

## MMSEA, Section 111 Frequently Asked Questions

### What is MMSEA Section 111?

Section 111 of The Medicare, Medicaid and SCHIP Extension Act of 2007 institutes mandatory reporting requirements for group health, liability (including self insurance), no-fault insurers and workers' compensation insurers/plans. Insurers are to report certain prescribed claims information in regard to Medicare beneficiaries to the Secretary of Health and Human Services.

### What are the major responsibilities for insurance carriers and other primary payers?

Determine Medicare entitlement status of the claimant.  
Submit entitled claims to Medicare on a quarterly basis.

### What are the penalties for non-compliance?

Failure to comply may result in a \$1,000.00 fine per day, per claim, and possible civil penalties. Fines can go into effect as early as January 1, 2011.

### Who is Responsible for Reporting?

The Responsible Reporting Entity (RRE) would be the insurer or self insured plan, please refer to the July 12, 2010 "User Guide" for definitions of RRE, insurer and self insured plan). This document can be viewed at CMS dedicated MMSEA web page <https://www.cms.hhs.gov/MandatoryInsRep/>

**Third-party administrators (TPA) are never RREs.** CMS has confirmed that TPAs of any type have no reporting responsibilities for liability insurance (including self-insurance), no-fault insurance or workers' compensation. (Unless the TPA is a Self Insured Entity of its own)

### What are the current Implementation Timelines?

Registration Period	May 1, 2009- December 30, 2010
Test and Production Query Files Accepted	July 1, 2009
Claim Input File Testing	Q 3 and 4 2011
WC ORM/TPOC Live Production Files Due	Q 1 2011
Liability ORM/No Fault ORM Files Due	Q 1 2011
Liability TPOC Files Due	Q 1 2012

### Can an RRE assign MMSEA Reporting Requirements to their TPA or a vendor?

CMS will allow the use of agents for MMSEA Section 111 reporting. However, if an agent is designated, the RRE remains responsible and accountable for compliance. Where an entity reports on behalf of another entity required to report, it is doing so as an agent of the second entity. Therefore, if a TPA will report on behalf of the insurance carrier, they would be considered an agent. If that TPA who has been designated to report on behalf of an RRE would like to use an agent, CMS will allow this and has set up their system accordingly.

### How will the RRE submit data to CMS?

The data submission process will take place electronically with the Coordination of Benefits Contractor (COBC).

### When do RREs need to register?

The registration Period is 5/1/09 – 12/30/10. RREs must register on their own behalf. If an agent will be used for reporting they should be designated at the time of registration. Please review Section 8 Account Registration and Set Up Process in the NGHP User Guide Version 3.1 July 12, 2010

### How will the Registration Process work?

At registration an **Authorized Representative** (AR) will be assigned. This should be a person who can legally bind the RRE to the requirements of MMSEA Section 111 reporting. This person will not be a user on the COBC secure web site, but will sign the data use agreement as well as designate and sign off on the **Account Manager** (AM). At the time of registration, the AR will decide how many RRE ID numbers are needed (there is no limit to the number of RRE IDs which can be set up). The number of IDs needed will depend on how the RRE wants to set up the reporting process. If the RRE works with multiple TPAs and would like each individual TPA to be responsible for reporting they will register for an RRE ID for each TPA. If an RRE has 2 different claims systems (i.e. WC versus Liability) they should set up two RRE IDs so claims can be reported separately. If an RRE has several subsidiaries and wants to report those cases separately, they will register for multiple RRE IDs. Each RRE ID can send one data submission file per quarter and one query file per month. The **Account Manager** (AM) will manage the day to day processing of the data transfer. The AM can be an employee of the RRE, a representative of the TPA or a representative of an agent. **Account Designees** (AD) are people who will be designated by the AM and will have the ability to upload, monitor and transfer files. If an RRE wants to use their TPA to report, but the TPA wants to contract out to an agent to handle the reporting, CMS will allow this. The RRE will have an AR from their company designated. The TPA can be marked as the AM and the TPA will then name the agent they would like to use for reporting purposes. The TPA can then designate people from the agent to be ADs.

