



TUCKER ELLIS & WEST LLP
ATTORNEYS AT LAW

CLIENT UPDATE

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**MEDICARE'S SECTION 111 REPORTING PROGRAM:
REPORTING POSTPONED, BUT NOT FORGOTTEN – TIPS FOR 2011**

On February 17, 2010, to the great relief of RREs, counsel and insureds, CMS announced a postponement of active reporting under the Section 111 Program. While a collective sigh of relief ensued, this pause provides an opportunity for reflection and preparation of claims management SOPs that satisfy obligations under both the MMSEA and MSP laws (that is, for both the reporting and recovery of Medicare payments).

As a supplement to our prior publications on the subject ([a complete Section 111 Resource Guide is available](#)), this Client Update will provide new program details and recommendations to assist in those efforts.

MMSEA Reporting Updates

Revised Reporting Timetable: Reporting Starts January 2011

Mandatory reporting will now begin during the RRE's designated seven day submission window in First Quarter 2011. TPOC settlements/payments made on or after 10/1/10 are subject to reporting. Reporting of settlements or payments made earlier in 2010 are acceptable, but not required.

Earlier Reporting Allowed

RREs can report sooner than 1/1/11 if they are able; and in fact CMS encourages earlier reporting, even if only as to select products/insurance lines, just to be sure that the reporting processes are working well before the official start date of 1/1/11.

Threshold Dates and Amounts Unchanged

All of the interim threshold dates and dollar amounts are unchanged. Thus, payments ≤ \$5K are exempt from reporting for TPOC dates through 12/31/11. The threshold figures for the years 2012 (≤ \$2K) and 2013 (≤ \$600) remain in place.

Revised RRE Rules

In a CMS Alert dated 2/24/10, CMS gave final directives for determining "who must report." The most significant changes:

• **Deductible Liability Policies**

Insureds with deductible liability policies will not have to report (with limited exceptions). Instead, the insurer is

responsible for all Section 111 reporting with respect to the policy. The insurer must report both the deductible and any amount paid in excess of the deductible, regardless of who cuts the check(s) and makes the physical payment(s). Thus, even on large-deductible programs the insurer is the RRE for its insured's deductible-only settlements, provided the insured informed the insurer of the claim.

This is a major and unexpected change to the Section 111 Reporting Program. Insureds that were preparing a costly reporting structure are relieved of that burden. Conversely, liability insurers, accustomed to having their large-deductible insureds operate a claims program semi-autonomously and with distant oversight, will now be forced into a more active role. A solution to manage this role-reversal would be for the insurer (the RRE) to appoint the insured as the agent for all reporting under the policy. While the insurer cannot relieve itself of its ultimate RRE liability, it can shift the operational duties to the insured for Section 111 claims submission.

Notes:

- Insured entities that will not have to report by virtue of this new change should contact their EDI Rep and deactivate their RRE ID. The RRE ID access cannot be retained and used to perform Query functions if the entity to whom it was assigned has been relieved of active reporting obligations.

- Entities having a Self-Insured Retention (SIR) under an umbrella, excess, stop-loss, or reinsurance program are not affected by the deductible-driven RRE rule change, and will still have RRE reporting duties as set forth in the NGHP User Guide.

- **Acquisition**

If an RRE is acquired by another entity, the acquiring entity becomes the RRE as of the effective date of the acquisition, and is the RRE with respect to acquired claims, including ORM.

- **Bankruptcy and Liquidation**

When an RRE has filed for bankruptcy, it remains the RRE, and the RRE (or its insurer) must continue to report the court-ordered payments made from the bankrupt estate, as well as any payments made after a stay is lifted.

A company in liquidation continues to be the RRE and must report if its assets are used to fund a settlement, judgment, award or other payment. To the extent another entity (such as a State Guarantee Fund) also funds and makes a payment, it too is an RRE and must report.

No Guidance Yet; No Need to Report

In an Alert dated 2/24/10, CMS provided reassurance that until it issues further guidance, it is not necessary to report:

- Write offs and service recovery gestures or similar risk management activities;

- Payments by sponsors of clinical trials for items or services related to injury or complications.

“Mass Tort” and Product Liability Guidance: Awaiting Clearance

In the Alert dated 2/24/10, CMS again confirmed that specific instructions for using Fields 58-62 of the Claim Input Record will be forthcoming. Until then, Fields 58-62 should not be used. Similarly, CMS will soon issue guidance for ascertaining and applying the 12/5/80 reporting cutoff date, particularly in the mass tort and product “exposure” context. This guidance is much anticipated, and we will report that information just as soon as it is announced.

Foreign RREs: Registration is Now Open

RREs that are based in countries outside the U.S. and have no IRS-assigned TIN and/or U.S. mailing address can register for Section 111 reporting April 5-September 30, 2010. Production files for the foreign RREs will be due during the RRE’s assigned file submission window in 1st Quarter 2011. This delay in registration for foreign entities does not change their retroactive reporting requirements (report claims with ORM assumed as of 1/1/10; report claims with TPOC dates as of 10/1/10).

ICD 9 Diagnosis Codes: Mandatory as of 1/1/11

Claim reports submitted to CMS on or after January 1, 2011 must include ICD 9 codes

for the alleged cause of injury, incident or illness (Field 15 on the Claim Input Record) and in the diagnosis codes fields (starting at Field 19). This means ICD 9 codes are required for reports of settlements and payments made on or after 10/1/10, which are due to be reported starting 1st Quarter 2011.

