wiley

ALERT

Section 111 Bulletin: Round Up of Notable Medicare Reporting and Reimbursement Developments for Property and Casualty Insurers

February 13, 2015

Although 2014 began as a slow year for guidance on the reporting and reimbursement obligations of property and casualty insurers under the Medicare Secondary Payer (MSP) statute, there was a relative flurry of notable developments over the last months of 2014 and into the new year. In December, the Centers for Medicare & Medicaid Services (CMS) held the only Section 111 Town Hall Teleconference of the year for Non-Group Health Plans (NGHPs). Agency representatives primarily discussed issues regarding implementation of recent CMS Alerts that reflect both significant and mundane changes in NGHP reporting requirements. But perhaps the most significant development occurred on the litigation front, where a federal court held in September that a Medicare Advantage Organization may bring a private cause of action against an NGHP for reimbursement of health care benefits paid under the Medicare managed care program, adopting reasoning applied by the Third Circuit in *In Re Avandia Marketing*. In addition, CMS issued updated versions of its NGHP User Guide in October and again in January and February 2015. Although three User Guide publications in less than four months is unusual for CMS, the revisions were largely anticipated as they implement changes to those reporting requirements detailed in recent Alerts and discussed during the Town Hall teleconference. The latest update offers expanded guidance on CMS's willingness to look to amended complaints to determine the date of incidence for an exposure, ingestion, or implantation claim.

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

Edward R. Brown
Partner
202.719.7580
erbrown@wiley.law

Practice Areas

Health Care

Section 111 Insurer Reporting and MSP Reimbursement

This Bulletin addresses each development in turn.

Federal Court Allows Medicare Advantage Organization To Bring Private Cause of Action Against Primary Plan

In September, the United States District Court for the Western District of Texas held that a Medicare Advantage Organization (MAO) may bring suit against a primary plan, such as an NGHP, under the MSP statute. *See Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co.*, No. 13-CV-611-LY, 2014 WL 6663522 (W.D. Tex. Sept. 24, 2014). In the absence of Fifth Circuit precedent on the issue, the court relied on the Third Circuit's reasoning in *In re Avandia Marketing*, 685 F.3d 353 (3d Cir. 2012), to hold that Humana, an MAO, could assert a private cause of action against the NGHP for double damages. Slip op., at 3. Specifically, the court agreed with the Third Circuit that Section 1395y(b)(3)(A) of the MSP statute [1] unambiguously provided Humana with a right of action. *Id.* The court reasoned that the broad provision placed no limitations upon which private actors "'can bring suit for double damages when a primary plan fails to appropriately reimburse any secondary Payer.'" *Id.* (quoting *In Re Avandia Mktg.*, 685 F.3d at 359). In so doing, the court further agreed with the Third Circuit's conclusion that "any private plaintiff with standing may bring an action," not solely the Medicare beneficiary or injured party. Slip op., at 3.

The *Humana* decision is noteworthy in that, to date, no circuit courts other than the Third Circuit have considered whether the MSP statute's private cause of action extends to MAOs.[2] Whether the district court's decision will add weight to the *In re Avandia* holding remains an open question, but the fact that the *Humana* court rejected a magistrate judge's Report and Recommendation in reaching its decision may portend future disagreement on the issue.

CMS Ends 2014 and Begins 2015 with a Step Up in Section 111 Activity

First and Only 2014 Town Hall for Non-Group Health Plans

On December 10, 2014, CMS held a Section 111 Town Hall Teleconference for NGHPs regarding their obligations as Responsible Reporting Entities (RREs) under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). The discussion focused largely on CMS's decision in November 2014 to permit RREs to report only the last five digits of a beneficiary's Social Security Number (SSN), rather than the full SSN or Medicare Health Insurance Claim Number (HICN), as previously required, when reporting settlements, judgments, awards, or other payments with Medicare beneficiaries. This change reflected CMS's arguably late compliance with the mandate of Section 204 of the Strengthening Medicare and Repaying Tax Payers Act of 2012 (SMART Act). Agency representatives also addressed other less newsworthy regulatory developments and answered a few unique questions raised by callers.

CMS Town Hall Highlights

John Albert, a senior technical advisor at CMS, kicked off the teleconference with remarks that generally drew attention to and echoed the content of recent Alerts issued by the Agency. As outlined in a previous Bulletin and detailed in a November 25, 2014 Alert, Mr. Albert gave technical reporting instructions for entry of partial SSNs. As of January 5, 2015, RREs may submit the last five digits of an individual's SSN along with the beneficiary's first initial, surname, date of birth and gender.

