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MEMORANDUM

September 10, 2009

To: All Judges and Attorneys
From: Peter J. Calderone, Director and Chief Judge
Subject: Medicare Articles

Enclosed please find two Medicare articles by Rob Lewis, Esq. that addresses, among other things, the insurer reporting requirements that may be of interest to you.

Enclosures

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Section 111
Medicare Reporting

By Dorothy E. Kelly
and Robert T. Lewis

An illustration of how mandatory data exchange will allow Medicare to connect the aspects of MSP compliance.

The Next Chapter in Medicare Compliance

We await the implementation of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), not because it gives the Centers for Medicare & Medicaid Services (CMS) astonish-

ing visibility into the industry's existing Medicare Secondary Payer (MSP) statute compliance efforts, though it does. We await the implementation of Section 111 not because it promises civil money penalties so severe that at \$1,000 per claim, per day of non-compliance, CMS could destroy a claims organization, though it does. We await the implementation of Section 111 not because CMS has been charged with ensuring compliance, or because it finally has the tools and resources to do so, though it does. Though the formal purpose of Section 111 is to enable other MSP compliance provisions, the amendment creates a new opportunity to obtain funds through penalty provisions. While we would never assume CMS would favor penalties over successful implementation of Section 111, it would be unwise to ignore the unintentional consequences of the model.

The purpose of this article is to examine the three aspects of MSP compliance. The

first aspect is to ensure Medicare is reimbursed for any payments it may have made when another payer should have been the primary payer. This is accomplished by satisfying Medicare's conditional payments. The second aspect of compliance is to ensure Medicare does not make payments in the future that another payer should make, or should have a plan for making. This is accomplished by setting funds aside from a settlement through a Medicare set-aside arrangement. The third aspect of compliance is to ensure Medicare is aware of instances in which an insurer or self-insurer is making or has made payments to Medicare beneficiaries in a workers' compensation, no fault or liability claim. This is accomplished by providing required data to Medicare in an electronic fashion according to the Section 111 Mandatory Insurer Reporting Requirements.

This article will focus on the third aspect of compliance, Section 111 report-



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ing, and will illustrate how mandatory data exchange will allow Medicare to connect the aspects of MSP compliance. We seek to inform the reader about the substantive requirements of Section 111 reporting, its utility to Medicare, and its relationship to the claims settlement process and, therefore, the practical considerations it raises for attorneys.

Background

The Medicare Secondary Payer (MSP) statute allows the Centers for Medicare & Medicaid Services (CMS) to pursue damages against any entity that attempts to shift the burden of medical costs to Medicare. The purpose of the MSP statute is to ensure that CMS is not primarily responsible for payment of medical expenses for Medicare beneficiaries if another payer is available. The provisions of the MSP may be found at 42 U.S.C. §1395y(b).

The MSP statute specifically provides that Medicare may not make payment on behalf of a beneficiary if, “payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan... or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.” 42 U.S.C. §1395y(b)(2)(A)(ii). As a result, Medicare will look to one of these designated plans or policies as the “primary” payer for all injury- or illness-related medical expenses. Under this statute, CMS has the right to seek reimbursement of medical expenses paid by Medicare that an insurance carrier or self-insured should have paid. 42 U.S.C. §1395y(b)(2)(B). Additionally, the statute provides for a private cause of action for double damages for failure to provide primary payment or appropriate reimbursement. 42 U.S.C. §1395y(b)(3)(A).

The rationale behind the MSP statute has been addressed many times, perhaps never better than in the Eleventh Circuit’s treatment in *United States v. Baxter International*, 345 F.3d 866 (11th Cir. 2003), cert. denied, 124 S. Ct. 2907 (2004). The MSP statute is a “collection of statutory provisions codified during the 1980s with the intention of reducing federal health care costs.” *Id.* at 875. The court in *Baxter International* noted that since enactment of the MSP statute, “Congress has expanded its

reach several times, making Medicare secondary to a greater array of primary coverage sources, and creating a larger spectrum of beneficiaries who no longer may look to Medicare as their primary source of coverage.” *Id.* at 877. The *Baxter* court also noted that studies have shown that failure to follow the MSP statute “is costing the taxpayer billions of dollars.” *Id.* at 891. According to the 2008 Annual Report by the Social Security and Medicare Boards of Trustees, Medicare’s Hospital Insurance Trust Fund expenditures are projected to exhaust reserves by 2019. *Summary of the 2008 Annual Reports* by Social Security and Medicare Boards of Trustees, available at <http://www.ssa.gov/OACT/TRSUM/index.html>.

