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Section 111 Reporting Basics

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Overview

- What is Section 111 Reporting?
- Purpose
- Process: Queries and Quarterly Reporting
- CMS Updates

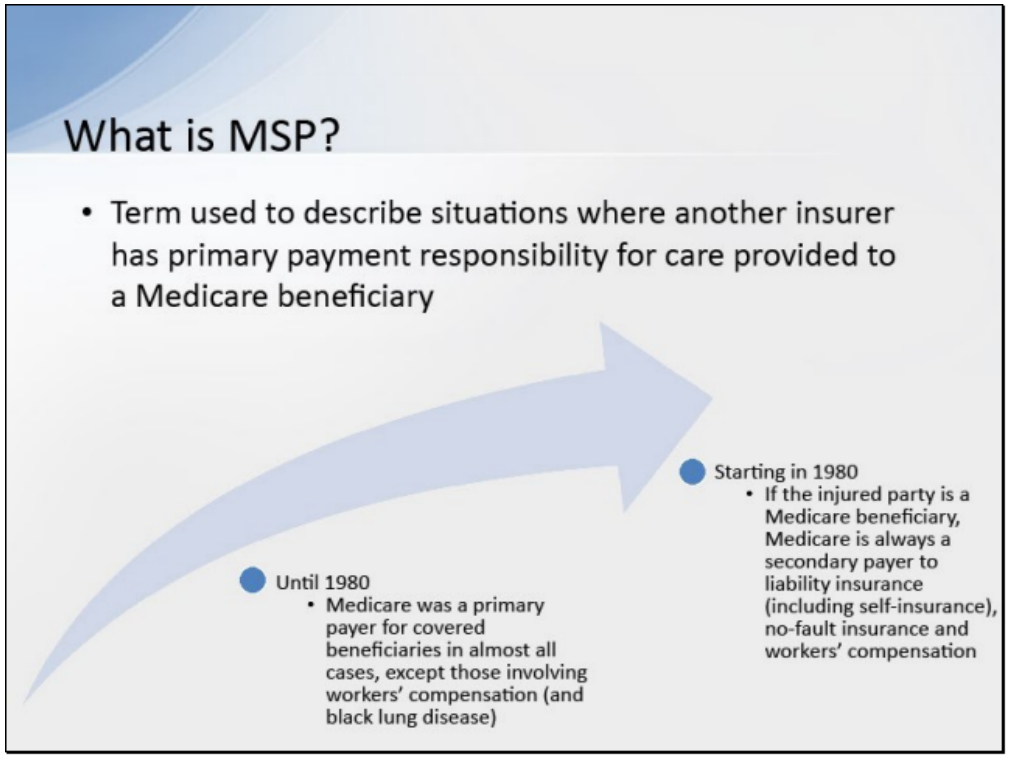
What is Section 111 Reporting?

A law that added *mandatory* reporting requirements for NGHP insurers providing coverage to Medicare beneficiaries

Effective 5/1/2009; NGHPs obligated to notify Medicare about "settlements, judgments, awards, or other payment from liability insurers (including self-insurers), no-fault insurers, and workers' compensation" received by, or on behalf of, Medicare beneficiaries.

Purpose

Section 111 reporting requirements are an addition to the already existing Medicare Secondary Payer (MSP) law.



Enacted so that some of the costs of caring for Medicare beneficiaries could be borne by other types of insurance

- Spreading payment for healthcare costs across multiple insurers helps extend the life of the Medicare Trust Fund
- Helps to ensure that Medicare beneficiaries have adequate access to care

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Purpose

- Discover billions in Medicare conditional payments and seek (immediate) recovery.
- Cease making ongoing conditional payments.
- Ensure settlements “adequately consider” Medicare’s interests.
- **ENFORCES THE MSP ACT**

