CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Erica Watkins
November 17, 2016
1:00 p.m. ET

Operator: This is Conference #: 4039564

Operator: Good afternoon, my name is (Shannon) and I will be your conference operator today. At this time, I would like to welcome everyone to the Town Hall Teleconference Event for Non-Group Health Plan Arrangements.

All lines have been placed on mute to prevent any background noise. If you should need assistance during the call please press star, zero on your telephone keypad and an operator will come back to assist you.

It is now my pleasure to turn today's conference over to John Albert. Mr. Albert you may begin your conference.

John Albert: Thank you, operator. Hello and good afternoon, my name is John Albert I'm a Senior Technical Advisor with the CMS division of Medicare Secondary Payer Operations. We are the division that oversees the Coordination of Benefit and Recovery program for all Fee-for-Service Part A and B Medicare.

For the record today is Thursday November 17th, 2016. This is the NGHP Recovery Town Hall teleconference that was advertise in an alert dated October 26th, 2016.

In addition to myself, here in the room with me, who will be speaking is Suzanne Mattes of CMS. She is the Deputy Director of the Division of Medicare Secondary Payer Operation. Also speaking today will be Kristina Pickholtz

Divine, (Kristina) is the Non-Group Health Plan Project Manager with the Commercial Repayment Center. There are also several others in the room who will not be speaking including Caren Wolan, the Project Director of the Commercial Repayment Center.

The agenda for today's call will be, first I will discuss recent pending MSP recovery portal – MSPRP portal enhancements. I will then discuss the upcoming Social Security Number Removal Initiative. I will then turn the call over to the CRC who will present on, first, the list of lessons learned during this first year of NGHP Ongoing Responsibility for Medicals recovery, also referred to commonly as ORM . Secondly they will then follow up with information about the authorization process. And third the CRC will go over some helpful tips related to ORM recovery.

The call will then come back to me and I will then present on the 2016 and 2017 NGHP dollar threshold alert. I will also add on to the CRCs' earlier presentation regarding diagnosis codes. Finally Suzanne Mattes will provide some additional information regarding the final conditional payment process.

A transcript of this call will be made available in the coming week or two. An alert will be posted notifying you that the transcript has been published and where to find it.

Before we start I want to mention a disclaimer that we always mention before these types of calls. While we strive to be accurate we sometimes make mistakes and say something that contradicts official CMS instruction published on CMS's web pages. The transcript is not intended to be a user guide, manual or official instruction from CMS. If we state anything that contradicts the official guidance published on our website the published guidance represents the official CMS policy until it is modified by CMS.

Finally I want to take the time to thank everyone who submitted questions and feedback to the e-mail box that was included on the October 2016 announcement for this call. We appreciate your feedback and many of your questions have been incorporated into our presentation today. We will

keep this mailbox open for 30 more days in case there are any other comments you have in reaction to hearing our presentation. As Section 111 has now fully implemented for some time, we expect to have more of these of calls to integrate reporting and recovery issues for the same broad audience.

And with that, I'd like to now jump into the agenda. The first topic on the agenda relates to the MSPRP portal improvement. Many changes were made in our October release to bring consistency between how the Commercial Repayment Center or CRC and the Benefit Coordination and Recovery Center also known as the BCRC, cases are viewed and handled. These changes include the case statuses displayed for CRC cases have been revised to better match how the case statuses are displayed for BCRC cases.

Also, authorized users may now submit unlimited disputes, any time prior to the case being demanded, after either a conditional payment notice or a conditional payment letter has been issued. Users may now request an update to the conditional payment amount in the portal. Beneficiaries and beneficiary representatives, with verified proof of authorization, who logged in using multifactor authentication, may now request an Electronic Conditional Payment letter or a mailed copy of the Conditional Payment letter.

Additionally, if requested, these users will also receive an electronic or mail version of the No Claims Paid by Medicare letter where the overpayment amount is $0. Additionally, of interest on CRC recovery cases, recovery agents who are associated to a case as the insurer Section 111 recovery agent may now submit a recovery agent authorization. Remember a Section 111 recovery agent has authorization on a pre-demand insurer debtor case. And then to see active recovery agent authorization and verified status of authority on an insurer debtor case both pre and post-demand.

And for cases where users submit settlement information, authorized users can now add or update settlement information after clicking the initiate Demand letter action on the case information page. And they can view, read-only, settlement information after it's been provided. Two significant portal improvements or enhancements that we expect to be implemented in the first quarter of 2017 include the following. First, we will be adding accounts

receivable data to the portal. While the portal does provide a variety of pre-demand data for the authorized user to view, it does not currently provide any post-demand data such as accounts receivable balance and refund data.

