TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: October 29, 2008

TARGETED 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
October 29, 2008
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the Question and Answer Session if you'd like to ask a question, please press star 1 on your touchtone phone.

Today's call is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the meeting over to one of your speakers, Mr. John Albert. Thank you. You may begin.

John Albert: Thank you. My name is John Albert with the Centers for Medicare and Medicaid Services. And I wanted to welcome everyone to yet another Town Hall Teleconference that we're hosting as part of the implementation of Section 111 of the (MMSEA) Act.

The purpose of this call for those on it is this is primarily to discuss or seek questions and input and provide answers regarding the reporting requirements for in shorthand would be the non-group health plan recording process also referred as liability, worker's comp and no fault reporting process CMS is designing.

Just this past week we uploaded an Interim User Guide for the non-GHP reporters to the Web page. That contains the proposed file and record layouts that CMS in discussing internally as well as with others outside of CMS has determined to be the data elements that CMS needs to fulfill its obligations under the MSP statute in terms of worker's comp, liability and no fault insurance MSP coordination and recovery activity.

If you are not a non-GHP party this call is not for you. It's primarily again for worker's comp, liability and no fault question and answers regarding Section 111 of the MMSEA.

With that I wanted to introduce a couple of people who will be on the call and primarily answering the questions. And that is (Barbara) Wright who is a Technical Advisor here within CMS as well as (Bill Decker) who leads the what used to be referred to as the Voluntary Data Share Agreement Process which is being used as the model for developing the requirements under Section 111.

With that I wanted to turn the call back over to the Operator to start taking any questions. I just want to reiterate that this cut at the record layout that we've done is a first step. And we're seeking input in terms of, you know, thoughts about the data elements, et cetera. We are here to listen as well as to provide guidance.

It's these kinds of back and forth discussions are helpful in making sure CMS and industry can implement this legislation as efficiently as possible for all to essentially make sure that benefits are coordinated properly between Medicare and other payers.

So with that I'd like to turn it over to the Operator so we can start taking questions. The call - this call will run until 2:30 this afternoon Eastern Standard Time.

Coordinator: Thank you. At this time if you'd like to ask a question, please press star 1 on your touchtone phone. You will be announced prior to asking your question. Once again that's star 1 for questions. And our first question comes from (Theresa Lynn). Thank you. Your line is open.

(Theresa Lynn): Thank you. I have a question regarding the RREs. If they - when they initially register and they do not know who their agent may be, may they go back at a later date and add that information in?

Man: (Well you) can go back at a later date and add that information in. But it's going to have to be before the file exchange process actually starts. We - if you're going to be using an agent to manage the file exchange process for you, you're going to have to know who that agent is before the file exchange process starts.

(Theresa Lynn): Okay than you.

Man: Yeah we can't begin testing until we know who that agent is and, you know, get all the proper information from them. So...

(Theresa Lynn): May I ask a follow up?

Man: Sure.

(Theresa Lynn): What if they decide to change agents?

Man: You can make a change with our coordination of benefits contractor at any time. As long as the contractor knows who to be expecting information from and who to be getting the information back to, we'll be fine.

(Theresa Lynn): Thank you.

Coordinator: Our next question comes from (Katy Fox). Thank you. Your line is open.

(Katy Fox): Hello this is (Katy Fox) from GAB (Marks Coalition supporter). Wanted to find out if an agent is identified by an RRE and that agent will be providing data for say hundreds of individual RREs, will each RRE be given an implementation date through the coordination process? So will the date be specific to that RRE or to the agent?

Man: That's a good question. That - I don't think we've had that before. I mean typically the agents submit, you know, all of the files at one time. Obviously the, you know, I guess it's kind of a workload planning issue on our part. It's something that we haven't actually, you know, had a question about. But...

Man: In GHP -- which is - this is not what we're talking about today -- but in GHP the - everyone would register at the same time. And for a non-GHP situation which reporting is not on a standard timetable, I would assume that an agent who is known to our COBC would be reporting for someone when they had something to report.

Woman: (True).

Man: Okay.

Man: (Yes it's) still generally coordinated with the reporting so (unintelligible)...

Man: Yeah.

Man: ...would have some type of reportable event each quarter.

Man: Right - a known reportable event - yeah. But I mean currently right now just learned that the - we do work with agents right now and that they do submit on different timeframes for different reporters. So...

(Barbara) Wright: Keep in mind though that each RRE will have to register separately and name their agent.

Man: Yeah that's the critical...

(Barbara) Wright: And then assignments will be made.

Man: Yeah we'll reinforce that point. The RREs name the agent not the other way around. So an RRE when it is ready to report they'll have to name that agent that that particular RRE has designated as the agent.

(Barbara) Wright: And it would be fair to say it's something we covered in one of the other calls is RREs can mix a liability, no fault and worker's compensation in a single submission as long as it's for that RRE. And there can be arrangements for multiple submissions within the same timeframe.

But fundamentally you do have to do the initial registration separately. That's going to be the starting point for everything.

(Katy Fox): So just to confirm what I've heard is that each RRE when they register and they name an agent will be given an individual initial date.

Man: Yes.

(Katy Fox): So then the agent if they have say 500 RREs that they will be reporting for, each agent will have an individual, specific date. But then follow up reporting can be done quarterly or are all the dates going to remain individual to the RREs?

Man: Well it would be the individual RREs that we would assign the - and a lot of this stuff has to do with planning for workload, because we're trying to spread the file submissions out by the different RREs across each quarter. Because obviously if we get into a situation where we're trying to take in a lot of data all at the same time it could cause, you know, delays in response (to) things like that so...

(Barbara) Wright: But if part of your question was if you're an RRE who has enough - a high enough workload that you've got situations where you either need to report ongoing responsibility or settlements, judgments or awards frequently enough that you're going to have to report each quarter, then I believe you will have an assigned submission window that will remain the same each quarter. Correct (Bill)?

(Bill Decker): That's correct. And the submission window is assigned by the coordination of benefits contractor during the registration period.

(Katy Fox): Okay thank you very much.

Coordinator: Our next question comes from (Caleb Gleason).

(Caleb Gleason): Hi I had a question on the bullets at the beginning of the document under the General Requirements section. A note that RREs must implement a procedure in their claim resolution process to determine whether an injured party is a Medicare beneficiary.

The response file that's generated for our claim detail record or file looks like it actually is doing Medicare eligibility check and populating fields in the response files depending whether, you know, the result was yes or no.

So I'm curious what was meant by that bullet point? Are - is there an expectation to do checks before you submit your claim detail file?

John Albert: Yes there is an expectation. Under the statute we are only asking for reporting of those individuals who are, in fact, Medicare beneficiaries. We don't expect insurers to report every single claim that they process and pay.

So we do expect to check ahead of time. We - people have asked how they identify whether or not someone is a beneficiary. And we've pledged to assist to the extent possible in helping people with tools to do that. We are inquiring through our counsel whether or not we can give responsible reporting entities in the non-GHP area a query access that would let you know whether or not a particular social security number belonged to a beneficiary.

(Caleb Gleason): Okay so that would be similar to what the query only file that's submitted under (BDSA) under GHPs...

(Bill Decker): Yeah.

John Albert: Yes we do have some outstanding questions though. That's why we're doing some further development. Because for group health plan situations insurers

generally - they basically have an ongoing relationship with that individual. They're insuring them on an ongoing basis. Who you're going to be reporting on in the non-GHP world in many instances is not actually the insurer's direct client. It's like if they're insuring Suzie it's who Suzie hit with her car.

So there isn't that ongoing relationship. So we do have some other questions that we've had to ask to find out whether or not we can give the query access.

(Caleb Gleason): Okay thank you.

Coordinator: The next question comes from (Carol Sheehan). Thank you. Your line is open.

(Carol Sheehan): Yes I had a question about (ISO). We've been told by (ISO) that they've been building the capability to do this reporting for us. Have you begun to work with them or discuss this with them?

