wiley

ALERT

Section 111 Bulletin: CMS Announces "Major and Significant Changes" in Revised User Guide for NGHPs During July 28th Town Hall Teleconference

August 5, 2010

On July 28, 2010, the Centers for Medicare & Medicaid Services (CMS) held a teleconference for Non-Group Health Plans (NGHPs) focusing on both policy and technical issues related to insurer reporting under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. At the start of the call, a guest speaker from the CMS Coordination of Benefits Contractor (COBC) announced that CMS had posted a new version of the NGHP User Guide (dated July 12, 2010) on the Agency's Section 111 website. In his words, the updated User Guide offers "major and significant changes" from Version 3.0. While this may be true if comparing User Guide versions, insurers that have followed the CMS "Alerts" posted throughout the spring and summer on the Section 111 website and listened in to earlier teleconferences may view the new User Guide as more of a welcomed compilation of current CMS guidance than as new guidance. CMS did caution readers to rely upon the newly incorporated language in the User Guide and not on the earlier Alerts as some language has changed.

A summary of the thirty-one User Guide revisions is available, in order of appearance in the User Guide, at page six of the User Guide. The COBC representative highlighted eighteen of those changes or corrections at the start of the call. Here are the **Top Ten** from his list:

1. "Section 7.1 was replaced in its entirety with language from the 'Alert for NGHP—RREs/Who Must Report' dated May 26",

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

Practice Areas

Health Care

Insurance

Privacy, Cyber & Data Governance

Section 111 Insurer Reporting and MSP Reimbursement

2010.

2. "Sections 11.1.1 and 11.1.2 were added to consolidate information regarding matching injured party information to Medicare beneficiaries and update and delete transactions to previously submitted claim records."

3. "It was noted in Sections 11.1.1, 11.10.1, and 12 that [Responsible Reporting Entities] RREs must store the [Health Insurance Claim Number] HICN returned on response files in their internal systems and are required to use it on future transactions. The [Social Security Number] SSN may be submitted initially for an injured party on the Claim Input File and Query Input File if the RRE does not have the HICN, but once a HICN is returned after matching the individual to a Medicare beneficiary, it must be used going forward."

4. "The requirements for reporting ICD-9 diagnosis codes in Section 11.2.5 were updated to clarify that ICD-9 diagnosis codes submitted should be those that reflect the illnesses/injuries claimed and/or released by the settlement, judgment, award, or for which [Ongoing Responsibility for Medicals] ORM is assumed. . . . ."

5. "Sections 11.7 and 11.10.1 were updated to remove the requirement related to submitting empty fields or otherwise notifying the COBC when you have nothing to report for a particular quarter."

6. "A new event was added to the Event Table in Section 11.7.4 to explain that two separate reports may be required for the same incident, injured party and insurance policy claim, when ORM and [Total Payment Obligation to Claimant] TPOC reflect different insurance types."

7. "Section 11.10.2 was updated to reflect the language in the Alert dated May 27, 2010, "Periodic Workers' Compensation and No-Fault Payments."

8. " The language from the 'Alert Regarding Risk Management Write-Offs' dated May 26, 2010 was added to Section 11.10.2 along with changes announced during the June 30, 2010 NGHP Town Hall Teleconference. *Please read this section in its entirety as the language in this Guide supersedes the*

language in the original Alert."

9. "The language from the 'NGHP Alert—Clinical Trials' dated May 26, 2010 has been added to Section 11.10.2."

10. "Section 21.1 was updated to correct the description of the '03' disposition code. While a record returned with an '03' is considered error-free and matched to a Medicare beneficiary, the record is not considered accepted since the dates reported do not overlap the beneficiary's Medicare's coverage dates at the time the record was processed."

Many of the remaining eight updates highlighted by the COBC representative reflect changes to field and error code descriptions. The COBC representative also discussed the addition of Section 15.5, which provides information on the new Direct Data Entry option, and the updating of Appendix G to match language in the "Alert for NGHP RREs/Who Must Report" dated May 26, 2010.

Q&A Discussion

Among the notable topics discussed by CMS during the listener Q&A session were:

DDE Reporting: CMS reminded listeners that this abbreviated reporting option should be used only by "Small RREs", that is those RREs with only an "occasional claim to report"—which CMS defined as less frequently than quarterly—and absolutely no more than 500 "claim reports" each calendar year. Because every "add", "delete", and "update" transaction will count toward the RRE's annual limit of 500 claim reports, CMS cautioned that 500 is not as large a number as it may seem. First, a "claim report" is not synonymous with a payment to a claimant. A claim report is a "hit against the database." In addition, CMS advised that RREs should not set up an RRE ID for the purpose of running Direct Data Entry (DDE) queries because a separate query function is not available under the DDE option. Querying and reporting are one transaction. Thus, every time an injured party's submitted information fails to match the information of a Medicare beneficiary in the database during the DDE entry process, that submission will still count toward the 500 limit.