Considering the government’s need to preserve the Medicare program, it is obvious why the Medicare Secondary Payer statute’s story is so important. The history and past application of the MSP, or failure to apply it, are well understood by many in the insurance industry. It is the next chapter of MSP compliance, implementing the Mandatory Insurer Reporting Requirements under Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007, that the industry anxiously awaits.

Section 111 of the MMSEA mandates that liability insurers, including self-insurers, no fault insurers and workers’ compensation plans identify claimants who are entitled to Medicare benefits and submit certain information to CMS concerning these Medicare-eligible individuals. This information must be provided in the “form and manner (including frequency) specified by the Secretary” of Health and Human Services. See 42 U.S.C. §1395y(b)(8). The data that CMS seeks concerns the identity of the Medicare eligible claimant, as well as “such other information as the Secretary may specify.” See 42 U.S.C. §1395y(b)(8). The statutory language further states that the information will be submitted “after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).” See 42 U.S.C. §1395y(b)(8).

What Do Form, Manner and Frequency Mean?

With the March 16, 2009, publication of the Mandatory Reporting User Guide 1.0, CMS

outlined the form, manner and frequency with which it expects to receive data from liability insurers, self-insurers, no fault insurers and workers’ compensation plans. Conceptually, the data exchange is simple. Each Responsible Reporting Entity (RRE) must register with CMS via the Coordination of Benefits Contractor Secure Website. During registration, an RRE must provide its contact information, agree to CMS’s terms, select an electronic file transmission method, and identify a reporting agent, should the RRE choose to select a vendor to oversee the data exchange. CMS will validate the RRE’s registration information, and will assign the RRE an Electronic Data Interchange representative, who will assist the RRE to meet the technical demands of the reporting process. Reporting is quarterly, and an RRE is assigned four one-week periods per year during which it must provide its data to CMS. An RRE identifies which claimants in its system are indeed Medicare beneficiaries by participating in CMS’s electronic Medicare query process. Once an RRE identifies which claimants in its system are indeed Medicare beneficiaries, it transmits an electronic “claim input file” to CMS, which contains the information specified by CMS concerning those Medicare beneficiaries in the format stipulated in CMS’s User Guide.

Until now, insurers and self-insurers wishing to comply with CMS policy were often at the mercy of a plaintiff or claimant for information concerning Medicare entitlement. Often, the only way that information was available to an insurer or self-insurer was through a signed consent form from the claimant. Anticipating the burden that Section 111 reporting has placed on insurers and self-insurers, CMS has developed a “query process” whereby an RRE will be able to determine a claimant’s Medicare status electronically— and without authorization—as long as a RRE has access to the claimant’s name, date of birth and Social Security number. The query process will streamline MSP compliance for insurers and self-insurers, and will arm the defense with Medicare entitlement information early in the claim process.

Practically, identifying the required data and collecting it successfully on a large scale is more of a challenge than the simplicity of this description suggests. CMS’s record lay-

out divides the data fields into three categories: required, optional and situational. Required fields center on the identity of the Medicare beneficiary, the identity of his or her representative, the plan of insurance responsible for paying the beneficiary, and the type of payment being made. Optional fields center on two concepts: data elements that pertain to the plan, insurer or self-insurer,

TPOC information

is frequently seen when resolving liability claims, as well as when settling both contested and accepted workers' compensation claims.

and data elements that CMS will eventually require, but does not require at the outset of the reporting process. Situational fields become required only when certain conditions exist. Evaluating these requirements provides insight into what Medicare intends to accomplish with its data-gathering exercises and informs attorneys of the obligations claim-handling organizations will face, and thus, the impact on a settlement process.

Section 111 Required Data Elements

As stated above, required CMS data fields center on the identity of the Medicare beneficiary, the identity of his or her representative, the plan of insurance responsible for paying the beneficiary, and the type of payment being made. Section 111 requires an RRE to report "settlements, judgments, awards or other payments," that involve both the responsibility for ongoing medical benefits and the termination of all liability through a one-time payment. Ongoing responsibility for medical benefits (ORM) is defined as an entity's "responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with a claim." See User Guide 1.0

at page 7. Essentially, if an insurer or self-insurer has a claim that involves ongoing medical treatment responsibility, such as a no fault or workers' compensation claim, the existence of that claim must be reported to CMS as an "ORM" claim—as long as the claimant is a Medicare beneficiary.

Likewise, Section 111 requires that one-time payments to Medicare beneficiaries that terminate a claim for medical benefits be reported. Under the terminology invented by Medicare for Section 111 reporting, this type of payment is referred to as the "total payment obligation to a claimant" (TPOC) and is defined as a "settlement, judgment, award, or other payment in addition to/apart from ORM." See User Guide 1.0 at page 8. An insurer or self-insurer must report the date it satisfies its total payment obligation to the injured party. It must also supply the dollar value of the transaction in the claim input file. TPOC information is frequently seen when resolving liability claims, as well as when settling both contested and accepted workers' compensation claims.