(Bill Decker): Well I mean we've had listening session with multiple entities out there. But we don't have, you know, any direct relationship with (ISO). But I mean yeah. They're - they definitely are interested in trying to facilitate this if that's what you're...

((Crosstalk))

(Carol Sheehan): Right and I guess what I'm looking for is your blessing that if (ISO) and other entities out there are doing this you don't have an issue with that. I mean we feed...

(Bill Decker): (Yeah).

(Carol Sheehan): ...(ISO) now. There are a lot of carriers that feed (ISO) now.

(Bill Decker): They would be - they are one of many possible agents that responsible reporting entities could choose to use to submit data. But groups like (ISO) are not RREs. So the ultimate reporting responsibility is with the, you know, worker's comp liability or no fault insurers.

(Barbara) Wright: And whether you would decide to use (ISO) or someone else if you have an entity that's currently involved with you for reporting purposes, you may wish to work with them. If you don't have someone you may wish to choose one entirely new whether it's (ISO) or any other entity.

And we're aware that there are some groups out there that will probably be out selling their services that aren't in this type of data collection now but are interested in other aspects of Medicare and see this as an opportunity.

So we do not select the agents. And agents do not happen automatically just because they're (GPAs), et cetera. The responsible reporting entity is just that. And we expect them to contract or make whatever arrangements they need if they don't wish to submit directly.

(Carol Sheehan): So you wouldn't have a problem accepting a report from (ISO) on behalf of an insurance company?

(Bill Decker): No.

(Barbara) Wright: That's why everyone needs to register their particular agent.

(Carol Sheehan): And can I ask one other question about us being able to determine who are Medicare eligible. I just want to make sure you under - maybe you can give us

a timetable when you expect to get this answer that you've been waiting for about whether you have the ability to get this query ability out to us.

(Barbara) Wright: We expect to have that within the next week or so.

(Carol Sheehan): All right - good. Thank you.

(Barbara) Wright: We have someone here in the room. I'm not sure if you can hear them or not. But the question keeps coming up. We cannot - your query access or any access will not allow you to search for SSN. It is based on having the social security number or the Medicare health insurance claim number or (HICN). That's a basic starting point.

And we use that along with several other pieces of information such as (unintelligible) and date of birth and name to validate that a particular SSN does in fact belong to a particular individual who is the beneficiary.

Coordinator: Our next question comes from (Sonia Marshall). Thank you. Your line is open.

(Sonia Marshall): Hello everyone. This is (Sonia Morgan Marshall). I'm with (Royal MSA) Consultants. My question is we note that there has to be an initial filing of Medicare recipients. At what time should a plan or an RRE or an agent initial a report in the Medicare recipient. Is it at the time of filing of the claim, the time it's accepted, the time the first payment is made?

(Barbara) Wright: I think this is fairly well covered in the interim record layout that came out. But what the trigger is there's the settlement judgment award or other payment on or after July 1, 2009. So if you have a situation where you've assumed ongoing responsibility for (medical) before 7/1/09 and that

responsibility carries over through 7/1/09 and later, then you are going to have to report that information on that individual if they are a Medicare beneficiary.

We are giving extra time for people to go back and check for those. But for anything that's a reportable event you've had the settlement, judgment or award or other payment for the first time on or after 7/1/09, yes you need to be reporting those the first quarter after the event happened.

(Sonia Marshall): So the date of accident has nothing to do with the reporting requirements?

(Barbara) Wright: No - the date of accident just because someone was in a car wreck in June '09 doesn't mean it's not reportable. It's when you have the settlement, judgment or award or other payment that triggers (that).

(Sonia Marshall): Thank you.

Coordinator: The next question comes from (Marcia Nigril).

(Marcia Nigril): I'm sorry about that. Hello two things - I understand worker's compensation, no fault. To me it seems like a no-brainer; should be pretty easy to follow. But with liability we have some unique issues.

And I was wondering is it possible to have a separate teleconference just dealing with the liability insurance carriers and self insured entities and how it's going to affect them? Example being, you know, we have a judgment and it's tempered by the claimant's own negligence, you know. Is - and the judgment comes in and it's (affirmed). And is Medicare going to accept a lessened or decreased reimbursement of their medical bills.

(Barbara) Wright: What would be helpful to us if (you have a process of policy issues) like that is go ahead and send them to our mailbox so that we can make sure we can either give you pointers to the exact location where that policy information is currently available or get you the information otherwise. Because the general response to what you just said Medicare is not bound by the allocation of parties.

So if there's a settlement for $100,000, you don't make the determination. The parties don't make the determination of whether or not that's for medical. They simply report that entire settlement.

(Marcia Nigril): Understood - but what there's a judgment or, for example, a class action. See those things are like peculiar to the liability and that's kind of, I think, (would be helpful).

(Barbara) Wright: Our general rule is (if) there's essentially a full hearing on the merits we defer to a court of (competent) jurisdiction on any allocation they would make. But aside from that we're not bound by allocations of the parties.

So - but we won't rule out a separate call for liability. But we do need to know what the issues are to set up a liability call. Without having some idea since a lot of (your) would arguably be policy based, we need to have some idea of the issues ahead of time.

(Marcia Nigril): Okay - perfect. Thank you.

Coordinator: Our next question comes from (Nancy Dobbins). Thank you. Your line is open.

(MaryEllen): Hi this is (MaryEllen) at SCHP. And my question is if they're an insurer but we do have some ASO accounts, are we considered an agent for those ASO groups?

(Barbara) Wright: For non-GHPs when you look at the definitions and reporting responsibility sheet that was attached to the reporting statement, the RRE is the applicable plan which is defined as the insurer, the worker's compensation law or plan. (Let me look again and make sure - or the self-insured).

So if you're telling me for certain lines you have an administrative function only, then...

(MaryEllen): Yes.

(Barbara) Wright: ...it sounds like you have it for someone or some entity that is self-insured. And they would be the RRE. If they wish to use you as their agent for that aspect of their business that would be up to them.

(MaryEllen): Okay thank you.

Coordinator: Next question comes from (Steve Dalton).

(Steve Dalton): Thank you. I have a housekeeping question first. I submitted a number of questions in advance of the call. And I want to make sure that there is - if there is a plan to address those separately. Or should those be raised on this - in this forum?

(Barbara) Wright: Please go ahead and raise them. What we were using some of the questions that came in and to the extent that we had time people were trying to

familiarize themselves with the questions so that hopefully they'd have an answer.

(Steve Dalton): Okay great. I guess first question I would have then relates somewhat to the conversation that you had previously about the query function. If - assuming that a query function is not agreed to, will there be some sort of a reasonable person standard that will apply in the case where a claimant refuses to provide information to us that will allow us to conduct reporting?

(Barbara) Wright: What we're looking at is some type of sample model form that if completed would at least put the RRE in compliance for reporting purposes. We haven't finalized any draft on any such sample model form because depending on whether or not people have query access would depend - would affect how much we put in the form (of) what we would allow the form to be used for.

(Bill Decker): But again keep in mind again that if you don't have the SSN to begin with, you can't query for Medicare entitlement. So that's - we can't stress that enough.

We are very aware of the difficulty in, you know, getting SSNs, you know, in a - as the culture has changed throughout not just insurance but everywhere in terms of identity theft and HIPAA and all that that it can be difficult to procure, you know, those numbers. And we want to try and provide everyone with as many tools as possible for gathering that.

(Barbara) Wright: If you can think of particular documents (that would be helpful to you) in asking questions or obtaining information about social security numbers, please let us know.

We do have one alert available on the Web site that explains that in both for group health plan as well as non-group health plan that if insureds don't already have this information, they will be asking for it. And it also gives them a chance to go to our Web site to verify that the document you hand them is actually an official government document - that it's not something you have (ginned) up for whatever reason.

We've had at least one group say that they might be able to come up with some specific language they thing would be helpful. And we said please submit that to us. If we agree then we'll look at putting that on letterhead and putting it out to the public too.

