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MEDICARE'S SECTION 111 MANDATORY REPORTING PROGRAM

(Includes Most Recent CMS Updates and User Guide Directives, Version 2.0)

OVERVIEW

Pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111), the new mandatory reporting requirements apply to Group Health Plans that provide coverage to Medicare beneficiaries, as well as to liability insurance providers (including self-insurance), no-fault insurance, and workers' compensation plans that pay settlements, judgments, awards or other payments to Medicare beneficiaries. Reporting obligations took effect January 1, 2009 for the Group Health Plans; the non-Group Health Plans (liability insurers, no-fault insurance, self insurance, and workers' compensation) are preparing now, through extended registration and training periods, to start reporting by second quarter 2010, if not before. This article, first published in May 2009, will solely address the non-Group Health Plan reporting requirements, with particular focus on the impact this new program will have on the work and routines of liability insurers and self-insured entities. **Bold text is used in this version to clarify the reporting process, highlight new material, and share updates derived from CMS Guidance, including the recently revised CMS User Guide (Version 2.0) issued July 31, 2009.**

The purpose of the Section 111 reporting process is to enable The Centers for Medicare & Medicaid Services ("CMS") to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. In general, when the injured party is a Medicare beneficiary and the date of incident is on or after December 5, 1980, liability insurance (including self-insurance) and no fault insurance are primary payers to Medicare. By law, workers' compensation is always primary to Medicare, regardless of the date of injury.

CMS will use the reported data to undertake appropriate reimbursement/recovery actions to recover funds paid for services rendered to its beneficiaries. These reporting responsibilities do not replace or eliminate existing obligations for any person or entity to make appropriate reimbursement to Medicare, or to assist Medicare in its efforts to recover monies. For example, Medicare beneficiaries who receive a liability settlement, judgment, award or other payment have an obligation to refund associated conditional payments within 60 days of receipt of such settlement, judgment, award or other payment.

Issued: May 20, 2009
Revised: August 31, 2009

THE REPORTING PROCESS: HOW IT'S SUPPOSED TO WORK

First A Few Key Terms

Some of the most frequently used terms in describing the new Medicare reporting obligations are set forth here. A more complete Glossary of Acronyms and Definitions can be found in Appendix 1.

CMS – The Centers for Medicare & Medicaid Services; an agency of the Federal government, part of the Department of Health and Human Services. CMS is responsible for the oversight of the Medicare program, including implementing the Section 111 reporting provisions.

RRE – "Responsible Reporting Entity"; the entity responsible for complying with Section 111.

ORM – "Ongoing Responsibility for Medicals"; refers to the RRE's responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with the claim. This typically only applies to no-fault and workers' compensation claims.

TPOC – the "Total Payment Obligation to the Claimant"; refers to the dollar amount of a settlement, judgment, award or other payment obligation – generally a "one-time" or "lump sum" payment – to or on behalf of the injured party, separate and apart from ORM.

MSP – "Medicare Secondary Payer"; is the term used when the Medicare program does not have primary payment responsibility (that is, another entity has the responsibility for paying before Medicare). Medicare is a secondary payer to Group Health Plan coverage in certain situations and is always a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation.

The Responsible Reporting Entities (RREs) will submit information electronically on liability insurance (including self-insurance), no-fault insurance and workers' compensation where a settlement, judgment award or other payment is made to an injured party who is a Medicare beneficiary, and where medical expenses were either claimed or released as a part of the claims-handling process. The actual data submission process will take place between the RREs and the CMS Coordination Of Benefits Contractor (the COBC). The COBC will manage the technical aspects of the Section 111 data submission process for Section 111 RREs.

Key Steps in the Process

1. Registration, Account Setup, and Training

Section 111 RREs are required to register with the COBC, set up an account, **identify authorized users (Authorized Representative, Account Manager, and Account Designee (optional))** and satisfactorily test the data exchange process before submitting production files. Registration runs from May 1, 2009 through September 30, 2009; **testing begins on January 1, 2010**. Registration and testing will take place using a new application on the COBC's secure website (COBSW) for Section 111 processing. Each RRE will be assigned a Section 111 Reporter ID for use with reporting, and as part of the

Registration process, each Section 111 RRE will be asked to sign a Data Use Agreement. **Note: The Data Use Agreement imposes obligations on the RRE to adopt policies and procedures to ensure that sensitive personal and identifying data obtained from CMS during this process shall be safeguarded and used solely for authorized purposes.**

2. "Go Live"

After successful training, RREs will submit their initial files. The initial submission will contain information for all liability insurance (including self-insurance), no-fault insurance and workers' compensation claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award or other payment date is on or after January 1, 2010, **and which meet or exceed the dollar value threshold for reporting.** In addition, the RRE's initial file submission must include claims for which ongoing responsibility for medical payments (ORM) exists as of July 1, 2009, regardless of the date of the initial acceptance of payment responsibility.

3. Ongoing Reporting: Quarterly Submissions

RREs will be assigned a quarterly file submission timeframe (a 7-day window) during which they are to submit files. These quarterly file submissions are to contain only new or changed claim information **(such as the new assumption of ORM, or to report payment information on a claimant who has just become covered by Medicare)**. Quarterly files must contain resubmission of any records found in error on a previous submission, with corrections made. No interim file submissions will be accepted.

What Happens With The Data Submitted?

