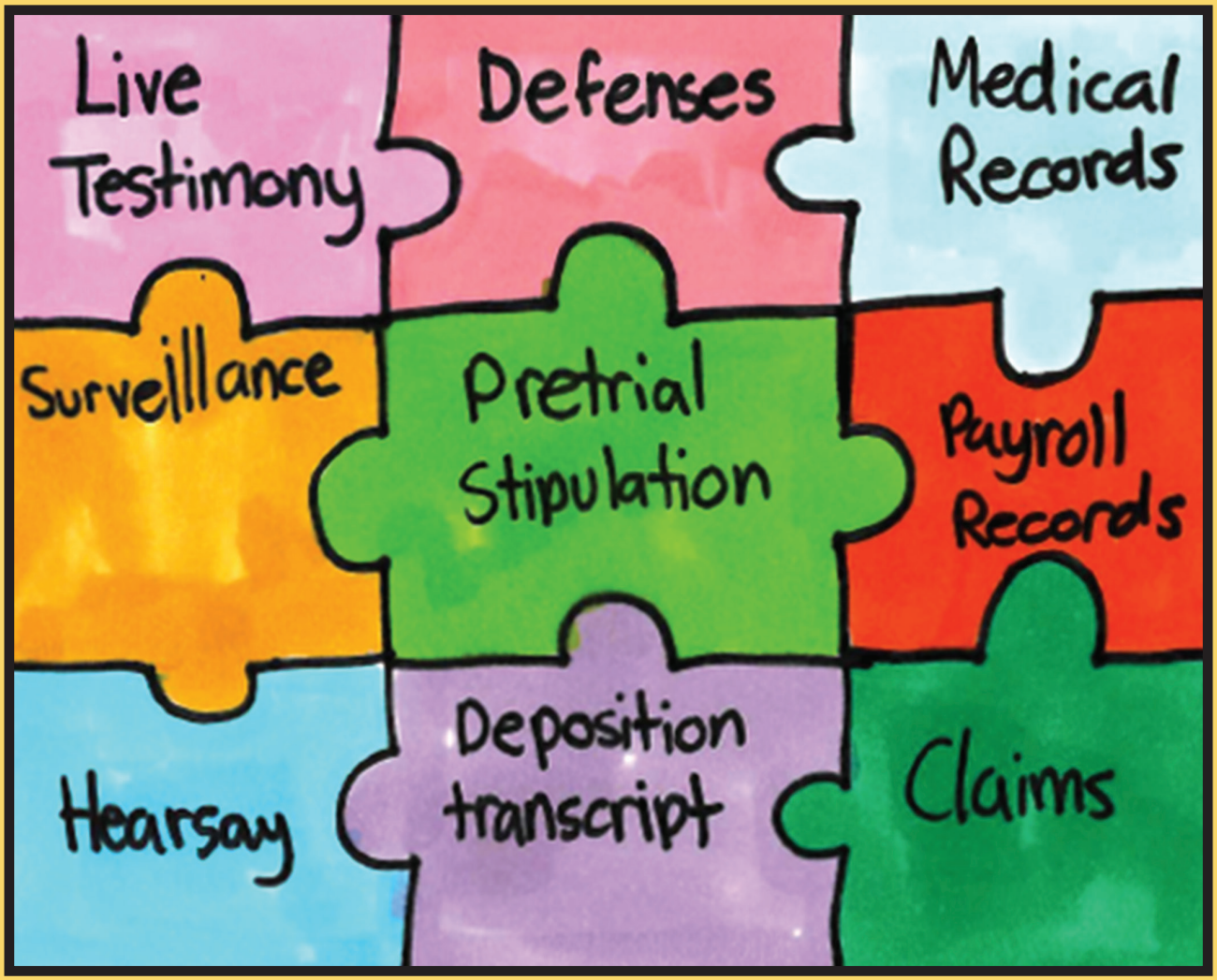
THE FLORIDA BAR
WORKERS' COMPENSATION
SECTION

NEWS
& 440 Report

Summer 2021

EVIDENCE MATTERS



This article was featured in *The Florida Bar Association's Summer 2021 News and 440 Report* and reprinted here courtesy of the Florida Bar's 440 section.

Revisiting Medicare's section 111 Reporting Law How It Works and Impacts WC Claims

by Mark Popolizio

It is the silent 800-pound gorilla in the room that has a direct impact on Medicare secondary payer (MSP) compliance—the Centers for Medicare and Medicaid's (CMS's) section 111 reporting law. While section 111 reporting has been in place for just over a decade, how it all works remains a mystery for many workers' compensation defense lawyers (as well as claimant lawyers). While defense counsel rarely pushes the section 111 reporting buttons, it is important for counsel to understand how section 111 reporting works and impacts larger MSP compliance issues and settlement. This article revisits section 111 reporting and provides a general refresher on Medicare's reporting law.