As a result the Benefits Coordination and Recovery Center, BCRC is often asked by callers to provide this information over the phone. Adding this accounts receivable information to the portal should improve the user experience and reduce the number of calls that need to be made to the BCRC. Portal users will soon have the ability to view their case, accounts receivable balance and refund data on the MSPRP case information page for both BCRC and CRC cases.

Another pending portal improvement will be the ability to submit a redetermination request. When this enhancement is implemented the debtor and their properly authorized representatives will have the ability to submit a redetermination request, also known as the first level appeal, on the portal for either a BCRC or a CRC case. The functionality and web pages being added to support redeterminations submitted on the portal will mimic the functionality already in place for disputes submitted on the portal.

In addition portal users will be able to see redetermination status information including the redetermination received date, redetermination decisions (such as favorable, unfavorable, partially favorable or dismissal) and the redetermination decision.

I would now like to provide everyone a brief update on the Social Security Number Removal Initiative or SSNRI. For all official CMS guidance on the SSNRI, be sure to check the link labeled Social Security Number Removal Initiative under Medicare-general information which is within the Medicare tab at CMS.gov. I'll say that again. The Social Security Removal Initiative is under the Medicare general information, which is under the Medicare tab that you see at the top of the homepage of CMS.gov. This link provides the latest information regarding the SSNRI process or initiative for CMS as a whole.

As of today the expected implementation is scheduled for April 1st, 2018 through December 31st, 2019. However, considerable work is taking place to get ready for SSNRI, including working with our many external stakeholders to ensure SSNRI is implemented as efficiently as possible with minimum interruptions to ongoing activity. These stakeholders include both our Coordination of Benefits Agreement, also known as COBA, claims crossover trading partners and Section 111 Responsible Reporting Entities.

As part of this effort we will be hosting SSNRI town halls for both COBA and Section 111 early next year. Expect announcements or alerts to be posted this December. As of now we expect the town halls for COBA in Section 111 to be held the second and third week of January.

I would now like to pass the microphone over to Kristina Pickholtz Divine, the Non-Group Health Plan Project Manager for the Commercial Repayment Center.

Kristina Pickholtz Divine: Thank you John. Good afternoon and thank you again for joining us today. The CRC would first like to address lessons learned from the past year. As many of you may be aware the CRC systematically filters all claims before issuing CPLs, CPNs and Demand letters so that the conditional payments specifically sought for recovery are related to the No-Fault insurance or Workers' Compensation claim.

You may have received letters for the Statement of Reimbursement or SOR, including conditional payments that do not relate to the No-Fault insurance or Workers' Compensation claim that was reported. Through feedback from the NGHP community and analysis of disputes and cost demand redetermination, the CRC revised the auto grouping or filtering logic used to define associated medical claims to the accident or injury being pursued as part of its NGHP ORM recovery effort.

After several rounds of enhancements the CRC is pleased to report improved grouping logic as observed through accuracy of claim relatedness during clinical reviews. Please note that due to an increase to manual quality reviews, throughout the group or improvement process, outbound correspondence

volumes were reduced from July to October of this year to gauge the impact of implemented changes. This means that our clinical auditors manually reviewed the claims presented on the statement of reimbursement to ensure high accuracy of the implemented changes.

Going forward, manual clinical reviews will continue but will be reduced in volume to allow for increase correspondence to be issued to the NGHP community. Please note that claims with a date of service within 30 days of the date of incident will no longer be reviewed due to high success rates during clinical review. Also note that through our continued quality improvement efforts the CRC will continue to analyze disputes and post-demand redeterminations to further assess and refine the process as necessary.

The CRC would like to thank the RREs and their agents for being as patient as they've been. We've also been asked to remind RREs and their agents that the CRC relies heavily on the ICD-9 and ICD-10 codes that are reported to CMS, whether this is through Section 111 reporting or by contacting the BCRC. The CRC has encountered many situations where we have received disputes or post-demand redeterminations asserting medical claims were received – asserting medical claims are unrelated only to find that based on diagnosis code reported to CMS, our system had no choice but to deem them related.

We're attempting to improve our communication of this issue where it occurs on individual cases, but we'd be happy to consider any other suggestions on remediating this type of situation across the board.