So if you can think of anything, please let us know.

John Albert: Yeah we definitely, you know, we'll take suggestions in terms of language or types of forms. Again we're not - there's no problem with, you know, people providing suggested language. I mean you know your business relationship with your customers better than we do. And (that's been) - and so we, you know, welcome any suggestions.

(Steve Dalton): So just a follow up question - in terms of that model form that you're speaking of, would that be something similar to the social security/medical release that's currently used to obtain the information to determine eligibility?

(Barbara) Wright: Well there's nothing that stops an RRE right now from if they can get a release signed with the social security number doing something that way. But if we can give you query access, all you'll basically need is the social security number.

Where the model form will become more important is if we are unable to give you query access. Then we're looking at language that if the form is completed would, like I said, at least consider you in compliance for Section 111 even if you didn't have the SSN.

(Steve Dalton): And even if we - even if the claimant would not provide it to us?

(Barbara) Wright: Yes.

(Steve Dalton): Okay. Could I ask one additional question please while I have you?

(Barbara) Wright: Sure.

Man: Sure.

(Steve Dalton): If there are multiple care - this is in the case of a liability matter. In our company there are a number of divisions in business lines that both work comp and liability as well as others.

In a liability case where there are multiple carriers involved and it is determined that the plaintiff is a Medicare eligible, who's - which carrier would have the responsibility for reporting? Or would all carriers have the responsibility for reporting?

(Barbara) Wright: As of the way we have things right now, the reports are like policy specific/person specific. So if you have - even if you had - let's say you had a multi-car pileup. And you had four or five drivers and the claimant is John Smith.

If (he'd be) getting money off of each policy, he would eventually have a report from each of the settlements, judgments or awards. We are looking into or trying to gather as much information as we can about variety of arrangements when you have a class action or multi-district litigation, et cetera, to see whether or not we can come up with some possible alternative for some of that reporting.

But in a typical car wreck if (there were simply more than one plan at issue), they're both going to be reporting.

(Steve Dalton): Okay I have several other questions as well. But I'll forego that for now in the interest of time.

John Albert: Thank you.

Coordinator: Next question comes from (Loren Friedman). Thank you. Your line is open.

(Loren Friedman): Hi I'm a lawyer. And my question - and this may not be the right forum for it but the most recent General Counsel Memoranda that I saw talked about the coordination of benefits and Medicare (certified) and so on only applies to worker's comp. And then, of course, you had the SCHIP Extension Act which extended the information reporting to the third party liability claims and so on.

And it seems informally that in some cases they're seeking to do coordination of benefits with third party claims that aren't worth (their) time. And sometimes they're not. Do you guys have any insight on that as to whether we need to make set aside arrangements and coordination of benefits for ordinary auto accident or medical malpractice or so on...

(Barbara) Wright: First of all, excuse me, first of all I don't believe there is a General Counsel Memo that says that there are no liability set asides. We, in brief, we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for worker's comp.

In either case CMS approval of a set aside amount is not required. It is a voluntary process.

(Loren Friedman): Right.

(Barbara) Wright: And lastly Section 111 does not mandate or specify anything about liability set asides. So no that isn't really a topic for right now.

(Loren Friedman): So this is not the forum to ask whether CMS is looking for coordination of benefits on liability settlements?

(Barbara) Wright: You can give me a call separately if you'd like to do so.

(Loren Friedman): Okay and who is this?

(Barbara) Wright: (Barbara) Wright.

(Loren Friedman): W-R-I-G-H-T?

(Barbara) Wright: Yep.

(Loren Friedman): Could you give me the phone number please?

(Barbara) Wright: If you dial 786-1000 you'll be able to dial in and get my extension.

(Loren Friedman): And what area code?

(Barbara) Wright: (One zero).

(Loren Friedman): Say it again please. What area code?

(Barbara) Wright: 410-786-1000.

(Loren Friedman): Thank you very much. Bye.

Coordinator: (Rod Rayburn) your line is now open for your question.

(Rod Rayburn): This is (Rod Rayburn), (Mattie) Insurance Services. This is - another caller touched on this (unintelligible). But I heard your response. But this was a memo June 19, 2008 (ISO). And I understand you have no connection or dedication to (ISO).

We have submitted record layouts in the (ISO) claim search universal formal to CMS for its review. CMS has agreed to review the records and data elements prior to publishing its own draft of record layout. Has that been done or is that a question for (ISO)?

John Albert: (Yeah) they submitted comments. And we know the record layout. Yeah as part of our (listing sessions) we've had discussions with AIA and (ISO) and other groups. So yes we've seen that. And we've heard their comments on the record layout.

(Barbara) Wright: And we're looking to obtain comments or information on any other record layout for databases or clearinghouse type entities that are out there that are gathering reporting information for non-GHP.

(Rod Rayburn): All right.

Coordinator: Our next question comes from (Rosanna Ditcio).

(Rosanna Ditcio): Yeah hi - question regarding - well follow up for checking for Medicare eligibility which could be the query function. Is this going to be a (typical) requirement because it's a dynamic attribute of a claimant? You know, they may not be on Medicare at one point. But then they go on or off down the line. So is this some sort of...

(Barbara) Wright: We're basic - if you have a situation where there is for ease of reference a lump sum payment or a single obligation (which is paid through) a structured settlement or an annuity, you're going to be a single reporting. If you have a situation such as (they) most frequently occur in worker's compensation where you assume an ongoing responsibility for medical, yes you are going to have to check.

If they're not a beneficiary at the time that responsibility is assumed. We are looking into trying to decide actually how frequently you will have to double check whether or not they have become a beneficiary.

(Rosanna Ditcio): So now and I guess as part of that I was looking through those requirements, at the point of settlement I guess if you guys could document how you want to behave at the point of settlement meaning we checked. This guy wasn't on Medicaid - Medicare. We settled the claim out.

And then he was on Medicaid or Medicare and the claim (isn't) settled. I'm assuming at that point - that post-settlement we're no longer liable to report any information on that.

(Barbara) Wright: Okay first of all you (twice) said Medicare and Medicaid. And at least for Section 111 this is solely reporting connected to Medicare beneficiaries. Any obligation with respect to the Medicaid program would be separate.

Secondly if it is a single obligation settlement with no ongoing responsibility then you are going to be reporting only once. And if they're not a beneficiary at the time of the settlement, judgment or award you won't be reporting.

(Rosanna Ditcio): Okay when you talk about settlement is that (med) and/or indemnity? Sometimes you can settle out the indemnity with no settle on med. And sometimes you can (throw) again settle the med without an indemnity settlement. But they can be exclusive.

(Barbara) Wright: You generally have a priority right or recovery. So we expect you to report.

(Rosanna Ditcio): And that's the trigger regardless of the med still being open?

(Barbara) Wright: There will be situations where you will have done what, again, for ease of reference I'll call lump sum settlement or a single obligation settlement. But at the same time you will continue to have some medical (unintelligible).

(Rosanna Ditcio): Okay. Just please when you're writing out your requirements, state all of that down. This way when we read them we understand exactly where you're coming from and what we need to report to you.

So (data element) number - page 9 and 10, item 4 and 5, you - I realize you're asking for the HICN or the SSN. My opinion is the H - if we could get you that HICN. If it's, you know, if the guy is on (Medicaid) we would probably have been already to get to the SSN. So I realize that you're giving us a little

bit of an out with 4 and 5. But I think in practical purposes if we can't get 5, probably (we're not) 4 either.

And we need to address the issue of undocumented workers because there's one thing. So far I've heard everybody saying social security number they won't give it to us implying that they have one. But we can very well have people that really do not have a social security number for a various number of reasons.

(Barbara) Wright: Well what we said in the context of (unintelligible) is if you have like a resident alien or you have an illegal alien and there is no social security number, then you need to report if you get that information in the future.

