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Implementation of MSP Mandatory Reporting Provisions per Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

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October 1, 2008

This call provided a basic overview of outline of what Responsible Reporting Entities (RREs) for both Group Health Plans (GHPs) and non-GHPs (including Workers' Compensation, Liability, Self-insurance and No-Fault Insurance) can expect in the coming months.

First and foremost, CMS emphasized that they are focusing on complete and accurate reporting and not the penalty phase of the Extension Act. For non-GHP RREs, a grace period of one year has been granted for identifying claimants who are Medicare beneficiaries and for whom the primary payment responsibility was established prior to 07/1/09. In an effort to assist RREs in identifying applicable claimants, CMS is currently consulting with counsel and investigating whether they can provide a system by which RREs can perform queries to determine whether an individual is Medicare eligible.

A timeline (available at www.cms.hhs.gov/MandatoryInsRep) has been established to identify the times in which a RRE must register with the COBC through the Coordination of Benefits Secure Web site (COBSW). The COBSW has been identified as the portal through which all information will be submitted and communications will be received in response to submissions. Electronic registration for GHP RREs will run 04/01/09 - 04/30/09 and electronic registration for Liability, No-Fault, Self-Insured and Workers' Compensation RREs is planned to take place 05/01/09 - 06/30/09.

Each RRE must register individually; registration by a designated agent for the RRE will not be permitted, but use of agents for reporting is permitted. The agent to be used must be identified during the registration period.

Upon registering through the COBSW, the RRE will be contacted by the COBC and assigned own dedicated Electronic Data Exchange Representative who will become the RRE's personal contact at the COBC. The representative will work with the RRE and their technology staff to set up and test the data exchange process. The testing period for GHP is scheduled to occur 04/01/09 - 07/01/09 and will occur 07/01/09 - 09/30/09 for non-GHP RREs.

Once the trial has been determined to be successful, then the production phase will begin. GHP RREs will submit their first production files 07/01/09-10/01/09 and non-GHP RREs will begin submitting production files 10/01/09-12/31/09. The RRE or its agent will submit the required information and in return will receive both an acknowledgement of receipt and the COBC response file, which will notate any errors. These errors need not be corrected immediately, but in the next scheduled reporting. The COBC already has 200 firms completing daily exchanges and report that once established it is a very smooth process. More specifics regarding the type of information that is to be required will be published as the data element is still being developed for non-GHP.

Additional CMS sponsored Open Door Forum Teleconferences, User Guides and computer based training programs are expected to be released over the last quarter of this year. User guides for both GHP and non-GHP RREs are expected within the next 30 days.

TELECONFERENCE NOTES

I. Welcome/Introduction – John Albert

- First of a number of conferences that will be sponsored for GHP and non-GHP reporting.
- Reporting GHP 1/1/09; all others 07/1/09
- CMS is focusing on complete and accurate reporting and not the penalty phase of the Extension Act.
- Reporting will be solely electronic. Instructions will be published on dedicated web page.
- Other sources of information are not accurate. CMS web page is ONLY source.

II. Who must report. – Barbara Wright

- Section 111 puts everyone on equal footing for same reporting requirements in all areas (WC, GHP, self-insured, liability). Reduce CMS "pay and chase" efforts.
- Responsible Reporting Entities (RRE): can it shift responsibility by contract (ie to TPA) answer: NO. Responsibility can not be shifted by any type of contract.
- If someone self-reports, prior notice does not substitute for compliance with section 111
- If there is a claims processing TPA (TPA as defined by CMS) then they have the ultimate reporting responsibility for GHP.
- For liability, no-fault and WC – in compared to GHP, biggest difference is TPAs, no matter how defined, do not have the underlying reporting responsibility and will only act as an agent.
- Employers may not be the RRE for GHP but ARE RRE for liability insurance if Self-Insured.
- CMS is not sponsoring or certifying any agents, and selections of agents is up to the RRE and RRE retains the responsibility even if they use an agent.
- Small employer exception- more info 9/22/08 document on CMS web site. GHP must request exception and CMS must approve.
- Expect to have document for WC, liability, no-fault published on site within next 30 days.
- Comments are not official instruction but the direction CMS is headed.
- What gets reported as the amount? Contested cases, resolved cases, etc. In process of coming up with more generic terms to cover every situation. As for amount, if it is a lump sum then what is the total payment obligation? If structure, then total amount, total value of pay out of annuity.
- Ongoing reporting responsibility? For WC or no-fault, situation where medical is open until exhaust limit is reached. In that situation then report when responsibility is assumed and again when responsibility is terminated.
- If WC RRE have responsibility for group of people in the past (prior to 07/1/09) but those people are still entitled to submit claims for medical, then they still must be reported.

There will be a year extension for obtaining info for people for whom the responsibility was established prior to 07/1/09.

- Looking for feedback on how often RRE should be required to check whether a person is a Medicare beneficiary. Accepting comments and suggestions.
- Timing of reporting – quarterly for WC, L and No-fault. Only QUARTERLY, no more or less.
- MSP issues – if $0 verdict must there be reporting? Simple answer doesn't cover all of the issues. Nuisance settlements – CMS recovery rights are determined when primary payment responsibility has been demonstrated, which may be by a judgments/C&R or otherwise. More info on web site.
- Still working on a model form for collection of information. Possible query function to RRE to allow them to search for whether someone is a Medicare beneficiary. TBD whether this can be done or what limitations will be imposed.
- Plan is everything will be electronic submission. No exceptions planned.
- Definition of the word "claim" – speaking of the claim as a whole, not a single service.
- Complain that CMS use of terms doesn't comport with WC industry definitions. Look to CMS regulations for definitions. Must use these. One example is "date of incident" not willing to change definitions to match those used by the industry but will make CMS definitions clear.
- Liability MSA questions, will CMS be staffing up? These don't relate to implementation and need to be submitted. Liability MSAs – CMS does not have a formalized process but the obligation to protect Medicare's interest is the same.
- CMS has taken the policy position if incident occurred or exposure ended before 12/80, that they will not assert a recovery claim. Looking at issue of whether these cases need to be reported.
- If multi-district jurisdictions or class actions, can these be excluded from the regular process? If suggestions then they will take them, but otherwise they are clearly reportable as soon as there is an award.
- Whether files submitted can combine GHP and Liability/WC/No-fault if RRE has responsibility for both areas – NO. Different reporting requirements. Can mix info between lines of business for Liablilty/WC/No-Fault because the report will be the same. Separate file from each RRE will be required.

III. Implementation of Timeline and Related Issues/ Registration Process for Responsible Reporting Entities – Bill Decker

- GHP electronic registration starts 04/1/08 –
- May 1, 2009 registration for non-GHPs RREs.
- Since new RREs are not being registered until after 1/1/09 or 07/01/09, do not have to begin sending data until registered. How will I be in compliance? Answer – will begin compliance at registration. As long as registered at assigned dates and timelines and continue reporting then will be in and remain in compliance.
- All registrations will be electronic and through secure web site – COBSW. Where register and portal for submitting info and where info will be received in response.
- Agents are not permitted to complete an electronic registration. For RREs only. If RRE is using an agent then agent info section of the registration form must be completed. Even

though agent not responsible, must know who this is. Computer training course is being developed.

IV. Data elements (including HICN/SSN), record layouts, testing – John Albert

- User guide for WC/L/NF available at a later date.
- Purpose of exchange of info is to allow CMS to build files and coordinate benefits appropriately
- Personal Info – SSN/HICN, name, DOB, sex. Used to validate whether person is a Medicare beneficiary.
- Transaction type: new, update or delete transaction where prior info submitted in error.
- Coverage Info
- Employer or Insurer information
- Once send a file in, will receive a response record in return. Will provide all info submitted as well as disposition codes that tell whether record was accepted and if not, then a listing of error codes (formatting, characters, etc.) when receive an error code record do expect to correct
- Late submission indicator will advise if info submitted was outside of time frame required.
- Submit non-MSP file under the expanded option, will allow GHP RRE to query Medicare entitlement data and to submit records of Rx coverage that is supplemental to Medicare.

Barbara Wright– notes immediately above are more specific to GHP, below are differences for WC/L/NF RREs.

- Process of submitting and getting response also applies to WC/L/NF as well
- Different categories on data element b/c need info for recovery actions.
- Section for injured beneficiary is deceased. Need to know claimant info as well as
- Who is primary plan?
- Policy holder and #s. Need to know different info than GHP b/c policy holder # isn't necessarily connected to the beneficiary in any way. Need multiple ways to tie everything together.
- Attorney info. May need to contact rather than beneficiary.
- Significant amount of information about the incident. WCIO (WC Insurance Org) standardized codes for areas listed in the incident section. Will use WCIO codes.
- DOI is an issue of concern that will be addressed
- Resolution – will make clearer terminology
- Model form for collecting SSN info as well as ability to give some sort of query function to RREs.

VI. Data submission/Web Page - William Decker

- What happens when the info is provided?
- Submit data to COB contractor through data exchange web site. For GHP, submit 2 types of files, MSP input files and non-MSP input files (if choose to).
- MSP input file will be submitted on a quarterly schedule

- Non-MSP input file is either quarterly or monthly. If choose expanded option, then recommend choosing
- Non-GHP reporters will submit data to COBC by method selected at registration.
- Non-GHP data exchange will be on a quarterly schedule. No monthly allowed for non-GHP
- All submissions will be acknowledged upon receipt.
- How do you get to the file exchange process and how does it work? After RRE registers, RRE will be contacted by the COBC and assigned own dedicated electronic data exchange representative who will become personal contact at the COBC. Will work with you and tech staff to set up and test the data exchange process. Once determined that it is successful then will begin the production phase. Does take time and may be somewhat complicated. Already have 200 firms doing daily exchanges. Once established, reported to be very smooth.
- Once in production, transmit data to COBC, processed and returns a response file to you. Review and make any corrections and begin to prepare your next input file.
- Very routine process for GHP.
- Additional instructions are forthcoming in the user guides (one for GHP and one for non-GHP RRE) Data element sets are very different between the two.
- Your COBC rep will be able to answer most questions directly (including technical questions).

VIII. Closing – John Albert

- Computer based training and additional open door forums are planned.

IX. Questions

- Receive responses that notify what errors are, are corrections submitted immediately? No wait for next quarter
- No record layout for Liability/WC/NF, but pending.
- Does this apply to stand alone dental plans or supplemental health plans? Formulating answer. Leaning toward dental not reported but still looking at issue.
- Presentation available as transcript, and recording but not for a week.
- Group Self-Insurer – Coverage under Long Shore Act – info regularly reported to the Dept of Labor, does the process need to be duplicated? Looking into issues and will be talking to the Dept of Labor to see if everything asking to be reported will be there. Comment: Date of incident does not exist in the context of the Long Shore Act. – investigating
- User guide for GHP not yet available but will be there asap.
- Will a TPA have to report HRA plans? Determined that FSAs do not need to be reported, but still looking at HRAs.
- When will data element for non-GHP be finalized? Goal is to be done by the end of the year at the very latest. But still in process of finalizing and there is no set date.
- If the claimant refuses to provide SSN, b/c no tax reporting requirement for liability settlement, how do you comply? Still working on this issue. Use alert on dedicated web page to explain

- Non-GHP – payment is assumed and there are ongoing medicals, should report exhaust limit. Not asking for $ amount reporting. If WC and no dispute and they are a Medicare beneficiary, then report to COBC and don't report a $ amount. If file is closed out b/c no further medical then report to COBC that file has closed. When you assume the obligation and when the obligation terminated. If there is a $5,000 limit, then will report when that limit has been reached, not payment of every claim. If there are no limits on medical then report when responsibility starts but then the record stays open.
- For the purpose of mutual companies, is each a separate RRE or only the parent company? For GHP there is no preference, Liability/NF/WC is not decided but assume that will be the same answer.
- Will receive both an acknowledgement and a response file.
- Entitled for benefits means that they have actually enrolled in the Medicare program.
- Document Control Number is a number that insurer makes up themselves, not something that CMS assigns.
- Employer EIN, mandatory? Yes, but further guidance forthcoming.

October 29, 2008

Today the first all Question and Answer teleconference was held by CMS for MSP mandatory reporting under MMSEA Section 111 for liability, self-insurance, no-fault and workers' compensation insurance. There was no set agenda for this call. Participants were simply able to dial in to reserve their spot in a queue for asking questions. At the conclusion of the call 46 people remained in the queue, which is more than were actually given the opportunity to speak during the 1.5 hour call. Additional teleconferences are planned; specifically, the call-in instructions site December 2008. The User Guide remains to be completed, so reference to the Interim Record Layout published at http://www.cms.hhs.gov/MandatoryInsRep was encouraged but all were cautioned that changes may be made from this tentative format.

The presenters indicated that they expect an answer as to whether a query function for determining Medicare status will be made available to RREs within the next week. Counsel continues to research whether this access can be allowed. If allowed, the query function will be limited to searches by SSN only. In the case that query access will not be allowed, they are working on a sample model form, which if completed will allow an RRE to be in compliance for reporting purposes even if they are unable to obtain a SSN from the claimant. They specified that they do not want to have insurers report every claim that they process and pay, and that they will be expected to establish a procedure for identifying Medicare beneficiary claimants before reporting them. The representatives also stated that they continue to work on determining a standard for how frequently an RRE must recheck the status of non-Medicare beneficiary claimants.

Many callers asked questions regarding agents and agent changes. The presenters acknowledged that they expect agents to change from time to time. If an RRE does not have notice that an agent will not longer be servicing their accounts, such as if the agent goes out of business, then it is expected that the COBC will work with the RRE in reestablishing a reporting program internally or with another agent as soon as possible. However, if use of an agent is discontinued per RRE decision then the change should be made by contacting the COBC and planning the transition to ensure that no reporting windows will be missed.

There were also several questions regarding settlements involving multiple carriers. The CMS representatives reiterated that reporting is necessary for each individual policy under which there is a payment responsibility, not one per person.

When questioned regarding the $1,000/day penalty, the CMS representatives explained that their focus in not on the penalty phase, but on obtaining quality data. They stated that they are unable to hold anyone to a standard that has not yet been published. They will be publishing a "high-level" one page summary discussing the identifiable factors which might make an RRE at risk for non-compliance. This will be published at http://www.cms.hhs.gov/MandatoryInsRep when available.

Right now there is no reporting exception for any settlement classified as a nuisance settlement. They offered to consider the possibility if more data is submitted to establish a common value of a nuisance settlement, but at this point there is no specific plan for making such an exception.

One caller had a question regarding liability MSA programs and Barbara Wright directed the individual to call her directly at (410) 786-1000.

TELECONFERENCE NOTES

I. Welcome/Introduction – John Albert

- Recently published the data elements for non-GH reporting, available on Mandatory Reporting page.
- Barbara Wright is the technical advisor in the process
- Bill Decker introduced as leading the voluntary data share process that is being used as a model.

II. Open Question and Answer Session –

- RRE – when they initially register and do not know who agents will be, may they add that info at a later date? –Yes, but must be before the final exchange process actually starts. If agent is being used to manage the process they must be identified before the process begins.
- What if agent changes? Can make a change with COBC at any time as long as the COBC knows who to be expecting info from and who to give to.
- If an agent is identified by a RRE, and agent is reporting for multiple RREs, will the date be specific to the RRE or to the agent? Not yet addressed, but seems as though agents do report on different time frames for different RREs. Timing based on workload, spreading out time frames based on RRE volumes. Each RRE will have an assigned submission window that will remain the same each quarter, assigned during registration period.
- Under General Requirements: RREs must develop procedure for identifying Medicare beneficiaries? Don't expect insurers to report every single claim that they process and pay. Expect to check ahead of time. How? Will assist to the extent possible in helping with tools to do so. Inquiring whether RREs can be given query access. Answer from counsel pending.
- ISO is reportedly building capability to work with COBC in this reporting requirement. Is there any issue with ISO doing this? –answer, they are one of many possible agents, but groups like ISO are not RREs so the ultimate responsibility is with the RRE. COBC do not select the agents and agents do no happen automatically. Expect RRE to make own arrangements for registering agent.
- Who are Medicare eligible? When will answer for query possibility be available– within next week or so. This will not allow you to search for a SSN. It is based on having the SSN as a basic starting point.
- Initial filing of Medicare recipients, at which time should they initially report? Trigger is settlement, judgment award or other payment after 07/01/09, but if responsibility carries over from pre-07/01/09, then will have to report on that individual. Settlement, judgment, award or other payment for the first time after 07/01/09 then needs to be reported in the

following quarter. Just b/c someone was in an accident in 06/09, doesn't matter, it is when payment responsibility begins.

- With liability, unique issues. Can there be a separate telephone conference specific to liability? Example, judgment tempered by claimant's own negligence. –Answer, won't rule out a call but best to send policy questions like this to mailbox. Generally, Medicare is not bound by the allocation of parties. If there is a settlement of $100,000, must report entire. Will defer to a court of competent jurisdiction on any judgment that they would make, but not otherwise bound by the parties.
- Insurer with ASO accounts, is the insurer considered an agent for the ASO groups? RRE is the applicable plan, so for certain lines if there is an administrative function only then it sounds like that it is for a self-insured, who would be the RRE.
- Query function, if not agreed to, will there be a reasonable person standard to apply where a claimant refuses to provide info to conduct reporting? Looking at a sample model form which if completed will put the RRE in compliance for reporting purposes. Form is pending knowing whether there will be query access, but keep in mind need the SSN to begin with. Aware of difficulty of getting SSNs. One alert available on the web site so claimant can confirm that it is a legitimate document by referencing the web site. Taking suggestions on languages and types of forms.
- Model form will be more important if unable to give RREs query access. If form is completed then will be considered to be in compliance even if don't have SSN.
- Multiple carriers are involved and plaintiff is Medicare eligible, then who has responsibility for reporting? Right now reports are policy and person specific, so if collecting from each policy then report is needed for each policy.
- Informal limited process available for liability MSAs, in either case CMS approval of MSA is not required, it is a voluntary process. Section 111 says nothing about MSAs so this is not the correct forum for the question. Can call Barbara Wright (410) 786 - 1000 for more information.
- ISO memo reports that CMS has agreed to review their data elements. Yes, they have seen their record layout and have heard comments. Willing to take from any others.
- Checking Medicare eligibility, is this a cyclical requirement? If a lump sum payment or single payment obligation then there is a single reporting, but if assume ongoing responsibility then yes, will have ongoing responsibility to check. If not a beneficiary at the time responsibility is assumed then looking into how frequently RRE will have to f/u check.
- Undocumented workers, what happens if a person does not have a SSN? May get WC benefits but will not be getting Medicare without a SSN and work credits.
- Liability settlements on behalf of multiple insureds, each with own policy, but one check, settlement agreement and release. One report for each policy/plan is required.
- Similarly, if husband and wife with one lump sum issued to them jointly, how is that reported? If the partied decide to allocate $99K to young wife and $1K to beneficiary, then still need to report entire settlement amount b/c not required to accept that allocation.
- If have an agent reporting but then decide to bring it in house, how does testing time work? Grace period? You would notify COBC of pending switch from agent to self-reporting. If agent goes out of business and have to take on without prior notice, COBC will work with RRE on testing period and regular production, but if releasing agent on

your own then planning should be in place to make the change seamlessly. Understand that agents and business relationships do change. Interested in quality of data first.

- How would a new carrier know that they need to be complaint? –answer, same way that they know that they need to be compliant with any law. Should be part of new business plan.
- Field 12 – the date of incident. Definition doesn't match with date of disablement or the last date of exposure (longshore) if someone is going to report and that info is not available, it's still shown as being required. How should this report be completed? Answer – info is going to have to be solicited because the information is critical. Important in determining any recovery claims. Someone is 75 and been on Medicare for 10 years, how would they know when to start looking for claims that may be subject to recovery? That is why date is needed. Date of disability or date of last exposure isn't necessarily when their treatment started from which they would be recovering. Deal with a certain amount of approximation with some injuries, such as exposure such as asbestos. If exposure before Medicare entitlement date, then they will only be looking at claims from date of entitlement forward so exact date of exposure prior to that won't apply.
- Alien issue – individuals without SSN, if they don't have SSN, then you won't be reporting but must continue to check to see if they do obtain a SSN in the future. Periodic verification requirement. Quarters of coverage for eligibility arises. In actuality, very few scenarios.
- Data dictionary available? Interim User guide is available. Will offer standardized definitions. See attachment A to the supporting statement. Specific questions to comment mailbox?
- If Medicare Set-Aside amount part of settlement pre-07/01/09, then there is no continuing obligation after 07/01/09. This only applies to continuing obligation for medical payment after 07/01/09.
- Question specific to client/school. If school is self-insured then RRE is the school, but to the extent that they have purchased a plan then it is that plan. District is a member of a self-insured pool, then RRE is probably the district. Can't answer now, must submit the specifics in writing.
- User guide will be available at unspecified date in the future. Interim guidelines are not final.
- $1,000 penalty, how will it be enforced and is their a time frame for compliance? Aim is quality of data. Can't hold to a standard that hasn't been published yet. **Will be publishing a high level one page summary discussing factors for being at risk for non-compliance.** In process of building reporting process first. Web site is where all official instruction will be. Every update to the web site is a new downloadable document.
- Can an insured designate two agents for reporting strictly liability? If $25K self-insured limit, when exhausted then second TPA takes over. Assume initial TPA will first be responsible agent by RRE, if transferred to next TPA can a second RRE be designated? Issue is the record submitted by one would have to be closed out and then rebuilt by another agent. Both parts of the split are self-insured but separate TPAs. Cannot answer, must be submitted by email for answer.
- Nuisance value settlement, any consideration about a minimum settlement value being exempt? Not at this time. Looking at the issue, but no plans to establish, one person's

nuisance is another person's windfall. Not likely to be as high as $20K, but might consider this if more data is submitted to show typical values of "nuisance" settlements. At this point, no specific plan.

- Mechanism for ICD-9 codes that may be in dispute? What if claimant is treating outside of their medical direction? How will disputes be addressed? Separate issue – part of lien recovery process.
- For example, if asbestos and WC, then WC will be secondary. If asbestos and liability and all exposure was pre-12/5/1980 then will not assert a recovery claim but only with respect to liability settlement. Looking to develop language that would eliminate reporting requirement when clear that exposure ended before 12/5/80.
- Correction process, how will that work? Submission process is quarterly and that is when any corrections will be made. May be asked to resubmit a record on next quarter if unable to post. If looking to correct (add/update/delete) then that will also be completed in the following quarter. Each of the individual record will contain error codes for correction. Notification will be by email to confirm that file was received, but actual correction takes place on the file itself as submitted through the web portal. Make actual corrections on file returned.
- Reporting is a requirement separate and apart from any other preexisting MSP requirements.
- If beneficiary is deceased, then there is a separate field for representative payee.
- Holland America question – will there be any exceptions if injured in foreign country, which may later include some kind of settlement for "diminished cruise experience" that is considered a "good will settlement" –would they be an RRE and make a report? Description led them to believe that yes, Holland America would be an RRE, technically fits as liability self-insured situation but will take a closer look upon submitting additional information

III. Additional Open Door Forums/Closing

- Planning next teleconference for liability/no fault/WC planned for December 2008.
- 46 questions remained in queue at end of call, more Q&A sessions anticipated.

December 11, 2008

CMS hosted a third Open Door Forum Teleconference specific to mandatory reporting requirements for Liability Insurance, Self-Insurance, No-Fault Insurance and Workers' Compensation (CMS collectively refers to this group as Non-Group Health Plans with one shortened version being Non-GHP) this afternoon. The focus of the conference was to announce that an updated Interim Record Layout was published to the CMS web site on 12/05/08. The representatives indicated that many questions posed to date were addressed in this document and suggested that everyone read the language carefully.

Two main items of interest that continue to remain pending are the publishing of a User Guide and the determination of whether a Medicare beneficiary query function will be made available to Responsible Reporting Entities (RREs). Once the query function issue is finalized, CMS will then be able to continue development of the User Guide for Non-GHP. A document outlining compliance standards, more information regarding computer based training, and technical-only conference calls are also forthcoming, but it was made known that their efforts are currently focused on Group Health Plans.

One issue that seemed to resurface multiple times throughout the call was that of when a termination record may be submitted by the RRE. In instances where ongoing payment responsibility has been established, for example, in workers' compensation, if a claimant is no longer treating and the carrier closes their file, this does not necessarily mean that the CMS record should be closed. While the reporting obligation may be put on hold for as long as there are no changes in status or information, the CMS record should remain open as long as the carrier continues to have ongoing payment responsibility. The CMS representatives clarified that they do not assume that this means the RRE is making any type of guarantee of payment. It is only meant to be left open so that if a claim is submitted to Medicare for payment, the file is flagged and primary payment responsibility will be further investigated.

Another point mentioned during the teleconference with specific reference made to the 12/05/08 Interim Record Layout document was a determination that was made regarding the reporting of pre-12/05/80 incidents. This does not apply to workers' compensation; however, "CMS has determined as a matter of policy that it will not recover under the MSP provisions with respect to liability insurance (including self-insurance) or no-fault insurance settlements, judgment, or awards where the date of incident **as defined by CMS** was prior to December 5, 1980."

Finally, with respect to the frequency in which an RRE might be expected to determine whether someone is a Medicare beneficiary, the representatives mentioned that if a query function is permitted, then other programs are allowed to query an individual as frequently as monthly. However, there is no rule in place for how frequently the status of non-Medicare beneficiaries should be checked.

TELECONFERENCE NOTES

I. Welcome/Introduction/Answers to Questions sent via E-mail – John Albert & Barbara Wright

- CMS will soon release documentation re: compliance standards.
- Mail box issue – questions will not be answered on an individual basis. Info used to update posts and/or downloads on web page.
- Listserve problem for web page updated, notice of update out before document is actually posted.
- Many answers to questions can be found in 12/05/08 new record layout has substantial additional text that answers questions. Read document for full answers.
- Query function question, no answer as of yet. As soon as there is an answer an alert will be posted on the web site with specific instructions.
- Covers ALL types of no-fault and liability insurance, no detailed list of every insurance possible will be provided.
- CMS will host technical only conference calls to address those questions. Look at Group Health Plan pages for an idea of the types of materials that will be developed, such as computer based training.
- When response records are returned there will be disposition and error codes and some are marked with internal use only, then RRE only needs to resubmit that record without making any changes to it.
- How is CMS is going to handle required data elements when not available to the insurer? If you don't have the data element, if that record is submitted without then it will error out. May be some exceptions to start building a skeleton file, but complete information will be necessary and this does not eliminate your responsibility to report.
- Document control number: every record should have a unique document control number formulated by submitter. This will was originally 10 characters but has been extended to 15.
- If register but don't have an agent until later, then contact assigned electronic data interchange (EDI) representative and provide updated information to that person.
- How can an RRE apply for an extension and how will that be approved? When registration starts, that is when everyone should register. No provision for extensions, but developing a document that discusses compliance issues. CMS is more interested in getting a good, clean data exchange running. No blanket extensions will be granted, but possible extensions on a case by case basis MIGHT be possible.
- Can do testing without having all of the data. Testing environment is separate from the production environment. Registration and testing compliance periods are critical. Must register on portal when available in April 2009.
- RRE has TPA and TPA wants to use another entity to submit files, who should the registered agent be? TPA should still be registered as agent and TPA is viewed to be subcontracting with someone else.
- RRE does not have to report every claim for medical item or service when there is an ongoing payment responsibility, but when information on report changes, then updated report will be necessary. For example, change in attorney info.

- WCIO codes in record layout could not be accessed by at least one person. CMS rep was able to confirm that the link is accessible, but there is an alternative method to access. First, you can copy and paste link into browser. Otherwise, in search engine type in "WCIO." On home page, click Products link, at bottom there will be links to nature of injury, cause of injury and body part codes links.
- Section 111 reporting is separate and does not affect pre-existing responsibilities such as pursing MSA approval, requesting conditional payment amounts, etc. If there is a structured settlement, settlement in 2005, then report of continued periodic payments is not necessary. 07/01/09 date is for any settlement that takes place thereafter.

II. Open Question and Answer Session

- Page 12, 12/05/08 document re: when a file is closed. Caller asked when would CMS conclude that anything was ever closed with respect to WC case? What would actually terminate? Situation is where WC has obligation to pay but there has not been a claim in some time. CMS is using open record to help avoid conditional payments from being made when WC is responsible. Just because there hasn't been treatment in a while doesn't mean that the record should be closed. Reporting obligation would discontinue if nothing changes unless any information changes. May be nothing more than an initial record that puts it on the CMS system and then another that closes the record.
- U.S. Dept of Labor receives all information for long shore cases. Can these files be shared? No contact has been made.
- RRE should register in states where self insured. In states where they are not considered to be self-insured, then may or may not be the agent. If reinsurance is paying the self-insured, but not paying individual claims, then RRE remains with the self-insured. For example, Medicare beneficiary is in an accident, entity is self-insured for first $100K and reinsurance for the rest and supportable claim for $200K. If self-insured pays out $200K and gets $100K from reinsurance then only the self-insured reports, not the re-insurance.
- Only Medicare beneficiaries need to be reported per section 111. Does not change any other pre-existing obligations. Reporting is not triggered by MSAs.
- RRE question re: programs change year to year. Is re-registration as agent necessary every time there is a new policy? Yes, if there is a change.
- Slip and fall could involve multiple defendants and one plaintiff. How do all defendants coordinate so that all reported codes are the same, etc? Each RRE has individual reporting responsibilities but slight differences in the codes being reported are ok. No need to have matching reports.
- Record layout – if employer is self-insured but reinsurer is paying money to claimant, then who is RRE? Would like to further discuss. Traditionally responsible for paying self-insured entity who makes the payout so reporting responsibility would be left with the self-insured.
- On data element for nature of injury and body part required for liability records? Look to 12/05/08 document. Until 01/01/2011, if RRE can not furnish the codes, then there is an alternative to provide text. However, as of 01/01/2011, codes must be used.
- NCCI codes for body part, nature of injury and cause of injury. Can these be used? Will consider.

- If Claimant is Medicare eligible by family member or spouse, does family member's information need to be reported? Need Medicare information for the injured party when that person is the beneficiary.
- How do you report when liability is transferred to another agency? If ongoing responsibility is terminated, then termination record should be submitted. Apportioned cases? Percentage of liability? Report portion that RRE has responsibility for. If RRE has assumed responsibility to pay medicals on an ongoing basis, then they need to know.
- What is considered a late submission? If a single reportable event that would never occur again, then if not reported within first submission window then it's late.
- If as litigation continues and body parts are no longer established, then reported as change? Yes.
- Ongoing responsibility, in NY state unless section 32 settlement whether responsibility continues is a gray area on a case by case basis. Not asking that RRE guarantees payment on every claim, but that there is an ongoing responsibility.
- Any thresholds for reporting to be defined? Age threshold, still discussing but not likely to be implemented due to likelihood of younger beneficiaries being identified due to injury.
- Trigger for reporting, verdict, settlement or other payment. Verdict may not necessarily close the claim, when would reporting be if appeal or further negotiation? Still working to define.
- If there are discrepancies, or name, DOB, gender, then changes will be made from SSA enrollment files and considered the official info. Only way to update is if individual goes to the SSA if any info is disputed by beneficiary.
- Goal is to eliminate pay and chase efforts.
- When will user guide be finalized? GHP is the priority. As soon as there is an answer on the query access then other parts of the manual will be able to be completed. The user guide is the next step. The 12/05/08 document is the best source to date.
- Ongoing medical obligation but no medical is being paid, award prior to 07/01/09 – should report ongoing responsibility, see 12/05/08 document.
- Illegal alien, paying WC, they provide a false SSN. How is dealt with? If not being used by person it is being issued to, then when submitted it won't match and CMS will reply that person is not a beneficiary based on the information that was submitted. If can't develop to a record that does match, then record will drop out.
- Michigan is a limited lifetime benefit state. Every claim entered would stay for life of individual? Yes, these would remain open records so that Medicare denies the payment and checks with WC before the provider can bill Medicare. Don't need to follow claimants forever because they won't be treated after the date of death. For MI, will involve claims from 1972 forward. Need more discussion.
- Section 111 does not mandate MSAs of any type, nor does it address MSAs at all. Inaccurate information is circulating. Again, no pre-existing obligations have changed.
- RRE could be two RREs for both GHP and non-GHP.
- If technically have the ongoing payment responsibility, then have the responsibility to report when claimants become Medicare beneficiaries. Will need to check status periodically.

- 12/05/08 document, pg. 12, top pg. 13 addresses issue of date of incident prior to 12/05/80.
- Barbara will specifically talk to people about liability MSAs, but not available to discuss Section 111 issues, which must be submitted via email. Can call her with respect to liability MSAs. Most effective way to have answers questions is through email.
- Joint Powers Authority that manage claims and pay out settlements on behalf of a group of entities. Not an insurer and members are not self-insured, but pool monies together. Will company be the RRE or will each member need to register and then identify the company as the agent? Liability situation. Is pool licensed as the insurer – no. Allowed by statute to establish a joint powers authority where instead of paying premiums, they pay contributions. Manage medical malpractice claims. If not licensed as insurer, then need to look into this further.
- Date of incident – date of loss, insurance industry does not define date of incident the way that CMS does. Look at definitions in the 12/05/08 for clarification. Will always need the data per CMS definition.
- What happens if information is sent on people who are not Medicare beneficiaries? Record will just be rejected. If there are instances of "dumping" then they will look into that. RRE is responsible for determining Medicare status.
- Can the number of fields required be reduced? Information may not be sorted out in their systems but most information is routinely received. Submit comments if you believe any fields can be reduced and why? Goal is long-term coordination of benefits between Medicare and all other payers.
- How often should carrier contact claimants to determine whether someone has become a Medicare beneficiary? If there is a query function is allowed, then it may be allowed as frequently as a monthly basis. No rule for frequency of checking beneficiary status.
- If no assumption of responsibility for medicals, then no reporting necessary.
- 17 questions remained in queue; 650 call participants.

III. Additional Open Door Forums – As Posted on the CMS Mandatory Insurer Reporting website

- January 22, 2009
- January 28, 2009
- February 25, 2009
- March 25, 2009
- April 22, 2009

January 22, 2009

The highlight of this teleconference was the announcement that a query function for determining Medicare status will be made available to RREs. The query function may be tested by RREs beginning 07/01/09, but will be limited to 100 records.

Once in active production, each RRE will be able to submit one query file per month, but each file may have an unlimited number of queries. The RRE must provide a SSN/HICN, name, DOB and gender of an individual. If 3 of the 4 data elements match to the same individual, then CMS will return a file to the RRE that will include the individual's HICN as well as the correct name, DOB and gender as verified through the SSA database. One field that may not be incorrect is the SSN.

If the information submitted does not return a match, then the CMS response will be that there is no Medicare beneficiary based on the information provided. CMS recommends that the data of an individual who has not been matched be maintained in the RRE's query file to be resubmitted on a monthly basis.

TELECONFERENCE NOTES

I. Welcome/Overview/Answering of Emailed Questions – Bill Decker, Barbara Wright, Pat Ambrose

- Non-GHP User guide is still in process, aiming for February release.
- Can register and test without having real data. Don't delay registering or testing.
- Alert being released asking about interest in CMS participation in conferences to present on Section 111 Reporting. Accepting date requests.
- Alternate data code sets - no final determination has been made.
- Mass torts – currently an open issue on how they will be reported.
- Request for separate WC vs. Liability/No-Fault teleconferences; possible in future.
- Reporting requirements also apply to insurers outside of the U.S.
- If case is already closed as of 07/01/09 but ongoing payment responsibility, CMS is investigating how far back carrier must go to determine which claims must be reported.
- Threshold for reporting purposes? Meeting later to determine.

Pat Ambrose

- Authorized representative: employed by RRE – an agent.
- Each RRE will have one Account Manager – oversees day to day processing and account info.
- Account Manager can be employee of RRE or agent, or rep from TPA
- Account Designee – upload and transfer files; monitor statistics, can be from RRE, TPA or agent.
- RRE will come to COB secured web site and will provide info about the Authorized Representative. Authorized Rep will receive a PIN, which should be provided to Account

Manager. Account Manager then returns to the COB secured web site to continue the registration process. Once completed, system will generate a profile report and issue to the Authorized Rep via email. Authorize Rep will need to sign and return the report. Once signed up, may invite other individuals to become Designated Individuals permitted to oversee the process/access.

