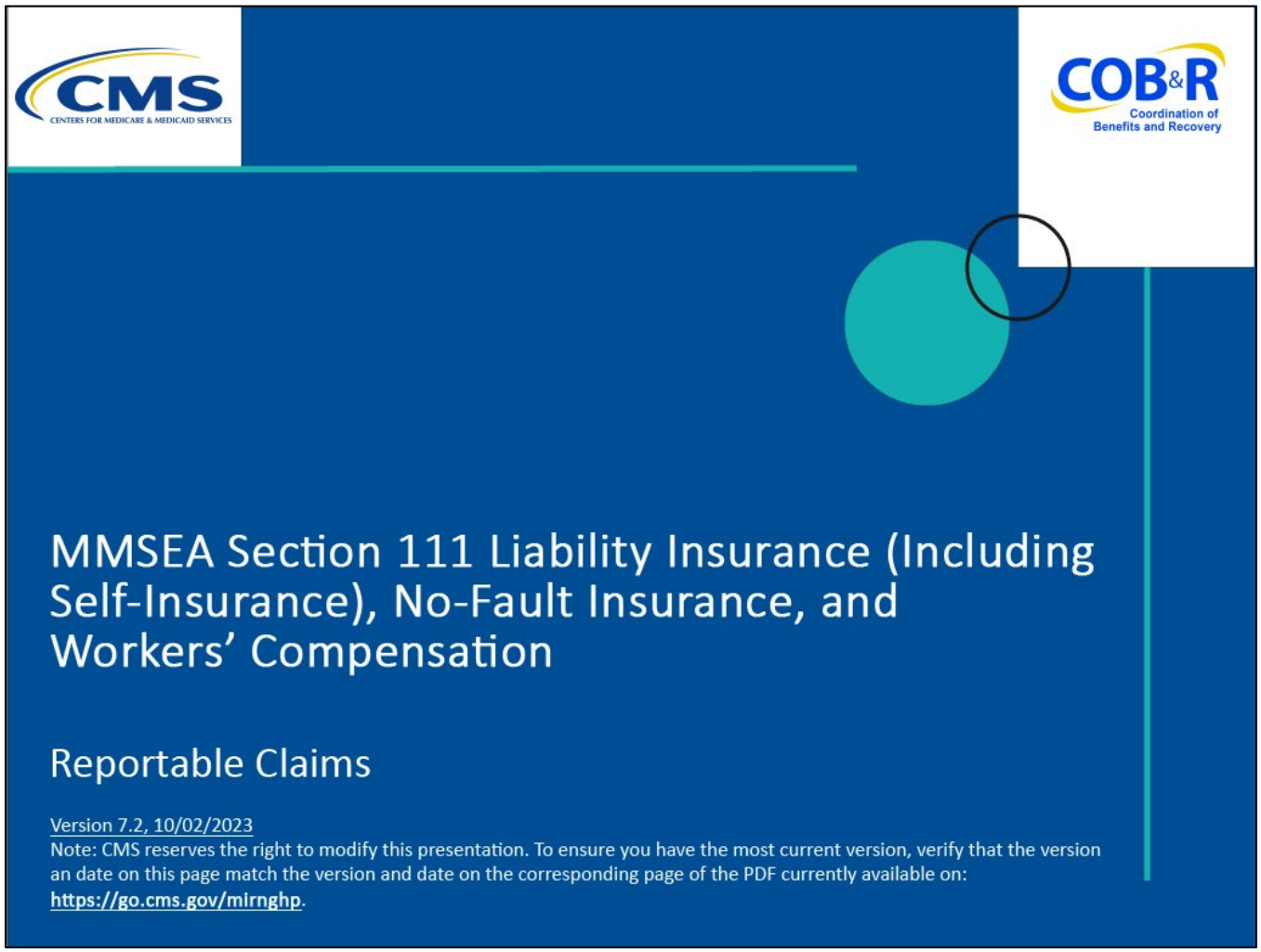
Reportable Claims Introduction

Slide 1 of 39 - Reportable Claims Introduction

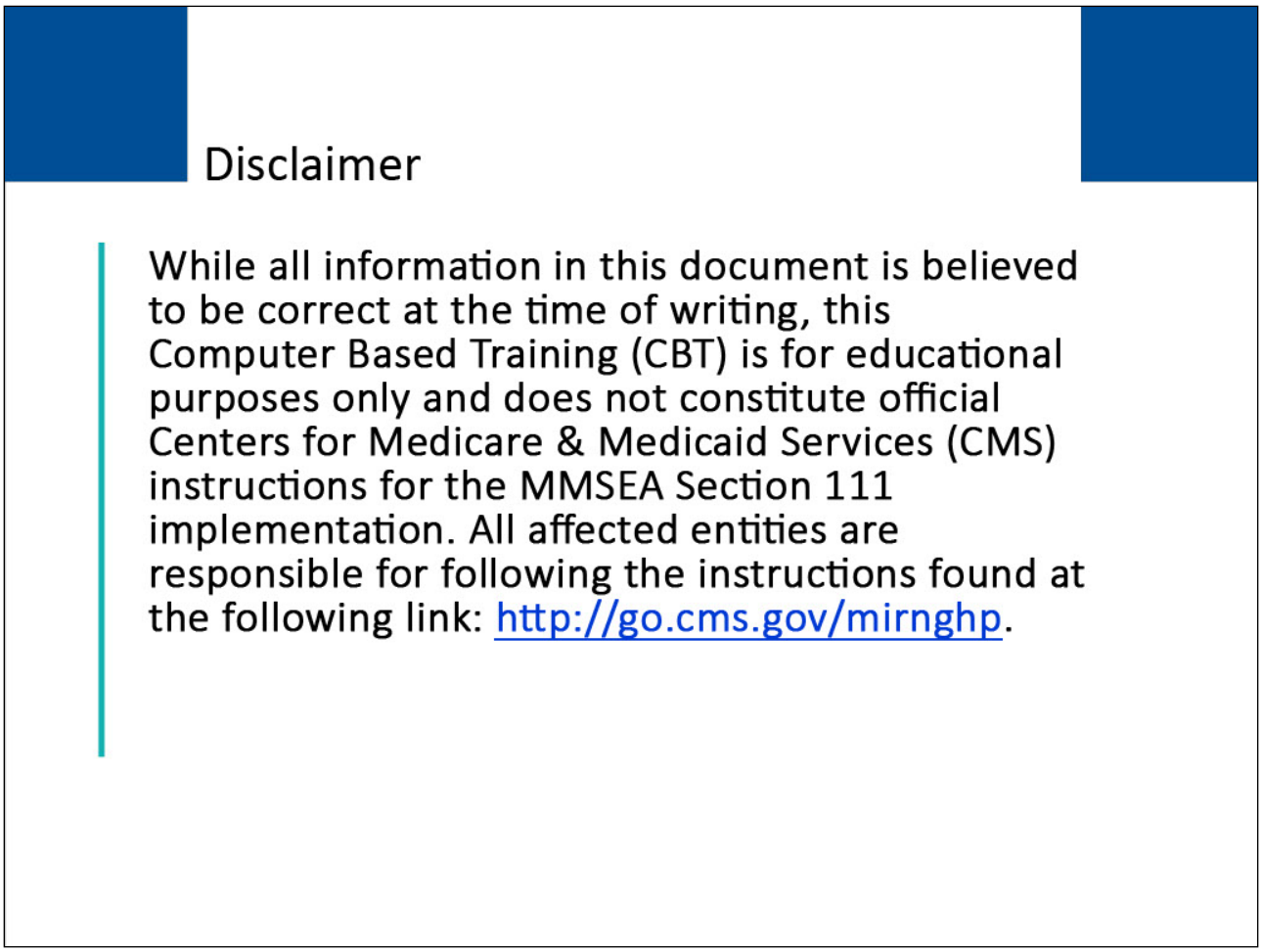


Slide notes

Welcome to the Reportable Claims course.

Note: This module applies to Responsible Reporting Entities (RREs) that will be submitting Section 111 claim information via an electronic file submission as well as those RREs that will be submitting this information via Direct Data Entry (DDE).

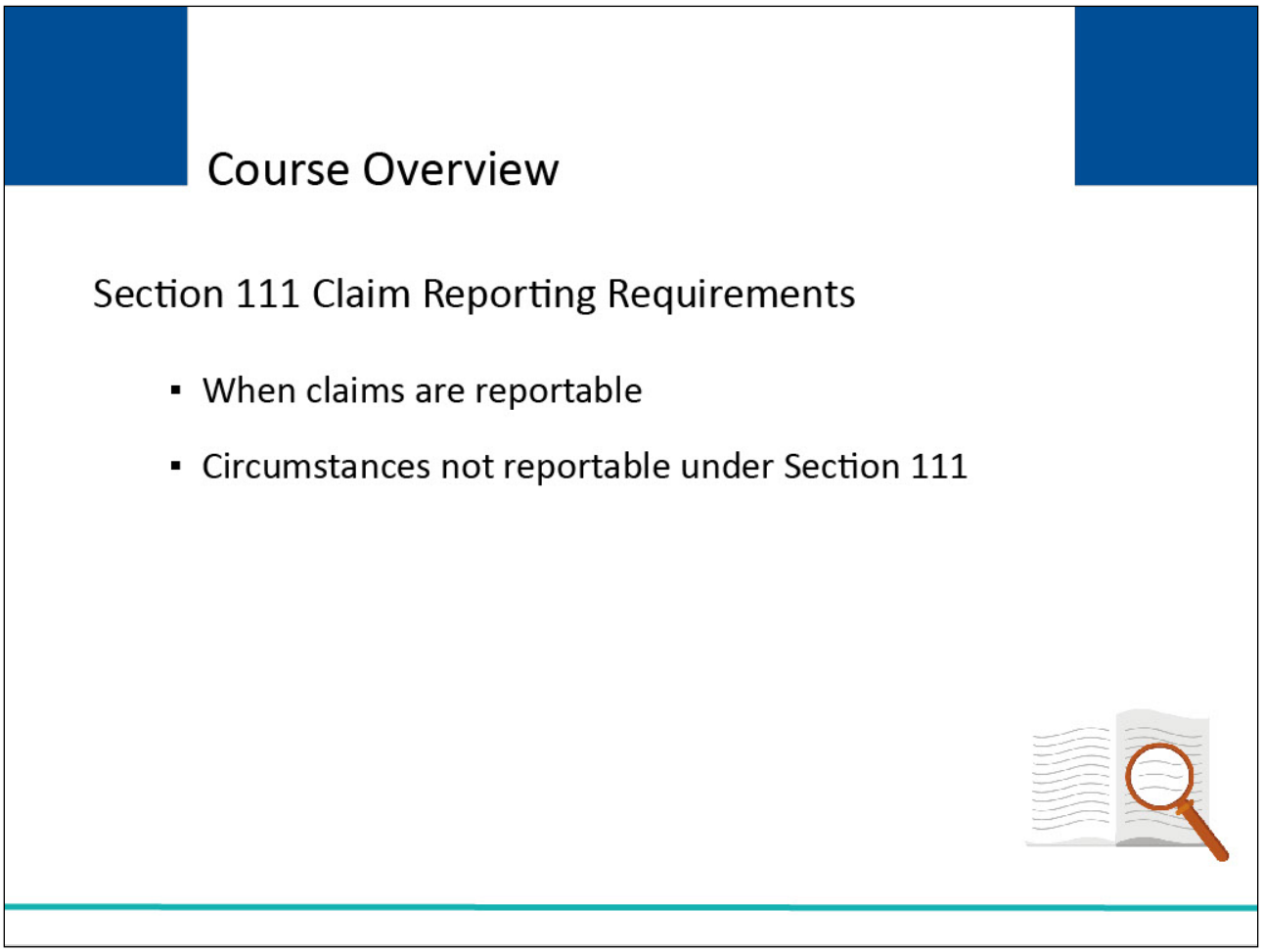
Slide 2 of 39 - Disclaimer



Slide notes

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation. All affected entities are responsible for following the instructions found at the following link: CMS NGHP Website.

Slide 3 of 39 - Course Overview



Slide notes

This learning module reviews the Section 111 claim reporting requirements. It explains when claims are reportable and provides information regarding circumstances that are not reportable under Section 111.

NOTE: Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are sometimes collectively referred to as "non-group health plan" or "NGHP."

The term NGHP will be used in this CBT for ease of reference.

Slide 4 -of 39 - PAID Act

PAID Act

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past 3 years.

This information will be provided on the COBSW S111/MRA and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

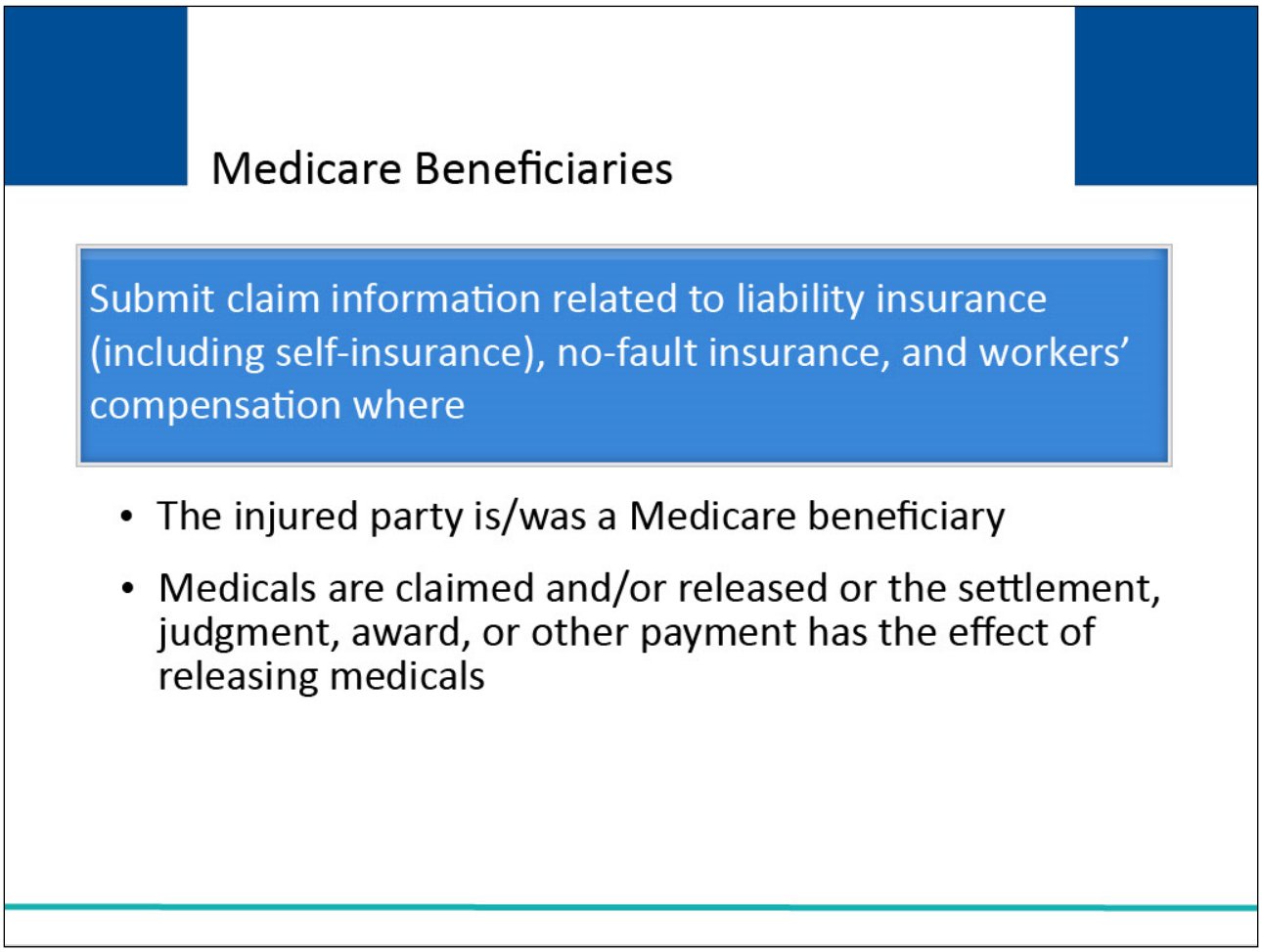
Slide notes

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past three years.

This information will be on the COBSW S111/MRA and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

Note: To support the PAID Act, the Query Response File will be updated to include Contract Number, Contract Name, Plan Number, Coordination of Benefits (COB) Address, and Entitlement Dates for the last three years (up to 12 instances) of Part C and Part D coverage. The updates will also include the most recent Part A and Part B entitlement dates.

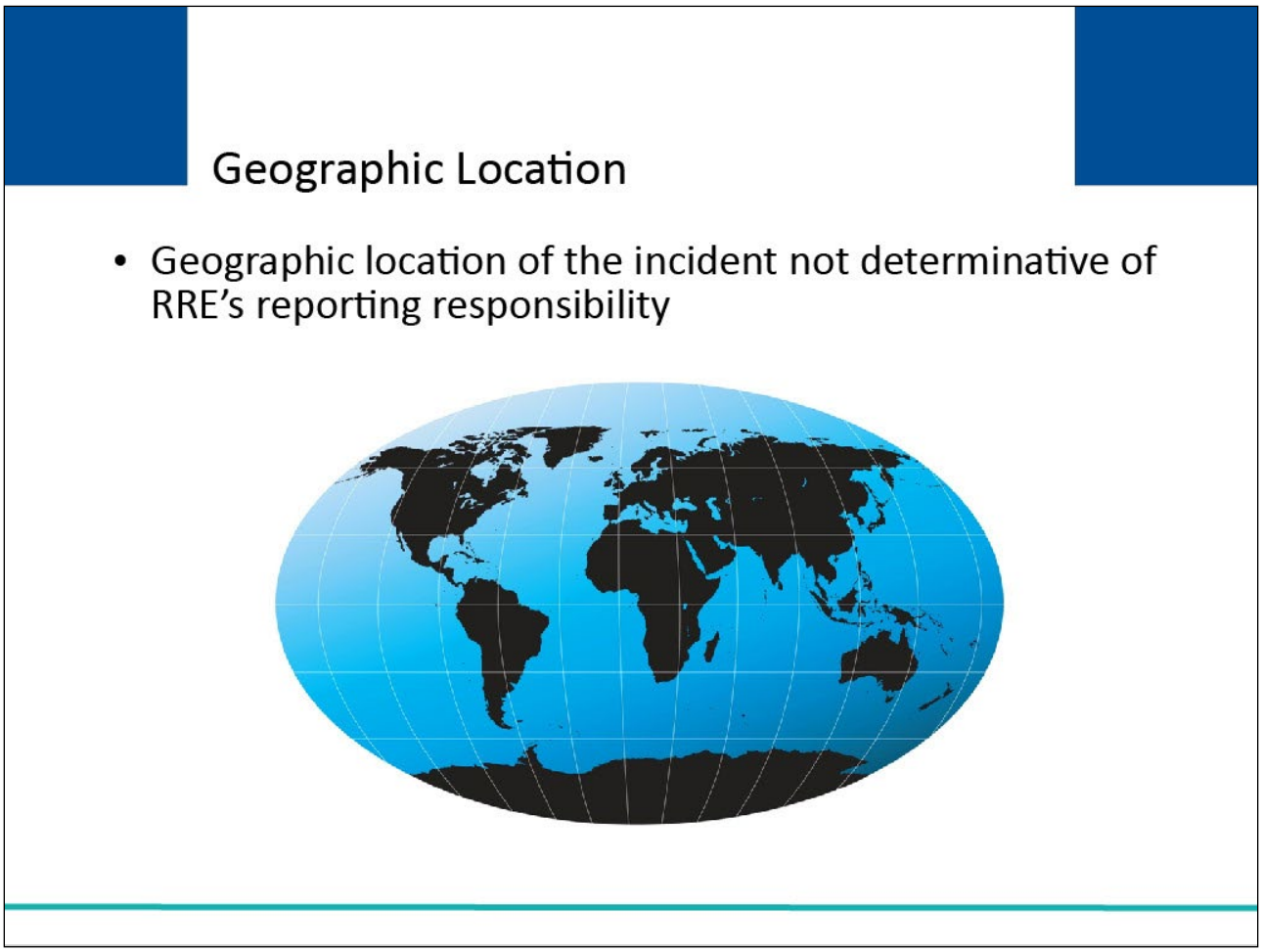
Slide 5 of 39 - Medicare Beneficiaries



Slide notes

Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation 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.