### How will RREs verify whether a claimant is a Medicare beneficiary for MMSEA Section 111 reporting purposes?

CMS has confirmed that they will provide a Query function to Non-GHP RREs to verify Medicare beneficiary status. The Query function will be an electronic file exchange process:

- **Each RRE ID can submit one query file per month.** The COBC will return a response file to the entity which submitted the file (either the agent or the RRE).
- The information required for the Query will be SSN (or HICN), name, DOB and gender.
- The SSN is **REQUIRED** to run the Query. If there is a match with the above data, CMS will send back the HICN for that person.
- Query Response files will be returned within 14 days.
- If the CMS response file indicates there is no match that does not mean the claimant is not on Medicare. It just means there was no match based on the data provided (some data could be incorrect). The Query function is only as good as the data submitted.
- Social Security entitlement information **WILL NOT** be provided through the Query.
- The Query function should be used to filter claims to determine which cases should be reported as CMS only wants data on Medicare beneficiaries. CMS discourages “data dumping” (sending all claims without verifying Medicare status) and recommends that the Query function is utilized.
- CMS confirmed that it is acceptable to report ALL cases where the claimant is age 65 or older rather than doing a Query on these files. This will not be considered “data dumping.”



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway , Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **Will CMS advise the RRE if a SSN is incorrect?**

CMS indicated that the Query function will not identify if a SSN is incorrect. CMS has made the decision that the only information that will be returned on the Query file is the claimant's Medicare status. Verification of Social Security status through the Social Security Administration will still be required for MSP compliance purposes to determine the need for an MSA allocation since CMS has no plans to offer any information other than Medicare entitlement status.

### **When will the data transfer process be tested?**

The voluntary testing Period ends 12/31/2010. However if testing is completed before January 2010, RRE's can begin submitting live data files in the last quarter of 2010. All users associated with the RRE's account will be able to submit test files. The Query function will also be tested at the same time as the data transfer. CMS encourages all RREs to register and begin testing within the above noted timeframes. Live data is not required for testing- the RRE should still go through the testing process even if they do not yet have all the required data. The mandatory testing period begins January 1, 2010 through December, 31, 2010.

### **When will an RRE be required to submit live data to CMS?**

Live Reporting will begin in the first quarter of 2011 and each RRE will receive a designated quarterly submission timeframe assigned by the COBC.

### **What if multiple RREs are involved in the same case?**

Multiple RREs involved in the same settlement are all responsible for their own reporting under each individual policy. This would apply when there is a workers' compensation (WC) case which involves a WC carrier as well as a third party liability carrier. This would also apply when there is no-fault and liability coverage on a case. The reporting process is claimant specific as well as policy specific.

### **Which claims need to be reported?**

- All Workers Compensation claims involving a Medicare beneficiary where a settlement, judgment, award or other payment is made as of October 1, 2010 or later. All Liability claims involving a settlement, judgment, award or other payment are to be reported in the first quarter of 2012.
- All claims involving a Medicare beneficiary where ongoing responsibility for medical payments exists as of January 1, 2010 regardless of the date of the initial acceptance of payment responsibility.

### **What is a total obligation to the claimant or TPOC?**

Then Total Obligation to the Claimant or TPOC refers to the dollar amount of a settlement, judgment, award or other payment in addition to/apart from ORM. A TPOC generally reflects a "one time" or "lump sum" intended to resolve or partially resolve a claim. It is the dollar amount of the TPOC to or on behalf of the injured party in connection with the settlement, judgment, award or other payment. Individual reimbursements paid for the specific medical claims submitted to a RRE, paid due to the RRE's ORM for the claim DO NOT constitute separate TPOC amounts.



