Responsible Reporting
Under MMSEA - SECTION 111

Risk Management Write-Offs and “Self-Insurance” Payments
MEDICARE SECONDARY PAYER MANDATORY REPORTING PROVISIONS IN SECTION 111 OF THE MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007

1. Overview.

2. Professional liability and general liability obligations, whether insured or self-insured.

3. Risk Management “write-offs” and broad “payment” obligations.

4. Important web-site and checklist information.
The purpose of Section 111 reporting is to enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries and determine primary vs. secondary payer responsibility.

Section 111 applies not only to Group Health Plans. It also applies to:

- Liability insurance, including self-insurance.
- No-fault insurance, and
- Workers’ compensation.
ENFORCEMENT

Non-compliance with Section 111 reporting will result in a penalty of $1,000 for each day of noncompliance with respect to each Medicare beneficiary.
PROFESSIONAL LIABILITY

All claims are reportable where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals.

Reports must be made, regardless of whether or not there is an admission or determination of liability.

The information reported includes: claimant name, DOB, SS#, gender, claimant’s attorney name and contact information, as well as information regarding the medical condition(s) for which payment is made.
CMS is not bound by any allocation made by the parties, even where a court has approved such an allocation. CMS does not normally defer to an allocation made through a jury verdict.

RREs generally are not required to report liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the date of incident as defined by CMS was prior to December 5, 1980.
Responsible Reporting Entities (RREs) are required to report Total Payment Obligation to the Claimant (TPOC) amounts from October 1, 2011 and subsequent.

The TPOC generally reflects a “one-time” or “lump sum” settlement, judgment, award or other payment intended to resolve a liability claim.

However, TPOCs can also reflect multiple payments, although this is uncommon with professional liability claims, unless there is a one-time annuity funding payment, followed by a lump sum payment reflecting the remainder of the total settlement.
TPOC THRESHOLDS
APPLIES TO BOTH PL AND GL

<table>
<thead>
<tr>
<th>Total TPOC Amount</th>
<th>TPOC Date On or After</th>
<th>Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>over $100,000</td>
<td>Oct. 1, 2011</td>
<td>Jan. 1, 2012</td>
</tr>
<tr>
<td>over $50,000</td>
<td>Apr. 1, 2012</td>
<td>Jul. 1, 2012</td>
</tr>
<tr>
<td>over $2,000</td>
<td>Oct. 1, 2013</td>
<td>Jan. 1, 2014</td>
</tr>
<tr>
<td>over $1,000</td>
<td>Oct. 1, 2014</td>
<td>Jan. 1, 2015</td>
</tr>
</tbody>
</table>
GENERAL LIABILITY

General liability claims also involve TPOC payments.

However, most GL policies include a “no-fault”, med/pay provision up to a certain dollar amount – the common med/pay provision for hospital general liability policies is $5,000.

If the patient’s injury falls under the GL policy and med/pay applies, this triggers an Ongoing Responsibility for Medicals (ORM) reporting, essentially reporting all of the personal, contact, and medical information required under TPOC reporting.

Once the med/pay limit has been reached, additional reporting is made in order to indicate that no further obligation for ORM remains and the claimant/patient should again be covered under Medicare.
ORM REPORTING REQUIREMENTS
APPLIES TO CLASSIC INSURANCE POLICIES AND ALSO TO SELF-INSURANCE

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Reportable ORM Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-Fault</td>
<td>Existed or exists on or after Jan. 1, 2010</td>
</tr>
<tr>
<td>Liability insurance</td>
<td>Existed or exists on or after Jan. 1, 2010</td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>Existed or exists on or after Jan. 1, 2010</td>
</tr>
</tbody>
</table>

NOTE: There is no threshold for ORM.
RISK MANAGEMENT ISSUES

For purposes of the Medicare Section 111 Reporting provisions, risk management write-offs or payments are considered liability self-insurance.

This is because payments made directly by a healthcare provider to a patient are not covered under your medical negligence liability policy. Therefore, if you make such payments, you are considered to be self-insured for those payments.

NOTE: This obligation does not apply solely to “brick and mortar” hospitals. CMS states the obligation applies to an entity “that engages in a business, trade, or profession”, including providers, physicians, and other suppliers of healthcare.
WRITE-OFFS BEFORE BILLING MEDICARE

When a provider knows they want to reduce a charge or write-off some portion of a charge BEFORE sending the bill to Medicare, they MUST submit a claim to Medicare reflecting the unreduced, permissible charges and showing the amount of the reduction or write-off as a payment.

