barbara Wright): I don't believe we've changed our position, what we have said all along is court approval by itself is not enough; we generally defer to a court when there is an actual hearing on the merit.

(Keith Dateman): Right, okay.

(Barbara Wright): But that's different than when the parties say, hey, here's our settlement, will you approve it, will you bless it. That's court approved but that's not something we're bound by. Similarly if there is a court interpretation of a state law that is contrary to our federal law then the federal law still supersedes and we wouldn't recognize any court designation under the state law.

(Keith Dateman): You may not want to address this here but there's another thing you ought to be aware of that a work comp insurer could be paying both directly to the claimant and in other situations under the 3C coverage be reimbursing an

employer for the payment. And I don't think you've dealt with that aspect. I'll send you a separate email on that.

(Barbara Wright): I would appreciate that very much, (Keith).

(Keith Dateman): Okay. What about situation where there is a payment after - there's still ongoing medical obligation but no medical is being paid? On a case that was say an award was made prior to July 1 but the only payment that's been made since July is...

(Barbara Wright): You should be reporting the ongoing responsibility. And I think we covered that in some detail in the 12/5 document. I think it's on Page 13. Wait, that's - let me see exactly where it is.

(Keith Dateman): All right. I just raised it because I wasn't entirely clear on that.

(Barbara Wright): Yeah, if you can't find it when you're looking through this again...

(Keith Dateman): I know where it is. Yeah, I'll look at the language again.

John Albert: The next version will have an index.

(Keith Dateman): Death cases, let me just see whether this clarifies what you're - because your answer seems somewhat contradictory. In a worker's comp death case you may have medical that relates to the injury and the death that someone is trying to collect. And - for the estate, for the claimant or to see it gets paid. You also have a separate action by the dependents even if they're Medicare eligible those are not of interest to you because it doesn't arise from the injury; am I correct in that?

(Barbara Wright): We would need to see the specific state law provisions involved. I mean, there are certain death cases that we have recovery rights and there are others that we don't.

(Keith Dateman): Well what I'm saying in worker's comp the claim of the dependent for benefits, we're talking about an indemnity payment, there's no medical involved, is a separate cause of action from that of the injured worker.

(Barbara Wright): Right. We'll look at it; I want to make sure it's not a situation - if for instance in order to be paid under the indemnity claim they were willing to release a state claim for something else then you're turning it into something more than indemnity even if in name it's indemnity. So we'll look at language to address the situation you're talking about.

(Keith Dateman): And the other question that's come up in a case where you have an illegal alien and you are paying worker's comp and they provide a false social security number from a reporting point of view how does that get dealt with and whose responsibility is it to correct that? Because some innocent party whose number has been used may be...

John Albert: You're absolutely right - this is (unintelligible). You're absolutely right, some innocent party's number may be being used; it may just be a made up number that tags to an actual innocent party someplace else. Your question is who is responsible for that and I guess the only real answer to that is the person who is mal-using the number.

The point from our perspective is that if we get an identification number either a health insurance claim number of a social security number and it shows up as accurate and valid on our system here at CMS it's because it's been vetted previously by other federal folks as a valid and accurate number.

Whether or not the number is being used by the person it was issued to is not something that we have any reasonable way of knowing.

(Barbara Wright): But remember let's say you had...

((Crosstalk))

(Barbara Wright): ...someone - the person who's falsely using the number is working for you under the name of John Smith. And the number actually belongs to Suzie Jones. When you submit the name and the date of birth, etcetera, that information it's not going to match on enough points and we're going to say this is not a beneficiary based on the information you've submitted.

(Keith Dateman): Okay.

John Albert: Unless they just stole an ID but that's, again, that's kind of beyond...

((Crosstalk))

John Albert: ...I mean, there are various...

(Keith Dateman): I'm talking from a reporting point of view you're going to send an error message back to the carrier saying this doesn't match?

(Barbara Wright): We would be saying we cannot identify a beneficiary based on the information you submitted.

John Albert: Right.

(Barbara Wright): But that's not a guarantee the person is not a beneficiary but it says based on the information you submitted, you know.

