

CMS RELEASES ADDITIONAL MIR DIRECTIVES & “DRAFT LANGUAGE” REGARDING RRE DETERMINATION

By: Mark Popolizio, J.D.

The Centers for Medicare & Medicaid Services (CMS) has released additional guidelines and proposed “draft” provisions to its Mandatory Insurer Reporting (MIR) directives with respect to the agency’s continuing implementation of the “notice and reporting” requirements of Section 111 of the Medicare, Medicaid & SCHIP Extension Act (MMSEA).¹ This newly released information pertains to liability insurance (including self-insurance), no-fault insurance and workers’ compensation, collectively referred to as “Non-Group Health Plans” (non-GHP or NGHP)

On July 29, 2009, CMS issued **two** Supplemental Alerts dated July 13, 2009 and July 17, 2009 (hereinafter referred to as the *July 13th Alert* and *July 17th Alert*).

The *July 13th Alert* introduces new reporting requirements regarding what the agency references as “*periodic workers’ compensation payments*.” The *July 17th Alert* outlines important information regarding the respective roles of the Authorized Representative and Account Manager under the Section 111 reporting framework, and the MIR registration process.

On August 1, 2009, CMS released another Supplemental Alert dated July 31, 2009 (hereinafter referred to as the *July 31st Alert*).

Through the *July 31st Alert*, CMS outlines long-awaited proposed additions and revisions to its directives governing Responsible Reporting Entity (RRE) determination.

CMS has released these proposals “in draft” and has opened same up for “public comment.” All “comments” regarding CMS’ proposals must be received by the COB by August 16, 2009. Page one of the July 31st Alert provides instructions on how to submit comments.

In addition, CMS posted a document entitled “*Reporting Do’s and Don’ts*” to its dedicated **Section 111 website**. Through this document, CMS provides additional information on several topics and issues pertaining to the registration process, including certain “errors” CMS has identified thus far.

All three *July Alerts* and the “*Reporting Do’s and Don’ts*” document can be obtained at http://www.nqbp.com/rl_cms_memos.shtml.

This article outlines the major points contained in the *July-Alerts* and the other newly released information as same relate to CMS’ continued development of its MIR guidelines.²

Note: In addition to the Alerts and other information which are addressed in this article, CMS has also just released a second version of its *User Guide* pertaining to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation.

The new *NGHP User Guide (Version 2.0)* consists of 225 pages and contains several changes, updates and revisions to CMS’ Mandatory Insurer Reporting Guidelines.

The author is currently preparing a separate article dedicated to CMS' *NGHP User Guide (Version 2.0)* which will be released in the near future.

In the interim, for the reader's convenience a copy of the new *User Guide* can be obtained at http://www.nquestbridgepointe.com/news/uploads/nghpuserguidev2_0.pdf.

CMS' July 13, 2009 "Alert" – *Reporting Periodic Workers' Compensation Payments*

Through the *July 13th Alert*, CMS introduces an additional reporting requirement regarding "periodic workers' compensation payments" and provides guidance as to how same must be reported under CMS' "reporting triggers."

By way of background, CMS has established two "reporting triggers" referred to as (1) "TPOC" - Total Payment Obligation to the Claimant and (2) "ORM" - On-Going Responsibility for Medicals. If a "reporting trigger" is met, then reporting is required via CMS' electronic reporting process.

Through the *July 13th Alert*, CMS has now announced that "periodic workers' compensation payments," in certain situations, will be reportable as ORM. In this regard, CMS states as follows:

In situations where the applicable workers' compensation law or plan requires the RRE to make regularly scheduled periodic payments to, or on behalf of, the claimant, and the applicable workers compensation law or plan specifically precludes these periodic payments from including any direct or indirect payment for past, present, or future medical expenses; the RRE does not report these periodic payments (they are not reportable as either TPOCs or ORM). Otherwise, these payments are considered to be part of and are reported as ORM.