The RRE electronically transmits a claim "data file" to the COBC. The COBC processes the data in this input file and determines whether the submitted information identifies the injured party as a Medicare beneficiary. Other insurance information for Medicare beneficiaries derived from the input file is posted to other CMS databases by the COBC. This is then used by other Medicare contractors for claims processing to make sure Medicare pays secondary when appropriate and/or is passed to the CMS Medicare secondary payer recovery contractor (MSPRC) for recovery efforts. When this processing is completed, the COBC electronically transmits a response file back to the RRE **(generally within 45 days)**. The response file will include notice of any errors found, and other information and instructions for the RRE. **Note: CMS emphasizes that RREs must react and take action on the information returned in the response file.**

Query: A New Tool to Ascertain Medicare Status

These new reporting obligations only pertain to Medicare beneficiaries. Accordingly, RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary and gather the information necessary for the Section 111 reporting. **CMS has issued Model Language that RREs can use to request confirmation of a claimant's Medicare status. This Model Form is drafted to remind Medicare Beneficiaries of their obligation to cooperate in the coordination of benefits process. (The CMS Model language is attached as Appendix 3).**

In addition, CMS is allowing RREs to query CMS on a monthly basis to ascertain Medicare coverage of claimants/plaintiffs. Use of the Query Process is optional, however, it is a tool that promises to be of benefit to the RREs, and CMS strongly encourages RREs to use the query function prior to submitting claim information for Section 111 reporting. The Query will assist the RRE in determining whether the claim must be reported under Section 111. Cautionary Note: the Query Process is to be used only for Section 111 reporting purposes, and not for ancillary information gathering or surveillance purposes.

SECTION 111 REPORTING: IN BRIEF

Who Must Report?

3Rs: Relationships, roles, and responsibilities are the keys to determining the reporting obligations.

- By law, reporting is to be done by "an applicable plan**,"** which means liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans

- RREs may **contract with** Agents **(for example, their TPA)** to assist in the reporting process. The CMS User Guide provides rules for the scope of services such approved Agents may perform. However, CMS cautions that accountability for submitting the reports in the manner and form required, and the accuracy of the submitted information continues to rest with each RRE.

- **In complex business organizations, CMS has established rules governing which corporate family members may be designated to carry out the reporting obligations:**

  - **An entity may register as a RRE for itself or for any direct subsidiary in its corporate structure. The entity may also register as the RRE for the subsidiary of that subsidiary.**

  - **A parent entity may register as a RRE for any subsidiary in its corporate structure regardless of whether or not the parent would otherwise qualify as a RRE.**

  - **A subsidiary may not register as a RRE for its parent.**

  - **An entity may not register as a RRE for a sibling in its corporate structure.**

  - **For purposes of this rule, a captive is considered a subsidiary of its parent entity and a sibling of any other subsidiary of its parent.**

- **When claims are resolved using some combination of an insurance deductible or insurance proceeds for a covered claim, depending on who makes the actual payment to the claimant, the following rules apply to amounts that meet the dollar threshold for reporting:**

  - **CMS treats a deductible as self-insurance. If the claim is resolved within the deductible:**

    - **The insured is the RRE if it makes the payment to or on behalf of the injured party.**

    - **The insurer is the RRE if it makes the payment (even if the insured is obligated to reimburse the insurer).**

  - **If a claim is resolved for an amount in excess of the deductible:**

    - **The insured is the RRE if it pays both the deductible and excess amount (even if the insurer will reimburse the insured for the excess amount).**

    - **But if the insurer pays the claim in excess of the deductible, it is the RRE, regardless of who paid the deductible.**

  - **If an insured entity chooses to pay a claim directly, without recourse or notification to its insurer, the amount paid will be deemed self-insurance and the insured will be the RRE.**

  - **If a TPA is involved in the payment process, it acts as an agent for the entity with whom it contracts, and payment by the TPA (whether deductible amount or excess) will be ascribed to the contracting party (the insured or the insurer) for reporting purposes.**

The following table illustrates these rules:

	Payment of Deductible	**Payment Amount Above Deductible**
Insured pays to or on behalf of injured party	**Insured is RRE if claim settles within the deductible**	**Insured is RRE, if it plays claim (even if insurer reimburses)**
Insurer pays to or on behalf of injured party	**Insurer is RRE (even if insured will reimburse)**	**Insurer is RRE for entire claim (even if insured paid deductible)**
TPA	**TPA is never the RRE; rather any payment is deemed that of the party that contracted for the TPA services**	

- **For re-insurance, excess, or umbrella insurance, or guaranty fund payments, the key in determining whether such insuring entity is a RRE is whether or not the payment it makes is to the injured claimant versus payment being made to the self-insured entity to reimburse the self-insured entity. Where payment is being made to reimburse the self-insured entity, the self-insured entity is the RRE and no reporting is required by the insurer.**

- **Fronting Policies – CMS acknowledges that the intent of both insurer and insured in entering into such arrangements is that the insured, rather than the insurer will pay all claims. Accordingly, when a claim is paid by the insured, the insured is the RRE.**

For Whom Must the Report Be Submitted?

- RREs are to report only with respect to Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award or other payment). If a reported individual is not a Medicare beneficiary, CMS will reject the record for that individual.

What Must be Reported?

- The identity of a Medicare beneficiary whose illness, injury, incident or accident was at issue, as well as such other information about the beneficiary, the incident, the injured party's attorney or representative, any involved product, and the payment, as specified by the Secretary to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim. (See a listing of Claim File Data Elements, in Appendix 2, at page 24).

What Claims Are To Be Reported?

- For claims involving payment due to a settlement, judgment or award, or other payment (that is, a single payment obligation regardless of how the payout is actually structured), with no separate assumption of ongoing responsibility for medicals, report such claims only if the settlement, judgment, award or other payment date is on or after January 1, 2010**, and meets the dollar-value reporting thresholds (described below)**.

- Also report claims where an assumption of ongoing responsibility for medicals ("ORM") occurred prior to July 1, 2009 and **the claim was still open, or subject to additional requests for payment on or after July 1, 2009. However, if the claim record had been removed from the RRE's current/active claim file prior to January 1, 2009 (referred to as the "look back period"), it does not**

need to be reported unless and until the claim is reopened, such as through an additional request for payment.

- CMS has agreed to certain interim dollar thresholds for reporting, in an effort to ease the transition and initial burden on the RREs. These reporting thresholds are expressed on a sliding scale, and will be phased out through **12/31/13**. For example, the threshold exempts reporting on settlements ≤ $5000, which are entered 1/1/10-**12/31/11**. The detailed rules for the Reporting Thresholds are set forth in the CMS ALERT issued March 20, 2009, **and in the User Guide, Version 2.0, Section 11.4 (issued July 31, 2009),** both of which are available on the CMS Section 111 website, www.cms.hhs.gov/MandatoryInsRep**.**

- Note: Group Health Plan file submissions for Section 111 may not be mixed with liability, no-fault and workers' compensation claim file submissions.