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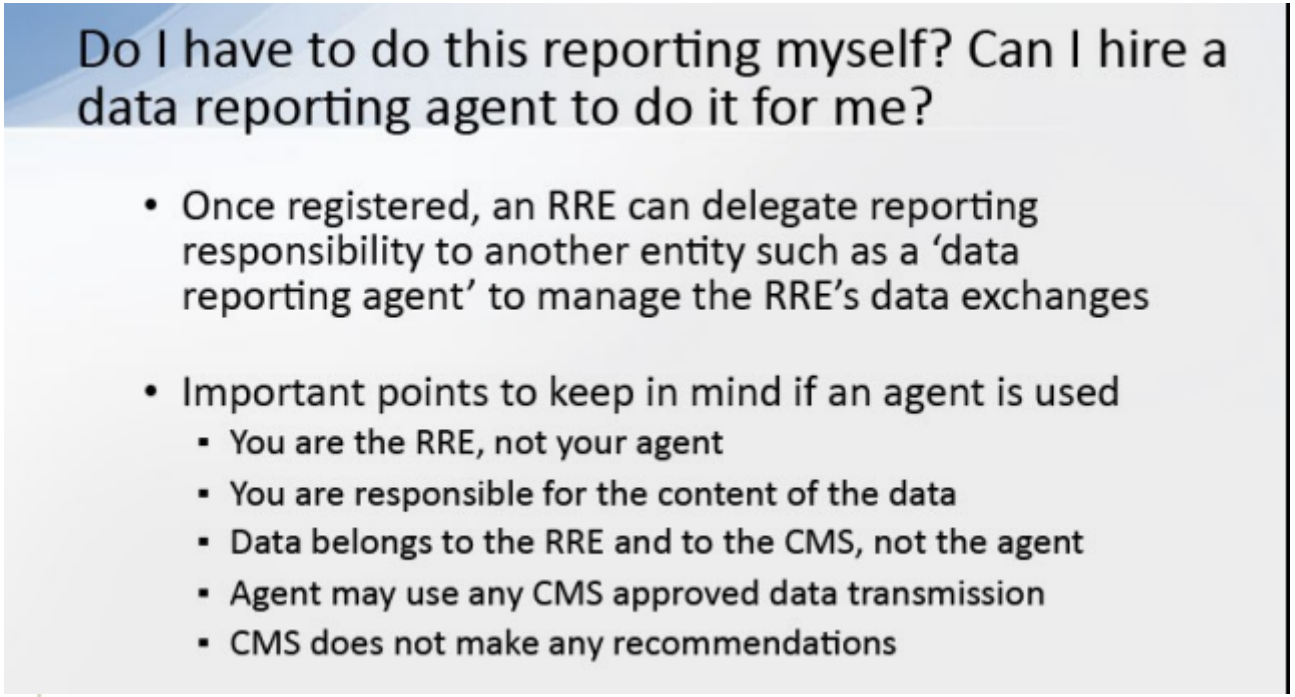
Process: Queries, Quarterly Reporting

What is a Responsible Reporting Entity (RRE)?

- The self insured entity or carrier that has assumed, been assigned or adjudicated as the primary payer responsible for ongoing medical care or has entered into a settlement/judgment/award to or for the benefit of the injured party.



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Process: Queries, Quarterly Reporting

Annual RRE Profile Report Recertification

- CMS requires annual recertification of the RRE Profile Report.
  - Ensures CMS has proper contact info at the RRE.
  - Cull out unnecessary RRE IDs.
- Email sent to the Authorized Representative, indicating 10 day response period.
- Reminder sent at 30 days.
- If not recertified within 60 days, then the RRE ID is "Deactivated":
  - No files can be submitted.
  - RRE is no longer in compliance and in danger of fines.

Process: Queries, Quarterly Reporting

Basics

- Query for Medicare eligibility
- Evaluate Ongoing Responsibility for Medicals (ORM)
- Report ORM and TPOC and when ORM terminates
  - Claims must be reported quarterly
  - Claims must be reported in a specific format
    - Fixed-width text file
    - Claim Header, Detail and Trailer Records
    - Auxiliary Records
    - TIN Header, Detail and Trailer Records

Penalty for non-compliance?