- Summary: If RRE is using a TPA but TPA contracts with another agent, then RRE sets up account by naming Authorized Rep from RRE and then name Account Manager at TPA, then Account Manager can name Account Designee, which would be their contractor.

Bill Decker/Barbara Wright

- Computer based training will be offered in near future. Training there now is directed at GHP; will not be helpful for non-GHPs.
- Many questions regarding types of insurance: includes any and all types of insurance at all that include claiming and releasing medicals.
- What happens if there is a change in RRE? Depends on terms of merger/acquisition. Very generally, ask that CMS be provided all updated information.

II. Review of Query Function

- Will allow query access to all RREs. Need to provide SSN/HICN, Name, DOB and gender of individual. If it can be matched to an individual, then will pass back a confirmation with most recent HICN that they have. If 3 of 4 characteristics match, then will correct the 4th item and pass back to RRE. Information will be matched with the SSA database.
- Provide software that will allow to transmit the file in HIPPA required format.
- SSN is still a required element. That is one element that will be required.
- If information submitted does not match, they will not “confirm” that the person is not a beneficiary but say that there is not a match based on the information provided.
- Look at GHP user guide for query-only process. Will not receive all Medicare data elements in the lay out, but it is a general over view.

III. Q&A Session

- Query function available to Claimants on mymedicare.gov that will show a claimant a conditional payment. This is not a final amount, and is not necessarily updated information. It is/may be published there once an amount is determined. Beneficiary must give attorney a password for review of a mymedicare.gov document.
- Agent will be able to submit files on behalf of the RRE for query function.
- Document control number? Unique to the quarterly input file, for matching purposes. Often use a date and record counter. How will each be uniquely identified for the life of the claim? RRE ID and Beneficiary IDs as well as by the DOI and type of insurance. DCN is used only for tracking responses and submissions of files. DCN is record specific rather than claim specific. Will RRE ID be required in input file on query function? Yes.

- Confidentiality clause in settlement? Confidentiality doesn't exist. 42 CFR 411.23/411.24. Requires beneficiaries to cooperate for purposes of COB efforts, deals with release of information.
- When register and set up account on COB web site, will indicate file transmission method. Claim input files and query files, can set up two different transmission methods for those two types of files. Account Manager and account designees will have the ability to up and download files by Connect direct or FTP. More detail in upcoming user guide.
- If the claim involves a product liability claim, then that information is reportable. Reporting is not dependant on a judicial finding. More info coming with mass torts discussion.
- Standard is to pursue recovery from the beneficiary, but when there is ongoing responsibility and if there is no settlement, then CMS may be pursuing recovery directly from the insurer. Demand will go to the address on the record, so the address given will be the one used.
- Once a query file has been sent and person comes back as not eligible, do they have to continue to check? If ongoing responsibility, then yes, these must be monitored in some form so that they can be reported when they become beneficiaries. Querying every month suggested.
- Can there be a safe harbor once a defined level of effort is met? Some claimants will not provide SSN. Working on answer.
- Will be able to begin testing query function after 07/01/09. Test files are limited to 100 records so won't be able to send in an unlimited number of test queries. Can send 1 file per month but there is no limit on the number of queries sent in that file.

IV. Additional Open Door Forums – As Posted on the CMS Mandatory Insurer Reporting website

- January 28, 2009
- February 25, 2009
- March 25, 2009
- April 22, 2009

January 28, 2009

The CMS hosted teleconference held today was strictly a session to clarify explanations and answer questions posed to the CMS representatives. Some points surrounding the query function were clarified, including that no information regarding a claimant's SSDI status will be returned. Further, the only CMS response will be whether or not a person can be matched to a HICN; therefore, someone who once was but is no longer a Medicare beneficiary would come back as a matching to a HICN. This should not affect a large number of claims. Finally, CMS recommends that all claimants be queried, even if 65 years of age or older, but if a file is automatically built and submitted for all claimant's age 65+ CMS will not consider this to be "dumping." On the other hand, if files are submitted for every Claimant without the RRE making an attempt to distinguish between those who are and are not Medicare-eligible, then this will be considered to be data "dumping" and will raise compliance issues.

Computer based training for NGHP is not yet available, but pre-registration is currently open. The CMS Mandatory Insurer Reporting site offers the following instruction:

If you are an RRE for liability insurance (including self-insurance), no-fault insurance, or workers' compensation, you may register for the NGHP CBT courses by contacting the COBC's EDI Department, at 646-458-6740. An EDI representative will take your company name, company type (e.g. liability insurer [including self-insured entities], workers' compensation, etc.) and the name, phone number and e-mail address for the individual(s) you would like to register. Once the COBC has processed your request, you will be registered. The NGHP curriculum is not currently accessible, but registrants will be notified automatically as soon as NGHP CBT courses are available

TELECONFERENCE NOTES

I. Welcome/Overview/Answering of Emailed Questions – Bill Decker, Barbara Wright, Pat Ambrose, John Albert

- User guide in process, release expected in February.
- Review of Query Function, previously discussed 01/22/09.
- Review of previous discussion: How to Register for Section 111 – on COB web site. Begins 05/01/09. Prior to registering must decide how you will submit files. Limited to submitting one claim file per quarter. If two lines of business, such as auto and WC, may register twice and obtain two RRE IDs.
- The RRE has a TPA processing claim; the TPA is delegating the file transfers to another agent. Authorized Representative is with the RRE, Account Manager with the TPA and then Account Manager/TPA can name their agent for file transfer as an Account Designee.
- Process for recovery have not changed.
- Reporting is required regardless of whether there has been a determination of liability. If settlement, judgment or other award, then reporting is necessary.

- Threshold would be solely for compliance with section 111, IF they choose to impose a threshold.
- Date of incident – must use CMS definition; might differ in cases of exposure versus trauma, but must report the DOI under CMS definition.

II. Q&A Session

- Excess carrier involved, does self-insured report in first time period, and then does excess carrier need to also report? Depends on how payment is being made. If Excess Carrier paying directly to the claimant then must report, but if making payment to the self-insured, then no.
- In query function, will not notify if someone has applied for SSDI, only if a current Medicare beneficiary.
- One query per month per RRE ID.
- Query function will return HICN if person is, or was ever a Medicare beneficiary.
- Field 77 – ongoing payment responsibility termination date. If you are reporting claim with RRE ongoing responsibility for medicals (ORM), two reports are required. Initial report and ORM indicator will = Y. During that period of time, do not need to report on claim again unless there is a material change. When ongoing responsibility ends, then send an update record. On the second report the ORM indicator should still = Y and include ORM termination date. Even though it has ended, the second record is still reported with a Y. Possible to report both ongoing responsibility and termination date in the same file.
- Can both the RRE and agent use the query system? Will accept one query file per month per RRE id. Who may submit that file? Any associated user may up or download the file.
- If there isn't a product liability claim yet, does the field have to be completed? Product liability info is needed to make sure there is not duplicate recovery and to process faster and more efficiently. If it hasn't happened, then don't report on it. Not asking for RRE to determine if there is a possible claim, but only identify if there is a products liability claim.
- Closure of file may be due to inactivity versus closure due to order to close. If there are any other reasons to close a file, please notify CMS for consideration.
- Will discuss to see if they can release Medicare entitlement date along with query function.
- Although NGHP RREs may register in May 2009, system may not be equipped to handle production query inquiries until July 2009.
- Must have a continuing query on an injured individual. Example: 25 year old with wrist injury, Carrier responsible for lifetime of medical care, but not likely to require any further treatment. Must benefit status be queried monthly for 40 years? Answer: technically, yes.
- Can we assume that all individuals 65+ are eligible and build a file to be submitted, or would that be a compliance problem? CMS recommends querying everyone regardless of age. It's ok to submit everyone over age 65, no compliance problems there.
- Compliance with reporting does not resolve any other obligations.

- Response file is returned to the person who submitted it. Any user of the COB secure web site will have access to the mail box. Transmit file back in the same method that it was transmitted to CMS.
- RRE Registration period will remain open indefinitely.
- When would the delete action used? Rarely. If claim was sent completely in error, then delete action would be used. CMS does maintain a record of deleted files.
- User manual will have more instructions for registration. Once web site is up, there will be help links. There will also be computer based training courses for registration.
- Can pre-register for training as soon as NGHP programs are available.

III. Additional Open Door Forums – As Posted on the CMS Mandatory Insurer Reporting website

- February 25, 2009
- March 25, 2009
- April 22, 2009

February 25, 2009

Today CMS announced that the User Guide will likely be available within the first two weeks of March. The User Guide will finalize many issues including: a final decision on the coding to be used in reporting; an interim reporting threshold; definition of a clear look back period for identification of Medicare beneficiaries with claims for which an RRE continues to have ongoing payment responsibility; and examples regarding the reporting of minor injuries when the insurer by state law has ongoing responsibility for medical payments. Updates to the User Guide will be published as Alerts on the CMS Mandatory Reporting web site and then incorporated into subsequent revisions of the User Guide. The focus of the next teleconference, 03/25/09, is anticipated to be Q&A regarding the User Guide.

Additional teleconferences are planned to address issues specific to workers' compensation and liability/no-fault individually. An additional call to address registration issues is anticipated to occur in early May.

TELECONFERENCE NOTES

I. Welcome/Overview/Answering of Emailed Questions – Bill Decker, Barbara Wright, John Albert

- Conference attendance requests/speaking engagements – speakers have limited availability but numerous requests, so they will set up additional teleconference events. Separate for WC and then another for Liability/No-Fault. These are anticipated in April. Another call re: registration issues expected in early May.
- User Guide for NGHP reporting will be released within the first two weeks of March, before next teleconference.
- Final determination on codes will be provided in User Guide.
- Interim reporting threshold will also be announced in User Guide.
- How far back will RREs need to look for claimants with ongoing medicals where cases are internally closed? User Guide will address this issue.
- Examples of when to report and what type of action
- Examples of 'minor injuries' that technically have open medicals pursuant to state law. Ex: hand sprain
- Joint powers authority – tentative language is going through clearance process
- Mass torts – meeting in March for further discussion
- User Guide will not address ALL issues, but additional info will be posted as alerts and incorporated into subsequent versions of the User Guides
- WC has been primary to Medicare since inception of program, so DOI does not affect reportability for WC.
- Non-compliant employers for WC when State Funds are responsible for future medical – language for this will be in the User Guide or an alert shortly thereafter
- Questions regarding number of records: when reporting, report on a beneficiary by beneficiary basis and ALSO report by type. If Medicare beneficiary that is being paid liability as well as no-fault, will send 2 records on this individual, not 1.

- Confusion re: term Claimant. Where injured party is a Medicare beneficiary. Use claimant field where beneficiary is deceased, then claimant may be estate, family member or other. Will not typically complete the claimant information.
- Defense verdicts: tweaking prior language. Judgment was that no award, claim denied. Clarification is that this must be a judgment that results in payment. If no payment, then no reporting.
- Technical reporting issues – Almost all questions will be addressed in the User Guide. Will have additional calls after User Guide is released if questions remain.

II. Q&A Session

- Reporting threshold clarification – (interim) will be a dollar threshold.
- If you don't accept responsibility for ongoing medicals then only report once you reach settlement/judgment/award. If an appeal, then there will be no determination until the appeal is complete.
- Can an RRE have a separate account for the query function alone? Each RRE ID has an obligation to report. Will not grant RRE IDs solely for the query function.
- Obligated to go back as far as necessary to identify claimants to check whether they are Medicare beneficiaries, will clarify time period in User Guide.
- E&O claims reportable if medical payments are being made, but what if E&O policy excludes coverage for bodily injury but claimant is seeking medical? Requested that question be sent in email to be answered.
- Turn around time on a query? – a couple of days, at most.
- What is the best time to query? This is an individual decision, but recommended before settlement to allow enough time to meet reporting requirements. Even if not a beneficiary prior to settlement, recommend doing one additional query to confirm that status has not changed as of date of settlement/judgment/award.
- Reimbursement only coverage of the insured, this is not an RRE, correct? If entity A purchases policy and entity B only pays entity A, then no, entity B does not need to report. However, if entity B pays directly to injured party, then yes, must report.
- Not receiving a HICN on the response file does not ensure that the individual is not a Medicare beneficiary. Only if you have a clean input record.
- Captive insurance companies – for purposes of registration you can treat that as a parent and subsidiary so parent company can act as RRE for subsidiaries.
- Product liability field – still working on language for this. Virtually everything involves a product, so language is being refined.
- No early registration. Once registered, the EDI rep will attempt to accommodate RRE preferences for production schedules.
- The claim and/or the release determines whether or not a claim needs to be reported. Just because the award is limited to pain and suffering doesn't mean that it doesn't need to be reported if the intent is to compensate for medical.
- Every RRE is expected to test, but if one vendor is submitting based on many RREs, then testing will be limited, but expect test for every RRE is necessary.
- If parent company with subsidiaries, can choose to have only 1 RRE for all, but may break things up if that is the preference.

- Average testing cycle is probably about 2 weeks. Will specifically test all functions; add,delete, etc.
- Paying claims but only wage-loss and no medical, then do not need to query/report? Looking at language to address various parts of WC. Will be specific call for WC after User Guide comes out.
- The only time you will fill in the claimant field is when the beneficiary is actually deceased.
- Once reporting begins, will EDI rep be main point of contact for questions about reporting? Answer: hope that all answers will be clearly answered in the User Guide. Mail box for mandatory reporting will remain open.
- Timing of running queries is up to individuals, but caution not to query too soon as status may change. Advisable to keep person in query file. Also, should double check as of the date of settlement/judgment/award. If initial query one month before settlement/judgment/award, should do a follow up query. Have a 45-day window to give RREs the opportunity to do that.
- Assume that many entities will query as soon as the claim is filed. Warning is that sole query can not be relied upon. In cases on ongoing payment responsibility, ongoing query should be performed.
- More details regarding good faith efforts in reporting will be released later.

III. Additional Open Door Forums – As Posted on the CMS Mandatory Insurer Reporting website

- March 25, 2009
- April 22, 2009

March 24, 2009

This teleconference focused on the information published within the NGHP User Guide Version 1.0 published 03/16/09 and the Alert with updated information published 03/20/09. Additional issues continue to be researched and when resolved, answers will be published in additional Alerts and/or updated versions of the User Guide.

Of interest particularly for states that require life-time of open medical, a special exception for reporting termination of Ongoing Responsibility for Medicals (ORM) has been published. An RRE may submit a termination date for ORM if they can obtain a written and signed statement from the treating physician that no further treatment/services will be necessary. If the situation changes in the future then the RRE will need to submit an update record. A limited look back period has also been established. If ORM was assumed prior to 07/01/09 but "the claim was actively closed or removed from current claims records prior to January 1, 2009, the RRE is not require to identify and report that ORM under the requirement for reporting ORM assumed prior to July 1, 2009." However, once again, if subject to reopening then it must be reported with the original date of injury.

With respect to the 03/20/09 Alert, it was specified that although the extended testing period is permissible, if testing is successfully completed in time for reporting in the 4th quarter of 2009, then RREs are encouraged to do so.

Data continues to be collected and analyzed but the interim reporting thresholds were set based on their current data set. They indicated that in Total Payment Obligation to the Claimant (TPOC) for liability/self-insurance/WC, the first $5,000 threshold currently effective through 12/31/10, will eliminate 80% or more of an RREs reportable claims. The estimated that a threshold of $10,000 would have eliminated more than 90% so that is why the $5,000 interim threshold was established. RREs should not report anything under this threshold; if reported, an error report will be returned. It was very clear that the thresholds are subject to change.

<u>TELECONFERENCE NOTES</u>

I. Overview of New and Important Issues – NGHP User Guide and 3/20/09 Alert

- Items not in user guide, still working on mass torts, bankruptcy, insolvency, adding additional examples of RREs, model form.
- Must use CMS statutory definition of self-insurance, whether or not there is a formal plan of self-insurance.
- Must also use CMS definition of no-fault insurance. Further, liability insurance is ALL liability insurance. State liability programs are liability insurance.
- For purposes of this reporting CMS definitions control, not state law. Even if medicals remain open in a state, ongoing responsibility does need to be reported in order to assist in stopping inappropriate payments.

- Deceased beneficiaries, if beneficiary during reportable time period then need to be reported.
- States with lifetime no-fault benefits but settlement releases future medical, yes it is reportable.
- Multiple incidents within the same claim, two distinct accidents. If they have their own dates of incident then need to be reported separately.
- User Guide – Covers complete file layout, explains query function, detailed registration information, expands definition of RRE, expanded information regarding what to report and when (what triggers reporting) addressed look back period for ongoing medicals limited to situations that are open as of 07/01/09 or later. p. 51 of User Guide.
- User Guide – final decision on code set ICD-9 for now to ICD-10 in future. Allow for limited use of text for a limited period. After time period then codes must be reported. CMS is reviewing codes to determine if any are prohibited, will not consider codes that translate to "unknown."
- Extended permissible period for testing through the 4th quarter of 2009. Required date for go-live production files is 1st quarter of 2010.
- Software not available until RRE registers.
- Interim Reporting Thresholds – have not ruled out raising the thresholds for ORM in WC. $5K eliminates 80% or more of an RREs TPOCs reportable claims.
- ORM = confusion about whether paying TPOC means assumed ORM at some point. Generally, ORM concept is that the entity is going to pay on an ongoing basis when claims for medical are submitted. If only paying one sum, then it is likely to be a TPOC situation.
- Who is reported as the representative of a living beneficiary if there is an attorney and a guardian? CMS would like the attorney to be reported.
- Policy of paying pending investigation and investigation results in denial, yes, report during investigation and then close when denied.
- All TPOCs reported regardless of whether ORM remains open.
- Is MSA included as part of TPOC? Yes.
- Death benefits to dependents. If this does not release medicals with respect to the beneficiary does not need to be reported, but if it does, then it should be.
- If a policy excludes medicals, but if the settlement has the effect of closing out medical regardless, then it does need to be reported.
- Developing computer based training. Will announce on web site when training modules are available.
- Section 8 of User Guide – steps to take prior to Registration. How will you submit your files? This will determine how many RREs will need to be registered. For example, if you decide that you need to submit 3 different claim files each quarter, then you will need 3 different RRE IDs. This might happen if there is more than one claim system. Might also be if contracting with different agents.
- Authorized representative signs profile report and has ultimate responsibility for adherence with reporting requirements. Authorized rep will not likely be a user, but is ultimately accountable and overseeing at a higher level.

- Account manager is the person who is a user on the COBC secure web site. May be an agent or employee of RRE themselves. Organizational decision. Main contact with COBC. If several RREs, may use the same person or several individuals.
- Account designee has a log in ID and password for the site. Must be invited by the account manager to be associated with that account.
- If Multiple RREs may use same TIN or separate, choice per organization.
- After account manager has log in ID and set up account, then can invite other users to the RRE ID account, the account designees and can perform all of the functions of the account manager.
- Account manager has an option to manage designees, needs their email addresses.
- Account designees will receive an email with a secure token that will lead back to the site to allow for registration with the account.
- Account designees on log in will see a page listing all of the RREs that they are associated with.
- When to delete vs. update section 11.5.4
- 12.3.2 – Threshold Errors – don’t expect many delete transactions for NGHP so if 10% of total records are delete, that puts them on notice to see if something is wrong.
- If reasonably not expecting having anything to report, but do need to register a full quarter before you anticipate having the need to report.
- None of this applies to MMSEA 111, but …overwhelming number of questions regarding WCMSA process - voluntary process that is highly recommended. CMS for liability MSAs does not have the same process but regional offices may decide to review.
- If you can register and test and begin live production, then as of 10/01/09, please do so. Not required to wait until 01/01/2010.

II. Q&A

- Thresholds dated as of 12/31/2010, based on minimal data. Legislation does not include minimum thresholds. May adjust as additional data is provided.
- Qualified Exception, p 52 of User Guide. Will be required to report if subsequently reopened. If paying a medical bill every now and then, even if internally considered to be “closed” it is not considered to be closed by CMS. Closed when can guarantee that no longer making further payments and no possibility of reopening, however, will accept evidence from a treating physician that there will be no further treatment. CMS is affording the opportunity to close some records in that case, but must be reopened if condition changes and payment resumes. Purpose is to close wrist sprain in a state with lifetime medicals.
- If condition changes/worsens, then add new ICD-9 codes to the record.
- Will solely use ICD-9 codes.
- Multiple TPOC dates and amounts. If another update is sent how can it be specified that the update is for TPOC 1 or 2? No answer for this right now.
- Agent, but not registering RRE, how do you obtain software? Must wait for one of agent’s RRE to register.
- Can document control number be included on query response file? Will not have DCN until after reported so this will not be available for query file.

- 19 ICD-9 diagnosis codes on the record and 1 cause code that is ICD-9. This number is just to be consistent with internal CMS files, which allow for up to 20. They realize that it is not likely that there will be this many per record.
- If attorney or other rep info changes, update needed? Refer to 11.5 in user guide for changes that require update to record.
- Nothing has changed with any conditional payment recovery processes.
- If open in records, then should leave in query files to continue to follow benefit status.
- Error codes published are the only codes that could be received. Should design system around User Guide.
- Authorized representative email – must be an email address specific to that individual, cannot be a general email address. Will not be many emails sent to the authorized rep, but account manager will get copies. Cannot use generic email addresses for the account managers either.
- Document control number does not need to be maintained throughout history of entire report. It is only used for each individual submission and response. Will match incoming record to response record. No ongoing tracking. If submitting update, it will be the RREs choice to use the same DCN or a new one.
- For annuities, p. 111 – base TPOC on the time period used in calculating the payout or the minimum payout amount, whichever is the larger amount.
- Can under threshold be reported? Please adhere to the thresholds reported and preference is that RREs not report anything under the threshold.
- User Guide will be updated to add error messages for reporting outside of the threshold.
- Record lay out may be available in excel format, but compliance issue. May be able to as long as it is also available in pdf. Will check into it.
- Records submitted in error are not considered when determining whether there was a timely submission. If not enough information to submit, there is no point is submitting. Can’t submit partial info and add additional information later.
- Agents to perform the query vs. agent for production? One RRE ID may have multiple users who can upload and download files, may also have multiple users who FTP by file type. Every user that is associated with the RRE ID is allowed to use the ID for file transmission. One person from one company could be invited to be an account designee for queries and another person from another company could be invited for production purposes. So yes, two agents from two separate companies could be use
- Unrelated issue – if there are any MSPRC questions – msprc.info
- 1,045 on call. 37 questions in que.

III. Additional Teleconference Events

- 04/09/09 – WC only
- 04/21/09 – Liability/Self-Insurance/No-Fault
- 05/12/09 – NGHP Registration Issues Only
- 05/14/09
- 06/09/09
- 07/14/09
- 08/18/09

April 9, 2009

This teleconference was held to specifically address the concerns and questions of MMSEA mandated reporting of workers' compensation claims.

The web portal for registration is currently active for group health plans, and although NGHP RREs may not register until 05/01/09, the site is available for preview at www.section111.cms.hhs.gov. Simply accept the user agreement to be provided access to MMSEA information. There is a "How To" menu that may be of interest to RREs preparing for registration. CMS representatives also announced that computer based training courses should be published next week.

A new Alert was posted to the MMSEA web site and announced on the call. The Alert, dated 04/07/09, addresses reporting multiple TPOCs. File layout has been modified to include four additional TPOC Amount and Date fields to provide flexibility in reporting multiple TPOCs; a total of five TPOCs may now be reported. This is accomplished through the Auxillary Record, which only needs to be used if an RRE has an additional claimant to add due to death of a Medicare beneficiary or if there are multiple TPOCs to report. Of note, once an Auxillary Record is submitted, it must continue to be included on any subsequent update or delete reports for that claim.

CMS has received additional data which they are analyzing to determine whether increased thresholds for workers' compensation ORM claims may be raised from that last published in the 03/20/09 Alert.

TELECONFERENCE NOTES

I. Welcome

- Web portal is currently successfully accepting registration for group health plan RREs.

II. Overview of new and important information

- Registration will be available beginning 05/01/09. May visit home page to view materials regarding registration: www.section111.cms.hhs.gov
- Will be displayed a log in warning, accept and then will be able to view the How To Get Started information.
- User Guide specific to the COBCSW available, but must first obtain a user id and log in before viewing.
- Next week will publish first computer based training courses for NGHP
- New Registration Button – click for registering RRE and authorized representative begining 05/01/09. Authorized representative will be an executive of the RRE and will ultimately be held accountable for compliance. Authorized rep will never be a user of the COBCSW.

- COBC will validate registration information and send letter with PIN to authorized representative. Must give PIN to Account Manager.
- Account Manger will take PIN to COBCSW and click Account Set-Up button – must be completed by the Account Manager, who will obtain log-in ID and password.
- During account set-up, will assign file submission time frame and provide information on file submission options. Can not save a partially saved registration. All data will be lost if not complete, but should only take 15 minutes to complete.
- NIAC code must be provided, if do not have one then enter "00000"
- How many RREs depends on the number of claim input files that need to be submitted per quarter. If different geographical locations, then might be easier to register RREs for each location if unable to combine systems. May use same authorized rep and account manager for each RRE, or may separate as necessary.
- Do not have to register a separate RRE for each separate subsidiary if submitting for all through one claim input file.
- No limit to the number of RRE IDs, but recommend limited to the fewest number possible.
- After 05/01 account set-up, then will email a profile report that must be signed by the authorized rep and returned to the COBC. Once COBC acknowledges receipt of report, status will be changed to testing status. Then after 07/01, may begin submitting test files. After passed testing phase, status will change to "production status" but active production can not begin prior to 10/01/09.
- Production claim input file first required beginning 01/01/10.
- May process query files in last quarter of 2009.
- ORM once set to a "y" always remains a "y" – if ORM terminates the submit update record with ORM as "y" but include ORM termination date. Update record submitted, not a delete record.
- If erroneously reported ORM, then a delete transaction applies.
- Multiple claims for same individual should be reported separately.
- 45 day grace period for reporting ORM – once ORM is assumed, have 45 days to determine whether claimant is a Medicare beneficiary and reporting is necessary.
- Example: Report 1st ORM, Report 2nd when partial settlement amount provide update report with ORM "y" as well as TPOC date and amount, Report 3rd ORM "y" and provide same TPOC date and amount and also include ORM termination date.
- Will attempt to assign agents reporting for several RREs to the same EDI rep. Agent will have separate reporting time frames for each RRE. Those can not be combined by agent.
- When deciding how many RREs to establish, keep in mind that every RRE ID must report quarterly, even if nothing to report.
- Disposition code 50 – rare scenario. Send same record that sent before. If something has changed in the meantime, then submit most current information.
- Gaps in error codes provided in User Guide is intentional. Reserved for future use.
- With respect to SSN matching, as long as information submitted is or was valid then it should match with their system. All names associated with SSN should be This would apply to name change situations.

- NEW ALERT POSTED: MULTIPLE TPOC REPORTING - Instead of reporting the 2nd TPOC in TPOC field, in auxiliary space have added ability to report additional TPOCs and update.
- Threshold for ORM – questions seem to indicate interpretation that threshold is on a bill by bill basis; this is not correct. ORM threshold is a total for all claims.
- Have received additional data and may be able to raise $600 threshold for ORM reporting. Analysis is continuing.
- Authorized representative can not simply be a general position. Individual must be identified.
- May only use ICD-9 coding at this time. When change to ICD-10, will give advanced notice prior to change. Code set determination is final.
- If closed for Carrier/RRE's records prior to 01/01/09, then do not have to report ORM unless become active again.
- Whether a trust or a pool, the criteria of identifying the RRE would be the same.
- Texas –Question regarding non-subscribers. Anyone who has a plan, if what they are purchasing is liability insurance then will be reported as liability, if self-insured then reported as liability insurance, if defined as no-fault then report as no-fault.
- More information re: mass torts and products liability information continues to be pending.
- Judgment above policy limit? Any time judgment above policy limit is considered self-insurance and must be reported as such.
- Offshore captives are not exempt.
- Cases settle for fees and costs – if clearly settle for fees and costs only then may not require reporting, but still discussing. Bigger issue for liability.
- Working on the model form and hope to release by the end of the month.

III. Question and Answer Session – Workers' Compensation

- Testing is by RRE ID, it does not have actual claim information. Real data will be submitted only during active production phase.
- Occupational disease claims, problem is that first exposure date is unknown.
- Query process – how is last name handled with space or hyphen? When last name is submitted, it is matched based on exactly as submitted. Should enter exactly as claimant has provided name to Social Security.
- NY WC - 3rd party liability settlements, go into credit taking position. During that period they no longer have ORM. How should that be reported? Report the termination during credit taking period, but then report update if ORM resumes at a later date.
- Must check claimants who live outside of US as well.
- ORM in a state with lifetime benefits. Will there ever be a termination date? If there is a statement from the treating physician that further medicals are not expected, then can submit termination record.
- Need to keep data from separate RREs segregated.
- Cumulative trauma claim – exposure to job is not what CMS means by exposure – they mean exposure to a substance. CTS example, "not when they first started to type." Distinguish between occupational diseases vs. cumulative trauma.

- Penalties – if fail to report during appropriate window, can the report as soon as omission is realized? No, must wait for next quarterly submission window. Would they be penalized $1K/day between missed file and next reporting period? No policy yet.

IV. Additional Teleconference Events

- 04/21/09 – Liability/Self-Insurance/No-Fault
- 05/12/09 – NGHP Registration Issues Only
- 05/14/09
- 06/09/09
- 07/14/09
- 08/18/09
- 09/30/09
- 10/22/09
- 11/17/09
- 12/15/09

April 21, 2009

CMS hosted a teleconference this afternoon specific to liability/self-insurance/no-fault insurance RREs. Other than the announcement that computer based training modules are now available for NGHP, no new information was provided. Please contact me if you have any questions.

TELECONFERENCE NOTES

I. Welcome

- May 12th call limited to registration issues.
- May 14th call will be open to all NGHP questions.

II. Overview of new and important information

- Registration process – COBSW will be available for NGHP RREs to register on 05/01/09. Do not register early. www.section111.cms.hhs.gov ; accept log in warning; view home page. Under "How To" Menu see helpful information published there.
- Computer based training modules are available on www.cms.hhs.gov/mandatoryinsrep. If any questions about what info is needed prior to registration, take these courses to find out.
- Name authorized representative (executive in organization) at the time of registration. Agreement must be signed by the authorized representative.
- Authorized rep is never a user of the COBSW.
- Will be assigned EDI rep. If registering for more than 1 RRE, may request that all IDs assigned to one EDI rep.
- If make mistake at registration, contact EDI rep.
- Authorized rep will receive a PIN via USPS.
- PIN should be given to account manager.
- Account manager should return to COBSW and enter RRE ID and PIN. File submission time frame will be assigned at this time. Not based on when you register, but based on answer RRE gives to number of claims paid (strictly an estimate to give an idea of the size of the files that will be submitted). If register for multiple RRE IDs, could be assigned different submission time frames.
- Will email profile report to account manager and authorize representative. Authorized rep must sign profile report and return to the COBC. Once received, status will change to testing.
- How many RRE IDs might one need? No prescribed number or method. Depends on the number of separate claim input submissions an RRE needs to make per quarter. Each RRE may only submit one per quarter. If more practicle to submit two claim input files per quarter then will need two RRE IDs. May have separate

RRE IDs for different lines of business, but this is not mandatory. Do not need separate RRE ID for each subsidiary, but may have separate.

- If multiple RRE IDs, may use the same account manager; may use same TIN or separate TINs.
- An authorized representative can never be the same person as the account manager.
- No limit to the number of RRE IDs that you may register for, but for everyone's purposes, the fewer the better to ease management of accounts.
- Multiple TPOC Alert 04/07/09 – 4 additional TPOC date and amounts have been added to the auxillary record. Use the TPOC on the claim input first, do not need to submit auxiliary until additional need to be reported. In order to report additional TPOCs, send an update transaction action type 2 and include additional TPOC amount on the auxiliary record.
- 03/20/09 Alert – includes information on extended testing time frame and reporting thresholds.
- List of Acronyms has been published, will be available through computer based training and later added to the User Guide.
- Although emails regarding status will be sent to account manager, emails are not necessary. All users may log in and access status info on COBCSW.
- CMS will publish a list of ICD-9 codes that cannot be used for reporting. CMS will transition to ICD-10 codes in 10/2013.
- Disposition codes 01 or 51 will be returned on a Query. Will never get a 50.
- Disposition code 50 – will receive in rare cases on Claim Response File. This occurs when COBC does not finish processing claim input file within 45 days. When a 50 is received, resend in following quarter with any additional information. Previous record will complete processing; next record submitted will be treated as an update. WILL ONLY HAPPEN IN RARE CIRCUMSTANCES.
- ORM indicator and ORM termination date: Normal course of reporting, ORM indicator is set to a Y. When ORM is terminated, send an update record with 2 action type and ORM indicator should continue to be Y. On update provide ORM termination date.
- If initially reported ORM of Y, but later find that is incorrect, then that is the only time you would send a delete record with the Y and an add transaction with N as indicator.
- ORM with indicator Y = RRE has or at one time had ongoing responsibility for medical. Used for Medicare to avoid primary payment. This indicator is key to processing. Once on, it remains on unless erroneously reported and never had ORM. Even at termination date, leave Y indicator on.
- Testing time frame: from receipt of signed profile report until the first day of first production file submission period. Even after set to Production status, may continue testing.
- Even though HICN may change from time to time, CMS will always be able to match new and old. Request that this be used in lieu of SSN when available.

- Changing agents needs to be completed by RRE by changing information on COBCSW. No accommodation made by CMS. Will not be able to obtain a set of previously submitted claim records from CMS.
- Invite public comment on mass torts and product liability. Submit suggestions on how mass tort should be defined to mailbox. For product liability, looking to narrow down what is considered a claim that involves product liability. Any definitions may be submitted.
- Consider eliminating product liability fields for WC? This is still under consideration.
- When ORM stops with TPOC, are ORM payments also included when reporting total TPOC amount? NO. ORM $ amounts are not reported.
- If paying while under investigation then RRE still needs to report at ORM, when investigation is over then report termination of the ORM.
- TPOC – how is this structured? Single payment obligation regardless of how payment is structured. If an annuity, then report the total anticipated payout amount, not the cost of the annuity (unless for some reason the cost to purchase the annuity is greater than the payout, then the large of the two options will be reported)
- Hearing loss claims must be reported even though Medicare does not generally pay for these claims. This is because there may be associated costs that are payable.
- TPOC = payment to or on behalf of the beneficiary. If paid $100K to a provider, obligation is not eliminated if made on behalf on provider. However, if ORM, then not reporting those individual payments.
- Do not ignore payments made for services not payable by Medicare. Bottom line is where any medicals are claimed or released, then need to report.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- State of venue: strictly where the loss happened? CMS response is to use best judgment. If have a question on a recovery claim, CMS will go to the beneficiary's attorney to clarify.
- Query files will first be able to be submitted in a test mode July-Sept time frame and in Production mode after October.
- CMS is not bound by the allocation of the parties when paying settlement. CMS has priority right of recovery. If the injured party is a beneficiary but a majority of the settlement is paid to spouse for loss of consortium, then Medicare may assert priority right of recovery. CMS is not bound by the allocation of the parties. Will look to recover claims. RRE has the responsibility to report, CMS will not change recovery process.
- Once register as an RRE MUST report every quarter, even if it is an empty file.
- When error codes are returned, what response is appropriate? If for example, a threshold error, then reporting will be in a suspended state until resolution. Will work with EDI rep in coming to resolution. For a severe error, only option is to

delete the file but will continue contact with EDI rep to determine course of action.