When Do The Section 111 Obligations Begin?

CMS' Revised Implementation Timeline, announced May 12, 2009, requires:

- RREs must Register on the COBC Secure Section 111 website during the period May 1, 2009-September 30, 2009. **(Note: The registration process will remain open indefinitely. Entities that do not currently contemplate the need to report, or entities that change their corporate structure or see the need for additional RRE IDs in the future, will have the opportunity for ongoing registration.)**

- RREs then Test their **claim** submission procedures during the period January 1, 2010 through March 31, 2010. **(Note: Query files may be tested and submitted as early as July 1, 2009.)**

- Live Production and submission of reports begins no later than 2nd Quarter 2010. But if RREs complete their testing in time, they may begin submitting live production files during their designated 7-day reporting window in the 1st Quarter of 2010.

- Once underway, RREs are required to make Quarterly Reports. The RRE will be assigned a 7-day window each quarter during which the RRE must report.

- Reporting tip: RREs should send their files as close to the first calendar day of their submission time frame as possible in order to have the file receipt date fall within their submission time frame. **(In no event should the file be submitted more than 14 days before the assigned reporting window. Such early files will be deemed "in error" and will not be processed.)**

How To Manage The Technical Issues?

- All reporting is done electronically by submitting required data elements to the CMS Coordination of Benefits Contractor (COBC). The COBC will manage the technical aspects of the Section 111 data submission process. The COBC will assign each registered RRE an Electronic Data Interchange representative (EDI Rep) to work with them on all aspects of the reporting process.

How Frequently to Report A Claim?

- In the case of a settlement, judgment or award, or other payment without separate ongoing responsibility for medicals, only one report record is required to be submitted per liability insurance (including self-insurance), no-fault insurance or workers' compensation claim where the injured party is a Medicare beneficiary**, regardless of whether it is funded through a single payment, an annuity or a structured settlement**.

- When reporting ongoing responsibility for medicals (ORM), it is not necessary to report individual payments for each medical item or service. Only two events will need to be reported: the first report is when the RRE assumes the ORM, and the second report is when ORM terminates.

Open Issues: CMS Is Still Developing Reporting Rules With Respect To:

- Mass Tort claims.

- Clinical Trial liability situations.

- **Medical bill "write-offs" and other service recovery gestures commonly offered by hospitals and medical providers as a risk management/claim prevention tool.**

Tucker Ellis & West LLP will share Guidance on these topics as it becomes available.

FREQUENTLY ASKED QUESTIONS

I. Program Basics

Q: What Is Medicare?

Medicare is a Federal health insurance program for:

- People age 65 or older,
- People under age 65 with certain disabilities, and
- People of all ages with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has several parts: Part A – Hospital Insurance, Part B – Medical Insurance, Part C – Medicare Advantage Plan Coverage, and most recently Part D – Prescription Drug Coverage. Importantly, Medicare also invokes exclusions to coverage and there are various coverage and payment rules which determine whether or not a particular item or service will be covered and/or reimbursed.

Q: Does This Program Also Apply To Medicaid Recipients?

No. Section 111 is limited to Medicare. CMS is not accepting or requesting any reporting having to do with state Medicaid programs.

Q: Does This Program Apply To Veterans?

Yes. Veterans may still be Medicare beneficiaries, and for that reason, CMS wants a report so it can check to see if it paid claims that may be subject to recovery.

Q: Are There Confidentiality Concerns About Data Exchanges Involving Social Security And Medicare Information?

The Social Security Number or Health Insurance Claim Number (HICN) is essential to the administration of the Medicare program. Collection of the SSNs for the purposes of coordinating benefits with Medicare is a required, legitimate and necessary use of the SSN under Federal Law, and is thus permitted by HIPAA (Health Insurance Portability and Accountability Act). CMS also takes the position that the Section 111 program takes precedence over any conflicting state law that would otherwise purport to limit when SSNs can be collected and used. Furthermore, CMS maintains that the query process and exchange of information for Section 111 purposes does not require a claimant's signed release or authorization.

Q: <u>What Is The Significance Of The December 5, 1980 Date That Is Used As A Cut-Off For Reporting Of Some Claims?</u>

December 1980 is when the Medicare Secondary Payer Statute originated with enactment of the Omnibus Budget Reconciliation Act ("OBRA") of 1980, Pub. L. No. 96-499. OBRA amended the Medicare Act to make Medicare a secondary payer to automobile, liability, and no-fault insurance. (By law, Medicare coverage has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965.)

Accordingly, CMS seeks information on liability insurance (including self-insurance) and no-fault insurance payments that relate to a claim with a date of incident, as defined by CMS, after December 5, 1980. CMS has determined, as a matter of policy, that it will not recover under the MSP provisions with respect to payments where the date of incident as defined by CMS was prior to December 5, 1980 unless the claim involves exposure continuing on or after December 5, 1980.

<u>Note</u>: Application of the December 5, 1980 cut-off is specific to a particular claim/defendant. For example, if an individual is pursuing a liability insurance (including self-insurance) claim against multiple defendants (Companies A, B and C) arising out of a toxic exposure and the exposure allegedly cause by Company A preceded December 5, 1980, but exposure for Companies B and C did not, any settlement, judgment, award, or other payment with respect to Company A would not be reported; whereas a settlement, judgment, award, or other payment with respect to Companies B and C would be reported.

II. <u>Whether To Report</u>

Q: <u>What If The Beneficiary Is Deceased, Is A Report Still Required?</u>

Yes. Where the beneficiary is deceased, the reporting form calls for information on who/what entity has taken the Medicare beneficiary's place as the "claimant" (estate, family member, other). **If there is more than one "claimant", the RRE will be directed to complete an Auxiliary Record to supply information about the additional claimants.**

Q: <u>If The Claimant Happens To Be A Medicare Beneficiary, But Medical Care Is Not Part Of The Claim, Is It Still Necessary To Report?</u>

RREs are not required to report on a file which did not **demand,** claim and/or release medicals or have the effect of releasing medicals, such as "property damage only" claims or business disputes.

