



# **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.

## What is MSP?

- Term used to describe situations where another insurer has primary payment responsibility for care provided to a Medicare beneficiary

- Until 1980
  - Medicare was a primary payer for covered beneficiaries in almost all cases, except those involving workers' compensation (and black lung disease)

- Starting in 1980
  - If the injured party is a Medicare beneficiary, Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation

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

# 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**



# 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.

Do I have to do this reporting myself? Can I hire a data reporting agent to do it for me?

- Once registered, an RRE can delegate reporting responsibility to another entity such as a 'data reporting agent' to manage the RRE's data exchanges
- Important points to keep in mind if an agent is used
  - You are the RRE, not your agent
  - You are responsible for the content of the data
  - Data belongs to the RRE and to the CMS, not the agent
  - Agent may use any CMS approved data transmission
  - CMS does not make any recommendations

# 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

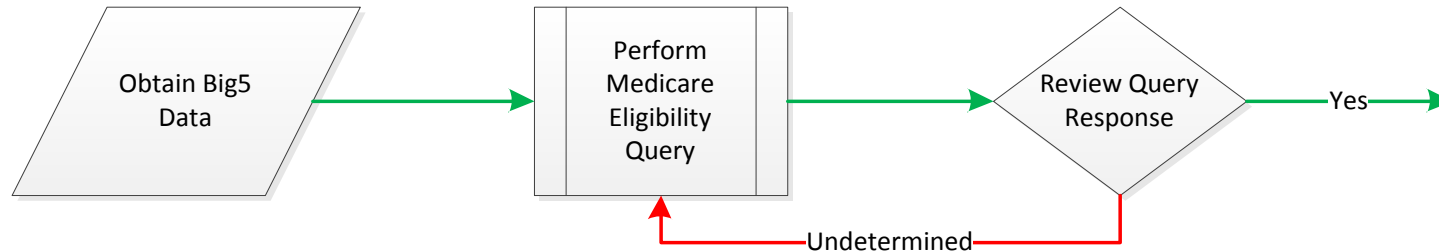
- Query for Medicare eligibility
- Evaluate Ongoing Responsibility for Medicals (ORM)
- Report ORM and TPOC and when ORM terminates
  - Claims must be reported quarterly
  - Claims must be reported in a specific format
    - Fixed-width text file
    - Claim Header, Detail and Trailer Records
    - Auxiliary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