- ORM closed prior to 01/01/09. Prior to 01/01/09, if administratively closed then NO LOOKBACK. Between 01/01/09 and 07/01/09 must look to CMS definition of closed, not internal standards/administratively closed. May need to report ORM and termination of ORM in same report.
- Assembling a group of example fact patterns with answers which will be published.
- In most cases, CMS has determined that the entity that bought the fronting policy was actually self-insured per CMS definition, but fact patterns vary…this is not to be a final determination.
- If need to add an additional RRE after 06/01 if the need for another RRE arises, may register then.
- If no need or expectation or reporting, then do not need to register right away, but within enough time for when they anticipate a reporting need.
- If RRE has 3 subsidiaries and want to include them under the parent company RRE, then when register the parent company, the subsidiaries should be reported with the registration.
- At registration will ask for total claims, not total reportable claims. Just an estimate.

IV. Additional Teleconference Events

- 05/12/09 – NGHP Registration Issues Only
- 05/14/09
- 06/09/09
- 07/14/09
- 08/18/09
- 09/30/09
- 10/22/09
- 11/17/09
- 12/15/09

May 12, 2009

CMS hosted a teleconference this afternoon specific to registration and technical issues regarding file and record layouts as well as data exchange. A Quick Reference Guide for Registration is also in queue to be published on the MMSEA Mandatory Insurer Reporting web site.

An important announcement was made in that the implementation timeline has changed and will be published on the MMSEA Mandatory Insurer Reporting web site, by Alert, with a projected publish date of Wednesday, May 13, 2009. Information should be confirmed when published; however, as reported on the call the dates are as follow:

- The new registration period is 05/01/2009 – 09/30/2009.
- Testing of Query Files may begin 07/01/2009.
- Testing of Claim Input Files will be delayed until 01/01/2010 – 03/31/2010.
- Live Production may occur as soon as RRE has completed testing phase and is changed to production phase if Production status is achieved by the RREs assigned reporting window in the 1st quarter of 2010.
- Live Production must begin as of the 2nd quarter 2010 reporting period 04/01/2010-06/30/2010.

Please note that if already registered, or registering in the near future, an RRE will likely be assigned a reporting window in 2009. CMS representatives have advised that RREs disregard this reporting window until 2010. The COBCSW should update accordingly.

Another extension is that TPOCs prior to 01/01/2010 do not need to be reported. Again, more information is pending in an Alert which is expected to be published tomorrow.

TELECONFERENCE NOTES

I. Welcome

- Specific for registration and technical questions. Representatives from COBC are present on call.
- 05/14/09 will be call for policy issues.
- Computer based training modules are available for NGHP
- Refer to User Guide as primary source of information, some answers on teleconferences may seem to conflict; refer to User Guide for final word.

II. Technical Issues (registration, file and record layout, and data exchange mechanics)

- IMPORTANT ANNOUNCEMENT by Barbara Wright. Document in queue to be loaded to web site. Have changed implementation timeline.
- Registration period extension May 1, 2009 – September 30, 2009

- Delay in testing period for claim input file. All RREs must submit live production for April – June calendar quarter for 2010. Testing will now be January 2010 – March 31, 2010. Can submit live production file in 1st quarter of 2010, but not required.
- Query function – can be available as soon as July 1, 2009 as long as completed registration and are in testing status. Query input files will be accepted.
- Exception re: TPOC reporting dates – Section 111 will not include TPOC with dates prior to January 1, 2010.
- Do not have to report any TPOC with date prior to 01/01/2010. Includes when considering a combined total. Actual details will be set forth in Alert to be posted by tomorrow.
- What's new page – only two calls this month are today 5/12 and Thrusday 5/14. In process of scheduling additional technical calls. Will be 2 calls per month. One policy and one tech.
- Revised implementation timeline will be published.
- Quick reference guide for Section 111 Registration. Will be posted soon.
- Pat Ambrose: www.section111.cms.hhs.gov
- NGHP User Guide – refer to section on the registration process. Also on COBCSW on How To option, there are several tips related to registration process. Also help pages on every page within registration process.
- Computer based training – Overview page – left side and click MMSEA Computer Based Training and follow instructions. Must enroll. No charge for CBT.
- Account manager must complete the account set up step. First time will obtain log in ID and password, so it must be performed by the Account manager. If named incorrect person, then contact EDI rep.
- To change file transmission method, contact EDI.
- If registered for RRE that isn't needed, then contact EDI to discontinue RRE ID.
- Registration process will remain open for future RRE reporting needs. Can add additional IDs later.
- During new registration must provide info re: subsidiary companies under RRE ID. If subsidiary is not involved in reportable business transactions, then need not be listed.
- TIN – for each subsidiary must be provided and must be different than TIN for RRE. All TINs for RRE and subsidiaries must be different. May bypass this page if having difficulty for initial registration, account manager can return later to complete.
- Can use same TIN for MULTIPLE RRE IDS, but different within each RRE ID (for subsidiaries)
- TIN must be associated with the applicable plan. No need to address every TIN that may be used.
- 8.1 of User Guide – no expectation to report for Section 111.
- Posting Quick Reference Guide for Registration –

- RRE IDs are assigned during the new registration process; same RRE IDs are to be included on the files submitted; must complete account set-up for each RRE ID. Number of RRE IDs depends on number of files that must be submitted per quarter.
- Everything done to comply with Section 111 mandatory reporting will be completed by RRE ID.
- Not required to obtain RRE for each subsidiary, but must if each is handling own reporting or separate claim input files
- Not required to obtain RRE for separate lines of business, but may if separate systems are being used for reporting if that suits individual reporting methods.
- Multiple RRE IDs may be assigned to same EDI rep. Contact any one of the EDI reps and request reassignment of all RRE IDs to one EDI rep.
- Query function is only available via query input file.
- Information is only returned if there is an actual match 01 if matched 51 if not matched. 51 = will not identify what information is incorrect. Need SSN/HICN to be correct plus 3 out of 4 of the following – first initial, last name, DOB, gender.
- Query input submitted once per calendar month but do not have to be 30 days apart. Once submitted in any given month, can not submit again until the 1st of the next month.
- Submit queries after assuming ORM and/or after TPOC date. May query before that time but if receive a negative response, then should continue to check. Can not guarantee that they will not be eligible by time of settlement. Important to recheck.
- Test query files limited to 100 records.
- Will be processed on a daily basis; commit to a 1 week turn around.
- Will be adding an acronym list with next version of the User Guide.
- Test beneficiary data test set will be provided at a later date for test input file data. Test beneficiary data will not be available for test query files. To test query file process, look for injured parties over age 65 to more likely to get a hit in the Medicare data base.
- How many error codes can be returned for the submission of one record – room for up to 10 error codes.
- Field 73 is to be used at discretion of RRE – to identify different office locations.
- Are transactions case sensitive? No.
- No fields for injured parties contact information. Do not need contact info for Medicare beneficiaries, b/c already have that info.
- What if more than 4 claimants to report per record? Only have room for 4; note that the claimants should be those other than the beneficiary or the injured party. If multiple claimants who are Medicare beneficiaries who are injured parties must be reported separately.
- Individuals who have only one name or spaces imbedded? Matching names against what appears on the Social Security Card or Medicare Card. Submit name exactly as written on SS or Medicare card.
- Testing period 07/01/09 for query and 01/01/10 for claim input files. Test files are processed nightly.

- Authorized representatives do not receive day to day communications; those go to Account Manager. Authorized rep only gets a profile report, or possible email that CMS has not received signed profile report, then any errors regarding timely submissions. Emails re: test and production status only go to Account Manager. Emails re: not submitting a file on time will go to Authorized Representative and Account Manager. Email re: threshold errors, etc. will only go to Account Manager.
- May pick different transmission methods for query files and claim input files.
- Can RRE submit monthly query files themselves and then use an agent for claim input files? Yes.
- All User IDs associated with RRE ID will have the capability of transmitting files.
- Can RRE change agent after registration and before testing? Yes. General info provided during set up can be changed subsequently. Can add or remove an account designee at any time.
- Must adhere to the reporting thresholds. Do not report claims under threshold.
- Is there a lag between the time someone is Medicare eligible and assigned a HICN. Will it show up on query right away? HICN and Medicare coverage start dates are established in advance of Medicare coverage effective date. Can be assigned a HICN before benefits are effective.
- John Albert – Disposition 51 – CMS will not identify which data elements are wrong. Don't want to risk providing an erroneous result. That is why so many data elements must be matched an unable to return response of which are incorrect.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Liquidation company under state control – would state be the RRE? Have not finished working out policy; this is policy question but will not have answer by Thursday.
- RRE might have multiple TINs. If so, all that is required is one TIN. On separate databases, might have other TINs associated. Can submit claim files with different TINs to direct to the appropriate databases.
- Agent may have 1 log in ID and password with connection to multiple RRE IDs. Once associated to RRE ID, agent can log in and all RRE IDs associated with will be listed. Will be able to monitor all from one log-in.
- Test query files may begin as of 07/01/2009; once pass testing requirements, the system will turn the RRE ID from testing status to production status.
- Production may not begin before 01/01/2010. February 2010 will be the very earliest live production file can be submitted; but not required at that time.
- Account designee – must be an actual person, should not be a distro list email. Should register each individual. Absolutely required due to security requirements.
- In reality, the Account Manager may complete first part of registration naming Account Representative; but Account Representative needs to sign off on and return profile report via mail before Account Manager can complete part 2 of registration.

- Register as soon as RRE has all necessary information and understands how files will be submitted. At that time will be assigned time frame for Production Claim Input Files. Can send as many test files per month as want or need; Production queries can only be sent once per month; Claim Input Files once per quarter during submission window.
- Initial assignment of EDI representatives is random, but if there is a need for common EDI reps amongst multiple RREs, just contact one EDI rep to request that all be assigned to same rep.
- Registering early doesn't mean that you'll get an early submission time frame. It's based on number of claims expected to be reported.
- If registering now RRE will see assigned submission dates marked for 2009; can ignore those and the system will be updated. Will be same range of dates in 2010.

IV. Additional Teleconference Events

- 05/14/09
- 06/09/09
- 07/14/09
- 08/18/09
- 09/30/09
- 10/22/09
- 11/17/09
- 12/15/09

May 14, 2009

CMS hosted a teleconference this afternoon to address policy and procedural questions surrounding Section 111 MMSEA Mandatory Insurer Reporting.

A Quick Reference Guide for Section 111 Registration has been published on the Mandatory Insurer Reporting web site. This includes quick tips for registering one RRE, multiple RRE IDs, obtaining one EDI representative for all RRE IDs and determining how many RRE IDs are necessary based on the reporting plan.

An Alert dated 05/11/09 has also been published on the Mandatory Insurer Reporting web site. As previously announced on the 05/12/09 town hall conference call, there is an extension of the registration period and a delay in the testing/live production periods, outlined as follows:

- The new registration period is 05/01/2009 – 09/30/2009.
- Testing of Query Files may begin 07/01/2009.
- Testing of Claim Input Files will be delayed until 01/01/2010 – 03/31/2010.
- Live Production may occur as soon as RRE has completed testing phase and is changed to production phase if Production status is achieved by the RREs assigned reporting window in the 1st quarter of 2010.
- Live Production must begin as of the 2nd quarter 2010 reporting period 04/01/2010-06/30/2010.

Another extension is that TPOCs prior to 01/01/2010 do not need to be reported. Dates associated with reporting of ORM have not changed. [When ORM was assumed prior to 07/01/09 and continues as of 07/01/09, the individual must be reported. If ORM was assumed prior to 07/01/09, CMS continues to grant an extended delay in reporting until the 3rd quarter of 2010, in order to allow the RRE additional time to identify all reportable individuals. In instances where a claim which technically has ORM is actively closed or removed from the current claims records for inactivity prior to 01/01/09, the RRE is not required to report that claim unless it is later reopened and ORM continues, at which point the initial date of injury must be reported.

CMS is also working on model language which will be published on the Mandatory Insurer Reporting web site. This language should be used by RREs to demonstrate their good faith efforts to obtain a beneficiary's information to allow for confirming benefit status. Additional information regarding the process to be used will be released with the language. There is currently language available for group health, but this should not be use for NGHP.

TELECONFERENCE NOTES

I. Welcome

- Bill Decker – Brief opening today to allow for questions.

II. Policy Issue Questions Submitted via Email/FAQs

- Barbara Wright – Quick Registration Reference Guide is now available. Don't use link on What's New page, so please refer to NGHP page for downloadable version.
  Alert that changes implementation timeline for NGHP. Extended registration through 09/30/09 – can still register now. If no reasonable expectation of having anything to report, then no need to register now, but if situation arises in the future expect to register 90 days before any anticipated reporting to allow for testing. Testing will begin in 1st quarter of 2010, if testing completed early enough in quarter and reporting date has not passed, then may report in 1st quarter. Live production will begin 2nd quarter of 2010. Query function available as of 07/01/09 if RRE has registered and in testing status by that date.
- TPOCs prior to 01/01/2010 not reportable. Reporting dates associated with ORM have not changed.
- If 3 TPOCs before rising above the threshold, 3rd date that causes total to rise above threshold controls timeliness for all 3.
- Revised Implementation Timeline is in the queue to be posted on the web site.
- Model form for NGHP will be published. Do not use GHP form.
- Funding delay field is only reported if the start of the funding is delayed. Not delayed if TPOC is through a structured settlement if just because payments are made periodically.
- Do not deduct attorney fees and costs from TPOC amount.
- Documentation for termination of ORM – is a standard discharge report enough? If the discharge report indicates that the person needs no more treatment, then that is fine; but, if no indication regarding need for care then that isn't necessarily enough.
- ORM – confusion about TPOC connected to ORM. TPOC amount is calculated without consideration of ORM. Do not calculate sum or ORM payments as part of the TPOC amount.
- Pool fund members, if some members are administrative only members, can pool be the RRE for those members? No. Essentially pool only processes claims.
- Will announce at a future date when switch to ICD-10 will occur.
- Qualified exception for ORM – ORM assumed in 2007, RRE had under standard practice closed the record prior to 01/01/09, but still have responsibility b/c in lifetime medical state. In this situation they do not have to report it as long as there is no further action. If ORM assumed in 2007 and still open on records, then do have to report. If ORM opened on or after 01/01/09, then do need to report and can only close pursuant to state rules, or if physician's statement that no further treatment will be required.
- Structured settlements where minimum payout is $0 – how is TPOC amount calculated? Must report the minimum payout OR the time period used in calculating the costs of the annuity (expected payout), whichever is greater.
- ORM is not used in terms of a final future payment under a structured settlement. ORM is used when RRE has CURRENT ongoing responsibility.
- Example given of short term ORM, only 15-20 medical bills will be paid. Without more info, seems that this is ORM for short term and reportable.

- Generally no-fault will be reported as ORM until exhausted or evidence of no further treatment. Or TPOCs.
- Email stated that Social Security Administration has a service that allows employers to check employee SSNs. CMS has no comment on this other than to follow any SSA user agreements.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- TPA is funding the losses or payment losses. If insured has a TPA that it uses to pay deductibles on its behalf to the injured party then the insured would be the RRE for that particular deductible payment.
- Amount above the deductible question. Basic rule is when insured is making payment to the insurer for the deductible and then the insurer then pays the injured party then the insurer is the RRE for both above and below the deductible. Looking into making the insurer responsible for all reporting. Also looking at flip that would make the insured the RRE for both above and below the deductible. More guidance forthcoming.
- If there is no deductible, then the insurer will normally be the RRE.
- High deductible definition – no reason why there wouldn't be the same process for low or high deductible. Real issue is b/c deductibles are self-insurance, how are they will be handled.
- Model form – not really a form, but model language to use that would potentially offer a safe harbor if completed.
- When the insurer makes an award/settlement, if structured settlement stipulates the annuity, then to be clear, the RRE is the insurer but need to report TPOC based on minimum payout of annuity, or expected benefit based on time period used to calculate the annuity.
- Punitive damages are a part of the total TPOC amount.
- Plaintiff doesn't have any reporting responsibility under section 111, so CMS will not draft section 111 specific instructions for plaintiffs. No prior obligations have changed. Should continue to report to COB when there is a pending case and/or contact MSPRC for conditional payment amounts.
- Clinical trials – no settlement reached, however, payments being made to that person for complications arising out of clinical trial. Working on language specific to clinical trials.
- Internal hospital write offs – working on final wording to clarify. If patient falls out of bed and complains of hip pain, hospital takes x-ray to confirm no injury but then $1K itemized charge on the account. Provider will likely bill Medicare for a DRG amount, not specifically the x-ray from the fall. Is this a write off? Not billed but in the end, paid b/c of DRG payment. More info coming.
- ORM – at what point is ORM assumed? For auto accidents. Report ORM as soon as accepting liability, in a situation where a medical bill is paid as part of the investigation, that is not considered ORM or TPOC, don't need to report it. TPOC does not automatically mean a settlement. Need to report ORM as soon as RRE knows that they will pay bills, not based solely on the fact that the first bill is paid. ORM for WC has a threshold that they are looking at raising.
- WC deductible. Insurer is still required to pay 1st dollar but is reimbursed by the insured. Endorsement does not change insurers obligation under WC law. TPA may go to insured

for funding within deductible layer and to the insurer for the excess. Who has the contract with the TPA? Often the insurer has the contract with the TPA, so then insurer would be the RRE.

- Can't comment on possible fines. To eliminate risk for noncompliance, register and follow steps along timeline.
- 12/05/80 exposure claims – date of incident question. Exposure refers to actual exposure as opposed to ingesting something that stays with them for years, exposed as it remains in the body. Does example refer to actual exposure? Exposure to the substance, when exposure from the outside source ceases, the exposure ceases. With gel implants removed prior to 12/5/80 and no rupture then exposure ended prior to 12/5/80, but if ruptured then exposure was felt to continue. Exposure language will be tightened up.
- Attorney fees paid directly to attorney included in TPOC? Most liability insurance situations = entity settles with Doe for $100K, from which Doe pays attorney (no attorney's fees are deducted from TPOC regardless of whether insurer cuts 2 checks). If there is a separate settlement situation where settle with Doe for $100K and will pay attorney fees above and beyond that $100K, then only report TPOC as $100K. This will typically apply to WC where attorney is paid directly. CMS will complete a pro rata reduction of attorney's fees and costs that are actually borne by the beneficiary.
- Traditional insurer uses another company's paper in another state. Insurer that handles and pays the claims is the RRE and not the company on whose paper it's written. Entity X needs fronting insurance, purchases fronting policy but fronting policy never pays anything, the purchaser pays all of the claims. Then the purchaser is in fact the RRE. The company which never has any intent to pay claims is not RRE.
- P. 19 of user guide – Joint Powers Authority - if you have to obtain the member's consent then the member would be the RRE.
- If the only cash that is being paid out is through structured settlement and the annuity is purchased by the insurer, not independently by the beneficiary post-settlement - if payout doesn't start for 6 months then that is the delayed payout date should be reported. TPOC date should still be the TPOC date as defined, but delayed funding would be included if beneficiary does not receive payment for 6 months. Only use check date when there is no written settlement agreement. Use date payment obligation was established by written agreement. Date of first structure payment would be included as when payment was delayed (if that is the case).
- Query files are only as good as the information on it. Developing model language for soliciting language from the potential beneficiary. Demonstrating attempts may provide somewhat of a "safe harbor" although that is a term that he hesitated to use. Will show attempts to obtain that information. What is liability if have incorrect information? This is why CMS is working on model language. Will discuss when model language and process is released. This will demonstrate that the RRE made a good attempt to obtain the information. Beneficiary is obligated to cooperate to coordinate their benefits with Medicare
- If individual refuses to provide SSN, then please await model language.
- 1,040 callers.
- In process of setting up additional technical town hall calls each month for NGHP.

June 2, 2009

Only technical issues were addressed in this call. One significant announcement was that an updated User Guide is being complied and will be released within the next several weeks.

Also of note, although the system is automatically generating emails to registered RREs notifying them to begin testing, these emails should be disregarded due to the revised implementation timeline. Test beneficiary information for the purposes of test files will be provided in Fall 2009.

CMS stated that they are also continuing to look at ways to limit the number of RREs reporting on one claim so that both the deductible and above deductible amounts can be reported by same RRE. Further direction in this regard will likely be published in the next version of the User Guide.

TELECONFERENCE NOTES

I. Welcome

- Section 111 web site has complete listing of all teleconferences through the end of the year.
- Only technical issues will be addressed.

II. Technical Issues

- Implementation schedule review for NGHP. Timeline is on the CMS Mandatory Reporting web page.
- Registration is open for NGHP. Has been extended to 09/30/09. Registration will always remain open in the event that there is a new RRE or need for additional RRE IDs
- 07/01/09 – COBC will begin accepting test/production and query input files.
- 01/01/10 – Testing for claim input will begin. Once testing complete, will accept Production claim input files.
- 2nd quarter of 2010 – first reporting.
- Query file testing begins 07/01/09
- Claim file testing from 01/01/2010 until date of initial claim input production file is required in 2nd quarter.
- Testing for claim input file may be 3 months or more.
- If testing multiple RRE IDs using the same source or system. Test with one RRE ID first and once pass testing for that RRE ID, then submit subsequent test files for remaining RRE IDs (may submit same test files)
- For those using X-12 translator – companion guide is posted to NGHP page 270/271
- HEW software is available for query process from EDI rep. Windows version will be posted to the web site for download.
- Query process changes are being considered (no live date as of yet) adding fields for claim no./tracking/doc control no. Also, may be changes to HEW software.

- Documentation for development is posted on mandatory insurance reporting web page. In addition to User Guide see also 03/20/09 Alert, 04/07/09 Alert, and 05/11/09 Alert.
- Updating reporting User Guide as soon as possible (probably several weeks from publication)
- Sign up for computer based training modules. Go to web page and click on MMSEA 111 computer based training. Instructions will be found there. Process overview, registration and account set-up, FAQs, Query process and basic File Format.
- May sign up for CBTs prior to registering. Do not need RRE ID to sign up for CBTs.
- Changes of profile report have been made. (No. of covered lines removed, replaced with No. of claims)
- CMS will allow for separate agents under same RRE ID. Not necessary to include all agents info during account set up.
- Secure FTP – Section 111 reporting COBC is using its own data center (not CMS data center). Use the User Guide Documentation and companion guide for secure FTP file transfer info.
- May use any secure FTP client/software that may be available.
- No file naming standards for uploading to FTP.
- Separate directories for test and query files. Make sure send to the proper directory.
- Each test query file must be limited to 100 records, may submit multiple test query files.
- If ORM limited to specifically defined condition, is mechanism in place to ensure Medicare will not deny payment outside of scope of accepted condition. CMS uses the diagnosis codes/text of injury (for now until diagnosis codes are required) so important to be as specific as possible about the particular defined condition.
- Empty claim input files p 40 & 55 – if no new info to supply on a quarterly update file – once an RRE ID has gone to production status and nothing to report at file submission time frame then send empty file. In any quarter where nothing to report, then send empty.
- RRE is registering and naming agent – may RRE submit query and agent submit claim input file all under same RRE ID? Yes.
- Availability to alter reporting structure at a later time? May always alter by adding or discontinuing the use of an RRE ID. To discontinue, must make request through EDI rep.
- Secure FTP – require COBC secure web site log in and password as stated in User Guide.
- Send deletes only when a record has been sent in error. To change a key field, send a delete record to remove and then send an add record. Right now info is correct in User Guide, but will clarify.
- User Guide will update to further define diagnosis code field using an assumed 2 decimal position.
- Test beneficiaries will be provided in Fall 2009 prior to claim input testing. Will post file for download in a pdf. And txt. Format. Claim data will not be provided. Guide suggests that real claim data be used for testing, but may fabricate data and that is acceptable.
- Will require both attorney name and attorney's firm when reporting? Changes in User Guide to accept either firm or individual attorney name; will not require both.
- Subsidiaries that have closed or been sold, but still paying on a claim for that subsidiary. Should claim be reported under old TIN or current? All claims should be reported with TIN of entity has current responsibility to pay claim. TIN on claim file is what counts,

not the TIN at registration. TIN at registration is for authentication of entity, TIN on claim file is for identifying parties for possible recovery process.

- How first and last names should be submitted on the claim input file and query file? Submit as it appears on SS or Medicare card.
- Will account designee and account manager receive an email when query response file is available? Will be sent to the account manager only. All users associated may log into the COBC secured web site and check on status, but emails will only go to account manager.
- Does the authorized representative have to complete the registration? May delegate the new registration task as long as they provide all of the authorized reps info during the registration. However, authorized rep must sign and return report to COBC. 2nd step of registration, account manager must complete that step of registration themselves.
- If one carrier is both a no fault and a liability RRE, it's possible to have a claim falling under both no fault and liability - should be submitted as 2 separate add records, maintain each as separate records.
- COBC receives info on Medicare eligibility and enrollment well in advance of actual Medicare eligibility. As of date of eligibility, query file will match.
- Data that changes but is not considered to be significant. Please see event table in User Guide. For example, attorney info changing does not require update record.
- Sample data use agreement is on Profile Report; also in section of User Guide.
- RREs required to report on Medicare eligible who do not elect to receive benefits? 01 response indicates that individual is or was covered by Medicare. No need to make a distinction between eligible or enrolled.
- Default zeros when do not have info – questions asked, will be clarified in updated User Guide.
- Submit a file beginning on 05/08 – do not need to include claims with settlement or TPOC date of 05/01. 45 day grace period – see User Guide.
- TPA #1 is transferring claims to TPA #2; if claim pending at time transfer taking place, how does transition take place? Assume TPA is agent on behalf of RRE. Second agent can maintain records of first agent. Can not provide info to RRE or agent re: claims previously submitted. However, 2nd agent may update records originally submitted by a different agent.
- Can't use RRE ID only for query files; each RRE ID must also submit claim input files.
- Automated email notifications have been going to RREs who have registered. Those regarding beginning testing should be disregarded due to new implementation timeline.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault – Technical Issues

- Sedgwick CMS will support up to 1,000 RREs. Have had agent registration issues. Is there any way to correct large problems that may span large numbers of RREs? Problems with agent info supplied during registration. During account set up step, account manager is asked to provide agent TIN. TIN will match to those already in a list and will display the information if found, if not will need to enter manually. If entered incorrectly, then will show up on the searchable list and incorrectly on subsequent registrations of same agent.
- If an RRE changes agents, within a month, only 1 query input file would be accepted despite the possibility of having 2 agents within same month. RRE will need to coordinate efforts between agents in providing agent 1 query data to agent 2.

- When response code is returned is the definition of code clear? On query process there will only be a 01 or 51, no error codes. No additional information will be provided. On claim input file, if there is an error code – disposition code will identify the specific error.
- User Guide is being updated to identify more specific emails that will be generated by the system. Day to day emails just go to the account manager and not the authorized rep. Only email or letter to authorized rep & account manager might be a warning, for example that file is late or has not been received (compliance issues).
- Each user must have separate and distinct email address.
- PIN – first position was a zero (no longer working). When entered using leading zero, it was as if it wasn't there. Now PIN is locked and unable to complete set up. Contact EDI rep to reissue/reset.
- If SSN and HICN are both available, should send both in query file? CMS will take both. On query response will supply back current HICN as Medicare has it on record.
- RRE with long list of subsidiaries – if going to report on behalf of all of them, is listing of all required? No, not required. Asking for that info, but not a requirement. More so for CMS to f/u to make sure that all RREs who should be reporting are registered and reporting. In terms of reporting data, it's the proper TIN that's required.
- If register WC and liability departments separately – would need 2 RRE IDs. May combine claim info and report under 1 RRE ID if they chose to do so if data from each department can be managed through 1 system.
- When registering a new RRE (no claims until go live in 09/09) – how do you estimate number of claims? Zero? No – give an overall claim estimate, best guess is fine.
- TIN for subsidiaries – can you use TIN for parent company only without deciding which subsidiary is applicable? Yes. As long as TIN is for RRE for that claim, then parent co TIN is acceptable.
- Field 64 in record lay out – self insurance indicator. How is this utilized for a claim that has multiple RREs? Large deductible – RRE is insured who is funding deductible but settles above? Answer is being developed in RRE examples. If reporting under separate RRE IDs, then in the deductible/self-insured report would be turned on, in the second report for 2nd RRE, self-insured indicator would not be turned on. Not final answer because looking at ways to limit the number of RREs so that both the deductible and above deductible can be reported by same RRE; expect reporting only under policy. NOT FINAL.
- Can disregard the voluntary data sharing program data.
- Don't include hyphens when reporting SSN or HICN.
- Once CMS receives data, they will assume responsibility for security of that data.
- Field 81 – no fault insurance limit insert all 9's if there is no dollar limit.
- Account designees can upload and download files – don't receive email notifying that response file is ready but may log in at any time and will be displayed the RRE listing page and actions that may select. Option will allow account designee to see status of responses.
- Attendees – 305

June 9, 2009

The biggest issue repeatedly addressed was how wage loss payments will be reported, especially given their frequency. CMS is leaning toward requiring a quarterly reported TPOC for wage loss. This would include the total of all wage loss payments made over the course of the quarter. However, as the call progressed, additional information was provided. It seems CMS is not truly interested in the bi-weekly wage loss claims except to the extent that some members of the industry have advised that they only pay wage loss and have no ongoing responsible for medical. CMS has interpreted this to mean that there is in fact medical, but it is being incorporated with that wage loss payment – why else would wage loss be paid? They stated that they would like to find a way to exclude reporting of wage-type payments, especially in cases where RRE is also reporting ORM, but need to develop a clear rule. If there is a state law that requires acceptance of medical if wage loss is paid, then they stated that those particular states may be exempt from reporting wage loss but the statues should be emailed to their mail box for review. Further guidance in this area will be forthcoming.

Additional pending issues include: determining the RRE in cases of bankruptcy; clinical trials (language currently in clearance to be released); reducing the number of RREs for above and below deductible situations; potential ORM threshold increases for workers' compensation; reporting hospital write-offs; reporting foreign addresses and telephone numbers; providing a list of ICD-9 codes that will not be accepted; providing a 'deactivation' option for RREs that register but have nothing to report (in lieu of submitting 'empty' files quarterly); and limiting language for mass torts/products liability reporting.

CMS also expressed preference for a HICN over a SSN and suggested that this number may be easier to obtain from an individual. By enrolling in the Medicare program the beneficiary agrees to comply with Medicare's coordination of benefits efforts, therefore, they suggest that RREs take this angle when collecting data. Model language to assist in this data collection process is also pending.

TELECONFERENCE NOTES

I. Welcome

- NGHP reporting for Section 111 – Policy Only call
- SSN – how can these be collected? Primary identifier is the HICN, need this number rather than any other number. Can send SSN with additional identifying information, but preferred is HICN.

II. Policy – Introductory Remarks

- Profile reports – currently system is only sending email with profile report to the authorized rep and not the account manager (oversight on CMS' part). Changing system this weekend. After change, account manager will also receive a copy.

- Agent information – supplied during account set-up step on COBCSW. When entering TIN, do no provide dashes in that field. If another RRE has also entered agent's TIN, once entered then the info will be pre-populated. Some mistakes in data entry. If problem is noted, then contact the agent and have agent contact EDI dept to have that info corrected. EDI rep only needs to change once and it will then be updated for all RRE IDs who have entered that TIN for their agent.
- June 2, 2009 call – takes 2 weeks for transcript to post.
- Status of pending issues:
- Bankruptcy/litigation issues – working with industry and internal meetings. Will provide rules for determining whether an RRE.
- Clinical trials language is in clearance right now
- Large deductible/deductible plans (not final) but looking to minimize number of RREs. If insured or insurer pays both above and below deductible then payor will likely be the RRE.
- Employment discrimination cases- must be reported if claim or release medicals.
- Potential ORM increases to WC threshold – still pending.
- Hospital write-off actions – will be meeting with industry.
- Multiple representations – what if conservator as well as attorney? In those cases the attorney should be the representative.
- Foreign addresses and telephone entries – language/change in clearance.
- Indemnity payments for WC – are these TPOC or ORM? Expecting to conclude that they must be reported as TPOC but looking at frequency. Problem is the number of entries to report, don't want bi-weekly so looking at issue.
- What does "other payment" mean? This is meant to be a catch-all.
- Attorney fees/costs – if there is a settlement and the claimant is expected to pay fees and costs out of settlement then report the gross amount. If the attorney fees/costs are paid separately and apart from settlement with the beneficiary, in that case only report the settlement amount.
- Once register, must submit null or void files for quarters where there is nothing to report. Looking at option to "deactivate" rather than submitting void files.
- Invalid ICD-9 codes – codes that do not give any information should not be used. Will provide a list.
- December 5, 1980 liability/exposure issues. Inquiries have focused on perceived legal exposure. CMS is looking at physical exposure. Working on language to clarify.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault – Policy Only

- Husband physical injury, wife loss of consortium. Settlement includes release of all claims. Report full amount and make clear of how it has been apportioned among claims (although CMS is not bound to that apportionment).
- Discussing work loss in the context of no-fault vs. WC. Normally make monthly work loss payments. CMS is looking to minimize the number of work loss payments. Looking to total each quarter's work loss payments in quarterly file submission (not final).

- Protection and indemnity clubs. Basically indemnity insurance – members pays settlement or claim before club reimburses. Assume that the member is the RRE. Rule to pay to be paid policy in which club pays directly. In that case would club be RRE? Submit question to mailbox and will consider information.
- CMS does not reply to mailbox inquiries individually. Pull together all questions and use them to expand list of rules/concepts. Expect to put out draft Q&As for comment before eventually being put in User Guide. Will be posted on Section 111 web site.
- If beneficiary is deceased and check paid to more than 4 claimants. At this point only up to 4 can be reported so report maximum for now. CMS taking need for additional under advisement.
- Member of a JPA who JPA pays claims, so they are the RRE but the member registers as an RRE, how does member unregister? If erroneously register for RRE ID, or if have one but if no longer needed, then contact EDI rep to be placed in discontinued status. With respect to JPA – look to requirements in User Guide. Some situations where members may be the RRE rather than the JPA.
- If RRE has separate TIN for WC and Liability, they can register once with one TIN and get one RRE ID if submitting both lines of business together. Can use multiple TINs on claim input/TIN reference file.
- If there is more than one NAIC, just use one.
- Texas non-subscriber programs – not traditional WC program. Do not fall under WC. Under TX state law, entities are prohibited from indicating that a non-subscriber program is WC. Must report as what it is. Need to analyze what is being provided, in many cases it will be liability, in others it will be no-fault.
- Not in habit of changing file submission timeframes but if extraordinary circumstances, then EDI rep might be able to change.
- Weekly indemnity payments to be TPOCs. WC Carrier sends a check each week – if this is the case, is each payment a separate TPOC? Info from industry as a whole is that these payments are not always limited to wages. May also include medical. Statute requires that CMS not defer to the allocation to the parties so as of right now they are looking at this as though it must be reported as a TPOC. At most would likely be once per file submission (quarter). If clear enough definition, would like to find a way to exclude wage type payments from the reporting process in general. Situation is that WC pays wages but is not paying any related medical. Because of that, CMS does not think it makes sense that wages are accepted but there is no medical. If can ensure that these are clearly wages, then CMS would like to be able to eliminate the wage payment.
- If under state law, will always be reporting ORM if also paying wages, then CMS will look at this as a way to possible eliminate reporting of wages for those states that might have these or similar laws. Submit info to mailbox for consideration.
- Does account manager have to be an employee of the RRE? Up to the RRE. Account manager does not have to be an employee of the RRE. Can be an agent or TPA. On the other hand, may have agent be account designee. Account manager should be person who is responsible for day-to-day activity.
- In CA, can have a situation where doctor has determined no further treatment but provided disability award (ability to compete in the marketplace). However, in this situation RRE has also reported ORM.