Yet, if medicals are claimed and/or released, the settlement, judgment, award or other payment must be reported regardless of any allocation made by the parties or a

determination by the court. CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. While this information may be relevant as to whether or not CMS has a recovery claim with respect to a particular settlement, judgment, award or other payment, it does not affect the RRE's obligation to report.

Q: <u>What If The Claimant Is Not Currently Getting Medicare; Does The RRE Have To Monitor The Individual's Medicare Status?</u>

Yes, but this only becomes an issue in situations where an entity has assumed responsibility for paying ongoing medicals over time for an individual. If the individual was not a Medicare beneficiary at the time responsibility for ORM was assumed, the RRE must continuously monitor the status of that individual—CMS contemplates this may be done on a monthly basis - and report when that individual becomes covered by Medicare – unless responsibility for ongoing medicals has terminated before the individual becomes a Medicare beneficiary.

Q: <u>If The Defendant Or Insurer Has Not Admitted Liability, Is It Still Necessary To Report?</u>

Yes. Reporting is required regardless of whether or not there has been a determination of liability as long as there has been a settlement, judgment, award or other payment **(TPOC), or if the RRE has assumed responsibility for paying medical expenses (ORM)**.

Q: <u>If The Only Expense Is For A Defense Medical (IME), Is This Reportable?</u>

No. Payment made specifically for the purpose of a one-time payment for defense evaluation, paid directly to the provider or other physician furnishing this service, does not trigger the reporting requirements.

Q: <u>If The Plaintiff's Attorney (Or Beneficiary) Says They Will "Notify Medicare", Is It Still Necessary For The RRE To Do Section 111 Reporting?</u>

Yes. Notice to CMS of a pending claim, pending action, settlement, judgment, award or other payment by an individual or entity other than the RRE does not satisfy a RRE's reporting obligations. The RRE must use the established Section 111 reporting process to satisfy its reporting duty.

Q: <u>If There Is Nothing New To Report, Can The RRE Skip The Quarterly Report?</u>

No. If you have no new information to supply on a quarterly update file, you <u>must</u> submit an "empty" claim file with a record filled out in such a way as to indicate a "zero detail record count." Your EDI rep can assist in this situation. **<u>Note</u>: CMS is developing a process that will be added to the Section 111 website to allow the user to indicate that the RRE has nothing to submit in a particular quarter in lieu of submitting an actual empty file.**

Q: Are The Interim Dollar Thresholds Just For The TPOC Settlements And Payments, Or Do They Also Provide A Reporting Exemption For ORM Reports?

The interim dollar thresholds only apply to TPOC payments (settlements, judgments, awards or other payments) and only when the TPOC is paid for liability insurance (including self-insurance) or workers' compensation. There is no threshold exemption for TPOC paid for no-fault insurance.

There is no *de minimis* dollar threshold for reporting:

- **ORM amounts for no-fault insurance**
- **ORM amounts for liability insurance**

There are strict criteria for a threshold exemption for workers' compensation ORM; when all criteria are met, the exemption applies only if the total payment for medicals is < $750.00.

TPOC claims reported below the specified dollar threshold will be considered to be reported in error. The only exception is that an RRE may, at its discretion, report TPOCs under the threshold on a claim record with ORM.

Note: Where there are multiple TPOCs associated with the same claim record, the combined cumulative TPOC amounts must be considered in determining whether or not the reporting threshold is met. Where the RRE is responsible for reporting both the payment of a deductible and any amount above the deductible, the sum of these amounts constitutes the TPOC value for threshold calculation purposes.

III. How To Report

Q: Is It OK To Err On The Side Of Caution And Report On All Settled Claims And Let CMS Figure Out Who's A Beneficiary And Who Isn't?

No. It is not acceptable for a RRE to send information on every claim record without regard to the injured party's Medicare status. CMS will monitor ongoing claim file submissions to make sure that RREs have implemented a procedure to reasonably identify an injured party as a Medicare beneficiary rather than dumping their entire set of claims to satisfy Section 111 reporting requirements.

Q: Must The RRE Do This Reporting Itself, Or Can This Task Be Outsourced?

Yes and no. A RRE must register for itself on the COBSW, but during that process it will have an option of designating an Account Manager to handle much of the day to day reporting obligations. The RRE can contract with an Agent, such as a TPA, consulting company, or data service company to serve as an Account Manager and

assist with this project. However, the RRE cannot contractually shift its ultimate responsibility for the accuracy and integrity of its data and CMS will look to, communicate with, and hold the RRE responsible for Section 111 program compliance.

An Agent can service multiple RREs, but must test and submit each RREs' files separately each quarter.

Q: When And How are ICD-9-CM Codes Supposed To Be Used?

ICD-9-CM refers to the International Classification of Diseases, Ninth Revision and is the official system of assigning codes to diagnoses and procedures. CMS requires information about the alleged cause of the Medicare beneficiary's injury, illness, or incident, and the corresponding diagnosis(es) for the condition. This information will facilitate proper claims payment, lead to more accurate coordination of benefits, and contribute to appropriate recovery efforts.

At the present time, it is sufficient to provide a free-form text description of the illness or injury. But beginning 1/1/11, both a cause and diagnosis of the injury must be expressed in the form of ICD-9 Codes.

CMS cautions that not all ICD-9 Codes will be accepted as valid for purposes of Section 111 reporting. Certain codes have been declared "insufficient" because they do not provide enough detailed, useful, and/or adequate information.

CMS publishes a list of valid ICD-9 Codes each year, at www.cms.hhs.gov/icd9ProviderDiagnosticCodes/06_codes.asp. For convenience, a list of invalid codes is included in the Section 111 User Guide which is available on the Section 111 Reporting website.