- $1,000 per day per claim

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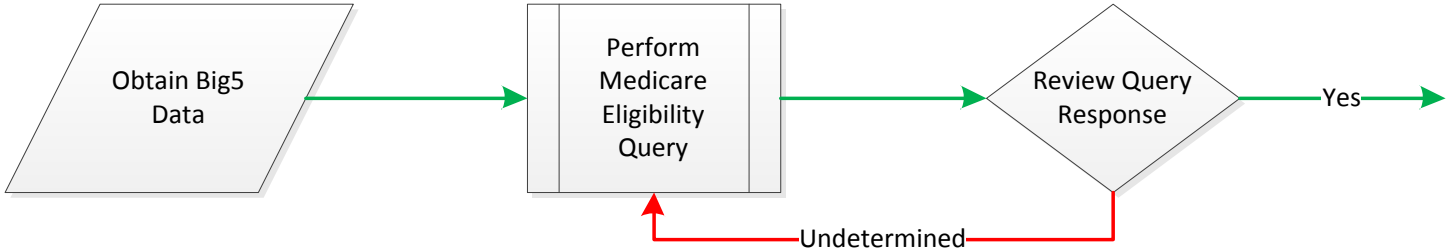
Process: Queries, Quarterly Reporting

Query for Medicare Eligibility



- Medicare Query Function may only be performed once per month. Submit "Big 5" to CMS
- First, match must be made on SSN, HICN, or MBI
- Then, 3 of the other 4 fields must match
  - First Initial of first name
  - First 6 characters of last name
  - Date of Birth
  - Gender (If "Unknown" is submitted, then CMS defaults to male)

Process: Queries, Quarterly Reporting

Query Response

It contains the following Medicare eligibility Disposition Codes

- 01 = Match found
- 51 = Eligibility is “Undetermined” based on the information provided
- DP = Duplicate possible (when providing last 5 digits of SSN)

Important Aspects

- Once a ‘Y’, always a ‘Y’
- “Partial Match” is not returned, even if SSN is matched

Critical that accurate data is collected.

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Process: Queries, Quarterly Reporting

Liability TPOC Reporting and Recovery Thresholds

- Acceptance of Ongoing Responsibility for Medical (ORM) as of 01/01/2010
  - Generally applies to Workers' Compensation and No-Fault claims.
- Occurrence of a Total Payment Obligation to the Claimant (TPOC)
  - Applies to Liability, Workers' Compensation and No-Fault claims
  - Settlement, Judgment, Award releasing medicals
    - ✓ WC minimum TPOC threshold >$750
    - ✓ Liability minimum TPOC threshold >$750