Mr. Albert also discussed a technical Alert issued on November 10, 2014, which promises RREs the option, effective July 13, 2015, to submit recovery agent information to CMS, enabling the agent to receive recovery-related correspondence. Under the new process, if RREs choose to submit agent information, both the RRE and the agent will receive recovery-related correspondence. Mr. Albert next addressed a previously unannounced change regarding multi-factor authentication fulfilling another SMART Act mandate. The change, to be effective no later than January 1, 2016, will implement an expanded MSP web portal to allow other beneficiary authorized users to access payment and claims information they cannot currently access. CMS will implement the change once its multi-factor authentication test meets federal IT security requirements.

After his general discussion of recent and future developments, Mr. Albert introduced Jeremy Farqhuar of the Medicare Benefits Coordination & Recovery Center (BCRC). Mr. Farqhuar reiterated many of same points made by Mr. Albert, offering more technical detail and explanation. For example, Mr. Farqhuar discussed a minor change detailed in a Technical Alert issued on October 27, 2014 that slightly modifies the naming convention used for the Claim Response, TIN Response and Query Response Files. The change, which will go into effect on April 5, 2015 and relates to the timestamps on file submissions, should solve the occasional problems experienced by RREs when submitting multiple claim files at one time.

Mr. Farqhuar also addressed a number of questions that CMS had received since the last Town Hall forum. He directly responded to questions regarding SSN submission and reiterated that reporting threshold changes, discussed below, have been in effect since October 1, 2014, and thus Total Payment Obligation to the Claimant (TPOC) liability amounts greater than $1,000 must now be reported. As of January 5, 2015, using the CJ07 error code, CMS began rejecting any liability TPOC of $1,000 or less with a TPOC date of October 1, 2014 or later.

- ***December 4, 1980 Cutoff for Asbestos-Related Claims***
  Regarding an Alert issued on August 19, 2014, a representative from a state insurance guaranty association inquired whether the December 4, 1980 cutoff for asbestos-related and toxic tort claims applies to the most recently-amended complaint. Specifically, the caller asked whether there would be a reportable event if an initial suit alleged asbestos exposure after that date, but an amended complaint limits alleged exposure to time periods prior to December 4, 1980. CMS confirmed that, following the Alert guidance, it would rely on the most recently-amended complaint as long as the complaint was not amended for the sole purpose of excluding Medicare from pursuing recovery. This guidance has since been augmented in the latest User Guide released on February 2, 2015 and discussed below.

- ***Loss of Consortium***
  In turning to caller questions, CMS affirmed that a Section 111 report need not be filed for a family member who signs a release on behalf of an injured party (i) in his or her capacity as a legal representative and (ii) without releasing any loss of consortium claim that the individual may have, whether alleged or unalleged. Second, CMS repeated its response given in an earlier Town Hall call, and discussed in a previous Bulletin that a state bar on loss of consortium or other claims will not exempt the reporting of a separate record for the legal representative. As long as the released party who is or was a Medicare beneficiary at the time of the release, reporting would be required despite state law prohibitions against the claims. CMS added that a memorandum regarding reporting requirements on loss of consortium claims is under consideration.
- ***Reporting of Accidental Death and Other Benefits***
  CMS affirmed that RREs do not need to report accidental death benefits that are separate from medical expenses and may or may not be paid. In contrast, CMS responded that both hospital confinement and total disability benefits should be reported even where they are paid pursuant to a set schedule and are not designated as payment of healthcare services.

Overview of Revised NGHP User Guides

October 6, 2014 User Guide, Version 4.3

This User Guide primarily incorporated changes to the technical reporting process and notably included no significant changes to Chapter 3, which contains most of the substantive guidance for Section 111 reporting.

- ***ICD-10 Codes Delayed***
  Chapters 4 and 5 of the revised NGHP User Guide now reflect the delay of ICD-10 diagnosis code implementation from October 2014 to 2015. In an Alert issued on May 13, 2014 and more recently in a January 28, 2015 Alert, CMS announced this change directed by the Protecting Access to Medicare Act, which was enacted on April 2, 2014 and prohibits CMS from using ICD-10 codes on or before October 1, 2015. Prior to that date, RREs may submit ICD-10-CM diagnosis codes on test claim files but are not permitted to submit the ICD-10-CM codes on production claim files.

  In Appendix J of Chapter 5, CMS added two "missing excluded" no-fault ICD-10 codes. It made two other technical changes to the Appendices, including updates to CS field error codes, to accommodate ICD-10 reporting.

