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Effective July 1, 2009: New CMS Mandatory Insurer Reporting Requirements

The Centers for Medicare and Medicaid Services (CMS) are imposing new requirements as part of the agency's Medicare Secondary Payor (MSP) coordination efforts. The new reporting program was authorized under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)¹, and is designed to assist CMS in ensuring that Medicare benefits are paid secondary to other available insurance coverage, including insurance settlements.

Under the new program, which goes into effect on July 1, 2009, the entities described below will be required to report all qualifying payments to Medicare beneficiaries to CMS. Specifically, CMS will require disclosure of settlements, judgments, awards, or other payments that are made on or after July 1, 2009. The mandatory reporting program will cover a number of insurance providers, including liability insurers, no-fault insurers, and workers' compensation carriers, and will impose quarterly reporting requirements for all covered entities. All affected insurers should take steps now to prepare for the new program

requirements, as CMS is authorized to impose hefty fines for non-compliance.

Who Must Report?

A. Liability Insurers

Under the new Section 111 reporting program, liability insurance (including self-insurance), no-fault insurance, and workers' compensation carriers will be considered responsible reporting entities (RREs). As set forth in detail below, as RREs these insurers must report all settlements, judgments, awards, or other payments to Medicare beneficiaries to CMS.

B. Other Insurers

Re-insurance, stop-loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds, and the like will also be considered RREs under Section 111 in cases where payment is made directly to the injured claimant or his representative. If payment is made to a self-insured entity to reimburse that entity, the re-insurer, stop-loss insurer, excess insurer, umbrella

¹ P.L. 110-173.

CLIENT ADVISORY

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insurer, guaranty fund, or patient compensation fund is not required to report the payment, as the self-insurer will be considered the RRE in that situation.

C. Insurance Pools

Entities that are self-insured in whole or in part with respect to liability may elect, where permitted by law, to join with other similarly situated entities in a self-insurance pool. If the self-insurance pool is a separate legal entity with full responsibility to resolve and pay claims using pool funds without the involvement of the participating entity, then the pool will be considered the RRE for purposes of Section 111. If, however, any of the above listed conditions are not met, the participating self-insured entity will remain the RRE and retain all reporting responsibilities.

D. Third Party Administrators

RREs may not limit their reporting responsibilities by contract or otherwise. For example, where there are multiple defendants involved in a settlement, each RRE involved in the settlement remains responsible for its own reporting. Co-defendant RREs may not avoid reporting by agreeing to have one of the defendant insurers make payment and report the settlement to CMS. RREs may, however, contract with third party administrators (TPAs) or other entities to actually file the CMS required submissions. To utilize a TPA or other entity, the RRE must designate the entity as its agent during the registration process. Even when acting through an agent, the RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of the data submitted.

What and When to Report

A. Total Payment Obligation to the Claimant

Under Section 111 RREs are required to report both a total payment obligation to the claimant (TPOC) and an ongoing responsibility for medicals (ORM). Reportable TPOCs include those settlements, judgments, awards, or other payments that are made on or after July 1, 2009, whether the payment obligation is executed through a single payment, a structured settlement, or an annuity. TPOCs will only be considered "paid prior to July 1, 2009," and, therefore, exempt from reporting, if all aspects of the settlement, judgment, or award, including court approval, if required, are completed prior to July 1, 2009. If partial payment is made prior to July 1, 2009, and the remaining payment is made after July 1, 2009, the RRE must report the remaining payment to CMS when it is made. If a TPOC judgment is being appealed and payment is withheld pending the appeal, the RRE should not report the TPOC until the appeal is concluded and payment is made.

CMS has indicated that the amount of the TPOC will have some impact on the RRE's responsibility to report. However, at this time, CMS has not yet published the interim dollar reporting threshold. If, in a given quarter, the RRE does not have any reportable TPOCs, the RRE is still required to submit an "empty" report to CMS.

B. Ongoing Responsibilities for Medicals

Ongoing responsibilities for medicals (ORMs) include structured settlements or other agreements to pay for future medical treatment. This



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type of reportable award typically occurs in response to no-fault insurance or workers' compensation claims. ORMs must be reported if the RRE's payment responsibility arose prior to July 1, 2009, and has not been closed before that date, regardless of the date of initial acceptance of payment responsibility. If the ORM arose prior to July 1, 2009, but the claim was actively closed or removed from current claims records prior to January 1, 2009, the RRE is not required to report it under the new program. RREs may also delay reporting for individuals for whom an ORM arose prior to July 1, 2009, until the RRE's assigned submission in the third calendar quarter (July to October) of 2010. Additionally, an interim dollar reporting threshold for ORMs is currently under consideration by CMS.

When the recipient of an ORM is not a Medicare beneficiary at the time responsibility to pay for ongoing medical treatment is assumed, the RRE is required to monitor the status of that individual. If and when the individual becomes a Medicare beneficiary, the RRE must report the ORM, unless its responsibility to pay for ongoing medicals terminated before the individual became a Medicare beneficiary.

If the RRE has assumed ongoing responsibility for medicals but there is no possibility of associated future treatment (for example, if the individual has a relatively minor fully healed flesh wound), the RRE may submit a termination date for the ORM. Prior to submitting an ORM termination notice, the RRE must obtain a signed statement from the injured individual's treating physician that he will require no further medical items or services associated with the claim or claimed injuries. Such a statement is required regardless of

the fact that the claim may be subject to reopening or a claim for further payment.

