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ALERT

Section 111 Bulletin: CMS Revives Mass Torts Working Group and Previews New Section 111 Guidance

October 22, 2010

There was scant new guidance from the Centers for Medicare & Medicaid Services (CMS) in August and September on Section 111 reporting under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), whether delivered by Alert or through Town Hall discussion. According to CMS that is about to change, and with no time to spare as Section 111 reporting for Non-Group Health Plans (NGHPs) appears likely to commence without further delay in the first quarter of 2011 for most responsible reporting entities (RREs). During its most recent October 14, 2010 Town Hall teleconference, CMS announced that Alerts "are in the queue" on a number of subjects. Also, on September 29, CMS resumed discussion with the Mass Torts Working Group, on hold since December of last year, regarding CMS's consideration of a limited reporting exception. Insurers in that group have since called upon the Secretary of Health and Human Services to delay the start of mandatory insurer reporting for a unique and limited number of claims while discussions continue with CMS. We discuss both developments below.

Mass Torts Working Group Meets

On September 29, 2010, CMS opened up its conference line for a 90-minute discussion with interested parties regarding what CMS has titled a possible reporting exception for "Liability Insurance Settlements, Judgments, Awards, or Other Payments" in "cases involving exposure to an environmental hazard" where: (i) exposure on or after December 5, 1980 [the effective date of the MSP Statute] has been released; and (ii) there is *incontrovertible evidence* that exposure on or after December 5, 1980, did not/does not exist."

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

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Section 111 Insurer Reporting and MSP Reimbursement

Prior to the call, CMS shared a draft with the call participants of the "rules and limitations" for such an exception, including (i) that the burden shall fall on the parties to establish, with documentation, that exposure ended prior to December 5, 1980, (ii) that this determination is consistent with the claimant(s) allegations, evidence obtained in discovery, and any subsequent releases, and (iii) all parties validate the determination.

There was a lively debate as participants shared serious concerns that CMS's draft did not address all needed scenarios. For example, insurers expressed a well-reasoned position that they should have no Section 111 obligations when policies incepted before December 5, 1980, because Medicare was not a secondary payer when they underwrote those policies. To impose such obligations would give retroactive application to the MSP Statute in violation of long-standing constitutional principles. In addition, insurers challenged CMS's position that a broad general release (which would include, by implication, post-December 5, 1980 liability) could itself ever trigger Section 111 obligations, finding CMS's assumption unsupported by the language of the MSP Statute and its legislative history. At the end of the call, CMS welcomed redline comments and revisions (requesting them by October 12), but did not state if or when it expected to issue the exception.

Of significant note, the American Insurance Association (AIA) has requested that Secretary Sebelius delay both the October 1, 2010 Total Payment Obligation to the Claimant (TPOC) date and the first quarter 2011 reporting obligations of RREs that settle or otherwise pay on what CMS has previously defined as "Group 2 Claims" while CMS and insurers continue to work toward resolution of the many outstanding issues concerning the application of Section 111 to these claims. Group 2 Claims relate to the allegations of individuals claiming "bodily injury, mental anguish or disease from the claimants' exposure to a deleterious product, substance or condition where the bodily injury or disease for which damages are sought manifests instantaneously or [during] some period subsequent to the initial exposure." Examples of Group 2 Claims include claims relating to asbestos, benzene, chemicals, silica, welding rods and lead paint. As stated by AIA in a recent follow-on letter to CMS, "by clarifying the application of the MSP Statute and Section 111 obligations in relation to Group 2 Claims, CMS can remove an important area of uncertainty for all affected parties (beneficiaries, their counsel, NGHP and counsel, even judges and courts)."

We participated in the September 29 call with CMS and would be happy to discuss the proposed reporting exception in more detail with interested clients.

Alerts In The Queue

CMS anticipates releasing the following guidance by the end of this month:

1. Date Of Incident For Cumulative Injuries: CMS will define this date as the earlier of (i) the date of treatment if before formal diagnosis or (ii) the first date of formal diagnosis by a medical practitioner.

