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ALERT

Section 111 Bulletin: June 10th CMS Teleconference Draws Many Questions on New Direct Data Entry Reporting Option

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On June 10, 2010, the Centers for Medicare & Medicaid Services (CMS) held its monthly "town hall" teleconference for Non-Group Health Plans (NGHPs) focusing on technical issues related to implementation of the mandatory insurer reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Picking up from its last policy-focused teleconference on May 27, CMS announced that the four new Alerts previewed on that call have now been posted to the Agency's Section 111 website, which was recently rearranged to accommodate the increasing volume of Agency guidance. As we discussed in our last Bulletin, these Alerts address: Periodic Payments, Clinical Trials, and Risk Management Write-offs, and fix an unintended error in Appendix G to the Alert dated February 24, 2010, and entitled *Who Must Report*.

CMS also announced that it is still working on an Alert that will define and address lump sum indemnity payments, not to be confused with the issues addressed in the periodic payments guidance referenced above.

Other topics discussed during yesterday's teleconference include:

Direct Data Entry: Responding to numerous questions from callers, CMS representatives elaborated on the new direct data entry (DDE) reporting option, announced in a CMS Alert dated May 25, 2010, which will allow Responsible Reporting Entities (RREs) with fewer than 500 claims per year to manually enter and report claims information online through the Coordination of Benefits Contractor (COBC) website rather than electronically in flat, text, ASCII file format through

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

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software available from the COBC (HTTPS, SFTP, and Connect:Direct). CMS promised an online user guide, computer-based training modules and quick help links to assist RREs in using this alternative reporting system. CMS also clarified that DDE cannot be used to run a first-step, informational query prior to reporting a claim, although the DDE process will check the Medicare status of the injured party when a claim is submitted after settlement, judgment or other form of payment. If a claim is rejected because the claimant is not identified by the Medicare database as a Medicare beneficiary, that failed submission will count as one of the RRE's 500 allotted claims submissions. In response to a caller question, CMS acknowledged that it had not considered how an RRE using the DDE reporting process might query a claimant who is not yet Medicare eligible but for whom the RRE retains ongoing responsibility to pay medical expenses (ORM). Because periodic querying of such individuals could potentially consume a large portion of an RRE's 500 submission allotment if that RRE regularly assumes ORM liability, CMS was encouraged to resolve this issue.

CMS then clarified that RREs electing to use the DDE option could not make use of the regular querying process for determining a claimant's Medicare status. CMS reminded listeners, by way of example, that RREs with specialty business lines that are not integrated with the rest of their business (and thus we assume acquire a separate RRE ID number) may choose to report specialty claims payments through the DDE option even though they report the claims payments of other lines through the standard Section 111 reporting process. CMS also explained that RREs will be able to switch from DDE to standard reporting, and vice versa, if the option they initially choose does not work well for their claims volume, but the Agency made it clear that RREs will not be allowed to switch back and forth on a frequent or ongoing basis.

ORM Termination and Deletion: CMS stated that if ORM coverage were reported in error, an RRE could submit a delete file. If, however, there were simply no medical bills or claims ever submitted under an ORM settlement, the RRE could not delete the coverage file but instead must submit a file update and supply an ORM termination date with the next quarterly file. CMS noted that the lack of claims being submitted by a claimant to the insurer is not conclusive evidence that no medical treatment has been provided; rather, the claimant's bills may have been submitted directly by providers to Medicare, in which case Medicare would be interested in recovering its payments from the insurer that accepted ORM responsibility.

Querying: CMS clarified that for claim input files submitted with both a Health Insurance Claim Number (HICN) and a Social Security Number (SSN), if the querying system does not find an exact match for the HICN, it will make the assumption that the input file has incorrect information and will not go on to query the SSN.

Plaintiffs' Counsel: CMS explained that plaintiffs' attorneys do not have the ability to query their clients' SSNs to determine Medicare eligibility as only RREs have querying authority. As plaintiffs' counsel are among the parties liable to CMS under MSP law for reimbursement of conditional payments, this explanation and the apparent inflexibility of the reporting system have surprised counsel on both sides of a liability claim who believe that claimants' counsel may be able to facilitate the early sharing of that eligibility information with insurers' counsel if they have the ability to definitively establish their clients' Medicare status.

Error Codes: On a more technical note, CMS discussed several additional error codes that are not included in the current version of the User Guide but will be added to the revised version, due out around July 1, 2010. Please contact the Wiley Rein Section 111 Team for more specific information.

Mass Torts Working Group: As stated in our June 1 Bulletin, CMS announced during the May 27 call that it intended to set a date for a conference call on mass torts reporting issues within "the next few weeks". Yesterday, CMS responded more cautiously to a caller inquiring about the status of the meeting by merely acknowledging that a date for the call has not yet been set, but they hoped to hold it in the near future.

The next NGHP town hall teleconference, which will address policy issues related to Section 111 implementation, is scheduled for June 30, 2010.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences typically held twice a month 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 June 10, 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.