

# MEDICARE INSIGHTS

A PUBLICATION OF KITCH, DRUTCHAS, WAGNER, VALITUTTI & SHERBROOK

Monday, November 23, 2009

Volume 1: Number 1

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*Alert! MEDICARE SECTION 111 REPORTING UPDATES Alert!*

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**In our effort to keep you current regarding developments in the Medicare Section 111 Mandatory Reporting process, we have prepared a brief overview summarizing some of the recent comments and clarifications CMS has expressed in its November 17, 2009 town hall teleconference as it continues to refine the rules and guidelines.**

## **Identifying Proper RRE**

CMS continues to indicate they are discussing final language for a definition of Responsible Reporting Entities (RRE). CMS invites companies with unique business structures or captive situations, which do not fit under the current RRE definitions in the User Guide, to contact CMS via email to relay the structure with sufficient detail so that CMS can evaluate it and provide a "ruling" on the proper RRE.

CMS published a **proposed** clarification of the Responsible Reporting Entity definition on July 31, 2009. A subsidiary entity cannot be the RRE for a sibling or the parent entity. A subsidiary could however be the reporting agent for the parent company. When the language is "final," the new definitions will replace the existing Section 7.1 of the Non-GHP User Guide regarding "Who Must Report."

## **Write-Offs Still Being Considered By CMS**

CMS has advised that it is still in the process of drafting language addressing hospital and risk management "write offs." CMS has stated it "hopes" to have this information available in early December. They are also working on language addressing payment waivers in clinical trial settings.

## **Inability To Obtain HICN/SSN**

CMS has devised a specific method for obtaining an individual's HICN/SSN to determine Medicare beneficiary status. If followed, the RRE will be considered to be in compliance with its reporting obligation if an individual still refuses to provide a HICN or SSN. If the individual is known to be a Medicare beneficiary, the method will not provide a safe harbor for the RRE. If a claimant does not have a SSN, they cannot be a Medicare beneficiary and need not be reported

One area they refused to comment on was whether an RRE can use the SSN for reporting purposes if the RRE has SSN information in a billing department or credit file rather than in the claim management file. They suggested seeking legal assistance in this determination.

## **"Product Liability" Field removed from Data reporting**

Data field 58 has been changed to remove the "product liability" designation and replaced it with parameters to determine if the claim related to a mass tort situation. If the claim relates to one of two broad mass tort definitions (primarily exposure and ingestion type circumstances) then additional information is required. The mere involvement of a product is no longer a data element.

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## **New Extension of TPOC Reporting Dates**

TPOC (one-time single settlements or payments) need only be reported where the obligation to pay is established on or after **January 1, 2010**. Any TPOC amounts prior to January 1, 2010 do not need to be reported.

## **Reporting Multiple TPOCs**

If multiple TPOCs are paid over time, when the total amount reaches the threshold dollar amount to report, reporting must be done as a total TPOC amount at the point of reporting. Any subsequent TPOCs must be entered on the Auxiliary Record.

## **Impact of Never Events on Reporting**

Never Events that result in Medicare not paying for all or a portion of the care provided is irrelevant to the reporting requirements. If there is a write-off by the provider as a result of a never event, the language being developed by CMS for write offs will cover the reporting obligation. If a claim is instituted regarding a never event

and a payment is made to or on behalf of the claimant, reporting will be required.

## **Reporting Impact on MSP**

The new reporting requirements do not change the mandates of the Medicare Secondary Payer Act (MSP). As a result, the existence of threshold dollar amounts for reporting under MMSEA does not change the obligations to protect Medicare's right of reimbursement in claims involving Medicare beneficiaries under the MSP. MMSEA also does not expand nor contract the use of MSAs where appropriate to protect such interests.

## **Non-Medical ORM In Workers' Compensation**

CMS has emphasized that where a workers' compensation law or plan requires RREs to make regularly scheduled periodic payments to, or on behalf of the claimant, but the applicable workers' compensation law or plan specifically precludes these periodic payments from including any direct or indirect payments for past, present, or future medical expenses, these payments are not reportable as TPOC or ORM for purposes of Section 111 compliance.

## **Closing Note**

Above are just some of the recent changes and updates from CMS regarding its ongoing effort to initiate the reporting under Section 111. While we are hopeful this information is of use, it does not substitute for legal advice. We are available to assist you with evaluating and implementing the requirements of this increasingly complex law, and remain positioned to work with you toward your ultimate compliance.

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