John Albert: Yeah, if John Smith, you know, the record comes in under John Smith and John Smith, you know, is using Suzie whoever's SSN it won't match. But if John Smith is in fact a stolen ID then potentially a record could be built for John Smith who is not the person, you know, they are representing to you. But that kind of goes beyond - that gets into, you know, fraud and that's kind of beyond the purview of this...

(Keith Dateman): No all I'm saying is once we get the record and if we try and correct, you know, and say, okay, we can't find anything either then does it drop out of the reporting requirements?

John Albert: If you send us a record that doesn't match our data systems here we'll send you back a notice saying it doesn't match our data systems. If you can't develop, on your end, for a record that does match our data systems then in fact what you just said, the record will drop out, yes, that's what will happen.

(Barbara Wright): Now in your situation if the underlying premise is the person doesn't actually have a social security number then ultimately you're home free because they aren't a beneficiary. So if they didn't get reported...

John Albert: Right.

(Keith Dateman): Okay, thank you.

Coordinator: Our next question comes from (Theresa Filino), your line is open.

(Theresa Filino): Hi. We're from Michigan (Norfolk) state and you basically said if we close the file it doesn't always mean it's going to be closed because Michigan is unlimited lifetime benefits. So you're actually saying that every single claim we put in will basically stay there for the life of the individual because they can come back to us at any time if they decide to...

((Crosstalk))

(Barbara Wright): ...for Michigan it should remain as an open record.

(Theresa Filino): So...

(Barbara Wright): What that means is not that they're necessarily going to be coming back to you if they don't have something associated to treat for. It once again puts something in our claims processing system so that if we identify something that appears to be related to their Michigan no fault medical situation the provider or supplier is going to be obligated to go back and check with you, bill you, if they believe it's related before they can bill Medicare.

(Theresa Filino): Then do these automatically drop off when the person is deceased?

(Barbara Wright): Well when they're...

(Theresa Filino): Is it up to us then track every person to find out if they're deceased?

(Barbara Wright): Well when they're dead we aren't going to get anymore claims after their date of death. So even if it stays open...

John Albert: They won't be treated after their date of death, that's right - more accurate...

(Theresa Filino): I would hope not.

(Barbara Wright): That's true, we will still be getting claims on the actual date of death but not for treatment subsequent to the date of death.

John Albert: Yeah.

(Theresa Filino): Now in the situation again because I may have closed the file five years ago and suddenly they come back to me and I have to reopen the file. At that point when I reopen the file if I'm going to make any medical payments then I have to report it?

(Barbara Wright): If we've got, okay...

John Albert: No.

(Barbara Wright): ...you need to keep in mind if you've submitted an open record and we still have an open record you don't need to resubmit it unless you have updated information on the person.

(Theresa Filino): But what if the claim happened before July of 2009, the claim happened five years ago.

(Barbara Wright): You have ongoing responsibility so that person is supposed to be reported to us if there's no way for you to ascertain that at all then at minimum you need to report it the next time you get a claim. But we may have to have further discussion about what Michigan needs to do for all the quote, technically open records.

(Theresa Filino): I was going to say, gosh, that could be every claim we've had for the past, well since 1972.

(William Decker): That's why we need to talk a little bit further about it here.

(Theresa Filino): Okay. And then did I understand right as far as the (MESA), the development of the (MESA), what's going to be required if we're required to get preapproval and then also the health set-aside or the - basically the escrow account, are there any details on how that's going to be handled yet?

(Barbara Wright): Could you repeat that again? What your question is, I'm sorry.

(Theresa Filino): Okay for a liability settlement when we need to protect future medical...

(Barbara Wright): For liability settlement you said?

(Theresa Filino): Yes.

(Barbara Wright): Okay. I will repeat what I said in a prior call that Medicare set-asides are outside the scope of the Section 111 reporting. We haven't changed current procedures; if you wish to contact us separately about liability set-asides you can contact me but, you know, it's outside the scope of this call and it's not tied to the reporting despite allegations by some entities that Section 111 mandates liability set-asides or mandates worker's comp set-asides; Section 111 has no such requirement.

(Theresa Filino): Oh, okay.

(Barbara Wright): It doesn't change preexisting obligations in terms of protecting the trust fund but Section 111 doesn't address set-asides at all.