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway, Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **What is the trigger for reporting ongoing responsibilities for medicals ORM?**

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 otherwise required to assume ORM-not when or after the first payment for medicals under ORM has actually been made. CMS has confirmed that medical payments do not actually have to be paid on the claim for ORM to be required.

### **What if a claimant is not a Medicare beneficiary at the time ongoing responsibility for medicals (ORM) is assumed? Does that claim need to be reported?**

If an individual is not a Medicare beneficiary at the time responsibility for ongoing medicals is assumed, the RRE must monitor the status of that individual and report the case when the individual becomes a Medicare beneficiary. This would be done by continuing to Query the claimant on the RREs monthly Query file.

**Exception:** *Responsibility for ongoing medicals has terminated before individual becomes a Medicare beneficiary.*

### **Does the Date of Injury affect which cases need to be reported?**

The date of incident does not affect the RRE's reporting responsibilities for worker's compensation. Since the program's inception, Medicare has been secondary to worker's compensation. Liability and no-fault insurance MSP provisions went into effect December 5, 1980. CMS has determined as a matter of policy that it will not recover under the MSP provisions with respect to liability insurance or no-fault settlements, judgments, or awards where the date of incident as defined by CMS was prior to December 5, 1980 unless the claim involves exposure continuing on or after December 5, 1980.

### **What about claims that are closed and/or inactive?**

For ORM assumed prior to January 1, 2010, if the claim was actively closed or removed from current claims records prior to January 1, 2010, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to January 1, 2010. If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original DOI (as defined by CMS). **What does this mean...?** If a claim is closed and/or inactive prior to 1/1/2010, the RRE does NOT need to report it unless a subsequent payment is made causing the file to be reopened.

### What about reporting thresholds?

CMS issued an alert dated 3/20/2009:

[http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert\\_UserGuideSupp\\_NGHP.pdf](http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSupp_NGHP.pdf)

For **workers' compensation** ORM, claims meeting the **all** of following criteria are excluded from reporting:

- a. "Medicals only."
- b. "Lost time" of no more than 7 calendar days.
- c. All payment(s) has/have been made directly to the medical provider.
  
- d. Total payment does not exceed \$750.00.

For **liability insurance (including self-insurance) and workers' compensation TPOCs**, the following dollar thresholds apply:

- a. For TPOCs dates of After 10/1/2010, TPOC amounts of **\$0.00 - \$5,000.00** are exempt from reporting except.
  - b. For TPOCs dates of January 1, 2011, through December 31, 2011, TPOC amounts of **\$0.00 - \$5,000.00** are exempt from reporting.
  - c. For TPOCs dates of January 1, 2012 through December 31, 2012, TPOC amounts of **\$0.00 - \$2000.00** are exempt from reporting.
1. For no-fault insurance there is no low dollar threshold for reporting the assumption of ORM or for reporting the TPOC (i.e. a lump sum settlement amount).
  2. For liability insurance there is no low dollar threshold for reporting the assumption of ORM.
  3. For liability insurance and worker's compensation TPOC's the following requirements and dollar amounts apply:  
RRE's are not required to adhere to the reporting TPOC thresholds for claims reported with ORM.

Where there are multiple TPOC's associated with the same claim record, the combined, cumulative TPOC amounts must be considered in determine whether or not the reporting threshold is met.

The threshold dollar and date ranges apply to the date when the threshold is met (the most recent TPOC date). The COBC will use the most recent TPOC date supplied on the claim report when checking the threshold ranges. Timeliness of reports will be determined based upon the applicable date for the TPOC which caused the threshold to be met (the last and or most recent TPOC amount used for the threshold check).



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway , Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **How do a RRE report Multiple Settlement/TPOC Amounts?**

If a RRE negotiates separate, different settlements at different times, each settlement amount is to be reported and maintained ongoing in separate fields. Information pertaining to five TPOC's can be reported. The first will be reported on the Claim Input File Detail Record and TPOC's 2-5 will be reported on the Claim Input File Auxiliary Record.