C. Report Contents

Each RRE report must include, at a minimum, the following:

- Information regarding the identity of the injured party/Medicare beneficiary (e.g. name, social security number, contact information, Medicare Health Insurance Claim Number, dates of birth and death, gender, and beneficiary information in cases of death);
- Information about the incident (e.g. date, nature, and cause of injury, venue, ICD-9 diagnosis or body part code, and product liability information, if applicable);
- Information concerning the policy, insurer, or self-insured entity (e.g. insurance type, name and contact information of policyholder, policy and claim numbers, and no-fault / exhaust information, if applicable);
- Information about the injured party's representative or attorney (e.g. name, firm, contact information, social security number, and bar number); and
- Settlement/payment information (e.g. settlement date, amount, whether contested, and funding).

Reporting Process

A. Registration

RREs must register with the CMS Coordination of Benefits Contractors (COBCs) and fully test the data submission process between May 1, 2009 and June 30, 2009². After testing is concluded, the RRE will receive a profile report, which will include its assigned seven (7) day reporting period. The RRE must verify, sign, and return the profile report to the COBC to complete the registration process.

² An RRE with nothing to report during this time period is not required to register and complete testing by June 30, 2009 but, in the event that it has a future situation in which it has a reasonable expectation of having to report, it must register in time to allow a full quarter for testing before the initial report is due.



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B. Reporting Period

The first report for liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs will be due during the fourth calendar quarter (October to December) of 2009 during the RRE's assigned submission timeframe. After that initial report, payments must be reported quarterly during the RRE's assigned 7-day period. Interim reports are not accepted, although reports may be submitted up to 14 days before the assigned reporting period. Those early submissions will be held by the COBC until the start of the 7-day submission period.

If the settlement, judgment, award, or other payment is completed within 45 days prior to the start of the 7-day submission period, the RRE may submit that claim during its next quarterly filing. This "grace period" allows the RRE time to process the newly claim information internally prior to submission to the COBC.

C. Timely Filing Audits

Records not received timely will be processed but marked as late and used for subsequent compliance tracking. Additional material for compliance tracking will include the frequency with which an RRE submits reports with errors that must be returned and re-submitted. A civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant may be imposed for non-compliance.

D. CMS Response

After a 45-day processing period, CMS will provide the RRE with a response file. The CMS response file will indicate, with regard to each report, whether it was accepted or rejected for errors.

E. Correcting Previous Filings

In response to the CMS report, RREs must submit "add" reports when a previously submitted report was not accepted because of an error or when the RRE assumed ongoing responsibility for medicals previously but the patient just became entitled to Medicare. RREs must also submit "delete" reports when the original report should not have been sent, or when the RRE needs to change a key field submitted previously. Finally, the RRE must submit an "update" report when the RRE needs to send the ORM termination date to indicate that the responsibility for ongoing medicals has ended³; when the RRE has had an ongoing ORM and there is a separate TPOC but the RRE continues to retain the ORM; or to change information that is used by Medicare in its claims payment and recovery processes.

F. Reports To Be Filed On-line

All queries and reporting will be done through the COBC Secure Website (COBSW). Passwords on that website must be changed every 60 days, so CMS encourages RREs to login and change their passwords every month to avoid password expiration.

Three separate methods of data transmission are available for RRE electronic reporting: Connect:Direct, Secure File Transfer Protocol (SFTP), and Hypertext Transfer Protocol over Secure Socket Layer (HTTPS). RREs that expect to transmit files with more than 24,000 records in one file submission on a regular basis are encouraged to use either Connect:Direct or SFTP. HTTPS is more suitable for use with smaller files. To submit reports using Connect:Direct, an RRE must first establish an AT&T Global Network System (AGNS) account. This setup

³This update should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment.



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can take a significant amount of time, so RREs are encouraged to begin this process as soon as possible.

Preparedness Efforts

To prepare for the implementation of these new reporting requirements, RREs must develop procedures in their claims review processes to determine whether an injured party is a Medicare beneficiary and to gather the information necessary for Section 111 reporting. As part of this preparation, RREs must also consider whether they want to handle reporting in-house or work with a Third Party Administrator (TPA). In either event, the appropriate person must be identified and involved in the development of the new processes to conform to these reporting requirements.

As RREs examine their existing and pending claim files to identify claims that will require reporting, they should look for patients' Medicare Health Insurance Claim Number (HICN), as that identifying number is the CMS preferred patient identifier. Social Security Numbers (SSNs) are also accepted. In the event an RRE does not know whether an injured party is a Medicare beneficiary, it is encouraged to take advantage of the query process that CMS has instituted to allow RREs to determine Medicare entitlement of an injured party prior to submitting claim information. The query record must contain the patient's SSN, name, date of birth, and gender. If the patient is a Medicare beneficiary, the COBC's response to the query will include the patient's HICN. Querying patients and submitting only those reports that pertain to confirmed Medicare beneficiaries is preferred by CMS.

For more information on the new Section 111 CMS reporting requirements, or to request assistance in developing internal

processes for compliance, please contact Mary C. Malone, N. Beth Dorsey, John Mumford, or Lauran G. Stimac at 804. 967.9604 or by email mmalone@hdjn.com, bdorsey@hdjn.com, jmumford@hdjn.com or lstimac@hdjn.com. Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at www.hdjn.com.



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