



Government Affairs Alert

March 2, 2010

CMS Issues Version 3.0 of the MMSEA Section 111 NGHP User Guide and Three Alerts Regarding MMSEA Section 111 Reporting Guidelines

On February 26, 2010, the Centers for Medicare and Medicaid Services (CMS) issued Version 3.0 of the Medicare Medicaid and SCHIP Extension Act (MMSEA) Section 111 User Guide pertaining to liability (including self-insurance), no-fault and workers' compensation plans, defined as Non-Group Health Plans (NGHP).

The updated User Guide is 249 pages and includes various revisions. To view Version 3.0 of the NGHP User Guide, [click here](#).

Update and Addition Summary

PMSI Settlement Solutions has detailed some of the most pertinent updates and additions below. This is not an exhaustive list, and due to the significant amount of important changes PMSI recommends all Required Reporting Entities (RREs) thoroughly review the entire User Guide 3.0.

- Instructions for Foreign RRE Registration and how to report foreign entity information in the Claim Input File
- Changes to the RRE Registration and Reporting Process to include abandoned RRE IDs, ceasing and transitioning reporting and changing RRE information
- Updated information regarding use of ICD-9 codes including a listing of excluded codes and a link to current valid ICD-9 codes
- Clarification for handling foreign addresses
- How to report multiple total payment obligations/settlements to the claimant (TPOCs)
- Additional information regarding the determination of "receipt" date by the Coordination of Benefits Contractor (COBC) and the requirements for the File Submission Date (Field 4) on the Claim Input File.
- RRE options when they have nothing to report on a quarterly file submission
 - Option 1- submit an empty Claim Input File
 - Option 2 – the Account Manager for the RRE ID can log into the Coordination of Benefits secure website (COBSW) and perform an action on the RRE Listing page to indicate the RRE has nothing to report.

- Updated information regarding Ongoing Responsibility for Medical (ORM) termination date
 - Instructions for handling situations when ORM terminated in less than 30 days
 - ORM termination dates should only be submitted when the termination of ORM is certain. ORM termination dates cannot be more than 6 months greater than the file submission date.
- Confirmation that Accident & Health policies are considered reportable as no-fault insurance
- Further information regarding frequency of Query Input File submission
 - If more than one Query Input File is received during one calendar month or received while a prior file is still processing the new file will suspend and the EDI Representative must be contacted for resolution
- Updated requirements for Representative Fields
 - First and last name or firm name are required (not both)
 - Representative TIN is optional
- Mailing address line 1 should only contain a street number and street name. Any other information (apartment number, suite number, etc) should be included in mailing address line 2.
- Clarification of reporting joint settlement with multiple defendants
 - Where the defendants have joint and several responsibility, each RRE must report the total amount of the settlement, judgment or award
 - Where multiple defendants each have separate settlements with the plaintiff, the applicable RRE reports that separate settlement amount
- Updated information regarding the Query process
 - If an RRE submits “unknown” as the gender on a query, the COBC will change this to a value of “male” for matching purposes and may return the value of “male” on the response record even if a match is not found.
- Updated information on Claim File Testing
- Instructions for use of both versions (1.2.0 and 2.0.0) of the HIPAA Eligibility Wrapper (HEW) software
- Additional and updated response File Error Codes are included
- Updated Threshold Error Information



- Alerts issued subsequent to the date of the most current User Guide supersede the applicable language in the User Guide.
- No interim file submissions are accepted unless the RRE or their agent is specifically requested to do so by the assigned EDI Representative
- When a Social Security Number (SSN)/Health Insurance Claim Number (HICN) should be corrected by an RRE
 - RREs only need to correct the HICN/SSN in cases where an incorrect person was submitted and accepted on the input record. HICNs may be reassigned by the Social Security Administration at times but the COBC is able to cross-reference the old HICN to the new HICN. Therefore in those instances where the correct person was previously submitted and the HICN changes for that person at a later date, the RRE does not need to correct the record
- Reporting more than five Total Payment Obligation to the Claimant (TPOC) amounts
 - If more than five TPOCs need to be reported for a single claim, add the sixth and any subsequent TPOC amounts to the amount reported for TPOC Amount 5 as an update transaction.
- New reporting date requirements for initial production Claim Input Files
 - RREs have until assigned file submission timeframe in the **first calendar quarter of 2011 (January – March 2011)** to submit their first production Claim Input File.
 - RREs may commence production Claim Input File reporting prior to January 1, 2011 as soon as testing is completed and their RRE ID has been moved to a production status.
 - RREs are required to report TPOC Amounts with TPOC Dates **October 1, 2010** and subsequent according to the interim reporting thresholds specified in Section 11.4 of User Guide 3.0. TPOCs with earlier TPOC Dates will be accepted.
 - RREs are required to report claims on which ongoing responsibility for medicals (ORM) exists as of **January 1, 2010** and continuing regardless of the date of an initial acceptance of payment responsibility. If a claim was closed prior to January 1, 2011, it does not need to be reported unless it is reopened. Earlier reports of ORM will be accepted and RREs may report ORM claims closed prior to January 1, 2011 at their discretion.
- Routine maintenance is performed on the COBSW and Section 111 SFTP server third weekend of the month as needed. During this time access will be limited.