(Theresa Filino): Okay.

John Albert: Unfortunately there's some inaccurate information, you know, out there that is not CMS information. And again I would refer everyone to the official CMS Web page mandatory ins rep the cms.hhs.gov/mandatoryinsrep as the one and only official source of CMS implementation information regarding Section 111.

(Theresa Filino): Okay, thank you.

Coordinator: Our next question is going to come from (Gregory Johnson), your line is open.

(Gregory Johnson): Oh hello. I'm based out here in California. And in the worker's comp world as well as other areas some claimants receive benefits from more than one payer maybe in more than one state occasionally sometime from various different insurance coverages, liability, work comp, even health. As the one central point, sort of the catch point of all of this data ultimately are you then when you see that duplication occurring is CMS then going to report back to the payers who sometimes aren't aware that this duplicate payment is occurring?

John Albert: I mean in terms of the 111 reporting and response we don't provide information regarding other coverages back to the submitter.

(Barbara Wright): I mean it's generally our assumption that if we've got multiple records we've got a situation where it's cumulative. We have no reason to believe that it's necessary duplicative.

(Gregory Johnson): Even if it's the same body part or even the same date of loss?

(Barbara Wright): Well as examples have been given on this call even for worker's compensation an individual could have a claim against two or three entities for the same situation.

(Gregory Johnson): But in any case you don't see part of your role as reporting back to the payers of this duplication when other payers are paying...

(Barbara Wright): No we aren't doing any type of investigation to determine that it's duplicative versus cumulative.

(Gregory Johnson): Okay.

(William Decker): That falls out of the purview of this program.

(Gregory Johnson): Very good. Thank you.

Coordinator: Our next question is going to come from (Megan Daniels), your line is open.

(Megan Daniels): Hi, thanks. We'd like to confirm our understanding regarding the (interplay) if any of the roles related to a reporting entity for a group health plan and the roles related to liability, no fault and worker's compensation being discussed today. So for (unintelligible) we're a group health plan that coordinates benefits with other entities such as no fault insurers, worker's comp insurers, etcetera. We just want to make sure that the rules pertaining to the group health plans are the only rules that pertain to us.

And I know this question might have been answered but we still want some sort of definitive clarity on this.

(Barbara Wright): Okay and this maybe - go beyond what you're asking but someone who is a responsible reporting entity for group health plan purposes if it's a self insured employer who processes their own claims they could separately be a responsible reporting entity for non GHP purposes particularly if they're self insured. So they could have more than one reporting responsibility.

If you're talking about priority of payments GHP, the responsible reporting entities must report to us and so must the non-GHP. And we are secondary to both of them. So in terms of what we will pay and won't pay we build multiple records; if we have information out there that someone has group health plan coverage but they're also involved in a liability situation we will bill the record for both of those.

But when the claim comes in we're not going to pay it conditionally if there's an open group health plan record, we will deny it because regardless of whether there's any liability payment there is a group health plan that is still primary to us.

John Albert: For purposes of reporting those reporting processes for group health plan versus non group health plan are separate and distinct and would require two registrations and file submissions.

(Barbara Wright): Does that cover what you were looking for?

(Megan Daniels): Yes, thank you.

Coordinator: Our next question is going to come from (Margaret Casting), your line is open.

(Margaret Casting): Hi, thank you. I think we've already established that in many situations worker's compensation claims are going to have ongoing responsibility. My question is on the reporting, if you have someone, for example, who is 58 at the time that has a worker's compensation claim and we don't have any activity so on the insurer's side you close the file because you think it's probably done but technically there is ongoing responsibility.

Are we going to have the responsibility in CMS's eyes to run queries based upon that individual's birth date to see when they might become Medicare eligible and then report the claim?

(Barbara Wright): Yes, if you technically have the ongoing responsibility you have a responsibility to report when they become a Medicare beneficiary as long as you have that technical responsibility.

(Margaret Casting): So literally hundreds of thousands of worker's compensation claims - be ran through queries based on birth dates and sent in if not millions.

John Albert: We, I mean...

(Barbara Wright): It depends on your individual state law, I mean...

(Margaret Casting): Okay.