## Penalty for non-compliance?

- \$1,000 per day per claim

# 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.**

# 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

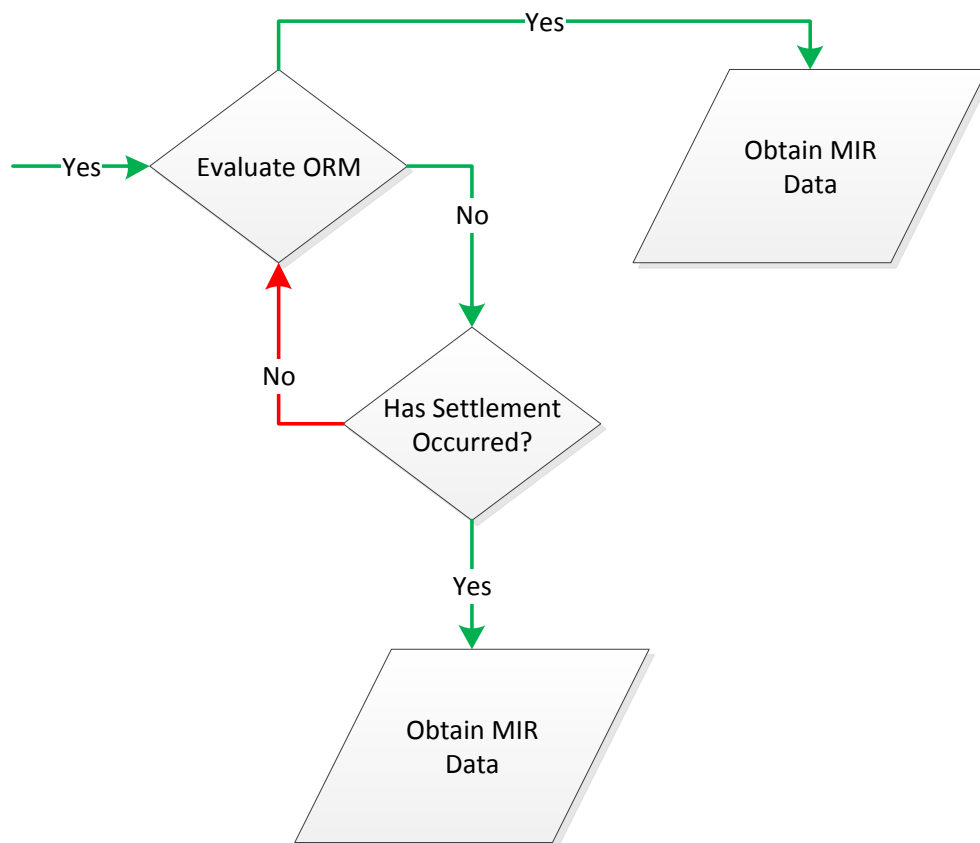
# Process: Queries, Quarterly Reporting

## 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

# Process: Queries, Quarterly Reporting

## Obtain Section 111 Data Necessary to Report the Claim

Some of the required data  
that must be reported  
includes

Medicare ID

First letter of beneficiary first name

First 6 letters of beneficiary last name

Beneficiary date of birth

Gender of beneficiary

RRE Tax Identification (TIN)

