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CMS ANNOUNCES A "QUERY ACCESS" SYSTEM TO DETERMINE MEDICARE ENTITLEMENT FOR NGHP REPORTING UNDER SECTION 111 OF THE MMSEA

By: Mark Popolizio, J.D.

On January 22, 2009, CMS held its fourth national "Town Hall" teleconference in conjunction with the continued implementation of the agency's Mandatory Insurer Reporting (MIR) requirements under Section 111 of the Medicare, Medicaid & SCHIP Extension (MMSEA).[1] CMS then held a follow up "Question and Answer" (Q/A) session on January 28, 2009. This teleconference and Q/A session related exclusively to "liability insurance (including self-insurance), no-fault insurance and workers' compensation" which is collectively referred to under the MIR as "Non-Group Health Plans" (non-GHP or NGHP).[2]

Through these forums, CMS further addressed various aspects of its MIR proposals, including several provisions contained in CMS' *"Revised" Interim Record Layout (12/05/08 Version)* released last month. **The most significant new policy announcement made by CMS was the introduction of a direct "Query Access" system in the NGHP context to assist Responsible Reporting Entities (RREs) (or its Agents) ascertain a claimant's Medicare entitlement status.**[3]

This article discusses the expected operating parameters of the forthcoming NGHP "Query Access" system, and the overall significance of same in the bigger picture of Section 111 compliance. In addition, CMS' statements pertaining to other key aspects of its MIR directives are highlighted.

Before embarking on this analysis, it should be noted that the below outline of the NGHP "Query Access" system is based solely on CMS' oral pronouncements. CMS' official written directives on this issue have not yet been released. Once CMS' written directives are released, all RREs and interested parties should carefully examine same to determine if any of the information contained therein differs from that as outlined below. Furthermore, the reader should become fully knowledgeable with CMS' written MIR documents to more fully appreciate the agency's oral proclamations regarding the other MIR proposals highlighted in this article.[4]

With said caveats, the author provides the following summary:

Determining Medicare Entitlement Status Under Section 111

To appreciate the significance of the "Query Access" system, it is first necessary to understand the potential problem that said system is designed to rectify. The starting point of the analysis requires an understanding of the actual statutory text of Section 111 as same relates to the obligation to "determine" Medicare entitlement status. In this regard, Section 111, in pertinent part, provides:

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

> (ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.[5]

As will be noted, Section 111 does *not* provide a process through which a RRE may "determine" Medicare entitlement status. Specifically, Section 111 does not provide an implied consent provision allowing a RRE to request Medicare entitlement information; nor does it require a claimant to execute an authorization permitting a RRE to obtain entitlement status information from the Social Security Administration.

The absence of specific statutory provisions on this fundamental component of Section 111's "notice and reporting" obligations has raised legitimate concerns for RREs. This concern relates specifically to the likely situation where a RRE's efforts to determine Medicare entitlement status are thwarted by a lack of cooperation on behalf of the claimant and/or his or her counsel (i.e. refusal to execute an authorization allowing the RRE to submit an request to the SSA), inability to locate the claimant, or other reasons. In these situations, determining Medicare entitlement status may be difficult or impossible.

Notwithstanding, CMS has consistently stated that the RRE remains responsible for devising its own procedures to determine a claimant's Medicare entitlement status, including performing follow up status checks to ascertain if a claimant who was *initially* determined *not* to be Medicare entitled subsequently becomes entitled to Medicare.[6]

However, despite CMS' firm stance, the agency clearly recognized the potential problem at its initial Town Hall teleconferences held on October 1, 2008 and October 29, 2008. At that time, CMS advised the industry that it would consult with its legal counsel to determine if a "Query Access" system could be established for the NGHP sector, similar to that which had been already implemented in relation to Group Health Plans (GHP).

After several months of consideration, CMS has now announced that a "Query Access" system will be established in the NHGP context. This is widely viewed as a welcomed addition to the MIR as this system will provide RREs with a coordinated process to help them meet a key obligation under Section 111. The question now becomes just how will the "Query Access" system operate?

CMS' NGHP "QUERY ACCESS" SYSTEM – OVERVIEW

As noted above, CMS' official written policies regarding the NGHP "Query Access" system have not been released. Information concerning the exact operating parameters of this system will be contained in CMS' *NGHP Section 111 User Guide* targeted for release in February, 2009.

