ADVISORY NO. 438

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TOPIC: MEDICARE'S MANDATORY INSURER REPORTING REQUIREMENTS LOOMING IN THE NEAR FUTURE

THE BASICS, FOR WORKERS' COMPENSATION (NGHPs)

The 2007 amendments to Section 111 of the Medicare, Medicaid & SCHIP Extension Act (MMSEA) regarding Mandatory Insurer Reporting (MIR) require certain entities referred to as Required Reporting Entities (RREs) administering "Applicable Plans" to determine if a claimant (including an individual whose claim is unresolved) is entitled to benefits under the Federal program. If so, the RRE must, using an EDI format, submit the information described in the act (the claimant's SSN or HICN and the EIN, where applicable) to the Center for Medicare & Medicaid Services (CMS) through a CMS Coordination of Benefits Contractor (COBC) in the form, manner and frequency described by the Secretary of the Department of Health and Human Services (DHHS).

For purposes of workers' compensation, a workers' compensation carrier, an "Applicable Plan" and an RRE are one and the same. Workers' compensation is grouped with the Non-Group Health Plans (NGHPs), although it is distinguished from the other types of such plans in some respects.

The purpose of this whole exercise is to allow CMS to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim by Medicare for any payments it made and that it presents that the primary insurer (that's you) should have paid. The full statutory language of Section 111 is reprinted at:

https://www.cms.gov/MandatoryInsRep/Downloads/StatutoryLanguage.pdf

IMPORTANT DATES AND DEADLINES

February 25, 2009: The next Open Forum teleconference for workers' compensation is Wednesday, February 25, 2009, at 12 noon to 2:00 pm, CST. The number is 888-677-4905 and the Passcode is "SECTION 111". Written questions should be submitted to: PL110-173SEC111-comments@cms.hhs.gov

If you miss this teleconference, the recording/transcript should be made available on the CMS MIR web site soon.

May 1, 2009: Earliest date an RRE can register with Coordinator of Benefits Secure Website (COBSW)

June 30, 2009: Last day an RRE can register with the COBSW

July 1, 2009: Implementation date for NGHP (including workers' compensation). If the medical payments have been made prior and the claimant is Medicare eligible as of this date, that claimant's data must be submitted in the initial quarterly Section 111 Input Claim File.

October-December 2009 The quarter during which RREs must submit their initial quarterly Section 111 Input Claim File, during their assigned 7-day submission timeframe.

July-October 2010 Because some RREs may not have been collecting all the necessary data elements for individuals for whom responsibility was assumed prior to July 1, 2009, CMS is permitting RREs to delay reporting for these individuals until the RRE's assigned submission period for the third quarter of 2010. If the RRE has information the claimant is a Medicare beneficiary and has the SSN or HICN of the claimant, then the record should be sent with the initial submission in the fourth quarter of 2009.

WHAT YOU NEED TO DO NOW

1. Determine if you qualify as a Required Reporting Entity (RRE).
2. Contact vendors qualified and experienced in EDI, and preferably experienced in dealing with the CMS Coordination of Benefits Contractor (COBC).
3. Begin collecting the necessary data, including whether a claimant is a Medicare beneficiary and the claimant's Social Security Number (SSN) or Health Insurance Claim Number (HICN).

Query Access: There is currently no process created by the act or the agency by which Medicare beneficiary status may be determined. CMS has stated that even though it is in the process of providing a Query Access source, the RRE is still responsible for creating methods of obtaining beneficiary status, along with the SSN or HICN of the claimant. CMS has indicated that even if there is a "non-match" from the Query Access system that does not guarantee the claimant is not a Medicare beneficiary. Gathering this information may be quite difficult if the claimant cannot be found or is uncooperative. While the Query Access system for NGHPs has not been completed, it will be similar to the system already used for GHP cases. Refer to the GHP User Guide on the CMS MIR web site. Testing of the system will not commence until July 1, 2009. It is likely that queries may only be made monthly by a single authorized person for

each RRE. In order to obtain Medicare beneficiary status information, the RRE will need the name, SSN, date of birth and gender of the claimant. In a teleconference, CMS indicated the NGHP process will be similar to the X12 270/271 process under GHP. CMS will likely issue HIPPA compliant (HUW) software for this process.