At - for a lump sum or a single payment situation we assume you would not get that information because you wouldn't have any further connection with the person. But if it's someone that you have for whatever reason assumed ongoing responsibility, this would fall in with the idea that you will have to recheck every so often whether or not they're a beneficiary.

John Albert: But the practice...

(Rosanna Ditcio): (But to understand) how you're going to handle undocumented workers that don't have it. There's no reason - worker's comp which are not reportable to - for income taxes or anything else so we can issue checks and documents without ever having an SSN.

John Albert: But then you'd have a questionnaire where their answer would be they're not on Medicare. And let me assure everybody on the phone right now that there are no illegal aliens drawing social security benefits. To draw social security benefits...

(Rosanna Ditcio): Well I understand that.

John Albert: To get social - you have to get at least eligible for social security to get Medicare. And so the situation everybody keeps bringing up is not applicable. You might have somebody injured and get worker's comp or liability situation. But they're not going to be on Medicare.

((Crosstalk))

(Rosanna Ditcio): Right but my point is all I'm asking for - all I'm asking for is just for you guys to document that so that when we read the specifications our answers will be - the answers to our concerns and questions will be address (for) you guys. And you guys will have acknowledged these scenarios.

Because I think that for most of our issues when we read the documentation there's more - and I realize it's a work in progress. But the more information you can give us the less (unintelligible),

John Albert: I can assure you on this issue this will be well documented. Because his question has come up - it's probably one of the more common questions we've received from both the group health plan side as well as the worker's comp, liability, no fault side. So...

Woman: (Right well)...

John Albert: ...thank you.

Coordinator: The next question comes from (Tamara Wilson).

(Tamara Wilson): Hello - thank you. I've got a few questions relating to liability insurance and kind of keys into the question that someone else asked about whether or not we need a separate call for that.

But in some circumstances there can be settlements on behalf of multiple insureds with - each with their own policy. But there's one check cut and there's one settlement agreement and release. And I didn't quite read the data entry layout as fitting that situation very easily. And similarly if there's multiple plaintiffs like a husband and wife and there was a lump sum issued to both of them, how the reporting would work in that situation.

And then finally how the dollar amount reporting would work if it's usually with a case if on the insurers that I work with is that the settlement check if there's a known Medicare beneficiary, the settlement check either is not issued until after the lien has been resolved or the portion of the money that might be necessary to satisfy Medicare's interest is paid into a separate escrow account. What dollar amount would be reported in those situations?

Sorry for jumbling three long questions together at once.

(Barbara) Wright: Well and I'll try to get (everything) and correct me if I don't get it right. You said there are multiple policies involved in the situation with a particular plaintiff. This goes back to what we said before.

If each policy has a different obligation or a set amount, then the way things stand right now there would have to be a separate report with respect to each of those policies - for each of those plans.

So as I said we want (to) time accumulated as much information as we can about things that happen particularly in some of the bigger product liability, et

cetera, of where it's not necessarily subrogated out up front unless the obligation is (the first).

The second thing you said was talking about husband and wife situations. Again this goes to allocation by the parties. If you have a situation where a beneficiary and his much younger wife are insured, for example, and there's a settlement for 100,000. If you decide - if the parties decide to allocate 99,000 to the young wife, 1000 to the beneficiary, you're not required to (respect) that allocation. So you still need to inform us of the settlement amount.

The third thing was - I forget what the third thing was.

(Tamara Wilson): What if the Medicare patient is already taken care of? Let me just give you an example. Suppose there is a $1 million settlement. There's 250,000 of medicals that were paid by Medicare. And either there's an actual - something worked out with Medicare before the settlement check is issued. So 750 goes to the plaintiff and 250 goes to Medicare.

Or what more typically happens is that 250 or $300,000 is paid into an escrow account to make sure the money is still there because unfortunately it seems to be taking anywhere from three to ten months to get the information to determine the amount of Medicare's interest.

(Barbara) Wright: Okay...

(Tamara Wilson): And states don't let the insurers sit on settlement checks that long.

(Barbara) Wright: The fact that usually the Medicare - the - has been protected does not eliminate the reporting requirement.

(Tamara Wilson): Okay no I understand that. I was just wondering...

(Barbara) Wright: Well...

(Tamara Wilson): ...if it was a net amount that gets reported...

((Crosstalk))

...of the gross amount.

(Barbara) Wright: It's still the gross amount. And you may or may not have noticed that we clarified or changed the data elements relating to the settlement compared with what was in the supporting statement of federal register.

What we have done there right now that we're asking for is if funding is being delayed with the settlement, that could be helpful to our contractors to know so that they aren't issuing a demand letter before there's - there are any funds available. (Okay)...

(Tamara Wilson): Okay I'm sorry. I didn't see a place for enter - I thought the reporting - am I correct that the reporting is due when the check is actually issued to the plaintiff since the file is not complete until there's a check cut.

(Barbara) Wright: (No) we said settlement, judgment, award or other payment. So if you have - and let me find where it is in the data elements.

(Bill Decker): (Unintelligible) at the time (unintelligible).

(Barbara) Wright: Yeah I'm trying to find exactly where we (unintelligible) put it...

(Tamara Wilson): Okay that's fine. I can figure that out. So you're saying it's the date the settlement agreement gets signed and delivered...

(Barbara) Wright: (Here it is).

(Tamara Wilson): ...for example.

(Barbara) Wright: It's field (79) page (27) that we're talking about like the lump sum or single payment obligation. And we've got dates of payment obligation was established. This is the date the obligation was signed. If there's a written agreement unless court approval is required.

If court approval is required it's the later of the date that the obligation is signed or the date the court approval. If there's no written agreement it's the date the payment or first payment if there will be multiple payments.

(Tamara Wilson): Okay thank you.

Coordinator: Our next question comes from (Indira Morrow).

(Indira Morrow): Hi thank you. I think that my question has been answered on the (ISO) issue. I had another question about changes in the agent that is reporting on behalf of an RRE.

Assume for a moment that we have an agent reporting and then decide to bring that reporting in house. How much time would we have to do our testing after the fact? Because we have the information being reported already and now we're doing it internally.

John Albert: (You want to take that)?

(Bill Decker): Yeah I mean you would - first as the RRE you would first notify the coordination of benefits contractor that you were going to make the switch from an agent reporting for you to you reporting for yourself. The information that is going to be reported is the same body of information in either case. It's just that you will be reporting it rather than having an agent report it.

If your agent suddenly goes out of business, for example, and you have to take on the reporting responsibility yourself without any prior notice. The coordination of benefits contractor will, I'm sure, work with you on getting you through a testing period and then into regular production.

I would - I believe however that if you're going to make the change on your own and release the agent from the agent's obligation, you would have notified the coordination of benefits of that decision on your part when you made the decision so that adequate planning could be in place for you to make the change seamlessly.

John Albert: I mean at this time we don't have, you now, defined parameters in terms of these kinds of things and how long they take. But obviously, you know, under - I mean there are obligations that, you know, under the statute that we're trying to lay out in terms of, you know, when particular information needs to be submitted to CMS.

So that we would hope that in any transition that takes place that that would - those time frames would be met. But we can take that under advisement. And because we've received a couple of questions like this today which is, you know, something we haven't really looked at in terms of putting out in terms of the information out on the Web page.

We will try to provide as much of that information in writing through formal guidance. But we are aware that, you know, again agents can come and go. And business relationships can come and go. And we want to help make sure that that, you know, transition is as smooth as possible for all involved. Because as I've stated on some of these other calls, we're interested in quality of data first so...

(Indira Morrow): Okay thank you very much. A second question - assume for a moment that we were a carrier that never had liability exposures to this and are new at having to report sometime the middle of next year - year after. How would a carrier know that they would need to do this if they've never been exposed to this before?

(Barbara) Wright: Are you saying you're gaining or starting a new line of business that...

(Indira Morrow): Let's say I'm a new company and we've never done anything before. And the kind of business that we did would not have been subject to this. Now we are say writing worker's comp for the first time. How would a new carrier know that they need to be compliant with this new regulation.