Slide 6 of 39 - Geographic Location

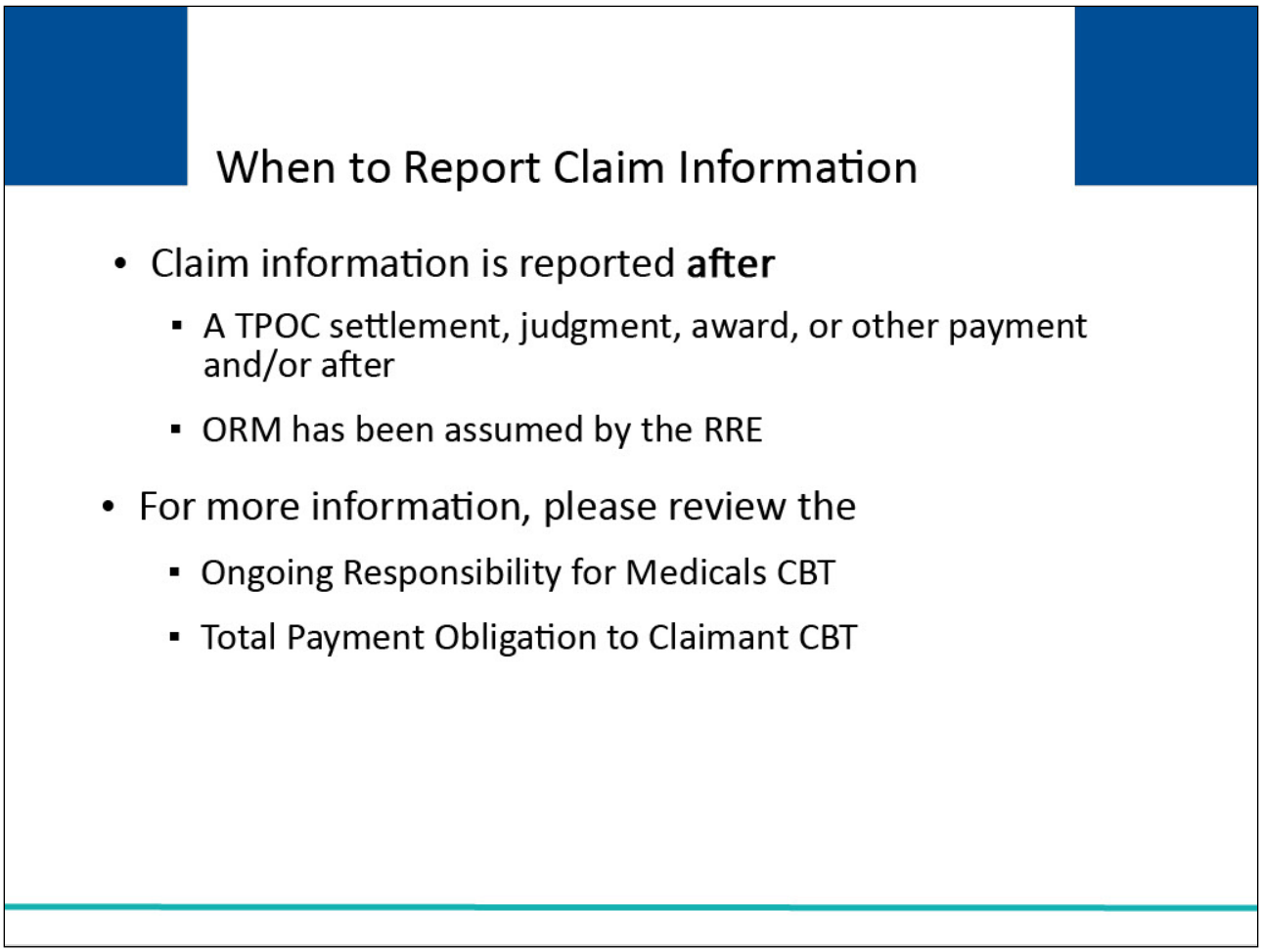


Slide notes

The geographic location of the incident, illness, or injury is not determinative of the RRE's reporting responsibility.

Medicare beneficiaries who are injured or become ill outside of the United States often return to the U.S. for medical care.

Slide 7 of 39 - When to Report Claim Information

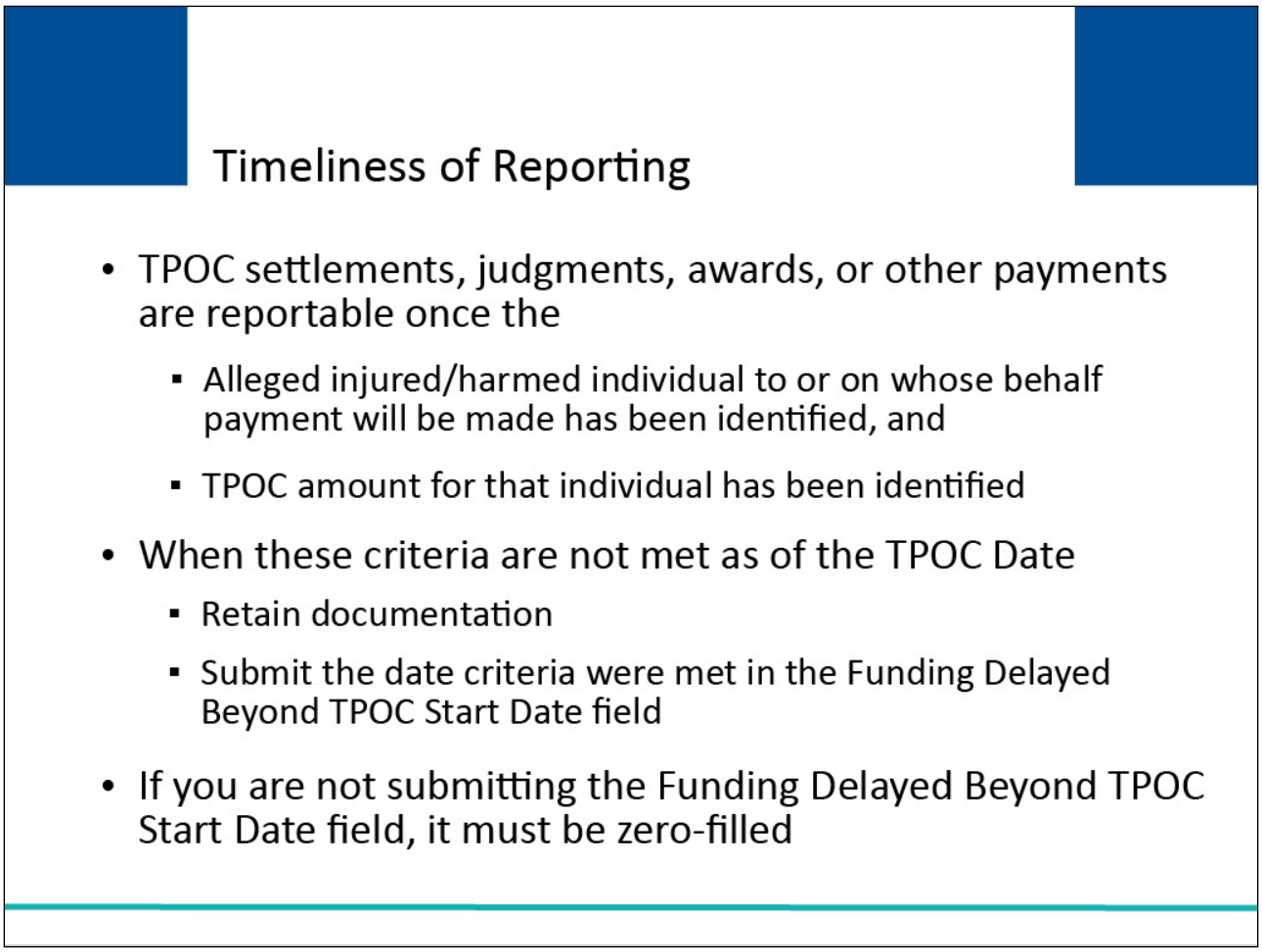


Slide notes

Claim information is reported after there has been a Total Payment Obligation to Claimant (TPOC) settlement, judgment, award, or other payment and/or after ongoing responsibility for medicals (ORM) has been assumed by the RRE.

For a more thorough explanation of these topics, please see the Ongoing Responsibility for Medicals CBT and the Total Payment Obligation to Claimant CBT.

Slide 8 of 39 - Timeliness of Reporting



Slide notes

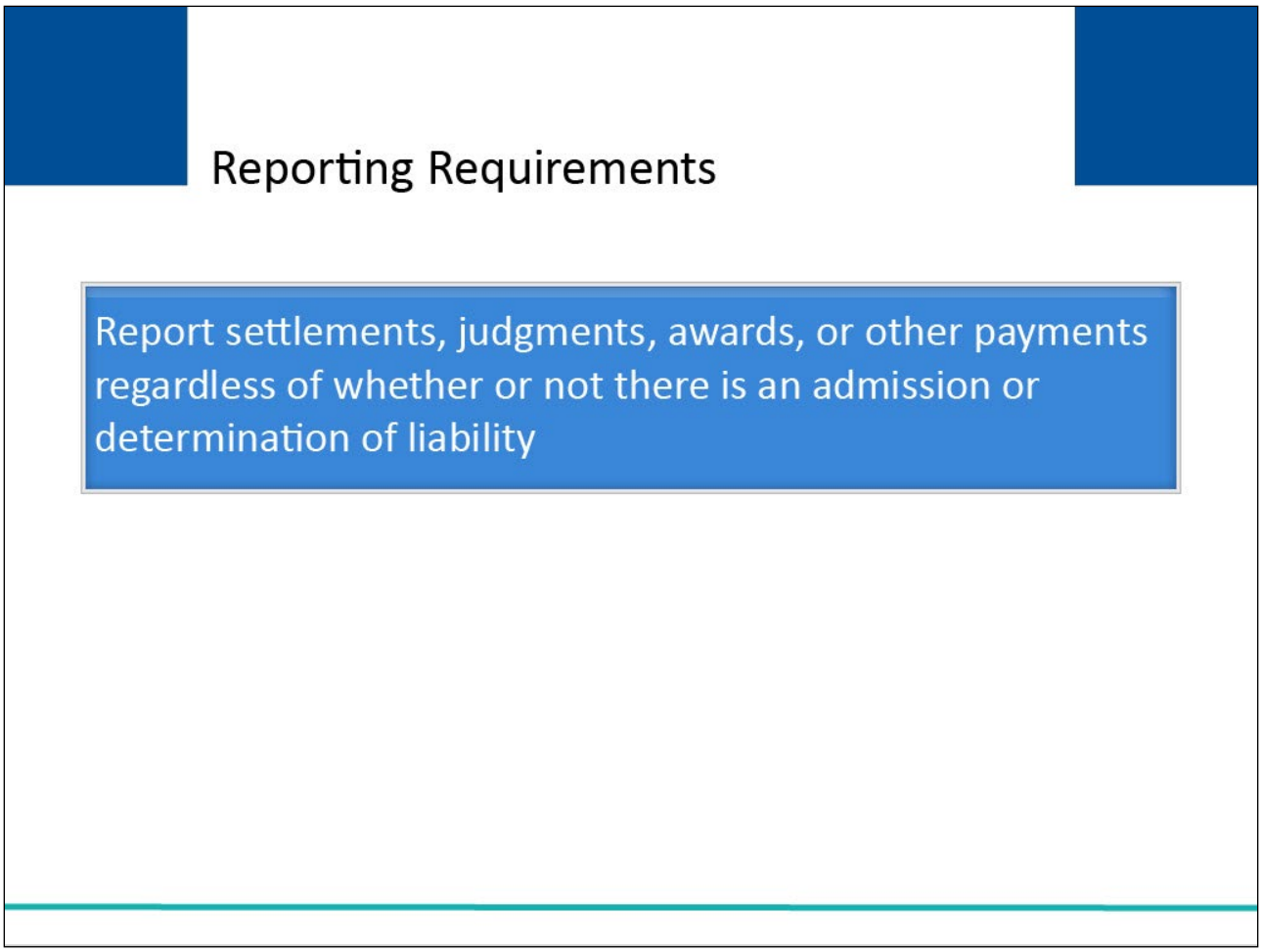
TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met:

- the alleged injured/harmed individual to or on whose behalf payment will be made has been identified and
- the TPOC Amount for that individual has been identified

Where these criteria are not met as of the TPOC Date, retain documentation establishing when these criteria are met.

RREs should submit the date these criteria were met in the corresponding “Funding Delayed Beyond TPOC Start Date” field. If you are not submitting the “Funding Delayed Beyond TPOC Start Date” field, it must be zero-filled.

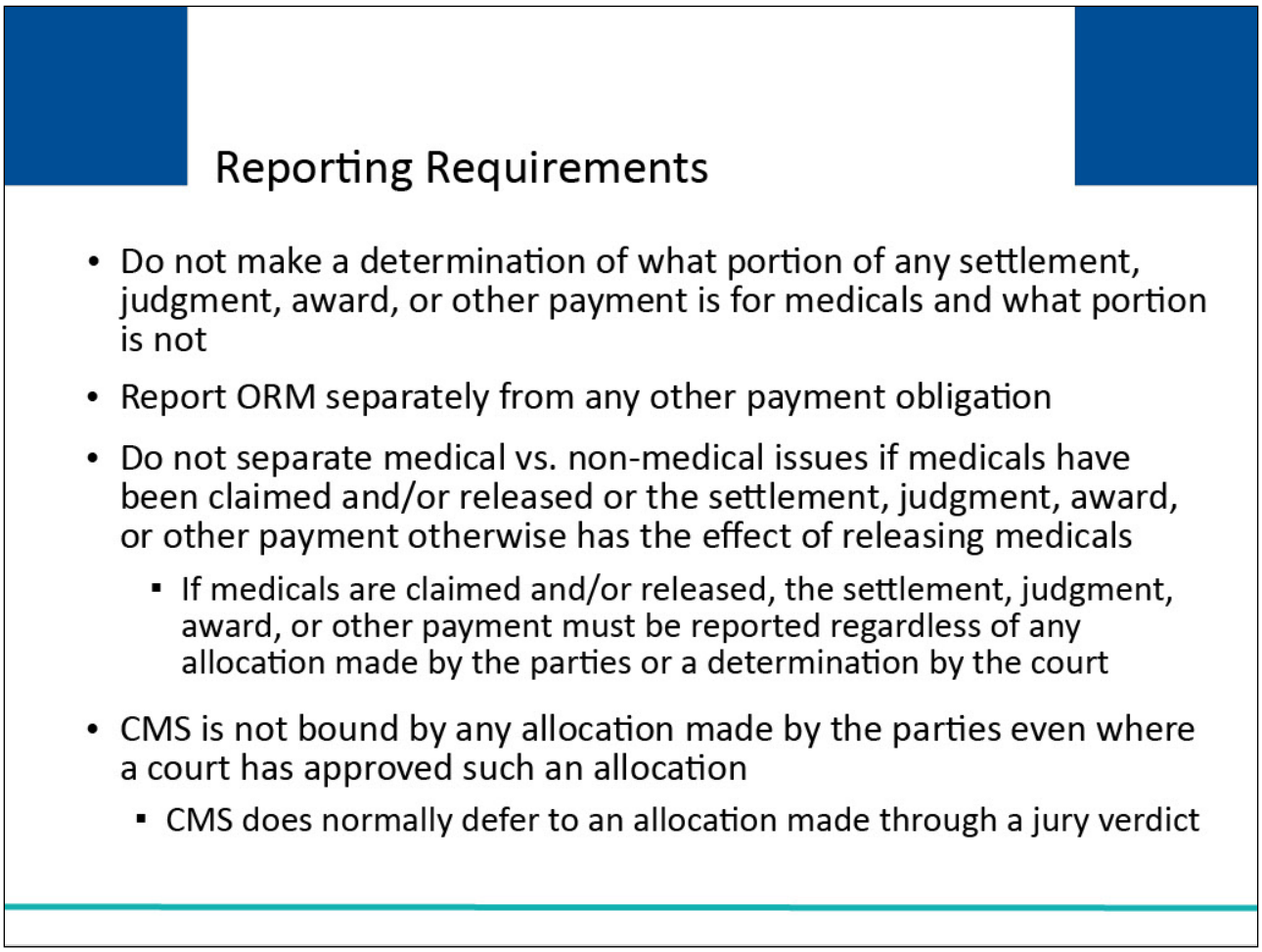
Slide 9 of 39 - Reporting Requirements



Slide notes

RREs must report settlements, judgments, awards, or other payments regardless of whether or not there is an admission or determination of liability. Reports are required with either partial or full resolution of a claim.

Slide 10 of 39 - Reporting Requirements



Slide notes

For purpose of the required reporting for 42 U.S.C. 1395y(b)(8), the RRE does not make a determination of what portion of any settlement, judgment, award, or other payment is for medicals and what portion is not.

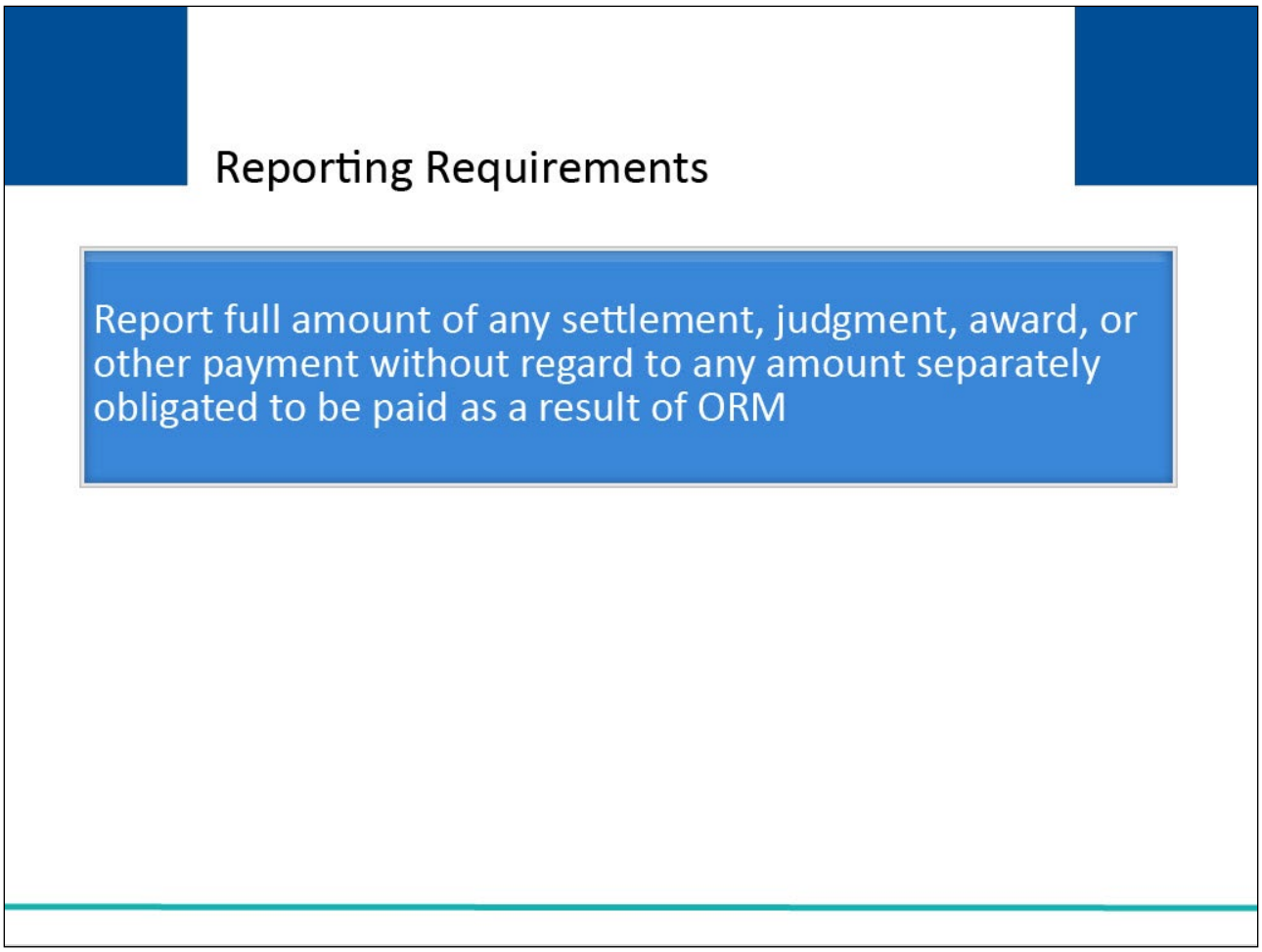
The RRE reports ORM separately from any other payment obligation but does not separate medical vs. non-medical issues if medicals have been claimed and/or released or the settlement, judgment, award, or other payment otherwise has the effect of releasing medicals.

