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Mandatory Insurer Reporting

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- Android 6.x (Chrome Browser Only)
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* Official support for the "latest" version of a newly released browser, among those noted above, will be added within 8 weeks of public release. Until then, the previous version will continue to be supported instead.

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Mandatory Insurer Reporting

April 24, 2019

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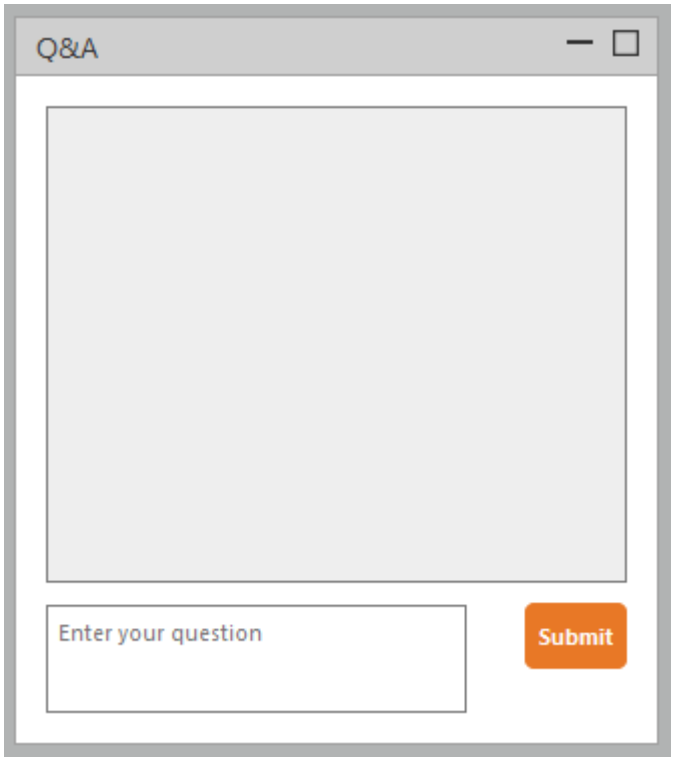

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Today’s presenter

Rafael Gonzalez
President Settlement Solutions

Frank Fairchok
Vice-President Settlement Solutions

Discussion topics

- Rules on Civil Monetary Penalties
- Medicare Secondary Payer Act
- Administrative Guidance
- Mandatory Insurer Reporting
- Reporting ORM, TPOC, and ICDs
- Disposition, Compliance, and Error Codes
- Civil Monetary Penalties
- Takeaways

RULES ON CIVIL MONETARY PENALTIES

Rules on civil monetary penalties

- In December 2018, CMS announced it will move forward with a **Notice of Proposed Rulemaking (NPRM) on Civil Monetary Penalties (CMPs) and Medicare Secondary Payer Requirements**