(Barbara) Wright: The same way they should know that they need to be compliant with all laws that their assets (unintelligible) (secretary). (Compare) provisions in general - it just should be part of their business plan in determining what laws or regulations they need to meet and be in compliance with.

And if your - if a new company is going to start up, write new insurance, presumably that's part of your plan of how you would do the applicable reporting and make the necessary contacts so that will happen.

(Bill Decker): And if that is the case then, you know, we would expect that entity to come in and register the secure Web site and, you know, begin building its process to test and implement reporting obligations. And, of course you know, we would allow adequate time for testing, et cetera. But that process will be the same for either existing companies today or new companies tomorrow or ten years from now assuming, you know...

(Indira Morrow): Okay thank you very much.

(Bill Decker): Okay.

Coordinator: Our next question comes from (Doug Holmes).

(Doug Holmes): Hi this is (Doug Holmes) with EWC. Had a question about the - I think it's field number 12 - the date of incident. And I noticed that that (spot - its requirement) that the report include the date of incident and the definition still does not - it doesn't match with the date of disablement which would be the typical say worker's comp definition for the last date of exposure which would be the long shore definition.

And so if someone is going to report here and that information is not available on their existing systems or they don't have it, it's still showing as being required. It may be that that information is not available in which case how should this report be completed?

(Barbara) Wright: It's basically information that's going to have to be (elicited). If you don't have it that field is a critical to CMS (in terms of any recovery plan whether it) (unintelligible) and how much it is. It affects what claims we look at for recovery purposes.

(Doug Holmes): So you're - the date of incident is important for MSP determination. That's what you're saying and that's why you're asking for it?

(Barbara) Wright: It's important in determining any recovery (claims) and what rights do (we have) over each (section); any settlement, judgment, award or other payment. And this is the definition that we use under our statute and regulations.

(Doug Holmes): Okay.

John Albert: But you're outside of Section 111. This (would pertain)...

(Doug Holmes): Right I understand that.

(Bill Decker): But like to put some boundaries around it let's say you had somebody that was 75. And they'd been on Medicare for ten years. If we didn't have that and we got a report, how would we know where - when to start to look for claims that we'd be subject to potentially recover?

So it's a way to sort of put a boundary around the start and end date of the situation.

(Barbara) Wright: And if we used your date, your facility as (the establishment of date) of last exposure, that's not necessarily when their treatment started that we paid for. That's why we need what in your case appears to be an earlier date than would be established under some of the state worker's compensation rules or under the Longshoreman's Act.

(Doug Holmes): Yeah we may just not have the - may not have had the information even if we asked for it. When someone first began to be exposed to something that

eventually disabled them, you know, that can be pure speculation. So but you still have...

((Crosstalk))

(Barbara) Wright: We do deal with a certain amount of approximation particularly when it's like asbestos or (unintelligible) chloride or something like that. And typically that may be a date prior to when they became a beneficiary. And those dates we're obviously not going to use those dates earlier than when they became the beneficiary.

So one of your problems if you're taking exposure type cases, et cetera, if we're able to get to the (unintelligible), we'll know their entitlement date. Once the exposure is before that it won't even be an issue.

(Doug Holmes): Okay thanks. I just have one other question that's a follow up on the alien question. If someone is covered for worker's compensation but they -- as someone else talked about -- individuals who may not have a social security number -- maybe undocumented aliens -- then someone - I think (Barbara) you mentioned that you would take the alien number if they have an A number. Then that would need to be...

(Barbara) Wright: No.

Man: (Unintelligible).

(Barbara) Wright: What we're saying is that if they don't have a social security number you're not going to be reporting them. But if you have continuing responsibilities for that individual and they're in the United States ten years or whatever then at some point they become the beneficiary. You are - for people that have

ongoing responsibility for that aren't beneficiaries at the time. You originally assumed that responsibility. You are going to have to do some periodic verification.

(Doug Holmes): Okay.

(Barbara) Wright: And we'll...

((Crosstalk))

(Doug Holmes): (So if someone is an) undocumented alien becomes injured; receives a worker's comp award of some sort and subsequently gets a social security number, then that's when the obligation to report would kick in?

(Barbara) Wright: If you have an ongoing responsibility. If it was a single payment obligation, no you're not going back and doing something years later. This is - this ongoing obligation is only with respect where you have an ongoing responsibility (unintelligible).

(Doug Holmes): Okay thanks.

John Albert: And again going back to the entitlement for Medicare, you have to have earnings - covered earnings under social security to be eligible for Medicare. And you're entitled either on end stage renal disease, disability or age. And you have to have a minimum number of quarters of coverage to become eligible.

So we're really talking about - I think on very few if any of these scenarios would ever come to be...

(Barbara) Wright: I mean of the ones (George Mills) (said) yes there would be because that's often based on coverage of a descendent. If someone gets a social security number and they're married that's a resident here who is working, then yes. You are going to end up having to report that. But that's not typically going to be your liability, no fault or worker's compensation situation. That's typically...

(Doug Holmes): So that would be in the Claimant 2 record or the support records where someone who's a relative or claiming through?

(Bill Decker): (If you use that to send) you would link to the appropriate claim number which is - would tie in the relationship that (Barbara) is talking about.

(Barbara) Wright: And as I said that's not typically going to happen for liability, no fault or worker's compensation. They're either going to have their own number and have worked long enough to qualify or it's not going to be relevant.

(Doug Holmes): And if we - just one final thing. If we end up with a large or any size guest worker program, then there would - there might be some other kind of number as well in which (you'd) have to make some adjustments.

(Bill Decker): (Probably at the time that it became the law - work with social security to figure that out). But it would be pure speculation until, you know, it's a law.

(Doug Holmes): Thank you.

Coordinator: The next question comes from (Bruce Mosley). Thank you. Your line is open.

Woman: (Bruce) had to step out so I'm going to ask the questions for him. I just have two. The first one is from our IS Division. They want to know is there a data dictionary available?

John Albert: I mean the user guides that - we have an Interim Guide out now that basically has the file and record layout. We do offer or will offer standardized definitions of terminology for, you know, (none of that) may be in there yet. But that will be the case, I guess, when they've got a dictionary.

You know, there are for example certain terms that are used differently by both CMS and, you know, the insurance industry, et cetera. And we - where we see these kinds of things, you know, popping up we try to define from Medicare's point of view what that term means.

So...

(Barbara) Wright: (If you haven't looked at it) again there are some definitions - definition of reporting responsibility -- Attachment A -- to the supporting statement to the Paperwork Reduction Act package that was published on August 1 in terms of if you're talking just elements that are in the record layout.

The interim layout that we put out recently we did try to give you as much information as we could at this point such as not just putting data (bytes) and telling you how we're defining data (bytes). And not just putting the total payment obligation - telling you when that will start. For example, when the obligation is actually established in - or approved by the court, et cetera.

John Albert: And if there are, you know, I mean obviously there will always be questions about, you know, certain data elements. But again we appreciate, you know, hearing comments on the materials as we put them out on the Web through the

CMS Resource Mailbox mentioned on the Web page. So - and we will continue to do outreach sessions like this as we, you know, move down the line in terms of towards...

(Barbara) Wright: So...

John Albert: ...implementation.

(Barbara) Wright: ...if there's a specific term there that's giving your problems...

John Albert: Yeah.

(Barbara) Wright: ...then send a comment into our public comment mailbox.

Woman: Okay and my second question is if a claim is settled prior to 7/1/09, it was stated that we need to report if benefits for medical care continues. Do we still need to report if CMS has already approved the allocation of MSA?

(Barbara) Wright: Your question mixes two different things. If there is a set aside amount that is part of the settlement, that is not a continuing obligation on your part if it's already been settled and paid.

If you (had) - what we're talking about continuing to report is where medical claims are still subject to be submitted and potentially approved (is essentially).

Woman: Okay. Okay thank you very much.