If medicals are claimed and/or released, the settlement, judgment, award, or other payment must be reported regardless of any allocation made by the parties or a determination by the court.

CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. CMS does normally defer to an allocation made through a jury verdict or after a hearing on the merits.

However, this issue is relevant to whether or not, CMS has a recovery claim with respect to a particular settlement, judgment, award, or other payment and does not affect the RRE’s obligation to report.

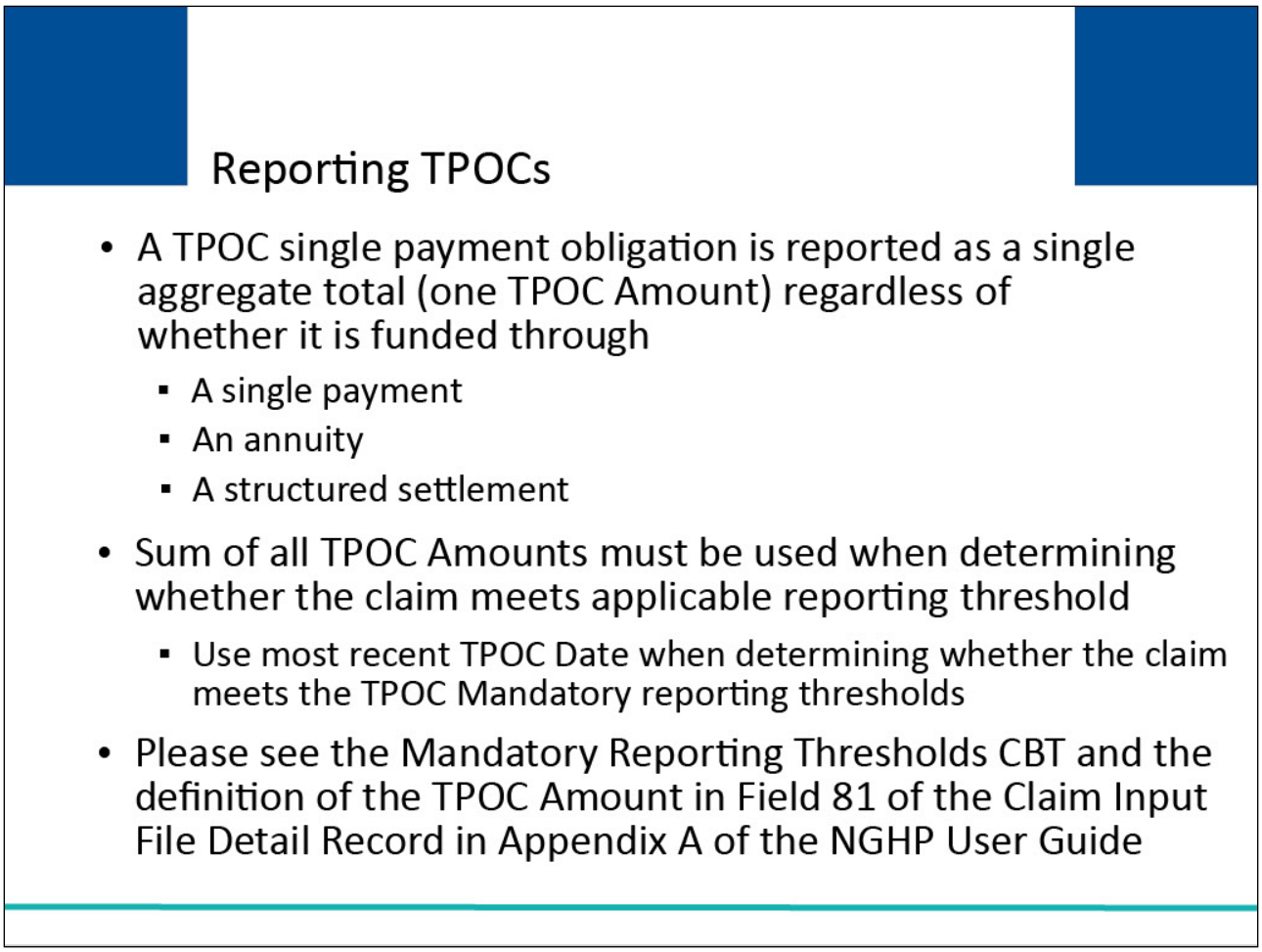
Slide 11 of 39 - Reporting Requirements



Slide notes

RREs must report the full amount of any settlement, judgment, award, or other payment amount (the TPOC Amount) without regard to any amount separately obligated to be paid as a result of the assumption/establishment of ORM.

Slide 12 of 39 - Reporting TPOCs



Slide notes

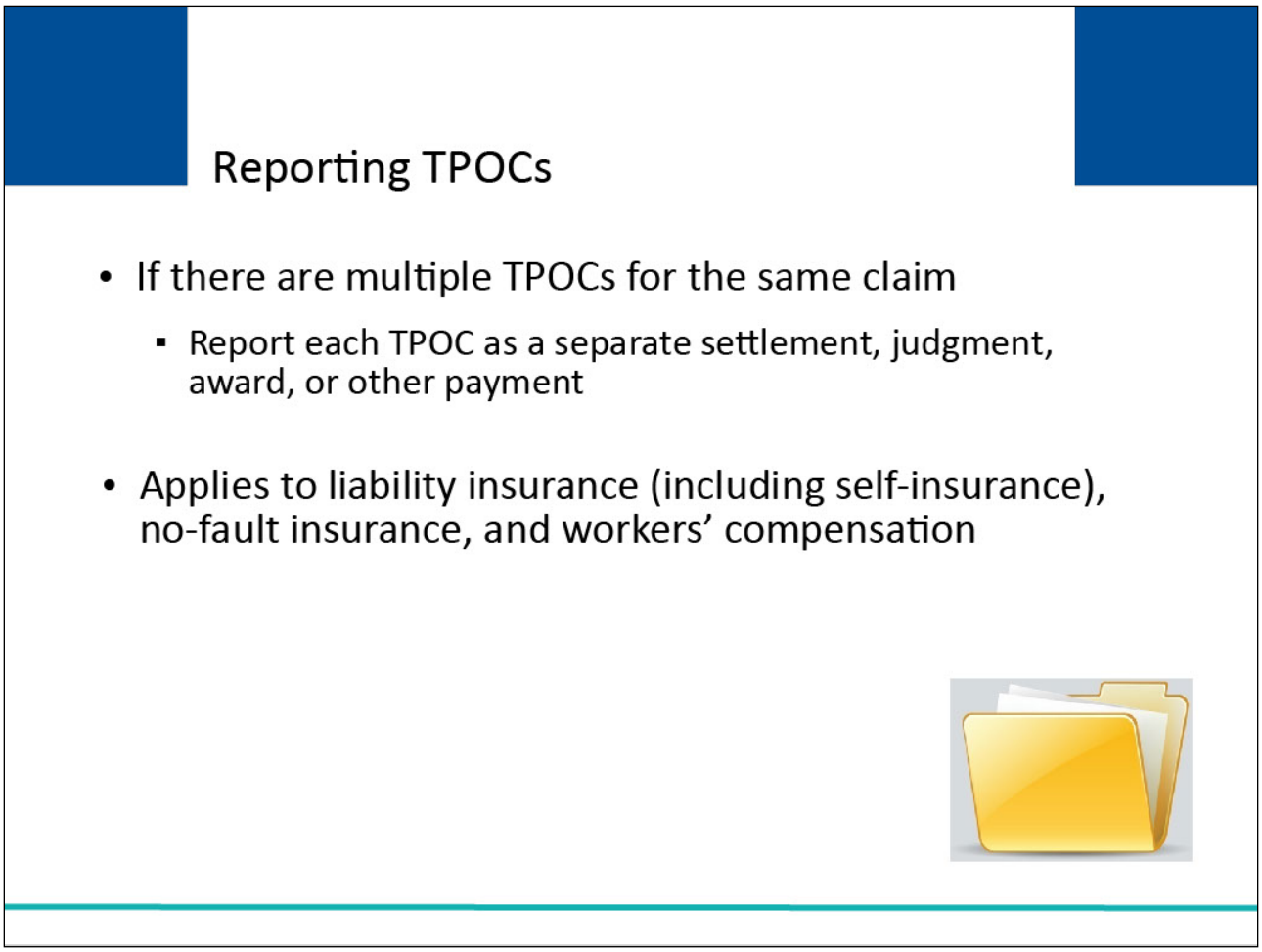
A TPOC single payment obligation is reported as a single aggregate total (one TPOC Amount) regardless of whether it is funded through a single payment, an annuity, or a structured settlement.

However, the sum of all TPOC Amounts must be used when determining whether the claim meets the applicable reporting threshold.

Use the most recent, latest TPOC Date associated with the claim when determining whether the claim meets the TPOC Mandatory reporting thresholds.

For a more thorough explanation of these topics, please see the Mandatory Reporting Thresholds CBT and the definition of TPOC Amount in Fields 80 and 81 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V.

Slide 13 of 39 - Reporting TPOCs

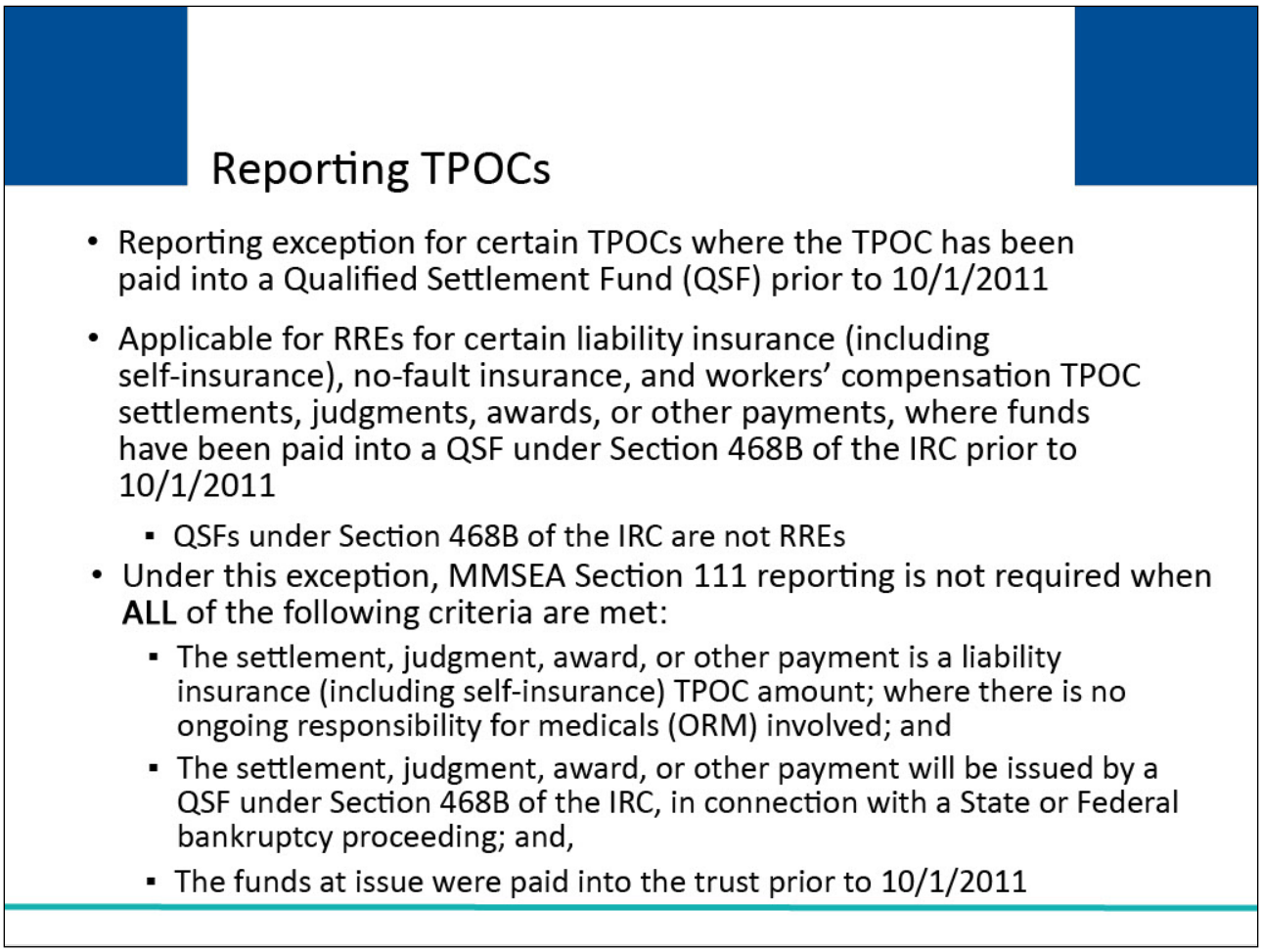


Slide notes

If there are multiple TPOCs for the same individual for the same claim, each new TPOC must be reported as a separate settlement, judgment, award, or other payment.

This applies to liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

Slide 14 of 39 - Reporting TPOCs



Slide notes

There is a reporting exception for certain TPOCs where the TPOC has been paid into a Qualified Settlement Fund (QSF) prior to 10/1/2011.

This exception is applicable for RREs for certain liability insurance (including self-insurance), no-fault insurance, and workers' compensation TPOC settlements, judgments, awards, or other payments, where funds have been paid into a QSF under Section 468B of the Internal Revenue Code (IRC) prior to 10/1/2011. (Note: QSFs under Section 468B of the IRC are not RREs.)

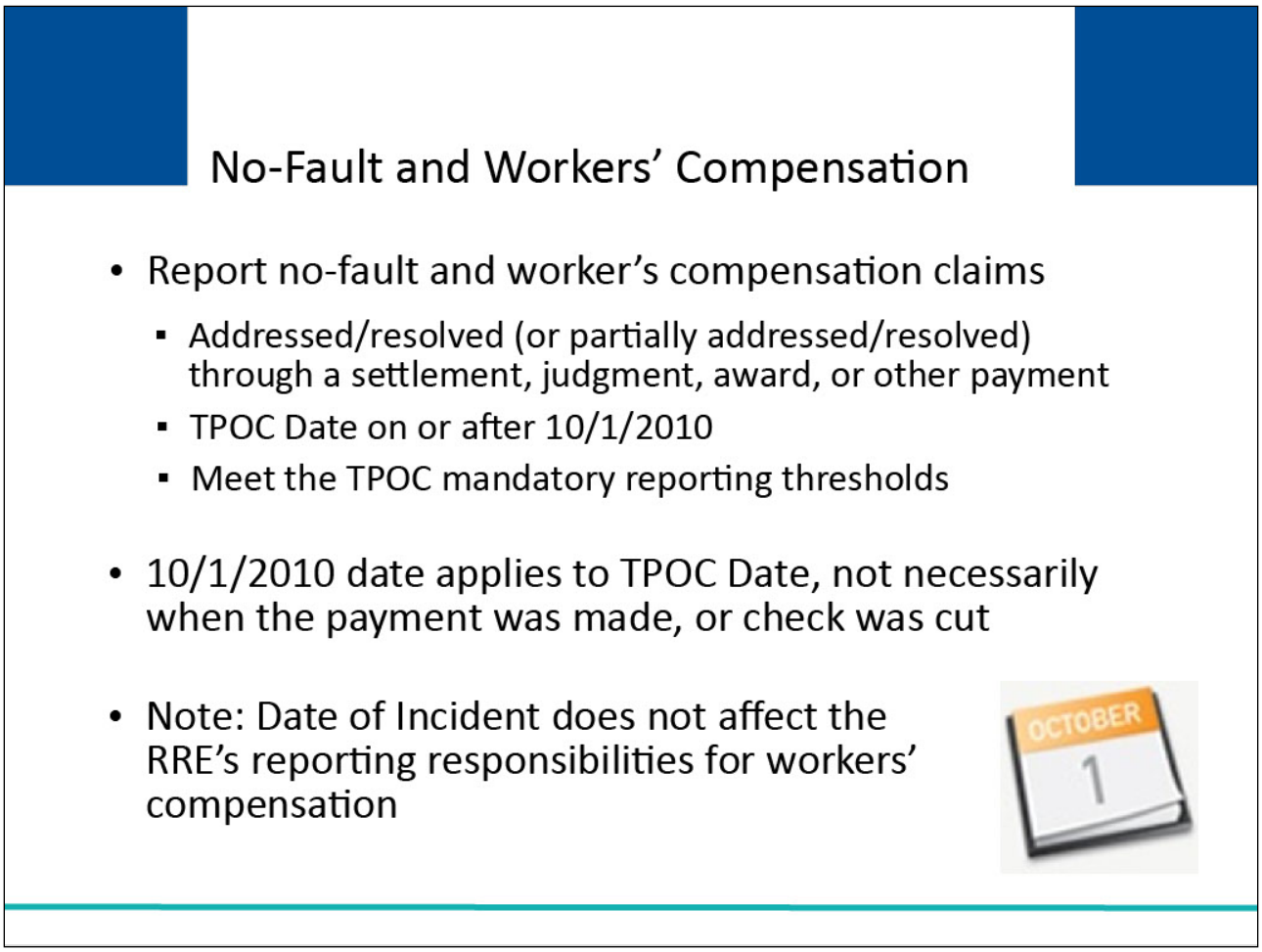
Under this exception, MMSEA Section 111 reporting is not required when ALL of the following criteria are met:

The settlement, judgment, award, or other payment is a liability insurance (including self-insurance) TPOC amount, where there is no ongoing responsibility for medicals (ORM) involved;

The settlement, judgment, award, or other payment will be issued by a QSF under Section 468B of the IRC, in connection with a State or Federal bankruptcy proceeding; and,

The funds at issue were paid into the trust prior to 10/1/2011.