RREs may elect to begin using the ICD-9 Codes before 1/1/11. Care must be taken to use valid codes and enter the five character code accurately, otherwise the submitted record will be rejected. (The ICD-10 Codes are due out soon. They will have a different configuration. ICD-10 Codes are not to be used until further notice.)

Q: How Should The Date Of Incident Be Reported When The Exposure Date Is Not Known With Certainty?

CMS recognizes that in cases involving alleged occupational disease exposure, ascertaining the first date of exposure may not be know with certainty. The RRE is expected to use its best estimate based on all available evidence and to carefully document for itself how and why it arrived at a particular date of incident. A date of incident used for Section 111 reporting purposes cannot be in conflict with or inconsistent with other evidence and information that may be documented within the company's internal litigation or claims files.

IV. Special Situations

Q: Is There A Potential For Multiple Reporting? For Example, Who Reports If Multiple Co-Defendants Settle A Claim Or Suit?

Reporting is to be done on a beneficiary-by-beneficiary basis, by type of insurance **(liability, no-fault, workers' compensation)**, by policy number, and by RRE. Consequently, it is possible that a RRE will submit more than one record for a particular individual in a particular quarter's submission window. Depending on the number of policies at issue for a RRE and/or the type of insurance or workers' compensation involved, a RRE may be submitting multiple records for the same individual. Medicare contemplates that such reporting will be cumulative rather than duplicative.

In a situation where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurers issue payment for a settlement, judgment, award or other does not shift RRE responsibility to the entity issuing the payment. All RREs involved in the settlement remain responsible for their own reporting**, and will report their portion of the settlement separately. In this situation, there will be multiple records submitted for the same individual but they will be cumulative rather than duplicative.**

But if multiple parties enter into one settlement in which the parties are jointly and severally liable for the entire payment, then each party must report the total amount of the settlement. CMS will identify and sort out the redundancy "at the back end".

Q: How Are Structured Settlements Treated?

A structured settlement or annuity is considered a single payment obligation. If it was funded before 1/1/10, it does not have to be reported. If the structure was agreed to, received court approval, or was funded by the RRE after 1/1/10, it must be reported, but reported just once. The amount to be reported is the total payout amount or guaranteed minimum amount, whichever is greater. Structured settlements that plaintiffs choose to enter on their own, and not as a condition of the Release or Settlement Agreement, do not have to be reported.

Q: Does The Confidentiality Provision In A Release Exempt The RRE From Reporting?

No. As far as Medicare is concerned, the Confidentiality Agreement does not bar reporting. Medicare still requires reporting on the settlement, including the dollar amount paid. CMS refers to two regulations, 42 CFR § 411.23 and 42 CFR § 411.24, as authority requiring Medicare beneficiaries to fully cooperate with all Coordination of Benefits efforts, and they must agree to the release of all information necessary for that objective.

Q: **<u>If The "Settlement" Consists Of A Write-Off Of Bills, Or Providing A Gift Card Or Other Form Of Service Recovery Or Goodwill Gesture, Is It Still Reportable?</u>**

Yes. According to CMS, those types of actions demonstrate a primary payment responsibility**, are akin to "self-insurance"** and will need to be reported **if they meet the interim dollar thresholds**. Similarly, if a healthcare provider agrees to provide future care to the injured beneficiary, then that is considered "ORM" and must be reported as such. <u>Note</u>: As of **8/18/09**, CMS indicated it is reconsidering the reporting rules with respect to hospital write-offs, and the use of service recovery gestures, gift cards, etc. **CMS is conferring with industry representatives and will issue further Guidance on this issue.**

Q: **<u>If the Incident Occurred Outside the U.S. or if the RRE is a Non-Resident Domiciled Outside of the U.S., Does CMS Still Have the Jurisdiction to Compel Reporting?</u>**

Yes. The geographic location of the incident, illness or injury is not determinative of the RRE's reporting responsibility as Medicare beneficiaries who are injured or become ill outside of the United States often return to the U.S. for medical care. **Similarly, CMS expects foreign entities that make payment to U.S. Medicare beneficiaries to comply with the reporting requirements. Foreign entities that lack U.S. addresses or tax identification numbers (TIN) are directed to call the COBC EID Department (646.458.6740) for assistance in setting up reporting processes.**

Q: **<u>If Payment Is Being Made By A "Medicare Supplemental" Policy, Is It Necessary To Report? After All, Those Policies Will Be Secondary To Medicare, Right?</u>**

Pursuant to statute, Medicare is secondary to liability insurance (including self-insurance), no-fault insurance and workers' compensation. An insurer or self-insured entity cannot, by contract or otherwise, supersede federal law.

Q: **<u>Is Reporting Still Required If The RRE Entity Is Bankrupt Or In Liquidation?</u>**

Yes. A bankrupt entity is the RRE to the extent that settlements, judgments, awards, or other payments are paid to or on behalf of the injured party from the bankrupt estate after approval by a bankruptcy court.

Similarly, an entity in liquidation is the RRE to the extent that settlements, judgments, awards, or other payments are paid from the assets of the entity in liquidation.

But to the extent, a portion of the settlement, judgment, award, or other payment obligation against an entity in liquidation is paid by another entity from that other entity's assets (e.g. a state guarantee fund) the entity that makes the payment is the RRE.

In some instances, serial payments may be made from the assets of an entity in liquidation/bankruptcy, in that situation, the entity should report amounts as additional TPOC amounts.

V. Impact On Claims Handling & Litigation

Q: What Impact Will These Reporting Obligations Have On The Conduct Of Claims Investigations And/Or Discovery? Is There Anything The Claims Rep Or Counsel Should Do Differently?

- Early in the claims handling process, require claimants/plaintiffs to produce a copy of their Social Security card and Medicare beneficiary card (both sides). There is valuable information on the card, including the Beneficiary's exact name as provided by CMS, **the Medicare Health Insurance Claim Number (HICN),** and entitlement date, which will help correctly identify beneficiaries and determine reporting obligations. **Note: CMS has issued Model Language to help the RREs ascertain a claimant's Medicare status. Use of the Form language (attached at Appendix 3) will evidence the RRE's efforts to comply with the Section 111 program. This should prove useful when Medicare Beneficiaries, claimants and/or their counsel refuse to provide SSNs and HICNs, in violation of 42 C.F.R. § 411.23.**

- During discovery, ask about the claimant's use of other names or aliases; you may need this information when querying the CMS database to correctly identify a beneficiary.

