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Section 111 Bulletin: CMS Clarifies Mandatory Medicare Reporting Requirements For Liability, No-Fault, and Workers' Compensation Insurers

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CMS Clarifies Mandatory Medicare Reporting Requirements For Liability, No-Fault and Workers' Compensation Insurers

I. Extension of Testing Period

The Centers for Medicare & Medicaid Services (CMS) recently announced that it has extended the data transmission testing period for liability, no-fault and workers' compensation insurers required to electronically report the resolution of claims involving injury to Medicare beneficiaries under Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA). These insurers (or their designees) must register as Responsible Reporting Entities (RREs) with CMS and test their electronic reporting capabilities before submitting actual claims data. Although testing may still begin at an insurer's election in July 2009, CMS has extended the testing period through December 31, 2009. As a result, RREs are now required to complete testing and begin submitting live data files no later than their assigned submission window during the first three months of 2010, three months later than originally required.

II. Dollar Thresholds

In addition to giving insurers more time to test their electronic reporting processes, CMS has established two categories of reporting thresholds for some liability and workers' compensation claims that will limit, on an interim basis, the number of claims insurers must

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report: one for "Ongoing Responsibility for Medicals" (ORM) and a second for "Total Payment Obligation to the Claimant" (TPOC). No thresholds previously existed. In contrast, there is no dollar threshold for ORM or TPOC claims for no-fault insurers. They must report *all claims* involving injury to Medicare beneficiaries regardless of value.

The following new thresholds apply:

- **Thresholds for Ongoing Responsibility for Medicals (ORM):**
  - ***Workers' Compensation Insurers***, through December 31, 2010, may choose not to report claims that meet **all** of the following criteria:
    - "Medicals only"
    - "Lost time" of no more than 7 calendar days
    - All payment(s) made directly to the medical provider
    - Total payment does not exceed $600

  - ***Liability Insurers*** have no *de minimus* dollar threshold under this category, which means they must report all claims accepting any responsibility for payment of covered medical services for Medicare beneficiaries.

- **Thresholds for Total Payment Obligation to the Claimant (TPOC):** For both liability and workers' compensation insurers, during the noted periods below within the specified dollar ranges, there are **no** TPOC reporting requirements:
  Interim Period TPOC
  Amount Reporting Exemption July 1, 2009 - Dec. 31, 2010 $0 - $5,000 Full Jan. 1, 2011 - Dec. 31, 2011 $0 - $2,000 Full Jan. 1, 2012 - Dec. 31, 2012 $0 - $ 600 Full

It is important to note that where there are multiple TPOC claims reported by an RRE on one record, **the combined TPOC** must be considered in determining whether or not the TPOC amount has been exceeded.

For TPOC claims involving a deductible, where the RRE is responsible for reporting both the deductible and any amount paid above the deductible, the threshold applies to the total of these two figures.