Section 111 Optional Data Elements

Section 111 reporting will include dozens of optional data elements, many of which fall outside of the realm of a traditional claims-handling system. Several data points that CMS deems critical to the recovery process will be marked as optional during initial implementation of the Section 111, but these data points will become required fields at dates specified in the future. For example, it will be acceptable for an RRE to submit a description of the injury or illness and resulting trauma through a free-form text entry until December 31, 2010. Other fields, which house the ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) External Cause of Injury "E Code" and the ICD-9-CM Diagnosis Code are currently optional and will become required beginning January 1, 2011. Because both are currently optional, but one or the other must be chosen, both fields are listed in CMS's Section 111 data fields. These fields may present a compliance problem for an RRE that does not currently capture the information according to CMS's specifications. As such, data-gathering exercises and claims-handling procedures will likely

be altered as CMS's optional fields become required elements.

Section 111 Situational Data Elements

In many cases, CMS will require certain information only if certain conditions are met. For instance, if settlement proceeds are dispersed to a living Medicare beneficiary directly, only the identifying information for that recipient must be listed in the claim input file. If settlement proceeds are dispersed to the estate of a deceased Medicare beneficiary, the claim input file must not only list the identifying information for the deceased beneficiary, but it must also supply the identifying information for the estate or individual receiving survivor benefits.

This is but one example of a circumstance that will require reporting situational data elements under Section 111. It demonstrates, however, that while most aspects of the data exchange that would be quite obvious to anyone with intimate knowledge of a claim, those data elements may not be easily identifiable on a programmatic level. However, the requirements of Section 111 will result in *all* of the data being provided on a programmatic level because the information must be transmitted to CMS through the electronic process outlined in this article. CMS will receive most of its data from insurers, large self-insured entities and agents of those groups. Though CMS has provided little information on the civil penalties it is empowered to impose, an RRE could suffer the same civil penalties for flawed reporting that it could face for not reporting at all. Therefore, it is of critical importance that Required Reporting Entities understand the requirements under this statute and develop means to comply.

How Medicare Intends to Use the Section 111 Data

The statutory language clearly expresses CMS's purpose in obtaining this information: "in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim." See 42 U.S.C. §1395y(b)(8). In its August 2008 supporting statement, CMS divides coordination of benefits into two concepts: "post-payment" and "pre-payment" activities.

Common Working File Change Request 5371 connects the coordination of benefits concepts to the collection of Section 111 settlement data, and creates an operational policy for denying payment of medical bills submitted on behalf of a Medicare beneficiary after the settlement date. See CMS Change Request 5371. Examining these policies illustrates how CMS will rely on the Section 111 reporting data to ensure the future viability of the Medicare program. See August 1, 2008, CMS Supporting Statement on Section 111 Reporting.

Then: Post-payment

Prior to the implementation of Section 111, CMS's cost-saving focus has been on post-payment activities. That is to say that Medicare's efforts to protect the Trust Fund have centered on recouping dollars that have already been paid. It is CMS's practice to routinely pay for treatment rendered to a Medicare beneficiary on the condition that it will be reimbursed if a primary payer is identified at a later date. If a primary payer is identified, Medicare refers to the payments it has made in the primary payer's stead as "conditional payments."

The process by which Medicare would discover a primary payer situation is not simple. A Medicare beneficiary, his or her attorney, or a party affiliated with the primary payer must notify the Medicare's Coordination of Benefits Contractor (COBC), supplying data closely related to the Section 111 record layout, either in writing or through the COBC's hotline. The COBC then passes the data on to the Medicare Secondary Payer Recovery Contractor (MSPRC), which initiates a search of medical claims already paid by Medicare on the claim. Once Medicare learns that the parties have reached a settlement, it issues a demand for reimbursement of the paid medical claims. This process is a post-payment activity: it involves retroactively recovering dollars that it has already paid when another primary payment source was available.

Though its recovery right has been absolute for many years, Medicare's ability to recognize opportunity for recovery has been limited. Medicare's recovery usually occurs in instances in which a beneficiary, his or her attorney, or an affiliate of an insurer proactively provided the recovery opportunity to CMS by self-identifying.

Further, the identification and lien resolution processes have traditionally been accomplished by a claimant's counsel—especially in liability cases—leaving many insurers and self-insurers unfamiliar with the procedures.