Based on comments made by CMS at recent Town Hall teleconferences, the introduction of this additional reporting requirement stems from the agency's concern that a workers' compensation RRE may, in certain instances, issue indemnity payments (or some other type of "periodic payment") which includes payment of medical expenses.

At the July 14, 2009 Town Hall conference,³ inquiries

were raised concerning use of the phrase "*specifically precludes*" and how same will be interpreted in light of the fact that most state statutes concerning "periodic payments" (e.g. payment of indemnity or wage loss type benefits) typically do not contain an express provision "specifically precluding" payment of medical; although payment of medical is not contemplated as part of the "periodic payment," nor the proper statutory payment classification designated for the payment of medical.

On this technical interpretational point, the basic question raised is essentially whether CMS is expecting a RRE to report a "periodic payment" which does *not* include "direct" or "indirect" payment of medical expenses as part thereof (e.g. a payment made strictly for indemnity, such as temporary total disability) based solely on the fact that the underlying law or plan governing such payment is devoid of an expressly stated provision "specifically precluding" payment of medical.

Based on CMS' limited oral comments on the issue thus far, this would not seem to be the case. However, from the author's perspective CMS' response to this inquiry at the teleconference did not necessarily address the underlying premise of the question and the author is not necessarily confident that the agency completely comprehends the potential interpretational complications created by use of the phrase "*specifically precludes*" as stated in the *July 13th Alert*.

The author recognizes that a strict interpretation of the language contained in the *July 13th Alert* could arguably be read to suggest that reporting may be required even when the "periodic payment" does not include payment of medical. However, while the author obviously defers to CMS in terms of when reporting is required, from the author's observations a strict application of this directive in this manner would not appear to serve the objectives of Section 111 reporting. Along these lines, CMS may ultimately measure the need to report simply by focusing on whether the "periodic payment" in a practical sense includes payment of medical.

Notwithstanding, at the same time there is a degree of legitimacy to the inquiry from a pure textual interpretational viewpoint given the actual wording of the directive. The focus point in this context being just how the apparent disconnect between the directive's express wording and the reality of typical statutory construction is to be reconciled textually, and in relation to CMS' actual intent.

Accordingly, it may be helpful for CMS, in the interest of clarity, to provide additional guidance on this issue, and if necessary, to issue a revised wording of this directive to assure that the text of the directive is congruent with the agency's actual intent in all respects.

CMS' July 17, 2009 "Alert" – Authorized Representative & Account Manager Determination

The **July 17th Alert** is aimed at further explaining the duties, responsibilities and limitations of the Authorized Representative and Account Manager within the Section 111 reporting framework, and in relation to the "registration" and "account set up" processes under the MIR.

By way of background, the *User Guide* (Version 2.0) outlines CMS' "five step" registration process and related account set up process in Section 8 (p. 23-29). CMS has created three main roles as part of the MIR reporting framework. The specific title designations are: "Authorized Representative," "Account Manager," and "Account Designee." The Authorized Representative and Account Manager play pivotal roles in relation to the registration and account set up processes.

The July 17th Alert basically serves to reiterate many of the directives previously issued by CMS pertaining to the Account Representative and Account Manager with respect to registration and account set up.

In this regard, CMS emphasizes the following points in the July 17th Alert:

- The RRE must determine who will serve in the roles of Authorized Representative and Account Manager prior to registering.
- The Authorized Representative and Account Manager may not be the same individual. RREs need to name *different* individuals for each role.
- The Authorized Representative must decide who will serve as the Account Manager prior to registering.
- The Authorized Representative cannot be a user of the Section 111 COBSW for any RRE ID and may not obtain a login ID.
- The information to be provided regarding the Authorized Representative and Account Manager on the Section 111 COBSW is provided at *different* times.

Specifically, information regarding the Authorized Representative is provided during the "*new registration*" phase while information regarding the Account Manager is to be provided during the "*account set up*" phase.