The ALERT document, dated June 23, 2008, and found on the CMS MIR web site can be used to urge cooperation from a reluctant claimant or claimant's counsel. CMS has indicated it may provide a form making it easier to obtain this information from the claimant or other sources.

SOURCES

Because this is still a work in progress for non-group health plans (including workers' compensation), this cite should be checked for updates regularly. All necessary links, reports and downloads are located here. We recommend you sign up for the automatic email notices: http://www.cms.hhs.gov/MandatoryInsRep/

You may also have already been contacted by TPAs and/or vendors which provide information and services related to the Section 111 requirements. Many have already developed these systems for Group Health Plans (GHP).

GLOSSARY—It is recognized that many of the terms used in this process are not generally used or conflict with those used in the insurance industry. For purposes of Section 111 instructions and reporting, it is crucial to understand and use CMS definitions.

CBT—Computer-based training
For mandatory insurer reporting for non-group health plans, will be made available by CMS once the curriculum is formalized. You can sign up now and will be notified of the dates, once available.

CWF—Medicare Common Working File
File created by Medicare on a beneficiary. Shared by Medicare claims processing and by the Medicare recovery contractor.

Claim—for purposes of RRE submissions, refers to the overall workers' compensation claim, rather than a single claim for a particular medical item or service.

CMS—Center for Medicare & Medicaid Services. Governmental entity that administers Medicare and Medicaid programs, including Section 111 MSP reporting.

COBC—Coordination of Benefits Contractor. CMS contractor through which the required information is transmitted.

DCN—Document Control Number. A unique number, limited to 15 alpha-numeric characters, created by the RRE and assigned to each detail record.

DHHS—The U. S. Department of Health and Human Services. Primary federal government agency that overseas CMS and implementation of Medicare and Medicaid.

DOI—Date of Incident. The Input Claim File has a field for the CMS DOI for accidental injuries (the same for CMS and for workers' compensation acts—the actual date of the accidental injury) and for exposure claims (the date of first exposure). For exposure claims, there is a separate field to put the date of incident as defined by the relevant workers' compensation act. So, in Texas, you must determine both DOIs for CMS and under the Texas Act. Remember, CMS definitions must be used, unless specifically directed otherwise.

EDI—Electric Data Interchange. Refers to the electronic data transmission process.

EIN—Employer Identification Number

GHP—Group Health Plans
Also subject to Section 111 requirements, but with different criteria unique to those kinds of plans. All other kinds of "plans", including workers' compensation are grouped into Non-Group Health Plans (NGHPs).

HICN—Medicare Health Insurance Claim Number. One of two alternative numbers RRE must include in its file submission to the COBC. The other is the SSN.

Medicare—A Federal program that pays for certain covered health care provided to enrolled individuals 65 and older, certain disabled individuals and individuals with permanent kidney failure.

MIR—Mandatory Insurer Reporting. The mandatory reporting requirements of Section 111.

MMSEA--Medicaid & Medicare SCHIP Extension Act of 2007. 42 USC 1395y(b)(Section 1862(b) of the Social Security Act).

MSP—Medicare Secondary Payer. Medicare is considered a secondary payer for covered beneficiaries. The term refers to situations where another entity (such as a workers' compensation carrier) is required to pay for covered medical expenses, before Medicare does,

and without regard to the claimant's Medicare entitlement. Medicare has always been a secondary payer to workers' compensation since the inception of Medicare in 1965.

MSPRC—Medicare Secondary Payer Recovery Contractor. Other insurance information provided will be provided to the MSPRC by the COBC by posting to the CWF for recovery efforts.

NGHP—non-group health plans, including liability insurance (including self-insurance), no-fault insurance
and workers' compensation insurance.

