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ALERT

Section 111 Bulletin: CMS Clarifies Delay of TPOC Reporting for Liability Insurers During December 9 Town Hall and Issues New Alerts

December 16, 2010

In our last Section 111 Bulletin, we reported that the Centers for Medicare & Medicaid Services (CMS) had responded to liability insurers requesting a one-year delay of their reporting obligations under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 111) by postponing the reporting of all liability TPOC settlements (or other TPOC payments representing a "total payment obligation to the claimant") until the first quarter of 2012. Like many of CMS's other initial Section 111 pronouncements, the November 9, 2010 dated Alert raised many questions as to its intended scope.

On the most recent Town Hall call on December 9, 2010, CMS clarified the November 9 Alert. CMS began by reiterating the relatively straightforward directive that the TPOC reporting delay applies to liability insurers, but only with respect to their liability TPOC payments. Reporting of such payments now must begin in the first quarter of 2012 for TPOC obligations incurred on or after October 1, 2011, although CMS encourages Responsible Reporting Entities (RREs) to commence reporting on a voluntary basis before that time. What previously was not so clear was CMS's statement in the November 9 Alert that the delay applied to "all liability insurance TPOC amounts with no Ongoing Responsibility for Medicals (ORM) involvement." CMS explained on the call that if a single settlement, for example, has both a TPOC and an ORM component, the ORM settlement must be reported if it occurs on or after January 1, 2010 (adhering to the original reporting timeline that requires reporting in the first quarter of 2011), but the associated TPOC settlement need not be reported

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unless it occurs on or after October 1, 2011. We note that the settlement must also meet the "timeliness" reporting criteria set out in the CMS Alert dated October 14, 2010.

As explained in our November 15, 2010 Bulletin, reporting of the perhaps rare TPOC payment under a workers' compensation or no-fault policy must still begin as previously scheduled in the first quarter of 2011.

In response to a question posed by a caller, CMS stressed that the extension was not limited to Mass Torts TPOC payment scenarios. The Agency offered that it is still looking at issues specific to that context, which include the effect of a general release on reporting obligations where post-12/04/80 injury is neither alleged nor proven. (December 5, 1980 is the effective date of the Medicare Secondary Payer statute.) CMS also announced that it will hold at least one additional Mass Torts Working Group call after the new year.

December 9, 2010 Town Hall

In addition to discussing the November 9 Alert, CMS spent the majority of the allotted time on the Town Hall call summarizing two other November Alerts, previewing Alerts "in process," and answering Resource Mailbox questions. Fewer than a dozen live questions were answered.

CMS has posted two new Non-Group Health Plan (NGHP) Alerts since our last Bulletin. (Note: the dates of these Alerts do not reflect the dates they were posted on the CMS website.)

- **ALERT: Special Default ICD-9 Code for NGHP Responsible Reporting Entities (RREs):** CMS announces in this Alert dated November 12, 2010, that it will allow NGHP RREs to use a "NOINJ" (no injury) default diagnosis code instead of an ICD-9 code in "extremely limited and specific [reporting] circumstances." When "a settlement, judgment, award, or other payment releases medicals or has the effect of releasing medicals, but the type of alleged incident typically has no associated medical care," and the claimant "has not alleged a situation involving medical care or a physical or mental injury," then an RRE reporting a liability insurance TPOC may use the code "NOINJ" in ICD-9 code fields describing cause of injury and diagnosis. CMS emphasizes that RREs that have assumed ongoing responsibility for payment of a claimant's medical expenses (ORM) may not use this code. CMS identifies typical situations in which the code may be appropriate as claims for loss of consortium, errors and omissions liability claims, directors and officers liability claims, and employment practices liability claims. CMS cautions that RREs that misuse the new NOINJ code are at risk of non-compliance with reporting requirements. Discussing the Alert during the December 9 Town Hall call, CMS recommended that RREs carefully read the Alert regarding restrictions on the use of this code. CMS noted that RREs should not use the NOINJ code if any bodily injury is claimed, alleged, or typically associated with the type of claim. CMS also emphasized that RREs should not use the default code merely because they have trouble finding a correct ICD-9 code.
- **ALERT: TIN Reference File Address Validation:** Through this Alert, CMS announces the multi-phase implementation of more rigorous address validation routines and a new TIN Reference Response File that will alert RREs to specific errors found on TIN Reference Files and indicate whether each TIN

Reference File record was accepted or rejected. The new process should be in place by July 2011. In the lead-in phase, beginning January 10, 2011, the Coordination of Benefits Contractor (COBC) system will replace certain error codes with compliance flags, which are described and explained in the Alert. CMS plans to update the next version of the NGHP User Guide to include this information.