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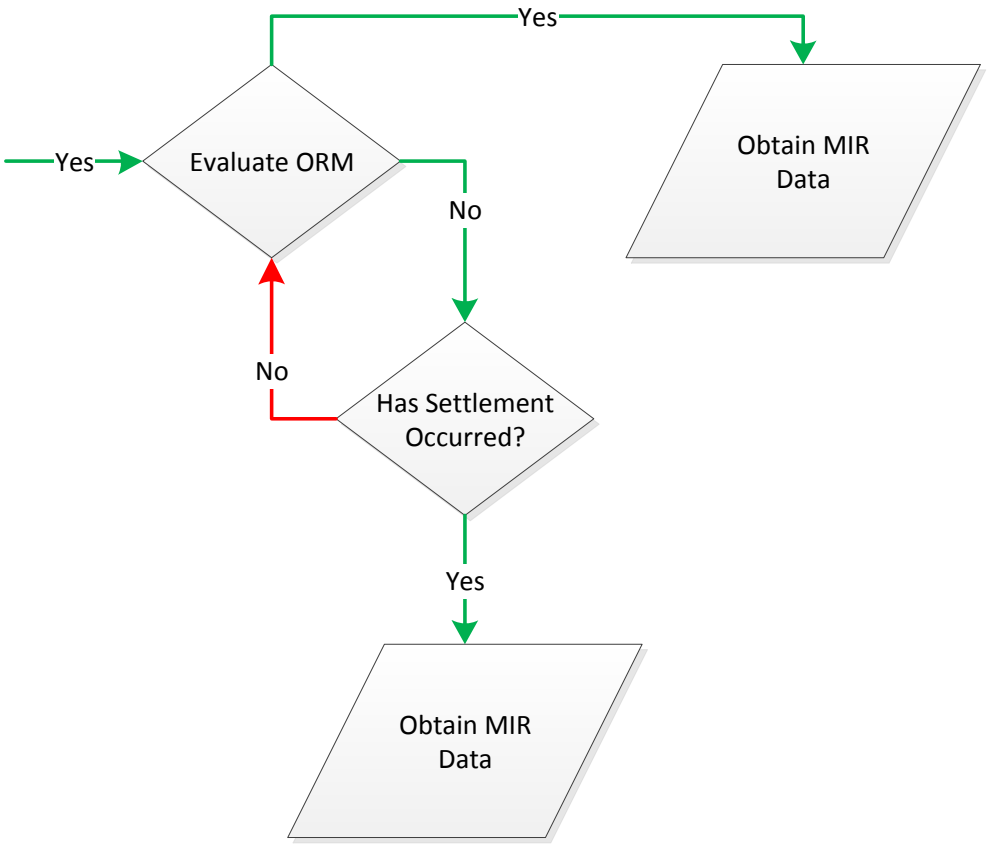
Annual Threshold Review and Calculation

- Section 202 of the SMART Act requires CMS to annually calculate the threshold at which the reimbursement amount to Medicare would result in the receipt of funds at or below the recovery cost to Medicare
  - Only required for liability claims
  - Optional on WC claims
  - Applicable to physical trauma based injuries
  - Current $750 threshold for both WC and Liability

Process: Queries, Quarterly Reporting

Evaluate ORM and TPOC



Section 111 requires RREs to report claim information for Medicare beneficiaries after

- Ongoing Responsibility for Medicals (ORM) has been assumed
- After paying the Total Payment Obligation to Claimant (TPOC) in the form of a settlement, judgment, award or other payment

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Process: Queries, Quarterly Reporting