Query Access—System accessible through the COBC by which an RRE can determine whether a claimant is an eligible Medicare/Medicaid beneficiary. As of February 2009, system does not yet exist for NGHP. The current system available for GHP reporting must be modified to reduce the data available, as a privacy concern. This is a work in progress.

RRE—Required Reporting Entity. For purposes of workers' compensation, the same as an "Applicable Plan" and the workers' compensation carrier. The entity responsible for complying with the reporting requirements of Section 111. While the RRE may contract to with a vendor to actually submit the data, the RRE remains legally responsible for the submission. The RRE's legal duty for Section 111 reporting is non-delegable.

Section 111—Refers to section of the MMSEA which addresses Mandatory Insurer Reporting for group health plans (GHP)[subsection (b)(7)] and for liability insurance (including self-insurance), no-fault insurance and workers' compensation insurance (NGHP)[subsection (b)(8)].

SSN—Social Security Number. One of two alternative numbers RRE must include in its file submission to the COBC. The other is the HICN.

TPA—Third Party Administrators are never RREs for purposes of Section 111 reporting, but may act as an agent for such purposes on behalf of an RRE. An "applicable plan" (an RRE/workers' compensation carrier) cannot contract away its reporting obligation. An RRE may, however, contract with another party, including a TPA, to actual perform the reporting.

Profile Report—Document issued by the COBC to an RRE upon completion of the registration process. It will contain the assigned RRE ID, the assigned 7-day file submission timeframe and information to verify. It must be verified, signed and returned by the RRE.

HTTPS—Hypertext Transfer Protocol over Secure Socket Layer. One of three alternative modes for data submission to the COBC, utilizing an ASCII format. The others are SFTP and

Connect:Direct via AGNS.

SFTP—Secure File Transfer Protocol. One of three alternative modes for data submission to the COBC, utilizing an ASCII format. The others are HTTPS and Connect: Direct via AGNS.

Connect: Direct—Formerly known as NDM, one of three alternative modes for data submission to the COBC, automatically converted to EBCDIC format. Via AT&T Global Network System (AGNS). Especially designed for larger amounts of data. RREs that do not have an existing account should contact resellers of AT&T services as soon as possible as set up may take a significant amount of time.

ORM—Ongoing Responsibility for Medical payments. Acceptance of which triggers two submissions: an initial record filing and a second/final filing on the end date (if there is one).

FREQUENTLY ASKED QUESTIONS

How does a carrier determine if it is an RRE?

A Required Reporting Entity is an "applicable plan" which is defined by 42 U.S.C. 1395y(b)(8)(F) as "…the following laws, plans, or other arrangement, including the fiduciary or administrator for such law, plan or arrangement:(i) Liability insurance (including self-insurance), (ii) No fault insurance. (iii) Workers' compensation laws or plans." So, for purposes of workers' compensation, the workers' compensation insurance carrier is the RRE.

What triggers Section 111 reporting?

Any settlement, judgment, award or other payment to a claimant who, at the time of the triggering event, was a Medicare beneficiary. A one time payment to a physician for purposes of "defense evaluation" does not trigger the reporting requirement.

What are the RRE's responsibilities if, at the time ongoing medicals are assumed, the claimant is not a Medicare beneficiary?

The RRE has no responsibility to report this individual. It does have the ongoing responsibility, however, to continue to monitor the claimant's Medicare beneficiary status and report that individual if and when he/she become a Medicare beneficiary.

What data elements must be collected and reported?

The RRE must first determine if a claimant is a Medicare beneficiary. CMS is developing a Query Access system where RREs may obtain that information. The RRE must also collect the SSN or HICN of the claimant along with other data necessary for the transmission. As of February 20, 2009, the NGHP File Layout Pages have not been finalized. There will be dozens of fields in each file transmission. The latest version Interim Record Layout Information is dated 12/05/2008 and can be found at the dedicated Section 111 Web page at www.cms.hhs.gov/MandatoryInsRep . Regular visits to the site for updates are recommended.