- Where you have information that the injured individual is/was a Medicare beneficiary early in your claim review process, you know that you will be reporting for that person at the time of a settlement, judgment, award or other payment. However, for an individual who is not yet a Medicare beneficiary at the time he/she files a claim, or for a claimant you are initially unable to identify as a beneficiary, you must determine that individual's beneficiary status as of the date of any settlement, judgment, award or other payment. Plan to inquire about the claimant's Medicare status throughout the discovery process; have the claimant make a representation of their Medicare status as a condition of settlement negotiations; and plan to query the Medicare database to check the claimant's official Medicare status just before making a payment, settlement, judgment or award.

- Although CMS does not require a claimant's signed release or authorization to Query CMS and exchange the patient's sensitive identifying information, state courts may hold otherwise. To avoid the potential of discovery disputes, motions for protective orders, sanctions, or charges of misappropriate use of personal

information, it will be wise to obtain a written authorization from the claimant to facilitate the defendant/insurer's Section 111 reporting obligations.

Q: <u>Will These Reporting Obligations Impact The Settlement Process? What Are Practical Tips For The Claims Rep Or Outside Counsel?</u>

- Since a goal of this program is to ensure Medicare has access to sources of potential recovery when it is a secondary payer, insurers or other payers should consider issuing multi-party checks (with Medicare's name on the check). Another approach is to put a certain percentage of the settlement in a multi-party check, to cover the anticipated Medicare recovery amount, and then pay the balance to the beneficiary and representative.

- If the Settlement will be structured in whole or in part, get a copy of the Structure Payout Projection, as the RRE will need to understand the time period used in calculating the purchase price of the annuity, and know the total payout amount and any guaranteed minimum payout amount for the Section 111 report.

- **If the claim or litigation involves multiple co-defendants and each settles separately, do not use a global release. Each party should use its own Release to facilitate individual reporting of their respective share of the settlement.**

- **Continue to include indemnity language in the Release, for the consequences of future subrogation/recovery efforts.**

- **Include language in the Release that reporting to CMS is an exception to, not elimination of, confidentiality requirements.**

Q: <u>What Are The Reporting Obligations In These Trial Scenarios?</u>

<u>Defense Verdict</u>

If judgment is entered against the claimant, and no payment will be made, then no report is due.

<u>Plaintiff's Verdict, But the Case Is On Appeal</u>

If any payment or partial payment of the verdict is made, pending appeal, it must be reported. If payment is not made pending results of the appeals/negotiation, then no reporting is required until the appeal/negotiation is resolved.

Punitive Damages

Even though punitive damage awards may be exempt from certain CMS secondary payer recovery actions, CMS still requires that the full amount of a jury award, including punitives, be included when the Section 111 report is made.

VI. Impact on Business Operations

Q: Will This Program Affect Record Retention Periods?

CMS recommends a record retention period of ten years for MSP related information, and cautions that absence of related information does not constitute a valid defense against an MSP recovery action.

Q: Does The Data Use Agreement Impose Any Special Obligations On The RRE?

Yes. The RRE's Authorized Representative must sign and return the Data Use Agreement as part of the Section 111 registration process. By signing the Data Use Agreement, the Authorized Representative, on behalf of the RRE, agrees to establish and implement "proper safeguards" against unauthorized use and disclosure of the data exchanged with CMS for the purpose of complying with the Section 111 reporting rules. This means the RRE and its duly authorized agent must establish appropriate administrative, technical, procedural and physical safeguards to protect the confidentiality of the data, to prevent unauthorized access to the data provided by CMS, and to ensure the data is only used for proper purposes.

To the extent the RRE contracts with an agent reporting on behalf of multiple RREs, the RRE has the duty to ensure that its agent will segregate data reported on behalf of each unique RRE to limit access to only the RRE and CMS and the agent.

Personnel with access to the data must be advised of the confidential nature of the information, trained on safeguards required to protect the information, and informed of the administrative, civil, and criminal penalties for non-compliance pursuant to Federal law.

By signing the Data Use Agreement, the authorized representative also agrees to give CMS access to premises where the Medicare data is kept for the purpose of inspecting security arrangements to ensure compliance.

Q: <u>For Small Companies With Limited Resources That Anticipate Infrequent Claims Submissions, Will CMS Accept Manual Reports To Save Time And Expense ?</u>

No. The Section 111 reporting program is designed for and built upon an electronic reporting platform. If a company does not have the resources to establish an electronic connection, it will, at a minimum, need to electronically register itself as an RRE and then identify an Account Manager with electronic capabilities to serve as its agent for the ongoing submission of claim files.

Q: <u>What Are The Penalties For Non-Compliance?</u>

A RRE that fails to comply is subject to a civil monetary penalty of $1000 for each day of non-compliance with respect to each claimant. This penalty is in addition to any other penalties provided by law. CMS is working on developing "model language" that will assist RREs in demonstrating their good faith compliance with Section 111 reporting obligations.

CMS will also take note of claim records that are submitted late. Records not received timely will be processed but marked as late and used for subsequent compliance tracking. Non-compliance will be flagged. RREs must review the flags, apply corrections to internal systems or data, and, if desired, resubmit records with corrections. <u>Note</u>: CMS reserves the right to conduct onsight inspections and audits of the RRE and/or their agent(s) to assure compliance with data security arrangements and all other Section 111 reporting requirements.

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APPENDIX 1

ACRONYMS & DEFINITIONS

In its Section 111 Program materials, CMS utilizes a variety of acronyms, definitions and terms, many of which are admittedly unique to Medicare and do not follow industry custom. This terminology is critical to understanding the Section 111 reporting obligations and corresponding processes. Frequently used terms and abbreviations are set forth below:

Claim For purposes of RRE submissions, "claim" is used to refer to the overall claim for liability insurance (including self-insurance), no-fault insurance or workers' compensation, rather than a single claim for a particular medical item or service. Claim information is to be submitted for individual claimants where the injured party is a Medicare beneficiary.