The TPOC fields will be "positional" in the sense that the first TPOC should be reported in the Detail Record in fields 100-102, the second TPOC amount should be placed in the first available TPOC Date and Amount on the Auxiliary Record starting at Filed 93. Additional TPOC dates and amounts should be placed in the next available fields in the Auxiliary record. Subsequent reports for the claim should maintain all previously reported data in its original position/filed, except for fields being updated.

### **Who is the RRE when there is a self-insurance pool/joint powers authority?**

If the self-insurance pool (1) is a legal entity, (2) with full responsibility to resolve and pay claims using pool funds, (3) without involvement of the participating entity, the self-insurance pool is the RRE. If these three criteria are not applicable to the self-insurance pool, the participating self-insured entity is the RRE.

### **Who is the RRE when there is a state or federal established assigned claims fund?**

A state-established assigned claims fund provides benefits for individuals injured in an automobile accident that do not qualify for personal injury protection/medical payments protection from an automobile insurance carrier. Additionally, a state/federal fund can also assume responsibility for situations where an employer fails to obtain insurance or to properly self-insure. The RRE for these types of claims is as follows:

- Where there is a state/federal agency that resolves and pays the claims using state/federal funds or funds obtained from others for this purpose, the established agency is the RRE.
- Where there is a state/federal agency that designates an authorized insurance carrier to resolve and pay the claims using state/federal funds without state/federal agency review or approval, the designated carrier is the RRE.
- Where there is a state/federal agency that designates an authorized insurance carrier to resolve and pay the claims using state/federal-provided funds but the state/federal agency retains review or approval authority, the state/federal agency is the RRE.

### **When does a record need to be updated?**

1. A record update should be processed when there are updates/changes to the following data elements:
2. ICD 9 Diagnosis Codes Fields 1-19 starting at field 19 in the detail record
3. EIN/TIN Field 72
4. TPOC date 2-5 (auxiliary record fields 93, 96, 99 and 102)
5. TPOC Date 1 field 100 of detail record
6. TPOC Amount 1 field 101 of the detail record
7. TPOC Amount 2-5 (auxiliary record 94, 97, 100 and 103)
8. Claimant 1 Information fields 104-115 in the detail record
9. ORM Termination Date field 99 in the detail record



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway , Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **When should a record be deleted?**

A record should be deleted if it was done in error, should have never been reported. In addition, CMS has noted the following instances where a key field needs to be updated or where a file should be deleted and then resubmitted:

- Injured Party SSN or HICN fields 4 or 5 of the detail record
- CMS Date of Incident (Field 12 of the detail record)
- Plan Insurance Type field 71 of the detail record
- ORM Indicator filed 98 in the detail record

### **Can reporting be suspended?**

Yes, reporting can be suspended due to severe errors or a threshold error.

Files, with severe errors will be suspended from processing. The EDI Rep should be contacted to resolve the situation. Files with severe errors will be deleted by the EDI Rep and a corrected file must be re-sent. Severe errors include:

1. File does not contain a Header Record
2. Header Record not properly formatted.
3. Header record does not contain a valid Section 111 RRE ID
4. Header Record must be at the beginning of the file
5. File does not contain a trailer record
6. Trailer Record not properly formatted.
7. Trailer Record must have a corresponding Header Record
8. RRE ID on the Trailer Record must match the RRE ID of the Header Record
9. Record count on the Trailer Record must be equal to the number of the detail records submitted
10. File must start with a Header Record and end with a Trailer record

Files that exceed the threshold checks will be suspended from further processing until the suspension is overridden by the EDI Rep. An email will be sent to the Account Manager informing them of the suspension. The EDI Rep must be contacted to discuss and resolve file threshold errors. Threshold Errors:

1. More than 4% of the total records are delete transactions
2. 20% or more of the total records failed with a disposition code of "SP" due to errors
3. More than one Claim Input Field was submitted during the defined quarter



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway , Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **What ICD 9 codes are considered valid by CMS?**

CMS publishes a list of valid ICD-9 diagnosis codes once per year at [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06\\_codes.asp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp). CMS has determined that a certain valid ICD 9 diagnosis codes do not provide enough information related to the cause and nature of an illness, injury or incident to be complete, useful, and/or adequate for Section 111 reporting. A list of these invalid codes is provided in Appendix H of the NGHP User's Guide. CMS encourages RRE's to supply as many valid ICD 9 codes as possible as that will lead to more accurate coordination of benefits, including facilitating accurate claims payment and/or the determination of recovery amounts where applicable.