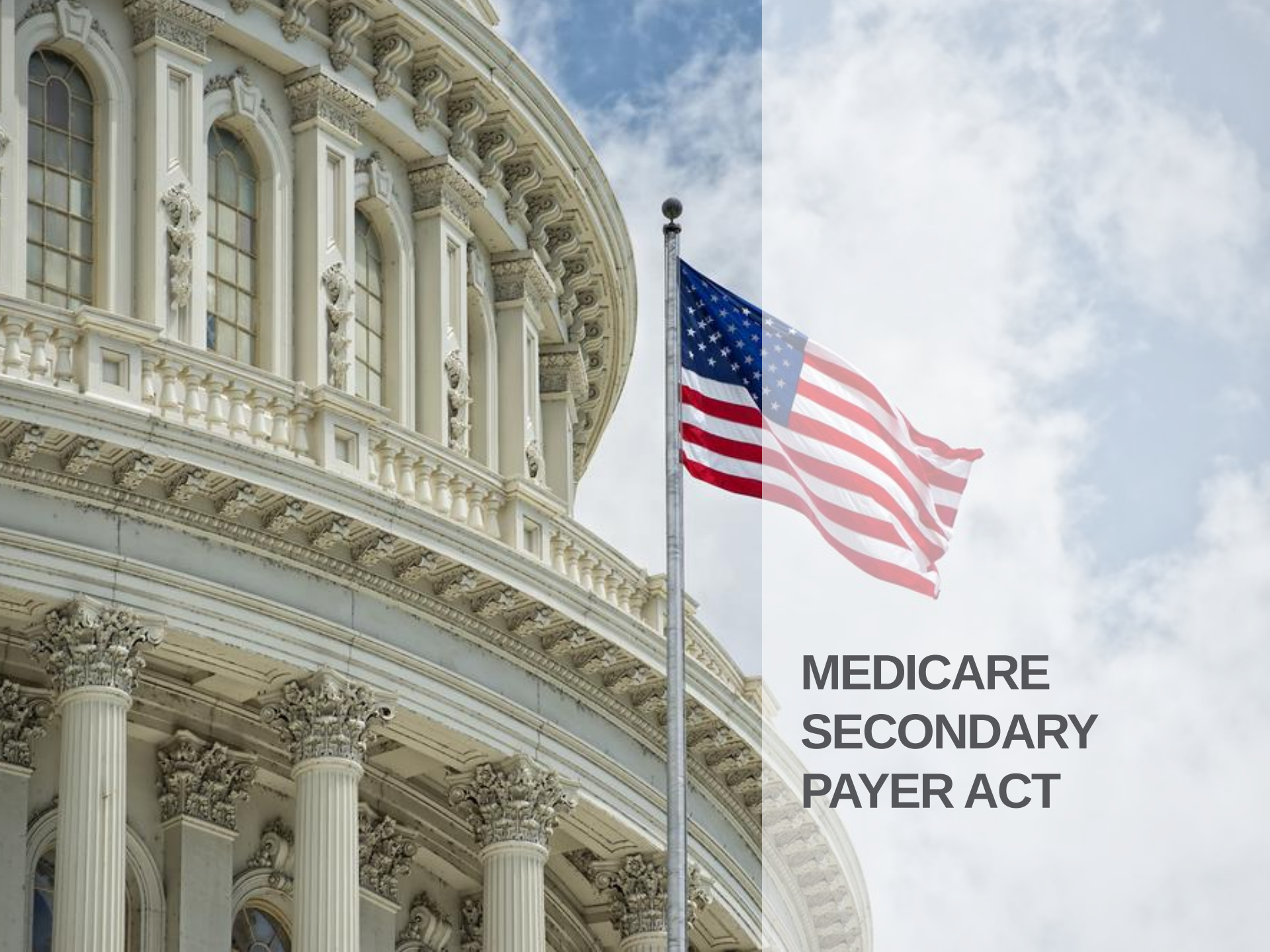
- The **Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act)** requires CMS to establish criteria and practices to impose CMPs

- This is a “significant” priority; the NPRM will be issued by **September 2019**

- It is anticipated that the NPRM will include **safe harbors for Responsible Reporting Entities (RREs)**, which can evidence good faith efforts to properly and timely report mandatory information

RREs will likely be subject to CMPs when they have failed or made mistakes in doing the following:

- Register as an RRE
- Report an otherwise reportable claim
- Report Ongoing Responsibility for Medical (ORM)
- Report termination of ORM
- Report appropriate ICD code(s) related to the claim
- Report Total Payment Obligation to Claimant (TPOC)

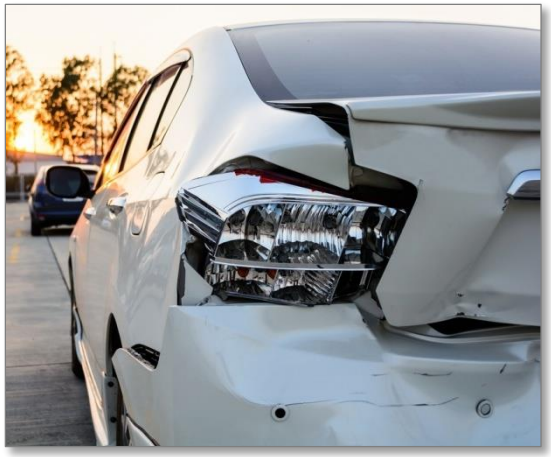


MEDICARE SECONDARY PAYER ACT

42 U.S.C. § 1395y(b) and 42 C.F.R. § Part 411 are the applicable statutory and regulatory provisions

- Medicare has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965.
- The liability insurance (including self-insurance) and no-fault insurance MSP provisions became effective December 5, 1980.
- The Act has been amended several times, including by the MMSEA Section 111 mandatory reporting requirements in 2007.

Pursuant to 42 C.F.R.