What is section 111 reporting? The term "section 111 reporting" refers to section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173). Section 111's provisions apply to both group health plans (GHP) and non-group health plans (NGHP) (i.e., workers' compensation, liability, self-insurance, and no-fault insurance). This article focuses on section 111 reporting in the NGHP context as codified at 42 § U.S.C. 1395y(b)(8).[1] Section 111 reporting is also sometimes referred to as MMSEA reporting or mandatory insurer reporting (MIR). CMS's NGHP reporting directives are contained in its Section 111 NGHP User Guide (which CMS periodically updates and modifies), along with interim policy "alerts."[2]

CMS describes section 111 reporting as "a comprehensive method for obtaining information regarding situations where Medicare is appropriately a secondary payer."[3] CMS uses the data collected through section 111 reporting to process claims billed to Medicare for reimbursement for items and services provided to Medicare beneficiaries as part of its MSP recovery activities.[4] Importantly, section 111 reporting does not replace or eliminate other obligations that may be applicable under the MSP, such as conditional payment reimbursement or addressing Medicare's future medical interests (i.e., Medicare set-asides).[5]

Who reports under section 111? The first step in understanding section 111 reporting starts with understanding who must report. This party is called the responsible reporting entity (RRE).[6] In general, RREs are insurers and self-insurers but, depending on the facts, could involve other entities such as self-insurance pools or assigned claims funds.[7]

Claimants and their lawyers are not RREs, however, and do not have reporting responsibilities under section 111.[8] Section 111 reporting is conducted electronically between the RRE and CMS via an electronic file exchange.[9] Of significance, an RRE that fails to properly comply with the section 111 requirements may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant.[10]

RREs may use agents to handle section 111 reporting for them; however, the RRE remains ultimately responsible and accountable for proper compliance under the law.[11] RREs using agents must specifically designate their section 111 reporting agent as part of the section 111 registration process.[12] Examples of section 111 reporting agents include Medicare compliance vendors, data services companies, and consulting companies.[13] In the author's experience, law firms and defense counsel are rarely section 111 reporting agents.

In general, under section 111, RREs must (1) determine if the claimant is a Medicare beneficiary, and if so, (2) report the case to CMS, along with certain required claims-related data and information, if it meets a section 111 "reporting trigger."[14] The next two sections examine each of these requirements in turn.

Determining the Claimant's Medicare Status

To help RREs determine a claimant's Medicare status, CMS has established what it refers to as the section 111 "Query Process." Only the RRE can use the Query Process, and as part of this system RREs must submit the following data points to CMS: the claimant's Medicare beneficiary identifier number (MBI) or social security number (SSN), along with the claimant's first and last name, date of birth, and gender.[15] The claimant's SSN is the critical data point necessary to determine a claimant's Medicare status. In the workers' compensation context, RREs usually encounter minimal, if any, problems supplying CMS with this data point as they generally have access

... continued, next page

to the claimant's SSN as part of the employment relationship, or this information is obtainable via discovery.[16]

CMS does not have set rules in terms of how often an RRE should query an individual, and its system allows RREs to submit query files as frequently as once per calendar month. In practice it is very common for RREs to submit query requests on a monthly basis. This is typically considered best practice to ensure the RRE appropriately identifies all Medicare beneficiaries for potential section 111 reporting purposes. If there is a data match, CMS will return a response record with a positive "disposition code" indicating that the claimant is a Medicare beneficiary.[17]

While the Query Process is helpful in identifying whether the claimant is a Medicare beneficiary, it does not currently return the Medicare "part" in which the claimant is enrolled (i.e., Parts A and B – traditional Medicare, Part C – Medicare Advantage, or Part D – prescription drugs), the actual dates of Medicare entitlement and enrollment, or the reason for entitlement.[18] Changes to what information CMS returns through the Query Process are coming, however. Specifically, per the recently enacted Provide Accurate Information Directly (PAID) Act, CMS is required to expand its section 111 Query Process to also return certain information pertaining to any Part C or Part D plan in which the claimant is (or was in the preceding three years) enrolled.[19] In June 2021, CMS announced that as part of its PAID Act implementation plans it will be returning the 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.[20] In addition, CMS will provide the most recent Part A and Part B entitlement dates.[21] Per CMS, these changes will become effective on December 11, 2021.[22] From a broader view, the information returned through the Query Process can also be helpful for insurers outside of the section 111 context with respect to addressing potential recovery claims. This angle will be explored more fully in a forthcoming companion article.