Next we'd like to discuss the previous correspondence backlog at the CRC. When the CRC went live in 2015 the program was staffed to support an expected amount of inbound and outbound correspondence. The CRC's rollout plan was quickly modified and volumes of correspondence exponentially increased. To support these volumes the CRC grew the size of the call center to provide high-quality and prompt customer service as well as the case record team to address the backlog of correspondence that had accumulated during the first quarter after go-live.

At this time correspondence is up to date with the exception of post-demand redetermination requests. The CRC continues to work through post-demand redetermination request as quickly as possible. Please do not resend your redetermination. The CRC is working through the backlog of redeterminations and will respond to these in the order in which they were received. As general guidance the CRC expects to review the following types of correspondence within a specified timeline.

Authorization 45days, CPN disputes 30 days, CPL disputes 45 days, post-demand redetermination 60 days, payments 20 days. Please note however, the CRC conducts quality assurance reviews on the sampling of responses to inbound correspondence and this can add to processing time prior to a response being issued to the debtor.

The CRC requests that the NGHP community send each letter to the CRC only once and recommends using the MSPRP to submit authorization and dispute correspondence, allowing the debtor to monitor the progress of these submissions online. The CRC would also like to remind the NGHP community that our response to a CPL dispute of a claim is still to issue a revised CPL to the debtor. The CRC cannot issue a CPN or demand for a beneficiary self-report unless the debtor explicitly states that they are accepting responsibility for the reported debt.

You will note that a revised CPL Statement of Reimbursement will notate claims that have been reviewed with an asterisk next to the claim line informing you that the review was completed for that claim line but not found to be valid. All validated claims will be removed from the revised CPL statement of reimbursement before reissuing to the debtor.

Next, we'd like to discuss the NGHP community's concerns surrounding perceived delays in case development. Since go-live the CRC received numerous requests for lead development. As a reminder when a request for lead development is received the CRC must first validate that all required information is present on the lead. If all required information is not present on the lead it cannot be developed until the lead data is updated.

Once all required, information is validated the CRC requests medical claims for the incident or injury. Lastly the CRC reviews the medical claims and makes a determination as to which type of correspondence should be issued to the debtor. For leads with all required information, this process can take up to 45 days to complete. For leads missing required information, such as an address, please work with us as we move forward through lead development when we are missing information. This process can take longer to complete.

Please also note that the CRC conducts quality assurance reviews on outbound correspondence. If a letter does not pass our QA checks it will be revised prior to sending, adding delays to the process but ensuring accurate information is sent to the debtor.

Regarding the process of correspondence faxed to the CRC, you may receive a busy signal due to the high-volume of faxes being sent to the CRC. CMS and the CRC strongly recommend submitting authorization and disputes through the MSPRP or utilizing the CRC's P.O. Box or courier address if you encounter difficulty with the CRC fax machine.

Using the MSPRP expedites the document process by immediately associating the submitted correspondence to the case rather than entering, scanning and indexing work queues and saves time for mailing. When you do have fax for those documents types, not supported by the MSPRP, please use a fax cover sheet to include contact information such entity name, address, representative information and phone number in order to assist associating the fax to the appropriate NGHP ORM case.

Please note that utilizing the fax machine does not expedite the processing of your correspondence. Faxes enter the CRC's work queue in the order in which they are received along with all other submission types.

Next the CRC would like to discuss duplicate cases that are being observed by the NGHP community. As an unintended result of transitioning some work from the BCRC to the CRC, some duplicate recovery cases were created.

We are working to ensure all truly duplicate cases are resolved. If you encounter a duplicate case please contact the CRC and we will research the lead and take action as appropriate. This should not be confused with the continuous recovery process which may occur on CRC cases.

As a reminder, this process is different from what you may have experienced with the BCRC prior to October 2015. With continuous recovery, the CRC may establish a second case for the same date of incident, MSP type and HICN when there are new related claims, no ORM termination date and settlement has not yet occurred.

Each case for the lead will have distinct CRC recovery I.D. number and the debtor will be afforded a new dispute and post-demand redetermination. Please note that the CRC may issue a continuous recovery case no more than once a quarter and no less than once a year.

Next the CRC would like to discuss the authorization process. Formal authorization is required to allow the CRC to communicate with any entity other than the applicable plan and the applicable plan must submit a separate authorization for each CRC recovery I.D. number to ensure recovery agents are included on correspondence post-demand.

Recovery agents identified through Section 111 mandatory insurer reporting will be included on all correspondence up to and including the Demand letter. Please note that the RREs authorization submission through Section 111 reporting does not allow the recovery agents to act on behalf of the applicable plan in the appeal process or be copied on correspondence after the demand has been issued. Recovery agents are required to submit authorization, known as a Letter of Authority or LOA, to continue working with the CRC once the demand is issued.