Section 111 mandates the data obtained in the self-identification process and then some. With an electronic stream of data heading directly towards a beneficiary's Common Working File (CWF), the Medicare Secondary Payer Recovery Contractor will have ample sources from which it can demand reimbursement for its conditional payments. This increased visibility must motivate insurers, self-insurers, claimants, and their attorneys to take hold of the lien identification and resolution process, as each is potentially liable for conditional payments under the MSP.

Now: Pre-payment

The data supplied to CMS under Section 111 provides pre-payment processes that should actually prevent Medicare from making payments when another form of insurance is primary. An example of a pre-payment activity is the collection of the "ORM Indicator" in the Section 111 claim input file. Using three basic pieces of information as limited as the identity of a Medicare beneficiary, an ICD-9-CM Diagnosis Code denoting the injury for which another form of insurance is responsible, and an ORM indicator equal to "YES," CMS has sufficient data to instruct its fiscal intermediaries to deny paying claims submitted by providers, physicians and suppliers who have rendered treatment to the beneficiary.

It is important to recognize that this pre-payment procedure is aimed at claims that have not yet settled, or that will not settle. As outlined in the discussion of CMS's post-payment procedures above, the primary vehicle Medicare uses to recover funds is a claim's settlement, judgment or award. In lieu of altering this procedure, Medicare has opted to expand upon the concept. Section 111 mandates that primary payers notify CMS of the assumption of responsibility to pay medical benefits. Collecting this information about open workers' compensation and no fault claims via ongoing responsibility for medical indicator gives CMS visibility into a claim that it could not access prior to Section 111's implementation. This

pre-payment procedure will assist Medicare in preserving the Trust Fund, saving dollars, human resources and systems to recoup those funds had they been erroneously distributed in the first place.

The Future: MSAs

Effective July 1, 2009, Medicare will implement a claim-processing feature that could

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alter payment processes for providers, physicians and other suppliers who bill Medicare's contractors and fiscal intermediaries. Earlier this year, in a "Common Working File" (CWF) change request, CMS explained the concept of a Workers' Compensation Medicare Set-Aside (WCMSA) to its provider audience. See CMS Change Request 5371.

Under the Medicare Secondary Payer statute, the settlement of a claim that releases a primary payer from medical liability should include a plan for the claimant's future medical treatment. Especially in workers' compensation, compliance of this sort is achieved through a WCMSA, which is a fund of money "set-aside" at the time of the settlement that must be exhausted before a claimant can use Medicare to pay for treatment related to a workers' compensation injury. In theory, a WCMSA prevents CMS from paying for an injured party's medical care after the date of settlement. CMS publicized the WCMSA as a compliance tool through a series of policy memoranda beginning in 2001. As CMS explains to its provider audience in Change Request 5371, "The CMS has a review process for proposed WCMSA amounts and updates its CWF system in connection with its determination regarding the proposed WCMSA amount." See CMS Change Request 5371.

Signifying that a primary payer has directed funds for claim-related diagnoses to an injured party through a WCMSA, the MSP Code in the claimant's Common Working File will ensure that the "Centers for Medicare and Medicaid Services (CMS) will have the capability to discontinue conditional payments for the diagnosis codes related to such settlements." See

Defense attorneys

should modify discovery practices... to demonstrate the insurer or self-insurer's intent to comply with Section 111.

CMS Change Request 5371. If bills are submitted for services rendered to Medicare beneficiaries who have sustained workers' compensation and liability claim-related injuries and received funds via a Medicare set-aside, Medicare's contractor will deny the claim for payment and notify the beneficiary. The information concerning the denial will be provided to the beneficiary via a Medicare Summary Notice (MSN), which, according to Change Request 5371, includes the following instructions: "Your claim has been denied by Medicare because you have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies)." See CMS Change Request 5371.

Change Request 5371 demonstrates Medicare's intent to use the Section 111 data to augment its enforcement of the MSP statute. Though WCMSA dollar amounts are not submitted as part of the Section 111 claim input file, Change Request 5371 reveals Medicare's ability to coordinate benefits proactively. What remains to be seen is how CMS will utilize the Section 111 data to develop new coordination efforts.

There has been much speculation about the visibility Section 111 creates into whether or not parties to a claim are complying with

CMS's existing MSP policies. An example of this would be a settlement of a claim without the appropriate preparation of a Medicare set-aside arrangement. The Medicare Secondary Payer statute is clear in stating that the parties to a settlement must take Medicare's interest into consideration when resolving a claim. Policy memoranda dictate that WCMSAs for settlements meeting particular criteria be submitted to CMS for approval. The Section 111 reporting data will enable Medicare to identify instances in which these procedures are not followed. Any settlement entered into with a Medicare beneficiary is a reportable event under Section 111, if it releases the primary payer from medial liability and exceeds CMS's low dollar reporting threshold. CMS would simply need to cross-reference the list of beneficiaries whose settlements exceeded \$25,000 as reported under Section 111, and determine whether a WCMSA was submitted to CMS for approval to understand which parties are in compliance with its policies and which are not.