When Claims Get Reported—CMS's section 111 "Reporting Triggers"

In a nutshell, under section 111, if the claimant is a Medicare beneficiary and the claim meets a CMS section 111 "reporting trigger," then the RRE must report the claim to CMS. There are two section 111 reporting triggers: (1) ongoing responsibility for medicals (ORM), and (2) total payment obligation to the claimant (TPOC). Reporting may be required under both triggers depending on the facts of the claim.

In general, ORM involves situations where the RRE has made a determination to assume responsibility to pay, on an ongoing basis, the claimant's medicals associated with the claim.[23] Of note, CMS states that "the trigger for reporting ORM is the assumption of ORM by the RRE—when the RRE has made a determination to assume ORM or is otherwise required to assume ORM—not when (or after) the first payment for medicals under ORM has actually been made. Medical payments do not actually have to be paid for ORM reporting to be required."[24] The ORM trigger is particularly applicable in workers' compensation cases given that it is common for workers' compensation insurers to provide treatment for the claimant's industrial injuries or conditions. ORM must be reported when the RRE assumes and terminates ORM.[25] As part of this reporting trigger, the RRE reports ORM only for injuries and conditions for which it has accepted responsibility.[26] Regarding ORM "termination," there can be several different situations that may permit an RRE to terminate ORM; common examples include, but may not necessarily be limited to: the claimant's death, settlement, state law (e.g., statute of limitations), policy limit exhaustion, and, in some instances, claims that have become inactive or that the insurer otherwise views as administratively closed.[27]

On the other hand, the TPOC reporting trigger refers to the dollar amount of a settlement, judgment, award, or other payment, in addition to or apart from ORM.[28] In general, CMS describes TPOC as a "one-time" or "lump sum" payment intended to resolve or partially resolve a claim.[29] A TPOC is the dollar amount paid to, or on behalf of, the claimant in relation to a settlement, judgment, award, or other payment.[30] TPOC reporting is applicable regardless of whether or not there is an admission or determination of liability.[31] In addition, reporting under the TPOC trigger is applicable regardless of any allocation made by the parties or determination by the court.[32] Currently, RREs must report TPOCs greater than $750 to CMS.[33] Thus, in practical terms, this means that workers' compensation settlements involving Medicare beneficiaries that settle for greater than $750 are reported to CMS under section 111.

... continued, next page

What information gets reported to CMS? An exhaustive examination of all the possible information and data points RREs may need to report to CMS is beyond the scope of this analysis. In general, this information includes the following items: date of accident/incident; insurer/insurance coverage information; the claimant's personal identifying information (SSN or Medicare ID, name, date of birth, and gender); the name and address of the claimant's attorney; ICD code information related to the claimant's injuries; indicator denoting assumption of ORM and ORM termination dates (as may be applicable); and TPOC dates and amount (as may be applicable).[34]

Tying It All Together

As the above demonstrates, while defense counsels are defending workers' compensation claims, there may be a whole world of section 111 reporting going on around them by their clients (or their reporting agents)—and this reporting has downstream impact on claims and settlements. While defense counsels will likely have minimal, if any, input or connection with the actual nuts and bolts of section 111 reporting, they should understand the larger impact section 111 has on claims and settlements.

In this regard, it should be noted that per the RRE's ORM report, CMS is already made aware of the claim prior to any settlement and generally uses the ORM report to start its conditional payment recovery activities prior to settlement. While, as noted above, a deeper examination into CMS recovery claims will be the subject of a future article, in general, the ORM report very often triggers CMS's contractor, the Commercial Repayment Center (CRC), to issue a conditional payment notice (CPN) to the workers' compensation insurer regarding potential Medicare conditional payments that may need to be reimbursed.[35] Thus, in cases where the insurer has ORM, it is likely the insurer (or its MSA vendor) is already dealing with CMS regarding potential Medicare conditional payment recovery issues. If counsel is not handling the conditional payment aspect of the claim, it may be helpful for him or her to check in with the client for a status of any CMS activity on this front. Knowing this information can be helpful in assessing claim and settlement value when approaching settlement discussions.

It is important to keep in mind that CMS is made aware of the settlement through the TPOC trigger and will have all the information it needs to pursue the parties for any outstanding conditional payments upon claim settlement, and potentially to inquire about other compliance considerations (i.e., Medicare set-asides). Thus, headed into settlement discussions counsel should be aware of how conditional payment issues are being addressed and how they may impact settlement. Likewise, counsel should recognize how Medicare's future medical interests (if applicable) should be addressed, and whether an MSA or some other future medical allocation should be included as part of the settlement. As part of these activities, the client may refer counsel to its MSA vendor, which very often handles these items for the insurer.