- The Account Manager his/or herself must perform the *Account Set Up* stage in order to obtain a Login ID and sign the User Agreement. The User Agreement can be found on p. 101 in the *User Guide* (Version 2.0) and contains very important information regarding the restrictions and limitations with respect to the data obtained through the Section 111 process. The author strongly recommends that all RREs and other interested parties carefully review the provisions of the User Agreement.
- In the event information regarding the Account Manager is mistakenly submitted during the "new registration" phase (instead of information for the Authorized Representative which is actually the information that is required during the "new registration" phase), then the Account Manager will not be able to successfully complete the Account Setup step and obtain a Login ID.
- If it is determined that either incorrect information or the wrong individual for the RRE's Authorized Representative was submitted as part of the New Registration step, then RRE's should contact their assigned Section 111 EDI Representative or the COBC EDI Department at 646-458-6740 before proceeding to the Account Setup step with your PIN.

CMS concludes the July 17th Alert by directing the reader as follows with respect to obtaining information regarding the registration process:

Please see the Section 111 User Guides and the "How To" documentation on the menu of the home page of the Section 111 COBSW for a description of the registration steps and user roles, particularly the "How to Get Started" document.

The Section 111 COBSW website URL is www.section111.cms.hhs.gov. You must click on the "I Accept" link of the Login Warning page in order for the home page to display. You do not need a Login ID to view the information on the home page. The User Guides can be found on the GHP and NGHP pages of www.cms.hhs.gov/MandatoryInsRep.

There are also Computer Based Training courses available to all RREs and their agents that cover the registration process. Please see the CBT page of www.cms.hhs.gov/MandatoryInsRep for information on how to enroll.

CMS' July 31, 2009 "Alert" – "Draft" Language for Public Comment (Concerns RRE Determination)

Through the *July 31st Alert*, CMS outlines long-awaited *proposed* additions and revisions to its directives governing Responsible Reporting Entity (RRE) determination.

As noted in the introduction to this article, CMS has released these proposals "in draft" and has opened same up for "public comment." All "comments" regarding CMS' proposals must be received by the COB by August 16, 2009. Page one of the July 31st Alert provides instructions on how to submit comments. CMS states that the proposals contained in the *July 31st Alert* will, when final, replace Section 7.1 ("Who Must Report") of the NGHP User Guide.

By way of background, the party required to report under Section 111 is referred to by CMS as the "Responsible Reporting Entity (RRE)." Over the past several months, CMS' directives concerning RRE determination have been an on-going area of concern and questioning. The industry has continued to seek additional guidance and clarity from CMS regarding RRE determination with respect to the actual directives as were contained in Version 1.0 of the *User Guide* and in relation to other situations the industry has felt have not otherwise been adequately addressed thus far by CMS. In these latter contexts, CMS has received repeated inquiries regarding RRE determination in relation to deductibles, captive and front arrangements, bankruptcy/liquidation and other specialized insurance arrangements.

In response, CMS has issued a proposed revision to Section 7.1 of the *User Guide* to provide further guidance and additional directives with respect to determining RRE status. In this regard, CMS states the following at the beginning of the *July 31st Alert*:

This draft document provides additional detail regarding who/what entity is a MMSEA Section 111 Responsible Reporting Entity for Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation.

The *July 31st Alert* consists of eight (8) pages, although the document itself does not contain actual page numbers. Nevertheless, to provide a more orderly review of the subject matter, the author will note the applicable page where the referenced information may be found within the document.

Through the *July 31st Alert*, CMS restates certain provisions as contained in the *User Guide*, provides additional information regarding others, and proposes *new* directives "in draft" governing RRE determination.

The size of the *July 31st Alert* precludes a direct recitation of the document in its entirety in the body of this article or a detailed outlining of each point discussed by CMS. Thus, below the author has highlighted only *selective* parts of the *July 31st Alert*. Accordingly, it is imperative that the reader perform his/her own independent review of this document in its entirety.