Coordinator: Our next question comes from (Alyssa Crasset). Thank you. Your line is open.

(Alyssa Crasset): Hi my name is (Alyssa Crasset) with (unintelligible) and Associates. And I have a few questions.

The majority of our business is with schools. And a school district or community college has a liability, worker's compensation program be funded by a joint (colleges) authority. Who in this case would be the RRE - the individual school district or the actual (APA)?

(Barbara) Wright: I'm sorry I didn't catch part of the question. If it's worker's compensation and it's...

(Alyssa Crasset): It's both - worker's compensation and liability.

(Barbara) Wright: Okay so the worker's compensation or liability (to the extent) the school is self-insured, it is the school. To the extent they've actually purchased a plan then it is that plan. And...

(Alyssa Crasset): So they all - (the districts) put in money. (They're) a member of the pool. The district is a member of the pool.

(Barbara) Wright: Okay.

(Alyssa Crasset): Self-insured pool.

(Bill Decker): Probably the district in that case that's going to be the RRE. But it's...

((Crosstalk))

...a question we really can't answer.

(Barbara) Wright: This is one it would be helpful...

Man: Right.

(Barbara) Wright: ...if you just submit the specifics in writing.

(Alyssa Crasset): Okay I actually a...

(Barbara) Wright: (Submit as much) detail as you can.

(Alyssa Crasset): I have a few questions along those lines that you might not be able to answer. Can I call (Barbara) on her direct line and get those answers directly from her?

(Barbara) Wright: It would be helpful is you would just submit it through the mailbox because one of the reasons we have the Web site is we have no way to contact every single...

(Alyssa Crasset): We have submitted the questions.

(Barbara) Wright: Okay.

(Bill Decker): You've already submitted these questions?

(Alyssa Crasset): Yes.

(Bill Decker): Through the mailbox?

(Alyssa Crasset): Yes.

(Bill Decker): Okay we'll be answering them then...

(Barbara) Wright: (Okay)...

(Bill Decker): ...(before).

(Alyssa Crasset): You will be answering them?

(Bill Decker): (Yeah).

(Barbara) Wright: Then call me and tell me what your email is and we'll make sure to check that particular incoming email if it's not high on our list right now.

(Alyssa Crasset): Okay.

Woman: Excuse me. What is the actual ETA for responses on the questions that are submitted to the (in) mailbox?

(Barbara) Wright: There is no specific ETA. We're trying to group all the different questions. We're answering them through the forums. Many of the questions we've received are showing up in the results, for instance, the interim record layout that we put out.

We simply don't have the staff or resources to respond to every single question individually. And the mailbox is an attempt to get the widest input possible and be able to provide you - provide the public with instructions or information that addresses as many possible aspects of an issue.

(Bill Decker): Let me say one other thing too just quickly here. We've mentioned a couple of times the interim file layout. And I just want to stress that these are interim file layouts. They are not the final file layouts that we will be publishing in the

final version of the User Guide which will be available for you to the folks on this call in the future.

This is - these file layouts and the instructions that go along with them are for essentially they give you a heads up on what is going to be, roughly speaking, the final version of these. But these are not - should not be taking them as the Bible of what the file layouts will be when we're done.

We need to have you tell us what you think about these things. And what you think about the data elements themselves and what you think what would go on - what's being said here today and get back to us through that mailbox so that we can respond to your needs as well as better understand what you will and won't be able to do down the line.

Woman: Well in this instance where we're asking if a joint power authorities (where - of) - they're going to be liable to - considered the RRE or the district. We have to be able to communicate to our clients what's going on.

(Bill Decker): We understand that. And we're going to - we'll give you an answer to that before this gets into final - (at least) by the time this is in final form. (Unintelligible).

Woman: Okay I have a question regarding the $1000 penalty? How is this going to be enforced and is there going to be a timeframe for compliance? In other words are we going to have like six months from...

(Barbara) Wright: Well as John has said our aim is quality of data. It's going to go through a testing process. We - before we would actually enforce any penalties we would expect to be able to publish procedures of how we would do penalties.

Are we at that step yet? No. We need to get the other things in place in order to do that. We can't hold you to a standard that we haven't published yet.

Woman: Okay.

John Albert: And there is one document that's out there now that it's a very high level...

(Barbara) Wright: It hasn't (unintelligible).

John Albert: Oh it hasn't? Oh - sorry - I retract that. Yeah we're going to be publishing a very high level one page summary that kind of, you know, it discusses like we consider - we're going to call it an at risk for non-compliance document which will kind of give everyone a general feel for what CMS expects at this time.

But we are far from publishing, you know, final specs in terms of that. Because again as (Barbara) mentioned, we're in the process of trying to build the reporting process first then - that's what we're most interested in.

(Bill Decker): I guess when we say we're publishing documents we mean generally speaking that they're - they will be appearing on our Web site.

(Barbara) Wright: The Web site is where all the official instructions will be. What all of you should know if you haven't noticed it already is virtually every update to the Web site is a new downloadable document. It's not additional information on the Web site itself.

And we are routinely doing those all in PDF format so you have them available if you want to use them for distributions, et cetera.

Woman: Okay and one more question. Can an insured designate two agents to - for reporting purposes?

(Barbara) Wright: If you would like to, for example, if you - insurer does worker's compensation (unintelligible) and they wish...

Woman: It's strictly liability and (you) have two people to report for a liability.

(Barbara) Wright: Are you talking about switching back and forth or are you just talking about some distinct (unintelligible) your liability that you want...

Woman: Okay we deal with clients that may have an example of $25,000 self-insured limits. And that is handled by one (TPA). When that 25,000 is exhausted, the second (TPA) -- which would be us -- takes over the handling of the file. I would assume the initial (TPA) would be responsible at the RRE so designates.

But what happens in the transition then? Can the client then - or the RRE then designate the second (TPA) as an agent? Or can that be done when the client registers?

John Albert: Well I mean I guess the - you're talking about reporting the same individual using...

Woman: Correct - the same claim.

John Albert: ...(the same) agent.

((Crosstalk))

Woman: ...like two (TPAs).

John Albert: I mean basically the issue with doing that is that, you know, that record submitted by the one would have to someone be closed out and then a new record built through the other agent. You know...

Woman: (Chances are daily business).

Man: Yeah.

(Barbara) Wright: Could you ask her one brief question on that. When you're saying you have a split like that is the first part self-insured and the second part is policy? Or are they both...

Woman: They're both self-insured. The first part the district has to pay the first 25. And the second part the district belongs to a joint powers authority which is a pool of districts that self-fund. And it's a separate (TPA) that administers those claims.

John Albert: Could you submit that one through the resource with those specific so we could, you know...

((Crosstalk))

Woman: Sure.

John Albert: ...that direction. Because...

Woman: (No problem).

John Albert: Yeah - thank you.

(Bill Decker): We don't have any guidance to give you on that.

John Albert: Yeah.

(Bill Decker): But for clarification if it - if the claim is less than 25,000 than only the first (TPA) would be involved correct? And if it's over 25,000 does just a file get transferred or does the first (TPA) process it up to 25...

Woman: Right - correct. The first (TPS) must exhaust the 25,000. And then the second (TPA) takes over the handling.

(Bill Decker): Okay.

John Albert: Okay thank you for that clarification.

Coordinator: Our next question comes from (Jeff Sigmore).

(Jeff Sigmore): Hi - (Jeff Sigmore) with (Goldberg Fidella). I have a question about the idea of a nuisance value settlement. Is there any thought - consideration about a minimum settlement value that's exempt from reporting?

(Barbara) Wright: At this time we haven't established any such limit. And past experience has been that one person's nuisance is another person's windfall. I've heard settlements as high as 800,000 referred to as a nuisance settlement.

(Jeff Sigmore): True enough - but when we deal with, let's say, the run of the mill. There's so many out there let's say 20,000 and below or in those context. The

administrative burden becomes so high for reporting that - has that been factored in?