Obtain Section 111 Data Necessary to Report the Claim

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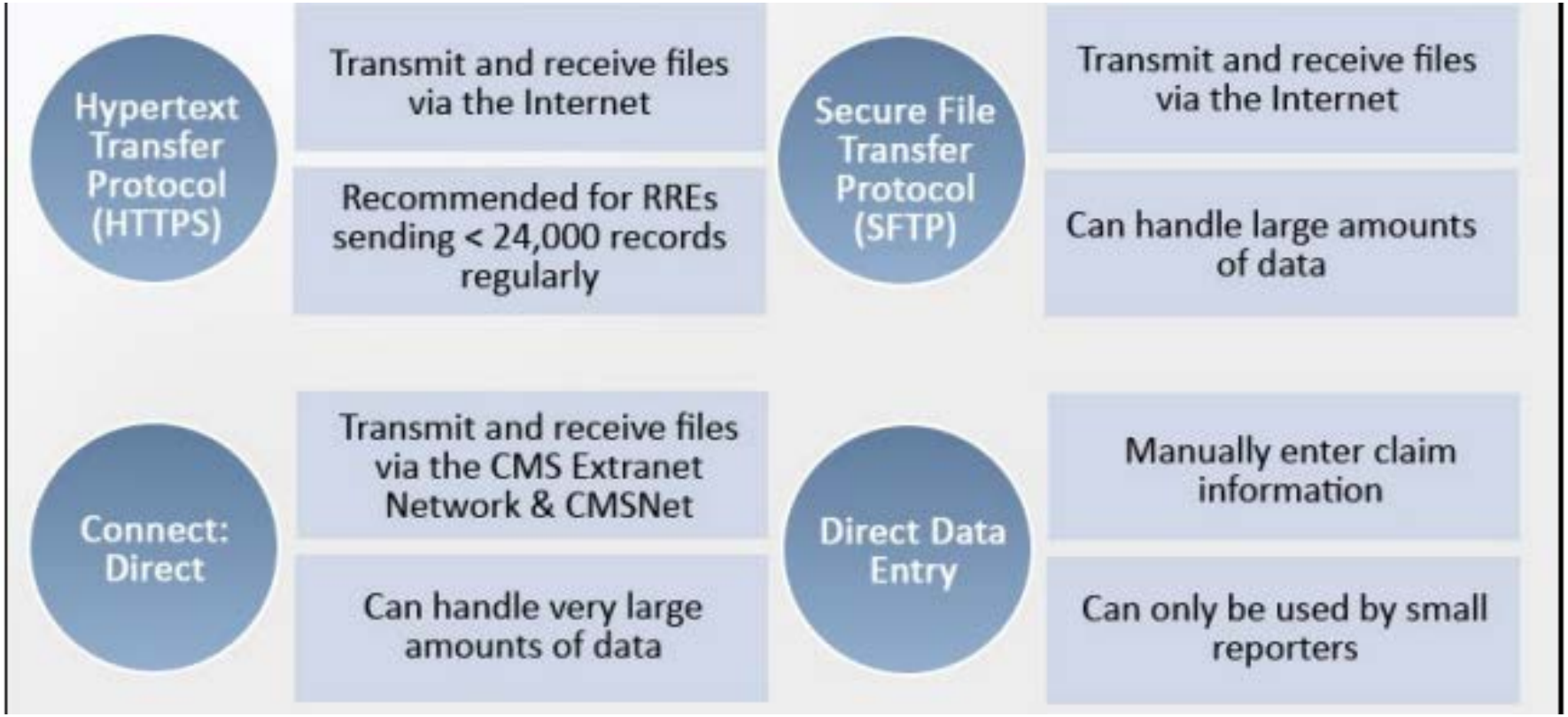
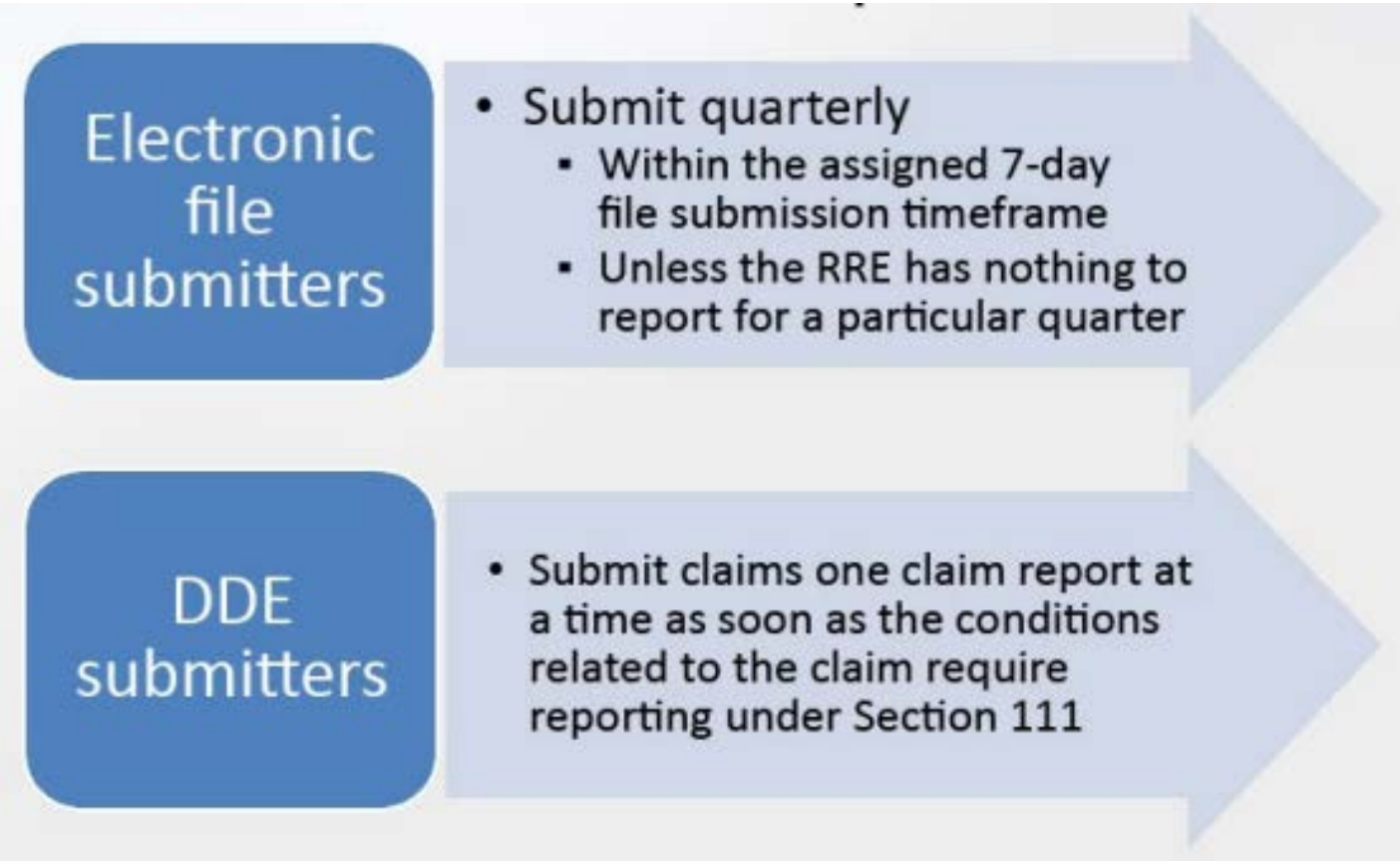
Process: Queries, Quarterly Reporting