CMS The Centers for Medicare & Medicaid Services; an agency of the Federal government, part of the Department of Health and Human Services. CMS is responsible for the oversight of the Medicare program, including implementing the Section 111 reporting provisions.

COBC CMS' Coordination of Benefits Contractor.

COBSW "Medicare's Coordination of Benefits Secured Website" for use in Section 111 reporting; www.Section111.cms.hhs.gov.

DOI "Date of Incident" – *(Important to note that CMS's definition of "date of incident" differs from that generally used by the insurance industry.)* For an MVA or other discreet accident or event, the "Date of Incident" is the date of occurrence. But for claims involving exposure (including occupational disease and any associated cumulative injury), the DOI is the **date of first exposure**. For claims involving ingestion (for example, involving a drug), the DOI is the **date of first ingestion**. And for claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).

GHP "Group Health Plans".

HEW "HIPAA Eligibility Wrapper" – A reference to the software and file format used to transmit data and information back and forth between the RRE and the COBC.

HICN "Medicare" Health Insurance Claim Number – CMS' official identifier for the beneficiary and is the preferred data element for matching records to Medicare beneficiaries. **RREs are encouraged to obtain HICNs from injured parties who are Medicare beneficiaries.**

ICD-9-CM **International Classification of Diseases, Ninth Revision, Clinical Modification. Used as the source for coding the "cause of injury" and "diagnosis" fields on the claim record.**

Liability Insurance (including self-insurance) is coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction which results in injury or illness to an individual or damage to property. It includes but is not limited to the following:

- Homeowners' Liability Insurance
- Product Liability Insurance
- General Casualty Insurance
- Malpractice Liability Insurance
- Automobile Liability Insurance
- Uninsured Motorists Liability Insurance
- Underinsured Motorists Liability Insurance

42 C.F.R. § 411.50

MIR "Mandatory Insurer Reporting"

MSP "Medicare Secondary Payer" – Is the term used when the Medicare program does not have primary payment responsibility (that is, another entity has the responsibility for paying before Medicare). Medicare is a secondary payer to Group Health Plan coverage in certain situations and is always a secondary payer to liability insurance (including self-insurance), no fault insurance and workers' compensation.

No-Fault Insurance Insurance that pays for healthcare services resulting from injury to an individual or damage to property in an accident, regardless of who was at fault for causing the accident. Some types of no- fault insurance include, but are not limited to certain forms of automobile insurance, certain homeowners' insurance, commercial insurance plans, and medical payments coverage/personal injury protection/medical expense coverage. For purposes of the Section 111 program, the definition of "No-Fault" found at 42 C.F.R. § 411.50 is controlling.

Non-GHP "Non-Group Health Plans": Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation.

ORM	"Ongoing Responsibility for Medicals" – Refers to the RRE's responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with the claim. This typically only applies to no-fault and workers' compensation claims.
RREs	"Responsible Reporting Entities" – The entities responsible for complying with Section 111.
Self-Insurance	Individuals/Entities engaged in a business, trade or profession are "self-insured" to the extent they carry their own risk (whether by a failure to obtain insurance or otherwise), in whole or in part. This includes responsibility for deductibles and co-pays on a liability insurance, no-fault insurance, or workers' compensation plan. (See 42 C.F.R. § 411.50).
SSN	"Social Security Number".
TIN	**Tax Identification Number**
TPA	**Third Party Administrator**
TPOC	"The Total Payment Obligation to the Claimant" – Refers to the dollar amount of a settlement, judgment, award or other payment **– generally a "one-time or "lump sum" payment –** in addition to/ apart from ORM.

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APPENDIX 2

CLAIM FILE LAYOUT

(Excerpts of significant data elements)

Field Name	Description	Required	Optional
Injured Party/Medicare Beneficiary Information			
HICN or SSN		√	
Full Name	**As it appears on the individual's Medicare or Social Security card.**	√	
Gender/Date of Birth		√	
Injury/Accident/Illness Information			
Date of Incident as defined by CMS	For an MVA or other discreet accident or event, the "Date of Incident" is the date of occurrence. But for claims involving exposure (including occupational disease and any associated cumulative injury) the DOI is the **date of first exposure**. For claims involving ingestion (for example, involving a drug), the DOI is the **date of first ingestion**. And for claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).	√	

Issued: May 20, 2009
Revised: August 31, 2009

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Field Name	Description	Required	Optional
Date of Incident as routinely used by the insurance or workers' comp. industry	For an MVA or other accident, the DOI is the date of the event. For claims involving exposure, ingestion or implantation, the date of incident is often the date of last exposure, ingestion or implantation.		√
Alleged cause of injury, incident of illness	Using ICD-9-CM codes **from the current list of valid codes accepted by CMS for Section 111 reporting**.	√ For new claim records submitted on or after 1/1/11	
State of Venue	U.S. Postal abbreviation corresponding to the state whose state law controls resolution of the claim	√	
ICD-9 Diagnosis Code(s)	**Using ICD-9-CM codes from the current list of valid codes accepted by CMS for Section 111 reporting**.	√ State as many codes as applicable for new claim records submitted on or after 1/1/11	
Description of Illness/Injury	Free-form text description of illness or injury including description of major body part injured and cause of illness/injury	√ Through 12/31/10	
Product Liability Indicator	Indicate whether injury, illness or incident was allegedly caused /contributed to by a particular product. Further indicate if the claim involves a mass tort situation.	√	