In Process Guidance

CMS identified the following "in process" guidance: (1) an Alert providing guidance for workers' compensation and no-fault insurers on "non-medical TPOCS," including "one-time lump sum" TPOCs; (2) an Alert providing guidance to foreign RREs; (3) a User Guide "update" regarding CMS's retention of dated ICD-9 codes; (4) an Alert introducing a new online query process on the Coordination of Benefits Secure Web Site (COBSW), which will be available after January 10, 2011 to all but those RREs registered for DDE as they will have the equivalent of real-time querying through the DDE system (Note: an RRE ID number is limited to 100 queries a month); (5) an Alert offering further guidance at least six months before implementation of the new TIN Reference Response File in July 2011; and (6) an update to the timeline on the Section 111 Web site Overview page.

Noteworthy Issues Addressed By CMS

- **Reasons for Voluntary Early Reporting:** CMS provided four reasons why RREs should consider voluntarily reporting liability TPOC settlements or other TPOC payments before the first quarter of 2012. According to CMS, early reporting (1) affords thorough validation of production reporting before penalties set in; (2) avoids having to shut down and then reallocate scarce IT and operational resources; (3) keeps newly learned information fresh in the minds of those involved in reporting; and (4) if the RRE will not otherwise be reporting ORM obligations, keeps log-in IDs for the COBSW active and avoids reactivation hassles.
- **Structured Settlements:** In response to what CMS said was a question submitted electronically to the Resource Mailbox, CMS reminded RREs that they should familiarize themselves with the distinction between TPOC and ORM payments. An RRE had asked CMS how it should treat a structured settlement that involved two indemnification payments and had suggested that it intended to report each payment separately. CMS replied that if the two payment amounts are fixed at the time of settlement, they constitute a single TPOC settlement and do not fall into the ORM category simply because there is more than one payment to be made over time. Section 11.8 of the User Guide makes clear that an ORM settlement is one in which the RRE agrees to "reimburs[e] the provider of services (doctor, hospital, etc.) or injured parties for [future] specific medical procedures, treatment, services, or devices like a doctor's visit, surgery, ambulance transport, etc. These medicals are being paid by the RRE as they come in." In contrast, in a TPOC settlement, judgment, award or other payment, the RRE accepts a liquidated or fixed-sum payment obligation, whether paid in one lump sum or through the installments of a structured settlement.
- **Property Claim Conundrums:** In response to a caller inquiry, CMS advised that an RRE settling a property claim will not need to report a TPOC settlement if the claimant only alleges property damage,

even if the general release has the effect of releasing medical expenses. Neither the caller's question nor CMS's remarks were clear as to the type of policy (if any) in issue, and CMS's advice was too general to know if it would apply to both insurers and self-insureds. We have identified this issue because CMS advised on an earlier Town Hall call that self-insured RREs must report any TPOC settlement, regardless of the scope of the claimant's allegations, if the release is broad and there is no underlying policy to show that there was no intention to insure against medical expenses. On the December 9 call, it was not clear whether CMS was excluding self-insured entities from its answer or had reconsidered and revised its earlier guidance. If the former, CMS does not appear to have carefully considered the tension between these two divergent approaches.

- **ICD-9 Guidance:** In response to various inquiries, CMS noted (1) that an insurer that accepts responsibility for medical payments long after an injury occurred should use ICD-9 codes that are valid at the time of reporting rather than rely on possibly-outdated codes contained in medical records created contemporaneously with the injury, and (2) that in the previous teleconference, it had misspoken when it stated that 3- and 4-digit ICD-9 codes are never acceptable. Some valid ICD-9 codes are only 3 or 4 digits; however, when the proper ICD-9 code range consists of 5-digit codes, RREs may not truncate the code to the leading digits. RREs should consult the table of valid codes if in doubt.
- **ICD-9 Computer-Based Training:** CMS announced that it will make three computer-based training courses on proper reporting of ICD-9 codes available to the public. These courses do not yet appear on the CMS Section 111 Web site.
- **Document Retention:** In response to an inquiry regarding how long RREs should retain documentation of reporting, CMS declined to give a specific answer or recommendation; however, CMS noted that RREs should take into account all statutory provisions that might apply should their reporting later be questioned. While explicitly disclaiming that it considered the False Claims Act to set a baseline, CMS noted that the Act has a statute of limitations of up to ten years.
- **Submission of Claimant's Incorrect Birth Date:** CMS clarified that an incorrect birth date will not cause an automatic error report if the other minimum personal claimant information is correct.
- **Total Permanent Disability Settlements:** CMS will be issuing a yet-to-be written Alert that offers guidance on whether and when periodic (non-wage replacement) payments for permanent disability must be reported.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held monthly by CMS, and we send periodic Alerts 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 Alert. You may also access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.

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