Report the Claim



Process: Queries, Quarterly Reporting

Report the Claim



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Process: Queries, Quarterly Reporting

Report the Claim

Group	Dates	Group	Dates	Group	Dates
1	1st – 7th of: Jan, Apr, Jul, Oct	5	1st – 7th of: Feb, May, Aug, Nov	9	1st – 7th of: Mar, Jun, Sep, Dec
2	8th – 14th of: Jan, Apr, Jul, Oct	6	8th – 14th of: Feb, May, Aug, Nov	10	8th – 14th of: Mar, Jun, Sep, Dec
3	15th – 21st of: Jan, Apr, Jul, Oct	7	15th – 21st of: Feb, May, Aug, Nov	11	15th – 21st of: Mar, Jun, Sep, Dec
4	22nd – 28th of: Jan, Apr, Jul, Oct	8	22nd – 28th of: Feb, May, Aug, Nov	12	22nd – 28th of: Mar, Jun, Sep, Dec

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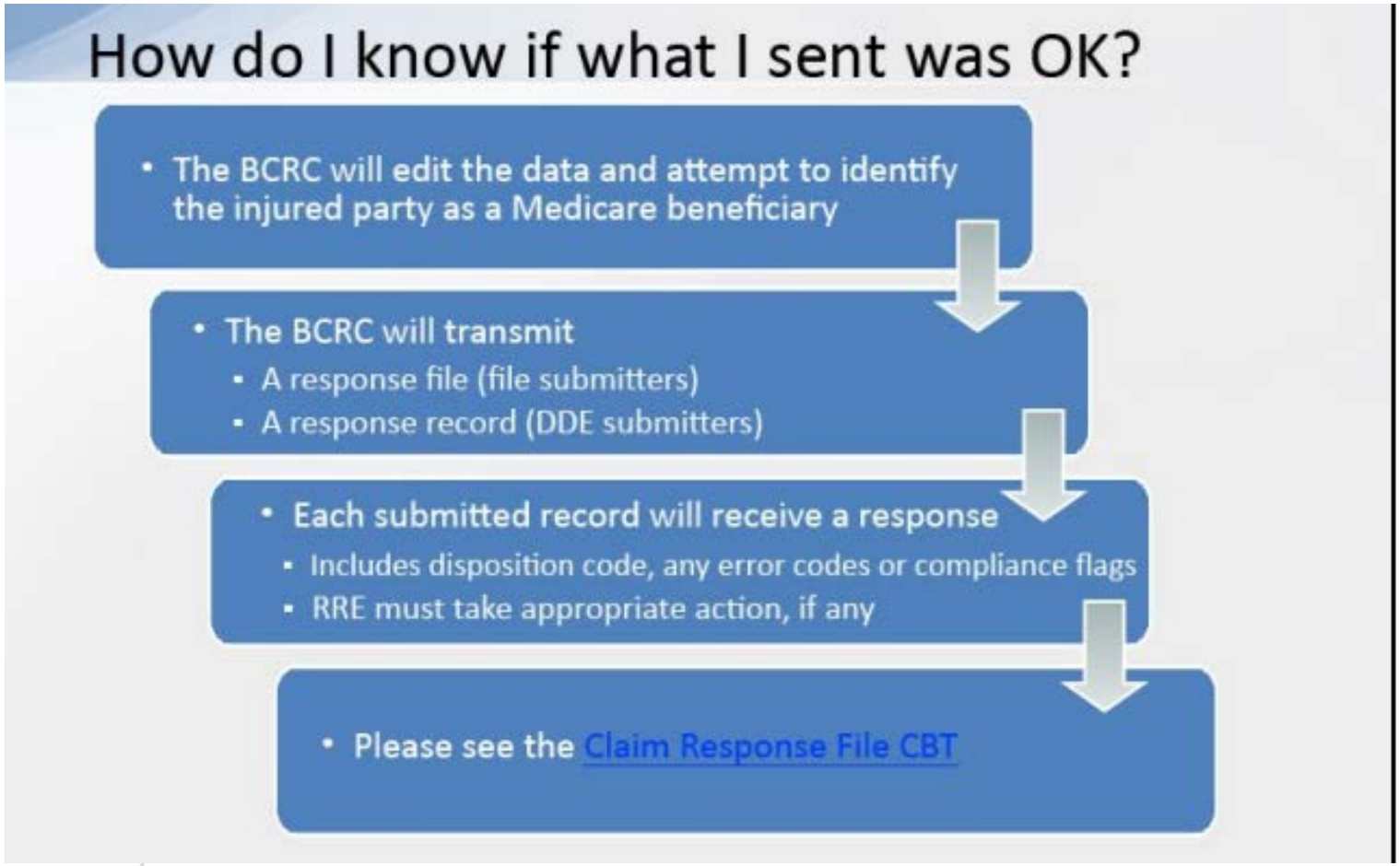
Process: Queries, Quarterly Reporting

Evaluate Claim Response



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Process: Queries, Quarterly Reporting

Evaluate Claim Response

- Claim Response file received within 45 days
- Disposition Status of each Claim Record
  - Good
    - 01 = Accepted with ORM
    - 02 = Accepted without ORM
  - Bad
    - SP = Claim rejected due to data deficiencies (or false negative)
    - TN = Claim rejected due to rejected TIN Address Record
  - Indifferent
    - 03 = Record is error-free but Medicare eligibility and RRE's responsibility do not overlap
    - 50 = Processing not complete; resubmit the following quarter
    - 51 = Not Medicare eligible; not common if eligibility checked in advance

Process: Queries, Quarterly Reporting

Evaluate Claim Response

- If a claim is rejected (SP), then applicable Error Codes are returned. Correct and resubmit the following quarter.
  - Error Codes are grouped by type:
    - CB: Beneficiary fields
    - CC: Claimant fields
    - CI: Injury fields
    - CJ: ORM/TPOC fields
    - CP: Plan fields
    - CR: Representative fields
    - CS: Self-Insurance fields
    - CT: Additional TPOC fields