Slide 15 of 39 - No-Fault and Workers' Compensation



Slide notes

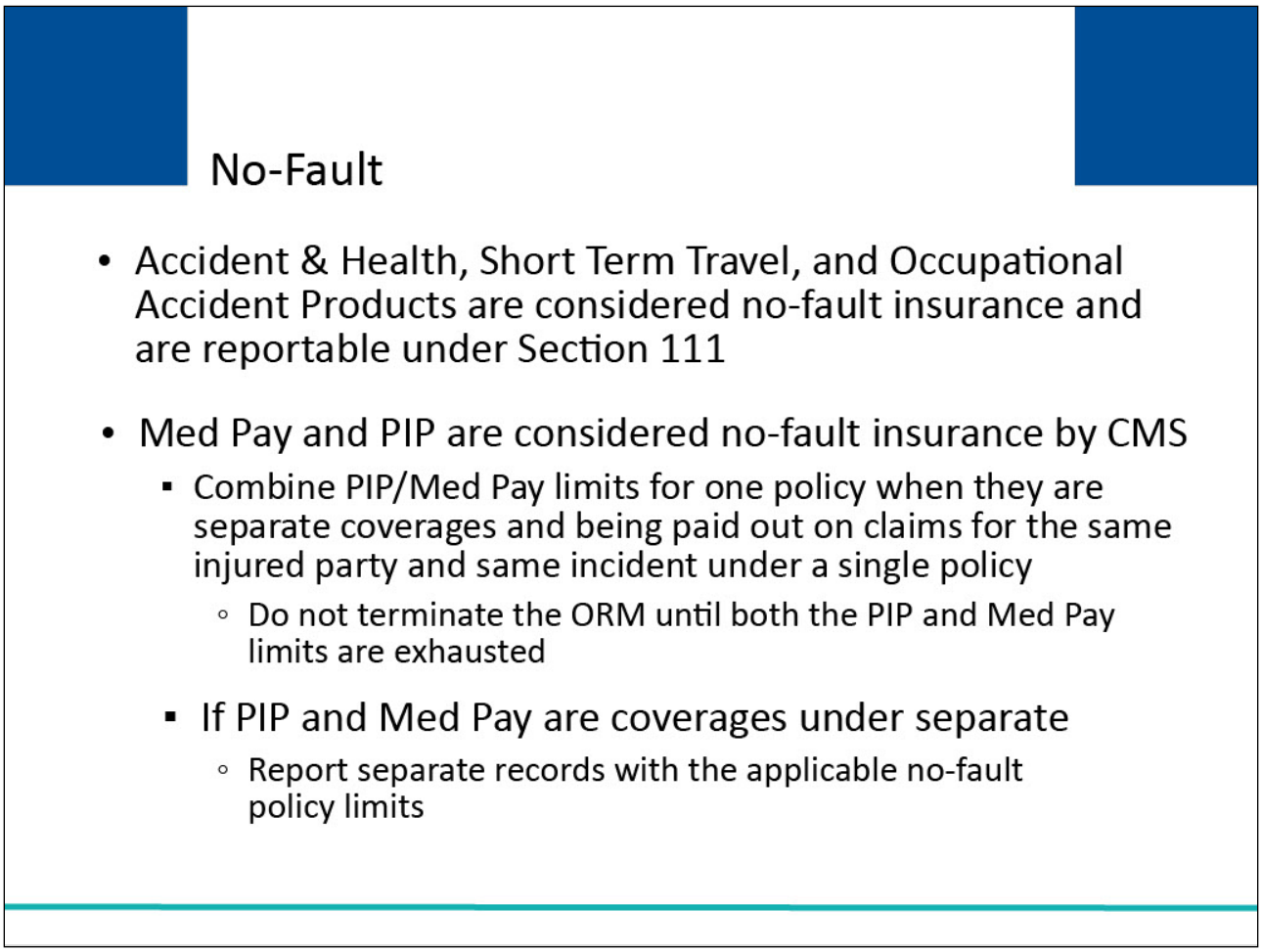
RREs must report on no-fault insurance and workers' compensation claims, where the injured party is/was a Medicare beneficiary, that are addressed/resolved (or partially addressed/resolved) through a settlement, judgment, award, or other payment with a TPOC Date on or after October 1, 2010, that meet the TPOC mandatory reporting thresholds.

This reporting requirement date of October 1, 2010, applies to the TPOC Date, NOT necessarily when the actual payment was made, or check was cut.

Remember, the Date of Incident does not affect the RRE's reporting responsibilities for workers' compensation.

Note: In some states, depending on various factors associated with the incident being reported, no-fault policy limits may vary. The reported Policy Limit should reflect the amount that the RRE has accepted responsibility for at the time the record was submitted or updated. Just as importantly, if the Section 111 record needs to be corrected to reflect a new Policy Limit, the RRE should update the record as soon as possible.

Slide 16 of 39 - No-Fault



Slide notes

Accident & Health, Short Term Travel, and Occupational Accident Products are considered no-fault insurance by CMS and reportable as such under Section 111.

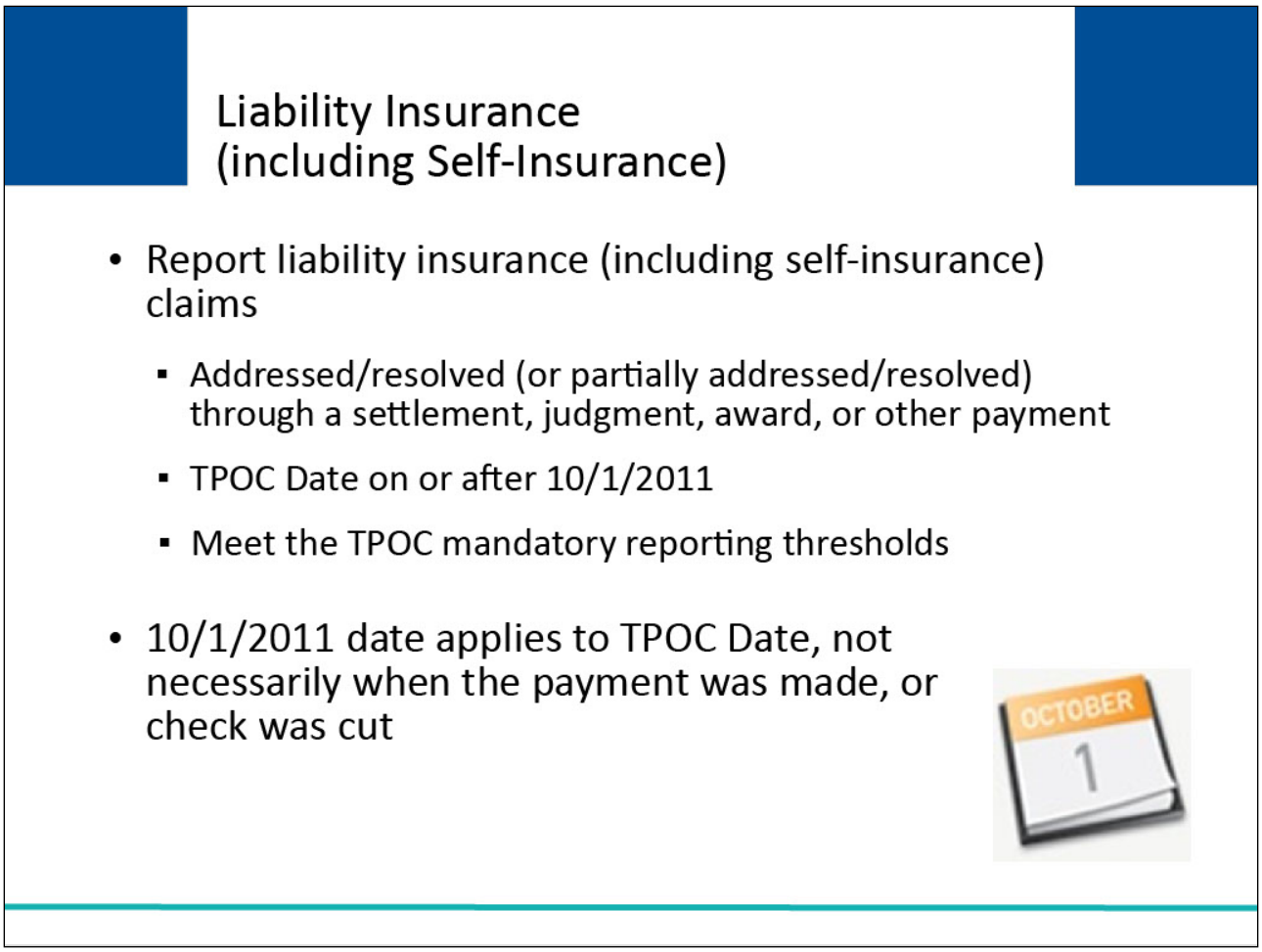
Med Pay and Personal Injury Protection (PIP) are both considered no-fault insurance by CMS.

RREs must combine PIP/Med Pay limits for one policy when they are separate coverages and being paid out on claims for the same injured party and

same incident under a single policy and not terminate the ORM until both the PIP and Med Pay limits are exhausted.

If PIP and Med Pay are coverages under separate policies, then separate records with the applicable no-fault policy limits for each should be reported.

Slide 17 of 39 - Liability Insurance (including Self-Insurance)

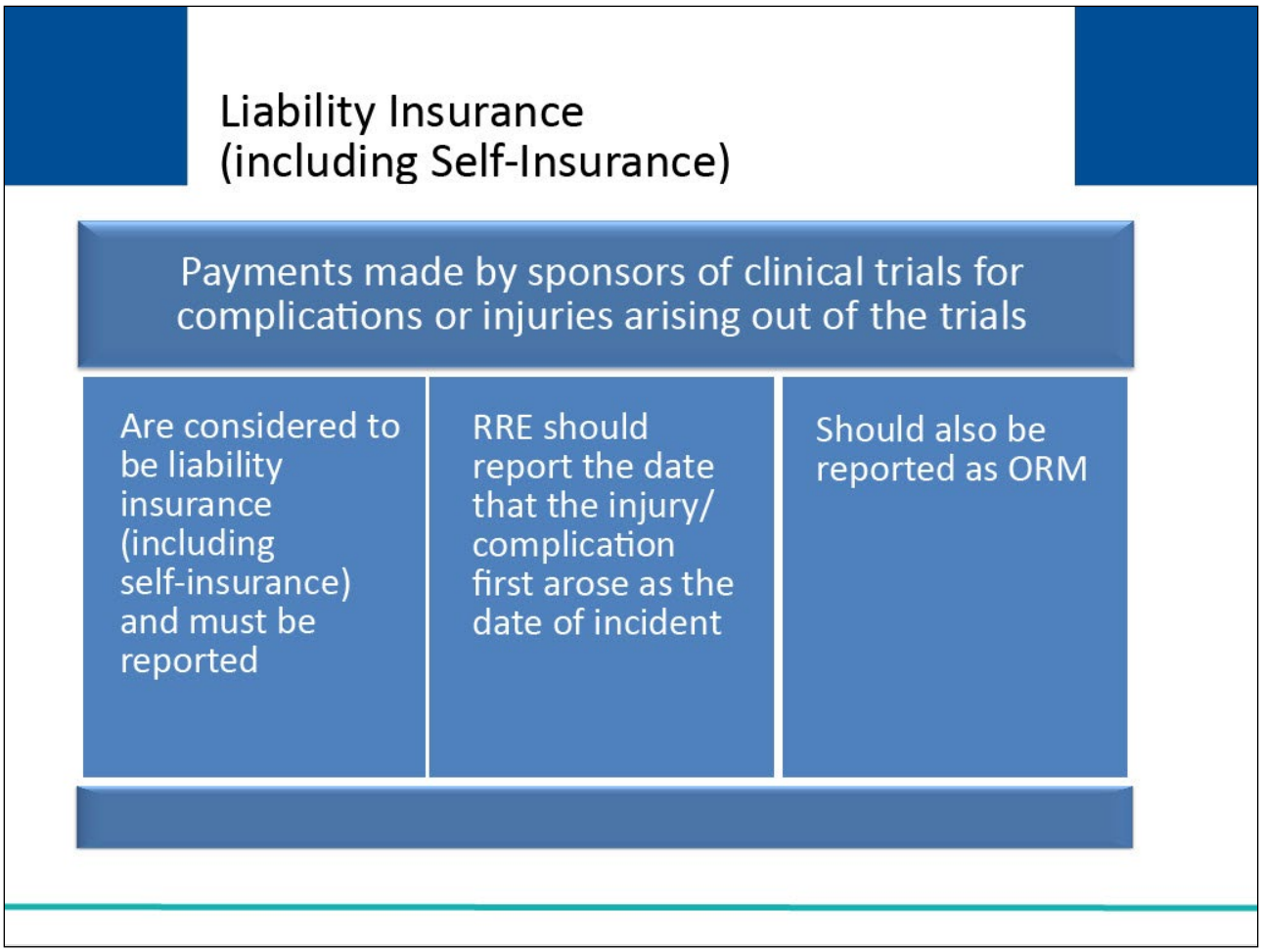


Slide notes

RREs must report on liability insurance (including self-insurance) claims, where the injured party is/was a Medicare beneficiary, that is addressed/resolved (or partially addressed/resolved) through a settlement, judgment, award, or other payment with a TPOC Date on or after October 1, 2011, that meet the TPOC mandatory reporting thresholds.

This reporting requirement date of October 1, 2011, applies to the TPOC Date, NOT necessarily when the actual payment was made, or check was cut.

Slide 18 of 39 - Liability Insurance (including Self-Insurance)

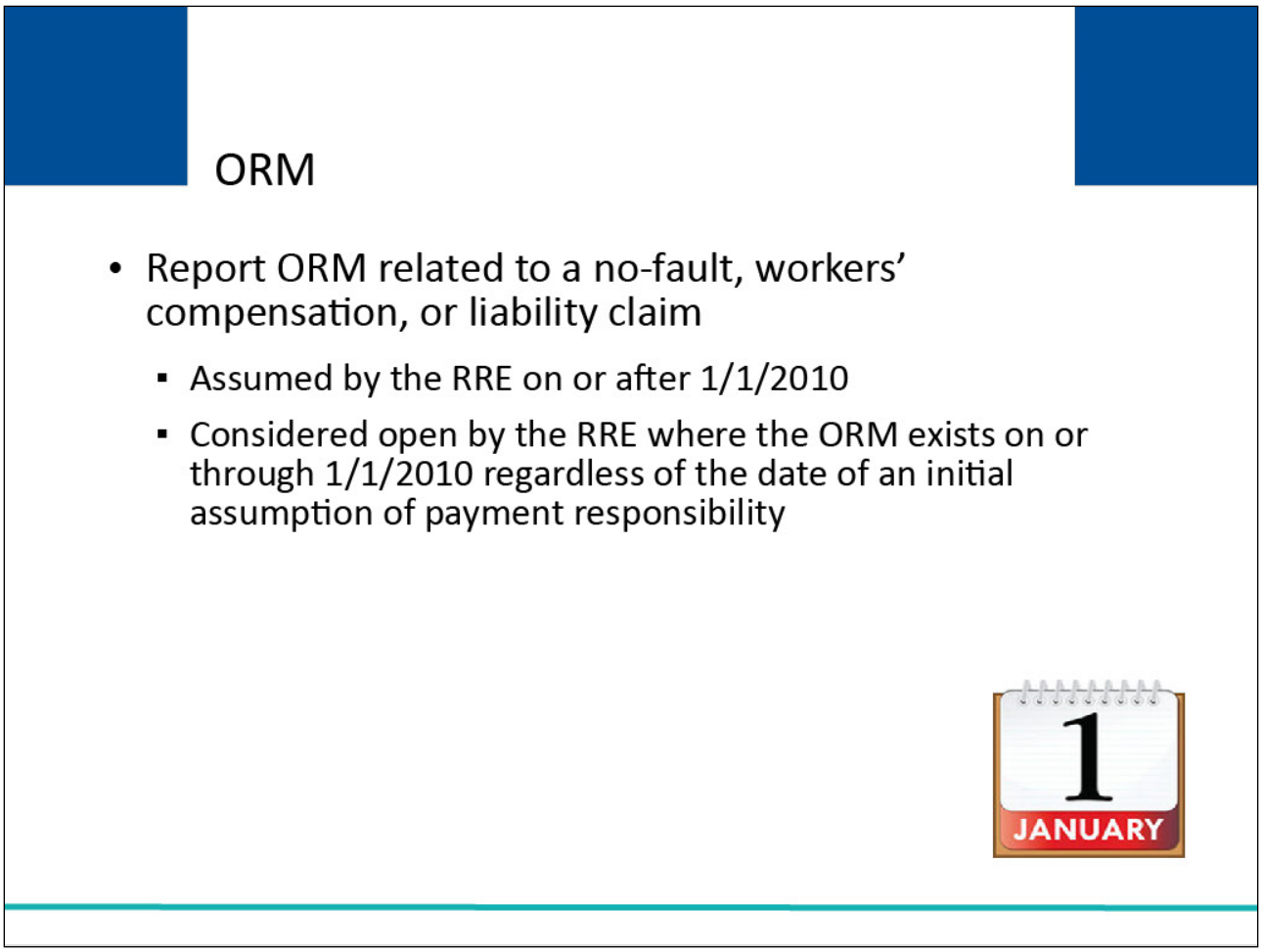


Slide notes

When payments are made by sponsors of clinical trials for complications or injuries arising out of the trials, such payments are considered to be payments by liability insurance (including self-insurance) and must be reported.

The appropriate RRE should report the date that the injury/complication first arose as the date of incident. The situation should also be reported as one involving ORM.

Slide 19 of 39 - ORM

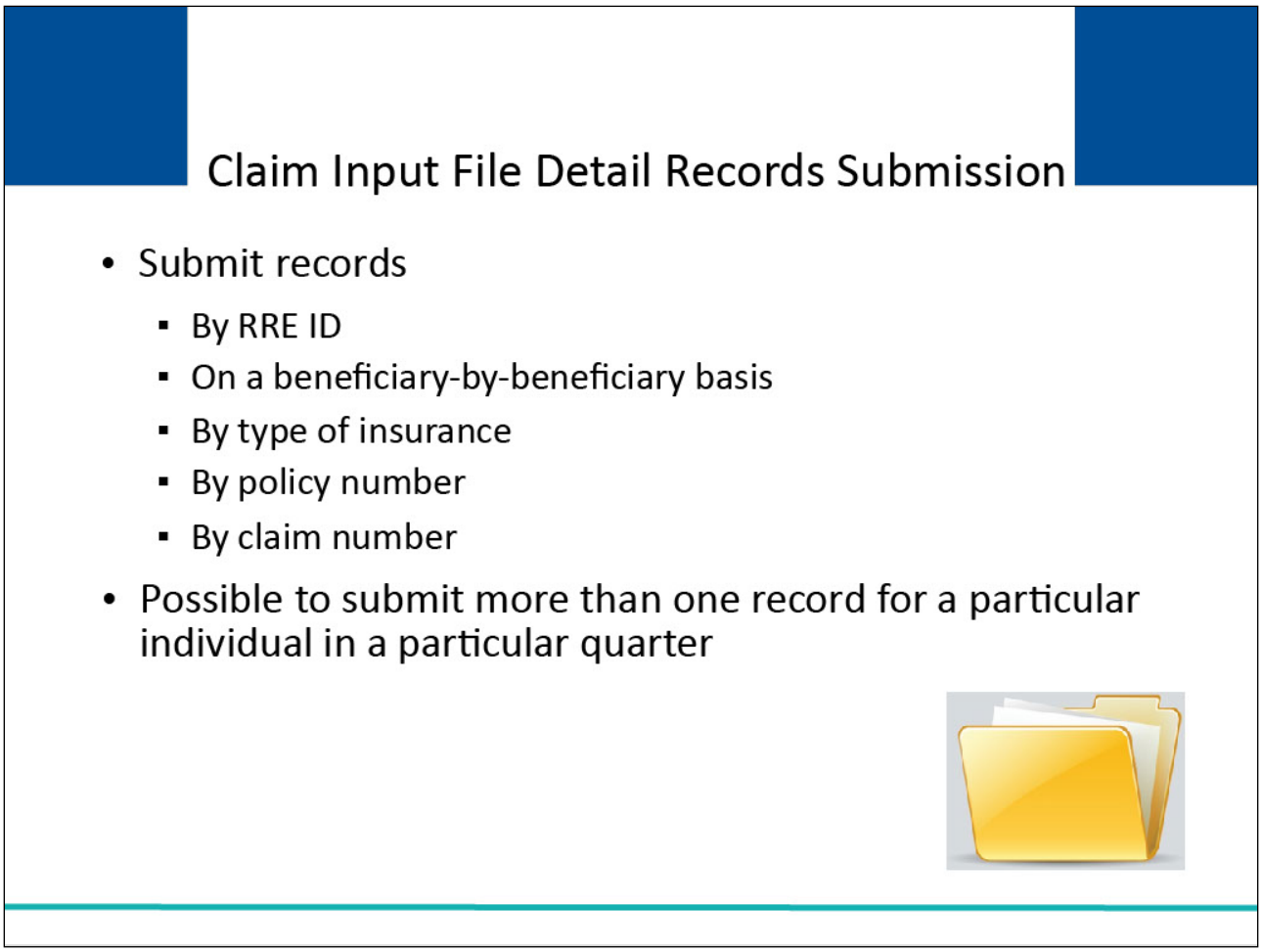


Slide notes

RREs must report no-fault insurance, workers' compensation, and liability insurance (including self-insurance) claim information where ORM related to a claim was assumed on or after January 1, 2010.

