Service: MSPA (Medicare Secondary Payer Accreditation)
Module: LEARNING MODULE 4
Medicare Mandatory Insurer Reporting (Section 111 Reporting), Part 1
Faculty: Heather Traxler, Director of Medicare Reporting, Sanderson Firm
Brian MacAllister, Sr. Medicare Unit Manager, Liberty Mutual

Summary

This module, taught by Heather Traxler of Sanderson Firm and Brian MacAllister of Liberty Mutual, provides a comprehensive overview of Section 111 reporting under the Medicare, Medicaid, and SCHIP Extension Act (MMSCA). The session introduces key concepts, processes, and compliance requirements for insurers to ensure Medicare remains a secondary payer.

Introduction to Section 111 Reporting: Section 111 reporting obligates Non-Group Health Plans (NGHPs), such as liability insurers, workers' compensation providers, and no-fault insurers, to report specific Medicare beneficiary claims to the Centers for Medicare and Medicaid Services (CMS). The purpose is twofold:

1. To facilitate Medicare's recovery of conditional payments after a settlement, judgment, or other payment.
2. To ensure Medicare does not prematurely pay for medical expenses when other primary coverage exists.

Key Reporting Requirements:

- **Thresholds:** Settlements for physical trauma claims above $750 must be reported. Non-trauma claims, such as those involving ingestion or exposure, have no monetary threshold.
- **Responsible Reporting Entities (RREs):** These entities are accountable for submitting accurate and timely data to CMS.
- **Total Payment Obligation to Claimant (TPOC):** This includes settlement amounts covering medical expenses, legal fees, and any Medicare Set-Aside (MSA) funds.

Query Process and Data Submission: The process for confirming Medicare beneficiary status involves submitting the "Big Five" data points – first and last name, date of birth, gender, and Social Security or Medicare Beneficiary Identifier (MBI)—to CMS. Accurate information is crucial for verifying beneficiary status and avoiding penalties.

Ongoing Responsibility for Medical (ORM): ORM pertains to situations where an RRE has an ongoing obligation to pay for medical treatment related to a claim.

Reporting ORM ensures proper coordination of benefits, enabling Medicare to recover conditional payments from the primary payer. ORM can be terminated due to settlements, policy limits, or medical determinations confirming no further treatment is required.

Upcoming Changes in TPOC Reporting: Starting in April 2025, TPOC reports must include detailed MSA information, such as total funding amounts, the duration of coverage, and whether payments are lump sums or annuities. This change aims to enhance Medicare's ability to coordinate benefits and enforce compliance.

Compliance Challenges and Enforcement: Failure to report accurately or on time may result in civil monetary penalties, garnishments, or lien actions. Accurate ICD coding, reflecting the nature of the claimant's injury, is vital to preventing disputes and ensuring the integrity of the conditional payment recovery process.

Section 111 reporting plays a critical role in Medicare compliance. It integrates with conditional payment recovery and coordination of benefits to protect Medicare's financial integrity. This session underscores the importance of accuracy and timeliness in reporting to avoid financial penalties and ensure seamless claims processing. Future modules will delve deeper into specific reporting obligations and compliance strategies.

Learning Objectives

1. Understand the mandatory reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act.
2. Identify key concepts such as Total Payment Obligation to Claimant (TPOC) and Ongoing Responsibility for Medical (ORM) and their reporting thresholds.
3. Comprehend the process for querying Medicare beneficiary eligibility and the use of the "Big Five" data points.
4. Analyze the implications of inaccurate or untimely reporting, including penalties and recovery actions.
5. Recognize the integration of Section 111 reporting with Medicare's coordination of benefits and conditional payment recovery processes.

Primary Takeaways

1. Section 111 requires reporting by Non-Group Health Plans (NGHPs), including workers' compensation and liability insurers, to ensure Medicare remains a secondary payer.
2. Reporting thresholds are > $750 for physical trauma claims but apply differently for ingestion, implantation, and exposure cases.

3. Accurate reporting of TPOC and ORM data, including ICD codes, is essential for compliance and coordination of benefits.
4. The new TPOC requirements beginning in 2025 will include details on Medicare Set-Asides (MSAs), funding periods, and payment structures.
5. Failure to comply with reporting obligations can lead to penalties, recovery actions, and disruptions in claim settlements.

Course Outline

1) Introduction to Section 111 Reporting
   a) Background and Purpose
      i) Ensures Medicare remains a secondary payer.
      ii) Facilitates conditional payment recovery and benefit coordination.
   b) Key Stakeholders and Responsibilities
      i) Responsible Reporting Entities (RREs).
      ii) Types of plans covered under NGHP.

2) Reporting Requirements and Thresholds
   a) TPOC Reporting
      i) Definition and threshold ($750).
      ii) Inclusion of MSAs in TPOC reports starting in 2025.
   b) ORM Reporting
      i) Definition and criteria for reporting.
      ii) Termination of ORM due to statute of limitations, settlements, or medical determinations.

3) The Query Process
   a) Use of "Big Five" Data Points
      i) First name, last name, date of birth, gender, and Medicare Beneficiary Identifier (MBI).
      ii) Monthly query process for Medicare eligibility confirmation.
   b) Matching Criteria
      i) Role of accurate data in successful matches.
      ii) Impact of errors on compliance and recovery processes.

4) Importance of Accurate Data
   a) ICD Coding
      i) Key role in benefit coordination and conditional payment recovery.
      ii) Transition from ICD-9 to ICD-10 for detailed diagnosis reporting.
   b) Penalties for Non-Compliance
      i) Monetary fines for late or inaccurate reporting.

   ii) Risk of garnishments and lien actions.

5) V. Practical Applications and Future Changes
   a) Integration with MSAs
      i) New data requirements for funding and payment structures.
      ii) Implications for settlements not submitted for CMS approval.
   b) Preparing for 2025 Changes
      i) Industry readiness and proactive compliance strategies.
      ii) Understanding multi-carrier settlements and reporting obligations.

6) Conclusion
   a) Recap of Section 111's Role
   b) Emphasis on Accuracy and Compliance in Reporting Processes

NOTE: Artificial Intelligence was used in the creation of this document.