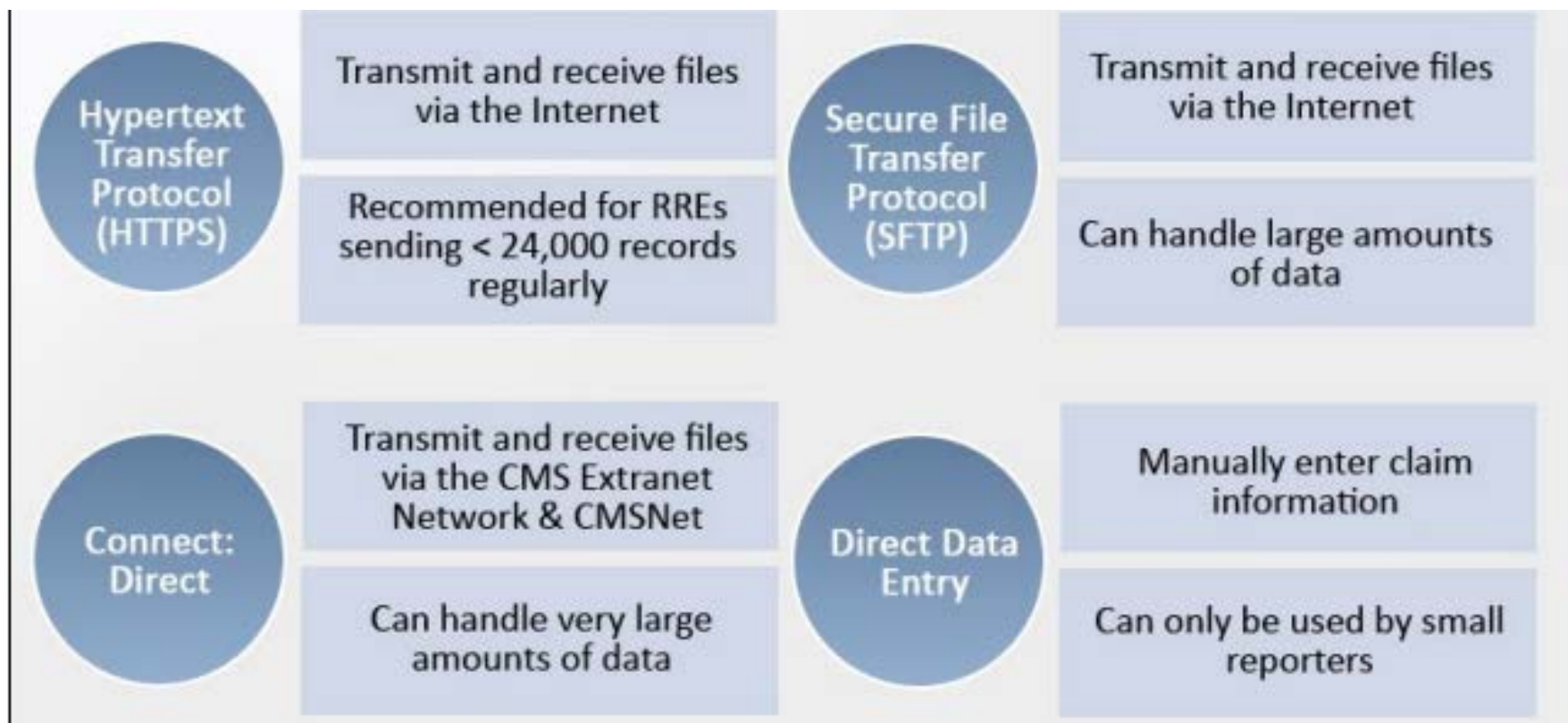
RRE address

ICD Diagnosis Codes

TPOC Dates and Amounts

# Process: Queries, Quarterly Reporting

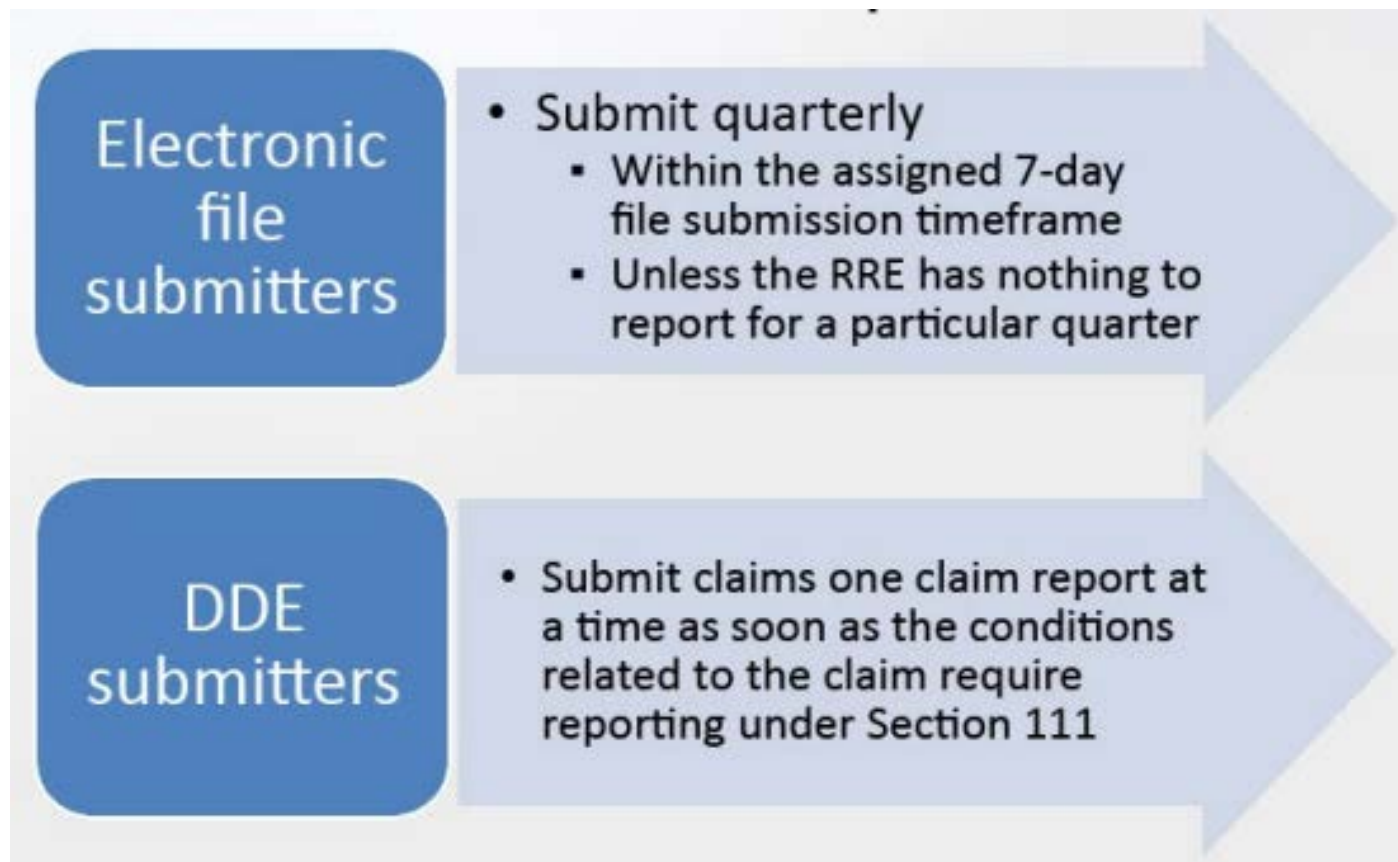
## Report the Claim





# Process: Queries, Quarterly Reporting

## Report the Claim



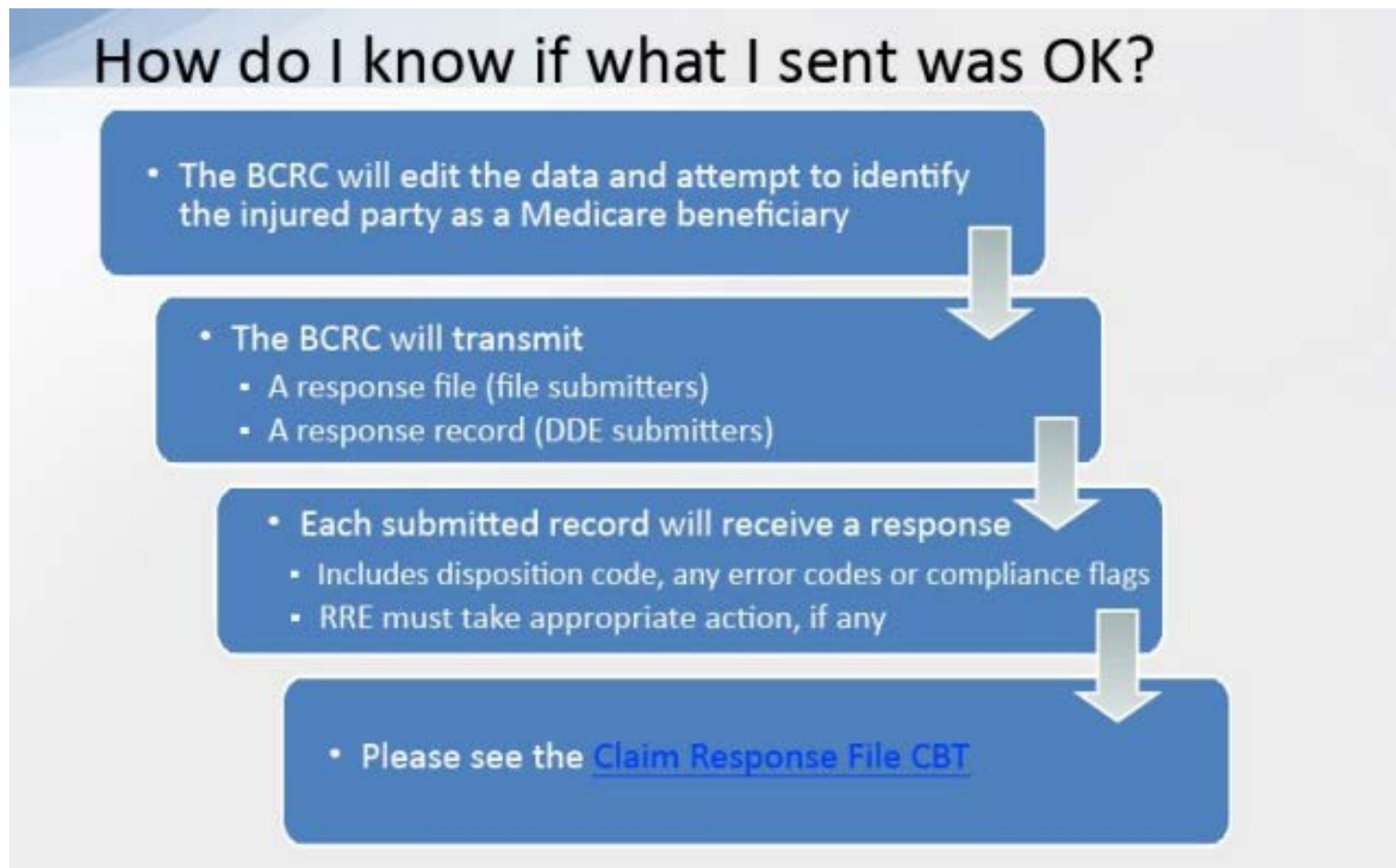
# Process: Queries, Quarterly Reporting

## Report the Claim

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

# Process: Queries, Quarterly Reporting

## Evaluate Claim Response



# 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
    - 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

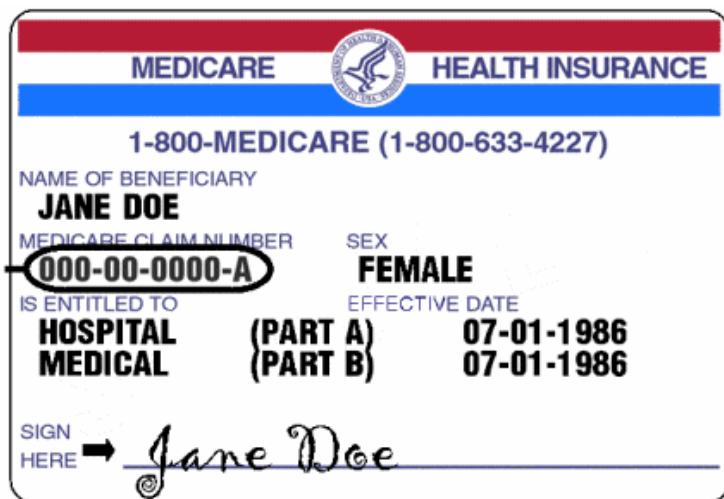
## CMS issuing demands on “Open ORM” claims

- 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.