In addition, RREs must report claim information for claims considered open by the RRE where ORM exists on or through January 1, 2010, regardless of the date of an initial assumption of ORM (the assumption of ORM predates January 1, 2010).

Slide 20 of 39 - Claim Input File Detail Records Submission



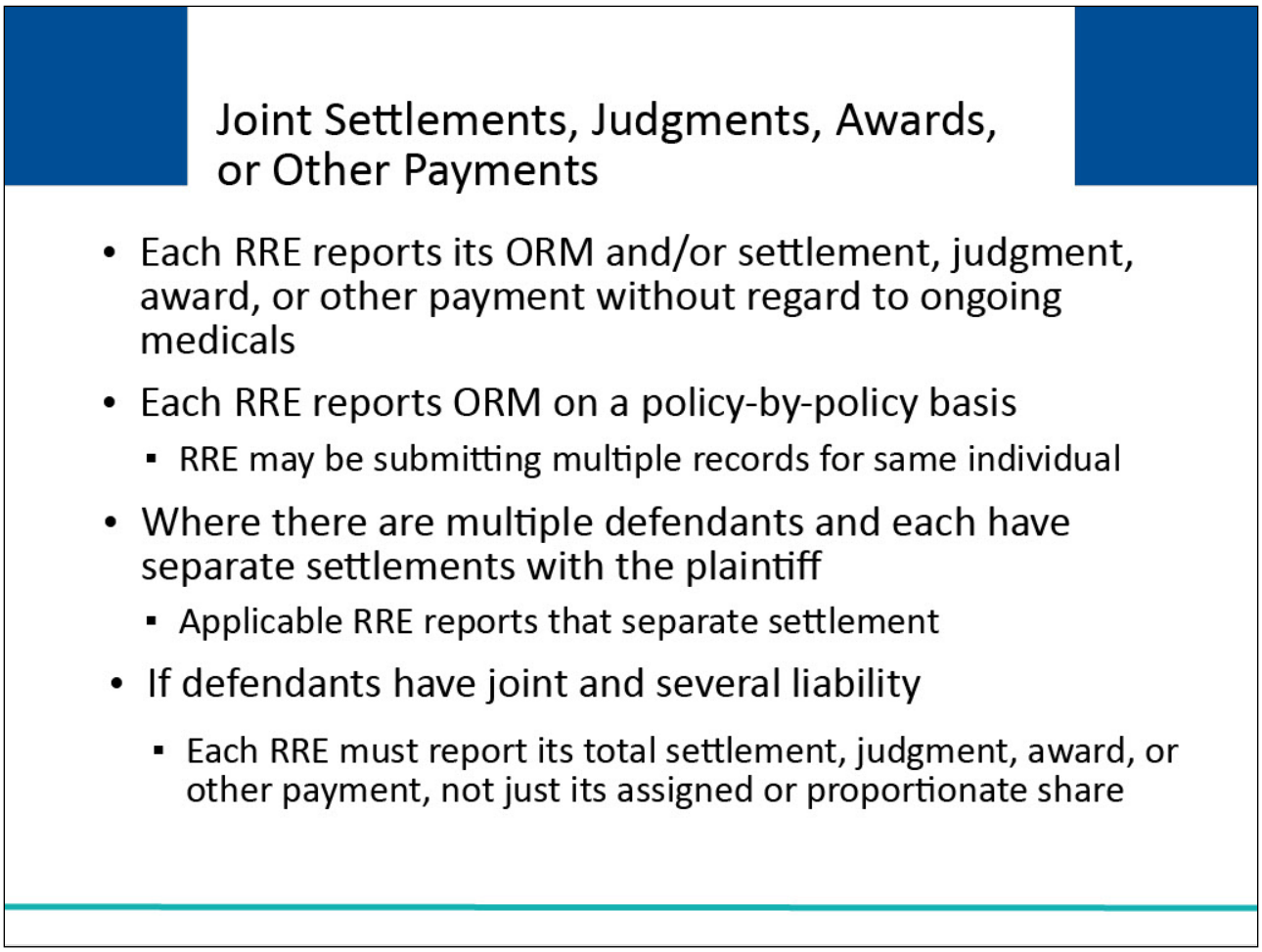
Slide notes

Records are submitted by RRE ID on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by claim number, etc.

The Policy Number should be submitted with a consistent format. When sending updates, enter the Policy Number exactly as it was entered on the original submission, whether zeros or a full Policy Number. To support previous system changes, Policy Number (Field 54) has been added as a key field. If this field changes, RREs must submit a delete Claim Input File record that matches the previously accepted add record, followed by a new add record with the changed information (i.e., delete/add process).

Consequently, it is possible that an RRE will submit more than one record for a particular individual in a particular quarter's Claim Input File.

Slide 21 of 39 - Joint Settlements, Judgments, Awards, or Other Payments



Slide notes

In the case of joint settlements, judgments, awards, or other payments, each RRE reports its ORM and/or settlement, judgment, award, other payment responsibility without regard to ongoing medicals.

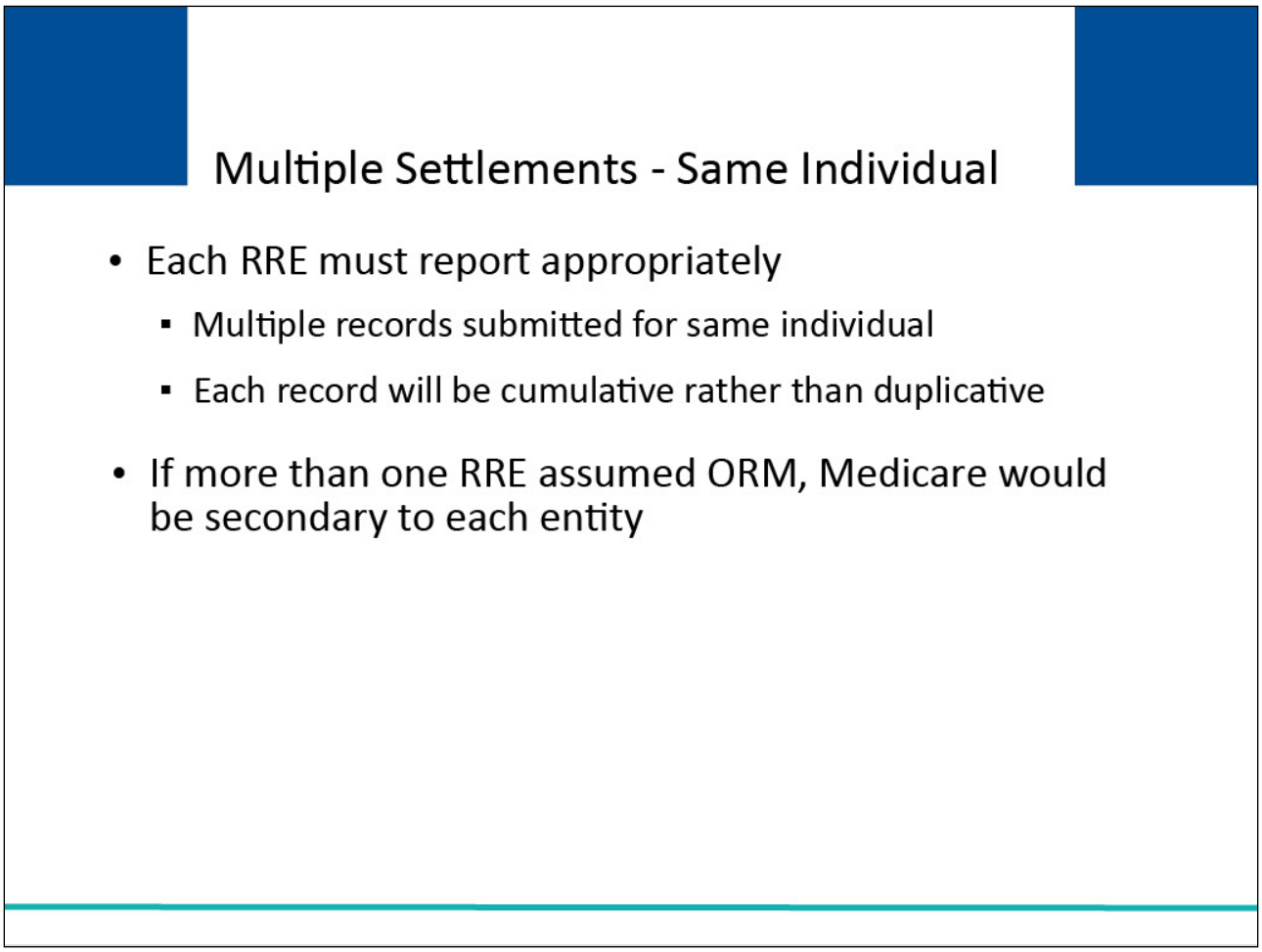
Each RRE would also report any responsibility it has for ongoing medicals on a policy-by-policy basis.

Again, depending on the number of policies at issue for an RRE and or the type of insurance or workers' compensation involved, an RRE may be submitting multiple records for the same individual.

Where there are multiple defendants and they each have separate settlements with the plaintiff, the applicable RRE reports that separate settlement amount.

For a settlement, judgment, award, or other payment with joint and several liability, each RRE must report the total settlement, judgment, award, or other payment - not just its assigned or proportionate share.

Slide 22 of 39 - Multiple Settlements - Same Individual

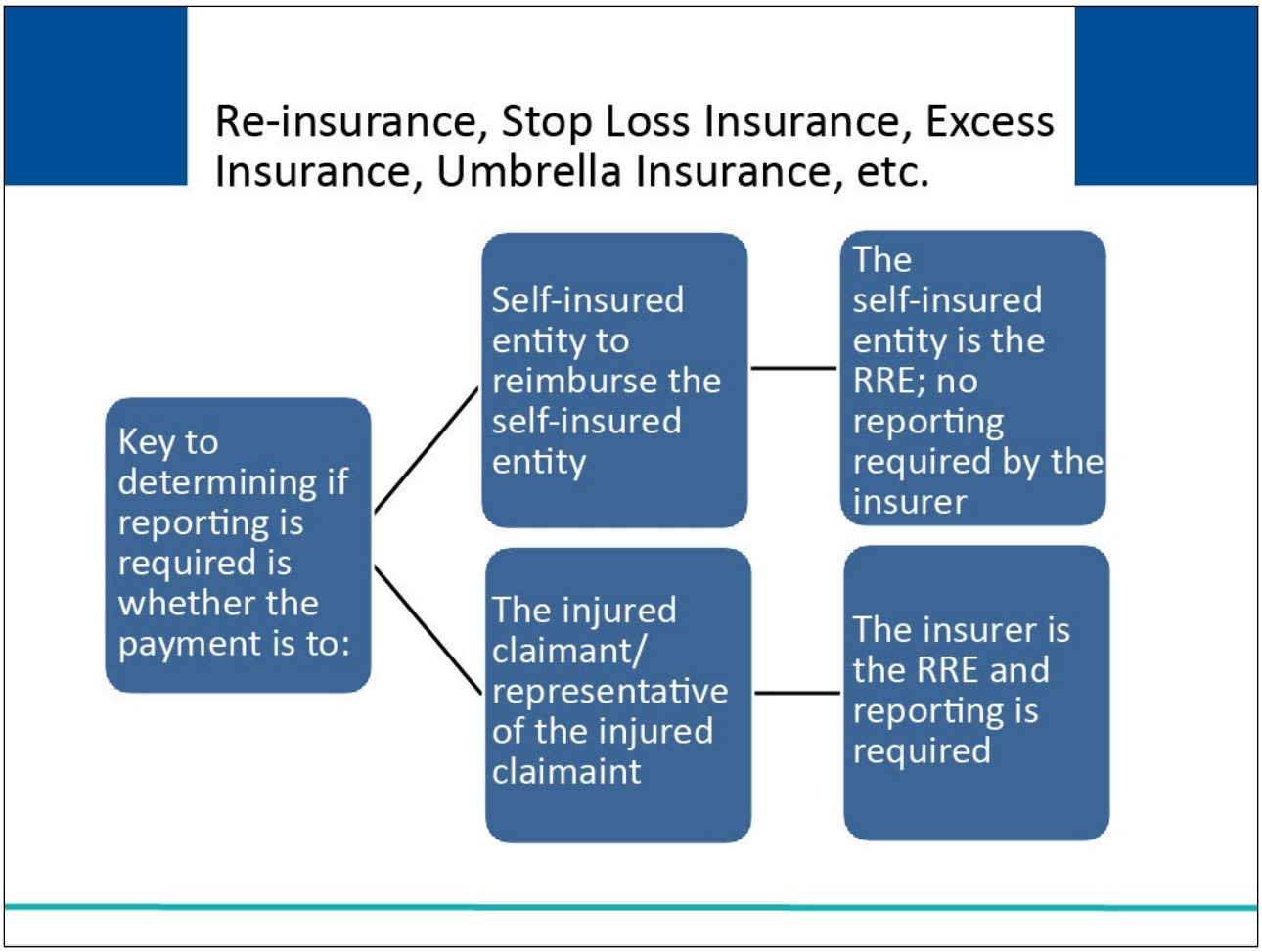


Slide notes

In the case of multiple settlements involving the same individual, each RRE must report appropriately. There will be multiple records submitted for the same individual, but they will be cumulative rather than duplicative.

Additionally, if more than one RRE has assumed ORM, Medicare would be secondary to each such entity.

Slide 23 of 39 - Re-insurance, Stop Loss Insurance, Excess Insurance, Umbrella Insurance, etc.



Slide notes

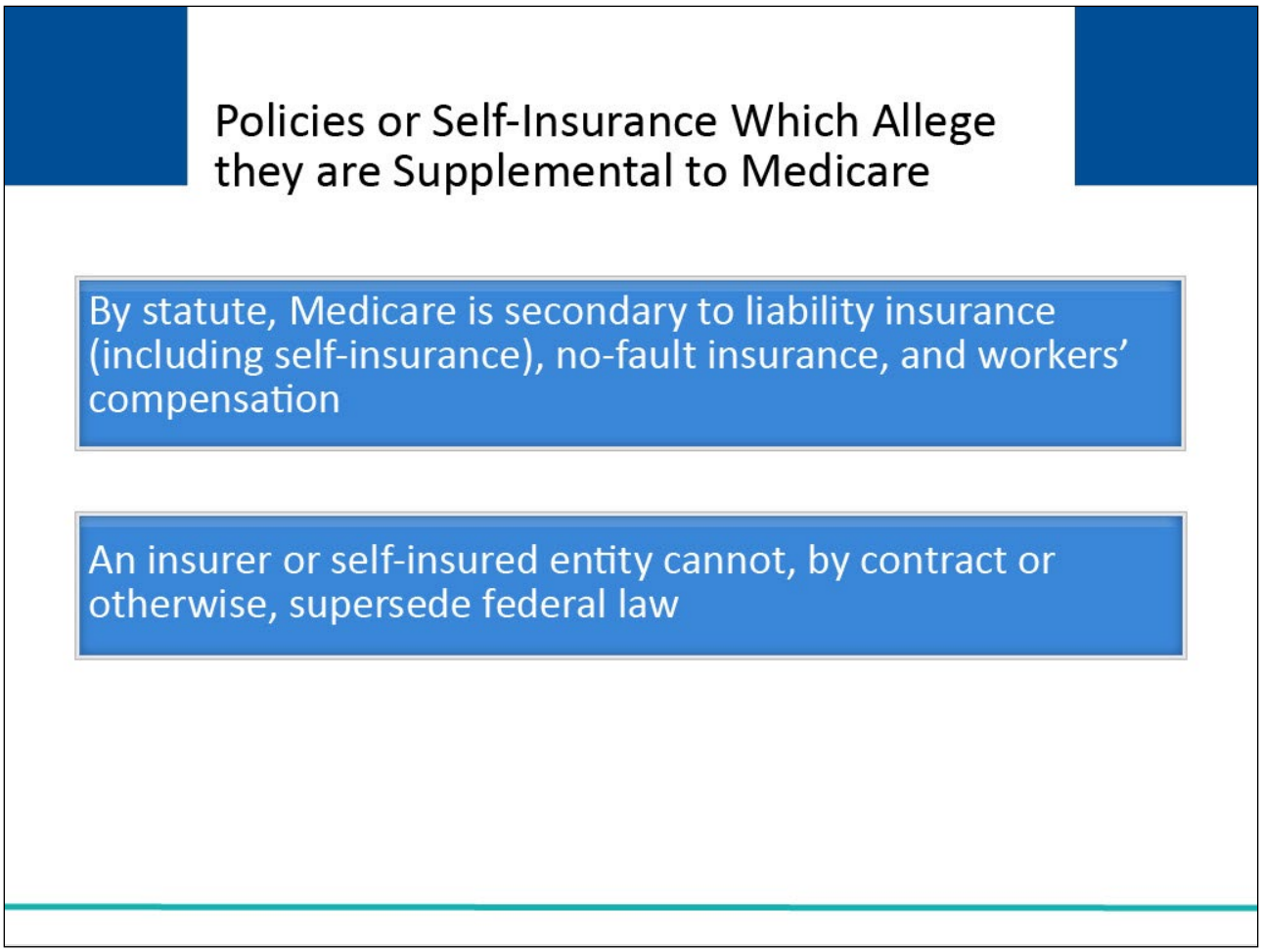
For re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds, etc. which have responsibility beyond a certain limit, the key in determining whether or not reporting for 42 U.S.C.

1395y(b)(8) is required for these situations is whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment to the self-insured entity to reimburse the self-insured entity.

Where payment is being made to reimburse the self-insured entity, the self-insured entity is the RRE for purposes of a settlement, judgment, award, or other payment to or on behalf of the injured party and no reporting is required by the insurer reimbursing the self-insured entity.