(Barbara Wright): ...I mean...

(Margaret Casting): Okay.

((Crosstalk))

(Barbara Wright): ...the responsibility is absolutely terminated then at that point they don't have to worry about whether the person ever becomes a beneficiary.

(Margaret Casting): Okay.

John Albert: That's one of the reasons we want to allow access - or we're trying to get access...

(Margaret Casting): Right because that...

((Crosstalk))

John Albert: ...to query data because the query process is a pretty simplistic process and can be automated.

(Margaret Casting): Okay because, yeah, that's going to be millions of records...

John Albert: Yeah.

(Margaret Casting): ...if not billions, so. Okay, thank you.

Coordinator: Our next question is going to come from (Judith Meers), your line is open.

(Judith Meers): Thank you for taking my question. I had a question about liability payments, say malpractice payments that are paid to Medicare beneficiaries who are enrolled in Medicare Advantage plans. Those plans are paid on a, as you know, are paid on a capitation basis and that capitation doesn't change by virtue of any malpractice payment, award, settlement that the beneficiary gets.

It's not like fee for service where Medicare could seek to recoup its individual fee for service payments that it made to providers who provided the care for the injury. But for a Medicare Advantage plan there's nothing for Medicare to recoup from the settlement as a judgment that that Medicare Advantage member in that plan got.

So I'm questioning whether - if the purpose of the reporting is to identify settlements and judgments from which Medicare could recoup its payments made for the injuries that were the subject of the liability payment, how you're thinking about this with respect to beneficiaries who are enrolled in Medicare Advantage plans when the plan has the obligation to pay for the services that the person needs.

(Barbara Wright): First of all it's not - the reporting is not just for recoupment it's also for proper claims payments. Secondly there are some Medicare Advantage situations where we may pay like a single claim or something. Third, people can move in and out of Medicare Advantage situations and particularly in liability there could be a period covered during when someone has a pending claim where they're both in and out of Medicare Advantage.

So for a number of reasons we need the information reported and...

John Albert: I mean, the issue of Medicare Advantage reimbursement and all is a separate issue that's actually CMS's components other than this one here actually attempting to address and it's all - I mean, we're very well aware of this issue but for purposes of Section 111 reportable incidents are reportable incidents regardless of whether they're in a Medicare Advantage plan or not.

(William Decker): And as we said before many times the idea here is not to focus on recoupment of payment it's to make payment correctly the first time. And accurate

reporting will help everybody make payment correctly the first time. We'll only go after money that we have paid incorrectly if we don't pay correctly the first time.

(Judith Meers): Well...

(Barbara Wright): Or that we've paid conditionally while someone's waiting for settlement judgment or award.

(Judith Meers): Well I thought I heard (Barbara) say there were three reasons, one - and I just want to make sure I understand this correctly - one was that it's not just about recoupment, it's about proper claims payment, all right. Then the second one I missed and the third one was people move in and out of MA plans.

(Barbara Wright): There are occasional situations where someone goes out of network and Medicare ends up paying.

(Judith Meers): Oh, I see, you mean for example like hospice or other situations?

(Barbara Wright): Well I mean I'm not familiar with all the details but I certainly over the years have seen, you know, a number of situations where we do make out of network payments on a very limited or very discreet basis. And those would all be recoverable as well.

(Judith Meers): Okay I understand your rationale. I think the likelihood is going to be fairly small with respect to most of these Medicare Advantage members but I understand your rationale. Thank you.

Coordinator: Our next question is going to come from (Debbie Mitchell), your line is open. Hello, (Debbie Mitchell), your line is open.

(Debbie Mitchell): Yeah I have a question with respect to the (unintelligible) 1980 (exposure) policy. Can you give us an update? You said you were working on a policy.

(Barbara Wright): I think that's addressed in detail in the 12/5/80 document specifically page, hang on just a second, it's at the bottom of Page 12 and the top of Page 13. And I think it would be easier if everyone specifically reads that because you need to understand the exact language that's there. But we have addressed the issue.

(Debbie Mitchell): Okay, I have another question. Now said to one of the callers that they can contact you at another time. Are you available other times other than by email and by this teleconferences?

