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Section 111 Audits and Safeguarding Against Civil Money Penalties Exposure

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Section 111 Reporting Obligations and Compliance

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Section 111

- MMSEA of 2007
- Electronic reporting for Medicare beneficiaries
- Civil Money Penalties (CMP)
  - Original statutory provisions mandated a CMP for noncompliance, of $1,000 per day, per claim
  - SMART Act of 2012 brought revisions which softened the statutory language.
  - SMART Act also required rulemaking process for regulations around when sanctions would and would not be imposed.

Section 111

- Civil Money Penalties (CMP)
  - What we think CMS will look at:
    - Egregious objective situations of non-compliance
    - RREs that never registered
    - Errors on same claims for multiple quarters
- Further discussion regarding CMPs to follow but first a brief overview regarding the mechanics of reporting…

Query Process

- Overview of Sec. 111 Overview & Reporting Obligations

RRE ⇄ Sec. 111 Reporting Agent ⇄ COB&R Coordination of Benefits and Recovery

Information transmitted electronically to CMS
- First/Last Name
- DOB
- MBI/HICN or SSN (last 5 acceptable)
- Gender

Return response = Medicare Y or N

- Occurs monthly
- Goal: to determine if a claimant is entitled to Medicare
- What the query doesn't tell you

ORM

ORM

- Ongoing Responsibility for Medicals
- Where ORM existed or exists on or after 1/1/2010
- Special Qualified Exception and Workers' Comp Exclusion

ORM = Y

- Assumption of ORM
- Indication to Medicare of primary payer
- Responsibility evidenced under MSP
- Reported via Sec. 111 during quarterly reporting period at the outset of assumption of ORM

ORM = N

- In denied claims
- In instances where carrier does not assume ORM
- This status isn't reported at outset; only if there is TPOC: ORM indicator = N

ORM Termination

- Date responsibility for ORM ends
- Indicator to Medicare that carrier no longer has primary payer responsibility
- Is often in conjunction with TPOC
- Is always associated with a specific date
- Is reported during quarterly reporting

ORM Termination – Examples

- Where responsibility has been terminated under state law – e.g. settlement, court order or SOL
- Where responsibility ends pursuant to the terms of an insurance policy –e.g. policy limits exhaustion or time-period beyond which responsibility exists
- Physician letter exception (Sec. 111 NGHP User Guide, Chapter III: Section 6.3.2)

Reporting TPOC

TPOC

- Total Payment Obligation to Claimant
- Typically a one-time lump-sum settlement event
- Usually is in conjunction with ORM termination (if work comp)
- Corresponding date/amount
- $750 Threshold

Fine Tune Reporting: Timing & Accuracy

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Timing

- Late Reporting Triggers
  - ORM
  - ORM Termination
  - TPOC
- General Rule: 135 days from when the event occurred
- How late reporting triggers operate
- Compliance Flags
  - Not *always* 100% accurate indication of late submission
  - Indicator that a submission would require review
- Importance of on-time reporting

Data Accuracy: ICD Codes

- Valid ICD Codes
  - Critical to error-free reporting
  - How Medicare utilizes ICD code data
    - COB and conditional payment recovery
- Over / Under reporting ICD codes
- Danger of pulling from EOBs indiscriminately
- Most common error type (CI errors) and likely will garner significant scrutiny by CMS
- Remediating on resubmission

Data Accuracy: TIN Reference File Errors

- What is the TIN Reference File?
    - Importance of valid address information
- TIN Reference File (TN) Errors
    - Common, but can be difficult to remediate because these codes may be triggered for many reasons
- Claim Input Files cross-referencing bad TIN Reference File Detail Records
    - TN99 Errors

Data Accuracy: Populating ORM Indicator

- CJ01 Errors
- Every claim record must contain valid ORM indicator – will either be set to Y or N
- Not a “switch” – remember ORM termination
- What happens if you reported ORM Y inadvertently?
- Watch for liability claims with ORM indicator to “Y”