With said understanding, the author highlights the following selected sections of the *July 31st Alert*:

Who Must Report (p. 1-2)

This section is essentially similar to that outlined by CMS in Section 7.1 of the *User Guide* (Version 2.0). In this section, CMS directs the reader to the definition of "Applicable Plan" as defined under 42 U.S.C. 1395y(b)(8) with respect to determining reporting obligations. This statutory section outlines the type of laws, insurance arrangements, and plans that fall under Section 111's reporting requirements. As part of this review, CMS also directs the reader to Attachment A of the *Supporting Statement*⁴ and Appendix G of the *User Guide* for further guidance regarding who is obligated to report under Section 111.

In relation thereto, CMS states the following principle, which it has continually stressed throughout the MIR process, with respect to determining reporting obligations under Section 111:

CMS is aware that the industry generally does not use the term "plan" or some other CMS definitions such as CMS' definitions for "no-fault insurance" or "self-insurance". However, CMS is constrained by the language of the applicable statute and CMS' regulations. **It is critical that you understand and utilize CMS' definitions for purposes of Section 111 when reviewing and implementing Section 111 instructions.** (Emphasis by CMS).

Third Party Administrators (TPAs) (p.2)

The language in this section is similar to that contained in Section 7.1 of the *User Guide* (Version 2.0) at p.19-20 regarding TPAs. In general, the major point outlined in this regard is that under Section 111 a TPA in the NGHP context⁵ cannot be a RRE based solely on its status as a TPA, except to the extent that it may self-insure its own exposures. However, a TPA may serve as reporting Agent. Furthermore, CMS stresses that a RRE may not shift its Section 111 reporting responsibility to an Agent, by contract or otherwise and remains ultimately liable for proper Section 111 compliance.⁶

The author directs the reader to review this section in the *July 31st Alert* in its entirety for a complete outline of CMS' statements regarding TPAs under Section 111.

Deductible Issues (p. 3-5) — NEW

CMS' "draft" language regarding "deductibles" is as follows:

1. Deductible amounts are self-insurance for MSP purposes.
2. If payment of the deductible or an amount exceeding the deductible is by a TPA:
 - a. Payment is considered to be made by the insured if the TPA is under contract to the insured/acting on behalf of the insured.
 - b. Payment is considered to be made by the insurer if the TPA is under contract to/acting on behalf of the insurer.
3. Where the insured or the insurer is the RRE for both the deductible and any amount exceeding the deductible:
 - a. The total of the deductible and any amount in excess of the deductible is used in determining whether or not any applicable reporting threshold is met.
 - b. The total of the deductible and any amount in excess of the deductible are reported with a Value of "N" for "No" for Field 64 regarding Self-Insurance.

4. If an insured chooses to pay directly without recourse to existing insurance, any and all payment (regardless of whether or not the amount exceeds the deductible) is self-insurance and the insured is the RRE. This includes where the insured pays a claim for the deductible amount or less and fails to report that amount to its insurer in order to preserve/improve its experience rating (or for some other purpose).
 5. If the settlement, judgment, award or other payment is the deductible amount or less:
 - a. The insured is the RRE for purposes of the deductible amount if it pays the deductible to or on behalf of the injured party.
 - b. The insurer is the RRE for purposes of the deductible amount if payment of the deductible is by the insurer (with reimbursement by the insured to the insurer).
 6. If the settlement, judgment, award or other payment exceeds the deductible:
 - a. The insured is the RRE for purposes of both the deductible amount and any amount exceeding the deductible if it pays both the deductible and any amount exceeding the deductible to or on behalf of the injured party (with reimbursement by the insurer to the insured for the amount exceeding the deductible).
 - b. The insurer is the RRE for purposes of both the deductible amount and any amount exceeding the deductible if payment of the amount exceeding the deductible is made by the insurer, regardless of whether or not the deductible amount is paid by the insured or by the insurer (with reimbursement by the insured to the insurer for the deductible).
- 7. Examples for deductible issues:**
- a. Deductible amount is \$500. Settlement is \$550. Insurer pays the claim. RRE is the insurer for both the deductible amount and the amount in excess of the deductible. (See #6b above.)