When an RRE accepts Ongoing Responsibility for Medical payments (ORM), what must be reported?

Only the initial record to reflect acceptance and a second/final record to reflect the end date. (if there is one). RREs should not report every payment made in ORM situations.

After the initial quarterly submission, what information must be included in subsequent quarterly submission?

(1) Any new claim accepted (medical payment made) since the prior submission where the claimant is a Medicare beneficiary. If the payment is within 45 days of the RRE's 7-day assigned transmission period, it may be reported in the following quarter.
(2) Any pertinent update, corrections and deletions to previous submissions
(3) Resubmission of data found to be in error as reflected in the CMS response file from the previous submission.

Is an RRE subject to fines for non-compliance?

Yes. Failure to report, untimely reporting and incorrect reporting will be tracked by CMS. Non-compliance is subject to fines up to $1,000 per day, per individual.

How does the RRE identify each of its individual records?

Each detail record on the Input Claim File must contain a unique Document Control Number (DCN) generated by the RRE. Limited to 15 alpha-numeric characters, the RRE can use any format. Many of the current CMS data exchange partners successfully use some form of a Julian date and counter as their DCN.

What must be reported in the RRE's initial submission?

Regardless of the date of the RRE's first assigned submission window, all required data as of July 1, 2009 (the implementation date).

Do medical payments made pending investigation trigger reporting?

Yes, this is considered assumption of responsibility for ongoing medical. If you stop payments as a result of the investigation, you must report the termination of responsibility for ongoing medicals.

How far back in time (DOI) must the RRE gather Medicare eligibility and claims information?

For liability insurance and no-fault insurance, CMS has determined that where the Date of Incident (DOI) (**as defined by CMS**) is prior to December 5, 1980, then no reporting is required. However, that is not the case in workers' compensation. In workers' compensation, a qualifying report must be made, regardless of the date of injury or date of incident.

Will a workers' compensation RRE be able to "close" the file a case of ongoing responsibility?

Probably not, even if you have "closed" the claim file for internal purposes, if the responsibility for medical is subject to reopening or subject to an additional request for payment, then the RRE has the ongoing responsibility to determine if the claimant is Medicare eligibility and report such. This requirement may be under reconsideration by CMS, as it has indicated it may consider cutoff date as to whether RREs must report ongoing responsibility cases even though the case is "closed" or "inactive" for a long period.

What are an employer's obligations under Section 111?

Unless you are a business or entity that qualifies as an RRE (to include certified self-insured's and self-insured governmental entities), no initiation of action is required. However, you will be asked, by the RRE, to supply your EIN.

What if the claimant or employer resists revealing their SSN, HICN and/or EIN?

CMS has provided a brief 20-page ALERT, dated June 23, 2008, which explains the need for and support for any such request. It may be provided to any reluctant party and is found at: https://www.cms.hhs.gov/MandatoryInsRep/Downloads/CollectionofSSN

sHICNsandEINsTINsALERT.pdf

How do I access the Computer Based Training (CBT) for workers' compensation (non-group health plan, "NGHP") Section 111 reporting?

You can sign up now for the training even though the curriculum has not yet been developed. Contact the COBC's EDI Department at (646) 458-6740. The EDI rep will take your registration information. Registrants will be notified automatically as soon as the NGHP CBT courses are available.

How can I get more information?

This whole process and supporting documents may be found at the CMS Section 111 (Mandatory Insurer Reporting) web page at: www.cms.hhs.gov/MandatoryInsRep . CMS has also conducted Open Forum teleconferences. Transcripts and recordings of those are available on the website as well. The web site should be referenced regularly as many of the aspects of this process are a work in progress. Updates and final reports will posted on the web site. As of the date of this Advisory, the next **Open Forum** teleconference for workers' compensation is Wednesday, **February 25, 2009**, at 12 noon to 2:00 pm, CST. The number is 888-677-4905 and the Passcode is "SECTION 111". Written questions should be submitted to: PL110-173SEC111-comments@cms.hhs.gov