(Barbara Wright): I said that I would specifically talk to people about liability Medicare set-asides and issues surrounding that because I field questions on that. I am not saying, because I can't and neither can anyone else here in the room, routinely be available for phone calls on Section 111 issues. As we've said we need to have the questions come in through the mailbox so that we can address as many as possible and document as people actually register then more technical questions they'll be dealing with with their EDI rep.

(Debbie Mitchell): So in reference to liability set-asides how can one contact you?

(Barbara Wright): My telephone number is 410 - you already have it from another call - 410-786-4292.

(Debbie Mitchell): Nine, two. Thank you.

(Barbara Wright): But as I said that's specifically for a single purpose.

John Albert: And if people start calling any of the other numbers expecting to get answers to questions they'll soon get no answers because unfortunately with limited resources and time, again, the most effective way for people to get their issues and questions answered is to submit the comments through the resource mailbox because, again, we're all, as you could probably tell, pretty busy trying to develop this program and just simply do not have the staff resources here to return individual phone calls.

But that's why we're trying to hold more of these types of teleconferences and, as you can probably see we've scheduled a bunch more for early next year as well. And there'll probably be even more as this goes on, so. So we appreciate your patience; we understand you're anxious for information but, again, submit them in writing through the Section 111 resource mailbox on the mandatory insure reporting Web page.

Woman: Please take the time to read the material. I know there's a lot to look at and a lot to digest. But the staff is working very hard to take the questions and the policies and put them out there for you to look at. And I know we're all busy; it's just the nature of the world we live in. But I do think that you will be better able to help them as well as they help you if you take the time to just walk through each of what you see on the Web site.

And then pencil down your questions or print it off or whatever you need to do because I think it would make it more efficient for both you and for they.

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

(April Johnson): Thank you. I had submitted a question and it pertains to joint powers authorities that manage claims and payout liability settlements on behalf of a

group of entities. And we specifically do this for public entity and nonprofit hospitals. So we are not technically an insurer and our members are not technically self insured but they pool their monies together.

So what we were trying to find out is is our company going to be considered the registered reporting entity for our members or do each of our members need to register as reporting entities and then identify us as the agents?

(Barbara Wright): Is this the worker's compensation situation or a liability situation?

(April Johnson): Only liability.

(Barbara Wright): It is - is the...

((Crosstalk))

(Barbara Wright): ...is it licensed as an insurer?

(April Johnson): No. Under California law we are allowed to by statute to set up this joint power authority where they, rather than paying an insurance company premiums, they pay us what are called contributions. It's essentially the same setup as an insurance company although not technically one. And we've been - manage medical malpractice claims.

(Barbara Wright): Okay, we - I actually had this - I have it right in front of me because I'm waiting for it to come up. We - I needed further information on whether or not it's licensed as an insurer. If it was licensed as an insurer it would obviously be the RRE but I think we want to go back and look at this if they're not licensed as the insurer. We are trying to facilitate the easiest way to do things

but unfortunately in order to manage it we also have to have some fairly flat rules.

So let us take a further look at this. I do have your - actually incoming question right in front of me.

(April Johnson): Great. Thank you very much.

John Albert: See, we do actually read the questions.

Coordinator: Our next question is going to come from (Jeff Bradburn), your line is open.

(Jeff Bradburn): Yeah, I just want - a couple - you've gone over a lot I just want some clarification just to make sure I'm on the right path on a couple of these items. Date of incident, that's going to be the date of loss but that shouldn't be confused with eligible claims. My impression right now is that an eligible claim would be any (pip) payment that we made after 7/01/2009 or, I mean, actually I'd should say rather than (pip) a no fault payment and any I guess a liability injury settlement that is made after that date, is that accurate?

(Barbara Wright): Not quite.

(Jeff Bradburn): Okay.

(Barbara Wright): First of all for date of incident you said date of loss and we've been made aware that the insurance industry does not necessarily define date of loss the same way - or date of incident the same way CMS does.

(Jeff Bradburn): Okay.

(Barbara Wright): In the 12/5 document...

(Jeff Bradburn): Right.

(Barbara Wright): ...you need to look at the two definitions that are there. We always need our date of incident. And it's a situation...