- b. Deductible amount is \$500. Settlement is \$550. Insured pays the deductible amount of the claim to or on behalf of the injured party. Insurer pays the amount in excess of the deductible. RRE is the insurer for both the deductible amount and the amount in excess of the deductible. (See #6b above.)
- c. Deductible amount is \$500. Settlement is \$550. Insured pays both the deductible amount and the amount in excess of the deductible (with reimbursement from the insurer). RRE is the insured for both the deductible amount and the amount in excess of the deductible. (See #6a above.)
- d. Deductible amount is \$500. Settlement is \$450. Insurer pays the claim. RRE is the insurer. (See #5b above.)
- e. Deductible amount is \$500. Settlement is \$450. Insured pays the claim. RRE is the insured. (See #5a above.)
- f. Deductible amount is \$500. Settlement is \$450. TPA under contract to the insured pays the claim. RRE is the insured. (See #2a & #5a above.)
- g. Deductible amount is \$500. Settlement is \$450. TPA under contract to the insurer pays the claim (seeking reimbursement from the insured). RRE is the insurer. (See #2b & #5b.)
- h. Deductible is \$500. Settlement is \$450. Insurance contract calls for the insurer to pay the deductible (and any amount in excess of the deductible, if applicable), with insurer seeking reimbursement of deductible amounts paid from the insured. For a specific claim, insured makes payment without recourse to its insurance. RRE is the Insured. (See #4 above.)
- i. Deductible is \$500. Settlement is \$550. Insured pays the claim without reporting the claim to its insurer (in essence, without recourse to its insurance). RRE is the insured. (See #4 above.)

Fronting Policies (p. 5) – NEW

CMS’ “draft” language regarding “fronting policies” is as follows:

The intent with “fronting” policies is that the insurer will never pay a claim. The expectation of both the insured and the insurer is that the insured will pay all claims. Where the insured does pay (sic) the claim, the insured is the RRE.

Bankruptcy (p.8) – NEW

CMS’ “draft” language regarding bankruptcy situations is as follows:

Where an RRE is bankrupt, it remains the RRE to the extent that settlements, judgments, awards or other payments are paid to or on behalf of the injured party after approval by a bankruptcy court.

Liquidation (p.8) – NEW

CMS’ “draft” language regarding liquidation is as follows:

1. To the extent that settlement, judgment, award, or other payment obligations are paid to or on behalf of the injured party, from the assets of the entity in liquidation, the entity in liquidation is the RRE.
2. To the extent that a portion of a settlement, judgment, award or other payment obligation against an entity in liquidation is paid to or on behalf of the injured party by another entity from that other entity’s assets (for example, payment by a state guarantee fund), the entity that makes the payment is the RRE.
3. To the extent that a payment does not fully satisfy the entity in liquidation’s debt to the injured party, the amount reported is the amount paid. Any subsequently approved interim or final payments would be handled in the same manner. That is, they would be reported as additional TPOC amounts.

Other Contexts:

CMS address several other situations with regard to RRE determination in its “draft” proposals as follows:

- *Corporate Structure (with examples) (p. 2-3) — NEW*
- *Reinsurance, Stop Loss Insurance, Excess Insurance, Umbrella Insurance, etc. (p. 5)*
- *Multiple Defendants (p. 5)*
- *Self-Insurance Pools (p. 5-6)*
- *State “Assigned Claims Fund” (p. 6)*
- *Workers’ Compensation, including State/Federal Agency situations (p. 7-8)*
- *Multi-National Organizations, Foreign Nations, American Indian, Alaskan Native Tribes (p. 8) — NEW*

The reader should review these sections in their entirety to obtain an understanding of CMS’ directives in these specific contexts.