To be considered valid, the Alleged Cause of Injury Code (field 15) must begin with an "E". and be on the list of valid ICD ( codes for Section 111 reporting. Regardless of the submission date, if any number of ICD 9 codes is provided (fields 19-55) at least one must NOT begin with and 'E' or 'V' and Not be on the list of insufficient ICD 9 codes. Insufficient codes, as well as additional "E" codes, will be accepted in the Diagnosis Code fields as long as one, valid numeric ICD 9 code is provided that is NOT on this list.

### **How does an RRE register if they do not have a US address?**

CMS recognizes that in certain situations, the RRE may be an entity with no associated Federal Tax Identification Number (TIN), US address and/or US phone number. In order to register and report under Section 111, a TIN and US address/phone number are required. RRE's must provide a TIN and US address if available. If none are available contact the COBC EDI Department at 646-458-6740 who will refer the matter to CMS for resolution. In some case CMS may allow the RRE to register under information for their US-based "managing agency company", but the RRE should not do so unless CMS approval is received.

### **When do you report claims involving appeals?**

If there is an assumption of ORM due to a judgment or award but the carrier/RRE is appealing the decision, and:

- Payment is being made pending results of the appeal, the ORM must be reported.
- Payment is not being made pending the results of the appeal: the ORM is not reported until the appeal is resolved.
- If there is a TPOC date/amount due to a judgment, award, or other payment but the carrier/RRE or claimant is appealing or further negotiating, and:
  - Payment is being made pending the results of the appeal/negotiation, the TPOC must be reported.
  - Payment is not being made pending the results of the appeal/negotiation; the TPOC is not reported until the appeal/negotiation is resolved.



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway , Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **What about minor injuries where medicals will not close?**

Assumption of ORM typically occurs with respect to no-fault insurance or worker's compensation. Because claims involve all levels of injury, the result can be the continuation of open ORM records even where, as a practical matter, there is no possibility of associated future treatment i. e., a minor fully healed cut in a state where worker's compensation requires life-time medicals. CMS has indicated that, in these instances, RRE's may submit a termination date of ORM if they have a signed statement from the injured claimant's treating physician that he/she will require no further medical items or services related to the claim or injury, regardless of the fact that the claim may be subject to re-opening or there may be a claim for further payment. If, in fact, there is a subsequent re-opening of the claim and further ORM, the RRE must report this as an update.

### **How does and RRE report medical payment coverage (med pay) and personal injury protection (PIP) on the same policy?**

Med Pay and PIP are both considered no-fault insurance by CMS. RRE's must combine Med Pay/PIP limits for the one policy when they are separate coverage and being paid out on claims for the same injured party and same incident under a single policy. ORM should not be terminated until both Med Pay and PIP limits are exhausted. If Med Pay and PIP are covered under separate policies, separate records with the applicable no-fault policy limits for each should be reported.

### **Are indemnity payments for lost time/wages reportable under Section 111?**

In situations where the applicable worker's compensation law or plan requires the RRE to make regularly scheduled payments to, or on behalf of, the claimant, and the applicable worker's compensation law or plan specifically precludes these periodic payments from including any direct or indirect payment for past, present, or future medical expenses; the RRE does not report these periodic payments (they are not reportable as either TPOC's or ORM). Otherwise, these payments are considered to be a part of and are reported as ORM.

### **When is the Claim Auxiliary File used?**

RRE's only need to report the Auxiliary Record if they have more than one claimant , which will occur when the claimant is deceased, or if they have more than one distinct TPOC to report for the claim.