Consequently, it is imperative that parties ensure that they are well versed with CMS rules and regulations surrounding conditional payments and Medicare set-aside arrangements to avoid potential post-settlement disputes.

Applicability

The MSP confers extraordinary powers of reimbursement to the Medicare program. CMS may recover "from any entity that has received payment from a primary plan," including an attorney. 42 C.F.R. §411.24(g). This issue was clearly demonstrated in a recent decision in the U.S. District Court for the Northern District of West Virginia in the case of *U.S. v. Harris*, 2009 WL 891931 (N.D. W.Va. 2009). That case, which was filed against a plaintiff's attorney, illustrated the consequences of a failure to abide by the MSP statute even in a relatively small case.

In *Harris*, the plaintiff's attorney had previously settled a claim against a ladder retailer after his client—a Medicare beneficiary—was injured in a fall. *Id.* at 1. The total settlement was \$25,000, and Medicare claimed that it had made \$22,549.67 in payments on the plaintiff's behalf. *Id.* at 1. Following notification of the settlement, and after reducing its demand to account for the attorney's fees, Medicare demanded reim-

bursement of conditional payments in the amount of \$10,253.59 from the plaintiff's attorney. *Id.* at 1. The plaintiff's attorney failed to object to CMS's demand through the administrative process, and the government ultimately filed suit in federal court in West Virginia, demanding the conditional payments, plus interest. *Id.* at 1. In March, Judge Frederick Stamp, Jr., issued a summary judgment ruling in the government's favor, requiring Harris to repay more than the full amount of the demand, plus interest.

The government's approach in the *Harris* case serves as a reminder to parties that Medicare's interest must be taken into account—regardless of the size of the settlement. Moreover, in cases such as *Harris* in which a party receives a demand from the government, it is imperative that the parties work within the existing administrative framework to object to the inclusion of any mistaken payments listed in Medicare's demand. CMS's demands frequently include charges based on unrelated treatment, treatment contrary to state law, and charges duplicated in the demand form. Negotiating these demands is critical. As *Harris* makes clear—waiting until the government files suit is too late.

It is critical that the plaintiffs' and defense bars collaborate to ensure compliance with all aspects of the MSP. Excluding crucial information from discovery, such as Social Security numbers or health insurance claim numbers (HICN), is not permissible. Without this required information an insurer or self-insurer cannot comply with Section 111. Without complying, it is highly unlikely any insurer or self-insurer will settle a claim for fear of significant civil penalties. Defense attorneys should modify discovery practices, interrogatories, requests for admission and deposition procedures to demonstrate the insurer or self-insurer's intent to comply with Section 111. These practices provide opportunities to collect CMS's required, optional and situational information, and should be used to obtain this information on behalf of an insurer or self-insurer.


Section 111 reporting requires significant programmatic work from an RRE to ensure compliance. Once reporting commences, CMS will receive a constant flow of frequently updated data concerning claims involving its beneficiaries. With this in-

formation, Medicare will be able to more effectively coordinate benefits and more efficiently recover conditional payments that were made on behalf of beneficiaries prior to settlement. Finally, CMS will be able to examine this data to assess an RRE's compliance, not only with Section 111, but also with its larger policy initiatives, such as satisfying conditional payments and including Medicare set-aside arrangements in settlements. If entities are non-compliant, CMS has significant punitive power. This amend-

ment to the statute, and its highly punitive enforcement possibilities, underscore that as the federal government attempts to save the Medicare program, litigation that involves Medicare beneficiaries is bound to only become more complex.

Conclusion

This article examined the three aspects of Medicare Secondary Payer compliance, concentrating on the third facet of compliance, Section 111 reporting. As there is

much summary information available regarding Section 111, we sought to provide a detailed analysis of the amendment's requirements, the manner in which Medicare will use the information presented through its data exchange, and Section 111's application to the settlement process. In conclusion, we advise all attorneys to become familiar with the three aspects of MSP compliance to protect your clients and yourselves. After all, your name is listed in the file Medicare collects under Section 111. 

August 2009

**CROWE PARADIS SECTION 111 MANDATORY INSURER REPORTING
FREQUENTLY ASKED QUESTIONS ©**

On July 31, 2009, the Centers for Medicare & Medicaid Services (“CMS”) released version 2.0 of the MMSEA Section 111 Medicare Secondary Payer Reporting User Guide. Yet fundamental questions still remain about this new mandatory reporting requirement and the continued administrative duties it creates. Given these uncertainties, CPSC is using its experience with the largest carriers, TPAs and self-insured organizations to provide our interpretation of these critical issues.