Where the insurer payment is being made to reimburse the injured claimant, the insurer is the RRE and reporting by the insurer is required.

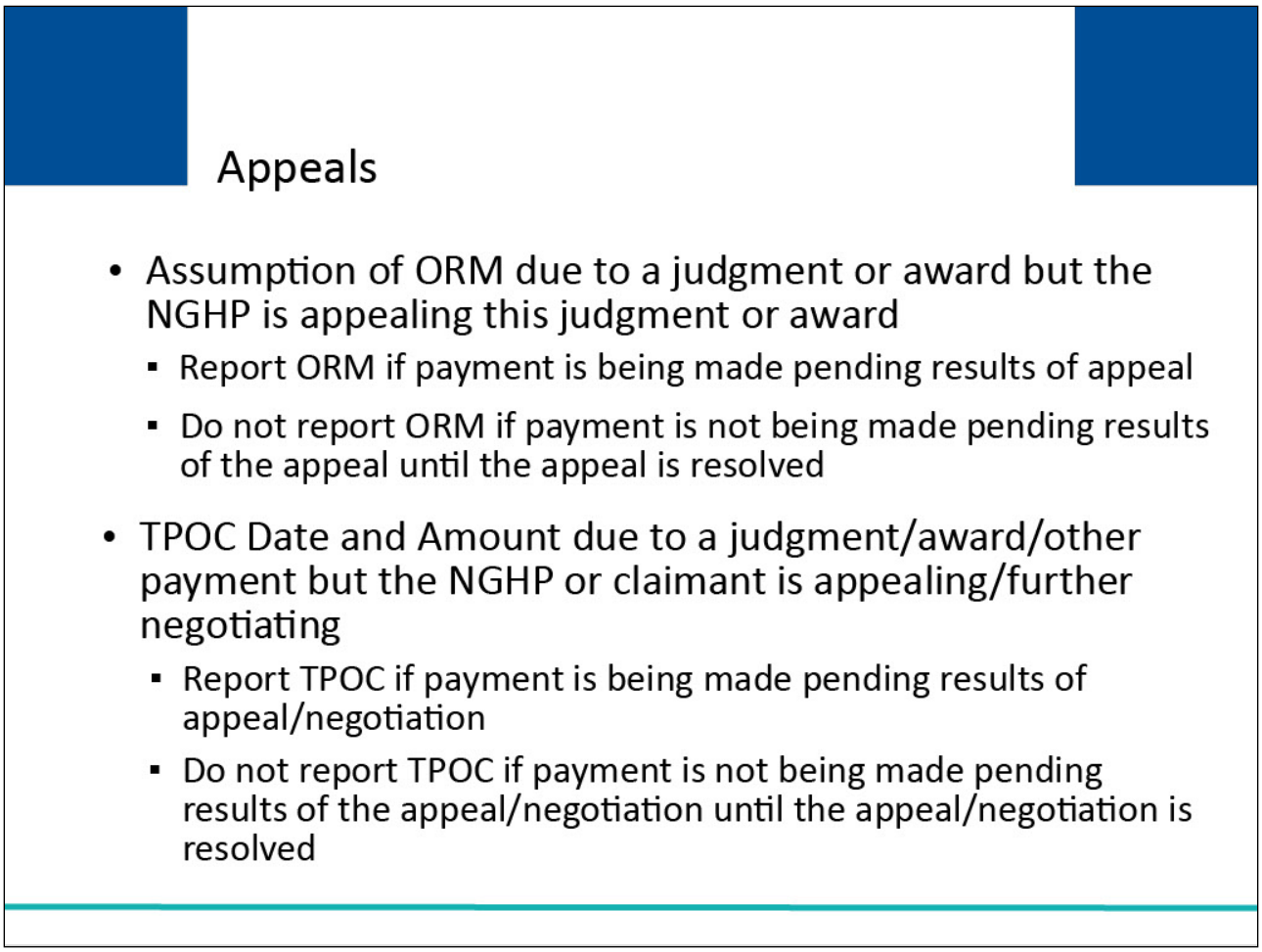
Slide 24 of 39 - Policies or Self-Insurance Which Allege they are Supplemental to Medicare



Slide notes

By statute, Medicare is secondary to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. An insurer or self-insured entity cannot, by contract or otherwise, supersede federal law.

Slide 25 of 39- Appeals



Slide notes

RREs must report ORM and/or TPOC information for claims involving appeals in the following situations:

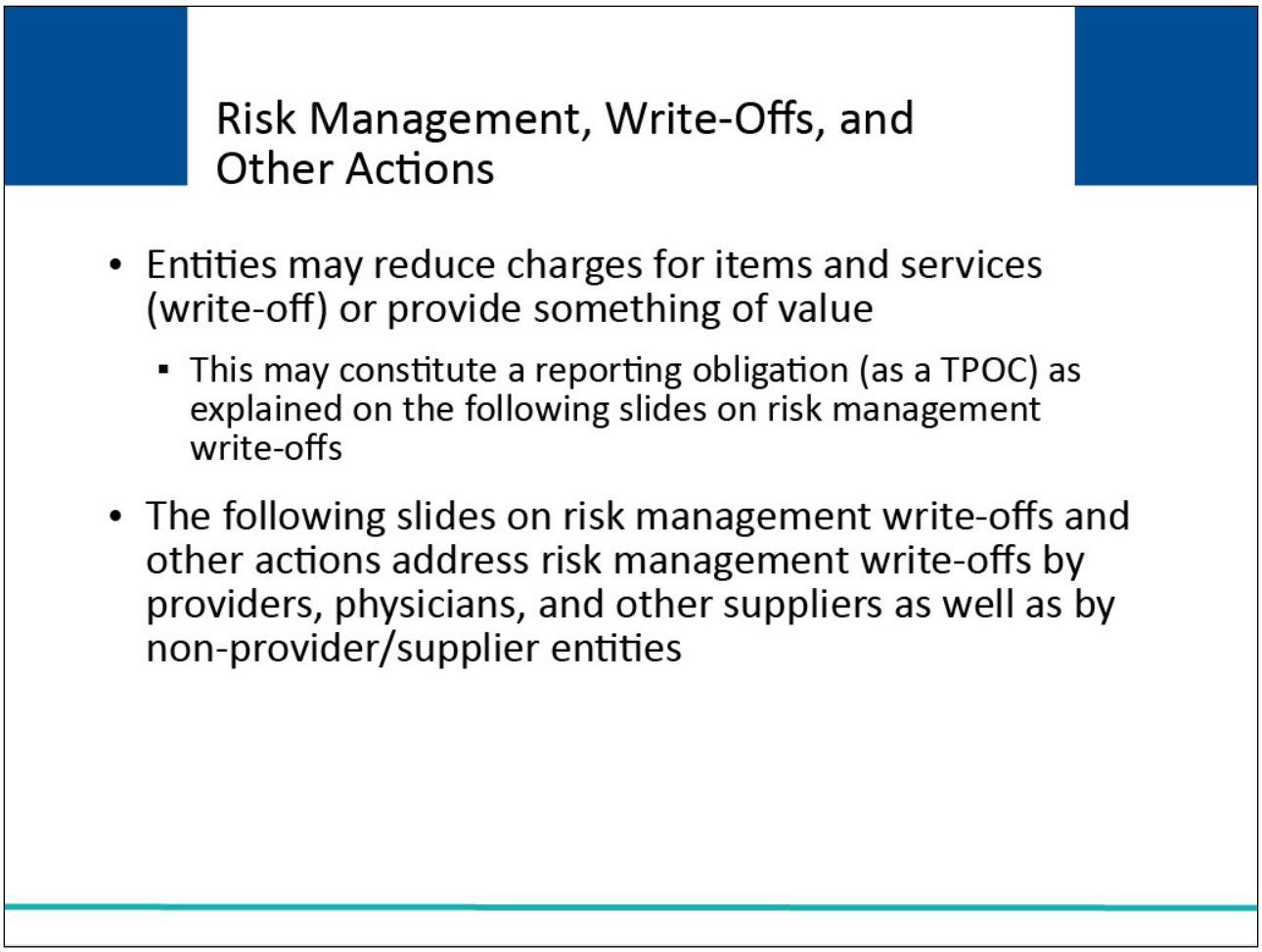
If there is an assumption of ORM due to a judgment or award but the liability insurance (including self-insurance), no-fault insurance, or workers' compensation is appealing this judgment or award, then report the ORM if the payment is being made pending results of the appeal. However, if payment is not being made pending results of the appeals, do not report the ORM until the appeal is resolved.

If there is a TPOC Date and Amount due to a judgment, award, or other payment but the liability insurance (including self-insurance), no-fault insurance, or workers' compensation or claimant is appealing or further negotiating the judgment/award/other payment, then report the TPOC if payment is being made, pending results of the appeal/negotiation.

However, if payment is not being made pending results of the appeal/negotiation, do not report the TPOC until the appeal/negotiation is resolved.

Note: Guidance on what triggers the need to report ORM has been clarified in the NGHP User Guide (Sections 6.3 and 6.5.1.1).

Slide 26 of 39 - Risk Management, Write-Offs, and Other Actions



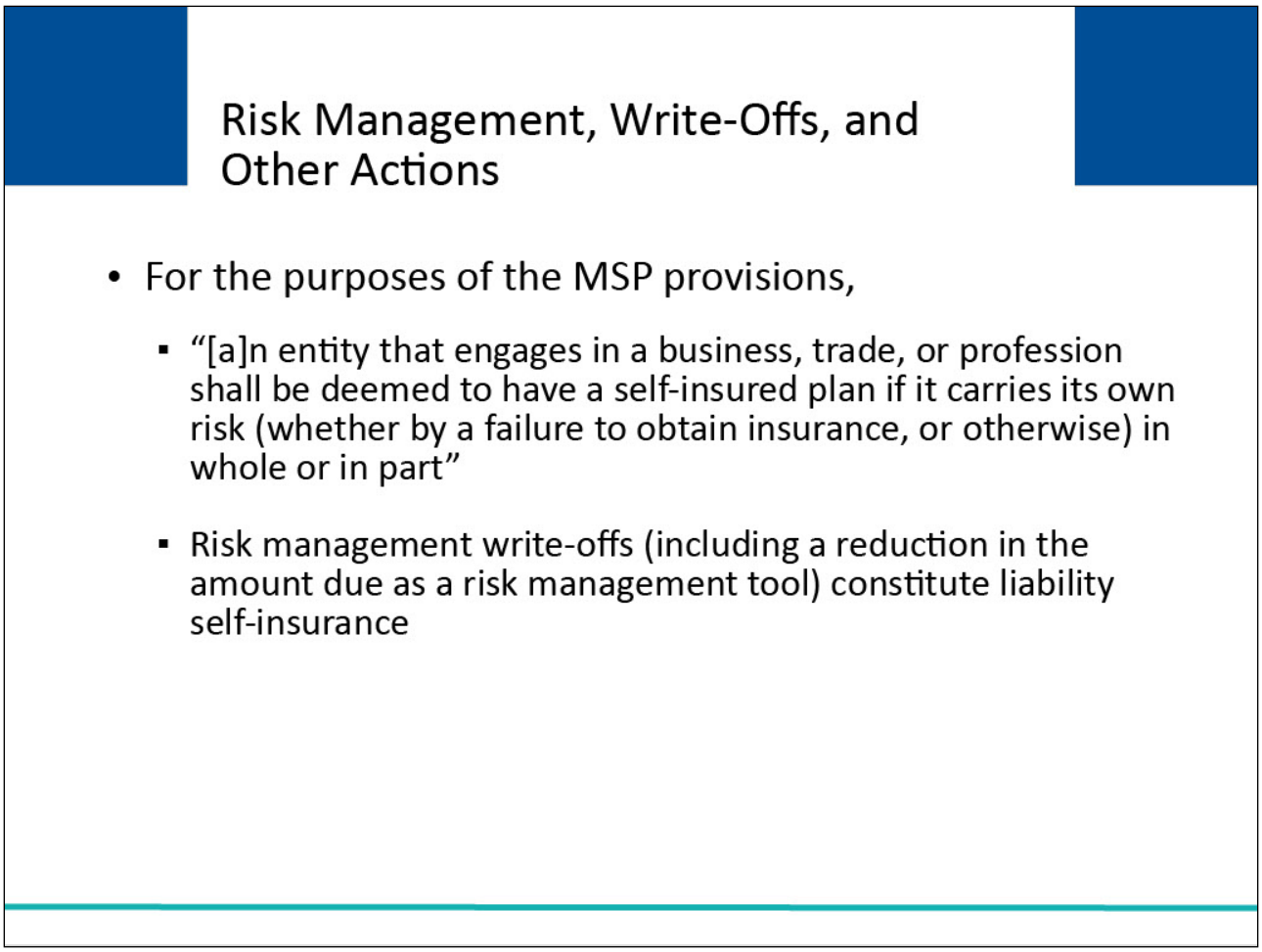
Slide notes

As a risk management tool to lessen the probability of a liability claim against it and/or to facilitate/enhance customer good-will, entities may reduce charges for items and services (write-off) or provide something of value (e.g., cash, gift card, etc.).

If an entity takes such actions, it may or may not constitute a reporting obligation (as a TPOC) as explained on the following slides regarding risk management write-offs.

Please note: These slides address risk management write-offs by providers, physicians, and other suppliers as well as by non-provider/supplier entities.

Slide 27 of 39 - Risk Management, Write-Offs, and Other Actions

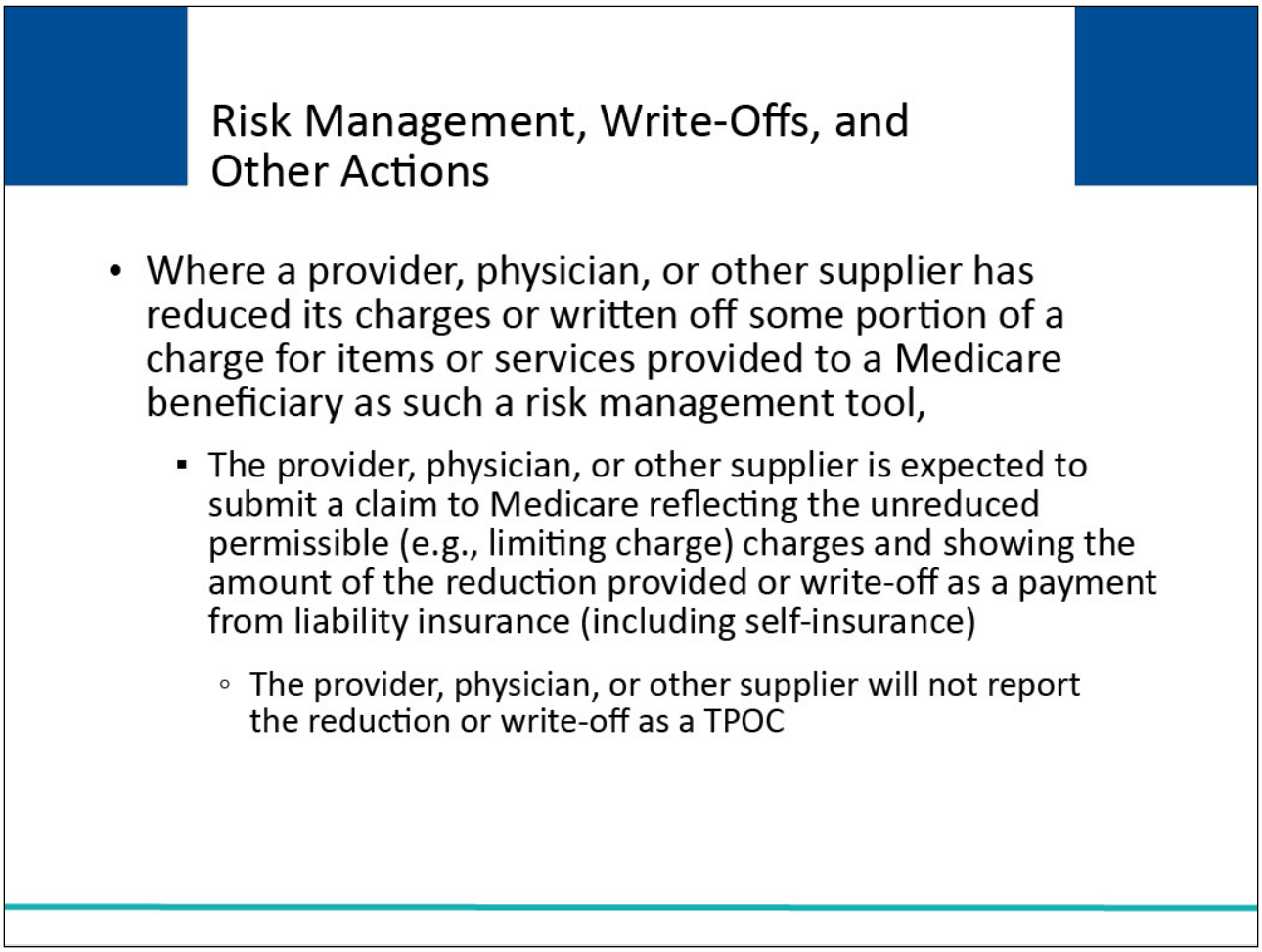


Slide notes

For the purposes of the Medicare Secondary Payer (MSP) provisions, "[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." (42 U.S.C. 1395y(b)(2)(A)).

Risk management write-offs (including a reduction in the amount due as a risk management tool) constitute liability self-insurance for the purposes of the MSP provisions.

Slide 28 of 39 - Risk Management, Write-Offs, and Other Actions

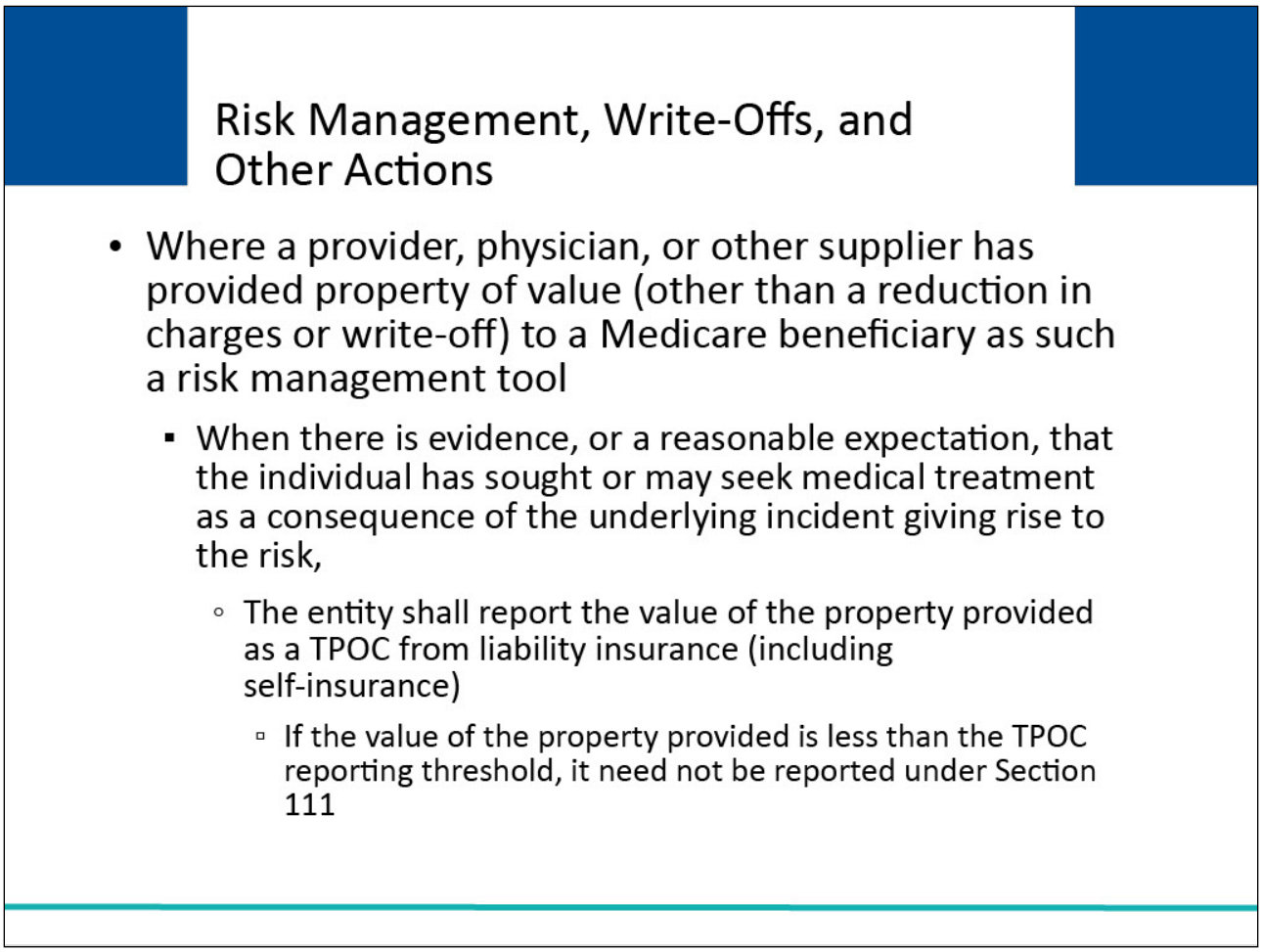


Slide notes

In instances where a provider, physician or other supplier has reduced its charges or written off some portion of a charge for items or services provided to a Medicare beneficiary as such a risk management tool, the provider, physician, or other supplier is expected to submit a claim to Medicare reflecting the unreduced permissible (e.g., limiting charge) charges and showing the amount of the reduction provided or write-off as a payment from liability insurance (including self-insurance).