(Barbara) Wright: We are looking at that issue but as I said at this point we have no plan to establish a de minimis now.

(Jeff Sigmore): Okay thanks.

(Bill Decker): I mean one of the things we're struggling with is actual data about it. I know we've heard in our meetings that 80% of the claims are $20,000 or less. But that 80% of the money is spent on the 20% that's there. So any data that people want to give us on the number of claims and/or the kind of breakout, that would be very helpful in this.

I mean I will tell you right now in our manuals -- our overpayment recovery manual -- our basic, our recovery (cutoff) is $10. So that's what it is now. Of course, you know, that doesn't mean we couldn't set one higher. But the better data we have, you know, the better, you know, decision we can make on that issue.

So if people have claims data, you know that they could share anonymously without, you know, turning in names or (something)...

(Barbara) Wright: Or if they have some way to redact it.

(Bill Decker): Redact it - the more data we have the better in terms of that. I mean we see this now in our group health plan which is our recovery. That the absolute majority are less than $250. But the majority of the money is much more than that.

So - but that would be helpful.

(Barbara) Wright: And keep in mind the $20,000 settlement while even if you said that was a relatively small amount, if Medicare has paid $20,000 for that person - particularly in liability situations where you have many that butt up against the policy cap. We paid far more than that. And are already limiting our recovery by virtue of the cap.

(Bill Decker): Right. (But we'll consider it). And as we get some data I don't think it'll be like 20,000 but I mean the fact - the reality of our situation because we have a limited budget. And we wouldn't be able to do anything with it anyway.

So, you know, the more data we can have to show people like our overseers -- like the GAO and OIG -- if we did set such a tolerance. At least we could - if we had facts that say it rather than just plucking the number out of the air so...

(Jeff Sigmore): So you're still going to be open to listening to that?

(Bill Decker): Oh yeah.

(Barbara) Wright: Sure.

(Bill Decker): Yeah definitely...

((Crosstalk))

...you know, we're - and that's why we're having these calls and trying - and having these meetings and these listening sessions is the more information we can get the better we'll be to make informed decisions that hopefully not create too big a burden.

(Barbara) Wright: (But some - we're) often quoted on calls we also have to say at this point there's no specific plan for (setting a) minimum amount.

(Bill Decker): But send it in and we'll definitely consider it.

(Jeff Sigmore): Okay thanks.

Coordinator: The next question comes from (Christine Quinn).

(Christine Quinn): Yes good afternoon. My name is (Christine Quinn). I have two questions. On is there going to be a mechanism for looking at ICD-9 codes that may be in dispute. And I'll give you an example.

In some states that my company does business in, the insured or the claimants are medically directed. Sometimes they go renegade and they will treat outside of the medical direction. At that point we are not liable for that. How does Medicare or CMS, should I say, plan to address the issues of disputes on lien amounts?

(Barbara) Wright: That's a separate issue in Section 111 reporting that has to do with a recovery process. We have (features) in place now for amounts to be disputed. But that's not a Section 111 issue.

(Christine Quinn): Okay my second question has to do with the data itself. The (MSP) statute -- I believe was 12-5-81 -- we actually have claims that are pre-statute. Do you expect those claims to be reported also?

(Barbara) Wright: We are looking at what language we need to do. And we always need to keep in mind the (unintelligible) liability. And, for example, (unintelligible) if you

have an asbestos situation (for worker's) comp, then Medicare has been secondary to worker's compensation since the inception of the program.

If you have an asbestos situation and it's liability insurance...

(Christine Quinn): Right.

(Barbara) Wright: If all exposure (peaks) before 12/5/80, then it is CMS policy that it will not assert a recovery claim with respect to any liability settlement. And that can depend on -- again I'll use asbestos as the example.

Let's say that you're suing five different entities. I've seen situations where three of the entities -- all exposure connected with them -- did in fact end before 12/5/80 wherefore at the last one there was some exposure after 12/5/80. We are looking at language that could potentially eliminate reporting when it's clear that the exposure ended before 12/5/80.

(Christine Quinn): So just say somebody was injured in an auto accident in an unlimited (unintelligible) state in '77. And they continue to treat to this date. How would you address rules regarding that as well?

(Barbara) Wright: Yes.

(Christine Quinn): Thank you.

Coordinator: Our next question comes from (Richard Fluminghaning). Thank you. Your line is open.

(Rich Fluminghaning): Thank you and good afternoon everyone. I'm (Rich Fluminghaning) with (AC) Philadelphia. And my question relates to the

correction process. If you could elaborate a little further on how that process is going to take place for an RRE.

In looking at the general requirements I see that they are supposed to be done on subsequent quarterly updates. And I guess email notifications are going to be sent if the RRE on file. Could you explain that - the process and how that will work?

(Bill Decker): I think you're - are you talking about corrections of errors we identify in the submissions or your need to correct data you reported mistakenly? I mean basically the submission process is quarterly. And that's when any corrections to either, you know, if you attempt to send a record to us and we can't post it to our system because of the problem, for example, with a particular field. And it's not formatted correctly, et cetera...

(Rich Fluminghaning): Right.

(Bill Decker): We would ask you to resubmit that on the next quarter's file. The other corrections that people talk about are if, for example, they need to either update existing information or, you know, they sent, for example, a record in by mistake that they shouldn't have sent in.

(Rich Fluminghaning): Okay.

(Bill Decker): And those - that's part of the add/update/delete process in terms of the transaction type. So basically there are methodologies in that file process to handle those. The first is, you know, that the data is formatted and sent correctly versus the information itself is correct or not.

(Rich Fluminghaning): Right now would the entire record need to be corrected or it would be a line item or a record feed if there are multiple records that are sent?

(Bill Decker): Yeah. I mean each - you - each of the individual records, you know, will receive a disposition code and possibly a series of error codes related to the individual format of the record itself. But then there's - if you need to correct an individual, you know, it's all done at the record level or (personal) level essentially.

(Rich Fluminghaning): Okay.

(Bill Decker): In terms of corrections.

(Rich Fluminghaning): And notification is by email to the RRE?

(Bill Decker): Well I mean there's - the notification - there will be an email notification process so that you know that we received your file or that we've transmitted a file - a response file to you. But the actual correction takes place on the file itself...

(Rich Fluminghaning): Okay.

(Bill Decker): ...that you submit through the Web portal.

(Rich Fluminghaning): Okay.

(Bill Decker): The larger answer is yeah you get an email from us but you'll also get a return file.

(Rich Fluminghaning): Yeah.

(Bill Decker): So you're going to make the corrections on the - after you have received the file in return from us. And then you'll submit the correction by submitting a new file to us.

(Rich Fluminghaning): Okay thank you.

Coordinator: Our next question comes from (Suzanne Hasha).

(Suzanne Hasha): Hello I'm (Suzanne Hasha) with American Physicians Insurance Company out of Austin, Texas. We are a liability carrier. When the physicians get sued for malpractice, that's when we enter the picture.

Now what we routinely have been doing all these years that we've been existence is when we cut the final settlement check with the plaintiff and his attorney, we always put on there if we know there's Medicare or Medicaid we put (that) in on the check forcing the plaintiff attorney then to do his work and notify you guys and try to either negotiate down the lien amount or whatever.

Does it - will that system no longer work? We have to jump on board and start doing this reporting as well?

(Barbara) Wright: Again you're sort of mixing two separate issues. The reporting is a requirement separate and apart from any other preexisting Medicare secondary payer obligations. Your use of three party checks when there's a settlement is a very good device to protect the insurer in terms of preventing the possibility of Medicare coming back against the insurer for money.

Our typical recovery process is through the beneficiary. And we don't expect that to change. But yes - the short answer is yes. The reporting is in addition to anything you're doing now.

(Suzanne Hasha): Okay now let me ask you something else. We already do a massive amount of reporting as it is. We do a closing report to the State Board of Insurance with all of this information. We also do a National Data Practitioners Databank Report where every doctor in which we make a payment on them has to go into the national databank.