Liability Insurance
411.50

No-Fault Insurance
Part 411.50

Workers' Compensation Law or Plan
Part 411.40

Liability Insurance (includes self insurance)

- Coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction, which results in injury or illness to an individual or damage to property.
- Includes, but is not limited to:
  - Homeowners' liability insurance
  - Automobile liability insurance
  - Product liability insurance
  - Malpractice liability insurance
  - Uninsured motorist liability insurance
  - Underinsured motorist liability insurance

Pursuant to 42 C.F.R.

Liability Insurance
411.50

No-Fault Insurance
Part 411.50

Workers' Compensation Law or Plan
Part 411.40

No-Fault Insurance

- Pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who is at fault for causing the accident.
- Types include, but are not limited to:
  - Certain forms of automobile insurance
  - Certain homeowners' insurance
  - Commercial insurance plans
  - Medical Payments Coverage/Personal Injury Protection/Medical Expense Coverage

Pursuant to 42 C.F.R.

Liability Insurance
411.50

No-Fault Insurance
Part 411.50

Workers' Compensation Law or Plan
Part 411.40

Workers' Compensation Law or Plan

- A law or program administered by a State (defined to include commonwealths, territories, and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses.

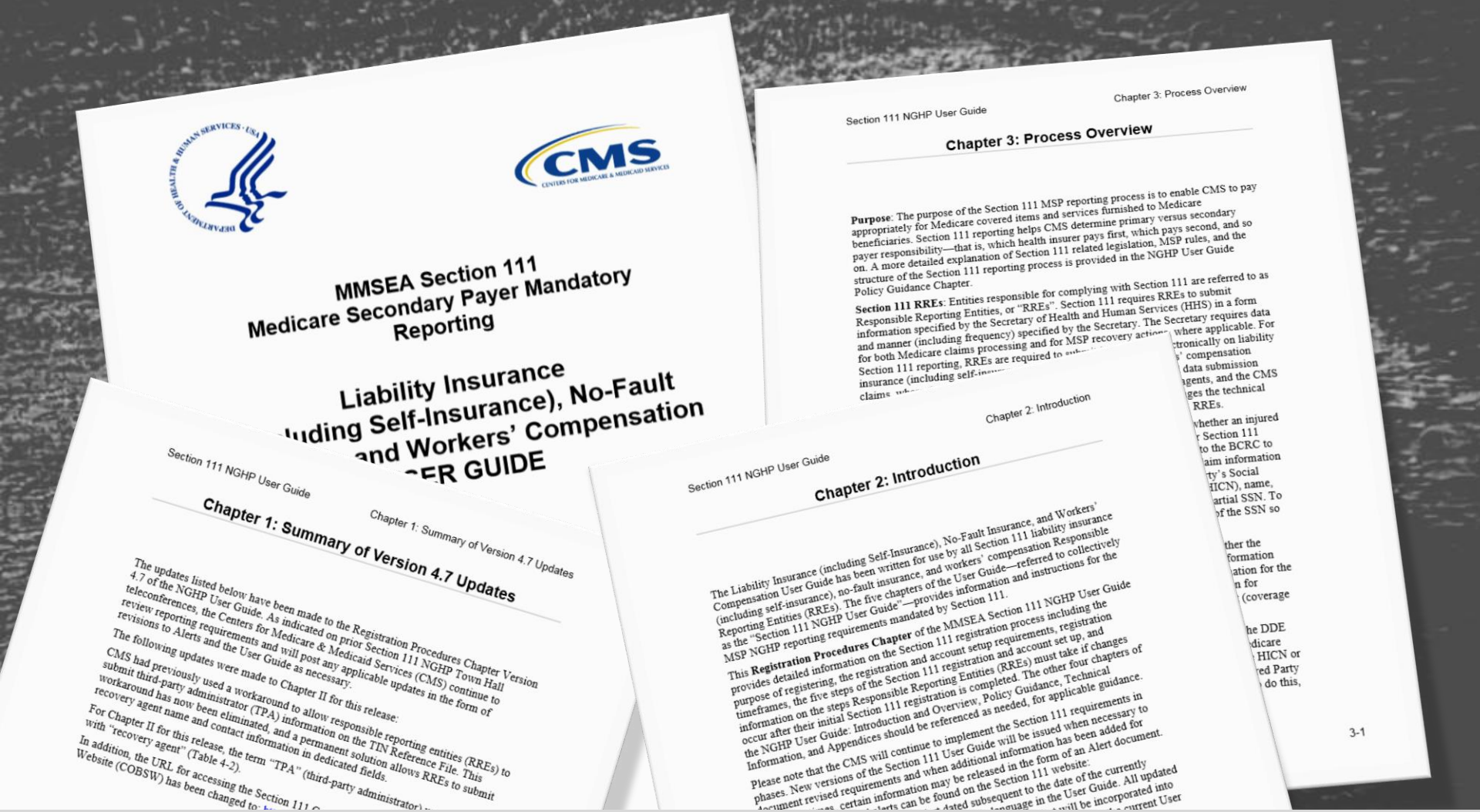
- Includes a similar compensation plan established by an employer that is funded by such employer directly, or indirectly through an insurer, to provide compensation to a worker of such employer for a work-related injury or illness.