1.) Q: What is the Medicare Secondary Payer statute (MSP)?

A: The Medicare Secondary Payer statute (42 U.S.C. 1395y) is federal legislation designed to reduce Medicare spending to preserve the Medicare Trust Fund. The statute mandates that Medicare should not pay medical costs for beneficiaries when there is a primary payer situation. A primary payer includes a workers’ compensation plan, liability insurance or plan, no-fault insurance, any entity that is self-insured, and a group health plan. If Medicare does pay for medical treatment in a primary payer situation, these payments are conditioned upon repayment by the primary payer. Medicare may initiate recovery as soon as it learns that payment has been made or could be made under workers’ compensation, any liability or no-fault insurance, or an employer group health plan. (42 C.F.R. 411.24).

2.) Q: What is the Section 111 Mandatory Insurer Reporting requirement?

A: Section 111 of the Medicare, Medicaid, & S-CHIP Extension Act of 2007 (“MMSEA”), amends the MSP statute requiring that certain “responsible reporting entities” (RREs) provide detailed information concerning settlements, judgments, awards and other payments” involving Medicare beneficiaries. Under the reporting scheme created by Medicare, RREs or their agents will be required to electronically exchange data with Medicare on a quarterly basis listing recent settlements, judgments, awards – or whenever ongoing responsibility for medical benefits begins and ends. The electronic data exchange will be done either by the RRE or an agent hired by the RRE. Failure to abide by the § 111 reporting structure carries a stiff penalty. Congress has authorized civil penalties of \$1,000.00 per day per claim for any RRE that fails to report a claim within the applicable time period. It is important to note that Medicare has not set any parameters for the penalty, other than those already delineated in the statute itself.

3.) Q: What is a “responsible reporting entity” (“RRE”)?

A: Under § 111, an RRE is an “applicable plan” of liability, no fault, workers’ compensation insurance or a self-insured entity. It is important to note that under Federal law entities that have chosen to make no plan for liabilities whatsoever are classified by Medicare as self-insured. In short, the RRE is the entity that contractually or legally assumes the risk for the accident or injury. With regard to multiple settlements, each RRE must report appropriately as to their payments. In the case of re-insurance, excess

confirmation that a claim has settled. Because compliance with § 111 will mean that RREs will be providing the information Medicare requires to recover conditional payments, it is near certain that an increased volume of demands will be issued. Thus, it is important that all primary payers including

liability carriers adopt a policy of obtaining the conditional payment amount and negotiating with Medicare for a reduction of that amount, prior to any settlement, judgment or award.

8.) Q: Our claims are handled through a self-insurance pool. Who is the RRE in this situation?

A: There is a three pronged test to determine if the pool or self insured entity should report. The pool should report if all of the following are satisfied (if fewer than three criteria are met, the self insured reports):

- i. It is a separate legal entity
- ii. With full responsibility to resolve and pay claims using pool funds
- iii. Without any involvement of the self insured entity

9.) Q: How does an RRE register with Medicare?

A: When registering, an RRE goes to a secure Web site created by CMS for the registration process. The RRE will have a lot of decisions that should be made in conjunction with its designated reporting agent prior to registration. The critical decisions that must be made include the number of RRE IDs that the RRE will need, the identities of the agents and employees who will have access to the data, and the transmission method for the data.

10.) Q: What are the roles of individuals in the registration and live data production process?

A: There are three main roles that should be assigned by each RRE. Those roles are Authorized Representative, Account Manager and Account Designee. The Authorized Representative is a person employed by the RRE who has the authority to agree to the reporting requirement and will ultimately be held accountable to the RRE's compliance. The Authorized Representative may authorize other users to the RRE ID account. The Account Manager will manage the day-to-day administration of reporting compliance. The Account Manager may be an employee of the RRE, a TPA or the assigned Agent for reporting purposes. An Account Designee may be assigned by the Account Manager. The Account Designee may be an employee of the RRE, a TPA or the agent engaged by the RRE solely for § 111 reporting purposes. The Account Designee is the person or entity assigned to physically transfer the data file to the COBC if the RRE and/Agent decides to outsource this function. Registration is an open process in order to update the users and RRE ID information as needed. See CMS' NGHP User Guide dated July 31, 2009 at page 22 for their guidelines on the use of agents in regards to reporting requirements.

11.) Q: How does an RRE determine whether an injured party is entitled to Medicare?