(Jeff Bradburn): But I thought you date of incident - I'm sorry - I thought your date of incident is going to be our date of loss.

(Barbara Wright): It's our understanding that under some state laws date of loss, if you're dealing with a situation involving exposure, ingestion or implantation that for date of loss they actually use like date of last exposure...

(Jeff Bradburn): Okay.

(Barbara Wright): ...where our date of incident is date of first exposure...

(Jeff Bradburn): Okay.

(Barbara Wright): ...we need to stay with our date of incident.

(Jeff Bradburn): Okay.

(Barbara Wright): But it's because it drives how we do our recovery.

(Jeff Bradburn): All right.

(Barbara Wright): Also in terms of...

(Jeff Bradburn): Okay, wait, can I just clarify one thing so you can...

(Barbara Wright): Okay.

(Jeff Bradburn): ...see where I'm coming from. You're answering the questions right from where you're coming from so I want to make sure you understand where I'm coming from. We are an auto carrier, auto insurance carrier.

(Barbara Wright): Okay.

(Jeff Bradburn): So typically a date of incident for us...

((Crosstalk))

(Barbara Wright): Yeah.

(Jeff Bradburn): Okay, all right. Great. Okay so...

(Barbara Wright): If you...

(Jeff Bradburn): ...I guess it's quite clear now that for an auto insurance carrier the date of incident is date of loss, right?

(Barbara Wright): The date of the car wreck is the date of incident.

(Jeff Bradburn): Okay. All right, excellent.

(Barbara Wright): We'll stay away from the word loss.

(Jeff Bradburn): Yeah, that's - fair enough - fair enough.

(Barbara Wright): In terms of ongoing responsibility if you have someone that has filed a claim and you've accepted, you know, Med pay responsibility and it's not yet exhausted as of 7/01/09...

(Jeff Bradburn): Right.

(Barbara Wright): ...and that's one that you have to report to us if they're a beneficiary...

(Jeff Bradburn): Okay.

(Barbara Wright): ...because you've got ongoing responsibility.

(Jeff Bradburn): All right, I mean, and I guess - and that's when the date of - your date of incident, our date of accident is irrelevant it's just a reporting deal we're going to report to you. Our obligation remains the same...

((Crosstalk))

(Barbara Wright): The same car wreck you had a liability settlement and that liability settlement took place June 28 and it's, you know, $50,000 payment then you don't have a reporting obligation to us under that liability.

(Jeff Bradburn): Okay.

(Barbara Wright): It doesn't change any other obligations...

(Jeff Bradburn): Okay.

(Barbara Wright): ...or responsibilities.

(Jeff Bradburn): Okay, all right. And so and, you know, on the other hand it doesn't matter if it occurred in 2000 if we make a payment on July 2, 2009 we need to send it in our next file that we send to you guys, right?

(Barbara Wright): It's the date of incident is not (determitive), no.

(Jeff Bradburn): Okay, all right. It sounds like you guys are leaning more towards the query capability for us to determine eligibility, is that accurate?

(Barbara Wright): We are trying to get authorization...

((Crosstalk))

(Jeff Bradburn): Right. That kind of - so let me ask the next one, what happens if we send you information on people who are not eligible or are not Medicare benefits, are you just going to reject the record and that'll be that?

John Albert: Yeah, I mean basically if they aren't then, yeah, we wouldn't do anything with the information if we couldn't find them.

((Crosstalk))

(Jeff Bradburn): There's no fines associated with a rejected records or anything like that?

(Barbara Wright): If we see instances of dumping we will have to look at that.

John Albert: Yeah.

(Barbara Wright): I mean, we're not interested if someone makes a few mistakes but if someone's dumping every single claim they've got because they aren't bothering to determine whether or not people are beneficiaries then yes we are going to have a concern. And keep in mind that a reject - simply submitting everybody a reject doesn't necessarily ensure you the person is not a beneficiary.

(Jeff Bradburn): Sure.

(Barbara Wright): If you haven't done your homework and gotten the right information a reject simply means we don't have a record that shows a person is a beneficiary based on the information you've submitted.

(Jeff Bradburn): Okay.

John Albert: And then we, again, as I mentioned earlier, I mean, we will be issuing documentation concerning quote, compliance...

