Highlights of February 23, 2012 CMS Teleconference on Section 111 Reporting

The Centers for Medicare and Medicaid Services (CMS) conducted a teleconference on Thursday, February 23rd to provide an update on technical and policy issues in implementation of the requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

Highlights of the Call Included:

1. HHS has announced a delay in the implementation of ICD-10 reporting. This also applies to Section 111 reporting and Medicare claims processing. A new timeline for implementation has not yet been set. CMS has an Alert pending on ICD-10 implementation.

2. CMS is reviewing a possible alert that would address the circumstances under which payments based on broad general releases would not need to be reported. They may develop criteria similar to that in the Alert on the 12/5/1980 as a guideline.

3. In cases where there are multiple periodic payments as part of a TPOC the individual payments should not be reported separately but should be included as part of the TPOC (see user manual).

4. Delays in the timeline for Liability reporting are still in place. CMS advises that the Alert dated September 30, 2011 and Section 11.4 of the User Guide should be followed.

5. The password reset requirement every 60 days is a general security requirement, so even if RREs would prefer to continue with the same password CMS does not have flexibility to revise this.

6. Empty file submissions should not be reported and RREs should consult their EDI reps.

7. If there is a claim for lost wages only in a death benefit case and there is no release of medicals, RREs may choose not to report.

8. RREs should not submit reports until they have assumed responsibility for ORM. However, if state law requires that the RRE make payments to an individual pending final determination of a disputed case such payments should be reported as state law requires that the RRE assume responsibility.

9. The entire settlement payment is to be reported, not just an amount allocated for future medical. Procurement costs included in the settlement should be reported as they are part of the total settlement amount.

10. CMS is reviewing policy with respect to Loss of Consortium. If there are any medicals claimed the loss of consortium payments should be reported. Note: there may be drugs or treatment for emotional distress in these cases. CMS plans to add language to the User Guide to address this issue.

11. CMS continues to require that write offs, reductions in charges and risk management payments should be reported the same as if there was a payment from another insurer.

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12. CMS continues as a matter of policy, even if an insurer denied payment for an insured, if the insured makes the payment it must be reported.

13. If a person is not a Medicare beneficiary and never has been and there is a TPOC the RRE is not required to report the payment. However, if there is ORM for a person who is not a Medicare beneficiary, the RRE is responsible to monitor and report when there is Medicare entitlement.

14. If there are multiple defendants in a case and there is no joint and several liability then each defendant should report its individual responsibility. If there is joint and several liability then the defendants must report the total amount of the settlement for the entire group. An alert on this topic is in review.

NOTE: THE NOTES ABOVE ARE NOT THE ACTUAL PROVISIONS AND ONLY BRIEF NOTES FROM THE CONFERENCE CALL. REFER TO THE CMS WEB SITE AND THE ALERTS AND USER GUIDE AS THEY ARE PUBLISHED.

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