In this situation, the provider does not need to report to CMS under Section 111, as long as there is no perceivable likelihood that the Medicare recipient will receive medical care from any other provider relating to the incident at issue.
WHAT CONSTITUTES A REPORTABLE EVENT FOR RISK MANAGEMENT?

Any Risk Management tool to lessen the probability of a liability claim against it and/or to facilitate/enhance customer good-will.

This includes:
- Reducing charges for items and/or services (medical bill “write-offs” that occur after the bill has been sent to Medicare) (See previous slide.)
- Providing any items of value – cash, gift card, etc.
If there is any evidence, or a reasonable expectation, that the patient has sought or may seek additional medical treatment from any healthcare provider as a consequence of the underlying incident, the provider shall report the write-off, payment, reimbursement or property of value (like a gift card), as a TPOC (Total Payment Obligation to the Claimant) from self-insurance.

However, if the value of the write-off or payment is less than the TPOC reporting threshold, it does not need to be reported.

See slide #8 for the TPOC reporting thresholds.
WHEN?

This obligation began with any write-off or payment made to a Medicare beneficiary on or after **October 1, 2011**.
BEFORE YOU BEGIN

Before you begin, determine:

- Individuals who will be the RRE’s Authorized Representative, Account Manager, and Account Designees.
- Whether reporting agents will be used.
- How claims will be submitted – one file for the RRE or separate files based on subsidiaries, etc.
- Which file transmission method you will use – I highly recommend the Direct Data Entry if the only thing you are reporting is Risk Management related.
REPORTING AGENTS

The RRE **must** register for reporting and file submission with the BCRC.

However, the RRE **may** designate an agent. The agent **may not** register on behalf of an RRE.

An RRE **may not** shift its responsibility to report under Section 111 to an agent, **by contract or otherwise**.

The RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of the data submitted.
REGISTRATION

Complete the New Registration and Account Setup for each RRE ID needed on the Section 111 COBSW.

You will receive your profile report via e-mail within 10 business days after registration is complete, indicating the registration and account setup were accepted.

The RRE’s Authorized Representative must approve the account setup, by physically signing the profile report, which includes a Data use Agreement, and returning it to the BCRC within 30 days.
NEXT STEPS

Once registration has been completed, you will be assigned an EDI Representative, who will be able to answer questions.

You will be assigned a date for your quarterly reporting.

You will be able to submit a Query File once per calendar month, to determine which patients/claimants are Medicare recipients, if you are uncertain of their status.

Be sure to establish internal reporting procedures, so all “claims” are captured and reported appropriately.
WHERE TO GO AND WHAT TO DO

Go to http://www.Section111.cms.hhs.gov.
From there, you will be able to:

Obtain a copy of the Section 111 NGHP User Guide.

Complete the registration process.

Obtain RRE IDs, Login IDs, and assign users for Section 111 RRE accounts.

Submit claim information via the Direct Data Entry option.

Utilize an online query function, the Beneficiary Lookup, to determine the Medicare status of an injured party.

And more!
HOW TO ASK CMS QUESTIONS ABOUT SECTION 111 REPORTING

Once you are registered, your assigned EDI Representative will be able to respond to many types of questions.

Be sure to visit the Section 111 page on the CMS Web Site at: [http://go.cms.gov/mirnghp](http://go.cms.gov/mirnghp) for updated information on reporting requirements, including updates for the Section 111 NGHP User Guide. Also, sign up for e-mail updates made to the Web page.

To submit a policy-related comment or inquiry to CMS regarding Section 111 Mandatory Reporting, you can use the following e-mail link: [PL110-173SEC111-comments@cms.hhs.gov](mailto:PL110-173SEC111-comments@cms.hhs.gov).
PLEASE CONSIDER

You can always discuss Risk Management write-offs with Medical Mutual’s Claims Department. However, remember that liability insurance is not “no-fault” insurance and Medical Mutual’s decision on whether or not to make a payment to any claimant will be based on a review of the medicine, including negligence and causation.

If Medical Mutual agrees to make such a payment to a claimant, it is possible that the involved physician will need to be reported to the National Practitioner Data Bank. This can be an important consideration.
QUESTIONS?