- Issue is when WC has stated that there is no ORM at all, just wages. CMS doesn't feel this is a likely scenario. Stated that they don't have a problem with not reporting wages where ORM is also reported, but as of right now can't find a way to distinguish between those RREs who are and those who are saying that there is no ORM, and are paying wages only. Need to work though to see if there is a way to not require TPOC reporting for wages if ORM is reported.
- Do not pay medical bills on a denied claim but then at settlement, in disbursement of funds, will pay past denied payments. Not ongoing, but repayment of past. Medicals disbursed to providers are disbursed from the total. In this case, report total as TPOC, not ORM.
- If pay 1 medical bill as a courtesy at the time of denial, but claim remains denied? Sole payment should be reported as TPOC.
- Liability claim settlement – TPOC but also have scheduled medical release that allows for payment of additional medical bills for specified amount for specified period of time after settlement. Agree to make payment if demand made that meets criteria following settlement. How would this be reported? If someone has a valve replacement within X yrs, then get an additional $ - in those situations, those are reported as additional TPOCs (CMS has additional recovery rights). New example, TPOC of $1K to settle plus up to $5K in medical benefits submitted over 6 mo period of time – this is ORM. Even if have not made ORM payment, as soon as responsibility is assumed, should be reported. Complete closing report after scheduled release is finished.
- If reporting under TPOC threshold, will be rejected with an error.
- Railroads – FELA – if medicals are being paid by insurance program separate from FELA (and assume that program is reporting as RRE) do also have to report future pain & suffering/lost wages? If releases medicals, then must report part 2 as well.
- PA WC – TPOC – biweekly payments. When report TPOCs, is the date of the agreement or the date of the payment? Look at User Guide. If settlement approved by court, vs. signed only, vs. check issued with no settlement then date of check.
- Fatal benefit, no medical paid for any beneficiaries. Indemnity only, would never be medical. If that is a provision of state law then that should be emailed to the resource mailbox for consideration.
- Advance payment requirement for liability claims (Montana) – must advance medical payments until settlement. Would advanced payments be ORM? Paying medicals while pending, then yes, ORM. At final settlement if there is additional cash payment then that is a TPOC. Are advanced payments subtracted from settlement amount? Yes. Then answer is–Don't know. Need to discuss to give consistent answer for reporting.
- More than 19 ICD-9 codes on a claim? Then only include 19. Include primary first.
- Auto insurance in FL, business in multiple states. In Texas they are a MGA (managing general agent, doing business in TX on another carrier's paper). MGA issues are still being looked into and will be answer. Submit specifics to mailbox.
- If refuse to give HICN, then remind beneficiary that law requires cooperation with CMS to allow CMS to properly pay claims on behalf of that beneficiary. Working on additional information to be provided.
- To use query function, is a release needed? CMS perspective – no. Anyone who is a beneficiary, along the same line of reasoning, that they have agreed to cooperate with CMS – position is that they have in effect given permission to release.

- WC – does CMS consider uninsured employer funds to be an RRE? Should be covered in User Guide – Yes.
- Second Injury Funds – no medical benefits paid by state agency; PPD paid by SIF, would SIF be RRE? Submit question in writing. Probably yes, but would like to further consider.
- Mass tort claims – processed through MDL (multi district litigation) and/or asbestos claims – any updates? CMS is looking for work group volunteers. Need to narrow down/refine language re: product liability so that info is only being provided in limited circumstances. More info in next version in User Guide.
- Query process for self-insured and self-administered but will use vendor for reporting. Would like to query themselves. Possible? Yes.
- Wage claims and medicals – most frequently in WC, but happens across the board. In liability situation, if single liability policy, not bound by the allocation of the parties. Must report full amount and then up to CMS to decide how it applies to any recovery they may have.
- ORM as of 07/01/09 – needs to be reported. TPOC pre 01/01/2010 does not need to be reported. Additional sample situations will be provided to address when responsibilities may end and how they should be reported. For example, if ORM as of 07/01/09, but TPOC before 01/01/2010 – additional info pending.
- What if first exposure prior to 12/05/80, but exposure continues after 12/05/80? Where exposure continues it is reportable.
- ORM termination date? System will accept a date in the future. User Guide will be updated.

IV. Next Teleconference

- 07/01/09

July 1, 2009

In the next 2-3 weeks CMS plans to release several draft documents to the MMSEA Mandatory Insurer Reporting web site for public comment prior to making final determinations on several issues. Also within 3 weeks a new version of the User Guide will also be released.

TELECONFERENCE NOTES

I. Welcome

- NGHP reporting for Section 111 – Technical Issues Only Call

II. Technical Issues – Introductory Remarks

- Refer to section 18.2 of User Guide if feel not receiving instruction/guidance needed from EDI rep. Enforce elevation protocol.
- Type of individuals to be reported during registration – changes to authorized reps or account managers. During new registration, provide info for the authorized representative (executive level, responsible and accountable for MMSEA section 111 requirements, not user). Second step after receiving PIN, must be performed by account manager. Account manager actively involved in day to day.
- Companion guide reposted is only for RREs who are using own x12 translator. Not needed if using HEW software.
- Date initial claim input file is due – claim profile report will only show quarterly time frame, no longer specific date given date changes.
- As of today may start test and production query input files as long as RRE has received signed profile report.
- Upon log in to COBSW screen will list all associated RRE IDs and submission time frames for each.
- Mandatory reporting starts 2nd quarter of 2010.
- Key fields listed in User Guide for claim input file submission. Set by other systems at the COBC, so there is some element that is out of the COBC's control. Name, DOB and gender are not key fields but are used in matching. HICN is the key field. For other fields, send most recent info you have.
- Claims to be reported by claim no./policy no. Change in claim no./policy no. may send an update record.
- Med pay and PIP – two coverages are considered no fault by CMS – field 71 with value D. Must combine Med pay and PIP limits for same injured party/incident/policy must be reported. If separate policies, then separate reports.
- Changes applied to User Guide update – published in about 3 weeks, draft currently under review.
- Changes include updates to reflect TPOC need only be reported for TPOC as of 01/01/2010 and subsequent.

- RRE has no domestic US address available/TIN, update info re how to complete registration.
- Foreign claimant and representative addresses instruction also included – state code default to FC (foreign country).
- Incorporate Alerts that came out subsequent to original User Guide publishing.
- ORM termination date is being added to list of occurrences that trigger an update record.
- May reopen by sending update with zeros in the ORM termination date.
- Dates in the future are acceptable in the ORM termination date.
- If 10% of more records were delete records then threshold error/review with EDI rep would occur. Threshold is being lowered to 4% to ensure delete function is being used properly.
- Secure file transfer method is being updated to clarify directory structure. Trouble? Discuss with EDI rep.
- System generated emails – a list is being generated with standard recipients.
- Claim input file – Appendix A – FC (foreign country) also being allowed in jurisdiction field for accident outside of US.
- No foreign address will be allowed for RRE on TIN reference file. If do not have US address, contact EDI dept for CMS resolution.
- Claim response file, increasing length. Will provide claim/policy nos. on response file.
- New appendix with list of ICD-9 codes that are incomplete for reporting.
- Also adding list of acronyms.
- Reworking error code table.
- Questions submitted to mailbox –
- Free software that may be available? HEW software is available, but no software available for claim input file. At some point hope to allow direct data entry, but no scheduled time frame.
- Default field 81 – when no actual limit? State law requires unlimited? Fill with all 9s if no such limit.
- Registered for RRE ID, no longer needed, then contact EDI to request deletion/disable.
- Separate TIN for liability and WC. Register twice if submitting files together? If RRE is the same for both only need to register under one TIN. Then submit claim input files using appropriate TIN for each claim.
- What triggers reporting for ORM? When ORM is assumed. Don't wait for actual bill for medical received/paid.
- How to report structured settlement in TPOC field 101 and subsequent on auxiliary record. See field description for field 101 for how to do this.
- Multiple subsidiaries – company sells a subsidiary with purchaser assuming liabilities. Separate IDs for each subsidiary? Change RRE ID? When RRE is no longer responsible send an update record with ORM termination date with indicator set to Y. Claims with TPOCs should be no action necessary by former RRE. New RRE would report any subsequent TPOCs going forward under their RRE ID.
- What date should be reported as accepted ORM? 10/01/09 claim submitted DOL 09/01/09, accepted coverage 11/01/09. Report date of incident – no date to report when ongoing responsibility was actually accepted.
- Is there a carriage return line feed (CRLF) at the end of each record? Yes.

- Which ICD-9 codes should be reported for Section 111 – used diagnosis codes, not procedure codes. Acceptible ICD-9 codes – additional info in new User Guide. List – current version 10/01/08 but updated annually. Will issue Alerts of when new list must be implemented each year. www.cms.hhs.gov/icd9providerdiagnosticcodes/06_codes.asp
- Detail record and auxiliary record but subsequently deleting, do you need to submit auxillary too or just the detail? Do not need to submit auxiliary record when submitting delete. May, but not must.
- Term agent refers to the entity who will actually transmit the file. If TPA is an account manager but then TPA is using a reporting agent, could define the TPA rep as account manager and reporting agent could be an account designee. Agent info supplied in registration should be for the reporting agent, not the TPA.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault – Technical Issues Only

- COBSW to see if response file is available for download. How is this downloaded? Depends on file transmission method. If using COBSW as file transfer interface then you will see the file name there as a link and be prompted with instructions for download. If using SFTP protocol then transferring directly to a server, software would be needed to upload/transfer/retrieve files to and from directory. Connect Direct over a closed network, in which case file is pushed from COBC to RREs data center.
- ORM when there has not been a payment on the file – what about for WC ORM when medical does not exceed $600? (missed answer, see transcript when published)
- Off shore captives without TIN. If RRE has no TIN then contact EDI department with situation and will refer to CMS in order to resolve registration issue.
- Not always receiving email notifications of assignment of account designee. (Broadspire). Go to account manager and have acct. mg. report to EDI rep.
- Adding a document control number to the query input file mentioned? RRE supplied DCN? Can this be added? Change in Queue – no scheduled release date, but it has been approved as a change that will be made.
- Query file testing for SFTP user. How will test vs. production query files be distinct? Secure FTP different directories. October 1 – test query info expected to be available.
- Insolvent carriers? Draft in 2 weeks – will release in draft for comment before including in User Guide.
- Responsibilities of the account manager. TPA is telling them that they cannot be the account manager. TPA can in fact be the account manager. The only thing the TPA/agent cannot be is the authorized representative.
- HEW software installed on individual PCs an unlimited number of times.
- If individual has an attorney & guardian, updated User Guide to indicate that if two reps, default to reporting the attorney.
- TPOC amount and date fields for multiple TPOCs – ongoing indemnity payments as TPOCs? Required? How will they be reported if only 5 fields? Language is being drafted, will be posted on web site in draft for comment within 2 weeks.
- Putting out additional analysis for whether off-shore captive is an RRE. Draft forthcoming.

- Query function – process for liability/no-fault/WC is only available via file exchange for registered RREs.
- Query function will not be available to other vendors/providers. In registration agree that query obtained data will only be used for section 111 reporting.
- Emails to authorized representatives – will first receive letter via USPS with PIN. E-mails: profile report, non-receipt of profile report. Does not get every-day emails. If no file is submitted within file submission period, if at risk for non-compliance then warning will go to authorized rep.
- 440 call attendees.

IV. Next Teleconference

- 07/14/09

July 14, 2009

Over the course of today's call, CMS representatives relayed some details surrounding new information that we can expect to become official once posted to the MMSEA Section 111 web site in the coming weeks. The new User Guide with changes is expected by the end of July 2009. An Alert regarding periodic payments for wage loss made through workers' compensation is in queue and should be published by the end of this week.

Barbara Wright read the contents of the Alert, which was also later discussed during the question and answer session. Although not official until published, she stated that CMS' policy will be that if state law precludes payments for past or future medical made in conjunction with indemnity payments, then there is no need to report the indemnity payments as TPOCs. If an RRE is making payments for both lost wages and medical then ORM should be reported. Later discussion seemed to suggest that even if state law is silent as to whether medical should be paid separate from indemnity, if the RRE is reporting ORM, then there is no need to report periodic wage loss payments as TPOCs.

Additional information was also provided concerning limiting the number of RREs in deductible situations. Essentially, despite the fact that a deductible is self-insurance, there can be 1 RRE unless both the insured and the insurer are making separate payments. Two examples are:

1. If insured has a deductible but this is paid by insurer and insurer is then reimbursed by the insured, then only the insurer is the RRE.
2. If insured pays the deductible and also pays above the deductible, but is then reimbursed by the insurer, then the insured is the RRE.

From a technical standpoint, there are some issues with the COBCSW that are being addressed with corrections to be uploaded this weekend. Files are not appearing on the file listing page from time to time, users are experiencing sort function errors, and incorrect response file dates are being returned. Some profile reports have been incorrect that they have not included a city and zip code, or as previously reported have incorrect file submission dates due to the change in the implementation timeline. If an RRE would like a new, corrected profile report, it can be obtained through the EDI representative.

TELECONFERENCE NOTES

I. Welcome

- Will begin with announcements/FAQs answered by Pat Ambrose and Barbara Wright.
- John Albert – have been receiving comments re: EDI service – please utilize 18.2 of user guide for elevation clause for response. Questions to EDI should be limited to technical questions. Policy should still be submitted to CMS mailbox.

II. Introductory Remarks

- Registration – critical to provide info on authorized representative. During account set-up (step 2) with PIN, must be performed by account manager. If entered incorrect authorized rep, then contact EDI Rep or EDI dept to correct prior to proceeding to account set-up (step 2).
- X-12 translators/HEW software – make sure submitted questions related to mapping to EDI rep for consideration.
- Sporadic problem with files uploaded with HTTPS and Secure FTP method. May see file upload successful message, but then do not see file on file-listing page. If not there the following day, please contact EDI rep to confirm transfer. In most cases it has been received and will be processed. Correction to system this coming weekend.
- When uploading only submit TEST files, not .zip or any other binary files. Will not pass upload process. Filler should be filled with spaces.
- RRE listing page on COBCSW – sort function. If using occasionally then selecting an action will fail. Correction this weekend. Avoid using sort until next week.
- Some response files with incorrect response date, correction pending this weekend. Occurs when response file isn't actually ready for download.
- Profile reports have been recently updated but was being sent without city and zip code info.
- Profile reports should only show assigned file transmission time frame for claim input file and the month and day for when file submissions are due. Year is not displayed. See Alert May 11, 2009 – provides info about when claim input files are initially due – 2nd quarter 2010.
- If RRE wants a new profile report in new format, contact EDI rep.
- Updated liability ins/self/no-fault/WC (non-GHP) user guide published by the end of July 2009.
- Claim input file testing begins January 2010.
- Hospital write offs for risk management purposes – issue still under discussion. No answer today.
- Product liability and mass torts – work group has not yet been established. To be involved send comment to mailbox.
- Periodic payments in connection with WC – Alert is in queue – in situations where the applicable WC law/plan requires the RRE to make regularly scheduled payments to the claimant and precludes payments for direct or indirect payments for past future or current medical payments – will not be reported as either TPOC or ORM; otherwise, considered ORM. Indemnity payments are for lost wages and cannot include medicals then do not report at all. But, if payments includes lost wages and possible medical then in that situation then those periodic payments needs to be reported as ORM. Alert should be posted by the end of the week.
- Self-insurance for purposes of MSP provisions – industry definition is not the same as CMS definition. 42 USC 1395(y)(b) specifically state if entity bears any risk then essentially self insured to the extent they bear that risk. Will not change definition.
- User Guide will identify which sections contain changes.

- Corporate structure and RREs – entity may not register for a sibling in corporate structure, but parent may register for any subsidiary in the corporate structure. Parent/holding company may register as an RRE and then designate one of 5 subsidiaries as its agent.
- Deductible issues – Rules as drafted currently are: deductible amounts are self-insurance for MSP. If amount paid is the deductible amount or less then insured is RRE unless payment made by insurer with reimbursement to the insurer by the insured. If insured chooses to pay directly, all payment is self-insurance and the insured is the RRE. If insurer is reporting the deductible or deductible plus amount above the deductible, this should be reported as a single payment, not partially self-insurance and partial policy. If insured makes payment of deductible and amount above-deductible with reimbursement from insurer then the insured is the RRE. Essentially, setting it up so that there is 1 RRE where there is a deductible unless the insured pays separately and insurer pays the amount above the deductible separately.
- Fronting policies – position is that clear intent is for the insured to pay all claims, so insured would be the RRE.
- Self-insurance pools, what if serves more than one function? May meet all criteria in current User Guide but also have some clients/members who are for administrative services only. To extent meets criteria but also provides admin only for other entities. If admin only, then not RRE for those entities for which it provides admin only.
- Can't make a subsidiary responsible for reporting of parent or sibling, other than as an agent, but not primary responsibility.
- How to register for self-insurance – misunderstanding of what self-insurance is, but most often liability self-insurance. If pay individual directly, no insurance – if it is self-insurance it is probably going to be liability, but may be WC. Typically choose liability/no-fault/WC if self-insured.
- Bankruptcy/insolvency – case study presented to CMS; individual TPOC for underinsured paid by insurance co. in that case the insurance co would report that TPOC. State guarantee association subsequently made a payment, in that situation State Guarantee Association would be the RRE. Then claimant filed proof of claim seeking balance, liquidator valued and paid at a percentage – in this situation, what would be reported is the actual payment on the liquidation by the company that is in liquidation (the company on whose behalf the payment is being made).

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Query process – claimant with name change. Name info must be as currently on record with Social Security.
- Profile reports – first submission date prior to 04/01/2010 – EDI rep advised that system has not been updated with new dates. As Pat stated earlier, profile reports are being changed. If want update, contact EDI rep.
- Occupational accident insurance claims (truck drivers) – this would be no-fault insurance.
- RRE examples to be put out for further comment. Only 2 RREs when there is a deductible if the insurer and insured are both paying. Otherwise, can narrow down to 1 RRE. Language will be issued with examples by the end of next week.

- Allowed amount in liquidation context – paid out in some %, if small interim payments are made, are these required to be reported or would final ultimate amount be reported? Will be addressed in draft language. Most likely interim payments will be reported as TPOCs.
- Policy pay in advance based on reserve amounts and then the insurer pays the claim. Claim is reserved for what they feel claim will ultimately cost and billed on an annual basis based on that cost. When they reserve claims, they bill for that cost on an annual basis (paid in advance) and then the pay the claims. Is the entity a TPA or is there a policy? A policy, but paying premium and deductibles in advance – in this case the insurer would be the RRE.
- Administratively closing claim with ORM – need statement from treating physician that no further care is required.
- No-fault wage payments that involve no payment of medical? Alert currently only addresses WC, but will look to see applies to no-fault.
- Joint and several liability – severally liable then responsible for reporting only their amount, if joint and several then each should report total amount and CMS will sort on their end.
- Protection and indemnity clubs (P&I clubs) – insurance group of members who are vessel owners. Club requires that the member pays first (assume member is RRE) sometimes pay to be paid rule is waived and club pays in which case, who would be the RRE? If member has to approve, then member remains the RRE because of involvement in the decision making. If member was RRE but then failed to report, could club be responsible for failure to report? No. only RRE will be held responsible for failure to report.
- Model language for obtaining SSNs – similar language for NGHP is in process (currently only available for GHP).
- Same individual with claims under no-fault and liability – each must be submitted on separate records since these are different insurance types.
- Reporting under the threshold – for claims that reflect no ORM you must adhere to the threshold. Will reject any under the threshold reports. If does have ORM and also reporting TPOC then the TPOC threshold will not be applied. Only required to report TPOCs 1/1/2010 and subsequent but may report TPOCs prior to that.
- Field 15 for alleged cause of injury/illness with ICD-9 – will CMS be evaluating ICD-9 codes? Yes, updates to User Guide. Must contain E code. Also will be publishing a do not use ICD-9 code list.
- What if TPOC threshold changes from 2010 to 2011 – previously below threshold but then meets threshold at a later date.
- State law does not specifically preclude exclusion of medical along with wage payment. If law says for lost time or lost wages or for days missed because of injury, but doesn't necessarily state anything about medical. If reporting ORM for that person anyway, then already covered. If already reporting ORM, then don't need to report periodic payments for TPOC. Would be nothing separate to report, only continuing ORM. Report point at which responsibility begins and terminates, not individual payments for wage loss.
- When CMS is pursuing recovery, will continue to follow standard process – typically recover from the beneficiary against any settlement, judgment, award received. Recover from insurer typically when there are ongoing medicals involved.

- Field 105 – claimant information data (state family or other) what would this be used for? If there is someone else who is a claimant because beneficiary is deceased, this is when that field is utilized.
- Insured settled with several insurers (policy buy-out) and funds put in escrow. Funds to pay any settlement of insured is coming from escrow. Mass torts will continue to be discussed by CMS. Hoping to develop this area.
- Claim reported after initial payment made on medical or when get claim in and know they will be paying medical but haven't paid yet. Should report when responsibility is assumed unless believe it is going to fit under WC threshold.
- What correspondence will be sent to the TIN reference file address? Primary contact will be from the MSPRC. COB will pass info on to other CMS contractors as needed.
- Fields 76, 77 – contact info to id an individual with whom a Medicare contractor could follow up directly with a person. Fields are optional. This would be for more informal follow up.
- Documentation of exposures prior to 12/05/80 – asbestos cases rarely ID the date of exposure to a particular product. Common that claimants do not have a specific recollection. If Claimant/estate states that they are not making claims for dates after 12/05/80 is that adequate to not report that claim? Issue is when the exposure took place. If they put in release that are not alleging or claiming exposure after 12/05/80, that would probably be sufficient, but should also be consistent with other records in file.
- If RRE is higher in the corporate structure then the captive, then that's fine, but if it's lower or a sibling, that will not work.
- If Claimant in NY settles third party action and WC goes into credit taking mode, do no have ORM, but may reapply if third party settlement is exhausted. Gap in ORM. How to report? CMS requested that this be put in writing with site to NY statute.
- Longshore cases – are reportable. Rules apply as they would to any other liability/no-fault/WC.
- Are self-insured medical payments for athletic injuries reportable? Yes, generally reportable.
- Language for clinical trials is forthcoming.
- Official guidance will always be published by Alert or in User Guide.
- If you have correct information then the query will give an accurate response. So if have assurance that you have correct information, then can rely on the query.
- 814 people on call.

IV. Next Teleconference

- 08/11/2009

August 11, 2009

Version 2 of the NGHP User Guide, dated 07/31/09, was recently published to the MMSEA Section 111 web site. In the call today, CMS representatives indicated that nearly every issue raised since the March 2009 release has been addressed in the new User Guide except for write-offs (hospital stays), product liability/mass tort (work group anticipated).

Note that the Interim Reporting Thresholds for WC ORM and Liability and WC TPOC have changed. A complete outline can be found on page 43 and 44 of the attached User Guide, but generally, dates were extended and for workers' compensation, the total payment of medicals was raised from $600 to $750.

CMS expressed concern regarding reported misuse of the Query Function by COBCSW Users and indicated that allegations of misuse are under investigation. They indicated that queries of entitlement information are to be limited to the RREs active and potentially reportable claims and if querying beyond that scope, then the RRE will be held responsible and access to the query function may be revoked.

A majority of the call was devoted to general announcements and questions submitted through the Section 111 mailbox, with a Q&A session that was shorter than normal. Many of the questions presented during Q&A have been addressed in the past and therefore, not every question is outlined in the summary below.

<u>TELECONFERENCE NOTES</u>

I. Welcome – John Albert - Technical Issues Call

- Latest version of User Guide posted to web site; as well as draft for public comment "What is an RRE" comment by 8/16/09.
- Items have shifted on the web page (certain limitations on the number of documents that can be posted on each page).
- Computer Based Training modules – new are being released.
- Most issues since March 2009 User Guide have been resolved and addressed in new User Guide.
- Concern regarding misuse of RRE IDs re: query Medicare entitlement information. Investigating and may be contacting RREs to confirm that request for such information is in fact for the RREs active claims. Concern that queries are beyond scope of what is allowed. RRE will be held responsible. Possibility to suspend access to query data is a possibility if misused.

II. Introductory Remarks – Pat Ambrose

- July 31, 2009 – Alert on What's New page for public comment. Draft language for definition of RRE is provided. Comments must be received by 8/16/09, midnight to PL110-173SEC111-comments@cms.hhs.gov
- If developing form for asking if someone is a Medicare beneficiary, should ask for HICN and not just SSN of injured party. HICN is preferred.
- New registration step – www.section111.cms.hhs.gov, when new registration step is completed and submitted online. Info will be validated by the COBC. COBC will send letter to the named authorized representative with a PIN. PIN letters are sent within 10 business days. If 10 days have passed, contact EDI Rep. Account set-up step is performed next – must be performed by Account Manager. Once completed on COBCSW and processed, a profile report will be sent to the RREs account rep and account manager via email. Also, will be processed within 10 business days.
- Query test file submissions may begin once RRE ID at testing status. Will create test query response file within 5 business days. If not received, contact EDI rep.
- COBCSW problem with response date – year 2003 was erroneously being returned for files that had not yet been processed. Problem has been corrected.
- Secure FTP file transmission process, problems with log ins associated with a large number of RRE IDs.
- Secure FTP – passwords are exactly 8 characters long. If shorter or longer than 8 characters, then log on will fail. Make sure as setting up secure FTP, use correct password associated with log in ID of exactly 8 characters.
- HEW software for query is available in Windows/PC version – available as download on COBCSW after logging in. May also obtain from EDI rep. Mainframe version is also available, but only available through EDI rep.
- Files must be a in a MS DOS text format. Open in word pad and save the file in the MS DOS text as the file type. See Computer Based Training modules.
- Query test and production files are now being accepted for RREs in testing status. Claim input file testing begins 01/2010, then due in 2nd calendar quarter.
- Changes to new Non-GHP User Guide
- Outstanding issues: write-offs (hospital stays), product liability/mass tort (work group anticipated)
- Section 2 provides complete list of changes/additions, but recommended re-read entire guide from start to finish.
- Reporting thresholds – dates extended and threshold for WC ORM was raised to $750.
- 11.7 and 11.10.1 – process will be added to COBCSW that will allow a user associated with RRE ID to indicate that RRE has nothing to submit in any given particular quarter in lieu of submitting an empty file.
- New fields added: allow for submitting a claimant name for that other than a specific individual. Use the first name, last name and middle initial in 106-108 (OR) the entity field in 109. Sometimes claimant is not a person but rather an estate or a trust.
- Updated requirements for ICD-9 diagnoses codes.
- Claim response file record has been increased to 460 bites from 400 bites.
- Technical Questions submitted to mailbox.

- Can parentheses be submitted in field 57 – yes. Will update User Guide to show that is possible.
- Suffixes related to names? Jr.? Recommend remove from last name field. Do no include period or punctuation mark in last name field. When reporting the last name on Query or Claim Input, recommend removing any suffix and period.
- RRE who is small and only has few production claims to convert to test data – requirement require 25 records. Recommend change the dates on some of the claims to create additional claim examples. Can submit the same injured parties with different dates and can overlay with test beneficiary info that will be supplied around 10/01/09. May use production data for testing, but may also manipulate data in order to pass minimum test requirement.
- If no-fault insurance benefit with limit, even if one payment exhausts limit, should be reported as ORM and not TPOC. May be one payment or multiple payments but no-fault and therefore ORM. Dollar amounts are not reported b/c ORM, not TPOC. ORM would be Y, report date of incident and any applicable no-fault insurance limits, and ORM termination date (if applicable).
- If have reported multiple TPOC dates and amounts and need to remove one, send update record zeroing out the appropriate amount, all others should stay in original location. Can that slot be reused if another payment is added later? Yes, can be reused.
- TPOC date 08/2009, does RRE have a duty to report? See updated User Guide – only TPOC dates of 01/01/10 and subsequent are required to be reported. Date for ORM is unchanged. ORM as of 07/01/09 and subsequent must be reported.
- For ICD-9 code reporting, the more inclusive, the better. Will focus recovery efforts only on applicable claims. Supply all applicable ICD-9 codes related to claim.
- Secure file transfer file transmission process. Secure FTP is completed via Section 111 Secure FTP server. Can be automated, however credentials (login and password) must be provided. User does not need to be signed onto the COBCSW to transfer a file, but instead, sign into Section 111 Secure FTP server.
- Reporting extension for ORM and special qualified exception for reporting – delay for 3rd quarter 2010 - see section 11.9. Describes extension for certain claims with ORM prior to 07/01/09. May be reported in 3rd quarter if having difficulty obtaining information for those claims.
- Should ICD-9 codes be updated? Yes. Changes to ICD-9 codes do trigger an update.
- Reporting ORM – if accepted on 08/01/09 and settle on 12/01/09, does that need to be reported in 2010? If ORM terminated on 12/01/09 – so yes, ORM was effective 07/01/09. Have option of reporting TPOC but not required to. However, must report ORM start and termination. If court approval is not until on or after 01/01/10, then TPOC would be based on court approval date and would need to be reported.
- Submission of multiple claim input files – plan to submit one with RRE ID for instate business and one submitted by an agent for out of state business. If submitting more than 1 claim input files per quarter then need one RRE ID per claim input file. Can use same TIN.
- If HICN is provided back on Query form, please include HICN on claim input file.
- File closed administratively, see section 11.9. Extension and exceptions apply to claims where ORM was assumed prior to 07/01/09. See special exception in 11.8 for when ORM

termination date may be submitted. Must be assumed prior to 07/01/09 and administratively closed prior to 01/01/09.

- Account manager sending info by Secure FTP must update password every 60 days or less. Any log in ID must have password update every 60 days.
- Is possible to submit query input files through one method and claim input files via another method.
- TPOC (one pre-01/01/10 and one after 01/01/10) and second would trigger reporting requirement. Do not need to include date prior to 01/01/10 at all. Will only look to 01/01/10 and subsequent. When checking for reporting threshold only calculate after 01/01/10 – anything using to report due to threshold should be included. So if including pre-01/01/10 TPOC in threshold total, then report pre 01/01/10 date.
- Disaster recovery efforts – contact EDI rep. Need to work with EDI rep to determine what an appropriate file submission would be. May have records flagged for compliance, but would have explanation due to EDI Rep report.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Profile reports – can a sample be published? Yes.
- Natural language translations between description field and ICD-9. CMS will take description provided and map it to an ICD-9 file for posting on internal Medicare files. Currently free form text field. If unable to map does not result in a rejection, but there may be follow up if additional follow up/clarification is necessary.
- If disposition code (50) with error, resubmit record with initial coding and any updated info. Action type would be the same as original submission.
- NGHP Model form language continues in review process but release is planned.
- Query files – have a choice of using HEW software for transmission or creating own translator. Do not supply software for claim input file.
- Date model language is expected? “shortly”
- Currently not considering revision of implementation timeline.
- Data fields are currently “essentially” locked-down. Current User Guide with a few exceptions, does represent the final state.

IV. Next Teleconference

- 08/18/09

August 18, 2009

The main portion of this teleconference was allocated to a question and answer period, with only minimal time spent on opening remarks. The issues CMS indicated continue to be pending are:

1. Finalization of language defining who is an RRE.
2. Establishment of a mass torts work group to further define reporting responsibilities in that area.
3. Language specific to sponsors of clinical trials is currently in the draft process.
4. The issue of hospital and medical doctor write-offs are still being considered. To the extent that the write off is a risk management tool, it may very well be defined as self-insurance and reportable with the hospital/provider being the RRE.

A corrected User Guide will be published due to missing text. This can be expected in the next few days.

One stance, that from my perspective and recollection has changed, is how WC RREs are to report ORM when there is a there is a third party liability settlement that puts WC in a credit-taking or "holiday" status. A similar question arose during the 04/04/09 teleconference, at which time the response was if ORM was reported but ongoing responsibility is terminated at any particular point, then termination was to be reported and update required if ORM is reestablished in the future, or, if there is a TPOC. Today, however, it was indicated that even if WC is in credit-taking mode, both liability insurance and WC remain primary to Medicare. Therefore, since Medicare could still recover from either the liability settlement or WC during that credit-taking period, ongoing ORM must continue to be reported during the credit-taking/holiday period. CMS representatives explained that if the credit-taking period works as it should and the claimant/plaintiff pays for medical care out of the settlement and does not bill Medicare then there should be no issues. Keeping WC identified as having ORM keeps Medicare on notice of a primary payer if the claimant/plaintiff submits injury-related expenses to Medicare for payment. CMS representatives indicated that in that situation they may seek reimbursement of those conditional payments from either primary payer.

TELECONFERENCE NOTES

I. Welcome – John Albert -

- Mainly Q&A session today

II. Introductory Remarks – Barbara Wright & Pat Ambrose

- Language in draft on who is an RRE? Comments submitted through 8/16 but have not reviewed all of them. Until all can be reviewed, will not answer who is an RRE questions.
- 18.2 of User Guide explains escalation process if issues with EDI rep.

- Mass torts – many have volunteered for work group. Need to send message to resource mail box if would like to be involved.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Hospitals and medical doctors writing off bills – will these trigger reporting? Still under discussion, hope to resolve within next few weeks.
- Most recent User Guide text missing around pg 74 & 75 – working to correct omission within days.
- Conditional payment info requests must be made through the MSPRC but can only assist if case self-identified through the COBC. Once reported to COBC, then MSPRC begins compiling information. Must still go through the normal process despite section 111 mandatory reporting. Must have consent to release form signed by beneficiary.
- Anticipate threshold if hospital write-offs? Likely same threshold in place for TPOCs.
- Sponsors of clinical trials – language in draft process right now.
- EDI reps will deal with technical issues only.
- Use of a foreign address – foreign off-shore captives 11.2.6 Use of Foreign Address. What is process in terms of contacting COBC directly? Process is to report to EDI dept, will relay info to COBC. Depends on the specific circumstances as to what US address info will be necessary. If captive has US EIN, can be reported as TIN. Also, captives can be reported by parent company (might be easiest route if US parent).
- WC first date of exposure (may have been 40-50 years ago) and under WC law, no need to know first date of exposure – caller feels this is impossible. Answer – include best estimate and document in own file why this is best estimate. If date is before someone has been a Medicare beneficiary, then doesn't make a difference.
- PIP and Medpay reporting question when policy limits exhausted. Assuming Medpay and PIP on same policy, so same record. Would report ORM, if then terminated, then submit update record to either extend or change to all zeros if open ended. If PIP and Medpay same policy but two claim numbers then can report on same, or if two claim numbers then can report on two separate records. Second claim would then be an Add rather than an Update.
- TPOCs only need to be reported 01/01/10 & forward. Settled claim on 12/31/09, then would not be reported? Will make multiple TPOCs over time because in liquidation. Then these are multiple TPOCs and will not report until meet the threshold. All TPOCs 1/1/10 & later. Allow to report TPOCs prior to 1/1/10 only if there was also ORM.
- 7/13 Alert – LWCC will have more than 5 TPOCs on all claims. WC statute does not specifically preclude payments for medical with indemnity. Read the Alert in full. Otherwise, payments are considered to be part of ORM. When reporting ORM, do not report the individual amounts (will not be TPOCs, but will be considered to be a part of ORM).
- Are manual forms for reporting available? No. No paper based reporting. If no in house tech capability, then expect that the RRE will obtain an agent for reporting.
- Product liability information – if work injury caused by defective product, should insurance company for product be the RRE providing info? When mass tort work group is together a better answer will be provided. This information will not necessarily be a

part of every claim. Will work on narrowing for WC, but can't give a definitive answer now.