  Consistent with the Agency's March 25, 2014 Alert, Section 6.2.5.1 of Chapter 4 and Table 4-F of Chapter 5 of the User Guide provide that ICD-10 "Z" codes (equivalent to ICD-9 "V" codes or factors influencing health status and contact with health services) are now excluded from Section 111 reporting and will remain excluded even after the use of ICD-10 codes becomes mandatory on October 1, 2015.

- ***Recognition of Same-Sex Marriage***
  This revised User Guide recognizes three new rules that will apply to the term "spouse" in accord with the policy adopted by the Department of Health & Human Services, which treats "same-sex marriages on the same terms as opposite-sex marriages to the greatest extent reasonably possible." Under the new rules, CMS will recognize any same-sex marriage legally entered into in a U.S. territory that recognizes the marriage.

January 5, 2015 NGHP User Guide, Version 4.4

The changes reflected in this User Guide comprise technical updates for partial SSN reporting by RREs and the change in TPOC reporting thresholds, discussed below. On the same day, the BCRC issued Version 5.2 of its *270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for Mandatory Reporting Non-GHP Entities,* also incorporating new guidance for partial SSN reporting.

February 2, 2015 NGHP User Guide, Version 4.5

Chapter III, Section 6.5 of this User Guide supplements earlier guidance on the liability cut-off date for exposure, ingestion, and implantation claims. Noting that RREs are not required to report where the date of incident (DOI), as defined by CMS, is prior to December 5, 1980, CMS advises that the DOI can be established by an "amended complaint or comparable supplemental pleading" that: (i) is filed prior to the date of settlement, judgment, award, or other payment and (ii) does "not have the effect of improperly shifting the burden to Medicare by amending the prior complaint(s) to remove any claim for medical damages, care, items and/or services, etc." Where a complaint is amended by court order and that order limits Medicare's recovery claim based on the criteria contained in the User Guide, CMS advises that it will defer to the order. It "will not defer to orders that contradict governing MSP policy, law, or regulation."

Other Noteworthy Developments in the Fourth Quarter of 2014

CMS Withdraws NPRM Regarding MSP and "Future Medicals"

On October 8, 2014, the CMS withdrew its Notice of Proposed Rulemaking (NPRM) for the handling of future medical costs in liability claim settlements. As previously discussed in our June 2012 Bulletin, CMS issued an advanced notice of proposed rulemaking, which was designed to clarify how Medicare beneficiaries may "protect Medicare's interests" with respect to MSP obligations when they receive settlements, judgments, awards or other payments from insurers related to claims for "future medical care" delivered after the date of settlement. CMS, *Medicare Program; Medicare Secondary Payer and "Future Medicals"*, 77 Fed. Reg. 35917. The Agency submitted the NPRM to the Office of Management and Budget (OMB) on August 1, 2013.

As a result of the regulation's withdrawal, CMS takes a few steps backwards in providing guidance regarding Medicare set-aside arrangements (MSAs), but it is important to note that it remains settled that MSAs are not required and that NGHPs have no obligation under the MSP statute to reimburse Medicare for payments that

CMS may make mistakenly for medical services received after settlement. Currently, the Agency will review MSAs for certain workers' compensation situations to determine whether a proposed set-aside amount will meet MSP obligations, but no formal MSA approval process exists for liability settlements. Finally, although CMS did not comment publicly on the withdrawn NPRM, we expect that the Agency will rewrite the regulation and resubmit it to the OMB.

Change in Threshold for Liability TPOC Reporting Effective October 1, 2014

Since October 1, 2014, a new mandatory reporting threshold for liability insurance TPOCs has been in effect. RREs must report payments of liability claims that exceed $1,000 for TPOCs dated after October 1, 2014. Previously, CMS decreased the liability threshold amount from "over $25,000" to $5,000 on October 1, 2012, and from $5,000 to $2,000 on October 1, 2013. In an Alert issued on February 28, 2014, CMS revised the mandatory reporting threshold beginning on October 1, 2014 from $300 to $1,000.

***

Our Section 111 Team routinely covers CMS's Section 111 NGHP Town Hall Teleconferences, and we send periodic Section 111 Bulletins to our clients addressing notable Town Hall discussions and other Section 111 developments. We also maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please let us know if you would like more information about any of the Section 111 topics discussed in this Section 111 Bulletin. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.

---

[1] "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." 42 U.S.C.§ 1395y (b)(3)(A).

[2] On November 4, 2014, the district court denied the Defendants' Motion to Certify Order for Interlocutory Appeal. *Humana*, No. 13-CV-611-LY (W.D. Tex. Nov. 4, 2014) (No. 53).