A: An individual is entitled to Medicare when:

- i. S/he is 65 years of age or older;
- ii. S/he is receiving Social Security Disability Insurance (SSDI) benefits for 24 or more months; or

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compensation claims meeting all (not just one) of the following criteria do not need to be reported through December 31, 2010:

- i. “Medicals Only”;
- ii. Lost time of no more than 7 calendar days;
- iii. All payment(s) has/have been made directly to the medical provider; and
- iv. Total payment does not exceed \$750.00.

(See CMS’ NGHP User Guide V2.0 dated July 31, 2009 at pages 43-45)

14.) Q: Does a claim that is closed due to inactivity, but not legally released from ORM still require reporting?

A: According to the MMSEA Section 111 User Guide released on July 31, 2009, CMS recognizes that by law an RRE may have ongoing responsibility for medicals but, “as a practical matter, there is no possibility associated with future treatment...to address this situation, RREs may submit a termination date for ORM if they have a signed statement from the injured individual’s treating physician that he/she will require no further medical item or services associated with the claim / claimed injuries, regardless of the fact that the claim may be subject to reopening or a claim for future payment.” It is important to note that, should the claim reopen and the claimant is determined to be a Medicare beneficiary, reporting under § 111 would become necessary. (See CMS’ NGHP User Guide V2.0 dated July 31, 2009 at page 68)

15.) Q: Do payments without prejudice need to be reported to CMS?

A: **Yes.** Where payment is made pending investigation, the RRE must report this as an assumption of ORM. If ORM terminates upon the completion of this investigation, the termination of ORM must be reported.

16.) Q: How far back in time does an RRE have to go to investigate Medicare status and collect data with respect to ORM cases?

A: For ORM cases assumed prior to July 1, 2009 – “if a claim was actively closed or removed from current claims records prior to January 1, 2009, the RRE is not required to identify and report that ORM...” If the claim later reopens, however, and the injured party is determined to be a Medicare beneficiary, regardless of the date of injury, it must be reported. (See Page 69 of CMS’ NGHP User Guide dated July 31, 2009)

17.) Q: What if we do not have sufficient information in our claims system to determine if a claimant is a Medicare beneficiary?

A: Section 111 provides RREs an opportunity to delay the reporting of claims lacking sufficient information where responsibility for ORM was assumed prior to July 1, 2009 in order to obtain the necessary information to determine the Medicare status of the claimant. Such claims are permitting to be reported up to and including the reporting period for the third quarter of 2010. Note that claims with assumed responsibility after July 1, 2009 for ORM are not eligible for delay due to lack of sufficient information.

18.) Q: Do I have to change my claims system to be fully compliant?

A: There is no requirement that RREs change their claims system. CMS only requires that reporting be accomplished in a specific format. RREs will have to use their discretion when assessing their claims systems. Reporting agents can be utilized to assist with obtaining the necessary information & format.

19.) Where do I go to get CMS' guidelines for § 111 Reporting?

A: CMS has created a central Web site for all communication regarding § 111. That Web site, available at: <http://www.cms.hhs.gov/MandatoryInsRep>, is a clearing house for all information about § 111 and includes guidance on the registration process, transcripts of CMS Town Hall conference calls, computer based training materials, the § 111 User Guide, and other supporting documentation. Of critical importance is the User Guide 2.0, which is available at:

<http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf>

The User Guide is subject to revision as CMS develops the requirements. As the process is continually refined, CMS will continue to release updates to its implementation plan through the Web site. As such, it is important that interested parties continue to return to the Web site on a regular basis to check in for updates about CMS' implementation procedures and timeline.

20.) Q: Is there any reporting requirement for Medicaid or state-funded assistance beneficiaries?

A: No. Section 111 of the MMSEA has no effect on the Medicaid program or other compliance programs that may be implemented by the several states. Section 111 simply requires that liability insurance (including self-insured), workers' compensation and no fault responsible reporting entities supply information in the form and manner required by the Secretary of Health and Human Services concerning settlements, judgments, awards and other payments made to or on behalf of Medicare beneficiaries.

21.) Q: How does CMS impose or enforce the penalties for failure to report?

A: Section 111 supplies a \$1,000.00 per day per claim civil money penalty for failure to report. CMS is still in the process of determining the fine structure and enforcement policies. These details have not yet been released. The best way for an RRE to reduce exposure to this substantial penalty is to establish processes and protocols that ensure that the letter and spirit of § 111 is complied with on a case by case basis.

22.) Q: If I have a "confidential" settlement, how will that be handled in regards to reporting under § 111?