- FELA claims – will sometimes pay co-insurance/medical charges if denied by the primary carrier. This describes two parties primary to Medicare and both would have reporting responsibilities. Medicare beneficiary, then have described ORM and will report ORM – will not report specific dollar amount. ORM active as of 07/01/09 trigger date.
- Liability settlement and WC goes into credit taking – both the WC and the liability are primary (credit is against liability carrier, not necessarily against Medicare). If had ORM and is terminated because of liability settlement, can presume that Medicare would have already recovered from the liability settlement. Medicare is secondary to both forms of insurance. Can go to either for reimbursement of any claims that have been paid. Under law, still secondary to WC, so WC has reached an agreement with another party with respect to payment of claims. Medicare is not a party and will not recognize that agreement. WC not being liable during that credit taking period is not an adequate defense. So final answer is that ORM would be reported.
- Authorized representative needs only be a person who the RRE agrees is someone who can legally bind the company. If a joint venture is an RRE, there is a person who can bind the joint venture. That person should be the authorized rep.
- Definition of TPOC but still confused – to report a settlement judgment or award if it is for indemnity only for WC? See 07/13 Alert, which controls. Indemnity payments then generally will be reporting ORM or nothing. If have ORM continuing and settling indemnity only in lump sum, is lump sum reported as a TPOC? If ORM is continuing then it is included within ORM and do not have to report anything further. If future indemnity for $100K and medical ORM remains open then no reporting responsibility of TPOC. WC settlements sometimes includes multiple defendants. If settling indemnity and medical for $100K, split between 2 defendants 50/50 – is $50K reported or due to joint and severable settlement report $100K? If joint and severable then report the total amount but if separate settlements then each report own. If not joint an severable, then isn't just a portion, they are actually separate settlements. If only single settlement that each party is jointly and severally liable then all RREs report the full amount and Medicare sorts it out on their end. Medicare would be entitled to go back to all/any entity for the full amount. If a settlement leaves medical open and is only related to indemnity then there is no TPOC reporting – yes, for WC that is true. Third question – re: third party credits. If third party credit then there is no ORM, but CMS says there is still ORM – so doesn't ORM relate to the injured worker or to CMS? ORM relates to ultimate responsibility to the claimant as well as with respect to Medicare. In a practical sense, there isn't an issue, but if it doesn't work, Medicare will not consider themselves to be bound. The most common scenario WC stops paying because liability is paying – as long as Medicare doesn't get billed then no issue; because sometimes this doesn't work and Medicare is still billed, this is why continued ORM by WC should still be reported. In some situations this could have an impact.
- If making payments because someone was exposed to asbestos and exposure continued beyond 12/5/80, and individual is receiving item/service – can't be said that only related to exposure before or after a specific date, but was related to ongoing exposure and

therefore there is responsibility. So if exposure was alleged past 12/5/80, then doesn't matter for what time period the treatment is for.

- P. 42 of User Guide – TIN used during registration and then TIN on claim input file. May submit same or different TINs. TIN of entity with payment responsibility should be used on claim input file. May want to report subsidiary TIN on claim input file b/c CMS follow up will be with the entity of the TIN on the claim input file. May better manage contact if correct subsidiary is identified.
- Only WC have ORM limits – if no-fault, PIP, Medpay – all reportable without threshold limits (even if only one payment and has met limit). Normally no-fault reported as ORM and then terminated when limit met. Could have low-limit policy where first report is both assumption and termination of ORM. For bodily injury liability claim, only need to report TPOC as of 01/01/10 forward, but if ORM to report prior to 01/01/10 and had TPOC prior to 01/01/10, if easier for RRE to report TPOC, then can report it, but not must.
- Hospital write offs – by definition, the provider is self-insured when providing care which is then being written off. The provider/hospital would be the RRE. Assume risk, so they are self-insured. Hospital uses it as a risk management tool. So if provide $2K in care as a risk management tool to not report to liability insurance, then this is self-insurance.
- ORM – will be rare for liability insurance. If a bill is paid to a medical provider as part of the TPOC – then total of both is total TPOC. If just a bill here or there, then there may be a small TPOC amount to report. If on an ongoing basis then would be ORM.
- Penalties do not run from DOL, $1,000/day is triggered by non-reporting within appropriate time when assume ORM or TPOC date as defined in the User Guide. Need to report in next claim submission window (plus 45 day grace period).
- If receiving reduced SS benefits at age 62 then application for Medicare is made so automatically enrolled at age 65. If not getting early benefits, then must sign up at age 65. As soon as application is processed then will be in the data base. If negative query and can confirm that information is correct, then can rely on that information.
- Cannot get signed statement from treating physician, but can get from IME – can this be used to terminate ORM. CMS has not made a final decision on this. Part of the issue is that IME physician is hired by carrier.

IV. Next Teleconference

- 09/08/09

September 8, 2009

No new information was presented over the course of today's teleconference, except that a corrected User Guide has been posted to the MMSEA Section 111 web site due to a prior formatting error. Also, an Alert and Model Language for NGHP RREs was posted 8/24/09. The Alert provides steps an RRE can follow in order to be in compliance with Section 111 Mandatory Reporting, even if an injured party refuses to provide SSN/HICN.

During the Q&A session it was suggested that if an RRE designates an agent as their account manager, then in order to retain access to the information reported for monitoring purposes, an individual with the RRE may be named as an account designee. This designation will allow the RRE to access the COBCSW page for the RRE ID because the authorized representative does not have access.

TELECONFERENCE NOTES

I. Welcome – Bill Decker

- Technical Issues call. Policy questions to be deferred to 9/30/09 call.

II. Introductory Remarks –Pat Ambrose

- Postings to Mandatory Reporting web site – NGHP User Guide corrected and reposted for formatting error. Pg. 74-75 language was cut off. No other changes. Dated 07/31/09 and is still version 2.0.
- NGHP Medicare HICN/SSN collection model language and Alert re: compliance has been posted. Dated 08/24/09. In downloads area of what is new page.
- New Alert re: receipt of multiple account designee messages. If registering as an account designee, if invited more than once before completing registration then all emails will contain the same token link. May use token link in any one of the emails in order to register. Once completed account designee registration, token link will no longer be valid. Once have obtained log in ID and invited to subsequent RRE IDs, will receive a notification email, but will not receive a new token link.
- If have account designee invitation pending, must complete registration before setting yourself up as account manager for another RRE ID.
- Error message during account set up step, most commonly because the account set up is already complete.
- Difficulty connecting to the secure FTP server. If so, contact EDI Rep.
- COBC has received several requests to change account managers from RRE rep to an agent. Recommend that RRE retain account manager role and retain agent as account designee rather than changing account manager to agent. Not required, but recommended for RRE to maintain more control.
- Registration process will remain open and operational indefinitely.
- Downloadable files with test beneficiary information, insufficient ICD-9 codes and error codes – should be posted within next few weeks.

- Assignment of no-fault claims (PIP) in Michigan – RRE is handling them manually and do not have associated policy number. If policy # required, what do they do? Submit a default value for the policy number field in order to get past that submission error code.
- Middle initial for an injured party – to be as it appears on the SSN or Medicare insurance card. Can leave it blank if do not have it. Middle initial will not affect the matching process.
- Threshold amount discrepancy – total TPOC amount if exactly equal to the threshold amount. The threshold is inclusive of those amounts. Any total TPOC between $0 and $5,000 is excluded from reporting. If exactly $5,000, will be rejected. Instead, User Guide states that amounts less than $5K will be rejected – not stated correctly. Should read less than or equal to $5K.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault – Limited

to Technical Questions

- Notifications for testing should have been turned off. Obviously have more than 30 days to test. Testing for claim input file begins 01/01/10. Query input files can be tested now.
- Error code CJ06 – ORM termination date may sometimes be the same as the date of incident, or less than 30 days. Can send ORM termination date out just past 30 days to get past that edit. Can set exhaust date to actual exhaust date but set termination date 31 days after DOI.
- Will issue Alert re: what future dates are acceptable for testing.
- How many times should register for RRE? WC and professional liability program. Two different TPAs handling programs. Whether need 2 RREs depend on how claim input files will be submitted. Need to work with agent to determine whether these will be submitted all in one file or two separate files. If two then need 2 RRE IDs. From CMS perspective can always mix WC, no-fault and liability submissions.
- Errors on COBC web site. When experience a problem, take a screen shot and send to EDI rep. Note time of day and date occurred and what action was being taken when error occurred.
- Significant time lag between step 1 and step 2 for registration. CMS not aware of large backlog. Should not take 5-6 weeks. If not received after 2 calendar weeks, then contact EDI representative.
- Small clients have registered, but don't have access to their own data because they are the only authorized representative and agent is the account manager. Requirement is that an authorized rep is NOT a user of the web site. If RRE does not have account manager, this can be delegated to an agent, but no particular advice as to how the RRE might also have access to the COBCSW. No "view only" availability currently. Solution may be to transfer account manager designation back to RRE and agent becomes account designee. Another solution may be to invite the RRE as an account designee.
- HEW software process inbound and outbound files in DOS format. Response is coming in UNIX format. Response file should be downloaded as an MS-DOS file, not UNIX. That format should be sent through HEW.
- Reporting agents are charging per query. If there is a statement from the treating physician that discharged and requires no further care, then ok to terminate ORM. If terminated, do not need to query again unless reopened. Discharge from care alone is not

always enough. Should be primary care physician stating that no further continuing care is necessary – needs to be evaluated case by case to determine if level of detail in physician's statement is adequate.

- Registration question – which steps should be completed by 9/30? Any penalties if not completed by 9/30? Not looking for non-compliance by registration alone. Real issue is whether registered soon enough to have a full quarter of testing that will allow to report by 2nd quarter of 2010.
- Obtaining SSNs 8/24/09 Alert. Does model language in file suffice or is there still a reporting component? If don't have HICN or SSN, can not report. RRE needs to keep info in internal files in case there is follow up later.
- Reversals of payments? Would be an update record. If then falls below threshold, will not be deleted. If ORM was terminated and then reopened then may send an update to zero out the ORM termination date to reopen.
- P. 141 in User Guide fields that do not appear to have correct start and end positions. Actually, start and end positions are correct for Fields 106-109 – same is true for auxiliary file.
- Final Alert re: who is an RRE – working toward releasing by end of the month.
- HEW software for query process. Is same software used for reporting? RRE is responsible for developing its own software. Only have free software for query process, not for claim input file.
- For liability, unless there is ORM (rare) then nothing to report until TPOC of 1/1/10 or later. Look back for WC, regardless of legal responsibility, if RRE had administratively closed a case prior to 1/1/09 then do not need to report. 11.8 and 11.9 in user guide. Reporting ORM open as of 07/01/09, but if administratively closed prior to 1/1/09, then do not need to report.
- No global issue with test query files for NGHP. Have had some issues related to secure FTP if user associated with a large number of RRE IDs, but steps being taken to correct. If have not received a response file for a query within timely manner, then report to EDI rep.
- General liability slip & fall, visit for evaluation is paid on a Medicare beneficiary – is this reportable as ORM or TPOC? If ORM, then termination date would be within days. See User Guide – if pay for medical exam for investigative purposes then not reportable as ORM or TPOC, paid provider directly. But if TPOC then would report with that corresponding amount.
- TIN reference file may be sent with each claim input file, or may submit only if changes to be made.
- P 132/133 of User Guide – representative's first name and last name. Don't always have persons name, if only have firm name. Need to collect that information.
- WC TPOC question – if disputed and no ORM and make TPOC prior to 1/1/10, then no reporting? If no ORM then yes, correct.
- ORM as of 7/1/09, but settled with TPOC prior to 1/1/09. TPOC not required to be reported but ORM would be reported.
- If first 3 TPOC fields are used, then need to retract the 2nd. Send update record with zeros. If then, subsequently, a 4th TPOC then can reuse the old 2nd TPOC field or put it in the 4th.

September 30, 2009

The most recent notice posted to the MMSEA Section 111 web site for NGHP is a notice regarding use of agents. Bill Decker summarized the notice, which states that the despite the use of an agent, the RRE is ultimately responsible for the integrity of the data provided. If there is an issue, CMS will address that with the RRE, not the agent.

Policies that continue to be pending finalization include: reporting of foreign addresses; reporting guidelines specific to clinical trials; "Who is an RRE" language; and mass torts and products liability guidelines.

TELECONFERENCE NOTES

I. Welcome – John Albert

- Policy Issues call.
- Aware of large volume of enrollments, some registrants are receiving error messages. Will be fixed this week. Best time to try is early in the morning or late in the day.
- Registration deadline of 9/30 is not as critical as the data submission window. Can register within the next week or two when fix to site is implemented.
- Won't find out of compliance solely b/c haven't registered prior to 10/1. Must only register in time to test first quarter of 2010, and live production second quarter of 2010.

II. Introductory Remarks –Bill Decker/John Albert/Barbara Wright

- Review of escalation process if not getting answers from EDI Rep. See User Guide, p. 104. Section 18.2.
- New info added to the NGHP pg dated 09/28/09 – concerns Use of Agents. Reinforces that agent simply for the RRE and is not responsible for the integrity of the data. If problems as a consequence of data issues, CMS will not be talking to the agent, they will be speaking with the RRE.
- Foreign addresses: if do not have a US address or US TIN, wait for further instructions from CMS before attempting to register. Under development and will be posted on the Section 111 web site. Publication alert will be made.
- Computer based training classes are available and accessible through Section 111 web site. Last updated 09/15/09.
- CMS emails to RREs/agents/authorized reps are being tagged as SPAM. Critical point: check filters.
- Most current documentation on web site – look to What's New page as well as NGHP page. Note there are limitations of how many documents can be posted per page so documents have been moved around. Working on a more dynamic web page, but for now, working within these limitations.
- Clinical trials language is in clearance with CMS

- Write offs – hospitals/physician/suppliers, continuing to meet so no final language but under consideration.
- RRE language – continuing to review comments and revise.
- Mass Torts/Products Liability – workgroup meeting yesterday and next week. Want to able to fit changes into current record format. Considering narrowing down terminology, possibly replacement. Product liability may be limited to specific types. Most concerned with for example, a pharmaceutical cases, if there is a 24 month plan to apply to be a part of the class. All info may not exist at the time of the TPOC date. Trying to find a way to collect that data.
- MSP provisions apply to all types of liability insurance, but only if there is a medical claim.
- Look at record layout to determine how to arrive at TPOC date. Remember 45 day grace period for those falling within that period before reporting period.
- Questions about representative's name and firm. In one past call, mentioned that they might offer choice of including one or the other. CMS made later determination that will not allow a choice, and needs information for both fields.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Indemnity + Medical + payments for loss of use/scars. Do loss of use/scar payments need to be reported as TPOCs? If the payments includes medical items and services related to the removal/ongoing treatment then reportable, but if merely damages and doesn't include medical then not reportable.
- Model language – what if injured worker refuses to sign this as well? What RRE needs to tell CMS with that form is that individual refused to give the info. What RRE can keep on file is attempt to collect the information. Person who is refusing does need to note on the form that they have seen the form but are simply refusing to reply. Document process and attempts. Try delivery receipt, certified mail, etc.
- Exposure on an asbestos case – is it reportable if exposure to product ending pre- 12/80 but exposure to other products extended after 12/80? WC or liability? 1980 is irrelevant if talking about WC. CMS has always been secondary to WC.
- Claims close, go back to work, but can't get a final letter from doctor. Lifetime medical state. To close file, do need something from doctor stating that treatment has ended. Otherwise, will need to continue to query each month and/or report if necessary.
- First aid claims – can these be handled without reporting? Employer is paying but not paying under WC, then considered self-insurance. If an individual or entity bears any part of the risk, then self-insured to the extent that they bear that risk. May not be WC, but would be liability self insurance.
- MSA applicability to liability claims – this is not a section 111 issue. Not the same formal process for liability set-asides that there is for WC; however, underlying statutory obligation is the same. For WC, the process is technically not required. For liability, underlying obligation is the same. If wish to pursue CMS approval of liability MSA, then go to regional office. If regional office declines to review, that is not any type of safe harbor. Not the same formal process, but there is the same legal obligation. Section 111 did not change any existing obligation, it added a reporting requirement.

- Reporting TPOC for auto claims. Is TPOC the combo of both property damage claim and BI claim, or just BI claim? If claim does not involve medical then exempt from reporting. If exempt then don't need to add it into other TPOCs.
- Ohio $15K deductible program. Can pay first $15K on their own but also participate in the state fund. Is it possible for employers to query when initially have the claims and then prior to $15K send to bureau for reporting? Depends on who is responsible for making payment. Sounds like self insured for $15K. Look for who is an RRE language pending.
- Attorney fields – only have firm not first and last name. These fields are required, but don't have this information. If reporting TPOC, don't need to be reported until 1/1/2010, so if not collecting that info now, then collect in the future. If ORM, then will take under consideration if these have been open for a while without that info. No answer other than, will need to get that info.
- Beneficiaries are under an obligation to provide their HICN. If refuse SSN – timing issue. Try to collect prior to settlement and then second attempt at the time of settlement. Try to request bills/claim form from physician because this will have HICN if there is one.
- No final answer as to whether foreign/parent company can register as RRE and use address of US subsidiary. Either register subsidiary as RRE or wait for foreign address info.
- Only time safe harbor for model language applies is if the injured party returns the form. Answer: document the process, and recommendation that at some point certified mail be utilized to show clear attempt to deliver. Timing is also an issue. If in litigation, might not have TPOC for several years. Must inquire at time of settlement because that is when benefits status matters. Must have a process.
- Use model language in following sequence: 1) approach individual 2) refusal 3) provide individual with model language. Not designed to be given to everyone, but to those who first decline to provide info. Should be second approach when there is no cooperation.
- Liability insurance – preferred method is to issue a demand to the beneficiary against the settlement, judgment, award or other payment. Legal right to go back to the insurer if not satisfied [42 CFR 411.24 (i)]. Not changing pre-existing processes. Labeled as pain and suffering does not bind CMS. Advised review 42 USC 1395y(b) and CFR if not aware of statutory and regulatory obligations. This is in relation to recovery process and not Section 111 – outside of scope of call.
- A flag in a notice does not automatically mean that a penalty is going to be assessed. May mean that there will be additional questions. Make sure have documentation to provide reasons behind late reporting, etc., for example, if late because not yet met threshold, be able to show that if questioned.
- WC claim administratively closed pre 01/01/09; reopened later and reported. What type of documentation is needed to avoid flag for late reporting? Will be flagged, but be able to document why it wasn't opened to start with.
- Completely internal service that is never billed to anyone, anywhere, is different from a hospital or provider that chooses not to bill particular services as write-offs. Will be policy for write offs.
- Hearing process or complaint process where can question reporting prior to imposition of penalties? If questions about particular response files, work with EDI rep. No final

process developed for civil monetary penalties (CMPs) yet, when it is developed it will be made public.
- Additional info on hospital write offs is pending. Meetings continue. No date projected.
- 40 questions remained in queue.

IV. Next Teleconference
- 10/06/09

October 6, 2009

TELECONFERENCE NOTES

I. Welcome – John Albert

- Technical issues call.

II. Introductory Remarks

- Transcripts of prior calls posted on web site. Most recent are not yet available. Rearranging info on web site. Finished in 1.5 wks, at which point all available transcripts will be posted.
- Reminder of escalation process if trouble getting answers from EDI rep.
- Foreign addresses – wait for further instruction from CMS before attempting to register.
- Updated companion guide posted to web site on 9/24/09. Additional info to help clarify the reporting requirements. Only for those not using HEW software for query files.
- Updated curriculum also posted around the same time.
- Will software be available for claim reporting as well as translation? No. RREs need to develop their own or contract with an agent.
- Reporting is quarterly – keep in mind 45-day grace period, which allows for some delay.
- Request for total number of paid claims per year. Only to identify size and scheduling of RRE.
- HICN is preferred but will convert from SSN if necessary.
- All state laws do not specifically preclude the periodic payments from precluding medicals. Suggestion from industry to revise that language to be more flexible. Under consideration.
- HICN field can be 10-12 characters; how should it be formatted? Left justified if less than 12.
- User Guide 9.2 table details how to format values.
- Self-insured for general liability in litigation, no settlement, judgment or award. Want to report claims under a separate RRE ID? Agree? Just because in litigation, doesn't necessarily mean that separate RRE ID is needed. Can all be reported under same RRE ID. But if needed b/c under a different system, then having second RRE ID might be helpful and may be used, but not must.
- Combining query files of multiple RREs into single file? NOT ACCEPTABLE. Data should not be commingled or queried under a different RRE ID. Commingling would violate data use agreement. Violation of privacy act.
- Review of which claims should be reported.
- If RRE registered but nothing to report, 11.10.1 – can submit an empty file or log into COBCSW and perform a function for the RRE ID showing nothing to report.
- Can RRE attorney be designated as account manager or account designee – yes to both. Can fulfill role of either.

- If change agents, does new agent need to submit new test files? If change, no testing is required but strongly encouraged. May submit test files at any time. Each RRE ID needs to be tested separately.
- Software for file transmission by HTPPS? Requires no additional software other than the current internet browser that RRE uses. Only need to go to the COBCSW to upload and download.
- Medicare start date is set but not yet reached, what will Query show? Should receive 01 indicating that beneficiary is on file is a beneficiary just before the person becomes eligible. If the HICN is assigned (often 3 mo. prior to entitlement) so query file submitted will likely match before actual beneficiary.
- Files must be submitted during assigned time frame – no deviations.
- User Guide p 144, claimant representative. What if multiple including attorney and guardian? In that hypo, if multiple then go with attorney rather than guardian.
- DOB discrepancy? Go with Social Security record. If in error, beneficiary would need to correct through the SS office.
- Test beneficiaries? Available in about 2 weeks – somewhat delayed. Will not be able to use test beneficiaries until 01/01/2010.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Submitted claim input file 10 days ago but no response? Because not testing claim input files until 01/01/2010.
- More than 5 TPOCs? Contact EDI rep – but please explain situation in which this may happen. When in a liability situation, when would there be multiple TPOCs to that extent? Send examples.
- What happens if report a record that does not include every data element requested? If the required elements not included then record will be rejected outright.
- Product liability and mass tort fields may be changed to make more flexible for the industry.
- ICD-9 exclusions, test beneficiaries, and error codes will be published in two weeks.
- ORM termination date 30 days later than DOI. If deceased as of DOI? Low limit med pay, they die, and then subsequent to that the benefits are exhausted. CMS record will terminate at death anyway, so only need exhaust date if before death. Will only pay claims for dates of service through the date of death.
- Issue – triggers for enforcement of violations. Any thought/effort to develop process for triggering of enforcement action/effort against an RRE? Policy question. Nothing further to offer. Receipt of a flag is not in and of itself an indication of a penalty. Expect to have a definite process, will be made public.
- Adding a DCN for query file? Do not have now but plan to add it.
- As Agent, required to use submission window assigned to client? Yes.
- Test beneficiaries will posted to the web site shortly.
- User Guide p.168 TIN Reference file – mailing address should reflect where RRE should have recovery efforts directly. Would that allow for a vendor address? No, because vendor is not the debtor. Will change in User Guide.

October 22, 2009

Although addressed on prior calls, the collection of Social Security Numbers and/or Health Insurance Claim Numbers was discussed again in the call today. Collecting the proper data in order to allow for compliance with Section 111 seems to be the first major hurdle many RREs are encountering. CMS has suggested that each RRE develop a standard process for collection of this data, and if the process fails, then the suggested model language may be employed. They have stated that a well documented collection process that does not simply begin with utilization of the model language, will demonstrate compliance. Use of the model language should be the last resort. They emphasized that the law does not require than an individual disclose their SSN; therefore, RREs should not advise claimants/plaintiffs that they are required by law to do so. However, if an individual is a current Medicare beneficiary, they are obligated to provide their HICN, despite the possible similarity to their actual SSN.

Due to the number of outstanding issues for which answers/solutions continue to be developed, rather than publishing multiple Alerts, CMS does plan to issue an updated User Guide before 1/1/2010. They stated that there will be no radical changes so RREs can and should continue to develop their systems and processes based on the current User Guide.

In the question and answer portion of the call, an attorney for a self-insured entity asked CMS for their opinion regarding a recent American Association of Justice (AAJ) article regarding MSP compliance. Barbara Wright commented that the AAJ was correct in their statement that Section 111 does not require MSAs; however, she reiterated her statements on prior calls that Section 111 does not change any preexisting obligations under the MSP, CMS does not have a formal review program in place for liability MSAs, and the lack of a formal process should not determine whether or not an MSA is necessary. She stated that this is an obligation dating back to 1980 and if an entity has not been taking steps to document how this obligation is being satisfied, then they should begin doing so now but CMS has no recommended process or opinion as to how this goal should be accomplished. She advised that establishing an MSA would probably be a reasonable method, but she could not offer any official statement. Very generally, she advised that the settlement should indicate whether there is a future medical aspect, and if so, how it has been addressed.

TELECONFERENCE NOTES

I. Welcome – John Albert

- Policy Call

II. Introductory Remarks – Bill Decker/Barbara Wright/Pat Ambrose

- Announcement for registration of foreign entities – please wait. No current process for registration.
- There is nothing in Section 111 law that requires the collection of Social Security numbers by an entity. Suggest that they should be provided if questioning whether person may or may not be a Medicare beneficiary, or the RRE does not have a HICN for the

individual. Insurers should not claim that it's the law that the SSN be collected; not the case.

- Test beneficiary data and ICD-9 codes not to be used will be published to the web site next week.
- Plan to update NGHP User Guide before the end of the year due to new information being developed. Not radically changing any process/information, but many tweaks.
- ICD-9 codes from last three versions published by CMS will be accepted. Version 27 was posted 10/1/09. New info will be implemented by COBC as of Jan 1 of following year to allow for time for system updates. All versions can be found on CMS ICD-9 web page. Will also accept Versions 26 & 25.
- Hospital write offs/clinical trials/mass tort language still being developed/under review. Moving away from mass tort and product liability terms. Weekly meetings are occurring.
- Interim periodic payments language is still under review.
- Receiving presentations from outside entities indicating that in order to be in compliance with Section 111, must complete MSAs. Barbara emphasizes that Section 111 has nothing to do with MSAs. In conjunction with protecting Medicare's interest, that is a pre-existing obligation and nothing has changed.
- When reporting TPOCs, report the full amount. No distinction/allocation of what is medical.
- Sample situation of more than 4 TPOCs – one example has been in a situation of bankruptcy and CMS will be taking a look at that.
- Permissible to send info on every claim regardless of Medicare status – as done with Query files? No. Should only submit those individuals who are Medicare beneficiaries. On a Production Query, may submit any individual for determining Medicare status. This does not similarly apply to Production Claim Input files.
- Increasing number of questions dealing with the recovery process. Will not be addressed. Not a Section 111 issue.
- Insurance policy with bodily injury coverage + medical coverage. When reporting, no-fault or liability? Select whichever is applicable to the payment. Med pay would be ORM for no-fault. Submit separate records for each type of coverage.
- 4 insurers each paying ¼ of total amount. Each ¼ is under the reporting threshold. If one settlement, then each must report the total settlement amount.
- 12/05/80 date, effective date for liability insurance. Physical exposures as of that date, not legal exposures.
- TPOC vs. ORM misunderstanding in incoming questions. Structured settlement is not ORM. ORM is limited typically to no-fault or WC.
- If funding delayed beyond TPOC date – in this situation, then identify the appropriate TPOC date but also utilize the funding delayed field.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Per MSP statute, no causation is necessary. Settlement, judgment or award in itself establishes primary payment responsibility.
- If partial settlement of ORM, for example, settle claim for attendant care, how is this reported? Leave ORM termination date open ended until ORM for that claim is entirely

terminated. May send an update record to report a settlement amount in a TPOC field, keep ORM indicator set to Y. If also settling indemnity, need to report full settlement for both indemnity and medical as TPOC? Hesitate to respond until current language regarding periodic payments is finalized.

- Delayed funding example would be settlement not paid out until MSA is approved by CMS.
- Termination date, exhaust date. If reported ORM, subsequently reported ORM termination date, may still send an update record and update with an exhaust date (no-fault). May submit change ORM date, or change termination date, if necessary. Don't need to report the date of death.
- Can't accept an ORM termination date that is less than 30 days from date of incident. Default to 31 days from DOI.
- Only CMS changes possible are to the User Guide. If based on statute/regs then will not be able to change.
- Permanent partial impairment payments under WC – how should these be reported? Person working on that issue is not present to answer.
- Can begin using model language now if process of attempting to collect data has already been exhausted.
- E code for cause of injury or accident. If asbestos exposure, don't see an appropriate E code. This question is on list to be reviewed on next technical call.
- Error code 51 on query response means nothing more than data sent could not be matched.
- Multiple NAICs – register according to 1) who is the RRE and 2) how files will be submitted. Goal is to consolidate to as few RRE IDs as possible. May use one TIN when register, and do not need to provide all on subsidiary file. When reporting on claim input file and TIN reference file, those should identify the appropriate entity for any follow up efforts.
- Most frequently the HICN is derived from the SSA with SSN followed by a suffix. However, HICN is separate from a SSN. Many different suffixes that can be used. CMS doesn't invent the HICN, they are supplied by the SSA to identify Medicare beneficiaries. Concern is that people who don't want to provide their SSN also do not want to provide HICN for the same reasons.
- If have correct SSN, then even if individual has benefits under spouse, the query response should be accurate.
- Caller indicated that law firm is trying to intercede as RRE for all asbestos claims in Wayne Co., MI. CMS does not endorse or advocate any particular entity or company as an RRE's agent. If the parties agree to use an agent then that controls. The RRE is the insured or the entity. CMS has not endorsed trusts as being RRE.
- HICN/SSN issue – to comply with MSP law, ask for HICN & individual is a beneficiary, then they must provide. If not a beneficiary, then ask for SSN, but have no obligation to provide.
- Caller indicated that MARC coalition claimed that they have info re: RRE language. Not correct. No information is final until it is published on the web site. All information appears first and only on Section 111 web site.
- CMS does not need to prove causation. Primary payment responsibility is demonstrated solely by settlement, judgment, award or other payment. If there is some way to frame

language that gets rid of release issue and doesn't put Medicare's interest in jeopardy, then language is welcomed. Concern is that claims may be settled but no actual exposure post 12/1980. Settlement will often release all liability after 1980, to the date of settlement, even if there was no exposure. CMS will not be put in the position of re-litigating the case as to causation, but if language is suggested, will look at it.

- Concern – short last names with suffix such as Jr. If SSA entered Jr. as part of last name, then may be issue. Will only match on first 6 letters of name, but if short name, then may be issue of whether suffix has been included.
- Caller, counsel for self-insured referenced American Association of Justice statement about MMSEA, Section 111 does not require MSAs in liability cases to account for future medical costs. When settling liability cases for Medicare beneficiary, can ignore MSP other than repaying conditional payments prior to settlement. Barbara Wright – earlier transcripts have included short points. AAJ is correct in that Section 111 does not require liability MSAs. However, also stated that Section 111 does not change any prior obligations. Do not have the same formal process for liability MSAs as WC MSAs. WC is recommended process, not a required process – not whether or not there should be an MSA in a case. For liability, no staffing or resources to impose a similar program. Have told R.O.s to review as they are able to. No safe harbor. Back to obligation that has existed since 1980. If entity has not been taking steps to protect Medicare's interests, they should now start taking steps to document how this obligation is being taken care of. CMS has no opinion or process as to how to reasonably consider Medicare's interest. Example of establishing an MSA sounds to be a reasonable method, but can't provide any official guidance. Need to have a process in place to document why or why not there are future medicals and how this was taken care of. Most entities have not even been considering the possibility of future medical.

IV. Additional Scheduled Teleconferences

- 11/03/09 – technical issues
- 11/17/09 – policy
- 12/08/09 – technical issues
- 12/15/09 – policy

November 3, 2009

Please note that some upcoming notices and information will not be published on the MMSEA Section 111 Mandatory Insurer Reporting web site as is the typical course, but rather, will be made available through the COBCSW. To access the information, such as beneficiary test data and listings of insufficient ICD-9 codes, you must be a registered COBCSW user and log into the web site.

Many callers reported difficulties with submitting and receiving query files and responses. These difficulties were all technical in nature and users were referred to seek assistance from their EDI representative. In once case a caller indicated that a positive match on a SSN and the HICN was returned. He apparently manipulated the data so that the HICN and other data was correct, but purposefully altered the SSN to be incorrect. Such a manipulation should have resulted in a positive match, since it should default to the HICN before the SSN, but it did not. Another caller indicated that data was manipulated so that there was a deliberate error in one of the four fields, which should have still resulted in a positive match, but did not. CMS requested that these examples be forwarded to the EDI department for analysis. Perhaps there was an error in data entry, but in any case, it is noteworthy that a large number of callers are reporting difficulty with the query function.

TELECONFERENCE NOTES

I. Welcome – Bill Decker

- Technical issues call

II. Introductory Remarks –

- New computer based training courses are available.
- Posting test beneficiary data, insufficient ICD-9 codes posting on Section 111 COBC secure web site instead of the MMSEA Mandatory Insurer reporting page. Must log in first. Available by Monday November 30, 2009. In the meantime, test data is available through EDI representative in a text or excel file. Available now.
- Plan to update Non-GHP User Guide by the end of the year. Definition of RRE, Mass Tort reporting requirements and other clarifications. No changes, only clarifications. Information on outstanding policy issues. File layouts will not change but field descriptions for product liability and mass tort field descriptions and instructions will change based on final policy for reporting.
- ICD-9 codes in current User Guide is one version for Section 111 reporting. Will accept any code on the last 3 versions posted to the CMS web site in field 15 and 19. New versions are published by CMS by 10/1 of each year. Will be implemented by 1/1 of the following year to allow for time for implementation. When first production files are due in 2010, CMS will accept versions 27, 26 & 25. Link to these files are in the User Guide.

Registration process will remain open indefinitely. If not completed can still do so.

- ORM termination date must be at least 31 days after DOI. If termination is less than 30 days, then default to 31st day. However, if no-fault exhaust date, field 82, has no time limits.
- No need to report the date of death. Will be notified by SSA.
- If no TIN or U.S. address, please continue to report to the COBC EDI department. Close to finalizing instructions for registration, but not yet finalized.
- Changes to add two document control numbers to the X12/270/271 query and response files.
- Working to make HEW software more automated for Windows PC server version. Changes to query input file and response in January 2010. More info forthcoming. Implementation will be done in such a way that if choose not to use a new version, may continue to use current version.
- Some secure FTP issues. Please report to EDI rep.
- If payment voided after being submitted, if one TPOC is being canceled then submit a delete transaction to remove the record entirely. If only wish to cancel 1 of multiple TPOCs then submit an update record.
- If more than 5 TPOCs to report. First, make sure defining TPOC correctly. Not a structured settlement. TPOC is the entire amount, not the individual installment payments. Possible to have more than 1 TPOC. If more than 5, then report to EDI representative for further instruction. Might occur in a bankruptcy situation where there are repeated small amounts awarded.
- Add 31 days to the date of incident for termination date if termination 30 days or less from DOI.
- Death of an injured party/Medicare beneficiary, if ORM termination date is less than 30 days from CMS DOI, exhaust date should be set to date of death for no-fault. ORM termination date set to 31 days after CMS DOI, even if after date of death. CMS will be notified by SSA in event of death and claims will be handles accordingly.
- Can CMS send a different disposition code if Medicare entitlement date is in the future? If match info to a Medicare beneficiary then will return the appropriate disposition code. Even if future dates, will not return a different disposition code. A 51 would not be a match, will not use if matches an individual with a future entitlement date – will return 01 as a match.
- What E code is used in field 15, alleged cause, to asbestos exposure? Recommend E8668 code for accidental poisoning by other and unspecified substance.
- At this time none of Section 111 documentation is available in Spanish.
- Testing is required for all RRE IDs. If multiple, test with 1 and then use same test files on subsequent RRE IDs.
- No 30-day requirement for testing period. May begin Jan 1 2010 and may continue testing until week of required reporting in 2nd quarter. At any point in future, may retest, even after active production begins.
- COBC has access to all IRS assigned TINs. Don’t need a list of what is approved. If it is valid, then CMS should be able to find and validate.
- Nothing to report in a particular quarter. Can submit a header record, no detail records and a trailer record. Also option for account manager/designee to log in and indicate that nothing to report.