On a closing note, while there is a connection between section 111 reporting and certain aspects of CMS's conditional payment recovery process, it is not foolproof in terms of identifying, obtaining, and resolving all potential conditional payment reimbursement claims. While section 111 reporting provides CMS and its contractors with the information necessary to pursue conditional payment recovery, this does not necessarily assure they will pursue recovery in a timely or accurate manner in every case. Accordingly, for reasons that will be discussed in a forthcoming article, it is often prudent for insurers and counsel to have processes in place, outside of section 111 reporting, to ensure conditional payment issues are also being addressed with CMS's recovery contractors, or any applicable Medicare Advantage or Part D plan.

***Mark Popolizio, J.D.**, is vice president of MSP compliance and policy for ISO Claims Partners. He is a nationally recognized authority in Medicare secondary payer (MSP) compliance. He practiced insurance defense litigation for 10 years concentrating in the areas of workers' compensation and general liability. Since 2006, he has dedicated his practice exclusively to MSP compliance, working with carriers, self-insureds, TPAs, and other claims professionals. He can be contacted at (786) 459-9117 or mark.popolizio@verisk.com.*

Endnotes

1 Section 111 reporting requirements for GHPs are codified at 42 § U.S.C. 1395y(b)(7).

2 CMS's Section 111 NGHP User Guide, Chapter I (Version 6.4, June 11, 2021), Chapter 2.

3 CMS's Section 111 NGHP User Guide, Chapter I (Version 6.4, June 11, 2021), Chapter 4.

4 *Id.*

5 *Id.*

6 CMS's Section 111 NGHP User Guide, Chapter II (Version 6.4, June 11, 2021), Chapter 3.

7 *See* generally, CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6. Expanding on this concept further, 42 U.S.C. § 1395y(b)(8) provides that the "applicable plan" is the RRE and defines the term "applicable plan" to include liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans.

8 *See*, n. 7.

9 CMS's Section 111 NGHP User Guide, Chapter I (Version 6.4, June 11, 2021), Chapter 6. It is noted that CMS has an established manual direct data entry (DDE) process using the section 111 COBSW (Coordination of Benefits Secure Website) for those RREs with a low volume of claim information to submit. *Id.*

10 42 U.S.C. § 1395y(b)(8)(E). At the time of this article's writing, CMS has outstanding civil money penalties proposals to implement section 111's penalty provision. *See*, 85 Fed. Reg. 8793, No. 32 (Feb. 18, 2020).

11 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.2.

12 *Id*.

13 *Id*.

14 *See*, 42 U.S.C. § 1395y(b)(8)(A). This section states, in pertinent part, that "an applicable plan shall—(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and (ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary."

15 *See*, CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 8, section 8.1. Of note, in some instances CMS will accept the last five digits of a claimant's SSN if the RRE is unable to obtain the full SSN. Regarding these data points, CMS must find an exact match of the Medicare ID or SSN (i.e., either an exact match on the last five digits or the full 9-digit SSN). Then, at least three out of the four remaining matching criteria must match exactly (all four if a partial SSN is used). *Id.*

16 In contrast, in the liability claims context, some liability RREs have encountered issues in obtaining a claimant's SSN. In these instances, the claimant (or his/her lawyer) has refused to provide the SSN to the insurer or objected to providing this information as part of formal discovery requests, and the courts have been called upon to address the issue. By way of example, in *Seger v. Tank Connection, LLC*, 2010 WL 1665253 (D. Neb. 2010), the court found the production of the plaintiff's SSN prior to settlement relevant and permitted under the federal rules of discovery. While acknowledging that section 111 did not require "this information be submitted to CMS until after a final settlement or judgment is issued," the court reasoned there was no "harm to the plaintiffs in providing the information sooner ... [as the plaintiff] will be required to provide the requested information eventually [and this information] could reasonably bear on the issues in the case." Accordingly, the court ordered the plaintiff in that case "to provide identifying information along with either his Medicare Health Insurance Claim Number or his Social Security Number." In *Smith v. Sound Breeze of Groton Condominium Ass'n*, 2011 WL 803067 (Conn. Super. Ct. 2011), the court allowed the filing of supplemental discovery aimed at obtaining the plaintiff's SSN prior to settlement, but limited its use for MSP-related purposes. The court in *Silver v. Milford Medical Center Associates*, 2017 WL 2452551 (Conn. Super. Ct. May 11, 2017), disagreed with *Sound Breeze* and denied the defendant's motion to file supplemental discovery requests to procure Medicare-related information. Further, in *Hackley v. Garafano*, 2010 WL 3025597 (Conn. Super Ct. July 1, 2010), the court found, in part, it was appropriate for an insurer to ask for the SSN of a 16-year-old plaintiff and his uninjured father to comply with section 111 reporting. In *Ruiz v. Rhode Island*, 2020 WL 1989266 (D. Rhode Island, April 27, 2020), the claimant would only provide the insurer with four digits of his SSN. Using these four digits, the insurer submitted more than 100 possible variations of the claimant's SSN through the Query Process but was still unable to confirm his Medicare status. In this instance, the court found, in part, that the insurer had "fully complied" with its section 111 reporting obligations given the efforts it had made to determine the claimant's Medicare status through the Query Process and through other means, despite the claimant's lack of cooperation.