Alert 1 – Information about Required Reporting for Risk Management Write-Offs, Clinical Trials, Foreign Insurers and Data Input Fields 58-62

On February 24, 2010, CMS issued an Alert stating they will issue additional guidance for risk management activity and clinical trials where the sponsor has agreed to pay for items or services related to injuries or complications and **RREs do not need to report information related to these activities until the forthcoming guidance is published.**



CMS stated they will also issue additional guidance related to the requirements for Fields 58-62 on the Claim Input File and reporting by foreign insurers. In the interim, RREs should continue to identify related claims so they can be reported as prescribed by the general MMSEA Section 111 guidance and any future guidance CMS may provide.

To view a copy of this CMS Alert [click here](#).

Alert 2 – NGHP RRE Compliance for Liability (including Self Insurance), No-Fault and Workers' Compensation

On February 24, 2010, CMS issued an Alert providing guidance on the steps NGHP RREs can work within the Section 111 NGHP reporting requirements and remain in compliance. In general, an NGHP RRE will be compliant with its Section 111 reporting requirements if it registers with the Coordination of Benefits Contractor (COBC), and once registered the RRE engages in testing with the COBC and once testing is completed, begins and continues to production data exchanges with the COBC.

CMS also noted that RREs are expected to compile the required data which includes, but is not limited to, maintaining a record of all the RREs data development activities. CMS recommended an RRE and/or its agent maintains ongoing communication with the assigned EDI Representative throughout the Section 111 reporting process.

The document outlines the specific details of compliance for each step of the process; RRE Registration, Testing the Data Exchange and Ordinary Production Data Exchange. RREs should review this document closely to confirm adequate steps are being taken to maintain compliance. Once an RRE is registered, if PMSI is acting as the reporting agent, we will be able to assist the RRE with ongoing compliance with testing and production data exchange.

To view a copy of this CMS Alert [click here](#).

Alert 3 – Who Must Report- Liability (including Self Insurance), No-Fault and Workers' Compensation

On February 24, 2010, CMS issued an Alert providing information regarding who/what entity is an NGHP RRE. This document is an update of the July 31, 2009 Alert on the same subject and replaces Section 7.1 of the NHGP User Guide.

Note: CMS confirmed in a Teleconference on February 25, 2010 that there is conflicting information in this document, specifically in Appendix G. CMS noted that a corrected document will be provided shortly. Determination of RRE status should be based on the corrected document.

CMS provided definitions for the terms *deductible*, *self-insured retention*, *payment* and *review and approval authority* in terms of this document.

- *Deductible* refers to the risk the insured retains with respect the coverage provided by the insurer.
- *Self Insured Retention* refers to the risk the insured retains that is not included in the coverage provided by the insurer.



- When referring to *payment* of an ORM or TPOC, the reference is to actual physical payment rather than to who/which entity ultimately funds the payment.
- *Review or approval authority* means that the self insured/agency/State agency has the ability to affect the payment or other terms of the settlement, judgment, award or other payment (including ORM)

The most significant update in this Alert pertains to deductible plans. Generally, the insurer is the RRE for Section 111 reporting for deductible plans regardless of funding. This change will impact insureds who may have already registered as an RRE in order to report under a deductible plan and no longer have a need to report as an RRE. However, CMS states that if an insured entity acts “without recourse to its insurance, it is responsible for Section 111 reporting with respect to those actions.” CMS does not explicitly define the term “acting without recourse” other than to give the following example:

A claim is made against Company X which has insurance through Insurer Y. Company X settles the claim without informing its insurer. Company X is responsible for Section 111 reporting for the claim regardless of whether or not the settlement amount is within the deductible or in excess of the deductible.

A self-insurance pool is the RRE if the statute authorizing the establishment of a self-insurance pool stipulates that the pool shall be licensed and regulated in the same manner as liability or workers’ compensation insurance. Absent meeting this exception, unless all three of the following characteristics apply to the self-insurance pool, the participating self-insured entity is the RRE:

1. The self-insurance pool is a separate legal entity.
2. The self-insurance pool has full responsibility to resolve and pay claims using pool funds.
3. The self-insurance pool resolves and pays claims without review or approval authority by the participating self-insured entity.

Where multiple defendants are involved in a settlement, judgment, award or other payment with joint and several liability, each insurer must report the total amount paid, not just their proportionate share.

CMS confirmed that a subrogation claim made by an insurer is not reportable.

The above details some of the most pertinent information in this Alert. However; PMSI recommends all RREs review the entire document to determine the impact to their organization.

To view a copy of this CMS Alert [click here](#).

PMSI Client Recommendations

PMSI recommends that any entity who is considered an RRE review the updated documents to determine organizational impact and RRE’s reporting responsibilities under MMSEA Section 111. A significant amount of updated information has been provided in the User Guide 3.0, which should be read in its entirety.



The MMSEA Section 111 reporting process is still evolving as CMS continues to implement the requirements, provide further instructions and address industry questions. RREs should access the CMS Section 111 web page (www.cms.hhs.gov/MandatoryInsRep/) frequently for additional information.

PMSI will continue to provide additional guidance as new information is issued by CMS. RREs may also obtain additional information by attending CMS bi-monthly teleconferences. To view the updated list of CMS teleconferences (revised February 24, 2010) scheduled for 2010 [click here](#).

PMSI Client Support

PMSI is committed to bringing our clients the most current information on MMSEA reporting requirements and provides a complete preparation and compliance program. As further information becomes available, PMSI's Government Affairs team will provide additional insight and analysis.

For more information on MSP compliance and related PMSI Government Affairs Alerts, please contact your PMSI Representative, call us at 888.MSA.PMSI or visit the [Industry Insights](#) section of our website at www.pmsisettlement.com.

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