Prior to July 2015 Section 111 reporting allowed entities to submit our recovery agent address in lieu of the debtor address. In July 2015, CMS implemented change request 32 which updated the TIN reference file to add specific fields for the recovery agent name and address. Utilization of these fields authorizes the recovery agent to dispute a CPN or CPL on behalf of the

applicable plan and receive a copy of the Demand letter. Appeal rights are not extended to the recovery agent without a verified LOA.

When updating this information through Section 111, debtor information should be supplied in fields 2 through 15 of the TIN reference file detailed record, while recovery agent information if applicable, may be supplied in field 16 through 22.

The RRE or applicable plans TIN must be supplied in field 3. Incorrect TIN reference file records could result in recovery demands directed to the recovery agent as the debtor rather than the proper applicable plan as the debtor.

Entities are expected to submit their TIN reference files in accordance with CMS guidance published on CMS.gov on the Mandatory Insurer Reporting for Non-Group Health Plan page. Please click on NGHP Training Material page and review the TIN reference file download for more information. An authorization maybe uploaded to a case on the MSPRP, mailed via the U.S. postal office, courier address, or faxed to the contractor that sends the correspondence which you are responding to with additional information.

Again, you are encouraged to use the MSPRP for authorizations as it provides you confirmation that the document was received and updates regarding the validity of the documentation submitted. 42 CFR 405.910 mandates that each LOA include eight required elements to validate the authorization. For information regarding LOA requirements please visit the Insurer NGHP Recovery page on CMS.gov and review the Recovery Agent Authorization Model Language PDF in the Download section at the bottom of the page.

Please be sure to submit your authorization early to allow adequate time for processing prior to submitting a request for lead development or include your LOA submission with other correspondence sent to the CRC. For example, you can submit your LOA and appeal at the same time for processing. Additionally the CRC recently began issuing Invalid Authorization letters or an (ACH 102) as noted in the lower right footer of the letter, to the entity who submitted the authorization documentation when they are not the applicable plan.

Lastly the CRC would like to work through a few helpful tips for NGHP ORM recovery. All recovery correspondence is mailed to the address provided for the applicable plan. The applicable plan is responsible to provide accurate recovery address information through Section 111 reporting and it's TIN reference file. If the applicable plan wishes to have another individual or entity involved with post demand correspondence, including filing an appeal, to resolve the matter on the plans behalf, the plan must submit a valid authorization to the CRC early in the process to allow adequate time for practicing prior to post-demand correspondence.

As a reminder you can submit your LOA with your dispute request, through a redetermination request or with any other documentation sent to the CRC to ensure that the documents are processed together.

Entities may submit documentation to the CRC through the MSPRP, U.S. postal service, courier address or CRC fax. Be sure to carefully review all recovery correspondence received. Work with the CRC if you are contacted by the CRC. When in doubt, applicable plans should review their recovery correspondence for a return address in Cleveland, Ohio.

The Cleveland, Ohio return address identifies the correspondence and case as belonging to the CRC. Failing to send correspondence to the correct entity will result in delays in processing correspondence including disputes, appeals and payments. There have been no changes to the reporting process or when Medicare pursues recovery from a beneficiary as the identified debtor. Please remember to always contact the BCRC to report or update MSP information. Medicare beneficiaries and their representatives, including attorneys, should always contact the BCRC.

The recovery of conditional payments made or a primary payment responsibility may occur after the primary payment responsibility is terminated. If the applicable plan's primary payment responsibility is not terminated and the CRC identifies additional conditional payments, further CPNs and demands maybe issued for these additional conditional payments.

The CRC will only issue you a Case Closure letter or CCD601, as noted in the lower right footer of the letter, when correspondence especially the CPN or CPL was previously issued and ORM has terminated, settlement has occurred or other action is taken to justify full Case Closure. Otherwise the CRC will not provide a closure letter. However, you may review the closure of the case on the MSPRP.

The CCD601 Case Closure letter should not be confused with a No Claims Paid to Date letter or CCD603, as noted in the lower right footer of the letter. The CRC will issue a No Claims Paid to Date letter when a search for related claims was conducted but none are identified at that time. ORM remains open and no settlement has been reported. The No Claims Paid to Date letter does not absolve the debtor from responsibility. Additional claims maybe identified at a later date and pursued as appropriate.