CMS has announced the following main features of the forthcoming NGHP "Query Access" system:

- CMS stated that the system will be essentially "identical" to that utilized in the GHP context, with the exception that CMS will not provide as much information as is provided in the GHP context.
- Until the *NGHP Section 111 User Guide* is released, CMS recommends that the public consult the *GHP User Guide* to review the pertinent section pertaining to query access.
- CMS will be issuing HIPPA compliant (HUW) software to be used.
- Queries may be made on a monthly basis per RRE ID number(s).
- Testing of the system will commence on 7/1/09, which is also the start date of the general data exchange testing period under the MIR as previously announced.
- CMS explained that the system is basically designed to operate as a "single access" system; that is it will accept a request from only one authorized party as part of the monthly request system. Thus, while a RRE and Agent may both have access to the system depending on account set-up, only one query file will be processed per month. CMS stated further that the RRE remains responsible for the "conditions and use" of the information obtained from the system.
- To obtain a Medicare entitlement status, the following information must be submitted:
    - Social Security Number (The SSN is the key required element)
    - Name
    - Date of Birth
    - Gender

If there is a "match" between the information submitted and the records contained in the Social Security Administration (SSA), CMS will issue a "response file" containing the applicable HICN number identifying that person as a Medicare beneficiary which should be used for reporting. However, the basis for entitlement or date of entitlement will not be provided due to privacy reasons. Likewise, information regarding whether the claimant has applied for social security disability (or the status of any such application) will *not* be provided.[7]

CMS advised that the system in some instances may be capable of still determining an individual's entitlement status even if the submitted identifying information is not totally correct. CMS gave the example of the system being able to determine status where the submitted identifying information was correct in all respects with the exception of gender. However, CMS stated that the SSN is the key piece of information that must be provided in all instances.

CMS stressed that a "non-match" return should *not* be viewed as CMS' "confirmation" that the individual is not a Medicare beneficiary; rather, only that there was not a match "based on the information submitted." On a related note, a question was raised as to whether CMS would establish a "safe harbor" for RREs in situations where a RRE was unable to obtain a claimant's social security number (SSN). The question being whether CMS would establish safe harbor provisions if a RRE was unable to obtain the SSN after meeting a defined level of effort and activity. In response, CMS only indicated that it was still considering establishing a "model form" to assist in determining a claimant's SSN.

Taken on their face, CMS' comments on these points suggests that it does not view the "Query Access" system as providing a "safe harbor" to RREs, either in terms of the validity of the information received there from, or in relation to the efforts and measures undertaken by the RRE to obtain the claimant's SSN. CMS' position on these important points (and the potential ramifications) may need to be further explored by the industry.

- CMS stated that any disputes regarding social security numbers are between the individual and the SSA.

As noted above, until CMS releases the *NGHP Section 111 User Guide*, the agency has directed the public to the *GHP User Guide* to obtain an idea of the operational features of the NGHP "Query Access" system.

A copy of CMS' *GHP User Guide (Version 2.0, December 17, 2008)* may be obtained at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPUserGuide121708.pdf. At the teleconference, CMS did not provide the actual section(s) or page numbers in the *GHP User Guide* to be reviewed.

From the author's review, the *GHP User Guide* contains two specific sections related to Medicare entitlement determination: Section 7.3 is entitled *Query Only Input File Requirements* and Section 9.1.2 is entitled *Beneficiary Automated Status and Inquiry System (BASIS)*.

At the teleconference, CMS referred to the "Query Access" system in terms of a "query input file" and referenced the process as being similar to the "X12 270/271" process under GHP. These are terms and concepts contained under Section 7.3 (*Query Only Input File Requirements*) of the *GHP User Guide*. Section 7.3 also references HIPPA compliant software which, as noted above, was also referenced by CMS as part of its description of the NGHP "Query Access" system. Furthermore, during the "question and answer" session of the teleconference CMS made certain comments indicating that the "BASIS" system would not be made available to NGHP; although it is noted that the required information to be submitted to determine Medicare entitlement under the NGHP "Query Access" is essentially the same as outlined under Section 9.1.2 *(BASIS)*.