(Jeff Bradburn): Right.

John Albert: ...in the near future. And even, you know, initially some of them will be high level but then we'll also be drilling down through, you know, we'll get more specific information like that.

(Jeff Bradburn): Okay and I guess a lot of this probably goes hand in hand with the, you know, with us being able to query.

John Albert: Yeah..

(Jeff Bradburn): Because if we can't, I mean, there's going to be a lot of folks who just aren't going to comply and...

John Albert: Yeah.

(Jeff Bradburn): ...and you can give us all the required information and say whether they are or not a recipient or give us accurate information. And so I think at $1000 a pop...

John Albert: I'm willing...

((Crosstalk))

John Albert: ...to bet that we'll be able to grant it but we still have to...

(Jeff Bradburn): Okay.

John Albert: ...get the official approval unfortunately and...

(Jeff Bradburn): One last - just on the all the required fields just completed my review of the initial - the insured record. It looks like we're missing - we capture a lot of fields, at least 15 of these requires I guess I'd say true data fields, you know, just not a blank record here or for future use. We're missing at least 15 of those. I'm a little concerned about - is there any way that we can reduce the amount of fields that are required in particular some of the, I guess, the - I realize that between the SSN and the HICN I think, maybe the injury codes or some other maybe attorney information that we can reduce?

(Barbara Wright): Well...

(Jeff Bradburn): Because that's a lot of requirements.

(Barbara Wright): If you looked at what's there that's all information for ongoing responsibility we need certain minimum things to set up records. And in terms of doing recoveries we need even more. And the statutory language specifically said that we should be getting information essentially for both.

If you - we have built in the concept that if you can't get a certain WCIO code, and as we explained earlier on this call, we have a delay factor built in that lets you submit text until a particular date...

(Jeff Bradburn): Sure.

(Barbara Wright): ...in lieu of that. But a lot of the information we understand people may not necessarily sort it out in their systems right now but they do routinely get it in the context of processing the case.

(Jeff Bradburn): That was...

((Crosstalk))

(Jeff Bradburn): Is that a no on reducing the number of required fields or should I just continue to submit what I hope can be eliminated and...

John Albert: Well again, I mean, we encourage you continue to submit...

(Jeff Bradburn): Okay.

John Albert: ...comments or questions especially since this document is, you know, fairly new we want to hear...

(Jeff Bradburn): Sure.

John Albert: ...you know, comments through the resource mailbox. But the point of this is not to, you know, overburden with, you know, pure reporting; the point of this is to effectuate smooth, efficient, long-term coordination of benefits between Medicare and other payers. And these data elements will help us do that. Which long term reduces a lot of the manual interaction that would typically occur between Medicare and all the other affected parties out there; that's the long term goal.

We recognize that not everybody uses certain code sets or they don't have them, you know, in certain systems or whatever and that's why we, you know, have that delay in terms of some of those code sets, for example, until say January 2011 but again the goal of this is - and we're kind of using our experience with the GHP process is that long term this results in a much more cost effective coordination of benefits program not just for Medicare but for all the other parties out there.

(Barbara Wright): And, you know, some of it is in terms of you may not routinely collect it now but if you've got an attorney coming to you if you make it known that they need to give you their firm name too it's - I see no reason the attorneys not going to cooperate.

Yes, we realize this imposes some burden but some of the things that we've been told people don't collect it's clear when they give us a list that they're list does not collect - include some things and they've even verbally said this in cases that include some things that may be somewhere in the case file but they currently don't sort it out or keep it separately. And that appears to be an

issue at least for some entities. Others it may be that they simply don't collect it at all.

(Jeff Bradburn): Okay. Well I have - I've got some concerns about some specific fields and I guess I'll handle those in a separate - I'll handle those in a separate communication.

John Albert: Yeah, please do. Thank you.

(Barbara Wright): Yeah.

John Albert: Thank you. Next question.

Coordinator: Our next question is going to come from (Deanna Green), your line is open.

(Deanna Green): Hi. I am calling from Kentucky and we do worker's comp, we're (TPA). And I just wanted to know since we have the burden of finding out if the person is a Medicare beneficiary how often will we have to contact them to get that information? We know we have meds open for life so as they grow older they will eventually become a beneficiary.