- If log into COBCSW and see submission time frame different than on profile report, that should not be the case. Report to EDI rep.
- Direct data entry on the COBCSW web site being considered? Yes, but no set plan or date in lieu of electronic file submission.
- Valid characters in the HICN field – defined as alpha numeric. No special characters. If both HICN and SSN, system will first check HICN. If no match, then will attempt match on SSN. On response record back will receive the most current HICN assigned to that beneficiary.
- Last name on a query response file is different than as submitted on query input record. However, match on SSN/HICN, gender and DOB. On response file will provide Medicare's most current information. If incorrect, then party needs to make change through the SSA.
- Threshold errors, 4% of more of the records being delete records? Threshold errors do not auto reject the file, it's suspended but EDI rep can override the threshold error.
- What is the current version of the X12/270/271 companion document for creating own software – dated 9/24/09.
- Possible for RREs to delete out of Secure FTP folders or can they be moved to a new directory? No plans are changed. Will be kept for 180 days. File naming convention under secure FTP is listed in the user guide with date and time stamp as part of file name.
- What firewall port? See section 15.3 of User Guide.
- Registration remains open indefinitely. Failure to register is not in itself going to result in a finding of non-compliance. Will see if this statement can be issued in writing.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- RRE is currently submitting Query files. Not able to find flat file format. Have tried multiple but none are being accepted by the HEW software.
- Attempting to test Query file and using mainframe HEW software successfully. Having trouble with secure FTP. Question data coming back. Record not matched. Last name field is now blank, first initial was changed to first initial of last name, DOB and gender or correct but names are not correct. Report to EDI representative.
- ORM on old WC claim transferred to guarantee association. CMS reserves the right to audit. Records should show when file was assigned to guarantee association. Data matching will also occur if already on file from prior RRE.
- Query file can be sent to COBC, but can't get HEW software to work properly in response. Referred to additional instruction on Section 111 web site & EDI rep.
- Model language is not available in word format. Will need to convert themselves, manually, into word format. Don't look just at the model language, also look at the Alert which describes how to use it.
- Products liability question. FOIA requests – information that comes in for COBC comes into a closed system that does not produce material that is not ordinarily accessible to Freedom of Information requests but might become subject to FOIA request. Already being collected by CMS now. Not a new collection process.
- Query testing situation. Ran two test and received HICNs. Resubmitted with HICN from response file but changed the SSN to be invalid, but came back as no match. Should not have happened. Report with examples to EDI Rep. Mainframe HEW software – problem

with response file b/c coming from Unix. Downloading from web site and then transferring to mainframe. Had to FTP to Unix and then copy to mainframe in text format.

- Fear of cancer claims – after chemical release or similar incident, individual fears cancer. If medicals are claimed or released, then not a matter of whether or not they were diagnosed with cancer. Even if not claiming a present injury. This is being claimed and/or released. Settlement would release future medicals associated with any possibility of cancer so it would be reported. Difficulty with ICD-9 codes. Can look into that area further, but answer is that it does need to be reported.
- Submitted a deliberate error test file and first came back as identified as beneficiary. If 1 error then will come back as a match. Need to reasonably check for errors. If reason to believe that someone is a beneficiary then should look more closely to confirm query. CMS cannot release privacy protected information to tell which fields do and do not match.
- Beginning query testing. What is response time? Seems to be up to 72 hours to show that file is in process. When log in will see RRE listing page. Select the test files results page which will show status of file and where it is in processing. Tried to use link, but not working.
- RREs and relationships with agents – RREs are designating firms to be their agents without talking to agent first. Agents should not be notified by CMS of their status of agent.
- Talking to EDI representatives. If rep doesn't seem to be able to manage the question that is being asked, then please refer to User Guide escalation process. 18.2. Please read User Guide prior to pursing escalation.
- $750 reporting threshold for WC ORM. What happens if exceeds $750 and then report "late." If this is a claim for something other than only medical, then would not fall under threshold. Look at all criteria first. Even if reported later, should be able to document process as to why it wasn't reported. If can prove that wasn't reported until exceeded threshold, then this should be sufficient if questioned. CMS reserves the right to audit.

IV. Additional Scheduled Teleconferences

- 11/17/09 – policy
- 12/08/09 – technical issues

November 17, 2009

Several questions were raised during today's call surrounding the issues and draft language pending per CMS' 07/31/09 alert. Of special note were questions regarding risk management and hospital write-offs and whether these types of claims would be reportable incidents. Parties were advised that CMS is continuing active discussion on all pending topics with a goal in mind to update the user guide by January 2010.

TELECONFERENCE NOTES

I. Welcome – Bill Decker
- Policy Call

II. Introductory Remarks -- Barbara Wright/Pat Ambrose
- Apparently several RREs are having SFTP problems on the COBC secure website. Pat Ambrose advised that they are currently working with a vendor to resolve these issues. In the interim, if an authentication error is encountered it should be reported to the appropriate EDI representative who will provide instructions for resolving the problem.
- If RREs experience a connection 'time out' they should NOT perform any directory listing; rather, specify the RRE mailbox with SFTP address in the time out issues. Again, contact the appropriate EDI representative for further assistance.
- Bill Decker addressed collection of Social Security Numbers (SSN), reiterating that CMS' primary focus is the Health Insurance Claim Number (HICN). CMS can be asked to look for HICN per user guide protocols.
- Bill Decker reiterated that if an individual does not have a SSN, then he/she cannot be a Medicare beneficiary so no reporting would be required for that individual.
- Several key issues related to reporting under Section 111 that have been pending resolution continue to be undetermined. Barbara Wright indicated that questions regarding clinical trial instruction, hospital write-offs, and risk management write-offs continue to be under discussion. It is CMS' goal to resolve these issues and provide a revision to the User Guide in relation to them by January 2010.
- Regarding registration of foreign insurers, preliminary discussions are ongoing within CMS. While this issue is pending, Ms. Wright did discuss a couple of situations involving transportation across international borders and manufacture of products to be sold in other countries but indicated that a final decision regarding reporting in these instances is still pending.
- Ms. Wright did indicate that cases involving mass torts will be easier to report as it is CMS' plan to revise fields 58-62 of the Claims Input Detail record. New terms will divide these claims into two groups with distinctions to be made between non-physical incidents (ie: absorption, inhalation, etc.) and general exposure cases. Identification of the specific product involved in Group 1 claims will need to be provided; however, this information will not need to be provided when Group 2 claims are reported.

III. Question and Answer Session – Liability/Self-Insurance/No Fault

- Reiteration was made regarding the fact that a "sibling" company may not function as an RRE for one of its fellow siblings; however, a holding company in position over each sibling may function as RRE for each sibling company. There were several questions raised surrounding this issue.
- If questions arise regarding responses from CMS to registration of RREs, the user guide should be followed for escalation of the question from the EDI representative to department director if needed.
- Barbara Wright indicated that RREs who have not yet registered because of the pending language changes outlined in the 07/31/09 alert should not delay registration based on the draft language.
- A state insurance fund raised a question regarding field #98, ORM indication field, as to when the entry in this field can be 'No'. It was stated that if a claim is settled with one lump sum payment and no ORM, then the TPOC amount can be included with 'No' in the ORM field.
- Pat Ambrose indicated that it was acceptable to report both ORM and TPOC on the same claims report.
- If a claim or query is submitted after TPOC date and the reporting entity is confident the information submitted was accurate, if the entity receives a '51' response from the query, then it can be assumed the individual is not a Medicare beneficiary.
- If there is no ORM on a reported incident, then no follow-up is necessary unless the claim is reopened with anticipated ORM at the time of reopening.
- Reminder was given that, at the time of settlement, judgment, or award, SSN information should be double-checked due to the potential of changes in status from the time of initial inquiry to the time of S/J/A.
- A question was raised as to who the RRE would be in this situation: There is a contract between insurer and TPA and TPA makes payments to the injured party directly, with the company (self-insured) reimbursing the TPA for payments due to compulsory state regulations. Draft language indicates the insurer would be the RRE because the TPA is acting as agent of the insurer. Contract should clearly delineate this agency status.
- In no-fault cases, reporting should be made pursuant to thresholds for no-fault claims (ie: $1000 limits).
- When liability cases are settled and there are liens from medical providers to be resolved, the payments to providers in resolution of those liens do not need to be reported. It was further clarified that if TPOC is made to Claimant and liens are negotiated subsequent to payment of TPOC, the payments to resolve those liens do not need to be included as an update to the TPOC amount.
- If a professional liability policy is issued with self-insured retention (SIR) and the carrier handles the claim within the SIR, the carrier would generally be considered the RRE. However, review of draft language was encouraged.
- If a signed release is obtained from a Claimant, check is issued with agreement to pay incurred expenses, and two additional payments are made over the TPOC threshold, an update can be submitted to update the record with regard to a new TPOC amount or the claim can be held and reported with one final TPOC amount once all payments have been made. Reference to the Section 111 website for details in this regard was recommended.

- Clarification of language regarding cumulative trauma claims is pending. CMS' definition of exposure may not be the same as that of the industry (ie: carpal tunnel syndrome cumulative trauma cases do not constitute "exposure" cases in the eyes of CMS). If payments are made on these types of claims by workers' compensation, then the claims need to be reported.

December 8, 2009

During the 12/08/09 teleconference, CMS announced that the updated User Guide would not be ready by year-end as previously expected. Rather, Alerts with changes will be published as soon as the information/guidelines are approved. There will be no changes to either the testing or first mandatory reporting periods, but any changes will be made effective at later dates to allow time for RREs/reporting agents to update their systems. Also to be released in January 2010 is a modified version of the HEW software, which is to be a more automated Windows version. The current version can continue to be used or entities may update to the new version at their option.

Callers seemed to indicate delays in production Query file response time; one caller stated it took 3 weeks to receive a response. CMS promised that they will continue to work toward their stated 14 day Query response time and that Claim Input Response files could be expected within 45 days. Another Query file issue is that if a "0" is provided by the submitter for the gender field (indicating unknown), when responding the COBC will default to entering a "1" in the response file, which identifies the beneficiary as a male whether they are male or not. RREs/Agents should be aware of that default in the system.

Another prevalent question was whether reporting is required if the parties are already in touch with the MSPRC regarding the repayment of conditional payments. The answer to this question is obviously yes, but it appears many are hoping that this is a reason to avoid reporting. This may be a common question that beings to be presented to us. CMS representatives indicated that reporting may spur an MSPRC investigation; however, that is not definite and parties should still contact the COBC/MSPRC independently to investigate conditional payments. Further, that contact most certainly does not result in compliance with Section 111. In any case, a beneficiary must be reported through the process in place.

TELECONFERENCE NOTES

I. Welcome – John Albert

- Technical issues call. Policy call on 12/15.

II. Introductory Remarks – Pat Ambrose

- New updated CBT modules available. Updated curriculum recently posted.
- Test beneficiary data, insufficient ICD-9 codes and Error codes – files have been posted on the Section 111 COBC Secure Web Site. Do not need to log in, but must accept log in warning. Click on Reference Materials to link to downloadable files.
- Unable to publish Non-GHP User Guide this year as previously announced. Instead, Alerts will be published as they become available. New User Guide will be published as early in 2010 as possible.
- No change to Non-GHP schedule for testing and reporting. Testing commences 01/01/2010. First production files due 2nd quarter 2010 during assigned submission time frame.

- However, changes pending will be effective at later dates in order to allow RREs time to incorporate changes into their systems.
- Anticipated User Guide updates/Alerts:
- Registration and TIN reference file to accommodate foreign RREs without a US address. Will allow use of a pseudo-TIN and new optional fields to accommodate an international address in free form text fields. Effective April 2010. More specific information will be published. Testing by foreign RREs will commence in April 2010.
- Changes to accept last 3 versions of valid ICD-9s
- Fields 58-62 – requirements not yet finalized. Field and record lengths will not change. Testing related to these fields cannot begin January 1st. More information will be published.
- HEW software will be modified, will be available in January 2010.
- Windows version of HEW software will be more automated.
- Corrections needed for error codes for Claimant and Claimant representative fields. Left justified with an extension of up to 5 digits. And remaining bites filled with spaces.
- Office site code should be 9 digits, if not used, filled with spaces. (optional field, but if using should be as a 9 digit number)
- Various pending policy issue changes – who is an RRE. Will impact what will be included on file submission. Policy notifications will be issued via Alert and posted to web site.
- ICD-9 codes – the last 3 versions posted to CMS web site will be used to validate fields 15 & 19. CMS posts new versions by 10/01 of each year. COBC will implement the following January of each year to allow for time for the RRE to incorporate into their system. Link in User Guide - 11.2.5. Will see a series of zipped files. Each labeled with a version. Use the 2nd of 2 version 27 files (updated 7/29/09), also download version 26 and version 25.
- Will transition to ICD-10 by 10/2013. Transition period anticipated.
- Secure file transmission process, fix has been applied to FTP server software. Should resolve performance issues/time outs.
- Query – when submitting a value of 0 for unknown, COBC will change to value of 1 for male, prior to matching. Will contain 1 regardless of whether there is a match or not.
- Do not need to supply subsidiary information during registration. Do not need to provide subsequently to EDI rep at this time. Optional. No need to send if unable to enter during registration.
- ORM termination date must be 30 days greater than the CMS date of incident. This is due to an internal system. If less than 30 days, default to 30 days. If no fault, put actual dates in field 82. No 30 day requirement in field 82.
- If RRE is a sole proprietor, may submit SSN as TIN. May result in a compliance flag. Please contact EDI rep.
- Fields 15 & 19, must use an E-code in 15, a V-code can be submitted in one of the diagnosis fields, but at least one must be submitted that is not an E-code or a V-code.
- Test data does not have to represent real claims in your system. Can be pulled for testing. Test data must be submitted to pass the edits. Recommend use test beneficiary data on the COBCSW. Or, select injured parties over age 65.

- Query file response time. To be returned within 14 days per User Guide. Claim Input – response file to be returned within 45 days. In both cases, responses will be created as soon as possible so may be before these dates but 14 day for query and 45 for claim response is what they are committing to.
- State of Massachusetts, maximum benefit of $8K over 2 years. When should ORM term date be reported? Initially submit with future ORM term date for 2 years, but use an update record if max benefit reached prior to 2 yrs.
- Don't accept future date in DOI or TPOC dates but do accept future date in other fields.
- If some work is already taking place with MSPRC related to the claim? Section 111 reporting MAY trigger an MSPRC investigation. Regardless of whether working with MSPRC or not, reporting is still mandatory.
- Alternative to submitting an empty file when nothing to report – will be available by April 2010.
- RRE is in process to reimburse Medicare for portions paid toward medical bills. Question of whether this claim needs to be reported? Yes, as long as meets Section 111 requirements, must be reported. Does not change any other responsibilities under MSP. MSPRC being notified does not change reportability.
- Decimals in ICD-9 codes must be removed before being submitted.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Correlation between test and production files? Will test be processed before production? Answer – these are completely independent systems.
- Legal issue, CA must pay up to $10K in medical, 90 days to accept or deny. If deny, only responsible for first $10K. Many cases denial is unchallenged and close file. However, for 1 year may be challenged and litigate the issue. Is there some period to wait before reporting ORM? If in first 90 days while investigating? If reported ORM and technically still have responsibility then it should remain open until you don't. Have a responsibility to pay up to $10K, but if deny have no further responsibility unless liability is established?
- New HEW software expected in January, around the 6th.
- If compliance flag that information is missing, if the type of flag in which could be a change of information, then should do so in an update file in the next quarterly file submission. If field that is required, then record will be rejected with an error code. Error codes must be addressed and corrected/resubmitted in next quarterly file submission. SP disposition code is as if was never sent to CMS to begin with. SP disposition is returned if any required fields was not filled in. IN that case, new file submission in next quarter – not accepted so no file to update.
- Query response file does not give a date of Medicare eligibility. Query after established ORM or a TPOC date in order to know what the status of the injured party is. Will only need to query one month after TPOC, but if have ORM, will need to query regularly as long as ORM continues. Entitlement based on age is always as of the first of the month – they think that is the case when becoming entitled for reasons other than due to age but can confirm that.
- ORM under WC accepted. Submit update record ORM equal to Y, update with TPOC. If update record is rejected then need to correct and resubmit. Once accepted with an 01 or 02 disposition code, keeping it unless deleted. If error on update, just the update rejected,

not the whole thing. If two different coverage lines then two separate records must be submitted. If no-fault ORM was accepted and then submit an add record for liability TPOC and that is rejected, then that has no impact on the ORM record that was already submitted. Those are two separate reports. Can't change something for two lines of coverage within the same record. Must understand that reporting by insurance type. No-fault and liability, even though considered one claim would be reported on separate records.

- Can submit an update to an ORM termination date. Should not submit a term date unless there is an expected term date. Should not automatically submit the termination date for every record without having other support for doing so.
- If required field is empty, if there is an error and rejected then will not be considered to be reported at all. Will need to submit correction on next quarterly file. Will be processed as late with compliance flag. No automatic penalty but warning that it was received later than it should have been.
- Must obtain information for required fields. Really must work to obtain that information in order to be compliant. In liability if never goes to litigation, then may never get this information for the number of required fields. No answer other than must get the required info for compliance.
- New User Guide for NGHP is expected by the end of January 2010, but might not be until February 2010. Will be published as early in 2010 as possible. Changes will be published in form of Alerts to be used in conjunction with current version of the User Guide.
- If know that Medicare has a recovery claim/issued demand, there is no field on Section 111 for reporting that; however, keep in mind that this knowledge does not change reporting requirements. This is a separate responsibility.
- Submitted query files and received responses, but responses had errors. Issues with query response files have not truly been issues upon investigation. If a 0 in the gender field, will automate and return as a 1 whether match gender or not. Mismatching reports, etc., had to do more with matching input records to response records (not always returned in the same order). Matching can be tricky if not returned in the same order.
- Fields 58-62; any decision on when those fields will be effective? Don't have requirements finalized so CMS system is not updated to process those fields. Exact date is pending. Will not be able to test with those fields beginning 01/01/2010. Can't collect information until requirements are defined. Wait for Alerts. Will not spring new requirements at the last minute without time to allow for changes/collecting data.
- Can continue to use current version of HEW software or opt to use the new HEW. Recommend upgrade to version 2 but don't need to do it right away.
- Production query files, caller's experience is that it is taking 3 weeks for response. CMS is working with system to meet 14 day return requirement.
- Have an injured party where the individual only has a single name. If on SS card that way, then would be in CMS' system.
- Transition from one agent to the next is the responsibility of the RRE an its agents. No harm done by duplicate claim input files being submitted. If reported an add record again, it would be processed and accepted – would be treated as an update.
- Indemnity TPOCs – revised language is in process of being published in an Alert to be released shortly.

December 15, 2009

During the 12/15/09 teleconference, CMS announced that their goal is to make the updated User Guide available in January 2010. There have been no alerts issued since the last teleconference. Final language regarding issues such as clinical trials, risk management write-offs, mass tort claims, foreign RREs, and RRE definitions is still pending. CMS emphasized the fact that the User Guide will continue to be a work in progress as future process and procedural changes are inevitable within the Section 111 reporting environment.

It was repeatedly emphasized by CMS that all entities are encouraged to communicate regularly with the appropriate EDI representative to raise issues or questions and remain in compliance with all Section 111 protocols. As part of their answer to the final caller of this teleconference, CMS indicated that there was a six year statute of limitations regarding their pursuit of conditional payments. Their discussion included a statement that the six year statute of limitations would be based on the date of CMS knowledge of the settlement, judgment or award. Because it was part of the final answer on the teleconference, no follow-up or additional information could be clarified in this regard.

TELECONFERENCE NOTES

I. Welcome – Bill Decker

- Policy call.
- Barbara Wright and Pat Ambrose also participating for CMS.

II. Introductory Remarks – Barbara Wright

- Language regarding the following issues is still pending final approval:
    - Clinical Trials
    - Risk Management Write-offs
    - Mass tort – specifically, fields 58-62. These fields will be reworded to eliminate trauma-based injuries. Claims will be classified as either Group 1 (where identifiable product or class of products is used) or Group 2 (where exposure is environmental). It is likely that completion of these fields during the reporting process will not be required until January 1, 2011, with CMS' final position to be outlined in a future alert or the updated User Guide.
    - Foreign RREs: Target 04/01/2010 to begin registration with registration required by 06/30/2010; again, watch User Guide/alerts for final timeline. Problems with registration are present when entity has no US address and/or no US TIN/EIN number.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- No change in RRE instructions now. RRE IDs are randomly assigned. If able, pursuant to prior instructions, you may combine all into one RRE IE. EDI representatives can assist with this determination.
- Railroad Retirement claims are NOT exempt from reporting requirements.
- Query test data can be used for purposes of production testing as well.
- The model form for obtaining SSN information does not have to be printed in color and may be modified to include a return address.
- Installment payments of a settlement/judgment/award: If a claim is settled with true installment plan (ie: payments will be made but are deferred to specified dates), the s/j/a should be reported as a lump sum TPOC at the time of settlement. If claim is settled as 2 separate settlements or with a contingency such as possible reopening in the future for new and further disability, then where there will be 2 or more separate TPOCS there should be a separate reporting as each payment is made.
- Question of "accident only" coverage was raised and was deemed not to be GHP. Language for handling of claims under this type of coverage under NGHP is pending.
- There is no threshold for # of claims to be reported by an entity which would allow the entity to be excused from reporting cases. At this time, even if there is just one reportable case per year, all claims must be reported. CMS indicated this may change in the future.
- CMS' goal with regard to the Section 111 reporting requirements is to obtain accurate data. Penalty guidelines will be developed but are not a priority at this time. Any questions regarding compliance should be directed to the EDI representative for current compliance assurance.
- Liability policy: If policy pays for any medical, claim should be reported as liability claim; if policyholder agrees to pay medical bills apart from policy, policyholder is deemed 'self-insured' by CMS in that instance and should report accordingly.
- Language regarding CCI is still pending; refer to 07/31/09 alert for details or questions until further clarification is issued.
- ICD-9 and E codes: If updates to ICD-9 or E codes are required, then Fields 15 & 19 will need to be completed.
- Reporting in situations involving lay-off of employees and a general release is signed as part of severance process: language regarding handling of this type of situation is pending.
- Representative (attorney) TIN or SSN: 42 CFR 411.24 provides basis for CMS requesting this information. The 1996 Debt Collection Improvement Act also gives CMS right to collect TINS. Procedure outlined on page 132, field #88 outlines process for obtaining this information.
- Question about pages 138-139 of the User Guide: Field #104, Claimant information. Value 'x' is placed in this field as amount of the estate of 'John Doe'. Field 105, then, should include the TIN for the estate, not the deceased SSN (unless no formal estate was established).
- Postal Service employees: Those hired before 1983 did not contribute to SSA and would likely not be eligible for Medicare based on postal earnings alone. No discussion ensued regarding potential non-postal earnings posted to earnings history.

- Subrogation claims: Question arose from review of transcript of CMS teleconference on 05/14/09. At that time, CMS indicated that parties on both sides of a subrogation claim would need to report the claim; however, CMS indicated today that they will review and clarify their position in a future alert.
- CMS indicated that they accept no reduction in their amount of recovery of conditional payments based on an allocation between the parties when multiple defendants are involved. They discussed their statutory right to pursue the full amount of recovery from each party that may be jointly and severally liable in any particular case.
- CMS reiterated that, with regard to liability nuisance claims, they are bound in their scope of recovery by the parameters of the settlement. Beneficiary can request a waiver of recovery and CMS will negotiate, at times, in these types of cases.
- Termination Date: a simple discharge note from a medical provider does not automatically provide a basis for termination date. There must be a statement from a provider confirming that no further treatment for the accident in question is necessary.
- Page 135 of User Guide: Field 100 - claim input record. Definitions are not repeated but some descriptions are found in the record lay-out itself.
- TPOC date is required to be reported if over the $5k threshold 01/01/2010 on files that were tested in 2009 with reported TPOCs. Reminder – there is a 45 day grace period in production mode.
- If defendant is named in PI lawsuit and is fully indemnified by another company, the defendant does not report but the paying entity would report the claim, in most instances.
- Mass tort question: What if fields other than 58-62 are not able to be completed during reporting cycle? CMS indicated that the phrase “when funding is available” will be defined in future alerts in this regard. RREs must make a determination as to who got paid and how much each was paid if information on TPOC not available at time of required reporting. Communication with EDI representative encouraged.
- Confidentiality question: Can RRE be notified if FOIA request is submitted for total amount of mass tort settlement? CMS indicated that generally, information that is beneficiary specific will not be released under FOIA request.
- California question: CMS answer pending regarding reporting of TPOCs where hospital is the claimant and there is no ORM.
- Statute of Limitations: CMS indicated they have a six year statute of limitations on recovery of conditional payments which begins at the time of their knowledge of the claim. This was discussed as a component of CMS’ answer to the final caller in the teleconference. No follow-up or clarification was able to be made in this regard.

IV. Additional Scheduled Teleconferences

- January 5, 2010
- January 28, 2010
- February 10, 2010
- February 25, 2010

January 5, 2010

TELECONFERENCE NOTES

I. Introductory Remarks

Pat Ambrose

- Foreign RREs without a TIN, and/or a U.S. address are unable to register on the COBSW, once the problem is resolved, foreign RREs will be given an extra quarter to get to production-ready status
- Even though they are given an extra quarter, they still must perform retroactive reporting with their initial claim input file.
- HIPAA Eligibility Wrapper (HEW) is being updated—most recent version will be available January 6 for download.

II. Question and Answer

- If Claimant dies, how would you report ORM termination? Same as anything else. ORM termination date is date of death.
- Do you report TPOCs only if it incorporates medicals too? Workers' Comp.—yes.
- You have to report the TPOC even if you are only settling the indemnity side of a lawsuit.
- Even if the injured Medicare beneficiary is living out of the country, you must report.
- Thresholds for reporting are not reported on an aggregate basis within an RRE, it based on the individual claim. If the threshold is $5000, and the total claim settled for 4,990, then you do not report, even if you have 10 claims that settle under the same situation.
- If there are multiple RREs involved with the single beneficiary, and there are separate settlements paid out by each RRE, they each apply the applicable threshold; however, if there is a payout among multiple RREs with joint and several liability, then they each must report the total settlement amount.
- The turn-around time for the monthly query is 14 days.
- The date for ORM Reporting is 7/1/2009 and the date for TPOC reporting is 2/2/2010 no matter if the company is liability, Workers' Comp, or a no-fault business.
- Under Workers' Comp, vocational rehab benefits like physical and occupational therapy that are Medicare covered items and services need to be reported.
- Vocational rehabilitation where the worker is simply retrained to do another task because of injury does not need to be reported.
- Submit a SSN or HICN whenever possible because of possible name changes, the SSN or HICN stays the same and alleviates any issues with searching.
- The HIC number can change over time.
- If a TPOC is exactly $5000, it does NOT have to be reported.

- If you run into a claimant who refused to provide the social security number, what constitutes due diligence? First, you should try contacting them to get the number either them directly or through their attorney. If that fails, then use the model language provided and have an appropriate procedure that you regularly use to document your attempt in contacting the non-compliant claimant. It is important to remember the HICN that CMS is more interested in as opposed to the SSN. Last, it is important to make the claimant realize that if they do in fact have a HICN, they must provide it; they do not really have an option as whether to provide it or not.

January 28, 2010

CMS announced that as of 02/08/2010, they are loosening the requirements with respect to the attorney information. Specifically, they expect to announce that either attorney name or firm name is acceptable and attorney TIN is optional. They specified that this information may become required in the future, but for now the minimum appears to be either information for either the specific attorney name or the firm, but no TIN.

They recapped that per the 12/23/09 Alert, information for fields 58-62 concerning mass torts are not required.

Although this was a policy call, several technical issues were discussed due to this being the first month of claim input file testing. It is recommended that the testing process begin early. Live data may be used, but testing can also be completed with the test beneficiary data which is available through the COBCSW.

TELECONFERENCE NOTES

I. Welcome – Bill Decker

- Policy issues call

II. Introductory Remarks – Pat Ambrose

- Technical info to share regarding testing for NGHP – review the technical alerts posted to Section 111 web site. On left side of overview page there is MMSEA 111 Alerts, on page dated 12/29/09 re: registration guidelines for foreign entities, dated 12/23/09 re: addition of DCN to the query process and HEW software upgrade, and dated 12/23/09 re: claim input file field requirements (additional information will be in new User Guide)
- Currently processing test files from RREs.
- As of 2/8/10 - Loosening of fields related to representative names and TINs. Includes injured parties representatives as well as Claimant 1-4 representatives. Edits will be loosened as of 02/08/10 for test and production files. Representative TIN will become optional fields. Representative name, only required first and last name OR representative firm name. ALERT is pending for official information.
- As the data is used by CMS, there may be future field changes, but will always be given plenty of notice to incorporate changes.
- An email is sent to account manager when a file hits the 20% error threshold. This email has been updated to list the errors found in the file. Error codes displayed will be accurate but descriptions are not. Descriptions will be corrected but in the meantime, refer to descriptions in the User Guide.
- Field 17 state of venue, US is acceptable but system is not currently accepting. Fix pending.
- TIN reference file errors – will not be accepted and will result in all records on claim file being rejected. EDI rep can look at a TIN error report and help identify which errors

actually occurred. Working on a new report to address TIN file errors so that they can be more clearly identified.

- Test beneficiary data may be loaded from Section 111 secure COBC web site. No need to login. Under reference materials menu option can find test beneficiary data.
- Office code or site ID field – leave it blank if not used, or if using must be 9-digits.
- Remember numerics must have leading zeros to completely fill the field blanks
- Each claim record must be 2,220 bites and must be filled with spaces to the end of record. Carriage return actually goes to bite 2,221. Fill record with spaces to make fixed length record.
- If using SFTP, when transferring put the file in the proper mailbox by RRE ID.
- Address formatting – suggest line 1 only include street number and name. Suite, Apt. #, etc, should go in address line 2
- ICD-9 diagnosis codes. May submit in fields 15 and 19 at this time but not required until 2011. Alternate is text in field 57. If using field 15 & 19, then the system will still edit them even though they are not required. If any one diagnosis code is not valid, that will create an error and the entire record will be rejected. Now is a good time to test submission of diagnosis codes.
- If only supplying one diagnosis code, that code must be valid. After 1st, may be E-codes/V-codes, etc., but must still be valid codes. No E-codes/V-codes as first ICD-9.
- Barbara Wright- policy
- Language for clinical trials, risk management write-offs, periodic payments for WC and no fault is still in clearance.
- Mass torts – fields 58-62 (Alert, these fields are not being used initially – fill with spaces for now). If already set up system and attempting to put info in, will it be rejected? Is changing to spaces a must? Pat believes the edits have been turned off so most likely nothing will happen, but RRE should test it.
- Fields 58-62 – "how are mass torts being handled?" moved away from concept of mass situations. More interested in getting additional info on exposure/implantation rather than trauma based injury. If have mass tort, no current additional requirements, but looking into policy.
- 12/05/80 effective date for liability/no-fault – give relief if all exposure clearly ended prior to 12/5/80 but settlement still claims relief for all dates.
- Looking for ways to conduct additional outreach on a broad basis, possible town hall calls on recovery issues.
- For NGHP, there is no exclusion for small employers. In GHP context there are certain situations when MSP does not apply for employers with less than 20.
- ORM, future termination dates where under state law entity is allowed to terminate if no required treatment within a specific time frame. In that case, cannot put in future termination date b/c don't know for sure that there will be termination. Only enter if this date is certain. If by law responsibility ceases at a certain time if not treatment, must stay open until you have reached that date, then can report termination.
- Occupational accident insurance, by CMS is defined as no-fault insurance.
- Attorney responsibility for RRE – no advice for attorney's responsibilities to RRE client.
- MSAs, or liability situations, MSAs are not required as far as CMS being involved in any determination as how much the MSA should be. Some regional offices are available for

review, if work loads allow. This is not the same thing as a blanket statement that liability MSAs are not required or not appropriate.

- Reporting requirements with respect to recovery – do not confuse with pre-existing and ongoing process with conditional payments. If self-identified by a party to the COBC on an individual basis while still pending, there is a process that begins to allow CMS to collect conditional payment information. This does not eliminate Section 111 reporting requirement.
- There are no record retention requirements tied to Section 111. No specific advice to give.
- Could RRE purchase insurance for Section 111 penalties/fines? CMS will not give any legal advice on this. If penalties imposed, would impose against RRE and would not be obligated to pursue from insurer.
- Periodic payments for WC & No Fault – if indemnity for lost wages, if ORM is already being report or continues as long as the periodic payments continue then expectation is that separate payments do not need to be reported. Have not come up with any situation where there would be continued reporting of indemnity payments without ORM. If a TPOC in that situation, likely to require reporting. Tentative – not final determination.
- Obligation to report complete settlement, judgment, award or other payment.
- 60 day window for reimbursement is triggered by the date of the settlement check. Obligation is 60 days from receipt of funds. Already pursue recovery directly from WC and no-fault. In liability, pursue recovery demand against settlement.
- If coverage is paying without regard to fault, it is no-fault coverage.
- Joint and several settlements. If multiple defendants in joint settlement agreement where each have responsibility, each must report entire settlement judgment award or other payment. If each separate settlement then only report what RRE has direct responsibility for.
- Consent to release vs. proof of representation with recovery process. If WC or no-fault and entity already has right to receive Conditional payment information without a release, then need a letter of authorization from the Insurer. If liability insurance, then cannot provide information without a specific release from the beneficiary. IN that case need a consent to release signed by the beneficiary saying it's proper to release info to the insurer and then letter from insurer identifying TPA as being authorized to represent Insurer.
- Model language letters are being returned to CMS. If sent to CMS will be shredded. This letter should be kept in RRE's file. Not for CMS.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Indemnity question – convenience store sued for sickness from bottle of water, bottled water company indemnified convenience store. Who reports? Did the store actually settle with the beneficiary? Provide actual payment to the beneficiary? If so, then reporting responsibility. It's not the ultimate source of the funds, it follows the party that made the payment. Equivalent of excess insurance.
- If someone is on SSDI but not Medicare at time of settlement, then no reporting requirement with respect to TPOC. If ORM, must monitor and begin to report as soon as

becomes eligible. Sometimes retroactive Medicare entitlement, in terms of TPOC, still off the hook. Won't be reporting until that award is set.

- Applicant attorney TIN not mandatory field now – will it be in the future? Will record how much additional work CMS must do in cases where TIN is not available. If they find that it requires too many resources and is necessary information, then may change to be required. Encourage development of that information, but not required. The more information provided, the more data matching opportunities and less follow up required.
- Settle liability claim for $100K, settlement docs agree part is to be for payment for Medicare conditional payments. How is TPOC reported? Full $100K? Yes – report full $100K per dates using User Guide guidelines.
- TPOCs to be reported when there is a settlement, judgment award or other payment releases or has the effect of releasing medicals. Not bound by the parties allocation. If settling only indemnity but have ORM then no report of TPOC.
- If HICN is correct, will not go on and validate the SSN.
- Any SSN given that starts with a "9" is really a tax ID number – this person will not be a Medicare beneficiary. There are no SSNs that start with 9.
- For no-fault, WC, will not likely have multiple TPOCs. May be limited circumstances when two TPOCs. For example settled for $, but if surgery occurred within 2 years then get another $ - in that example there would be 2 TPOCs.
- MSPRC activities – updating the recovery contractor's web site to make more user friendly and to add more documents to facilitate the recovery process.
- Call ended early at 2:45pm.

IV. Next Teleconference

- February 10, 2010 –

February 25, 2010

The most significant announcement made over the course of this call related to the delayed reporting requirements. John Albert stated that one reason the decision to delay reporting was made was to allow as many parties as possible the opportunity to be in compliance before reporting begins. He reiterated that the purpose of these delays and exceptions provided is to be sure that an efficient data exchange process is built with as minimal impact as possible to all those involved.

As you know, reporting has been delayed to begin in the RRE's assigned week in the first quarter of 2011. All Claimant/Medicare beneficiaries for whom the RRE has ORM as of 01/01/2010 (formerly 07/01/09) must be reported and all TPOCs as of 10/01/2010 (formerly 01/01/2010) must be reported.

Over the course of the call, Alerts were posted to the CMS MMSEA Section 111 web site, but the User Guide, although in queue was not yet posted. It is still expected to be published this week. One caller noted an inconsistency on page 12 of the Alert regarding reporting deductibles. Barbara agreed that they would need to clarify the language so a revised Alert will be forthcoming. The Alert focuses on the policy behind reporting of deductibles, which has changed. Deductibles will no longer be considered to be self-insurance. The insurer must report both the deductible and any amount in excess of the deductible.