2. Definition Of Timely Reporting When Required Information Is Not Known As Of TPOC Date: CMS advised that this Alert will inform RREs that they need not report if they do not know to whom payments will be made or how much the insurer will pay to individual(s) in a TPOC settlement (representing its total payment obligation to the claimant(s)). Although this sounds logical and seems to be the only reasonable interpretation of Section 111 requirements, the User Guide currently requires reporting within the first quarter following any

"settlement, judgment, award, or other payment" that meets the reporting thresholds, with no further qualification. See NGHP User Guide at 46. It would appear that CMS now understands that insurers often enter into settlements-whether mass torts, class action, or other settlements-before all settling claimants are known to them. CMS warned that until it changes the reporting system to reflect this new policy, RREs may receive compliance flags for submission of untimely reports. CMS suggests RREs ignore them.

3. Lump Sum Payments For Indemnity Benefits: CMS advised that RREs need not report one-time indemnity payments (*e.g.,* those required under workers' compensation or no-fault laws) if the insurer or self-insured entity will be making ORM payments (thus assuming on-going responsibility for the claimant's medical expenses). Otherwise, the RRE must report the indemnity payment as a TPOC payment.

4. Default ICD-9 Diagnosis Codes: A fourth alert will address a very limited reporting exception for RREs unable to determine the ICD-9 code because the claimant has not alleged any medical injuries or incurred medical expenses. In this situation, CMS will approve use of a "default ICD-9 code." CMS stated that it is likely to limit the use of the default code to loss of consortium claims, although it is considering extending the code's use to certain E&O and D&O insurance claims where medicals are not typically a factor. See related discussion of General Releases below.

What's Not In Queue

Conspicuously absent from CMS's queue list was its long-promised guidance for overseas insurers and syndicate members. Although many still expect CMS to narrow the definition of an overseas RRE to one "doing business" in the United States, as a court might define this phrase for jurisdictional purposes, it has been months since CMS spoke publicly to its preparation of this much needed guidance. CMS reopened "foreign RRE" registration in April of this year with the expectation that such RREs would begin reporting along with all other RREs in the first quarter of 2011. We have heard no report of further reporting delays.

Wiley Rein Comments On Recent Town Hall Discussion

The more notable discourse during the August 25, September 22, and October 14 teleconferences addressed the following subjects that continue to elicit many insurer questions:

General Releases-The Devil Is In The Lack Of Details: Although most reportable claims payments will compensate for bodily injury, payments that compensate only for emotional distress or mental anguish where no bodily injury is alleged also trigger reporting because Medicare does pay for some mental health services. CMS has made it clear that it believes an insurer must report "anytime medicals are claimed or released." What is stirring debate, however, is whether a general release of any and all claims, made or unmade with no mention of bodily injury or emotional suffering, can give rise to reporting.

During the last few teleconferences CMS answered this question affirmatively. It was not until the October 14 call, however, that CMS appeared to offer an exception to this broad general rule: if the underlying policy does not provide coverage for bodily injury or emotional distress, then a general release accompanying a payment under that policy (for example, a policy that only covers property damage) will not trigger Section

111 reporting. But when asked by a caller if a self-insured entity must report a payment made to a Medicare beneficiary solely for property damage but nevertheless accompanied by a general release, CMS appeared to waver but would not disclaim the need to report. Instead, CMS referred the caller to Section 11.10.2 of the User Guide, which states: "RREs are not required to report . . . 'property damage only' claims which did not claim and/or release medicals or have the effect of releasing medicals."

In response to another caller asking about releases in the context of employment practices liability (EPL) claims, CMS shared its pending consideration of a narrow reporting exception for loss of consortium claims, and possibly D&O and E&O claims, where "no meds or injuries are claimed" and thus reporting is implicated only by release. Such an exception makes considerable sense since it is likely that CMS will incur more expense in investigating such claims for conditional payments than it stands to recover.

Mass Torts/Reporting Date Of Exposure: In response to a question about how to select the date of exposure in the context of a full settlement and release of a claim involving a toxic substance, CMS reminded listeners that they need only report the date of first exposure. The field for reporting the date of last exposure is voluntary. CMS also reiterated that the relevant exposure for reporting purposes is the claimant's physical exposure, not the legal exposure a defendant may have, and that CMS currently requires reporting if liability for post-December 5, 1980 medical expense is released but not compensated, regardless of the dates of exposure at issue in the case. (As discussed above, the AIA has requested that CMS reconsider this position, which we agree is not supported by the law.) CMS clarified that, for reporting purposes, the question of exposure should be analyzed on a defendant-specific basis, rather than with reference to the exposure for which another defendant may be liable. When pressed on how this standard should be applied in specific cases, CMS deferred further comment, stating that the issue would be addressed by the Mass Torts Working Group.