“Reporting Do’s and Don’ts”

CMS has also posted a document entitled “*Reporting Do’s and Don’ts*” to its dedicated Section 111 website. CMS states that the purpose of this post “*is to alert [the public] to reporting issues and errors CMS has identified*” in relation to the registration process.

The following is a *general* overview of the issues addressed in this document:

- Information is provided regarding the registration process with respect to the Account Representative and Account Manager which is similar to that contained in the *July 17th Alert*.
- With respect to any technical problems involving the Section 111 data exchange, CMS advises that the RRE should contact its assigned EDI representative. If the issue is not resolved, CMS then directs the RRE to follow the “escalation process” outlined in the *User Guide*.

- CMS encourages the RRE to contact its EDI representative “as soon as possible” to initiate communication by letting the representative know when it is ready to submit test files, or if there are specific issues regarding file submissions.
- CMS states the following with respect to reporting:
 - Do not include non-MSP records on the MSP input file.
 - Test files should contain real data. In this regard, CMS states that “*during the testing phase, please include records for Active Covered Individuals 65 years of age or older, thus assuring more ‘hits.’*”
- CMS provides specific information regarding the limited circumstances when deletion of records is appropriate. In general, CMS indicates that “deletes” should *only* be filed (1) to delete an entire record that was created in error; or (2) to correct the effective date, insurance coverage type or patient relationship fields in regard to a previously successfully added MSP record. In relation to these two instances, CMS provides related information regarding “disposition codes” and proper “transaction” filings. The author directs the reader to the “*Reporting Do’s and Don’ts*” document itself to review the specific information regarding “disposition codes” and “transaction” filings.

Conclusion

Through CMS’ newly released guidelines and information, it is evident that the MIR process remains in a “work in progress” state on several fronts. The range and scope of the topics addressed by CMS in the *July-Alerts* underscores this point. Through these documents CMS addresses the reporting, registration and account set-up, and RRE aspects of the MIR process.

This is an important reminder that CMS will continue to release additional updates and information related to its MIR program. Along these lines, all RREs and other interested parties should continue to regularly monitor CMS’ dedicated website www.cms.hhs.gov/MandatoryInsRep for these expected releases and/or the issuance of other MIR information.

Likewise, close attention should be afforded to CMS’ upcoming Town Hall teleconferences. Page 10 of this article contains a listing of the currently scheduled Town Hall conferences for easy reference.

About the Author

Mark Popolizio, J.D. is the Vice President of Customer Relations for NuQuest/Bridge Pointe. Mark also served as Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) from 2006-2008 and remains active with NAMSAP concentrating on educational and legislative matters.

Prior to joining NuQuest, Mark practiced workers' compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included Medicare Set-Asides and Medicare Compliance. Mark is very active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations.

Mark has also published several articles on MSA/ Medicare issues. Mark can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.

Endnotes

¹ Section 111 of the MMSEA is codified at 42 U.S.C. 1395y(b)(7) and (8). Subsection (8) concerns liability insurance (including self insurance), no-fault insurance and workers' compensation which are commonly referred to by CMS as non-Group Health Plans (non-GHP or NGHP). Subsection (7) pertains to Group Health Plans which is *not* addressed by this article.

² In addition to this article, the author has released several other articles with respect to each of CMS' MIR documents as follows:

Supporting Statement (August, 2008):

CMS Publishes Summary of Proposed Guidelines to Implement Section 111 of the Medicare, Medicaid & SCHIP Act, NuQuest/Bridge Pointe "Settlement News," August, 2008.

Implementation Timeline (September, 2008):

CMS Releases Implementation Timeline Regarding Section 111 of the MMSEA, NuQuest/Bridge Pointe "Settlement News," September, 2008.

Registration Process (September, 2008):

CMS Releases Registration Process Instructions for Electronic Reporting Under the Section 111 of the MMSEA, NuQuest/Bridge Pointe "Settlement News," September 29, 2008 (Special Edition).

