

MMSEA Section 111 Reporting

*Medicare's New "Notice & Reporting" Law -
Practical Impact & Challenges to
Claims Handling and Settlement Practices*

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Session Overview

Part I: Background

What is CMS' Intent & Objective?

Part II: Section 111 Requirements

What is Required Under the New Law?

Part III: Current Section 111 Timelines

Part I:

Background - *What is CMS' Intent & Objective?*

Background

What Section 111 is About & NOT About

- “Notice and Reporting” statute; reporting claims that involved Medicare beneficiaries electronically.
- Precursor to Section 111 → **42 C.F.R. 411.25** – this CFR required primary payers to report claims for years before Section 111 was enacted (See e.g., U.S. v. Stricker lawsuit).
- Section 111 does not address Medicare Set-Asides (MSAs).
- It is still necessary to address MSA and Conditional Payments separately from Section 111.
- What is the objective of Section 111?
- Section 111 imposes stringent penalty -- \$1,000 per day, per claim

Part II:

Section 111 Requirements

What is Required Under the New Law?

Who Must Report? RRE Determination

- Under Section 111, “Responsible Reporting Entities (RREs)” must report.
- RRE determination is “fact and situational” specific
- CMS’ RRE directives contained in NGHP User Guide (3.1) Section 7. In general, RREs may include:
 - Carriers
 - Self Insureds (Deductible v. SIR)
 - Reinsurance, Excess, Umbrella
 - Joint Pools/State Assigned Funds
 - Liquidation
 - Fronting
 - Others

Who Must Report? RRE Determination

TPAs & RRE status

- Role and limitations of Section 111 “reporting agents”
- Specific issues and considerations

Direct Data Entry

- “Small Reporter” RREs – RREs that will submit 500 or fewer NGHP claim report per calendar year.
- Registration begins 10/4/10; Reporting to begin 1/3/11.
- No Query Function system available. Claims submitted that are not a MC match count against the 500 claim report limit.
- Claims must be submitted w/in 45 days of TPOC date; or w/in 45 days of ORM assumption

Determining Medicare Status

RREs required to determine CL's Medicare status

- Section 111 does:
 - NOT provide the process or procedure to use
 - NOT require CL and/or his/her lawyer to release necessary information to help make this determination
 - NOT provide an informed consent provision.
- Issues & Considerations
 - RREs must develop practice and protocol directed at determining Medicare status
 - CMS' **Query Function & Model Language**

Section 111: When Is Reporting Required?

CMS' "Reporting Triggers"

There are two "reporting triggers:"

1. TPOC – Total Payment Obligation to the Claimant; and
2. ORM – On Going Responsibility for Medical Payments

Reporting under both triggers may be applicable in certain circumstances.

Reporting Required:

- If the claimant *"is/was a Medicare beneficiary"* upon hitting a trigger and the "trigger" criteria are met.
- Regardless of whether or not there is an admission or determination of liability.
- Parties allocation of settlement proceeds (even if a Court has approved same) does not affect a RRE's obligation to report.
- No Medicare age threshold.
- Geographic location of accident, incident or illness does not matter
- WC from 1965 forward; Liability from on or after 12/5/80.

Reporting Trigger #1 - TPOC

Reporting required upon claim resolution (or partial resolution) via a settlement, judgment, award or other payment on or after October 1, 2010 (*where “medicals are claimed and/or released, or the settlement judgment, award or other payment has the effect of releasing medicals and the CL “is/was a Medicare beneficiary”*)

- If the claimant **“is/was a Medicare beneficiary”** and medicals are claimed and/or released (or the settlement, judgment, award, or other payment had the effect of releasing medicals) and which are addressed/resolved (or partially addressed/resolved) via a settlement, judgment, award or other payment on or after 10/1/10.
- Concerns a **single payment obligation** (*either lump or via annuity*) that is **reported only once** – regardless if funded via single payment, annuity or structure.
- Applies to both liability and WC -- however, per CMS this will likely be the main reporting trigger in the typical third party liability case, why?