ADMINISTRATIVE GUIDANCE

The NGHP User Guide

- Primary source for Section 111 reporting requirements

- Documents the Medicare Secondary Payer (MSP) Non-Group Health Plan (NGHP) reporting requirements mandated by Section 111 of the Medicare Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173)



The NGHP User Guide is made up of five chapters:

- Chapter 1- Introduction and Overview
- Chapter 2- Registration Procedures
- Chapter 3- Policy Guidance
- Chapter 4- Technical Information, and
- Chapter 5- Appendices

MANDATORY INSURER REPORTING

WHO MUST REPORT

- An applicable plan
- The term “applicable plan” means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:
  - (i) Liability insurance (including self-insurance)
  - (ii) No-fault insurance
  - (iii) Workers' compensation laws or plans
- See 42 U.S.C. 1395y(b)(8)(F)

WHAT MUST BE REPORTED

- The identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue
- Such other information specified by the Secretary of Health and Human Services (HHS) to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim
- Data elements determined by the Secretary

WHEN / HOW REPORTING MUST BE DONE

- In a form and manner, including frequency, specified by the Secretary
- Information shall be submitted within a time specified by the Secretary after the claim is addressed/resolved (through a settlement, judgment, award, or other payment, regardless of whether or not there is a determination or admission of liability)
- Submissions will be in an electronic format

PURPOSE

- To enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries
- Helps CMS determine primary versus secondary payer responsibility

Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities (RREs)

- The Secretary requires data for both Medicare claims processing and for MSP recovery actions
- Data submission process takes place between the RREs, or their designated reporting agents, and the CMS Benefits Coordination & Recovery Center (BCRC)

CMS allows RREs to submit a query to the BCRC to determine the Medicare status of the injured party prior to submitting claim information for Section 111 reporting

The query record must contain the injured party's

- Social Security Number (SSN) or Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)
- Name
- Date of birth
- Gender

Note: When submitting a SSN, RREs may enter a partial SSN (the last 5 digits of the SSN)

REPORTING ORM, TPOC AND ICD

ONGOING RESPONSIBILITY FOR MEDICAL (ORM)

- Refers to the RRE's responsibility to pay for the injured party's (Medicare beneficiary's) medicals associated with the claim
- Often applies to no-fault and workers' compensation claims - may occur with liability insurance (including self-insurance)
- The trigger for reporting ORM is the assumption of ORM by the RRE
  - When the RRE has made a determination to assume responsibility for ORM, or is required to assume ORM
  - Not when (or after) the first payment for medicals has been made
- Medical payments do not have to be paid for ORM reporting to be required

REPORTING ORM

- Liability, No-fault, and Workers Compensation ORM that existed or exists on or after January 1, 2010 must be reported
- Workers' compensation ORM claims are excluded from reporting indefinitely if they meet *ALL* of the following criteria:
  - The claim is for "medicals only"
  - The associated "lost time" is no more than the number of days permitted by the applicable workers' compensation law for "medicals only" (or seven calendar days if applicable law has no such limit)
  - All payments have been made directly to the medical provider
  - Total payment for medicals does not exceed $750.00

REPORTING ORM TERMINIATION

- The RRE should report the date that ORM terminated and should NOT delete the record
- The termination date should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment
- Termination date should only be submitted if one of the following criteria has been met:
  - Where there is no practical likelihood of associated future medical treatment
  - Where the insurer's responsibility for ORM has been terminated under applicable state law
  - ORM associated with the insurance contract is terminated

TOTAL PAYMENT OBLIGATION TO CLAIMANT (TPOC)