Joint And Several Liability: There has been considerable confusion over CMS's guidance concerning an insured's acceptance of joint and several liability and how that affects an RRE's Section 111 reporting. CMS explained that its reference to joint and several liability is meant only to refer to the scenario in which multiple tort defendants are jointly and severally responsible for paying a common judgment or settlement amount. In such a case, each RRE must report the full amount of the settlement, not merely the amount it anticipates paying towards the settlement on behalf of its insured. By contrast, in the case of an accident in which there are multiple defendant tortfeasors and the claims against each tortfeasor are handled and settled separately without any tortfeasor assuming liability beyond the amount it settled for, there is no joint and several liability and each RRE must only report the amount of its insured's specific settlement, not the total of all settlements.

Reporting ORM Payments: CMS was asked in September to opine on a specific question regarding post-January 1, 2010 insurer payments for medical services billed before that date in cases where the claim had also been closed before that date. CMS replied that anytime an RRE is paying new bills after January 1, 2010, even if the date of service is before that time, the RRE must report that payment. In the above scenario, the claim would be treated as re-opened for purposes of paying the new bill.

During the August 25 call, CMS clarified that, in the case of making ORM payments, the periodic payments themselves do not need to be reported individually. An RRE need only report the acceptance of an ORM obligation and then, when the ORM payments terminate, the RRE must report that occasion as well. On that same call, CMS also explained that, in cases where there is a settlement for a flat sum plus an agreement to pay additional related medical bills as they arise up to a certain amount over a particular period, the RRE should report the initial settlement as a TPOC and follow the rules for ORM reporting with respect to the additional payments.

ICD-9-CM Diagnosis Codes: CMS has answered many technical questions about identification and reporting of ICD-9-CM codes. CMS has previously explained that RREs must report ICD-9-CM diagnosis codes in two fields of the Claim Input File: Field 15 ("Alleged Cause of Injury, Incidence, or Illness") and Field 19 ("ICD-9 Diagnosis Code"). CMS currently provides a list of valid ICD-9-CM diagnosis codes, as well as a list of excluded ICD-9-CM diagnosis codes, for NGHP RRE use on its website; CMS updates this list once a year. Field 15 only accepts ICD-9-CM "E Codes" or external cause of injury codes; Field 19 does not accept E Codes or "V Codes." Should CMS amend the list of excluded ICD-9 codes, CMS advised it would give "plenty" of notice, probably at least six months prior notice.

In its September call, CMS explained that an RRE must choose codes from one of the three most current versions of the ICD-9 code set, which for 2011 will be Versions 26, 27, and 28. In its October call, CMS noted one exception. After a version is retired, RREs may update a previously submitted Claim Input File without updating diagnosis code numbers. Beginning October 1, 2013, all providers and suppliers covered under the Health Insurance Portability and Accountability Act (HIPAA) will be required to submit service claims to insurers and federal health care programs using the new ICD-10 code set. Accordingly, around that time, we anticipate that CMS will instruct RREs to use ICD-10-CM codes when submitting *new* Claim Input Files in lieu of the ICD-9 code set.

CMS also explained that RREs must code the injury alleged by the Medicare beneficiary, regardless of whether there is documentation in the beneficiary's medical records of a diagnosed injury. CMS has encouraged RREs to develop their own coding expertise but does not require or expect RREs to hire professional coders or medical professionals. Indeed, CMS has acknowledged that on occasion the RRE may need to make a best guess as to the correct diagnosis code where sufficient information is not available from claims records or the Medicare beneficiary. This is particularly true where an RRE may be reporting a claims payment only because the claimant signed a general release that arguably sweeps in unalleged claims for emotional distress or mental anguish. We submit that rather than guessing, the RRE should not be required to report such claims payments. See General Releases discussion above.