Data Accuracy: ORM Termination Dates

- CJ06
- Error is generated when an RRE submits an ORM termination date that's greater than 6 months after the submission date of the file
- RREs are expected to continue to monitor their claims through ORM termination in the event that any changes occur that may affect the statutory termination date

File Level Thresholds

- File level thresholds checks
  - Performed upon receipt of Claim Input Files
    - Checks occur prior to onset of processing
      - If triggered, file processing will be placed on hold and email notification will be sent to Account Manager
      - Require RRE communication with BCRC EDI Rep
        - » File may be released for processing or deleted

File Level Thresholds: Most Common Thresholds

- 5% Delete Thresholds
  - 5% or more of the records within a Claim Input File are delete action types
  - CMS monitors delete transactions very carefully
  - Delete transmissions acceptable in two scenarios
    - Removal of an entirely erroneous prior claim submission
    - Update to a key field (CMS DOI, Plan Insurance Type, ORM Indicator)

File Level Thresholds: Most Common Thresholds

- 20% Error Thresholds
  - 20% or more of the records within Claim Input File generated errors
    - Indicative of significant problems with submitted data
    - EDI Rep may be able to help RRE identify issues
      - RRE may choose to request release of file for processing or may request deletion in order that corrections can be made and file be resubmitted
        - If all records within the file generate errors the EDI rep may urge deletion of file, correction and resubmission

File Level Thresholds: Compliance Significance

- File level thresholds point to issues concerning accuracy and validity of RRE's Section 111 data
  - Occasional triggering of thresholds is not likely problematic
  - Repeated triggering of thresholds will raise significant red flags and could put the RRE at risk of being considered non-compliant
    - May put RRE at risk of incurring Civil Money Penalties (CMPs)

Civil Money Penalties

What is a Civil Money Penalty?

- The Secretary of Health and Human Services may impose civil money penalties (CMPs), assessments and program exclusion for various forms of fraud and abuse involving the Medicare and Medicaid programs.
- The Section 111 provision for CMP was stated as "shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant."
- The SMART Act revised this to "may be subject to a civil money penalty up to $1,000 for each day of noncompliance with respect to each claimant."
- Rulemaking process will provide a framework for how CMPs are calculated and enforced.

Rules on Civil Money Penalties

- In December 2018, CMS announced it will move forward with a Notice of Proposed Rulemaking (NPRM) on Civil Money Penalties (CMPs) and Medicare Secondary Payer (MSP) Requirements.

- As required by the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act), CMS is required to establish criteria and practices in which CMPs would be imposed under the Act.

- The notice provides that this is a “significant” priority and that the NPRM will be issued by October 2019.

Potential CMPs in Early Process

- Failure to register and set up account for each RRE.
- Failure to appoint individuals who will be the RRE's Authorized Representative, Account Manager and Account Designees.
- Failure to review file specifications, have correct software to produce Section 111 files, and comply with quarterly submission process.
- Failure to confirm information on annual profile report is correct/deactivation of RRE ID.

Potential CMPs Throughout Process

- Failure to correct process issues discovered and alerted to via compliance flags
- Failure to report complete and accurate claim details resulting in errors in the following areas:
  - Claim Information
  - Claimant Information
  - Injury Information
  - ORM or TPOC Information
  - Plan Information
  - Representative Information

Anticipated Civil Money Penalties

- However, RREs will likely be subject to CMPs in scenarios where RREs have failed to or made mistakes in doing the following:
  - Register as an RRE
  - Report an otherwise reportable claim
  - Report Ongoing Responsibility for Medical (ORM)
  - Report termination of ORM
  - Report appropriate ICD code(s) related to the claim
  - Report Total Payment Obligation to Claimant (TPOC)

Best Practices to Avoid Potential CMPs

- Due diligence!
  - Report in a timely fashion to the best of your ability
  - Make a concerted visible effort to address any errors as expediently as possible
  - Monitor CMS/BCRC email communications carefully
  - Be responsive to outreach from the BCRC.
  - Be communicative about any identified issues and efforts being made to address those issues

Questions?