- Refers to the dollar amount of a settlement, judgment, award, or other payment
- Generally reflects a “one-time” or “lump sum” settlement, judgment, award, or other payment intended to resolve a claim
- TPOC Date is the date the payment obligation was established:
  - The date the obligation is signed if there is a written agreement
  - If court approval is required, it is the date of court approval
  - If there is no written agreement, it is the date payment is issued

REPORTING ICD DIAGNOSIS CODES

- Where ORM is reported, RREs are to submit ICD codes for all alleged injuries/illnesses for which the RRE has assumed ORM
- When there is a TPOC**,** RREs are to submit ICD codes to reflect all the alleged illnesses/injuries claimed and/or released
- If an ICD diagnosis code previously submitted no longer applies to the claim, RREs may send an update transaction without that particular ICD diagnosis code, but must include all ICD diagnosis codes that still apply
- CMS encourages RREs to supply as many valid ICD diagnosis codes as possible for accurate coordination of benefits

DISPOSITION, COMPLIANCE, AND ERROR CODES

Disposition codes

‘01’ DISPOSITION

- Accepted by the BCRC as claims where the **RRE has indicated ORM**.
- The claim record does not need to be reported again until ORM ends.

‘02’ DISPOSITION CODE

- Accepted by the BCRC as claims where the injured party is a Medicare beneficiary during the time between the CMS Date of Incident
- TPOC Date and the **RRE has indicated No ORM**

‘03’ DISPOSITION CODE

- Found to be error-free and the injured party submitted was matched to a Medicare beneficiary
- **Medicare coverage dates are outside date of incident**
- **TPOC Date or the date ORM ended**

Compliance Codes/Flags provide the RRE notice that the submitted record was not in compliance with particular Section 111 reporting requirements

‘01’ COMPLIANCE FLAG

Indicates that the submitted **TPOC Date(s)** was not sent in time

‘02’ COMPLIANCE FLAG

Is a warning that **ICD-10-CM diagnosis codes are required** on all claim reports with a DOI of October 1, 2015 and subsequent dates

‘03’ COMPLIANCE FLAG

Happens if **ORM Termination Date** was not sent in time

Error codes

- When an error code is received related to a Claim Input File Detail Record and/or a TIN Reference File Detail Record, the corrected record(s) needs to be resubmitted on the next Quarterly Claim Input File submission.
- Error codes are prefaced with two letters followed by two numbers.

Error code begins with	Indicates
C	the error occurred in the Claim Input File
T	the error occurred in the TIN Reference File

Error Codes Description

Error code	Description
CB	Claim Beneficiary Information (CB01-CB11)
CC	Claim Claimant Information (CC01-CC74)
CI	Claim Injury Information (CI01-CI31)
CJ	Claim ORM or TPOC Information (CJ01-CJ07)
CP	Claim Plan Information (CP01-CP12)
CR	Claim Representative Information (CR01-CR94)
CS	Claim Self-Insurance Information (CS01-CS07)
CT	Claim Auxiliary TPOC Information (CT01-CT33)
SP	Errors returned by CWF (SP31-SP50)
TN	TIN Reference File Errors (TN01-TN36, TN99)

CIVIL MONETARY PENALTIES

POTENTIAL CMP IN EARLY PROCESS

- Failure to register and set up account for each RRE
- Failure to appoint individuals who will be the RRE's Authorized Representative, Account Manager and Account Designees
- Failure to identify reporting agent, if one is used
- Failure to indicate how claim files will be submitted
- Failure to communicate which file transmission method will be used

POTENTIAL CMP TEHNICAL DIFFICULTIES

- Failure to review file specifications, have correct software to produce Section 111 files, and comply with quarterly submission process
- Failure to confirm information on annual profile report is correct/deactivation of RRE ID
- Failure to monitor file processing status and update passwords every 60 days

POTENTIAL CMP THROUGHOUT PROCESS

- Failure to correct discrepancies discovered in and alerted to in compliance flags
- Failure to correct mistakes discovered in and alerted to in 356 possible error codes dealing with:
  - Claim Information
  - Claimant Information
  - Injury Information
  - ORM or TPOC Information
  - Plan Information
  - Representative Information

Takeaways

- CMS announced it will issue NPRM on CMPs and MSP requirements in September 2019.
- It is anticipated that the NPRM will include safe harbors for RREs' good faith efforts to properly and timely report mandatory information.
- However, RREs will likely be subject to CMPs in scenarios where RREs have failed to or made mistakes in timely and accurately reporting mandatory information.

Thank you!

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