A: Section 111 is a Federal law requiring disclosure of settlements, judgments, awards and other payments made to or on behalf of Medicare beneficiaries. As a Federal law, it supersedes state law contracts and must be complied with regardless of any private agreement between parties.

23.) Q: Is there a time limit for registering with CMS? If I have nothing to report this year, but might next year, can I wait to register and report until needed?

A: CMS recommends registering from May 1, 2009 through September 30, 2009 to facilitate the commencement of the testing period, which begins January 1, 2010. If an entity may be an RRE, it is strongly recommended that the RRE register in order to be ready for the testing period. CMS recommends that RREs set aside a full three months for testing before the commencement of live date production. Therefore, even if RREs do not anticipate having any claims to report initially, care should be taken to ensure that sufficient time is available for testing before the production of live data.

24.) Q: Do I need to report when a payment is made on a claim?

A: If the payment is such that it would qualify as an assumption of Ongoing Responsibility for Medicals (ORM) on a claim involving a Medicare Beneficiary, it may result in the need to report the claim to CMS. RREs are only permitted to report the assumption and termination of ORM, or to update files that were previously reported as ORM claims. Medicare does not want RREs to report every time a payment is made. It is important for RREs to remember that ORM assumption and termination is the critical reporting element, not the specific amount of ORM benefits that have been paid to or on behalf of a Medicare beneficiary. (See Pages 66-78 of CMS' NGHP User Guide, V2.0 dated July 31, 2009)

25.) Q: Does § 111 reporting apply in cases involving either a one-time medical payment or policies where medical coverage is not typically contemplated?

A: Section 111 applies any time a liability, workers compensation, no-fault or self-insured entity either assumes responsibility to for medical benefits or makes a payment under a settlement, judgment or award or other payment. If the facts and circumstances of the case illustrate that the payment was made to a Medicare beneficiary either for medical services or if the payment was made in compromising a claim that included possible medical care, then the claim may need to reported under §111. It is critical that RREs understand that this involves a case by case analysis. Simply because a particular policy may not offer coverage for medical benefits does not eliminate the possibility that the claim would be reportable to Medicare. If the allegations made include a medical component, the settlement, judgment, award or other payment will be reportable.

26.) Q: If Medicare has made no payments and we have confirmed this in writing do we still have an obligation report the Settlement, Judgment or Award under § 111?

A: Yes. Section 111 compliance is independent of conditional payments. Even where Medicare has stated, in writing, that it has made no payments on a claim, RREs must still report the claim if it qualifies as either an ORM or TPOC reporting event. It is important to remember that § 111 compliance is only one element of a comprehensive Medicare Secondary Payer compliance program. Simply reporting a claim to CMS under § 111 will not satisfy conditional payments or a Medicare Set Aside, if needed. Likewise, reporting a claim to the Medicare Secondary Payer Recovery Contractor (MSPRC) for the purposes of obtaining conditional payments will not comply with the reporting requirements under § 111.

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27.) Q: How does § 111 fit into a third party liability claim in workers compensation?

A: In workers compensation, a workers' compensation carrier may have an obligation to report the assumption of ORM, even though a liable third party is involved. If and when the third party claim settles, the third party or its carrier will have its own independent reporting obligation, most likely for a TPOC event. Therefore, it is likely that multiple reporting entities will report different events on the same claim given the different benefits available to the claimant under both workers' compensation and liability policies.

28.) Q: Does § 111 apply in Texas non-subscriber cases?

A: **Yes.** Texas non-subscriber settlements and payments must be reported under § 111. Section 111 applies to all settlements, judgments, awards or other payments made by a liability, workers compensation, no-fault or self-insurance carriers to a Medicare beneficiary. Under CMS regulations, Texas non-subscribers are typically categorized as liability or self-insured policies.

29.) Q: What are the initial reporting and registration dates provided in CMS' NGHP Alert dated May 12, 2009?

A: In a memorandum dated May 11, 2009, CMS announced new deadlines and dates for various aspects of § 111 compliance.

PRODUCTION AND TESTING OF DATA

CMS pushed all testing and live production of data into 2010. Testing for data production will not begin until January 1, 2010. Live production of data will not be required until the quarter beginning on April 1, 2010 and ending on June 30, 2010. Coinciding with this delay, CMS will require data concerning TPOC events only if they occur on or after January 1, 2010.

QUERIES

CMS announced that testing of the query process would begin on July 1, 2009 for all RREs that have registered by that time. As soon as query testing is completed, RREs can begin to submit live query files to CMS. Because the query testing process was expected to be completed quickly, RREs that registered and tested were able to begin exchanging query data with CMS in July.

For more information about Crowe Paradis' turnkey solution to Section 111 reporting, please contact Crowe Paradis at:

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