The CRC recently received inquiries as to what is required to substantiate a policy limit exhaustion dispute or post-demand redetermination. In order to process this documentation the CRC requires the beneficiary's name, the Medicare number and/or any other identifying information that will allow the CRC to match the correspondence to the correct case. The specific service and/or items being disputed or appealed and the dates that they were furnished, payment ledger to include payee name, date of service, services incurred, build amount and date process and/or date payment was made, certification letter, plan or policy that annotates the benefit maximum amount if not submitted through Section 111 reporting, and the name and signature of the authorized representative.

The CRC also received inquiries regarding the settlement process and would like to walk through those steps at this time. When the CRC has issued a CPN to the debtor and settlement information is received, the CRC will move the case forward to Final Demand. The CRC will only make one pass at case recovery, meaning Continuous Recovery, as previously mentioned in this presentation, will not occur.

Settlement documents will be reviewed, processed, and passed to the BCRC for beneficiary debt recovery, if applicable. When the CRC has not issued a CPN to the debtor and settlement information is received, the CRC will close out the case, passing all documentation to the BCRC to pursue beneficiary debt recovery, if applicable. Please be sure to submit a full copy of the Final Settlement Detail document, or FSD, to the CRC for processing.

The CRC received questions regarding the overlap of the redetermination process with the Intent to Refer debt to treasury or ITR process and the referral to treasury process. ITRs must be issued within 120 days of the date of the Demand letter regardless if there is an open post-demand redetermination for the case. The CRC issues the ITR letter as a reminder that if the debt is not paid or post-demand redetermination is not found to be favorable the case will be referred to treasury as of 180 after the Demand letter date.

The CRC may issue an Intent to Refer letter while a redetermination request is still open, but the CRC will not refer case to treasury until all correspondence is reviewed and processed. Please be assured that we will work all correspondence for a case before referring the debt to treasury.

Lastly, the CRC notes that Mondays, and any day after a holiday, have historically higher call volumes. We recommend placing your calls later in the week to reduce wait times. When calling, please listen to the entire IVR menu. Making a selection prior to completion of the IVR menu will restart the IVR menu and does not send your call to the intended selection. This early menu selection adds additional delays to connecting you with a CRC customer service representative.

Additionally please work with the customer service representative who takes your call. But if for some reason additional assistance or escalation is required you may ask to speak with a call center supervisor. The CRC will now turn the town hall back over to CMS.

John Albert: Thank you, (Kristina). Next on the agenda, I wanted to provide information regarding CMS's recovery threshold determination for calendar year 2016 and 2017. And to associate those alerts that were recently published on September 26th, and just this week on November 15th. As required annually by section 1862(b) of the Social Security Act, as modified by the Smart Act of 2012, CMS has reviewed the cost related to collecting Medicare's conditional payment and compared this to recovery amounts.

This information is used to establish a threshold for physical trauma base liability insurance including self-insurance settlement. CMS has also evaluated No-Fault and Workers' Compensation elements and recently established thresholds for those elements where the No-Fault and Workers Comp. entity does not have responsibility for – it does not have ongoing responsibility for medical. An alert was issued, dated September 26th 2016 that stated CMS would maintain the current $1,000 threshold for physical trauma-based liability insurance settlements through the end of 2016.

This alert also immediately established a $750 threshold for No-Fault and Workers' Comp. settlements or the No-Fault Insurer or Workers' Comp. Workers' Comp. entity does not have ORM. Another alert was just published Tuesday November 15th, stating that effective January 1st 2017; the thresholds for physical trauma-based liability insurance settlement will change from $1,000 to $750. The November 15th alert also state that CMS will maintain the $750 threshold for No-Fault insurance or Workers' Compensation settlement that was first established with that original September 26th alert.

This is again, where the No-Fault and Workers' Comp. entity does not have ORM. This means that entities are not required to report and CMS will seek to recover on certain No-Fault and Workers' Comp. and liability settlements as described in the September 26th and November 15th alerts. More information also about the threshold process will be published in the Section 111 user guide as well. But again, there already is information about the process in those user guides.

Please note that the liability insurance, including self-insurance threshold does not apply to settlements for alleged ingestion implantation or exposure cases. Alerts were published under the Non-Group Health Plan Recovery pages on CMS.gov, and as I mentioned a few seconds again, the Section 111 user guide updates are in the processes of being updated.

