ADVISORY NO. 440

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TOPIC: Medicare Mandatory Insurer Reporting USER GUIDE for Workers Compensation Issued

Update: This Advisory follows up and supplements FOL Advisory No. 438, issued February 20, 2009. In that Advisory, we explained the basic premise of the Federal mandatory reporting requirements, gave you important deadlines, explained what you need to do now, provided online resources for you and your agents, and provided a glossary of terms used in the Federal process. This Advisory updates and further explains this process.

This update is triggered by the publication of the MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation USER GUIDE, Version 1.0 by CMS on March 16, 2007. This Advisory is a summary of this 180-page document and is not intended as a substitute for actually studying the entire guide. The CMS web site should be accessed in order to obtain a copy of the guide:

http://www.cms.hhs.gov/MandatoryInsRep, then click on Liability Insurance, Self-Insurance, No-Fault Insurance and Workers' Compensation link. The USER GUIDE is in the Downloads section.

Summary: Section 111 adds reporting rules and does not eliminate existing statutory requirements such as the Medicare Set Aside requirements. "Applicable plans" (the same as an RRE for workers' compensation purposes) must report the identity of a Medicare Beneficiary whose injury was at issue after the claim is addressed through settlement, judgment, award or other payment, regardless of whether or not there is a determination or admission of liability, or if there is ongoing responsibility for medical. A person is Medicare eligible at age 65 or older, under age 65 with certain disabilities, and at all ages with end-stage renal disease. The data collected is used by CMS in processing claims billed to Medicare and for Medicare Secondary Payer recovery collection efforts. Medicare Beneficiaries are required to apply for all applicable workers' compensation benefits, included so-called non-subscriber plans. Healthcare providers are required to bill workers' compensation first. If the claim is in dispute and prompt payment is not made, the healthcare provider may bill Medicare as primary. Medicare may pay conditionally, subject to later recovery if there is a subsequent settlement, judgment, award or other payment.

This is the first of what are promised to be multiple versions of this USER GUIDE, as this process is still a work in progress. This new USER GUIDE provides more technical details along with explanations of how the process will work. It contains new details on registration, testing, file submission and response files. It now describes the Query process that can be used to determine whether an individual is a Medicare beneficiary. It contains the final decisions regarding the data set that will be used to describe an illness/injury. Importantly, it describes the so-called "look back" provisions, explaining how far back in time RREs must look for Section 111 reporting.

What You Must Do Now:

- Determine if you are an **RRE**.

- RREs must **implement procedures** to gather necessary Section 111 reporting data (SSN or HICN), to determine its "Look Back" obligations and to determine whether a claimant is a Medicare Beneficiary (Query Input).

- RREs must designate an **Authorized Representative** and an **Account Manager.** See USER GUIDE § 8.2 at pages 23-26.

- Before registration, the RRE must determine how it will submit its Section 111 data and how many RRE IDs will be needed . This reporting structure will depend upon the RRE's structure. See USER GUIDE § 8.2, Step 2: Determining Reporting Structure at pages 24-25.

- Between May 1 and June 30, 2009, RREs (NOT their agents) must **register** on the COB Secure Web site (COBSW). See USER GUIDE § 8 at pages 22-26.

Critical Definitions: FOL Advisory 438 listed numerous terms in a Glossary. Note that CMS definitions may differ from the same term used in the industry (See the definition of "Date of Injury" in FOL Advisory 438). The following are key terms and expansions of terms previously defined:

- **"Coordination of Benefits Contractor" (COBC):** [See USER GUIDE §5.3] The RRE (or its agents) work directly with the COBC in its role in collecting and updating data for CMS. The COBC does not process claims, does not answer claims specific questions or handle MSP recoveries. The actual date submission process will occur between the RRE and the

COBC, which will manage the technical aspects of the Section 111 data submission process. Each RRE (and NOT an agent) must initiate and complete registration with the COBC before testing by the RRE (or its agent) can begin. The COBC does assign each registered RRE an EDI Representative. That person will work with the RRE on all aspects of the reporting process. The COBC is distinct from the Medicare Secondary Payer Recovery Contractor (MSPRC) which is responsible for recovering from the Beneficiary and/or the workers' compensation carrier any amounts due Medicare.

• **"Required Reporting Entity" (RRE):** The entity legally responsible for Section 111 reporting requirements. Where the employer purchases insurance, the insurance company is the RRE. Where the employer is a certified self-insured (independent of other employers), the employer is the RRE. If an employer is "self-insured" for a deductible, (or so-called retentions), but the payment is made through the insurer, the insurer is the RRE. If a pool of self-insured employers (1) is a separate legal entity, (2) with full responsibility to resolve and pay claims using pool funds (3) without involvement of the participating employer, then the self-insurance pool is the RRE. If the pool does not meet these three criteria, each participating employer is the RRE. If a State/Federal agency has authority to resolve and pay claims, the agency is the RRE. The USER GUIDE § 7.1 "RRE for Workers' Compensation" at pages 20-21 discusses these and other scenarios, including receivership and assigned risk type relationships. If your situation is not clearly addressed, you should submit a written question to CMS. This expectation is addressed by CMS in its Pending Issues discussion. Each RRE will be issued a unique RRE ID number.

• **Agents:** Agents are not RREs for purposes of Section 111 reporting responsibilities. However, an RRE may contract with an entity to act as its agent in the reporting process. Registration with the COBC must be completed by the RRE. While the RRE may designate its intended agent during the registration process, the agent may not register on behalf of the RRE. Upon registration, the agent would then likely be the party to continue communication with the COBC. But all communications regarding Medicare recovery will be directed to the RRE, not the agent. Agents do not register with or pay any kind of fees to CMS to become an agent. In other words, CMS does not regulate or recommend agents. Agents must submit separate files to the COBC/CMS for each RRE ID they represent.

• **"Authorized Representative":** Each RRE must name an Authorized Representative in the RRE organization who has the legal authority to bind the organization to a contract and the terms of the Section 111 reporting process. The Authorized Representative: (1) may NOT be an agent of the RRE; (2) may not be a user of the COBSW (web site); (3) may perform the initial RRE registration, but will not be provided a Login ID; (4) must designate the Account Manager for the RRE; (5) must approve and sign the account setup (Data Use Agreement) with the COBC;

and (6) will be the designated recipient of any compliance notices from the COBC. See USER GUIDE § 8.2 at pages 23-26.

• **"Account Manager":** Each RRE must name one (and only one) Account Manager. This person may be an employee or agent of the RRE. This person controls the administration of the RRE's account and manages the overall process. The Account Manager may designate "**Account Designees**" to assist in these tasks. See USER GUIDE § 8.2 at pages 23-26.

• **"Ongoing Responsibility for Medicals" (ORM):** [See USER GUIDE § 11.6] Refers to the RREs responsibility to pay, on an ongoing basis, for the injured worker's (Medicare beneficiary's) medicals associated with a claim. This is particularly important for Texas because of the inability to settle/terminate lifetime medical obligations. ORM is to be reported without regard to prior payments for awards, orders, etc. outside the ORM obligation. Such reporting is not a guarantee of payment or a determination of liability; it is simply a report of the responsibility assumed. Only two reports, the initiation and then the termination of the obligation is reported. "Ongoing" refers to the RRE's obligation to pay on an ongoing basis, and is not a reference to "ongoing reporting" (which is not required). For claims with ORM, the RRE is NOT to report each time they pay for a medical service. The report of the initial assumption by the RRE of the ORM is made only once and is not repeated in each quarterly reporting period.

The claim would only be reported again upon termination of the ORM. That is unlikely to occur in Texas workers' compensation cases because of the lifetime medical obligation. The internal "closing" by the RRE of a file for inactivity does not constitute a termination, as the ORM is always subject to reopening. In such cases, the second report may never be submitted. [But see, Qualified Exception below.]

Special Exception: To prevent relatively minor injuries which as practical matter will not require future medical care from remaining open indefinitely, RREs may submit a termination date for an ORM if they obtain a signed statement from the treating doctor that no further medical treatment will be needed for the injury.

If the claimant is not a Medicare Beneficiary at the time the ORM is assumed, the RRE is obligated to monitor the status of the claimant and report when that individual does become a Medicare Beneficiary, unless the ORM has already terminated. [**Helpful Hint**: Create a standard letter for the treating doctor, in the right cases, to sign and declare the lack of need of future medical care for the compensable injury. Unless the claimant does, in fact, resurrect the obligation to pay medical, the ORM has terminated and the RRE is not then obligated to continue to monitor the claimant for future Medicare beneficiary status.]

Reporting Exception: Where the ORM was assumed prior to and continues as of the July 1, 2009, effective date, the RRE must report such Medicare Beneficiary. Because RREs may not

have collected the necessary data nor determined Medicare Beneficiary status on such past claims, CMS is permitting RREs to delay reporting of such claims until the third quarter reporting period 2010, if the required data has not been obtained for timely submission in the first authorized submission. [See, USER GUIDE § 11.7].

Qualified Exception ["Look Back"]: In prior discussions, a significant question was the so-called "Look Back" requirement. In other liability claims, Medicare became a secondary payer in 1980, but has been a secondary payer for workers' compensation since Medicare's inception in 1965. The question became: How far back in time must an RRE "look back" and report payments and/or ORM?. **The good news is that for ORM assumed prior to July 1, 2009, the RRE is NOT required to identify and report that ORM if the claim was "actively closed" or "removed from current claims records" prior to July 1, 2009.** If the ORM is later reopened, it must be reported with full information, including the original DOI (as defined by CMS). [See, USER GUIDE § 11.7]. See "TOPC" below for information on the separate reporting for payments other than ORM.

• **"Total Payment Obligation to Claimant" (TPOC):** Although not broadly applicable to Texas workers' compensation cases, it is a term you should be familiar with. It refers to the dollar amount of a settlement, judgment, award, or other payment in addition to/apart from ongoing responsibility for medicals (ORM). Because no settlement of Texas workers' compensation claims involving payments (for or in lieu of payment of medical bills) has been allowed for dates of injury beginning January 1, 1991("new law"), there is no TPOC data to submit on "new law" claims. The RRE would, in any event, not report TPOC for the initial report of a claim with ORM.

So, there may be the rare "old law" case where a settlement was reached and the medical was left open for a period to include July 1, 2009; in which case, the RRE would initially report the ORM , then report the TPOC when the ORM ends. It appears the only other "old law" claim where TPOC would be reported would be one where a settlement (CSA) or agreed judgment that limits medical is entered into on or after July 1, 2009 (a very unlikely event). See USER GUIDE, Event Tables at § 11.3.4 at pages 45-49; and Fields 100 and 101, Claim Input File Detail Record, Appendix A, at page 110-111. There are some nuances to this issue that merit further discussion with CMS. We will seek clarification from CMS. If there are scenarios you wish CMS to address, those questions should be proposed in writing to CMS.

• **Query Input File:** This is an optional file in the submission process that can be used by an RRE to request CMS to let an RRE know whether a claimant is a Medicare Beneficiary, triggering the Section 111 reporting process. Using the name, gender, date of birth and SSN/HICN of the claimant, CMS will respond by indicating if the claimant is a Medicare Beneficiary. See USER GUIDE §§ 13 and 14, Appendix D.

Pending Issues: There are a number of pending issues described in an Alert included with the USER GUIDE. These areas are where you can expect additional decisions by CMS in future versions of the guide. As such, you should submit your input and questions to CMS at PL110-173SEC111-comments@cms.hhs.gov. We suggest submitting questions in writing. While CMS will not respond in writing to any of your comments or questions, they may well address the issues in the USERS GUIDE or in the upcoming teleconferences.

You may submit any questions, but CMS is inviting questions and comments on the following pending issues:

- Interim dollar reporting threshold for "Total Payment Obligation to the Claimant" (TPOC) amounts. In other words, payments below this threshold do not trigger a reporting requirement.

- Interim dollar reporting threshold for "Ongoing Responsibility for Medicals" (ORM).

- ICD9 codes you will be prohibited from reporting

- Additional examples of who is and who is not an RRE. CMS expects the industry will provide additional examples of relationships requiring a determination of which party is the RRE (See "**RRE**" above).

Your questions may be addressed by CMS in the telephone conferences scheduled to discuss this process specifically for these insurance lines (non-group health). There are two conferences scheduled:

Tuesday, March 24, 2009 12:30-2:30 p.m., Eastern time

Tuesday, April 21, 2009 1:30-3:30 p.m., Eastern time

Call in No.: 1-888-677-4905
Pass Code: Section 111

Because of the volume of calls expected, it is suggested you begin dialing the number 20-30 minutes before the starting time. While you will be given the opportunity to ask questions, the queue is much longer than the time allotted. So, you may not be reached. Providing questions in writing before the calls will greatly increase your chances of obtaining a direct answer to your questions.

If you have any questions about this process, please feel free to contact Steve Tipton at smt1@fol.com .