This image shows a sample of an older Medicare card. It features a red and blue header with the text "MEDICARE" and "HEALTH INSURANCE" separated by the Medicare seal. Below the header, the phone number "1-800-MEDICARE (1-800-633-4227)" is printed. The beneficiary's name, "JANE DOE", is listed. The Medicare claim number, "000-00-0000-A", is circled in black. The sex is listed as "FEMALE". The card also shows the beneficiary is entitled to "HOSPITAL MEDICAL" (PART A) and "EFFECTIVE DATE" (PART B) with the date "07-01-1986". At the bottom, there is a signature line with the handwritten name "Jane Doe" and the text "SIGN HERE" with an arrow pointing to the signature.

**MEDICARE HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY  
**JANE DOE**

MEDICARE CLAIM NUMBER  
**000-00-0000-A**

SEX  
**FEMALE**

IS ENTITLED TO  
**HOSPITAL MEDICAL** (PART A)  
**EFFECTIVE DATE** (PART B)  
**07-01-1986**

SIGN HERE → Jane Doe



This image shows a sample of a new Medicare card. It features a blue header with the text "MEDICARE HEALTH INSURANCE" and the Medicare seal. Below the header, the beneficiary's name, "JOHN L SMITH", is listed. The Medicare number, "1EG4-TE5-MK72", is printed. The card also shows the beneficiary is entitled to "PART A" and "PART B" with the date "03-03-2016".

**MEDICARE HEALTH INSURANCE**

Name/Nombre  
**JOHN L SMITH**

Medicare Number/Número de Medicare  
**1EG4-TE5-MK72**

Entitled to/Con derecho a  
**PART A**  
**PART B**

Coverage starts/Cobertura empieza  
**03-03-2016**  
**03-03-2016**

# 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

# NAMSAP

National Alliance of Medicare Set-Aside Professionals



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