Payments To Medicare Advantage Beneficiaries: This is anther topic that has suffered from considerable confusion over the past year. One caller asked if an RRE must report claim resolutions with claimants who receive Medicare benefits through the Medicare Advantage program, the managed care alternative (known also as Part C) to original Medicare (commonly referred to as Parts A and B), which is administered by commercial entities that accept financial risk in the product underwriting. As explained by CMS on the October call, these Medicare Advantage plans have their own separate rights of recovery for conditional

payments against commercial insurers; however, it is CMS's position that because Medicare beneficiaries can move back and forth between original Medicare and Medicare Advantage plans on an annual basis, RREs must report claim resolutions with Medicare beneficiaries under *any* Medicare program. We agree with CMS that both CMS and a commercial carrier could have an interest in past medical expenses covered by a claim resolution, and that Medicare beneficiaries have the same obligation to use commercial insurance coverage first for their medical expenses. Moreover, it is not uncommon for Medicare beneficiaries to confuse the various "Parts" of Medicare. For this reason, it is important for RREs to understand which Medicare program insures a claimant and not return conditional payment money to the wrong secondary payer.

DDE Reporting: The last Alert issued by CMS for NGHPs is dated September 16, 2010 and discusses Direct Data Entry registration for "Small Reporter" NGHP RREs. The Alert revisits the definition of "Small Reporter" and provides an overview of the registration process that opened on October 4. Additional guidance is available from the Coordination of Benefits Secure Website (COBSW) at www.section111.cms.hhs.gov and through computer based training modules for which RREs can register on the Section 111 website at www.cms.gov/MandatoryInsRep. We understand the COBC also intends to post a separate DDE User Guide on the COBSW.

Lump Sum Settlement To Group As A Whole: One caller asked if a lump-sum settlement to a small group of people, all Medicare beneficiaries, with no allocations per person, requires the RRE to report separately the full value of the settlement with respect to each person in the group. CMS replied it did, but then cautioned that even if the parties had agreed to individual allocations, CMS would not be bound by them.

HICN/SSN Collection: Questioners continued to ask whether an RRE must obtain a Social Security Number or Medicare Health Insurance Claim Number (HICN) from every claimant and then query Medicare files for the claimant's Medicare status before settling any claim that might impose reporting obligations. In response, CMS gave its standard brief, and not entirely helpful, answer that RREs must report all settlements with beneficiaries, but took no position and offered no advice with respect to whether an RRE can reasonable rely upon a claimant's statement that he or she is not a Medicare beneficiary when that individual refuses to provide a SSN or HICN for querying. CMS continued to recommend that RREs keep a paper trail of all efforts they undertake to determine a claimant's Medicare status, such that the reasonableness of their efforts may be proved if later challenged by CMS.

Timely Reporting And Kick-In Of Penalty: CMS confirmed that it will recognize a 45-day window prior to the commencement of an RRE's 7-day reporting period during which the reporting of any claim resolutions may be deferred to the RRE's next quarterly reporting period. CMS advised, however, that there is no advantage to deferral of a report and that RREs should report all claim resolutions that fall within the 45-day period if possible.

RRE Definition: CMS noted that it does not intend to make any revisions to Section 7.1 of the User Guide: "Who Must Report," although it may supplement the Section with additional examples.

COB Training: The CMS Coordination of Benefits Contractor (COBC) has posted a new MSP Course Curriculum to the CMS MMSEA 111 Computer Based Training website, which, though not specific to Section 111, may be useful for addressing many Section 111-related compliance issues. The curriculum describes brief training courses available from CMS that provide "general information about Medicare and Medicare Secondary Payer, applicable to both GHP and NGHP." In addition to this MSP training, CMS's computer-based training courses for GHP and NGHP RREs remain available on its website.

Future NGHP Teleconferences: CMS has revised its website-posted schedule of the remaining NGHP teleconferences in 2010. There will be one teleconference on November 10 that discusses both policy and technical issues. The November 30 call is cancelled. Similarly, on December 9, CMS will address both policy and technical issues, canceling the December 20 call.

The following Section 111 Practice members contributed to this Bulletin: Kathryn Bucher (Chair), Howard Anglin and Peter Jenkins

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held monthly by CMS, and we send periodic Alerts to our clients addressing notable town hall discussions and other Section 111 developments. We also maintain a searchable electronic database of town hall transcripts back to October 2008. Please let us know if you would like more information about any of the Section 111 topics discussed in this Alert. You may also access our Section 111 webpage and the other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.