(Barbara Wright): Well the number if we're able to give you, you know, query access you should be able to set it up in a fairly automated fashion.

(Deanna Green): In other words annually we won't have to - there's just not a - should we check every six months?

John Albert: Well I mean the query function - and this hasn't all been decided - but we currently allow query of Medicare entitlement data as part of the old voluntary data exchange on as frequently as a monthly basis. And essentially there

should be no problem, you know, we haven't made that call yet but I mean we're trying to allow access to that function and that - it could basically run regular query processes through this, so. But we haven't made that final determination in terms of frequency but if we are able to grant that access it certainly would make your alls job a lot easier in terms of attempting to discern whether or not that person is a Medicare beneficiary.

(Barbara Wright): So no we don't have any hard and fast rule for the frequency of querying for entities with ongoing responsibility right now in terms of when you're - you've got like a liability settlement that's a, you know, a single obligation you need to know whether or not they're a beneficiary as of the date of settlement. Querying at the time they actually file the claim is not sufficient; you actually need to know their status when you have a settlement judgment or award.

(Deanna Green): Okay. And the ICD9 codes we see them although we see them come from the medical industry on our bills and claims. I don't think we're really qualified to look them up or pick them out. How are we to do that?

(Barbara Wright): Well remember that you'll have to have nature of injury and cause of injury but you'll have a choice of having the body part code or the ICD9 code. You won't have to have both.

(Deanna Green): Okay, okay, I did not realize that. And when we are submitting an application for an individual and we are primary but we think that there's product liability involved do we have to submit that on our form or will that product's liability carrier submit that?

(Barbara Wright): You're submitting information - that really relates again - it's different information or from a different source from a different angle about nature and

cause of injury etcetera. You should be - if it's involved or allegedly involved in the claim against you we need to know about it. For instance if it's worker's compensation and it's an asbestos claim we need to know that. If it's liability and it's a, say a Vioxx claim we need to know that.

(Deanna Green): Okay that's some information that we don't get now. Okay, all right. Thanks.

John Albert: Operator, we have time for one more question and then we're going to wrap it up.

(Barbara Wright): And can you give us some idea of how many people are in queue?

Coordinator: Yes, we have 17 questions still in queue. And our next question is going to come from (Norman Reese), your line is open.

(Norman Reese): Okay, thanks. My question pertains to non worker's comp cases only, liability. Assume all the first '09 we have an open liability file, we know the person is 65 subject to Medicare. Do we report that case at that point or wait until we settle the case?

(Barbara Wright): No it's when there's a settlement, judgment, award or other payment so if you're not making any assumption of responsibility for ongoing medical you're going to report when you have the settlement, judgment or award and I think if you read through the 12/5 document, I assume you haven't had a chance to do that yet.

(Norman Reese): No I haven't.

(Barbara Wright): When you go through the whole section of what triggers reporting I think it'll be clear to you.

(Norman Reese): Okay, thanks.

John Albert: Okay, it's 3:00 Eastern Time and time to end this call. I wanted to thank everybody for participating. I realize there are still some more questions in the queue but we've run out of time. There will be future Q&A session like this, please check the CMS - or the cms.hhs.gov/mandatoryinsrep Web page for future conference dates and subject matter.

Again, we strongly encourage people to submit their questions in writing through the resource mailbox. As a matter of fact we went over a lot of those questions here today. We do take those and it's the most efficient way to get your questions answered through the materials we publish on the Web.

On behalf of CMS I'd like to thank everybody.

(Barbara Wright): And also I'd like to add we will appreciate if the few people on the call who were going to send us additional emails on specific topics will do so. We'd appreciate that.

John Albert: And identify that you were on this call so that we make sure, you know, know who we're dealing with in that case.

(Barbara Wright): Again, thank you.

John Albert: Operator, how many people were signed up and participated today, final?

Coordinator: Let me see here we have 650 it looks like.

John Albert: Okay. Okay well thank you very much.

Coordinator: Thank you.

John Albert: All right.

Coordinator: That does conclude today's conference, everybody can now disconnect.

END