Medicare's interests with respect to this particular TPOC amount have been protected through this billing procedure; the provider, physician or other supplier will not report the reduction or write-off as a TPOC.

Slide 29 of 39 - Risk Management, Write-Offs, and Other Actions



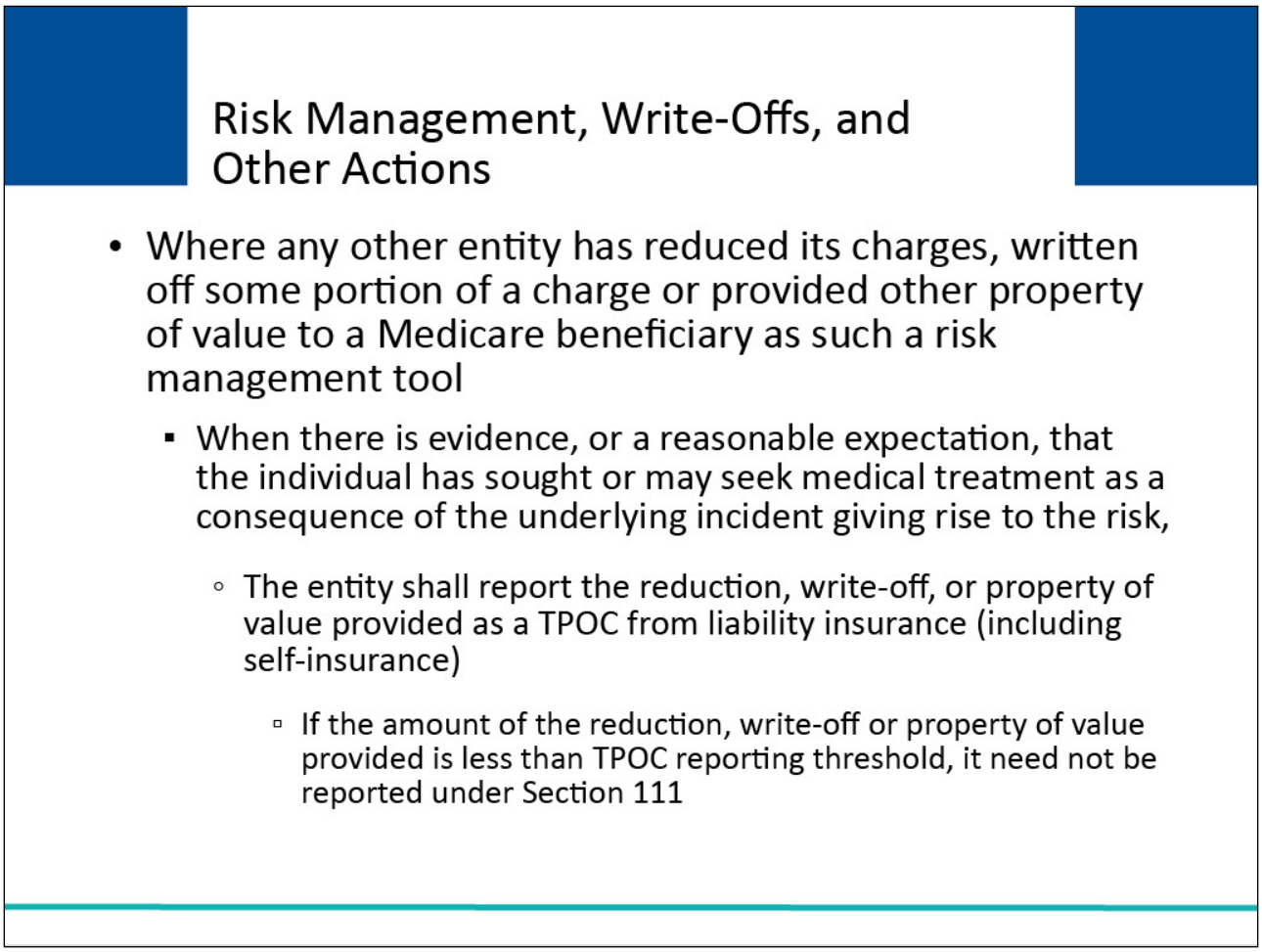
Slide notes

In instances where a provider, physician, or other supplier has provided property of value (other than a reduction in charges or write-off) to a Medicare beneficiary

as such a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the value of the property provided as a TPOC from liability insurance (including self-insurance).

If the value of the property provided is less than the TPOC reporting threshold, it need not be reported under Section 111.

Slide 30 of 39 - Risk Management, Write-Offs, and Other Actions

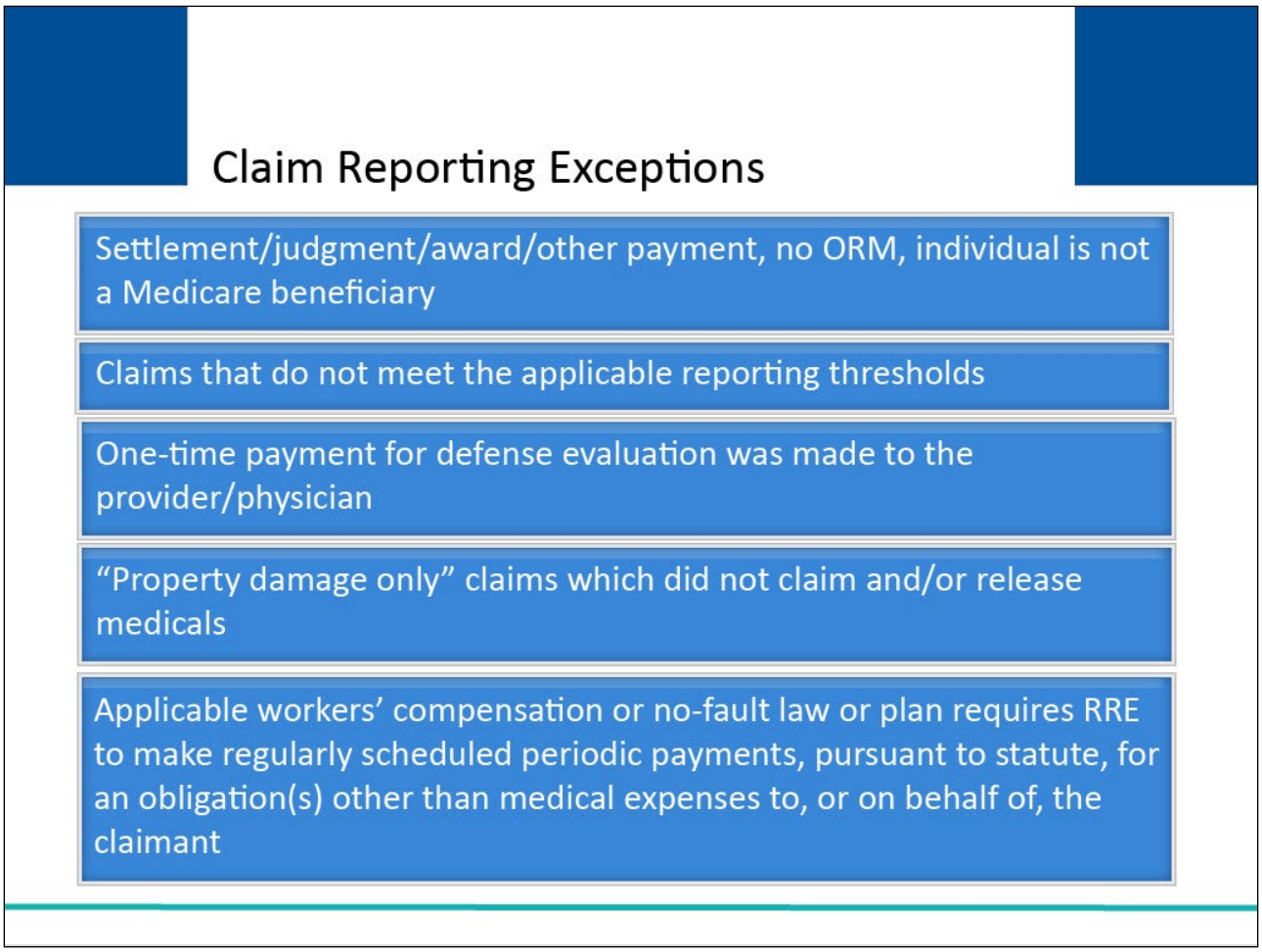


Slide notes

In instances where any other entity has reduced its charges, written off some portion of a charge or provided other property of value to a Medicare beneficiary as such a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the reduction, write-off, or property of value provided as a TPOC from liability insurance (including self-insurance).

If the amount of the reduction, write-off or property of value provided is less than TPOC reporting threshold, it need not be reported under Section 111.

Slide 31 of 39 - Claim Reporting Exceptions



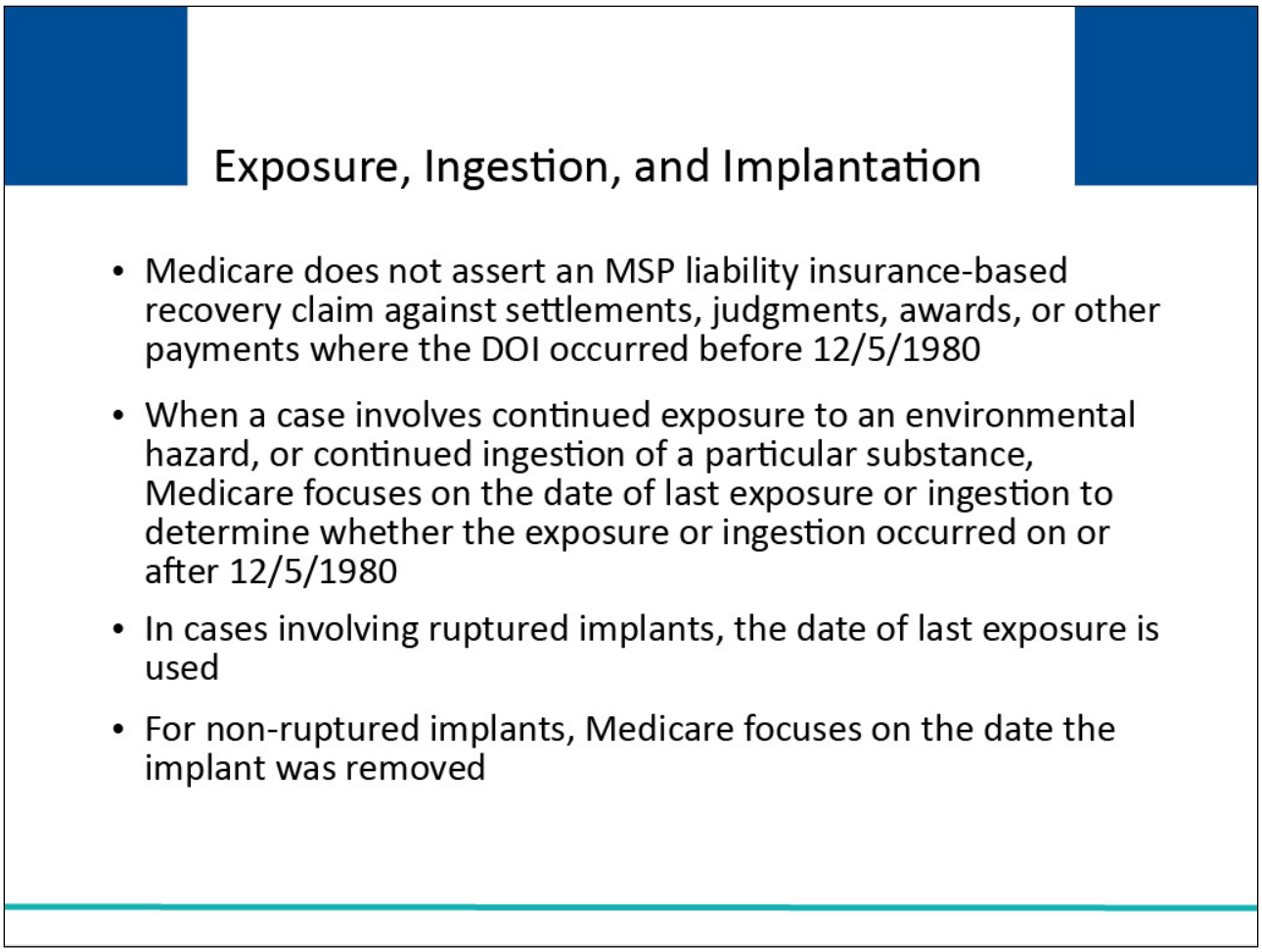
Slide notes

In regard to Section 111, RREs are not required to report liability insurance (including self-insurance) settlements, judgments, awards, or other payments for the following situations:

- Where there is a settlement, judgment, award, or other payment with no ORM if the individual is not a Medicare beneficiary
- Where the claim does not meet the reporting thresholds
- Where a one-time payment for defense evaluation was made directly to the provider/physician furnishing this service
- Where there is a "property damage only" claim which did not claim and/or release medicals or have the effect of releasing medicals; and
- Where the applicable workers' compensation or no-fault law or plan requires the RRE to make regularly scheduled periodic payments, pursuant to statute, for an obligation(s) other than medical expenses to, or on behalf of, the claimant, the RRE does not report these periodic payments as long as the RRE separately assumes/continues to assume ORM and reports this ORM appropriately.

Otherwise, such scheduled periodic payments are considered to be part of and are reported as ORM. To align with the terms and conditions regarding the acceptance of Ongoing Responsibility for Medicals (ORM) as described in Section 6.4 of the User Guide, the language around periodic payments or one-time settlements to compensate for lost wages has been clarified in Section 6.5.1.

Slide 32 of 39 - Exposure, Ingestion, and Implantation



Slide notes

As a matter of policy, Medicare does not assert an MSP liability insurance-based recovery claim against settlements, judgments, awards, or other payments, where the date of incident (DOI) occurred before 12/5/1980.

When a case involves continued exposure to an environmental hazard or continued ingestion of a particular substance,

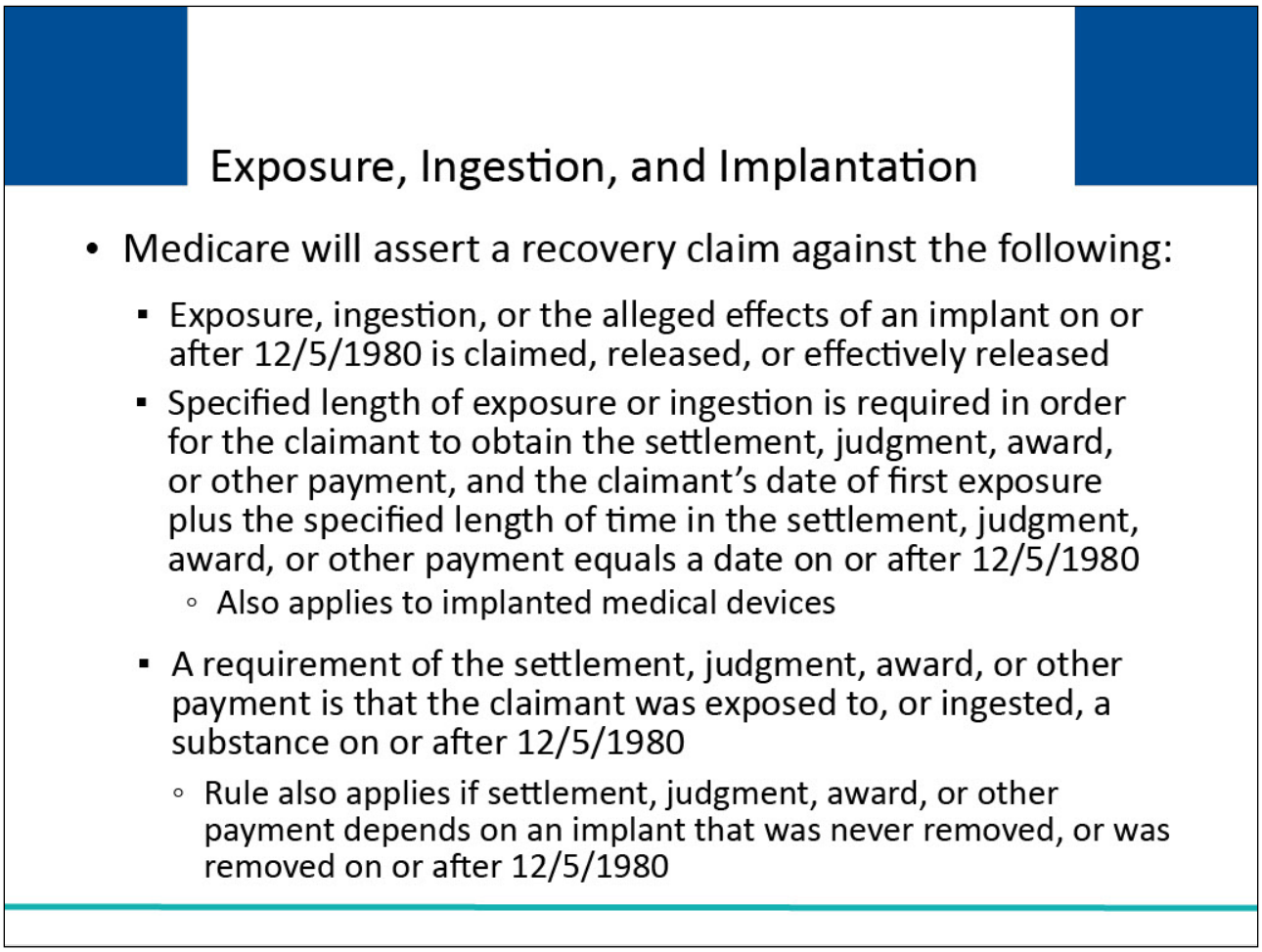
Medicare focuses on the date of last exposure or ingestion for purposes of determining whether the exposure or ingestion occurred on or after 12/5/1980.

