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ALERT

Section 111 Bulletin: Further Delay Of Section 111 Mandatory Insurer Reporting Remains A Real Possibility

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During the September 21, 2011 Town Hall teleconference held by the Centers for Medicare & Medicaid Services (CMS), callers asked CMS if it would again be delaying the implementation of mandatory insurer reporting for certain Non-Group Health Plans (NGHPs) under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. CMS acknowledged that multiple requests have been made for extensions of both (i) the October 1, 2011 date for property-casualty insurers' collection of information about settlements, judgments and awards that result in these insurers making a TPOC (total payment obligation to claimant) payment to a Medicare beneficiary, and (ii) the January 1, 2012 date for commencement of mandatory insurer reporting of such payments. Some listeners were surprised to learn that the requests remain under consideration at CMS as October 1 is less than two weeks away. Insurers are anxious for certainty and predictability, having ramped up and then received extensions on three earlier occasions due to CMS' failure to resolve important open issues about the scope of NGHPs Section 111 obligations. [See previous Wiley Rein Bulletins published on 4/20/09, 5/29/09, 2/18/10 and 11/15/10.] Reporting under Section 111 originally was to have begun in the fourth quarter of 2009 for all insurers. Today, only insurers assuming ongoing responsibility for the medical expenses of a Medicare beneficiary (ORM liability) must report.

Even if CMS again delays the implementation of reporting, it may not necessarily push back the October 1, 2011 date, so collection of information about post-October 1, 2011 settlements may still be required. CMS took this path last fall when it delayed the reporting of

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ORM payments, which then did not become reportable until the first quarter of 2011 for liability incurred on or after January 1, 2010. Equally important, because any delay in Section 111 reporting would not affect a property-casualty insurer's obligation under the Medicare Secondary Payer (MSP) statute to reimburse CMS for its conditional payment of a claimant's medical expenses, it behooves insurers to incorporate appropriate safeguards in all settlements.

The Town Hall teleconference also touched on many technical reporting issues and a handful of broader themes related to insurer obligations under Section 111. A representative from CMS's Electronic Data Interchange (EDI) contractor reminded teleconference participants that Responsible Reporting Entities (RREs) are obligated to correct and re-submit Claim Input Files that are returned with errors, noting that submitting a Claim Input File with errors will be considered "as noncompliant as not submitting a file at all." CMS promised that the MSPRC will be following up with RREs that are the "biggest offenders" in this area.

To address ongoing industry concerns about the ability of RREs to collect Health Insurance Claim Numbers (HICNs) and Social Security Numbers (SSNs), CMS announced that it is currently conducting internal studies to determine whether use of partial HICNs and SSNs and other Medicare beneficiary matching criteria could be used by RREs in submitting Claim Input Files, rather than requiring RREs to submit full HICNs and SSNs. CMS is trying to determine whether this practice would result in widespread false positives (and corresponding erroneous claim denials) or alternatively, whether it could present a workable solution to claimant refusal to share SSNs and HICNs.

The teleconference also focused on the required reporting of ICD-9 codes. Representatives from the EDI contractor acknowledged that there have been widespread complaints about CMS denying Medicare beneficiary claims for medical services unrelated to the bodily injuries alleged or released in liability settlements. Representatives stated that CMS is investigating these complaints, but emphasized that RREs should only report ICD-9 codes that describe the illness, injury or condtition compensated or released by the settlement or judgment. Although medical files from doctors and hospitals can be a reliable source of ICD-9 codes, medical providers may record ancillary codes related to preexisting medical condition, such as hypertension. RREs are cautioned to carefully verify that all codes reported are in fact related to the bodily injuries or emotional distress compensated by the RRE, and are the most specific codes available, rather than a broad general code that may result in erroneous denials of future medical claims. This guidance is straightforward in theory, but practically difficult to implement given the overwhelming number of ICD-9 codes, most claim handlers' lack of familiarity with and expertise regarding the organization of the ICD-9 database and the use of codes in medical diagnosis, as well as an insurer's lack of access to medical records that may be necessary to code correctly. In large part, it appears CMS is attempting to shift to insurers responsibility for the many deficiencies in the ICD-9 code system and for errors in medical record keeping.

The Wiley Rein Section 111 Team will continue to monitor CMS's consideration of requests for a delay in the implementation of mandatory insurer reporting. Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held most months 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 also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.