Even though mandatory reporting has been delayed to 2011, an RRE who chooses to report may begin to do so as scheduled beginning the 2nd quarter of 2010. CMS reports there are currently approximately 800 RREs who have successfully completed testing and may begin active reporting.

One outstanding issue regarding registration for foreign insurers has been resolved. They may begin registration as of April 1, 2010.

From a technical standpoint, there is a change in what codes may be utilized in reporting. V-codes may not be used in any instance. E-codes may now only be used in field 15 (for alleged causse), but not in the ICD-9 fields 1-19.

<u>TELECONFERENCE NOTES</u>

I. Welcome – John Albert

- Transcripts are delayed in posting. Any contradictions between transcripts and User Guide, should defer to the User Guide.
- A number of new documents in queue to be posted on Section 111 web site. None have been published yet. All forthcoming. (Midway through call, reported Alerts had made it to web site)
- Newest NGHP User Guide + 3 Alerts

- 1st Alert: RRE – Who Must Report document
- 2nd Alert: Issues that didn't make it into User Guide, but will be addressed later. Fields 58-62, reporting by foreign insurers, and clinical trials.
- 3rd Alert: Specific questions re: compliance and what CMS views as being in compliance.

II. Introductory Remarks – Pat Ambrose/Bill Decker/Barbara Wright

- NGHP technical call earlier this month was canceled due to weather, next is March 11, 2010. Call on March 16, 2010, is being changed to policy call.
- Notices for web site updates have not been received. Don't need to sign up again.
- RRE has until assigned file submission time frame in 1st quarter of Jan 2011 to submit first claim input file, but may commence prior to January 2011 as soon as testing is completed and RRE ID has been moved to production status. Ask that wait until after April 1, 2010 before active production files are submitted. Must still be submitted during assigned file submission time frame in each quarter.
- TPOCs Oct 1, 2010 and subsequent will be required for reporting. Earlier TPOC dates will be accepted.
- ORM claims as of January 1, 2010 and subsequent regardless of a date of initial acceptance of payment responsibility.
- 11.9 modifications. Earlier reports of ORM will be accepted, but not required unless exisited 1/1/10 or later.
- Extension for ORM has been removed. No longer needed given new reporting dates.
- Exception through 7/1/09 changed. ORM assumed prior to Jan 1 2010, if actively closed or removed prior to Jan 1 2010, not required to identify or report that ORM. Only those open as of Jan 1 2010 and subsequent regardless of when ORM was assumed. May report older if so choose. If later reopened, then required to report.
- No V-codes, ICD-9 codes beginning with V may be supplied in the diagnosis code fields. No E-codes will be allowed.
- List of insufficient codes ahs been changed to a list of excluded codes.
- Still using last 3 versions of valid codes on CMS web site – no change.
- May only use description of injury field in place of ICD-9 until 1/1/2011, if early production files are submitted. May not use as of 1/1/2011.
- ICD-9 may be derived by the RRE. Do not need to be pulled from bills or claims. Do not need to be official. Can be assigned by RRE. Used to match related claims but do not need to be an exact match.
- As of 1/1/11, field 15 + 1 ICD-9 diagnosis code will be required. Field 57 description field will be ignored.
- As of Monday, March 1, 2010, new files of error codes and excluded codes will be posted on the Section 111 COBCSW. Excel format and text format. Will correspond to User Guide 3.0.
- Bill Decker:
- Alert re: being in compliance. Bottom line – to be in compliance in general, will be compliant if registers for reporting and once registered, engages in data exchange testing and once testing is completed, RRE begins and continues with regular production data

exchanges with COBC. Therefore by participating in the Section 111 process in the manner described by CMS, RRE will be in compliance. Final warning is that data must be accurate data.

- Barbara Wright:
- Alert re: issues on hold until additional direction – it doesn't mention periodic payments for WC or no-fault. This has not been updated in version 3 of User Guide.
- Read Alerts in conjunction with the User Guide.
- Foreign insurers – can first begin to register as of 04/01/2010.
- Who Must Report Alert – biggest issue related to situations where there was a deductible. Major change, in situations where self-insurance is only a deductible then the deductible is reported by the insurer (both deductible and any amount in excess of deductible). If insurance is solely through a policy with a deductible, then no longer need to register/report.
- Deductible vs concept of self-insured retention. Alert helps clarify. Self-insured retention is risk not covered in policy provided by any insurer. Not deductible.
- Payment in context of who is an RRE, reference is to actual physical payment rather than the entity which ultimately funds the payment.
- Fronting policies, language a bit clearer. Insurer will not ultimately retain any risk under the policy. Insured will retain ultimate risk for all claims. Physical payment determines the RRE.
- Multiple defendants. Joint and several liability, then each entity must report and must report the total amount. Individual settlements then each report with respect to own settlement.
- Self insurance pool. Have not changed 3 characteristics identifying a self insurance pool. Added language that self insurance pool shall be licensed and regulated then the pool is the RRE. Involvement in resolving claims – reviews and resolves on own authority. If only an auditing function, then not RRE.
- Reinsurance, stop loss, umbrella insurance, etc. – situations where responsibility beyond a certain limit. Key is whether payment is to the individual claimant or to the entity. Address subrogation – if insurer pays a claim then the insurer is the RRE. If then files a subrogation claim and is indemnified by the 2nd insurer, indemnification payment is not reportable by either insurer.
- Appendix G – definitions and reporting responsibilities, changed language due to change in deductible language.
- John Albert:
- Delayed reporting one reason is to get as many parties in compliance before reporting begins. Purpose of these delays and exceptions is to be sure that an efficient data exchange process is built with as minimal impact as possible to all those involved.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Delayed start date of TPOC – agreement reached at mediation on Jan 10, 2010. Where court approval is required it's the date when court approval is received. Delayed funding date ties into fields 58-62, what they are looking at is that this will largely apply to mass tort situations where there is a settlement, judgment or award but the settlement has the ability for the people who receive the money to be identified subsequent to the

settlement. Need to use the delayed funding field in general will probably go away, rarely used. Next Alert should answer question. RRE should not have an occasion to use delayed funding field, really at all. Will make clear in future.

- Denied a body part, but then ordered to pay. Already accepted other body parts. Would want to send an update record with additional ICD-9 to include a new body part. Catch up amount would just be additional ORM that should have been paid and not necessarily a TPOC. If a situation where this is ORM and ORM continues then that would be true. However, if payment closes everything out then it would be a TPOC.
- Representatives. If under 18, will pay the parent. Would parent be the representative? Yes, but if both parent and the attorney, need to know the attorney. Only use Claimant field when the injured party is deceased. If no attorney, then parent would be the representative. Change in representative does not trigger and update requirement. May be submitted but not a must.
- If person dies the day that they are injured – would ORM be reported? If accepted responsibility then yes, but if subsequent TPOC, must report that too.
- Deductible is always reported by the insurer (whether large or small). If reinsurance, stop-loss, excess, then determined by physical payment. Distinguish between deductible or reinsurance issue.
- New Alert - Page 12 - Change in reporting definition at the end of the Alert, where deductibles are physically being made by the insurance company then insurance company reports everything. A revised version of this Alert will need to be published to clarify the language. This should be regardless of who makes payment. That whole paragraph may be deleted.
- There may be an MSP situation without a formal claim or formal release. This is why a check date alone is enough to trigger a TPOC report.
- Reporting thresholds will remain the same.
- If situation where insurer chooses to settle something without submitting through insurance, then they would be self-insured and be the RRE.
- Encourage reporting prior to January 2011 if ready. May be able to resolve issues prior to that time to make sure process runs smoothly.
- About 800 RREs have currently been granted production status.
- Finding that testing process for claim input files may take up to 3 months.
- Reporting claims with general releases of all potential claims. Severance agreement with employees, with a general release and severance payment. EEO claim pending, severing relationship. May be no medical claims but release is general to cover all potential claims. Could include medical/psych care even though they never brought those claims. Reportable? If so, what would ICD-9 be? Answer: looking further into severance and EEO. CMS will issue an Alert if needed. If medicals not claimed, but releasing claims they have never thought of. CMS doesn't want to leave it up to the insurers to determine if any associated medical. Issue to be considered would then be what ICD-9 code used if no injury claimed? Answer – unresolved.
- Direct data entry reporting for low volume reporting RRE. Should not hold on testing in order to wait for more info on direct data entry option. No details on when this may be available, or that it will materialize.
- V-codes are not accepted at all. E-codes, those are only accepted in field 15, alleged cause. Do not allow E-codes or V-codes in ICD-9 codes 1-19.

- Representative TIN is no longer required – change in User Guide.
- Joint and several liability settlements question. CMS won't give legal advice on how the settlement would be need to be worded. If 3 parties but if settlement itself identifies each amount each party must pay, parties are only obligated to the extent of their portion as documented in the settlement. CMS answer: avoiding giving legal advice. Comes down to joint and several liability. If yes, then report total amount. If no, then report individual amount.
- April 5, 2010 – entities not based in US and not having IRS TIN or US based address may register. Implementing changes to the TIN reference file so that an international address may be submitted. RRE will have a pseudo-TIN for registration screens.
- In connection with Section 111, looking into further outreach regarding the CMS recovery process in general. Nothing to offer right now but will make it known if a product becomes available.

IV. Next Teleconference

- March 11, 2010 (technical issues call)

March 16, 2010

In this call CMS highlighted an important distinction that injured individuals who are Medicare entitled (or formerly Medicare-entitled) need to be reported, not those who are simply Medicare-eligible. This analysis is obviously different than that for determining when Medicare might have a future interest to be considered in a settlement, in which case the focus is on when the individual is likely to become eligible for Medicare.

There have been no new Alerts or documentation posted to the web site since the last call, but CMS representatives are hopeful that several outstanding issues will be resolved and final language cleared within this calendar month.

A majority of the call was devoted to questions and answers, with only the first 15 minutes reserved for announcements. Calls will continue to be held twice per month for the foreseeable future.

TELECONFERENCE NOTES

I. Welcome – Barbara Wright

- Policy call, with one technical issue follow up from last call.

II. Introductory Remarks –

- Technical issue reported with RRE DCN field on new query input file. System was removing imbedded spaces. You may submit with embedded spaces. System problem has been corrected. Will now preserve and return with embedded spaces if that is how the query input file is submitted.
- No new documents posted since last policy call. 2/24 Alert, with language to be changed on attached definitions and reporting responsibilities. Correction pending. Language for periodic payments for no-fault/WC is still pending in clearance. Write-offs policy still in clearance. Finally, Foreign RREs may register as of 04/01.
- User Guide/Alerts – keep in mind that until more detail about foreign entities, the term foreign insurer references a foreign address or has no TIN.
- Specific issues of foreign entities – basic questions 1) which must report and 2) potential privacy issues. Send any questions/concerns regarding these two areas to the resource mailbox.
- Comments about subscription policies where different insurers are responsible for a difference percentage of a particular policy. Anyone of interest requested to flush this issue out a bit to the resource mail box. Be specific in comments.
- Comments re: indemnification. Assumption that doing so takes an entity “off the hook.” Look beyond indemnification alone. Indemnification alone would fall under RRE may not shift responsibility of RRE status to any other party. Is party an RRE to start with? If so, then retain that responsibility. Being indemnified by someone else doesn’t change that.

- Precision in terminology – if someone is Medicare eligible – eligibility precedes entitlement. CMS needs reporting on individuals who are entitled or who were entitled in the past. Not eligibility for reporting purposes, need entitlement.
- Large deductible holders. Can insurer shift responsibility to the insured with large deductible. Alert says no, have not changed that position. But, insured/insurer may work it out so that the insured acts as an agent of the insurer for reporting the deductible.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Opened for questions at 1:17pm.
- Disposition code 03. If resubmitted then as an add record as if the prior was not accepted. Will be adjusting language in the User Guide definition of disposition code 03. Should in fact resubmit as an Add Record.
- Third party claim connected with same accident. WC settles all aspects. Third party later settles. What is the second settlement? Liability insurer may need to report but if no relation to WC then no need to report third party settlement.
- If only closing compensation piece but medicals continue, would that be considered a TPOC? CMS is trying to address this as part of the Alert for periodic payments. Don't have an answer right now. If ending the periodic payments with a lump sum, looking to see if additional detail can be added to possibly exclude such a settlement from reporting. For now, rely on User Guide as written.
- ORM under PIP – paying for items such as glasses/dentures broken during accident or goes to ER just checked out without diagnosis. What ICD-9 code can be used for those scenarios? Seem to fall under V-codes which can't be used. No diagnosis so not sure how to assign code. No medical provider has assigned an injury. Barbara suggests code associated with eye claim if for example, glasses. Although may not pay for glasses, would assert recovery for eye-related claims if made.
- CMS approved/recommended sites for ICD-9 coding? Don't authorize/approve/certify. No problem using them or software but won't advocate for any particular source.
- ICD-9 codes, 1 is required. Field description is that if multiple injuries then asking for one ICD-9 code per body part even though technical requirement is just that 1 code be submitted. Will improve the whole coordination of recovery and claims payment process if all codes provided.
- If no reasonable expectation to report right now then don't need to register as an RRE right now. Register in time for full quarter for testing as soon as there is a reasonable expectation that reporting is necessary. Don't have a date for web-based reporting for low volume reporting, but suspect that information may be available within a month. If 5 claims per year to report then may be safe to wait for alternate reporting. Waiting for CMS to define "small reporter" in claims per year. IT team also needs to provide an implementation date.
- If replacing any device not covered by Medicare, if associated care necessary to obtain the device/equipment then may include a Medicare covered situation even if not covering the device itself. If you don't have an ICD-9, this is the path to get one.
- Not getting return HICN on query. This would depend on the disposition code returned. If 51 – then for whatever reason there is no match to a Medicare-beneficiary on file. Info supplying may not be the same that CMS/SS has or it may be individual is not a

Medicare beneficiary. If confident that they are, for example, if have Medicare card then not matching on data and should reexamine data.

- Is settlement of medical lien a TPOC? Paid at resolution of the case. Anything paid out as lump sum medical is reportable as a TPOC. If reporting ORM but paying lien, then "fine" but if no longer have ORM and making that payment then need to report as TPOC. If reported ORM and reported as of 1/1/2011 and now in 12/2011 reporting ORM termination. Paying for additional service during the ORM period of time, then don't need to report that separately. If paying for outside the ORM period and directly to provider/supplier or direct to injured beneficiary then describing a TPOC situation.
- WC TPOCs, widow death benefits – what is included in the death benefit? Would be essentially lost wages. If limited to lost wages or some indemnity, then no, not reported. But if anyway it can cover medical or past medical expenses then it must be reported.
- Loss of consortium claim, not reportable if no medical component claimed or released. Typically releases would include future medicals whether indicated or not. Important to look to the injured individual. If the injured party is NOT a Medicare beneficiary then not reportable. If for example spouse releases medicals for themselves (typically releasing potential psych issues, headaches, GI claims due to stress) but spouse is Medicare beneficiary then this is reportable because releasing medical for Medicare-beneficiary. Problem is no ICD-9 code to report.
- In WC, no periodic indemnity payments but only single permanent disability settlement. If medical left open would a single indemnity payment a TPOC event. ORM continues. Indemnity payment made once not at the end of a stream of periodic payments. Is this a TPOC event? Will be added to be addressed in the Alert addressing periodic payments.
- Definition of exposure as it relates to 12/05/80? Will this be altered/expounded upon? This is one issue that isn't resolved quite yet. Suggested language will be accepted. Issue no exposure claimed after 12/05/80 but still released. Mass torts workgroup (no meetings in past few months but not done) suggested clear enough language so that when clearly no exposure "uncontroverted evidence" of no exposure on or after 12/05/80 hoping to write language to eliminate.
- Liability MSAs – will this ever enter the world? This is already a factor. CMS does not have a formalized process for review of liability MSAs. The process for WC is voluntary. Informal process on liability side if anyone wishes to approach the R.O. and R.O. has the ability to do so then they can choose to review. Not the same extensive process for WC. Regardless of CMS process, or participation in the process, the statute has the same language in either situation. It is literally the same language. Where future medicals are a consideration then appropriate arrangements should be made for appropriate exhaustion of the settlement before Medicare is billed for injury-related treatment.
- MSPRC – not responsible for reviewing establishment or proposed amounts for set-asides. Will find info about the recovery process/general steps. www.msprc.info currently revamping web site.
- 50 disposition code – rare situation. To resubmit the following quarter. When resubmitting, would it still be an Add even if the information changed which would otherwise make it an update? Yes. Send as originally submitted.
- Pg 85 of User Guide – one time payments for defense eval. are not reportable. In WC sometimes follow up reports. Does this exclude all defense or just the first time? In state, allow 3 IMEs. Always paid directly to the IME. Expense rather than a medical in order to

determine compensability. IME would be a medical professional. Seeing the patient but not developing relationship & reviewing medical records. Initial reaction is that this can probably be lumped in with what's there but need to take it back. Request write-up and send to resource mailbox to consider extending language in User Guide to encompass this situation.

- Confidentiality being sited as a restriction in responding to request for information. State law sometimes prohibits even asking for the SSN so that the individual can be queried. Would model language cover? Model language is premised on individual refusing to give SSN. Can't interpret state law to say if can send model language. Concern is remaining in compliance when prohibited from asking under state law. In the eyes of CMS what is sufficient? Will take back and discuss with those who developed model language. (mentioned Hawaii).
- Hoping to release as many updates as possible within this calendar month.
- Continuing to move forward with 2 calls per month.

IV. Next Teleconference

- March 31, 2010

April 28, 2010

Today CMS confirmed that the direct data entry option that they have been considering for several months will definitely be made available for small RREs, with qualifying factors to be published in an upcoming Alert. Systems for this method of reporting should be in place by 01/01/2011.

Another change was announced with respect to reporting in quarters when an RRE may have no data to report. In the past, RREs were advised that an empty claim input file would need to be submitted but today CMS stated that no action will be necessary in quarters when there is no reportable data. This too will likely only have an affect only small RREs.

TELECONFERENCE NOTES

I. Welcome – John Albert

- Policy call.
- Currently receiving production files on a voluntary basis. Is allowing for testing of process.
- Alternate process for data submission: direct data entry option effective 01/01/2011. Alert is pending. In development now. Geared toward small, occasional reporters. Data requirements are the same.
- Will be a cap on the number of entities permitted to use direct data entry option. Instructions will be provided on how to notify CMS that you would like to participate.

II. Introductory Remarks – Pat Ambrose, Bill Decker, Barbara Wright

- Editing of TPOC dates, date must be greater than CMS date of incident. If equal to or less than date of incident then will reject.
- If nothing to report - Empty files – claim input file submitted with header and trailer with 0 record count – not required if nothing to report, but will be accepted if submitted.
- Typo fields 13-15 in TIN reference file. Should say foreign RRE, not foreign employer.
- Updating test data (test beneficiaries) on or about May 21. So RREs can set up test conditions and test getting specific disposition codes. Test beneficiaries will show entitlement dates to test 03 disposition code.
- ICD-9 diagnosis codes. Required 11.2.5 User Guide. Most questions submitted can be answered in that section.
- Collection of SSNs – issues. Interested in hearing from RREs re: interaction with Medicare-beneficiaries and collection of HICNs. Should have no trouble collecting HICN from anyone.
- Continuing to receive questions about the MSPRC recovery process in Section 111 mail box. Section 111 added new requirements; did not replace or eliminate prior obligations

with MSPRC. Should not stop requesting conditional payment information from MSPRC nor does this eliminate reporting requirements.

- Description of liability insurance, expect to change language to remove paragraph “special considerations” and replace with a reference to what should be done with respect to deductibles as currently stated in the Alert 2/24.
- Fields 58-62 for Products Liability 12/23 Alert – these fields do not need to be used until further instruction. No further instruction at this time. Leave blank/spaces as default values.
- Clinical Trials: still in clearance process. One last step.
- Periodic Indemnity Issues: expect to be out soon
- Risk Management: revised draft clearing within a short period of time.
- Mass Torts: expect to have more meetings with workgroup. One meeting before end of May.
- Entities with more than one line of business: as long as NGHP line, if RRE for more than one line may choose to report under 1 or separate. Can not combine NGHP and GHP.
- Government entities are subject to Section 111 reporting.
- Entity offers severance pay: does this have to be reported because of general release. If does not specifically mention medicals and doesn’t release anything related to GHP, a general severance does not need to be reported.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- When a claim with a general release, haven’t alleged medicals but requesting a general release. What ICD-9 should be used? Pat Ambrose: no suggestion. Assume that there is an injury that can be described. Pick best description possible. No recommendation if there isn’t a specific injury. Code set purpose is to avoid coming back to RRE to ask what settlement was for. Report the code related to the responsibility accepted – intent is when reporting ORM, critical to report codes accepted responsibility for. In some TPOCs, not accepting liability at all but do need to report codes for the alleged injury.
- Collection of SSNs. Statute requires that Medicare beneficiary provide HICN. That is the extent of what is required. Form is to give a paper trail to show what RRE has done in an attempt to collect data.
- Opportunity for early reporting, if chooses, are they bound by 7-day window of time? Any restrictions on submissions in 2010? Yes, should adhere to 7-day window and assigned time frame in 2010 or 2011. But if submitted outside of submission window would generally be suspended as too early, or processed as “late” although technically not late. EDI rep may also release to process. Suggest speaking to EDI rep before first early submission.
- Threshold amounts for claims under $5K through 2011. Less than or less than/ equal to? $0 to $5,000 (inclusive) so less than or equal to is correct. User Guide 11.4
- ORM initially accepted, but upon investigation, denied. If paid while under investigation then must report ORM. Denying liability but settlement, then regardless of admission of liability, TPOC must be reported. Report ORM while paying, once terminated then report termination of the ORM.

- Don't report zero TPOC amounts. If liability ends by Order of WC judge and there was ORM, then report ORM termination.
- Question about if HICN match, assume active benefits? Yes.
- If actually paying for ongoing medicals then need to know that, even if (as in California) statute requires payment of $10K in medical while investigating. Answer, yes, if paying first $10K during that period ORM must be reported. Trying to distinguish between state mandated benefits and ORM. CMS will not accept argument, in either case responsible for medical.
- P. 79 of User Guide if claim actively closed prior to 01/01/2010, not required to report. Many claims "closed" but still on electronic claims system. Medical activity concluded. Could the person still legally submit a claim and have it paid if related – yes, then open for medicals. If closed for medical, but reopens due to piece of mail which is not medically related. Would reopening for administrative activity mean it then needs to be reported? Technically, yes. Can write up and send in to see if CMS would consider an exception.
- Example – auto accident and officer tells someone to go get checked out. On evaluation 959.9 (unspecified injuries). If can't identify a specific body part, would 959.9 accepted in those cases? If on list of valid codes and not on excluded code list, then would be accepted. If that is all RRE has, then recovery would check around those dates to see what care may have been paid around that time period. Possible conditional payment for those claims which they feel might be related. Being specific, when possible, avoids confusion or assumptions.
- No current plan to add collection of data to specify right versus left side for body parts. May be provided for in ICD-10 codes, but can't confirm that. Transition to ICD-10 likely by the end of 2013.
- Repetitive stress injuries – how is date of exposure to be reported? Looking for more guidance as to how to report that. CMS takes under advisement.

IV. Next Teleconference

Technical NGHP Call: 05/13/10

May 27, 2010

A new User Guide is expected by 07/01/10, to incorporate information from several new Alerts. There is one new Alert recently published to the Section 111 Mandatory Reporting web site and four additional Alerts are already in queue to be published, likely this week. A brief summary of each follows.

Currently published is an Alert allowing for a new method of reporting for small RREs, reporting 500 or fewer claims per year – Direct Data Entry (DDE). Registration for this option begins 10/01/10 and reporting will be available beginning 01/03/11. There is no testing, assigned submission window or query option for this method. Data must simply be submitted within 45 days of the TPOC or ORM date and the entry will be rejected if the data does not match a to a Medicare beneficiary. Unfortunately, even unmatched claims will count toward the 500 per year limit.

The first pending Alert is regarding payments made by sponsors of clinical trials. CMS has confirmed that they will be defining such payments as liability/self-insurance and therefore, reporting is required; however the interim reporting thresholds set forth in 11.4 of the User Guide do apply.

The second Alert will address the reporting of periodic payments that may be associated with workers' compensation or no-fault insurance. CMS has determined that if the RRE is required to make regularly scheduled periodic payments for obligations other than medical, these are not reportable as long as the RRE separately assumes and reports ORM. Barbara Wright specified that this applies to periodic payments ONLY and indicated that the Alert may need to be revised to address a scenario where there is a TPOC to settle the indemnity portion of the claim but that medical remains open and ORM continues to be reported.

The third pending Alert is only an update to the prior 02/24/10 Who Must Report Alert, deleting a typographical error regarding changes made to Appendix G.

The fourth and final pending Alert addresses risk management write-offs. CMS reiterated its position that write-offs constitute self-insurance because they are a risk management tool used to lessen the probability of a claim or to enhance goodwill. Generally, if a provider/physician/supplier write off or reduce charges as a risk management tool, then information surrounding the write-off must be included on the billing statement to Medicare. CMS stated that this is no change from the current requirement and because they are put on notice in this manner, no Section 111 reporting will be required under that set of facts. They emphasized that the RRE does not have a choice to either report or report through billing, but must do the billing. If rather than a write-off, the RRE is giving something of value, then such a gift (cash, gift card, memberships, etc) then these are reportable TPOCs, but subject to the thresholds in 11.4 of the User Guide.

TELECONFERENCE NOTES

I. Welcome – John Albert

- Policy Call.

II. Introductory Remarks –

- Email notification not released, but on 5/25 Alerts page info re: direct data entry option information has been posted. Once moved to the appropriate area of the web site, will send email notification but is available now.
- Registration – if inadvertently registered for more RRE IDs then will be using, contact EDI rep and ask that they be deleted. If received profile report but have not signed it, must sign or registration will not move forward, even if using an agent. Authorized representative must sign.
- Dedicated web page – don't use submit feedback button, will not work. Use email address on the What's New Page.
- Mass Torts Work Group – sending appointment within next week.
- 4 Policy Alters in Queue to be posted to web site.
- 1st – clinical trials: when payments are made by sponsors of clinical trials, such payments are considered to be payments by liability insurance, including self-insurance and should be reported.
- 2nd – periodic WC/no fault payments: in situations where applicable law or plan requires RRE to make regularly scheduled periodic payments for obligations other than medical, these are not reportable as long as RRE separately assumes and reports ORM. Example: indemnity only payments for lost wages, RRE has implicitly assumed ORM therefore RRE shall report the ORM and periodic payments are not reported as TPOCs. If a TPOC situation that includes periodic payments, that whole amount must be reported for the TPOC
- 3rd – revision to Who Must Report Alert. Fixes error in appendix in definition of liability insurance. Second paragraph deleted and replaced. Language already in the Alert itself, but replaced in paragraph 2 in appendix.
- 4th – risk management write-offs or other actions. For MSP purposes, self-insured plan if carries own risk in whole or in part. Write-offs constitute self-insurance. As a risk mgmt tool to lessen probability claim or to enhance goodwill. If write off or provide something of value. Such action may or may not constitute a TPOC. If provider physician or other provider, reduces charges as a risk management tool, must submit a claim to Medicare showing amount of write off. Medicare's interest will be protected through such a billing procedure. Where provide property of value as a risk management took, entity shall report the write off as a TPOC. If property provided is less than TPOC reporting threshold, then need not be reported. Difference is if write off, must be shown through the billing process (this is not something new, but rather something that is required). Cannot choose to do Section 111 reporting rather than proper billing. If something other than write off then it is subject to reporting if within thresholds.

- CMS leaning toward, but not final, on cumulative trauma date of incident. Leaning toward DOI as date the injury or complication first arose.
- Running out of space on Alert page. Likely to be split between Alerts tab and Liability/WC/No-Fault Tab. What's New should tell where to find each Alert posting.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Texas can opt out of WC and be a nonsubscriber. Would this be a liability line or WC line of business. Correct. If opted out of WC, is correct that reporting should be as liability.
- Deceased claimants, WC. Claims open by statute but Claimant died pre 2010. Are those reportable? CMS position is claim closed on date of death.
- Interim reporting threshold p. 52, for WC. If easier for RRE to report these individuals rather than excluding them as under threshold, can they? Not preferable, but will look into whether possible. Will address on the next call.
- If an employee claim and employee signed off on medicals but no specific medicals associated with the claim. If in connection with a severance package with a general release, then no reporting. If another type of claim, not fine. No medical specified at the time of the release, what ICD-9 would be reported. If spouse or parent also sign a general release of medicals for themselves, even though they are not a party to the matter – concerned with stress related illnesses/diagnoses that could come up. That is purpose behind the medical release. Co-signer (spouse or parent if a minor). Have they claimed anything at all? Do they receive payment on behalf of themselves or solely on behalf of the child? -Final determination is that this needs to be resubmitted and evaluated to be addressed at a later time.
- Recognizing need for outreach regarding ICD-9 codes, CMS is trying to prepare some materials to assist.
- Insurance companies currently in liquidation. Hospital claim <u>on behalf of</u> a Medicare beneficiary, claim filed by the hospital – not reportable. Reassignments of benefits where a third party buys out the claim, that is reportable because paying for medical items or services.
- Farmers Insurance, Bonnie – reporting ORM termination within 6 months. System requirement; will accept future dates but cannot accept a date that is more than 6 months in the future compared to the date that the file is submitted/processed. Currently can't change the system.
- Parent company has former subsidiary, no longer owned, but maintains liability and pays claims. Parent company sold subsidiary but kept the claims (an asset sale). Parent company is the RRE for the claims for which it retained the liability.
- Disposition code 03 – not accepting the record. Giving some information back on response record, but the 03 means that the information provided does not effect Medicare payment. No overlapping Medicare coverage.
- Need to add to Alert, settling only indemnity but ORM reported as ongoing, does TPOC need to be reported? Will look at that point and update the Alert. Current Alert is with respect to periodic payments only, not a final settlement even if for indemnity only.

- Self-insured retention prior to professional liability insurance kicks in. If resolves with both layers then self insurer indicator field. Look at deductible vs. self-insured retention. If $100,000, but policy is for $90K, then $10K is self insured retention. If $100K policy with first $10K by insured then that is defined as a deductible. If insurer is reporting both the deductible and the amount above, enter N in self-insured indicator.
- Transcript for 05/13/10, content appears to be for 12/13 content.
- When reporting TPOC date use signature date or date received by the RRE? Look at the record layout for instruction. Field 100, not tied to a receipt date. Concern is that this will cause delayed reporting. May need to be creative. 45 day grace period, but if beyond that, no automatic fine. Be sure to document when release was received to cover any subsequent follow up by CMS.
- Medicare beneficiary a claimant and has died. Only have basic information on claimant beneficiary. Do not have SSN/TIN for the claimant 1 fields on detail record. Should report without the claimant information and just the deceased info? CMS needs to be able to identify the debtor. Not legal advice but option may be cut check to the party & Medicare. That may provide some protection to the insurer.
- Jan 5th call, asked about payments for Voc Rehab. Look at Alert for payments other than medical.
- Joint & Several liability, p 84 of User Guide. Example presented 3 car accident, 2 share liability and pay out own amount and have separate settlements. Look to p 6 of Who is the RRE Alert – multiple defendants.
- Updated NGHP User Guide published on or about July 1, 2010. Will contain all new Alerts collectively.
- Fields 58-62, to be filled with spaces. If data in those fields would it be rejected? No, not rejected but may be a problem down the road when those fields are repurposed if data from prior fields is still living there. Recommend all spaces, only.
- Dual payee check potential – can there be an Alert endorsing that methodology? Would be helpful to have something to point to. Problem is that is giving legal advice. Can only say that anecdotally that many insurers do that.
- Self-insured retention language limited to the Alert.
- E-codes specific to asbestos exposure? Caller couldn't find one, but no answer today.
- Risk management write offs – if provider/physician/supplier write off or reduction in charges as a risk management tool, then must include that information in the billing – this is no change; therefore, no Section 111 reporting. Not a choice to report or do billing, must do the billing. If tool is giving something of value, then reportable but subject to the threshold.
- If have an injury and later die from injury, in some jurisdictions for workers' compensation these are two separate claims. Death case may only be death and burial benefits but no medical benefits. Medical would be paid on other claim. This is a scenario where would not have ORM related to the death claim. CMS would defer to state law in that situation.
- Foreign insurers remains on list but nothing expected within next week.

IV. Next Teleconference – Technical NGHP Call: 06/10/10

June 10, 2010

TELECONFERENCE NOTES

I. Welcome – John Albert

- Technical Issues Call.

II. Introductory Remarks –

- Recent postings on Mandatory Insurer Reporting web site, What's New – Alert on Periodic Payments 05/27/10. On MMSEA Section 111 Alert Pg, Risk Mgmt. Write Offs and Who Must report Alerts. On MMSEA Section 111 – Direct Data Entry Alert. NGHP Transcripts pg, additional transcripts have been posted through May 2010. Two new Alerts pages separate from MMSEA Alerts page: New TAB NGHP Alerts – only one posted there currently, related to clinical trials. Mandatory Insurer Reporting page (last Tab) is being used as an archive to hold older documents. Tools there for searching/locating older documents thought the archive. Click on Issue date link in order to refresh the list and see the most recent posting.
- CMS still considering language for an alert regarding lump sum indemnity payments and when those should be considered as TPOC when ORM continues. Separate and apart from periodic payment Alert already posted.
- Updated NGHP User Guide still slated for publishing on or about 07/01/10.
- Direct data entry – review Alert. Option will be available in Jan 2011 in time for initial required reporting. Before deciding to switch to this method, consider limitations of this option. Specifically intended for RREs with only an occasional claim report for Section 111. Not intended for use as a query function. Will check status of injured party early in the entry process, but that counts toward the annual limits. If need to check status of more than 500 claimants over the course of a year, this option is not for you. May not use this option for query only, for example, reporting under a different RRE ID. Must also report under the direct data entry RRE ID. Direct data entry option may also take a significant amount of time.
- RRE IDs started registration process for but no longer need. Contact EDI rep or COBC EDI Dept.
- Revising display on file processing results of Section 111 COBSW to make easier to read. Same information presented but in a different format. To be implemented early July.
- Questions on how to use Agent system should be addressed to reporting agent, not CMS.
- WC MSAs and Section 111 Reporting. Initially ORM for WC is reported with no ORM termination date. Once WC MSA is submitted and approved (through WCRC) and TPOC date established, the settlement amount is recorded as a TPOC and ORM termination date reported to coincide with settlement. Second report should include ORM set to Y, and ORM termination date, TPOC amount and TPOC date.
- WC claims in dispute or being repealed – report?. Refer to 11.10.2. Depends on whether ORM is assumed and payments made while under appeal.

- ORM reporting – reportable if assumed by RRE, even if no actual medical bills received, paid or reimbursed by RRE.
- Error codes not yet documents in the User Guide but will be added to the next User Guide release. RRE sends delete transaction for a record that does not match a previously accepted record. In that circumstance, will get SP disposition code SP 48 or SP 49 error code. Also, SP 31 will be added. Only complex situation, where COBC has received entitlement information in advance of actual entitlement date (estimated about 90 days). If to become entitled on 07/01/10, query processed on 06/10/10 then it will most likely return a 01 disposition code (albeit a future disposition code). If claim record sent, will actually be rejected with a SP 31 error if not yet a Medicare beneficiary. Solution is to resubmit the record with a SP31 again on the next quarterly file. If no other errors, that is the only action necessary. Will look at the compliance flag programming to make sure RRE will not be flagged for late submission in such a case.
- ICD-9 code mapping from WCIO codes to ICD-9. Can't provide a prescribed mapping. RRE will need to create a mapping if RRE would find it to be helpful. ICD-9 codes do not need to be an exact match. MSPRC searches all claims and uses a tool to group claims by likely incident or injury. May be submitting one of the more generic ICD-9 codes (more common with e-codes in alleged cause). Make best effort to be as specific as possible. Concerns re: ill effect on RRE based on codes submitted. Better information = less work with CMS later. Ask that simply make best effort and continue to cooperate with CMS.
- RRE has ORM but made no payments before ORM officially ended, must still be reported. It's possible that Medicare made payments on the claim instead of the RRE.
- Can plaintiff attorneys query clients? No. Only RREs can query.
- Self-insured indicator – policy question re: self insured retention vs deductible. If reporting for coverage under a policy then record should be reported with self-insured indicator of N for no. If making a separate report because self-insured retention then would be Y for yes.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- If providing a HICN and a SSN – corrected information from a prior call. Will check HICN first and if no match, that is the end of the process. Will not check SSN as well.
- Reporting agent notified that an RRE has been deleted. If previously provided claim records that were submitted, what happens? If a claim report has been made under an RRE ID then the RRE ID will be set to an inactive status, but will never be deleted. If there was never any production on an unused RRE ID, then that RRE ID may be deleted.
- Beneficiary died but unable to get Claimant beneficiary information SSN. Previously mentioned issuing a dual payee check, adding Medicare to the check. But what about reporting the beneficiary if no SSN? Difference between protecting self for recovery purposes versus what is done to comply with reporting? Without SSN, record will not process. Report the record with injured party and RRE keep a record of the other Claimant 1-4 parties associated with the claim. If any follow up or issues later it can be produced.