Process: Queries, Quarterly Reporting

Evaluate Claim Response

- Other rejection codes
  - SP31: (false negative) Record submitted prior to Medicare entitlement; resubmit next quarter
  - SP47/48/49: Delete record failed; did not match existing record. Record may have been deleted via a different mechanism. May contact CMS to confirm.
  - SP50: Record locked by BCRC to prevent subsequent changes. Due to problems related to payment of Medicare claims in relation to the ORM record.
- If applicable, Compliance Flags are provided:
  - 01: Late submission of TPOC
  - 02: Late submission of ORM Termination

Process: Queries, Quarterly Reporting

Monitor the Claim

- If the claim has ORM, always report ORM = Y
  - ➢ If ORM settles or terminates, populated the ORM termination date and leave ORM = Y
    - o If ORM changes from Y to N, CMS will expect a Delete record

Process: Queries, Quarterly Reporting

States with Lifetime Medicals

- Report ORM = Y
- If indemnity settles, populate TPOC 1 date and amount and leave ORM = Y
- Om CMS' eyes, "administrative closure" does not terminate ORM.

Process: Queries, Quarterly Reporting

Write-Offs: TPOC or Not TPOC

- If the provider submits a claim to Medicare for payment reflecting the unreduced permissible charge and show the reduction or write-off amount as payment from Liability insurance, then no need to report as a TPOC.
- If the provider provides property of value (other than a reduction in charges or write-off) and there is evidence or reasonable expectation that treatment has or will be obtained, the value must be reported as a TPOC (thresholds still apply).
- If any other entity provides property of value, reduces its charges or writes-off some portion of its charges and there is evidence or reasonable expectation that treatment has or will be obtained, the value must be reported as a TPOC (thresholds still apply).

CMS Updates

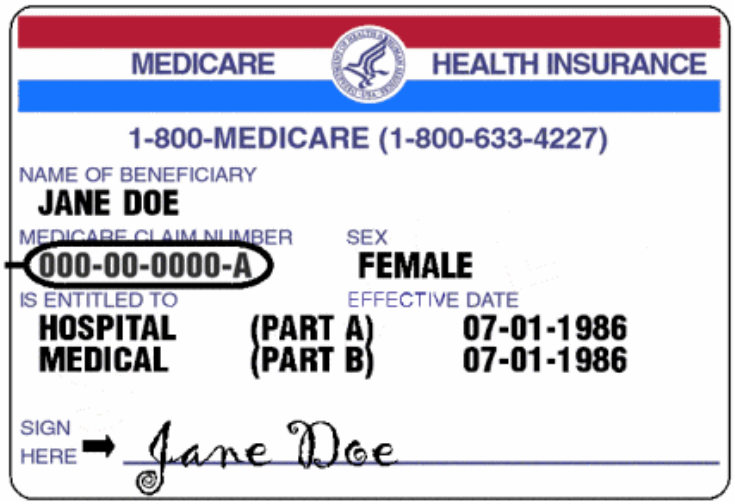
CMS issuing demands on “Open ORM” claims

- Sent to RRE and Third Party Recovery Agent (TPRA)
- 30 days to file informal dispute
- If no action, then CMS may issue a Demand
- Appeal rights apply once CMS has issued a Demand
- Payments must be made within 60 days to avoid interest
- Cases may be referred to the Department of Treasury and/or Department of Justice

CMS Updates

Change to Medicare Beneficiary Identifier (MBI)

- April 2018 – April 2019: CMS is rolling out new Medicare cards with MBI instead of HICN based on SSN.



CMS Updates

Change to Medicare Beneficiary Identifier (MBI)

- HICN may still be used for internal CMS exchanges
- MBI will be used for exchanges with beneficiary, providers, and external partners
- Impact to Section 111 Reporting is under review

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