17 CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 8, Section 8.1.

18 *Id*.

19 The PAID Act was signed into law on December 11, 2020. In general, the PAID Act, which amends 42 U.S.C. § 1395y(b)(8)(G), requires that CMS expand its section 111 Query Process to identify whether a claimant is currently entitled to, or during the preceding three-year period has been entitled to, Medicare Part C (Medicare Advantage) and/or Medicare Part D (prescription drug) benefits. If so, CMS is then required to provide the names and addresses of any such Medicare plans through the section 111 Query Process. CMS must now implement the PAID Act by December 11, 2021.

20 CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 1, p. 1-1.

21 *Id*.

22 CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 1, p. 1-1.

23 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.3. As part of its ORM definition, CMS explains that "[i]f an RRE has assumed ORM, the RRE is reimbursing a provider, or the injured party, for specific medical procedures, treatment, services, or devices (doctor's visit, surgery, ambulance transport, etc.). These medicals are often being paid by the RRE as they are submitted by a provider or injured party." *Id*.

24 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.3.

25 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.7.

26 *See* generally, CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.3.

27 Terminating ORM for claims that insurers view as inactive or administratively closed remains one of the more problematic areas of section 111 reporting. While full analysis of this issue is beyond the scope of this article, in general, under CMS's rules, ORM termination may not be permitted, even though the RRE considers the claim administratively closed. Regarding these cases, CMS's general rule is that an ORM termination date should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment. *See,* CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 6, Section 6.7.1. There are exceptions to this rule, which may permit an RRE to terminate ORM in these situations. For example, CMS states "[w]here there is no practical likelihood of associated future medical treatment, an [RRE] may submit a termination date for ORM if it maintains a statement (hard copy or electronic) signed by the beneficiary's treating physician that no additional medical items and/or services associated with the claimed injuries will be required." *See,* e.g., CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.3.2, and CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 6, Section 6.7.1. In addition, CMS indicates that an ORM termination date can also be submitted if the RRE's responsibility for ORM has been terminated "under applicable state law associated with the insurance contract" or per "the terms of the pertinent insurance contract, such as maximum coverage benefits." *See,* CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.3.2. CMS notes, however, that if there is subsequent reopening of the claim and further ORM, the RRE will need to update the record to reflect that ORM has resumed. *See,* CMS's Section 111 NGHP User Guide, Chapter IV (Version 6.4, June 11, 2021), Chapter 6, Section 6.7.1.

28 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.4.

29 *Id.*

30 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.4. CMS states that the computation of the TPOC amount "includes, but is not limited to, all Medicare covered and non-covered medical expenses related to the claim(s), indemnity (lost wages, property damages, etc.), attorney fees, set aside amount (if applicable), payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), and amounts forgiven by the carrier/insurer." *Id*.

31 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.5.1. On this point, CMS's reporting directives state that reporting is applicable in situations "where the party is (or was) a Medicare beneficiary and medicals are claimed and/or released of the settlement, judgment, award, or other payment has the effect of releasing medicals." *Id.*

32 CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Section 6.5.1.

33 *See* generally, CMS's Section 111 NGHP User Guide, Chapter III (Version 6.4, June 11, 2021), Chapter 6, Sections 6.4.1.1 through 6.4.4.1.

34 *See* generally, CMS's Section 111 NGHP User Guide, Chapter V (Version 6.4, June 11, 2021).

35 *See* generally, https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery. Again, as referenced above, a deeper review of CMS's conditional payment recovery process will be addressed in a future article. For purposes of this article., the author notes that the parties should not rely solely on CMS triggering its conditional payment activities from section 111 reporting.