RREs can find these ICD 9 codes on the medical claim records they receive from the injured party related to the claim, or they can *derive* ICD 9 diagnosis codes from the claim information the RRE has on file. An exact match to the ICD 9 diagnosis codes used by the medical provider or supplier is not required.

Only one valid ICD 9 diagnosis code is required, but CMS encourages RREs to supply as many valid ICD 9 diagnosis codes as possible, as that will lead to more accurate coordination of benefits, including facilitating accurate claims payment and/or the determination of recovery amounts, where applicable.

Caution: If more than one ICD 9 diagnosis code is supplied, all must be valid. If any one code submitted is invalid, the entire record will be rejected and will have to be corrected and resubmitted.

Guidance for Reporting Employment, Consortium and Other “Non-Medical” Claims

CMS has acknowledged the requests for guidance – or preferably, an exemption – for reporting settlements and payments that arise in situations where a claim for medical expense is not a central feature of the claim,

but the theoretical possibility of such a claim is introduced by broad form complaints at the outset of the case, or by the scope of a comprehensive, all inclusive General Release at the conclusion of the case. While such claims may technically meet the reporting definition for Section 111, the practical difficulties – such as trying to apply ICD 9 diagnosis codes when injuries are non-existent – is prompting CMS to consider the need for guidance on this topic.

CMS' Keys to Compliance

In an Alert dated 2/24/10, CMS outlined the criteria RREs must meet to stay in compliance with their Section 111 reporting obligations.

1. Registration – work with the COBC to successfully complete the registration process;
 2. Testing – begin the data exchange testing on schedule, inform your COBC EDI Rep of any system problems or issues, then successfully complete the testing process to COBC's satisfaction;
 3. Production – make routine, punctual production file submissions; consistently follow CMS data submission protocols; produce quality file submissions of data that can be adequately processed and used.
 4. Stay informed – RREs should remain in ongoing communication with their assigned COBC EDI Rep, and keep up with the latest CMS announcements about the Section 111 reporting program.
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New NGHP User Guide – Version 3.0

The new 250 page User Guide, released 2/22/10, provides the latest substantive guidance and technical instruction for reporting all Non-Group Health Plan claim payments. This version updates the prior edition of the User Guide and includes instruction for registration and reporting by domestic and foreign insurers, and RREs with no U.S. TINs; clarifies the ORM reporting rules; and changes some of the data requirements for “representatives” for injured parties and claimants. A complete listing of the changes made in the Version 3.0 User Guide is at Section 1, on page 6, of the new User Guide. The entire User Guide V.3.0 is available for download at <http://www.cms.gov/mandatoryinsrep/> (click on the NGHP tab).

Legislative Relief?

On 3/9/10, the “Medicare Secondary Payor Enhancement Act of 2010” (H.R. 4796) was introduced in the House of Representatives by U.S. Representatives Patrick J. Murphy (D-Pa) and Tim Murphy (R-Pa). The bill seeks to amend the MMSEA and MSP laws by: (1) providing a mechanism for Medicare claimants and applicable plans to make a good faith voluntary calculation and payment of the amount needed to reimburse CMS' conditional payments; (2) establishing a process for claimants or plans to obtain a Final Demand for Reimbursement within 120 days prior to an expected settlement date; (3) limiting MSP recovery efforts to claims of \$5K or more; (4) eliminating the need for RREs to access and report beneficiaries' social security numbers and HICNs; and (5) assessing a fee of \$30 every

time a Final Demand Letter is requested, and every time a conditional payment reimbursement is made. This Bill has been referred to the House Committee on Ways and Means and the House Committee on Energy and Commerce.

Prepare in 2010; Report in 2011

1. Develop standard investigative protocols and discovery requests to ascertain if the injured party was a Medicare beneficiary. Require outside counsel to use this discovery in all pending and future claims, as appropriate.
2. Design a claims report data form to efficiently collect the data elements that will be required for Section 111 reporting of required claims.
3. Train claims staff and outside counsel to recognize and report proper ICD 9 codes for cause of injury (Field 15) and diagnosis (Field 19, *et seq.*). Similarly, the RRE should fully test the submission of ICD 9 codes before active reporting begins in 2011.
4. Implement a Query schedule to check the Medicare status of injured parties in a timely fashion to ensure accurate reporting.
5. Establish settlement policies and protocols that will assure compliance with MSP recovery obligations whenever a Medicare conditional payment is known or reasonably suspected. This may include putting CMS' name on all settlement checks, ascertaining and paying Final Demand Letters directly, requiring proof that the

beneficiary satisfied repayment obligations before the settlement check is issued, or other strategies. These protocols must be thoughtfully established, clearly communicated to defense counsel, and strategically incorporated into settlement negotiations with plaintiff's counsel.

6. Revise "standard" releases to include a workable timetable for release of funds and to include language, protections, reps and warranties that acknowledge and address the parties' respective obligations to adhere to CMS' reporting and recovery requirements.

As entities move closer to the active reporting phase of the Section 111 program, Tucker Ellis & West LLP will continue to share important Section 111 updates as they become available. We also invite your questions and comments as we strive to provide the guidance you need to be successful.

For more information please contact:

Victoria L. Vance 216.696.3360
victoria.vance@tuckerellis.com

1150 Huntington Building, 925 Euclid Avenue
Cleveland, OH 44115

www.tuckerellis.com

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