Could - is there any way we could just provide you those documents where we don't have to go in and change our entire computer system to add all of this information, because it's already - the information is already out there with the federal government. It's just in a different entity. It's under the National Data Practitioners Bank.

(Barbara) Wright: Hopefully with your explanation that you're saying that (you're basically reporting) all of our data elements somewhere else, it should be a matter of either you or an agent figuring out a way to do a reformatting of the report and submit it to us. But no the other reports can't substitute.

(Suzanne Hasha): All right.

John Albert: And we tried actually for malpractice to get access to that data bank.

(Suzanne Hasha): Yes.

John Albert: And we were told no. They weren't - we're not allowed use of it.

(Suzanne Hasha): Okay yet because of the confidentiality.

John Albert: Yeah so...

(Suzanne Hasha): It's really mainly for hospital use and...

John Albert: Yes right.

(Suzanne Hasha): ...(unintelligible).

John Albert: Right it wasn't the intended purpose of the (unintelligible).

(Suzanne Hasha): Right.

John Albert: So they said no. But we did pursue that at one time.

(Suzanne Hasha): Well thank you. I'm glad you did.

((Crosstalk))

Now one other question if (we) have a plaintiff that has a representative payee - let's say they're a mentally ill person. They have a claim. And it's reported. Does the representative payee have the duty to do the reporting? Or is it the person paying them - the carrier - the liability carrier?

(Barbara) Wright: It's - if you look at our file layout, if someone - if the beneficiary (is alive and we're) collecting the information with respect to the beneficiary. If the beneficiary is deceased then we have a separate (seal through) as acts for the claimant either on behalf of the estate or directly.

(Suzanne Hasha): Right.

(Barbara) Wright: But simply having a representative (case) situation doesn't effect who the RRE is at all. It's still going to be...

(Suzanne Hasha): Right.

(Barbara) Wright: ...the insurer.

(Suzanne Hasha): In other words if you're a liability carrier and you issue a check, you report it. That's simplifying it.

(Barbara) Wright: Yes.

(Suzanne Hasha): Okay now let's see. I had one more - I think that covers it. Let's see - oh yeah the HIPAA releases. Have y'all encountered resistance with that with the confidentiality? Or is that waived - the HIPAA confidentiality?

(Barbara) Wright: HIPAA has projected concern. But actually no one is out there doing an assumption yet. So again we're trying to come up with ways to aid in obtaining the social security number.

(Suzanne Hasha): Well one place - the best place we usually find that information is once we get the plaintiff's medical records and start looking at them regarding the underlying negligent lawsuit against the doctor, it'll be in there. Usually that's how we can identify it pretty quick.

(Barbara) Wright: Typically where someone is a Medicare beneficiary the medial records are going to have that information.

(Suzanne Hasha): Yeah - all right.

John Albert: Yeah because when Medicare has paid the claim if, you know, and then they present the claims to you for payment, you would see the (HIC) number on the claim themselves that they submitted to us for payment.

(Suzanne Hasha): Right.

John Albert: So it might not be in the computer file but it might be available in the claims process some way. And that's where we're encouraging people to think about.

(Suzanne Hasha): Well we'll just report it and you guys figure it out, right? I guess is...

John Albert: Well we're trying to help.

(Suzanne Hasha): Yeah - all right.

John Albert: Thank you. Operator this is (John) and we want to take one more question and wrap it up. Before we take that last question I wanted to thank everyone for participating in this call.

I'm sure we'll have more of these. There's obviously lots of good questions coming in. And I'm sure there are probably some folks out there who are waiting in the queue to ask their question.

Again we encourage them to submit them through the Resource Mailbox on the Web page. And again we wanted to thank everyone for participating on this call. It was a good discussion.

But with that I'd like to turn it back over to the Operator to allow one more question to get through. And then we'll be done for today.

Coordinator: Thank you. Our final question comes from (Chris Arondale). Thank you. Your line is open.

(Chris Arondale): This is (Chris Arondale) with Holland America Lines in sunny Seattle, Washington. And welcome to everybody and I certainly appreciate the CMS participating in this question.

I come at it from a slightly different angel. Holland American Line is in the cruise business. And my question here really is is there going to be any set asides or exemptions for certain industries such as, in fact, our - the cruise industry? We're basically foreign flag ships. And we're involved with carrying people on cruises all around the world.

And typically what may happen in a situation where we get involved with a senior citizen or a Medicare patient is that the individual may on a shore excursion in some foreign country get injured.

And they're basically either treated in a foreign country for their injury. Or possibly treated onboard the ship in our ship's infirmary. And the medical charges if it has been an injury is typically waived by us as a gesture of goodwill.

We - when they get home we might then include some form of a settlement for them for their, if you will, diminished cruise experience as a result of getting injured while they've been on their cruise vacation.

My question then is would we be considered an RRE and have to make a report of an injured Medicare senior citizen who was injured overseas, treated

overseas, possibly receiving some follow up treatment back in the United States. That was I guess question one.

And question two - my understanding at least has been that when we do reach a settlement with an injured senior citizen, that many times the cost of their medical expenses becomes part of our settlement. And if we're, you know, dealing with the lawyers they are - my understanding is they then are the ones that would be dealing with Medicare. Or even perhaps if there's no lawyer involved that the senior citizen himself or herself would be dealing with Medicare with regards to any payment of any lien that Medicare may have.

John Albert: Is that the end of the question?

(Bill Decker): I'd like to volunteer to research this matter on your behalf personally myself.

((Crosstalk))

(But, you know) Medicare is not valid outside the United States. So any services provided outside of the United States, Medicare doesn't pay regardless of where they occurred.

There's exceptions like if you're driving the most direct route from Washington to Alaska - things like that. But no Medicare services outside the United States.

((Crosstalk))

But the question is if there's an accident outside the United States, do we have rights to recover?

(Barbara) Wright: Yes we do. I mean what you've described sounds like you're self-insured and you're making self-insured liability settlements. And keep in mind you're not monitoring their care once they get back to the United States. You may have treated them while they're on shipboard. And they may go home and have six or eight months of physical therapy.

Well if you settle with them quickly and it's a lump sum payment, probably we aren't going to have to do a recovery claim. But if it takes awhile, they may have gotten quite a bit of treatment that we have a recovery claim for.

As I said before our standard practice is to do recovery claims against a beneficiary's settlement, judgment or award. We don't, you know, in a liability situation we don't typically go back to the insurer. We have some reasons to do so. But that's not our standard practice.

(Chris Arondale): Thank you (Barbara). But I guess the question I might have had here is if this person had the accident and let's just take a typical example. When these folks get off the cruise ship and they go for either an excursion with an independent tour operator or they just simply misstep and fall down (onshore) through no fault of anyone.

We - as I said because of what happened as a gesture of goodwill, we will make some form of a settlement with them because of the diminished experience as far as going on their cruise vacation. So...

(Barbara) Wright: We will look at this further. But as described right now it appears to technically sit as a self-insured's liability situation. And from a technical standpoint that's where it's at.

We're certainly willing to listen to any other information you wish to submit. But...

(Chris Arondale): Sure - understood. I don't want to take any more time. And I guess I'll maybe enlarge on this a little bit with a write in to your Web site.

John Albert: With like if you have some real life examples that you can use as case studies that would be great.

(Chris Arondale): I'll be sure to do that. Thank you for your time. And thanks for all your efforts. And I just want to say I'm a part of the (RIMS) Association -- Risk Management Society -- and also a supporter of MARC - M A R C.

Man: Thanks.

Man: Thank you.

John Albert: Operator are you still there?

Coordinator: Yes I'm right here.

John Albert: I wanted to know how many people eventually dialed in.

Coordinator: Okay one moment please.

John Albert: The other question was how many people were still in the queue?

Coordinator: Okay we had 46 still left in queue.

John Albert: Okay.

Coordinator: And...

END