### **When and how will CMS fine for non-compliance?**

CMS has continually stated on conference calls that they are more interested in good quality data rather than passing out fines. CMS is expecting all RREs to register and test data according to the current timeline in place. Real data is not required for testing, so the RRE should register and begin testing as soon as possible. CMS has indicated in the past that the first step in compliance with Section 111 is to follow the timeline. If RREs want to be in compliance, they need to register and test within the appointed timeframes and be prepared to do live reporting in the first quarter of 2011. If the RRE is having any issues with being ready to report, they need to discuss their issues with the assigned EDI Representative.



Your Premiere Compliance Solution

**MedAllocators, Inc.**  
2905 Premiere Parkway , Suite 375  
Duluth, Georgia 30097  
Office 866.270.2516  
Fax 770.407.8277

Last Updated 1.21.2011

### **Can an agent servicing multiple RREs request the same quarterly reporting timeframe?**

CMS has indicated that they will attempt to accommodate specific requests by RREs or agents. This may include requesting the same reporting dates for multiple RREs or requesting one EDI Representative for multiple RREs for which an agent must report.

### **Does MMSEA Section 111 have an impact on or change the Medicare Set Aside Process?**

No. CMS has made it clear that MMSEA Section 111 does not change or alter any legal obligation/requirements under the Medicare Secondary payer statute (MSP). The MMSEA does not have a direct impact on the MSP. Therefore, insurers are still responsible for protecting Medicare's interest still need to be considered for both past (conditional payments/liens) and future (MSA) payments. MMSEA Section 111 does impose new claim reporting requirements on claims handlers, which are in addition to the necessity of protecting Medicare as a secondary payer under the MSP. The indirect impact is that CMS will now have a report outlining every case where Medicare should be protected as a secondary payer. **At any time in the future, CMS can select cases to audit for MSP compliance.**

### **How should a case involving deductibles or co-payments be reported?**

Please see the CMS Alert dated May 26, 2010 for the revised definition of Who Must Report. [www.cms.gov/MandatoryInsRep/Downloads/AlertWhoMustReportrev052610.pdf](http://www.cms.gov/MandatoryInsRep/Downloads/AlertWhoMustReportrev052610.pdf)

### **How does MMSEA Section 111 reporting affect claims handlers?**

Adjusters may need to adapt to system changes which will be necessary to capture all the data required for Section 111 reporting. Additional information may need to be obtained from claimants to comply with the data elements CMS requires to be reported. Expedited Medicare status will be important (through the Query function) to ensure timely reporting. Section 111 reporting brings a heightened awareness to Medicare conditional payments (liens). Adjuster should address potential Medicare conditional payments early in the claims process.

### **Who do I contact @ CMS if I have problem?**

If there is a program or technical problem involving Section 111 data exchange, the first person to contact is your assigned EDI Representative at the COBC. If an EDI Representative is not yet assigned, call the **COBC EDI Department at 646-458-6740.**

If after working with the EDI Representative, the problem still requires assistance at a higher level, please contact **Jeremy Farquhar, at 646-458-6614 or [JFarquhar@ghimedicare.com](mailto:JFarquhar@ghimedicare.com).**

If further escalation is necessary, contact the **COBC EDI Manager, Bill Ford, at 646-458-6613 or [WFord@ghimedicare.com](mailto:WFord@ghimedicare.com).** The **COBC Project Director**, with overall responsibility for the COBC EDI Department, is **Jim Brady**. Mr. Brady can be reached at **646-458-6682 or [JBrady@ghimedicare.com](mailto:JBrady@ghimedicare.com).**

See how MedAllocators can help you prepare for MMSEA readiness. To discuss MMSEA requirements, contact your Account Executive or Harold Brooks at 678-993-3312 [hbrooks@medallocators.com](mailto:hbrooks@medallocators.com) MedAllocators Reporter Specialist.