- Disposition code 03 – wording will be changed in new User Guide. Should say that record did not have errors and injured party did match; however, CMS did not retain a copy of the record because reporting does not overlap Medicare beneficiary's coverage therefore reported coverage is not primary to coverage.
- Only reporting TPOCs – no ORM. SP31 then record should always be resubmitted in next quarterly file for reconsideration.
- Key fields – if have 1 individual with 2 claims on the same DOI, there is no way to differentiate between them. In WC this is a potential situation. Technically the two reports would be associated. Policy number and claim number are not key fields. Separate records would go to the MSPRC with the unique policy and claim numbers. Not the best situation but able to operate reporting this way. Submit both reports. CMS will handle on the back end. If an exceptional circumstance, will need to be worked out manually after data is received. Call COBC EDI Rep and alter them to the fact of what is about to happen. Deal with it as it comes up.
- Don't check TPOC threshold if submitted with ORM indicator of Y. If just a TPOC, no ORM, then threshold checked.
- Possible to switch between direct data entry and regular reporting? Can't switch midstream, etc., limitations not specific yet, but if find that direct data entry does not work, may switch.
- Periodic WC payments – fatality benefits – if strictly for lost wages and not compensating for anything other than lost wages. If lumping together entire resolution of claim that could include some medical expenses and prorating over a period of time, then would need to be reported.
- If direct data entry – remember no query file capability. Submissions will be queried but will use up one of 500 uses. Meant to be a combination of query and data entry. If dependent on querying then direct data entry probably not appropriate.
- If sure that there are no medicals then maybe do not include release of medicals in the release if that is something you would like to avoid reporting. As soon as medicals released then must be reported.

IV. Next Teleconference

Policy NGHP Call: 06/30/10

June 30, 2010

TELECONFERENCE NOTES

I. Welcome – Bill Decker

- NGHP Policy Call

II. Introductory Remarks – Bill Decker/Barbara Wright

- Next call tentatively scheduled for 07/28/10. Only one call in July and August 2010, return to 2 calls per month in September.
- If do not possess a SSN then no HICN. Only reporting on Medicare beneficiaries. If do not possess HICN but do have a SSN, the query SSN.
- If no response to request for SSN or HICN, then document those attempts and keep a record of requests.
- Translations of documents into Spanish. General answer is if something in a foreign language, send to CMS to review and they will respond whether it meets their standards and RRE can then use it.
- If RRE submits both HICN and SSN and unable to get an exact match on HICN then CMS will not as a next step move to query the SSN.
- Last policy call re: 4 new Alerts to be posted. Many questions re: clinical trials Alert location. 3 of 4 are on NGHP Alerts and 1 is on What's New tab.
- Risk management write off Alert. Expect to make minor changes to language. Will change phrasing of reporting write-off/value of property to include "or reduced charges" but concept is the same. Don't expect any new codes in the billing process to identify this as Section 111 compliance; what CMS is saying is that the existing process already takes care of what they need.
- Cumulative trauma Alert forthcoming. DOI will be definite as first diagnosis or first treatment.
- Exception for reporting of lump sum indemnity payments. Working on language. When not simply a periodic payment may need the lump sum to be reported. Ties into calculation of the recovery claim, including pro rata reduction of fees and costs. Alert should give an exception to what already exists.
- No mass tort call scheduled yet. Do not need to use fields 58-62 until provided with additional information.
- Section 111 is a reporting requirement for purpose of coordination of benefits and recovery. Instructions are what needs to be reported and CMS will subsequently determine if they have a recovery claim.
- Inquiries suggest many are new to this process. Read User Guide, which spells out all requirements. Can't simply look at the statute and believe that you will understand the reporting requirements. Make use of User Guide and Alerts.

- Reporting of all TPOCs or only those which have the affect of releasing medicals? Looking at situations where medicals have been claimed and/or released not only release of medicals.
- ORM termination in dispute. One source says treatment is over another says treatment must continue? Exacerbation of pre-existing condition. Medicare goal is to be made whole. ORM open then deny payment for related claims but if ultimate judgment is that there should be payment for medicals, Medicare has to be able to go back and capture that. If ORM open and continuing to be resolved, must leave open until fully resolved. If provider bills and insurer denies…can't stop you from doing that, but until a determination is made, ORM should remain open.
- Recovery related question – settlement split 3 ways. TIN for the bank dealing with annuity – no. Splitting settlement doesn't mean only part is reported. Should report full amount.
- E&O claims reported? Still on list for consideration but as of now, yes, to be reported if claim or release or have the effect of releasing medicals. Direct data entry option might be best for E&O claims if rarely to release/claim medical.
- Insurance company in liquidation assigned claim to claim buyer. Who is RRE? RRE is the insurance company. Issue is when to report. When money is paid to the claim buyer on beneficiaries behalf that is when reporting should take place, not when the claim was sold.
- Death claims, IW died as a result of the claim. Required to report auxillary claim file info on indemnity payments made? If claim payment amounts are interrelated then needs to be reported but if separate then indemnity payments do not need to be reported through auxillary.
- Dead on the scene. Extreme cases; typical situation is that some medical services are provided. Document to provide as a defense that no medical treatment was provided, if that is the case.
- Long Term Disability lump settlement – claim or release of medical or settlement has effect of releasing medical? If strictly for lost wages and no medical aspect then no reporting. But if release language includes medical then needs to be reported.
- If body part initially reported but later found to be unrelated, can it be deleted? Remember that liability can be established for MSP purposes through compromise/settlement and reportable even if controverted.
- Under ORM threshold for WC, if easier to report may they do so? Yes. May report under ORM thresholds.
- Deceased beneficiary, claim handler is only issuing payments to medical providers. If reporting ORM then if cannot get claimant 1 information, will look at whether can submit beneficiaries own TIN again in estate. Edit in the system field is looking for non-0 value that does not match the beneficiaries SSN. Will need to take this under advisement and make adjustment to the TIN issue.
- COBC and MSPRC contractor questions – beyond scope of Section 111 so won't address those questions.
- Parties agree no medicals? Does it need to be reported? CMS not bound by allocation of the parties, but will generally defer to the finding of a court of competent jurisdiction where there is a hearing on the merits.
- A defense is not the same as a determination as to whether you should report.

- Part C plans – need to report Medicare advantage plan beneficiaries? Yes. Could be in or out at any time. May have limited situations where may have paid where there is Part C. Will still have recovery rights so need to have those beneficiaries reported to them.

III. Question and Answer Session – Liability/Self-Insurance/No-Fault

- Death claims – scenario #2 – how do you report medical claims when no treatment has been provided? Claims need to be reported as ORM and then, if one should receive a demand, need to indicate that the services in question were not related to the underlying incident. Reporting ORM doesn't actually mean you paid a bill, just that you reported a responsibility.
- Write-off alert, reporting requirements. Who are "other entities" (who may have some reason to do some type of write-off)? Anyone other than providers, physicians, or suppliers.
- Direct entry reporting with more than 500 claims. Will depend upon circumstances, but most likely will have to convert to file submission method. Direct entry for those with few claims to report.
- Production data feeds are not being accepted. How do we notify when the reporting hasn't started? Section 111 doesn't change processes that existed before – can call COB.
- Claimant who filed loss of consortium claim, and wife is Medicare beneficiary. Even though the release releases insurer from all claims, does this need to be reported? Yes. How would you code any kind of claim when there was no treatment? Do not have an answer today.
- Loss of consortium claims – if you use a release that requires the release of medicals, it will need to be reported.
- Wrongful death action in Alabama – Medicare liens do not apply to punitive damages. Question is always if medicals are being released.
- Workers' Comp: Do all lifetime medical payments need to be reported, or only those from a settlement? If on-going responsibility after 1/1/2010, you have to report those.
- Significant discussion regarding distinguishing between deductibles and self-insured retention; best explained in 05/26/10 Alert. Also for determining who is the RRE, many questions regarding reinsurance, to which 05/26/10 Alert was also referenced, directing callers specifically to the bullet point on reinsurance (RRE is determined by which entity is making direct payment to the claimant).

IV. Next Teleconference

No additional NGHP Calls currently scheduled – Planning on additional calls throughout 2010. Only 1 call in July and August 2010. September going forward, will return to 2 calls per month. 7/28/10 – tentative date, but final announcement will be posted.

July 28, 2010

This conference really focused on the publication of the new MMSEA Section 111 Reporting Requirements User Guide. They went through some of the changes in the User Guide, which are further described in the beginning of the guide. Also, they discussed the usage of the Direct Data Entry option and its purpose. It is imperative to advise clients that if there is a remote possibility that they will submit more than 500 queries/submissions, then this method should not be used. Penalties for going over 500 are forthcoming.

Another big key point was that many of the alerts were rolled into the User Guide. However, Barbara Wright warned that some of the language of the alerts were changed or modified from their original status to what is now published in the guide. The User Guide is the final authority on the terminology, and the previously published memos are now subordinate to the User Guide; so in application, you must give deference to the User Guide.

TELECONFERENCE NOTES

I. Welcome –

- Operator: Jessica
- Section 111 conference call

II. Introductory Remarks – John Albert

- Section 111 mandatory insurer reporting NGHP
- Wed. July 28, 2010

William Ford Announcements

- NGHP UG version 3.1 7/12/2010 is out on website
- Direct Data Entry Option—Alert 5/25/10
  - RRE's can change to DDE option and info is forthcoming
  - Before choosing, consider limitations—intended for RRE's for occasional section 111 reporting requirements
  - Near 500 claims, do NOT use this option
  - Not intended as use for query function—it will query and will count toward the 500
  - RRE's may not submit a query file and then submit a claim via DDE
  - Abandoned RRE Id's, contact EDI rep or main EDI 646-480-6740 to ask for RRE id to be deleted

- Changes in User Guide
  - 7.1 Replaced in its entirety—alert 5/26/2010

- 11.1.1 and .2 were added to consolidate info about matching party info to Medicare beneficiaries
- RRE's must maintain and hold the HICN and must be used going forward
- 11.2.5 ICD-9 diag. codes reported
- Be sure to use the files with Dx in the name as opposed to files w/ Sg in the name
- Empty files will still be accepted but not required.
- 11.7.4 2 separate reports may be required for the same incident when ORM and TPOC reflect different insurance types—ORM covered under no fault and TPOC covered under liability
- 11.10.2 updated to reflect language in alert 5/26/10 alert. Read this language b/c language in guide supersedes the alert
- 12.2 MSP does not apply at the time the record was processed.
- 15.5 was added to provide info on DDE option.
- Field descriptions in appx A were updated.
- All appendices were updated
- They said for a complete update of the changes in this User Guide, view pages 6-8 in the User Guide.

Bill Decker Announcements

- Translations of the model language for the form used to give Medicare beneficiaries to get HICN or SSN
    - Spanish or any other language—send CMS a copy, CMS will assume they are okay but need to verify
    - SSN Issue: is appropriate to collect SSNs of entire claim population or ask if Medicare eligible and if not, then not submit
        - Section 111 prefers RRE's to send CMS HICNs. If no HICNs, then can query w/ SSN. Problem is always is people wont give SSN? Answer: if believe Med. Beneficiary and want to query, use SSN or HICN. Can request using model language but if individual receives it and wont' return or not cooperates, then must document effort on hand. If you can't get ID info from individual and should be reported, then document.

Barbara Wright Comments

- Refer to guide when looking to alerts when alerts were rolled into the guide. The guide has the mandatory language and not the alerts.
- Date of incident for cumulative injury, no formal alert, but DOI is earlier of the date of treatment when it began and preceded formal diagnosis or initial treatment was sought
- TPOC's reported.
- Additional examples of who is the RRE's when self-insured—on 2 examples were submitted
- Questions re: risk management alert and inclusion in UG

        - Situations where provider is prohibited from billing Medicare for? Do they have to bill it just so they comply w/ reporting requirements? A. No should not be billing solely for that purpose
        - Everything that is provided free is not necessarily reportable?? Ie free parking vouchers or meal tickets?
- Indemnity: Person purchases a new indemnity policy, does that new company become the RRE? If there is an underlying responsibility for the TPOC or ORM? A. Depends on the terms of the buyout or purchase agreement. Normally, no change in RRE unless buyout. Indemnification does not change the RRE responsibility.
- Can RRE's look to state law's re: wrongful death statutes dealing with recovery claims? NO, distinction b/t reporting responsibilities and whether CMS will assert a recovery claim. Reporting responsibility does not change.
- Situations where settlement paid out on annual basis, TPOC payout does not alter reporting requirements. Only have to report TPOC settlements on or after 10/1/2010? Look to whether Medicals were claims and there was an effective release of the medicals.
- Implication of DDE: no requirement to use DDE.
- Where ORM was closed and taking action only to re-issue lost check, do not reopen, but if some other more important reason, reopen
- Errors and Omissions: if the policy specifically includes and is clear in the policy that it will NOT ever include bodily injury or medicals, then do not report. Must be explicit. Otherwise, if it is an agreement or settlement, then must report.
- Risk Management Alert:
        - This is how is properly billed, but not a new billing procedure
        - As long as the ORM continues, you have the obligation to report.

<u>Bill Decker Additional Comments</u>

- Gender code relationship to HICN they did receive it and are examining it.

III. Question and Answer Session –

- Q: MSP effective date: User Guide effective date when ORM indicator is set to yes. A. It shouldn't be returning the MSP effective date (test) if it is set to Yes. (technical problem with submission testing)
- Q: May 27th Alert re: periodic payments: example-- got a WC claim, and accepted responsibility and assumed ORM for meds. Beneficiary, report ORM as YES and later on, ORM terminates, settlement part—lump sum, then update and give TPOC info. If settlement can't be reached and goes to trial and judge issues judgment, and they pay out as periodic payments—is it periodic payments or lump sum? A: Report lump sum, not as periodic payments. Q: dealing w/ a death claim? Settle claim w/ lump sum—TPOC but if widow wants periodic payment, how report total payout? A: calculate it based on life expectancy—field 101
- Franco—Q: deductibility of reporting RRE: where an insured handles a claim and concludes a claim but does not report it to its carrier? Insurer is the RRE for the deductible and if normal procedures are followed, it will be viewed as not being without recourse.

- Q: WCC third party defendant is responsible for accident. TP defendant puts up $ to settle lawsuit. Business has a credit right against net settlement. What does the credit do? A: They are still reportable but you have a defense of the credit. Q: how to report that it is an ORM? A: report it as an ORM.
- Q: RRE status. If you have insurance carrier that ceased issuing a writing creating a liability insurance policy before Dec. 1980, is it considered to be an RRE regardless of whether the claimant had post 1980 exposure to a product? A. If there is a claim against a policy post 1980, then it must be reported. Touchstone is whether medicals are claimed and/or released.
- Q: User Guide updates re: TPOC amount, removing a TPOC previously reported, or do subsequent updates, report in that field w/ all 0's? If removing that TPOC, must keep sending auxiliary file? A: could not answer that ?
- Q: Delete records. User Guide key info must match as well as all other submitted info, do only key fields have to match or ALL fields? A: Only Key fields have to match.
- Q: f/u re: risk management alert for billing: where billing is prohibited or the physician should not be billing for a procedure, then should not be billing it just to get the procedure or service information show up.
- Q: ICD-9 codes when originally there is no claim for medicals and then eventually there becomes a claim for medicals. Can occur with a consortium claim. A. Consortium claim will be included in total reported amount. Issue is where spouse is injured and other spouse has emotional injury and has a consortium claim how do we go about reporting the emotional spouse's injury. Not answered; person not available to answer.
- Q: If a hospital pays their own claims, then the hospital must report the ORMS. A. If the charges are being billed to the hospital system, then not necessary to report. But if doctor w/in the system bills Medicare, then must report as ORM. Usually must report ORM b/c if patient goes to another doctor outside the system, and that doctor bills Medicare, then Medicare better know about it.
- Q: DDE and 500 claim limit. A. 500 data entries per year, not claims, should only be entering an individual once. Once you query and it comes back that the person is a Medicare beneficiary, and then you just upload the whole file.
- Q: Meeting for mass tort working group. A. Next 2-3 weeks.
- Q: Widow's benefits are being paid. A: If you are paying medicals, and not reporting ORM, this will cause problems.
- Q: multiple settlements w/ same individual and same carrier but under different policies, i.e. liability policy and a no-fault policy. Should the reporting be cumulative rather than duplicative? A. Report each claim separately, but report the settlement as one, and describe the allocation on each claim and how much is being covered by each policy.
- Q: Has CMS considered modifying the definition of a risk management write-off? A. No.
- Q: Have there been discussions about delaying the ICD-9 requirements? A. No. If you have medical bills you are taking it from, that's fine. But you must report the appropriate ICD-9 codes.
- Q: Will ICD-9 codes be in the file and the excluded codes list? A: Good catch! No shouldn't be doing that.

IV. Next Teleconference – August 25, 2010.

Notice and Agenda for Future Conferences

August 25, 2010 – Policy/Technical

September 15, 2010 – Policy

September 29, 2010 – Technical

October 14, 2010 – Policy

October 28, 2010 – Technical

November 10, 2010 – Policy

November 30, 2010 – Technical

December 9, 2010 – Policy

December 20, 2010 – Technical

August 25, 2010

SUMMARY

Much of this teleconference was a reiteration of the July 28, 2010 teleconference where the changes and updates regarding the new User Guide Version 3.1 were discussed. The Direct Data Entry option was also reviewed as well as the interim questions posed between now and the previous teleconference. Those questions are listed below in section I. The Q&A portion of the call was very insurance-specific and revolved much around particular fields in the reporting file. One thing they did reiterate was that the DDE system IS NOT A QUERY TOOL and should not be used as such.

TELECONFERENCE NOTES

I. Welcome

John Albert

- Intro

Pat Ambrose

- Updated notice for remaining 2010 teleconferences on the NGHP page mandatory insurer reporting
- Section 111 COB SW www.section111.cms.hhs.gov –there are files that contain error codes and descriptions found under the options on the login page. They are being updated to coincide w/ UG 3.1.
- COB login page under reference materials under that above website.
- DDE: see alert May 25, 2010 and UG 3.1. Working on releasing computer based training modules to give you an idea of what that option will look like.
- Complete UG help pages will be made available when DDE becomes active
- To be prepared, you will need the same information as you would need when using other methods. See UG 3.1. Pay attention to the field descriptions because in regards to the data entered, the same requirements will be applied as applied to the other reporting methods. As you are entering a claim, will get both data validation edits real-time as going from one page to the next; prompted to correct incorrect data as you go.
- Abandoned RRE Id's: if you are registered for an RRE Id and no longer want, contact an EDI rep or the central EDI department at 646-458-6740
- Changes to UG 3.1
  - Fields 57, 74, 75, 76 will only accept parenthesis. No other fields will allow them
  - Date signing up for DDE is October 2010, not 2011—15.5 of UG
  - Conversion to ICD-10 codes will be in 2013. Not planning on making RRE's to go back and convert the ICD-9 to ICD-10 codes for updates.
  - No longer a requirement to send an empty claim input file. Empty files are accepted, but not required

- All you report in the ORM field is a dash and no dollar amount
- Having more than 5 TPOC amounts is a rare occasion, but if you have more than 5 for the same claim/injured party, add subsequent amounts to the 5th amount listed and put the most recent TPOC date (this is on the auxiliary record)
- 11.5 covers most of this info

- Follow-up last call
  - ICD-9 Codes section 11.2.5 of UG where it talks about the requirements for ICD-9 codes. Excluded ICD-9 Codes found in appendix H.
  - Valid ICD-9 codes for Section 111 reporting found in 11.5 in UG. Recommends the Text file but Excel file contains the same information. Must make sure your ICD-9 codes are aligned w/ the CMS recognized codes or else they are invalid.
  - Gender code of 0 as unknown will convert the 0 to a 1
- Submit specific technical questions to EDI rep first before sending to the CMS resource mailbox

Q & A since July 28 call

- Claims are to be reported where the injured party (claimant) is a Medicare beneficiary. Medicare status of other claimants 1-4 are not relevant to Section 111 reporting. Key is to determine who the injured party is and then determine if Medicare beneficiary. If so, then report their info in the field. If deceased, report their claimants.
- What about last name w/ 2 words, how to submit. Submit with the space. If it shows w/ a space, then submit the last name exactly as it appears on the card.
- ORM does not require that the periodic payments be reported, just report that ORM exists and submit an update record or otherwise w/ ORM termination date.
- Recording agent is a company but an individual from hat company is often the AM or AD for the RRE. AM or AD are user roles on the COBCSW and must accept terms of their roles on the COBCSW.
- An RRE may have more than 1 reporting agents. Section 8 of UG
- An RRE who wants to use DDE for reporting, and who has not yet registered, wait until Oct. 3, 2010 to register instead of registering now, selecting another entry option, and having to change it later. If you do not register, you cannot get technical support from EDI.
- 8.1 UG where if an RRE has nothing to report, and doesn't anticipate having to report in the near future, then the RRE does not have to register at this time. Should be registering if you expect to have a reportable claim.
- Can RRE use DDE as a query tool? NOT A QUERY TOOL. It does match the information you supply to the Medicare beneficiaries, but to be used as a query tool.
- There are not other query options available other than the monthly query procedure
- An RRE can use a reporting agent even when using the DDE
- Most critical address is the RRE address, not the suite #
- Threshold amounts. See 11.4 of UG for the rules
- TPOC thresholds are eliminated completely in January 2013
- Can report claims that do not meet threshold, but will just get an error code saying not eligible

- Whether 2 liability payments on the same policy need to be reported separately? If same policy, combine TPOC amounts and submit one claim report, as long as they are the same insurance type.
- CMS has a claims system which allows multiple claimants on a single claim—max 7 claimants which all are Medicare beneficiaries. For example if 7 passengers on a bus all injured in an accident and all Medicare beneficiaries, would send 7 different claims transactions, one for each injured claimant but can have the same policy and claim number. UG 11.10.2.
- Fields 106-109 on the claims submission form: fields redefine each other, either use 106-108 OR 109 depending on the value using. Contact EDI rep if confused.
- Make sure account manager is reliable and responsible and will forward emails to the appropriate people when CMS contacts your RRE
- Only reporting 4 claimants when there is a deceased beneficiary
- NGHP RRE's will query on a monthly basis even though GHP can only query on quarterly basis
- Incomplete information on a claim report knowing it is incomplete, do you report? NO, do not report a claim you know will fail. Submit it the following month. CMS will not track a failed reporting so it is of no benefit to the RRE to submit incomplete information.

Bill Decker

- Need to send HICN w/ any info sending about a beneficiary or can send individual SSN and can check. Send DOB, name, age and will reply. If you don't have either, then do not send any information about the individual.
- CA statute says SSN's are confidential and do not have to be disclosed. Can still send the SSN if not sure if Medicare beneficiary. Federal law preempts state law. If they are over 65, send it b/c they are almost certainly a Medicare beneficiary.

Barbara White

- Mass Torts workgroup. Materials will be sent out regarding commonly asked questions. She did not want to address all questions and issues.
- Keep in mind for all reporting, coverage doesn't necessarily equal payment. Medicare may cover it, but someone else may be primary to Medicare.
- Reporting—settlement, judgment, award or other payment. If so, then must report.
- Section 111 doesn't eliminate or change the other policies or procedures.
- **September 15 NGHP policy call→is to be rescheduled.**

II. Q & A's

- 42 CFR 411.50 for definition of no fault insurance
- Asbestos cases when exposure occurred before 1980—do you release claims prior 1980? As of now, if medicals are claimed after 12/5/80 then no not released. If only claimed prior to 12/5/80, then yes. If it is workers' compensation, it is still reportable regardless of the date.
- TPOC payout over time is reported under TPOC #1. With bankruptcy, spread over a period of time, you will report the TPOC over time. Will be an alert posted.

- Inpatient claim. Hospital has a claim with a patient, and adjust off an expense, you need to follow Medicare's normal billing instruction about reporting an expense. This situation doesn't really implicate Section 111.
- If a TPOC was reported in error, do you have to keep reporting an auxiliary file? Only have to submit the aux record once.
- Field 102—Record Layout. Is that field in current use? Not in use. Fill it with zeros. It is not a required field.
- Do you include retroactive payments for partial disability in the TPOC amount for workers' compensation? Yes, even though it is retroactive.
- Some states require that if a person has no beneficiary then a payment is to be made to the state. If there is no beneficiary and a person dies, and a payment is made to the state, is that payment to the state a TPOC amount? Yes and it is reportable and needs to be listed in the file even though it is not a payment to a provider but to a state agency.
- A Medicare beneficiary is not required to provide the HICN to a provider; however, it is in the best interest of the beneficiary to provide it and it is in the insurer or the provider's best interest to request it.
- Reporting for deceased Medicare beneficiaries. Do instantaneous deaths have to be reported? Yes, an insurer is not in the position to determine whether any medical services were provided. Stick w/ reporting and CMS will determine recoverability.
- There is no statutory authority requiring a person to disclose their SSN or HICN. Refer to model language for suggested language to tell the beneficiary.
- Report your ORM as soon as it is assumed with the ORM indicator selected. Report zeros in the ORM termination date box. Then you send an update/auxiliary report w/ ORM termination date.
- If there is a claim to the insurer for reimbursement then it is reportable even though they are paying it directly to the insured, it is reportable.
- Subsequent transcripts will be posted ASAP
- If there is a situation where the physician is required to submit a 0 bill, then it must be reported, as long as it is required.
- When a provider writes off a bill, by definition that is ORM. While write off is not subject to section 111, should also report that write off as an ORM? It is your responsibility to report the ORM, but not dollar amounts, just that an ORM exists.

III. Next Call

- To Be Determined. The September 15, 2010 call has been postponed and a Memo will be posted on the website conveying the rescheduled date and time.

September 22, 2010

SUMMARY

One of the major topics discussed was the use of ICD-9 codes and what version will be accepted. It all depends on when the claim is submitted. Version 28 of the ICD-9 codes is currently posted on the website and will go into effect starting January 3, 2011. For claims submitted in the interim, you can still use Version 27; an RRE can also use Version 28 but it is not recommended because those new codes will not be in sync with the COBC's older codes (V. 27). It also depends on what submission method you use. If you use the DDE option, you can submit using Version 25, 26, or 27 because the DDE software has a converter built in to convert those codes to Version 28. Otherwise, you must use Version 28 starting January 3, 2011.

With regards to the DDE option, it is important to note that ALL DDE transactions count towards the 500 threshold limit. That includes initiating a claim, updating a claim, or deleting a claim.

TELECONFERENCE NOTES

I. Welcome

John Albert

- Intro.

Pat Ambrose

- New MSP information has been updated on the website
- New alert on NGHP for DDE option—9/16/10
- Aug. 25 transcript posted
- Section COBSW—www.section111.cms.hhs.gov, as of Oct. 18, 2010, will post the new error codes for test files based on 3.1 User Guide. Under reference materials page on the login page. There is also test beneficiary information available for download.
- DDE—Section 111 DDE Overview of who should consider it is available on the website, 9/16/10
- Complete DDE UG will be made available in January, can switch to DDE starting Oct. 4, 2010 and start putting claim information in starting 1/3/11. If you stated you will be having more than 500 entries, must contact EDI rep.
- All requirements for reporting apply to DDE. Reporting thresholds, who must report, who is the RRE, and what claims are reportable.
- Every transaction, including a claims report, updating a claims report, and deleting a claims report, ALL COUNT TOWARDS THE 500 LIMIT.

  - There will be a counter to keep tract of the number of submissions you have made
- Processing of Claims Input Files: Error returning for the TIN as opposed to returning an error code.—11.3 in UG for more information
- Now Computer Based Training Module regarding ICD-9 codes. Will get new email alert when this is updated. Conversion to ICD-10 codes will not happen until 2013.
- Alert—where other codes can be used in lieu of ICD-9 codes. To be used in very limited circumstances—Default code being created.

Technical Questions submitted since last call

- Incomplete information and whether an RRE knows they do not have enough information to submit a valid claim report, submit anyway or wait until get full information?
  - Wait to report until you have adequate information. Claim reports submitted w/ errors does not satisfy the reporting requirements—no compliance.

Reporting on ORM

- How long does an RRE need to query a person who is not a Medicare beneficiary?
  - Disposition code of 51 is not a Medicare beneficiary
  - If person becomes a Medicare beneficiary later down the road, while ORM is still active, then must still query. Once they become a Medicare beneficiary or ORM terminates, then can stop querying. – UG when an RRE can consider an ORM terminated.
- ORM related to a liability claim.
  - If the claimant settles with a TPOC, then no further monitoring is necessary. If there is ORM, then must consider monitoring.
- If all no fault insurances are to be reported as ORM?
  - Usually no fault is considered ORM, but it is possible for TPOC to be paid on a no-fault claim. –UG section 2
- ICD-9 and ICD-10 Codes
  - 9—in version 28 on CMS website, look at 11.5 UG where the requirements are described about reporting. There is a list on the website of valid ICD-9 codes, updated each year. Same lists that are used for providers.
  - Since version is 28 is on the website, will this change by 1/1/11. NO, it will remain the same, will not be updated. Versions are always effective in October and to be used for reporting the following January.
  - Changes to appendix H will be coordinated with the new ICD-9 version files in January.
- Whether an RRE can use the ICD-9 codes listed in version 28 prior to January?

  - You can, but recommends staying in sync w/ COBC and implement version 28 in January. Otherwise, you run the risk of certain new codes being rejected.
- What does the RRE do if they are unable to acquire the E-code from the treating provider? Is there a list available?
  - Yes, section 11.5 of UG. Contains valid E-codes for field 15.
- Conversion to ICD-10 codes—more to do w/ submitting hospital and nursing home claims to Medicare for payments. Haven't determined what the requirements will be. Contemplating allowing RRE's to continue using ICD-9 codes or ICD-10 codes, but NEVER intermix.
  - Requirements will be based on when the claim was submitted, not when the actual incident giving rise to the claim actually occurs.
  - It is a ways off and implementation will not be until 2013.
- Claim that an RRE wants to settle for $500 and the claimant/injured party indicates they are a Medicare beneficiary. Is the claim reportable?
  - Review the reporting requirements in the UG. ORM—January 1, 2010 and subsequent. TPOC, Oct. 1, 2010 and subsequent. Required reporting commences Jan. 1, 2010. See UG 11.10.2
- Workers' Compensation claims that have settlements and gone through state commissions. RRE indicating that they have reported the claim under other obligations, but do not require it under Section 111.
  - ORM is state mandates lifetime medicals, reporting requirements does not depend if RRE is currently making payments now or after Oct. 1, 2010. 11.8 and 11.9 of UG.
- Where someone engaged in litigation/claim and have a TPOC before being entitled to Medicare and ORM is established. Do they have to report the TPOC that existed before becoming a Medicare beneficiary? NO, as long as it was acquired before becoming a MB. Must still report the ORM.
- Mass Tort Work—Next Wed. 9/29/10.

Bill Decker

- Do new clients, non-Medicare beneficiaries, have to provide the liability carrier w/ their SSN's? It is not required to give out, nor collect them. Just need to establish whether the client is a Medicare beneficiary. If that involves you collecting their SSN, then that is what you need to do but can't tell you to collect them.
- If a student is a Medicare beneficiary and has a reportable event, then MUST report it.

Barbara Wright

II. Q & A's

- Workers' Comp TPOC, when ORM is assumed, does a lump-sum indemnity payment made down the road need to be reported?
  - Do not need to report it assuming that the ORM is open and remains open.
- Joint and Several Liability. Where there is J & S liability, what do you do if there are multiple payors, how do you know what the total payout is when there are multiple insurers paying out?
  - Depends on whether you are legally J & S liable then you have the obligation to determine what the total amount is. J & S payors have a duty to figure out what the total amount is because they could be on the hook for the full amount.
- When trying to put an ICD-9 E-code in, but not related to an accident, what do you do?
  - No answer yet.
- Bankruptcy. Third Party Claims Admin. Currently going through bankruptcy proceedings. What is the TPA's responsibility to register the RRE if no one at the Carrier has the obligation to contract?
  - Carrier would still be liable or someone who has the ability to contract for the carrier.
  - Trustee may be able to do the filing.
- Can you skip from ICD-9 code field 1 to field 3 and leave 2 open to be able to add a record?
  - Yes you can do that.
- Exposure Date needed to be reported? Does the RRE need to report the entire dates of exposure?
  - If you have the exposure on or after 12/5/80, then must report because they have a potential recovery.
- Periodic Payments. Do you have to report permanent partial disability payments where it meets all the requirements for non-report, would the TPOC be reportable?
  - If the insurer pays less than $750, and years later, the person files for permanent partial, with medicals NOT included, do they have to report that TPOC?
    - Claim must be for medicals only for the $750 threshold to apply.
  - If the claim is open by statute, then report it, and it is not just for Medical Only, you MUST report the ORM, even if it is years later.
- Payments must be made or on behalf of a Medicare beneficiary in order to be reportable. Otherwise, payments to a spouse or children are not reportable TPOCS.
- Clinical Trials and its reporting. Alert. When clinical trial sponsors have the responsible to pick up the costs of any adverse events, and they are supposed to report at TPOCs. The claimant wants to get out of the clinical trial. The site or clinical sponsor is responsible to pay for medical bills and are responsible to report the ORMs. ORM assumption arises when they found out about it, not the date of the incident.

- You cannot assume that just because the beneficiary is in a Medicare Advantage plans, your reporting obligation doesn't exist.
  - The reporting obligation still exists and should report ALL claims, even if the costs are paid by a Medicare Advantage plan.
- Medicare does not mandate that a WCMSA be used, but does require that Medicare's interests are protected, no matter how it is done.
- ICD-9 Codes, version 28 is active and to be used in January.
  - All depends on when you submit the claim and depends on whether you use DDE or other method. DDE will edit the codes and incorporate V. 27, 26, and 25 codes. Can use 28 because by Jan. 3, will be using V. 28.
- 11.4 Interim Thresholds for WC. WC claim to Medicals Only and ORM was accepted 7/1/11 and claim was less than $750. When the threshold expires, does the same claim become reportable, even though no changes to the claim?
  - No. Not reportable.
- If you elect to use the DDE option, how are query searches done under it?
  - There is no query, per se. You will enter on the first page, the party information: name, birthday, etc. Then before you go further, in real time, will search the database and see if there is a match or not. At that point, it is considered a claims submission and will count against your 500 limit.
  - DDE, you do not enter the information unless there has been a settlement, judgment, or other award, or TPOC or ORM.
  - You do not fill out first page for query function and then later come back and fill in the rest of the submission.
- 11.9 of UG. If the claim has been closed before Jan. 1 2010, but a payment was made after Jan. 1, 2010, is it reportable? Does the payment constitute a re-opening?
  - Not re-opening if you pay an already existing bill.
  - If you pay a NEW bill, then you are essentially re-opening the claim.

III. Next Call

- Mass Tort Call—Next Wednesday, September 29, 2010.
- Policy/Technical—unknown because agenda needs to be revised.