Field Name	Description	Required	Optional
Additional Product Detail: Generic name, brand name, manufacturer and alleged harm.		√ Prior to 1/1/11, required only in mass tort situations; on or after 1/1/11, required in all new claim records involving product liability situations.	
Self-Insurance Information: Information required to indicate if the event involves "self-insurance" as defined by CMS			
Policy Holder Name		√	
Plan Insurance Type		√	
Policy Number		√	
Claim Number		√	
TIN	**Federal Tax Identification Number of the "applicable plan"**		
No-Fault Insurance Plan details	**Limits and exhaust date**		
Injured Party's Attorney or Other Representative			
Indicate the type of representative	Specify whether representative is attorney, guardian/conservator, power of attorney or other	√ If injured party has a representative	
Representative Full Name		√	
Firm Name		√ On or after 1/1/11	
Mailing Address, Tax ID, Phone Number		√ If injured party has a representative	

Field Name	Description	Required	Optional
Settlement Judgment Award or Other Payment Information			
ORM Indicator	Indication of whether there is ongoing responsibility for medicals (ORM). Indicate Yes or No	√	
ORM Termination Date	Date ongoing responsibility for medicals ended, where applicable.	√	
TPOC Date(s)	Date payment obligation(s) established. Use the date the obligation is signed if there is a written agreement. But if court approval is required, use the date the obligation is signed, or the date of court approval, whichever is later. **Use the Auxiliary Record to report multiple TPOC amounts to the same claimant separately.**	√	
TPOC Amount(s)	Dollar amount(s) of the total payment obligation to the claimant. If there is a structured settlement, the amount is the total payout amount or annuity amount. For annuities, base the total amount upon the time period used in calculating the purchase price of the annuity (i.e., life expectancy) or the guaranteed minimum payout amount, whichever calculation results in the larger figure. **Use the Auxiliary Record to report multiple TPOC amounts to the same claimant separately.**	√	

Field Name	Description	Required	Optional
Funding Date	If funding is delayed, provide actual or estimated date of funding	√	
Claimant Information: Only To Be Used If The Injured Party/Medicare Beneficiary Is Deceased, and the Beneficiary's Estate or Other Individual is Serving as the Principle Claimant in the Case			
Indicate Nature of Claimant Relationship and Full Identifying and Contact Information	Relationship of the claimant to the injured party/Medicare beneficiary may be: estate, family member, trust, or other.	√ On or after 4/1/10	√ **1/1/10** – 3/31/10

APPENDIX 3

CMS MODEL LANGUAGE FORM FOR HICN, SSN COLLECTION

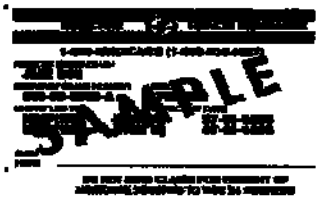
(August 24, 2009)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?		☐Yes	☐No
Medicare Claim Number:		**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)*	- -	**Sex**	☐Female ☐Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form if Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Issued: May 20, 2009
Revised: August 31, 2009

Section III

Claimant Name (Please Print)	**Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form	**Date**

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APPENDIX 4

RESOURCES & REFERENCES

Statutes

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), amended the MSP provisions found at 42 USC 1395y(b).

42 USC § 1395 y(b)(7)—mandatory reporting requirements for Group Health Plans.

42 USC § 1395y(b)(8)—mandatory reporting requirements for non-Group Health Plans (liability insurance, including self-insurance, no-fault insurance and workers' compensation).

Regulations

42 C.F.R. Part 411.

42 C.F.R. § 411.23 — Requires a beneficiary's cooperation in CMS's recovery efforts.

42 C.F.R. § 411.24 — Sets forth procedures and rules for CMS's recovery of conditional payments. Addresses release of information, right to initiate recovery, methods of recovery, claim filing process, and how CMS calculates the recovery amount.

42 C.F.R. § 411.50 — Includes CMS's definitions of various insurance and payment terms.

Websites

www.cms.hhs.gov/MandatoryInsRep — The CMS Section 111 website which contains all official implementing instructions and information, including the **224-page User Guide, Version 2.0**, transcripts of Section 111 teleconference calls, registration and training opportunities for Section 111 RREs and agents. Refer to this website for the latest version of Guidance documents and other important announcements. To receive email updates of Section 111 news and information, click on the "For email updates and notifications" link on this page.

www.Section111.cms.hhs.gov — The Medicare COBC's secure website for Section 111 reporting.

www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp — List of valid ICD-9 diagnosis codes; updated annually; optional for use in completing cause of injury and diagnosis fields in claim files until 12/31/10; mandatory thereafter.

www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf and
www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpic9.htm — additional information on ICD-9-CM.

www.msprc.info — Provides supplemental guidance on the Medicare secondary payer and recovery process.

www.cms.hhs.gov/manuals/IOM — Source for CMS' internet-only Manuals (IOMs). The IOMs are a replica of the official CMS manuals. The IOMs are a good source of general information about the Medicare and Medicaid programs. They also contain day-to-day operating instruction, policies and procedures, and are used by providers, contractors, state survey agencies and others to administer CMS programs. The "Medicare Secondary Payer Manual" is Publication #100-05, and available on this website.

Technical Assistance

Each RRE will be assigned a COBC EDI Rep to be the main contact for Section 111 file transmission and reporting issues. Call the COBC EDI Department be at 646.458.6740 for assistance.

CMS also provides the following contacts for more complex technical problems that require assistance above the level of the EDI Rep. Escalate your calls in this order:

1. Jeremy Farquhar (EDI Department Supervisor) — 646.458.6614; JFarquhar@ehmedicare.com.

2. William Ford (EDI Department Manager) — 646.458.6613; WFord@ehmedicare.com.

3. Jim Brady (COBC Project Manager) — 646.458.6682; JBrady@ehmedicare.com.

Training and Education

During implementation of the Section 111 reporting, CMS has been conducting a series of teleconferences to provide information and answer questions regarding the procedures. The schedule of upcoming teleconferences is posted on the Section 111 web site at www.cms.hhs.gov/MandatoryInsRep. Transcripts of prior calls are also available on the web.

CMS is making available a curriculum of computer-based training (CBT) courses to Section 111 RREs. These courses are designed to provide overviews of Medicare and the Secondary Payer program, and in-depth training on the Section 111 reporting requirements and procedures. Sign up information is posted on the website, www.cms.hhs.gov/MandatoryInsRep.