HICNs/SSNs: CMS also reminded listeners of another frequent CMS refrain—that Medicare HICNs take precedence over SSNs in the Medicare system. For example, if an RRE obtains an HICN when querying, the RRE must use the HICN for all future reporting purposes in lieu of the claimant's SSN. CMS also addressed the question of whether it is appropriate for an insurer to request and collect SSNs of its entire claimant population, or whether it may ask these claimants first if they are Medicare eligible and then only request SSNs from those answering affirmatively. CMS implied in its answer that although Section 111 only requires the reporting of "information on Medicare beneficiaries", an insurer cannot sit back comfortably and not report in situations where a claimant does not honor a request for information or answers the question negatively. Instead, the insurer should send the claimant the model form and document its success or lack thereof in

obtaining a response so as to ensure availability of safe harbor treatment if needed.

Errors and Omissions Coverage: CMS acknowledged that it is still considering the exclusion of certain policy types from Section 111 reporting, such as errors and omissions coverage. CMS agreed with a caller that if an E&O policy excludes coverage for bodily injury and medical expenses, then reporting under Section 111 is not required, *but* the scope of coverage must be clear. The parties cannot agree to coverage limitations where the policy language is unclear. A word of caution is in order with respect to this Q&A exchange. One important fact that the caller appeared to leave out of his question was whether the release agreed to by the settling parties was broader than the scope of coverage, such that medical expenses were released. Were that the case, and if CMS were to follow earlier guidance offered in the User Guide and during town hall calls, we believe it possible that CMS would require the insurer to report the settlement. CMS should clarify its guidance in this context.

Mass Torts: As with past calls, CMS answered a few questions regarding the December 5, 1980 exposure liability cut-off date, but indicated that continuing ambiguity and uncertainty about how this date affects reporting requirements and the definition of "exposure" will be the focus of the long anticipated Mass Torts working group call, which, CMS noted, should be held within two or three weeks. CMS did opine, however, that even where the parties agree that all exposure was prior to December 5, 1980, but the claimant nevertheless gives a broad release for future medical expenses that arguably ties to post-1980 exposure, the insurer must report its payment to the claimant to CMS. CMS also made it clear that despite the industry's frustration with CMS's delay in holding a working group call, "the law stands" and RREs must be prepared to report in accordance with CMS's current guidance if no accommodations are reached.

Deductibles: One caller asked to return to a question from the last NGHP town hall call regarding RRE identity when the insured with a deductible handles the defense of a claim and does not report the existence of the claim to the carrier until sometime after settlement and ostensibly payment of the claim. The caller wanted to know if CMS might view this situation as one in which the insured handles the claim "without recourse" to its insurance, and thus the insured must report under Section 111. CMS rejected this interpretation and confirmed that the insurer remains responsible for reporting the claim. CMS then advised that the insurer should require its insured to report all claims to it within a time period that would permit the insurer to meet its Section 111 obligations.

In an effort to clarify the ambiguities inherent in its guidance regarding the proper identification of the RRE in claim scenarios involving deductibles and self-insured retentions (SIRs), CMS invited the submission of hypotheticals that CMS might answer and then add to the User Guide as examples. Given the amount of criticism CMS has received for its deficient guidance, CMS expressed surprise that it had only received two hypotheticals via the Resource Mailbox.

Date of Injury/Date of Occurrence: While cautioning that CMS has not yet reached a final decision on the definition of these dates as applied to cumulative injuries, CMS did share that it was "leaning toward" defining Date of Injury (DOI) as the earlier of 1) the date of treatment or manifestation of the injury or 2)

formal diagnosis.

Overseas Insurers: CMS again did not report on the status of its promised guidance for overseas insurers "doing business" in the United States and thus, according to CMS, obliged to report under Section 111. This guidance is long overdue as the User Guide's prior blanket inclusion of "foreign insurers" in the pool of NGHPs that must report was overly broad and, we contend, in disregard of the constitutional limitations on the extraterritorial application of domestic law to overseas entities. The latest version of the User Guide simply states that "CMS will issue a separate ALERT addressing foreign insurers." *See* Section 7.1, page 24, of User Guide Version 3.1. The delay in the issuance of that Alert is duly noted as the registration process for overseas insurers reopened on April 1, and these insurers are expected to follow the same reporting procedures (and presumably, the same reporting schedule) as domestic RREs.

Abandoned RRE ID Numbers: CMS encouraged RREs to "turn in" ID numbers that they no longer intend to use to their EDI representatives.

Risk Management Write-Offs: One caller asked whether CMS would consider revising the definition of a reportable claim to exclude payments or other compensation that "enhances customer goodwill" or "lessens the probability of a liability claim." While CMS did not appear anxious to make further revisions to its write-off guidance, CMS invited the caller to submit the question to the Resource Mailbox.

Translations of Model Language/Safe Harbor Form: CMS encouraged RREs that have translated the CMS model "safe harbor" form requesting a claimant's HICN or SSN into another language to submit the translated document to CMS for review. In the meantime, CMS stated that these insurers could continue to use their translated forms. CMS encouraged insurers to send in their translations as it is interested in posting "useful" translations on the Section 111 website.

Future NGHP Teleconferences: CMS has posted a schedule on the Section 111 website of the remaining NGHP teleconferences through the end of the year. The next call will be on August 25, and it will address both policy and technical reporting issues. In September, CMS will return to its practice of holding two NGHP calls per month, one focusing on policy issues and one on technical reporting.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held monthly by CMS, and we send timely detailed summaries of teleconference highlights to our clients. We also maintain a searchable electronic database of the transcripts back to October 2008. Please let us know if you would like more information about any of the topics discussed during the July 28, 2010 call. You may also access our Section 111 webpage and the other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.