Interim Record Layout (Initial – October, 2008):

CMS Releases "Interim Record Layout" Information for Reporting Under Section 111 of the MMSEA, NuQuest/Bridge Pointe "Settlement News," October, 2008.

Interim Record Layout (Updated – November, 2008):

CMS Releases "Updated" Interim Record Layout for Reporting Under Section 111 of the MMSEA, NuQuest/Bridge Pointe "Settlement News," December, 2008.

Interim Record Layout (Revised – December 5, 2008 Version):

CMS Releases "Revised" Interim Record Layout (12/5/08 Version) for Reporting Under Section 111 of the MMSEA, NuQuest/Bridge Pointe "Settlement News," December 18, 2008 Edition.

CMS’ “Query Access” System (January 22, 2009 Teleconference):

CMS Announces “Query Access” System to Determine Medicare Entitlement for NGHP Reporting Under Section 111 of the MMSEA, NuQuest/Bridge Pointe “Settlement News,” January, 2009.

CMS’ “Updated” Town Hall Conference (February 25, 2009):

CMS Provides Additional Information Regarding Section 111 Compliance at Fifth National “Town Hall” Teleconference, NuQuest/Bridge Pointe “Settlement News,” March, 2009.

Section 111 NGHP User Guide (Version 1.0) and CMS’ March & April Alerts:

CMS Releases “NGHP User Guide” & Supplemental Alerts Regarding Section 111 Reporting, NuQuest/Bridge Pointe “Settlement News,” April, 2009.

CMS’ May Alert:

CMS’ May-Alert Announces MIR Timeline Extensions & Amends The TPOC “Reporting Trigger,” NuQuest/Bridge Pointe “Settlement News,” May 29, 2009.

Each of the referenced articles can be obtained by logging onto www.NQBP.com (select “Resource Library” and then choose “Settlement News”). In addition, each of CMS’ documents can be obtained at http://www.nqbp.com/rl_cms_memos.shtml.

- ³ Note: Before actually releasing the *July 13th Alert*, CMS at the July 14, 2009 Town Hall conference discussed and read its contents as part of the teleconference. In conjunction therewith, inquiries were raised regarding the phrase “specifically precludes” as outlined by the author in this section.
- ⁴ See endnote 2 for instructions on how to obtain a copy of the *Supporting Statement*.
- ⁵ By contrast, CMS states that in the group health context a TPA *is* automatically a RRE. See, 42 U.S.C. 1395y(b)(7).
- ⁶ See, CMS’ NGHP User Guide (Version 2.0, July 31, 2009) at p. 22.

UPCOMING SECTION 111 “TOWN HALL” TELECONFERENCES TO BE HELD BY CMS REGARDING SECTION 111 OF THE MMSEA

CMS will be holding one NGHP Technical Support and one NGHP Policy related teleconference event per month through the end of 2009.

NGHP Technical Support teleconferences will focus on answering technical questions regarding the Section 111 data exchange process, including how to use the COB website, error codes and other information technology related questions. NGHP Technical Support teleconferences are scheduled for the following dates:

August 11, 2009	September 8, 2009
October 6, 2009	November 3, 2009
December 8, 2009	

NGHP Policy teleconferences will focus on CMS policy supporting the Section 111 reporting process and are set for the following dates:

August 18, 2009	September 30, 2009
October 22, 2009	November 17, 2009
December 15, 2009	

Participation is by telephone only. All calls are held from 1 pm - 3 pm EST and will utilize the same call in number and passcode as listed below.

Call in number: 800-779-4354

Passcode: Section 111

CMS requests that you dial in approximately 20-30 minutes prior to the call as connection is not immediate. Any questions that you may have can be submitted via the following link prior to the call. PL110-173SEC111-commentscomments@cms.hhs.gov.

Please note that CMS could add or delete dates and/or otherwise make other modifications to the current schedule. Thus, it is recommended that you consult CMS' dedicated Section 111 website for possible schedule updates at the below link.

http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage