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CLIENT UPDATE **FEBRUARY 2010**

MEDICARE'S SECTION 111 REPORTING PROGRAM: *SEPARATING FACT FROM FICTION*

January 1, 2010 marked the start of a new decade and a new phase of active testing, data collection, and reporting under the Medicare Section 111 Reporting Program. As Responsible Reporting Entities (RREs) move quickly to finalize reporting protocols, there is still a great deal of uncertainty and misinformation about the scale, scope, and extent of the reporting obligations. As a supplement to our prior publications on the subject (a complete Section 111 Resource Guide is available), this Client Update will focus on helping RREs separate fact from fiction as they develop efficient and cost effective reporting programs.

Fiction: The new reporting program applies to both Medicare and Medicaid recipients.

Fact: This is a Medicare only reporting program. Only those settlements, judgments, awards, or other payments made to, or with respect to, a Medicare beneficiary, where medicals are claimed, or where the payment has the effect of releasing medical expenses, must be reported (subject to certain thresholds and exemptions). Settlements, judgments, awards, or other payments to Medicaid recipients are not subject to reporting under this CMS-sponsored program.

Fiction: Only personal injury settlements need to be reported.

Fact: Any payment that entails a release of a Medicare Beneficiary's claimed medical expenses is reportable, regardless of the nature of the underlying dispute that gave rise to the claim. While this will most commonly occur in the context of personal injury claims, medical expenses may also be claimed as an item of alleged damages in connection with a variety of actions, including employment, contract, professional liability, or D&O disputes. If a settlement, judgment, award or other payment has the effect of releasing claimed medical expenses, the payment must be reported in accordance with the Section 111 Reporting Rules.

Fiction: Year-end settlements that were agreed upon with Medicare Beneficiaries in 2009 are exempt from reporting.

Fact: If the negotiations occurred in 2009 but the settlement agreement is signed in 2010, it will be subject to the new reporting rules. Similarly, if the settlement is subject to a court approval that occurs in 2010, the

settlement will be subject to the new reporting rules. However, if all documents were signed in 2009 and all necessary court approvals occurred in 2009, the mere fact that the settlement was funded in 2010 will not trigger reporting.

Fiction: Smaller companies, government entities, and certain business categories are exempt from reporting.

Fact: The statutory mandate for the reporting obligations that apply to non-group health plans (NGHPs) does not recognize any exemption for reporting entities based on size of workforce, revenue stream, governmental status (e.g., state, local municipalities) or religious affiliation (i.e., parochial school, church, or university). If the circumstances of the claim and payment otherwise meet the reporting threshold and program requirements, the settlement, judgment, award, or other payment must be reported to CMS (42 C.F.R. §411.50)

Fiction: An entity's entire docket of claims must be screened immediately / continuously / monthly to check for plaintiffs or claimants who may be Medicare beneficiaries.

Fact: RREs that have ongoing responsibility for medical payments (ORM), typically in a workers comp or no fault setting, do have to monitor their payees to ascertain if any of them become Medicare beneficiaries during the period that they are receiving payments. The payee's new Medicare beneficiary status will trigger reporting obligations.

But for entities that expect only to pay claims in a single installment (whether as a lump sum or in funding a structured settlement), it is only necessary to know the injured party's Medicare status at the time of settlement. While CMS offers RREs monthly access to query the CMS database to check the Medicare status of injured parties, it is not necessary to repeatedly query the CMS system about all pending claims until a settlement, judgment, award, or other payment is about to be made. ***Note*:** Timing the query is important to ensure that qualifying payments are reported to CMS in a timely fashion.

Fiction: CMS must be notified in advance of every potential settlement and consulted during the negotiation about the amount of any lien and how repayment obligations will be met.

Fact: The Section 111 Reporting Program does not require RREs to notify or consult with CMS prior to achieving a liability settlement, judgment, award, or other payment. Although some insurance companies or liability payors, acting pursuant to a Medicare beneficiary's written consent, do contact the CMS recovery coordinator during the pendency of a claim to obtain detailed information about conditional payments that Medicare may have made, this is an infrequent occurrence. Most of the contacts with the Medicare Secondary Payor Recovery Contractor (MSPRC) are made by the beneficiary or a representative acting on behalf of the beneficiary. (For further information about the Mandatory Secondary Payor recovery process, visit http://www.msprc.info/.)

> ***Note:*** Section 111 reporting does not change existing obligations under the Medicare Secondary Payor provisions for any entity.

Fiction: Starting in 2010 a Medicare Set Aside Fund (MSA) must be established as

part of every settlement, judgment, award, or other payment to a Medicare beneficiary.

Fact: CMS has not mandated the use of MSAs with respect to liability payments.

Other Important Section 111 News and Updates

CMS is continuing to hold monthly Town Hall style teleconferences to provide updates and clarifying instruction for liability providers, workers' compensation plan administrators, insured and self-insured entities, and others. The following are highlights from the January 28, 2010 Town Hall call.

- **Foreign Entity RREs**

CMS issued an ALERT dated December 29, 2009 providing registration guidance for RREs who are foreign entities. Foreign entities are defined as entities that do not have a U.S. address and/or U.S. tax identification number (TIN) or employer identification number (EIN). CMS encourages foreign entities that do not have a U.S. TIN or EIN to apply at this time by completing the Internal Revenue Service (IRS) SS-4 application. To accommodate foreign entities that do not have a U.S. address and/or U.S. TIN or EIN, CMS is modifying the existing registration process. Foreign entities are not required to register until April 1, 2010. But after successful registration and testing, foreign RREs will be obligated to report all qualifying TPOC payments from January 1, 2010 forward. Foreign entities are urged to check the CMS dedicated web page for additional guidance and instruction, http://www.cms.hhs.gov/MandatoryInsRep/

New Rules for Reporting Representative's Information

The Medicare beneficiary's (or claimant's) representative's TIN is now optional: report it if you have it but it will not be a required field. Also, CMS clarified that RREs have the choice of reporting the representative's full name or firm name.

- **ICD 9 Diagnosis Codes (Field Codes 15, 19 et seq.)**

The ICD 9 Diagnosis Codes are optional in 2010 and it is advisable not to use these codes until required to do so in 2011. Any error in the Code will cause the entire submitted reporting record to be rejected. Rather than risk rejection, it is advisable to include a text description of the illness or injury in Field 57, and omit the ICD 9 diagnosis codes until they are required to be included in the submitted record. In the meantime, between now and January 2011, RREs should anticipate the need to train their claims staff to become familiar with the ICD 9 diagnosis coding and billing process.

- **SSDI Recipients**

While Social Security Disability Income (SSDI) recipients may eventually be entitled to Medicare after a certain waiting period, that future beneficiary status, alone, is not enough to trigger reporting. The key to reporting under the Section 111 program is Medicare beneficiary status as of the date of the TPOC payment. RREs can check the plaintiff/claimant's beneficiary status by querying the CMS database. (***Note***: as mentioned above, RREs that have ongoing responsibility for medical payments must be vigilant in monitoring the payee's status to watch for changes in Medicare status.)

- **Persons Having a TIN but no SSN**

Noncitizens working in the United States may have a TIN assigned for IRS purposes but are not eligible for, and thus do not have, a SSN. Those individuals cannot be Medicare beneficiaries and therefore settlements, judgments, awards, or other payments made to them are not reportable under the Section 111 Program.

Still Awaiting Final Guidance on These Topics

Reporting language is undergoing final clearance within CMS as to:

1. Reporting rules for write-offs, courtesy adjustments and in-kind service recovery gestures such as the issuance of gift cards.

2. Product Liability and "Mass Tort" data (Fields 58-62). ***Reporting tip*:** do not enter data in these fields until instructed to do so through Guidance.

3. The 12/5/80 DOI Threshold: CMS is developing language to identify the non-reportable claims that arise from exposures and dates of incident prior to 12/5/80. ***Note*:** be alert to any settlements that may qualify for this exemption, so they can be reexamined when the final reporting language is announced.

4. Clinical trials: The reporting obligations for clinical trial sponsors who assume responsibility for payment of expenses if trial subjects suffer injury or incur expense arising out of their participation in a clinical trial.

5. The definition of RRE: we await language that will better define the concept of RRE, which is especially important in complex business organizations and in determining reporting obligations between insurers and insureds, particularly when insurance deductibles are used to pay claims.

As entities move from the testing into the production phase of Section 111 reporting, Tucker Ellis & West LLP will continue to share important Section 111 program updates as they become available. We also invite your questions and comments as we strive to provide the guidance you need to be successful.

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