Similarly, in cases involving ruptured implants that allegedly led to toxic exposure, the exposure guidance or date of last exposure is used. For non-ruptured implanted medical devices, Medicare focuses on the date the implant was removed.

Note: The term “exposure” refers to the claimant’s actual physical exposure to the alleged environmental toxin, not the defendant’s legal exposure to liability.

Also, note that application of the December 5, 1980, is specific to a particular claim/defendant.

Slide 33 of 39 - Exposure, Ingestion, and Implantation



Slide notes

In the following situations, Medicare will assert a recovery claim against settlements, judgments, awards, or other payments, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111 MSP mandatory reporting rules must be followed:

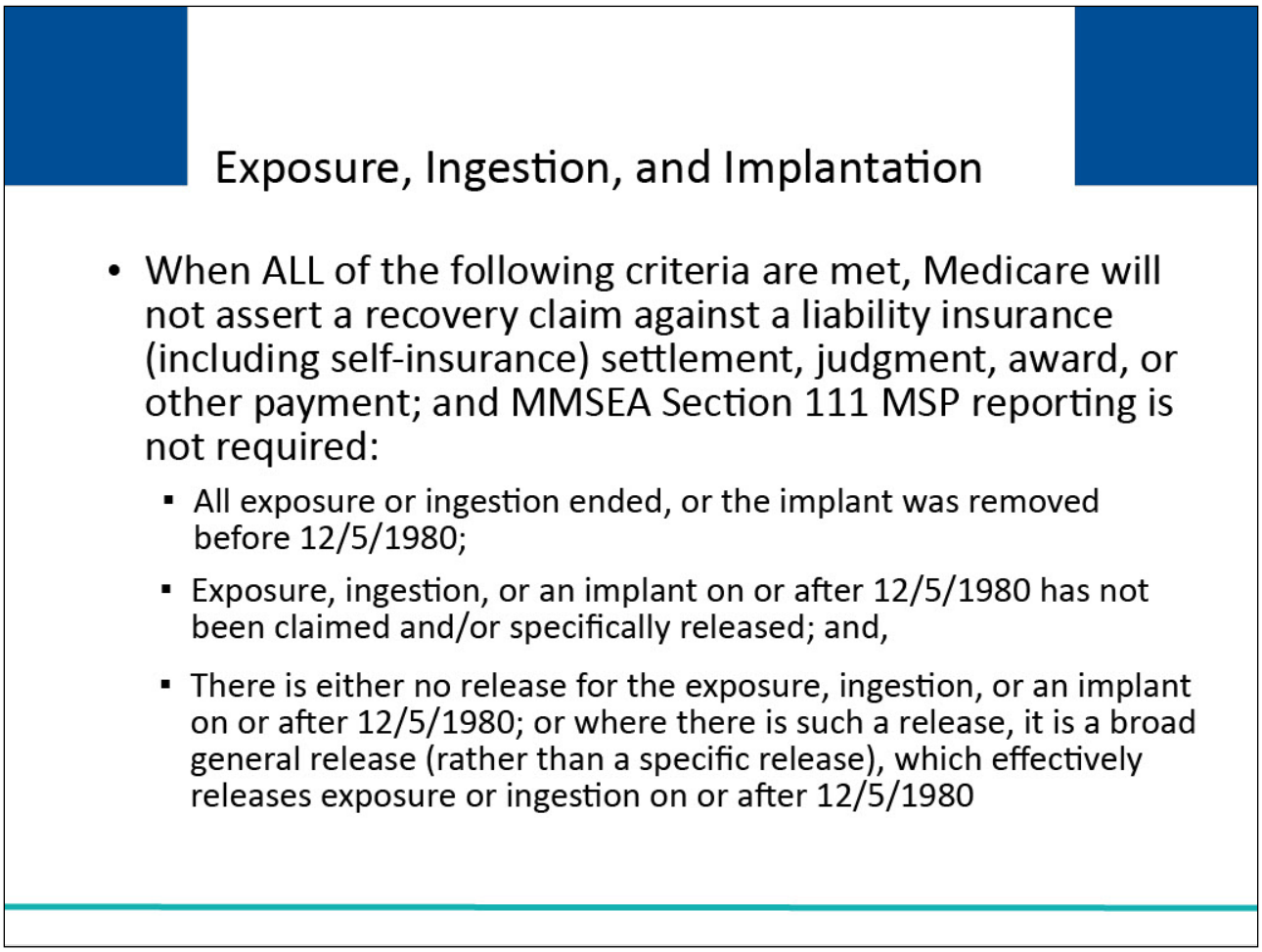
Exposure, ingestion, or the alleged effects of an implant on or after 12/5/1980 is claimed, released, or effectively released.

A specified length of exposure or ingestion is required in order for the claimant to obtain the settlement, judgment, award, or other payment, and the claimant's date of first exposure plus the specified length of time in the settlement, judgment, award, or other payment equals a date on or after 12/5/1980. This also applies to implanted medical devices.

A requirement of the settlement, judgment, award, or other payment is that the claimant was exposed to, or ingested, a substance on or after 12/5/1980.

This rule also applies if the settlement, judgment, award, or other payment depends on an implant that was never removed or was removed on or after 12/5/1980.

Slide 34 of 39 - Exposure, Ingestion, and Implantation



Slide notes

When ALL of the following criteria are met, Medicare will not assert a recovery claim against a liability insurance (including self-insurance) settlement, judgment, award, or other payment; and MMSEA Section 111 MSP reporting is not required.

(Note: Where multiple defendants are involved, the claimant must meet all of these criteria for each individual defendant in order for a settlement, judgment, award, or other payment from that defendant to be exempt from a potential MSP recovery claim and MMSEA Section 111 reporting):

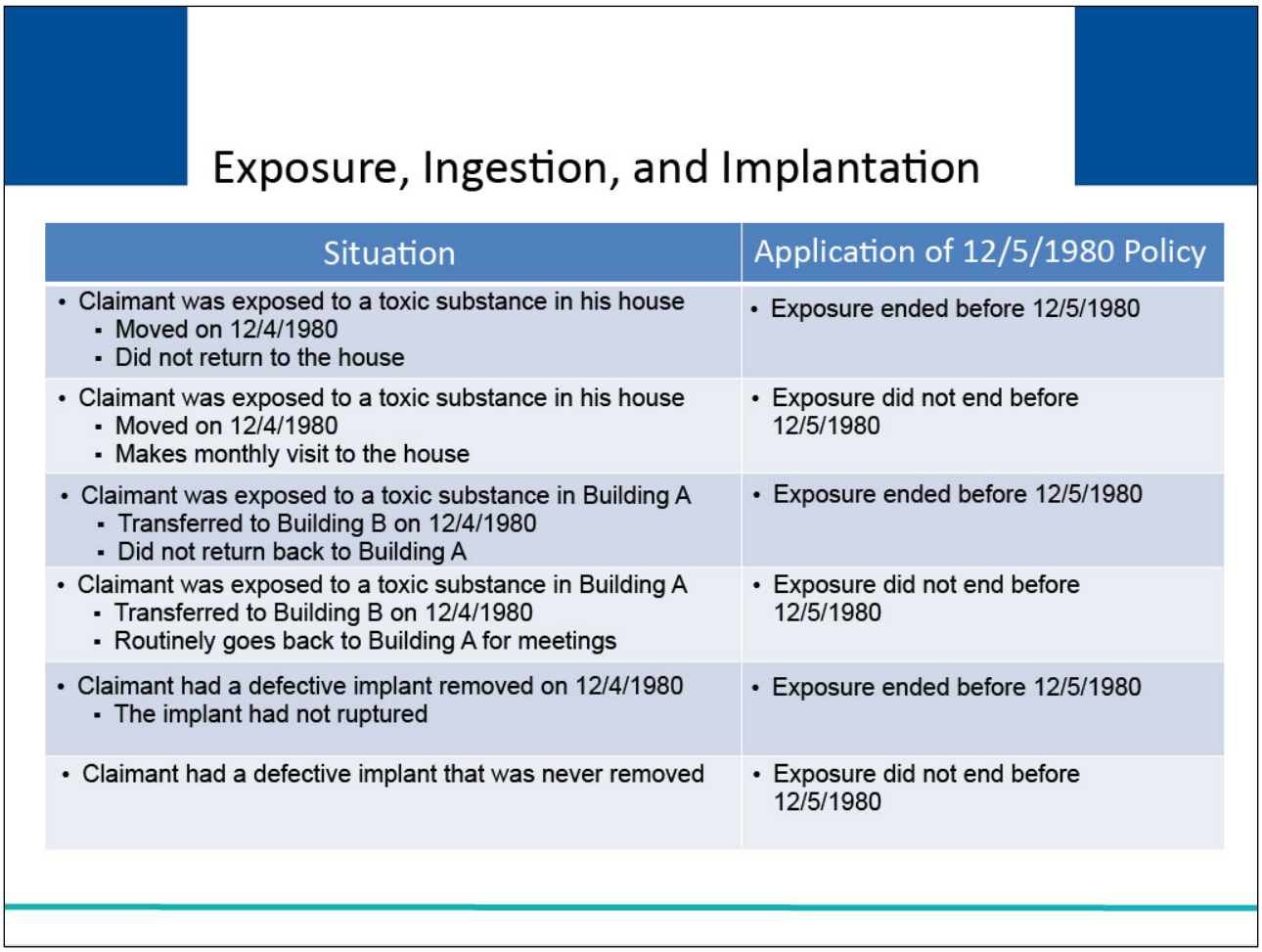
All exposure or ingestion ended, or the implant was removed before 12/5/1980; and

Exposure, ingestion, or an implant on or after 12/5/1980 has not been claimed and/or specifically released; and,

There is either no release for the exposure, ingestion, or an implant on or after 12/5/1980; or where there is such a release, it is a broad general release (rather than a specific release),

which effectively releases exposure or ingestion on or after 12/5/1980. The rule also applies if the broad general release involves an implant.

Slide 35 of 39 - Exposure, Ingestion, and Implantation



Slide notes

The following examples illustrate how the policy related to December 5, 1980, should be applied to situations involving exposure, ingestion, and implantation.

In the first example, the claimant was exposed to a toxic substance in his house. He moved on 12/4/1980 and did not return to the house. In this case, exposure ended before 12/5/1980.

In the next example, the claimant was exposed to a toxic substance in his house. He moved on 12/4/1980 but makes monthly visits to the house because his mother continues to live in the house.

In this case, exposure did not end before 12/5/1980.

For the third example, the claimant was exposed to a toxic substance while he worked in Building A. He was transferred to Building B on 12/4/1980 and did not return to Building A. In this case, exposure ended before 12/5/1980.

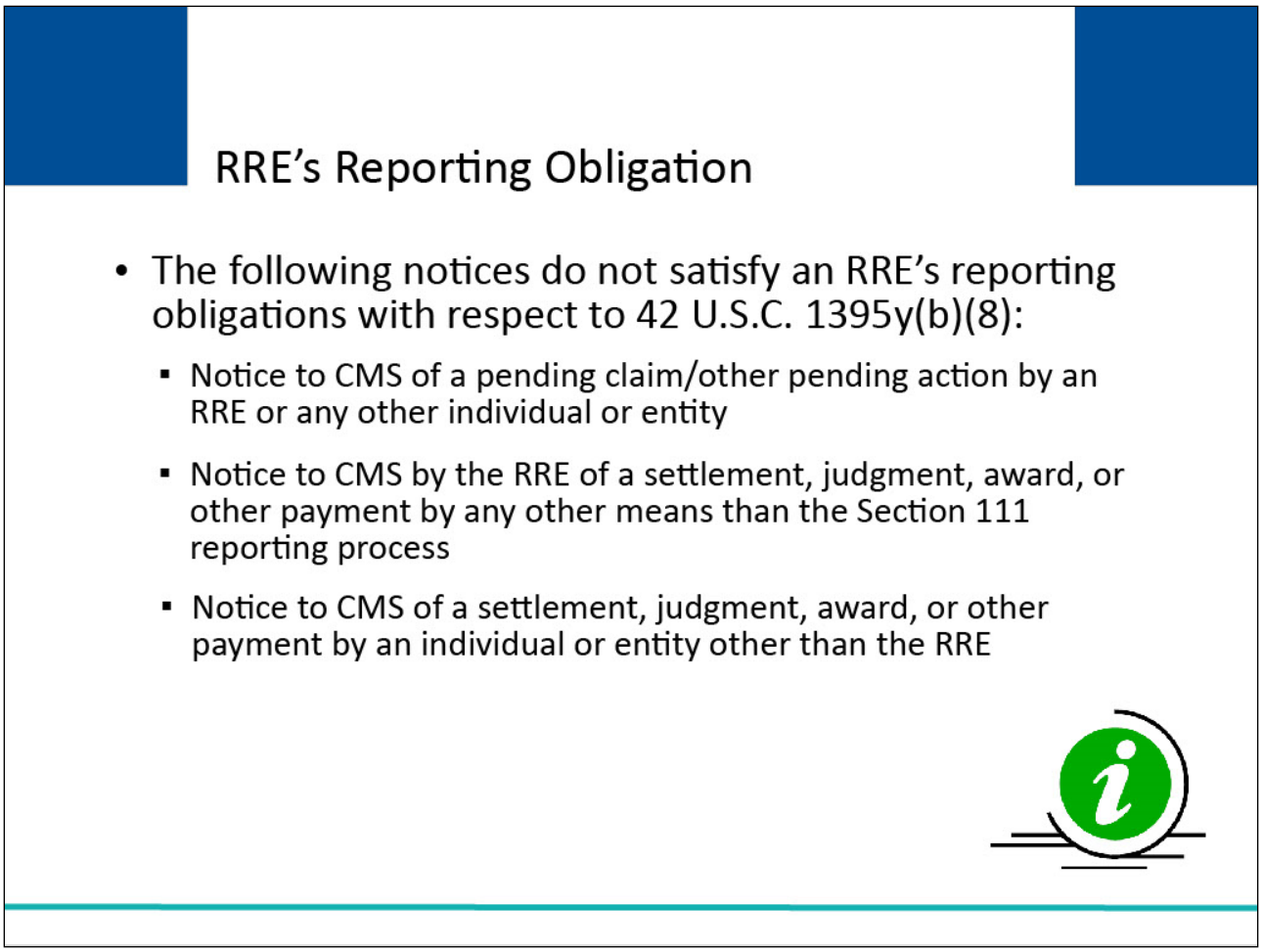
In the next example, the claimant was exposed to a toxic substance while he worked in Building A. He was transferred to Building B on 12/4/1980 but routinely goes to Building A for meetings.

In this case, exposure did not end before 12/5/1980.

For the fifth example, the claimant had a defective implant removed on 12/4/1980. The implant had not ruptured. In this case, exposure ended before 12/5/1980.

In the final example, the claimant had a defective implant that was never removed. In this case, exposure did not end before 12/5/1980.

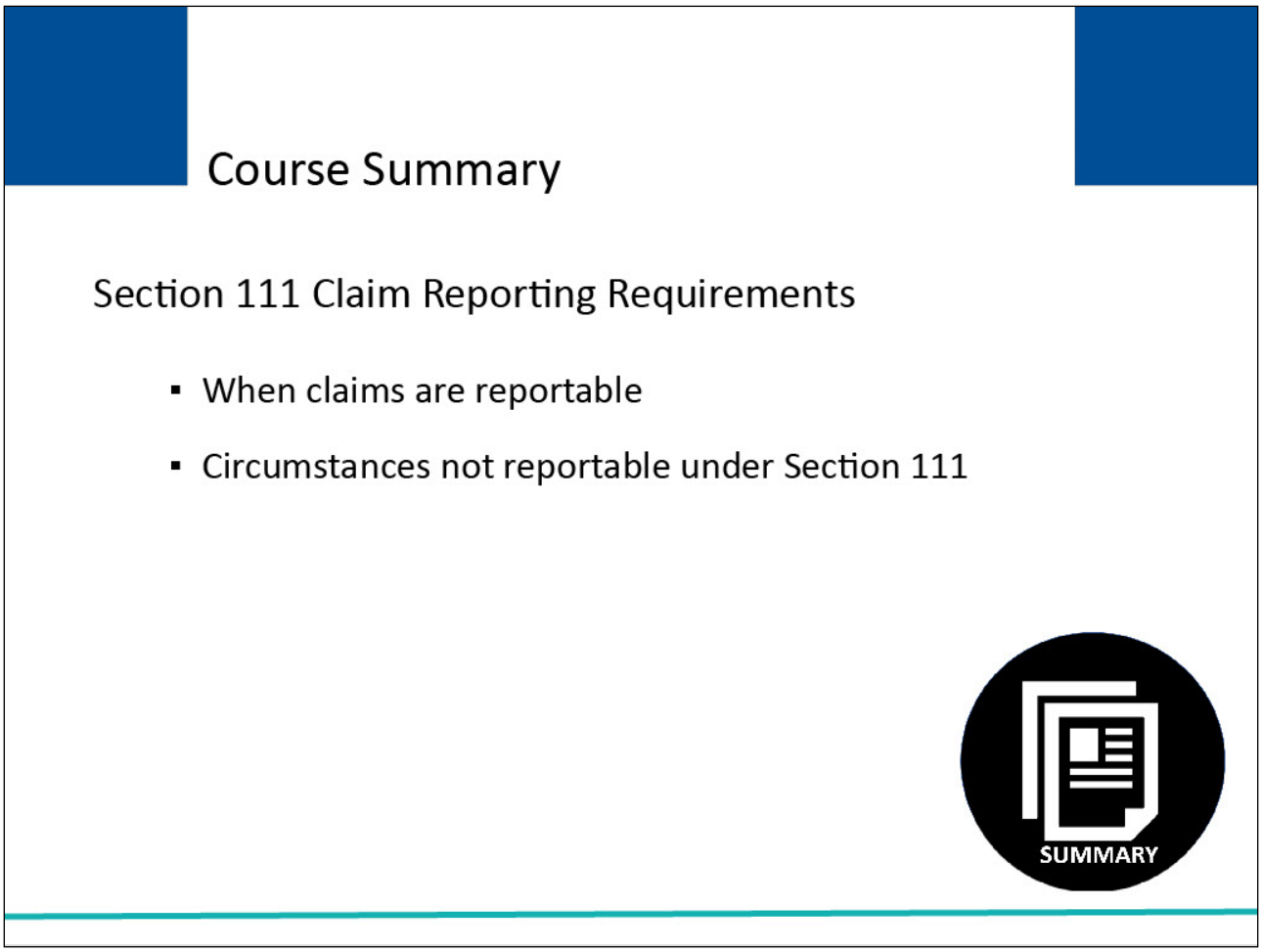
Slide 36 of 39 - RRE's Reporting Obligation



Slide notes

Otherwise, such scheduled periodic payments are considered to be part of and are reported as ORM. To align with the terms and conditions regarding the acceptance of Ongoing Responsibility for Medicals (ORM) as described in Section 6.4 of the User Guide, the language around periodic payments or one-time settlements to compensate for lost wages has been clarified in Section 6.5.1.

Slide 37 of 39 - Course Summary



Slide notes

This learning module reviewed the Section 111 claim reporting requirements. It explained when claims are reportable and provided information regarding circumstances that are not reportable under Section 111.

Slide 38 of 39 - Conclusion

Slide notes

You have completed the Reportable Claims course. Information in this course can be referenced by using the NGHP User Guide's table of contents.

This document is available for download at the following link: CMS NGHP Website.

Slide 39 of 39 - NGHP Training Survey

Slide notes

If you have any questions or feedback on this material, please go the following URL: Training Survey.