And now I want to go back to the issue of diagnosis reporting that (Kristina) alluded to. As she mentioned earlier, many questions have come up regarding diagnosis codes and their impact on COB in our operations. It's important to remember that Section 111 RRE reporting data drives most of the initial decisions CMS makes regarding coordination of benefit and recovery action. CMS' coordination of benefit and recovery process is built on the assumption that the RRE is reporting correctly and timely. And that's because the law requires them to report correctly and timely.

While we monitor overall submissions by RREs for anomalies and work with RREs to improve their submissions, with millions of record coming in every year, incorrect records are bound to make it through or late records are bound to make it through as well. I won't bother repeating the recovery issues (Kristina) referred to in her presentation. That can occur when there are the wrong diagnosis codes reported or when the list of diagnosis codes reported is incomplete.

But I wanted to mention how important it is for insurer coordination of benefit and recovery staff to work to ensure timely and accurate reporting. We have seen many examples where we are receiving conflicting information from debtors or Section 111 RREs that cause problems for us, you, and the Medicare beneficiary, as well providers and claims processing contractors. And sometimes the cause of the issue isn't obvious. For example we all know that improperly reported data can cause claim denials, incorrect diagnosis codes and are often the culprit but it can go deeper than that.

If a case is closed and claims are still being denied, has the record been turned, are there other diagnosis code outside this case that were reported and not part of the closed case? Or has the record been mistakenly reported again? In short, it is important to keep the lines of communication open and timely

between your reporting and recovery operation, just like it is for us as well. And keep that communication up with CMS to ensure accurate reporting and quick resolution of problems. We need your continued partnership on that.

And one last note regarding incorrect records, if claims are inappropriately being denied, the beneficiary or their agent should appeal to either the provider or the MAC to get the claims paid, and not the CRC or the BCRC. While the BRCR ultimately updates and corrects coverage records, and we encourage reporting of those updates as soon as possible, our COB and our contractors are not involved in claims processing operations or point of service decisions. There is a well-documented formal appeals process that all Medicare Beneficiaries and their agents can use to get their inappropriate claims denials corrected. But again, that appeal should be directed to the provider or the MAC not the BCRC or the CRC.

I will now turn the presentation over to Suzanne Mattes for a few remarks about the final conditional payment process.

Susan Mattes: Thanks, John. We wanted to make sure that folks review just a few reminders regarding the final conditional payment process. Firstly we certainly appreciate the fact that it's being utilized, so that's definitely a positive. And one of the reminders we wanted to make is that the process that's delineated in 42 CFR 411 and 39 is the process that has to be followed. And the reason that I'm emphasizing this is because we've received some questions regarding the responses of our contractors with respect to the 11-day turnaround timeframe for disputes.

In order to receive that 11-day turnaround timeframe opportunity, the case has got to be officially part of the final conditional payment process. This means that through the web portal, through the MSPRP, the 120-day check box has got to be checked and the dispute has to be re-reported through the portal. That's the only way that we're easily able to manage the workflow and the timeframe around the cases that are expecting to settle within that 120 day or less timeframe.

The other thing that we wanted to just remind folks of is that once the 120-day check box is selected, the case will then be shifted back to the BCRC for completion. It is our expectation that the case is approaching resolution through settlement, it has always been our procedure to have the BCRC work that particular case in order to ensure that all of the beneficially protections are applied, including the debtor reduction we're required to apply.

What that really means though is that the beneficiary becomes the debtor on that case. So if the insurers on the phone are interested in continuing to be participants in the resolution of that case, selection of the 120-day check box shifts the responsibility back to the beneficiary. That means that the beneficiary and his or her attorney is then able to pursue disputes, pursue appeals and so on and that sort of, unfortunately, means that by their nature the insurers and workers are no longer able to take those actions.

So, just a reminder in that regard and we certainly hope that folks will continue to use the process. I'll turn it back over to John.

John Albert: OK, thanks, Suzanne. Well I wanted to thank everyone for listening to what was obviously a lot of material. We hope you found our presentation helpful. As I mentioned earlier we are always interested in your feedback and we'll leave the e-mail box URL listed on this October 26th announcement for this call open for another 30 days. We are interested in comments on any of the topics discussed today and we'd like to hear you suggestion for future agenda. One specific path we would like feedback on and are soliciting right now, are the reporting and recovery thresholds that I discussed earlier.

Since these calls are evolving to include both Section 111 and other pre-payment coordination of benefits activity, along with the recovery process, we invite you to submit any such comments for future agenda topic accordingly. Again, thank you for listening and this concludes this call. And that's it.

Operator: This concludes today's conference call. You may now disconnect.

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