Reporting Trigger #1 – TPOC (Continued)

- **TPOC Date - Defined**

The TPOC date is determined as follows:

- Date the obligation is signed, unless Court approval required.
- If court approval required, it is the later of the date obligation is signed or the date of Court approval.
- If no written agreement, it is the date the payment (or first payment if there is multiple payments) is issued.

User Guide (V. 3.1) p. 166; (Field 100)

Reporting Trigger #1 – TPOC (Continued)

- **TPOC Amount - Defined**

TPOC Amount is the dollar amount of the total payment obligation to the claimant.

If there is a structured settlement, the amount is the total payout amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity.

For annuities, base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount (if there is a minimum payout), whichever calculation results in the larger amount.

User Guide (V. 3.1) p. 167; (Field 101)

TPOC Dollar Reporting “Exemptions:”

For liability cases (*except no-fault*) and WC TPOCs, the following dollar thresholds* reporting exemptions apply:

For claim reports where the last (most recent) TPOC date/amount is as follows, reporting under Section 111 is NOT required:

TPOCS prior to January 1, 2012 -

\$0.00 to \$5,000 (equal to or less than 5k) are exempt from reporting.

TPOC date is 1/1/12 to 12/31/12–

\$0.00-\$2,000 (equal to or less than 2k) are exempt from reporting.

TPOC date is 1/1/13 to 12/31/13 –

\$0.00-\$600 (equal to or less than \$600), are exempt from reporting.

***NOTE:** See rules for multiple TPOCs reporting -- See User Guide (V.3.1)

Reporting Trigger #2 – ORM

Reporting is required in situations where the RRE has assumed “ongoing responsibility for medical payments (ORM)” on or after January 1, 2010.

In addition, reporting is required where ORM exists on or through January, 1, 2010, regardless of the date of an initial assumption of ORM (the assumption of ORM predates January 1, 2010).

- ORM requires two reports: (a) When RRE assumes ORM and (b) When ORM terminates.
 - Exception: In certain situations ORM assumption and termination may be reported in the *same* record depending on situational factors.
- Continuing obligation to check a CL’s Medicare status during the ORM period regarding claimant’s who are not determined to be a MC beneficiary at the ORM is assumed.
- Assuming v. Terminating ORM

ORM Reporting Exceptions:

1. Qualified Exception – Where ORM Assumed Prior to 1/1/10

For these cases, reporting not required if the claim was actively closed or removed from current claims records prior to January 1, 2010.

In this instance, the RRE is not required to identify and report that ORM. However, if ORM is later assumed, then reporting will be required at that point.

ORM Reporting Exceptions:

2. Special Exception – The “Doctor’s Note”

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 items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or a claim for further payment.

However, if ORM is later assumed, then reporting will be required at that point.

ORM Reporting Exceptions:

3. WC Exception

For WC ORM, no reporting required for file submissions through 12/31/11 if all of the following apply:

- Medical Only;
- Lost Time for worker is no more than the number of days permitted by the applicable WC law for “medical only” (or 7 calendar days if the applicable law has no such limit)
- All payment(s) has/have been made directly to the medical provider; AND
- Total payment does not exceed \$750.

NOTE: No low dollar threshold for no-fault or liability claims in ORM trigger.

Remember, if claim activity takes the case out of this exception, then reporting will be required at that point

Special Considerations:

- Joint Settlements, Judgments, Awards, Other Payments – Who Reports?
- Risk Management Write Offs, Good Will Gestures, Gift Cards, etc. – these may be reportable – See User Guide 3.1
- 12/5/80 date and exposure cases
- Mass torts

Part III:

Current Section 111 Timelines

CURRENT SECTION 111 TIMELINES

- **7/1/09** Test/Production Query Input Files
- **4/5/10** Electronic Registration for foreign RREs
- **1/1/10-12/31/10** Claim Input file testing
- **1/1/11-3/31/11** All NGHP RREs to start reporting Claim Input files in accord with their assigned files submission timeframe per their RRE ID
- **4/1/11** All NGHP RREs must be reporting quarterly

QUESTIONS??

**Thank you for your time and
attention!**