Taking CMS' discussion and comments in totality, Section 7.3 (*Query Only Input File Requirements*) of the *GHP User Guide* would appear to be the applicable section that should be reviewed until CMS' releases its *NGHP User Guide* next month. The *NGHP User Guide* will contain the operative written directives to be followed regarding the NGHP "Query Access" system.

Other "Highlighted" Points Addressed at the Town Hall Teleconference

In addition to announcing a NGHP "Query Access" system, CMS addressed several other key points during the

teleconference. The following is a non-exhaustive list of other points discussed at the teleconference:

- CMS provided a lengthy and intricate example of the interplay between the various Section 111 roles in terms of registration, account management and actual data transmission. This issue was presented by CMS via an example in which the RRE wanted to appoint an Agent, with said Agent then wanting to use another party to perform the actual data transmission. CMS indicated that this would be permitted under the MIR so long as it was in accord with applicable reporting and submission procedures. In this regard, CMS addressed the various roles and responsibilities regarding *Authorized Representatives*, *Account Managers* and *Account Designees* under the MIR and discussed options in terms of who may serve in these roles and in relation to actual data transmission. The exact requirements, options and limitations regarding the various Section 111 roles, account management and data transmission will be fully outlined in the forthcoming *NGHP User Guide*.

- CMS is still considering using codes other than WCIO codes for reporting.

- CMS will be meeting with the Department of Labor to discuss Section 111 reporting for funds administered by the Department.

- CMS is still considering holding separate meetings to address its MIR directives for workers' compensation and liability.

- CMS will be meeting to discuss how mass tort cases will be handled under Section 111.

- CMS remains interested in exploring a "low value" or de minimus threshold below which reporting would not be necessary.

- CMS is determining whether it will establish a cut off date for reporting under Section 111 with respect to cases considered "closed" or "inactive." This issue relates to the larger question of just how far back the obligation to report under Section 111 extends.

  As discussed by the author in his prior article, there is a distinction between closing a file administratively for business reasons due to inactivity *versus* the extinguishment of the claim legally, such as via a judgment or expiration of the statute of limitations.[8] In the former situation, the file is "closed" from an *administrative* perspective, but not necessarily from a legal standpoint.

This distinction is recognized by CMS as evidenced by the following written directive contained in the *"Revised" Interim Record Layout (12/5/08 Version):*

> No settlement, judgment, award, other payment and "file is ready to be closed" -- Where there is no settlement, judgment award or other payment, including an assumption of responsibility for ongoing medicals, there is no report required.
>
> With respect to responsibility for ongoing medicals, a determination that a case is "closed" or otherwise inactive does not automatically equate to a report terminating the responsibility for ongoing medicals. If the responsibility for ongoing medicals is subject to reopening or otherwise subject to a further request for payment, the record submitted for responsibility for ongoing medicals should remain open. (Medicare beneficiaries have a continuing obligation to apply for all no-fault or workers' compensation benefits to which they are entitled.) Similarly, if a file is "closed" due to a "return to work" and no additional anticipated medicals, a report terminating the responsibility for ongoing medicals should not be submitted as long as the responsibility for ongoing medicals is subject to reopening or otherwise subject to an additional request for payment.[9]

Based on the above, RREs *may still be required* to report under Section 111 where there is on-going responsibility for medicals (as that term is defined by CMS) even though the case has been dormant, the claimant has returned to work or the RRE otherwise administratively "closes" the file.[10]

It is interesting to note that at the teleconference CMS discussed the possibility of setting some type of reporting cut off period in relation to "closed" and "inactive" claims. It is unclear whether the contemplated cut off period is also being considered in connection with claims "pre-dating" the December 5, 1980 enactment of the Medicare Secondary Payer

Statute (MSP). CMS' written directives regarding cases pre-dating December 5, 1980 are contained in the *"Revised" Interim Record Layout (12/5/08 Version).* [11]

In general, these written directives indicate that the reach of Section 111 could extend to workers' compensation cases with incident dates *prior* to 1980 since Medicare has been secondary to workers' compensation since the inception of the Medicare program in 1965. However, CMS stated that the situation could be different for liability (including self-insurance) and no-fault cases which are governed by the December 5, 1980 effective date of the MSP. In regard to these claims, CMS stated that reporting is *not* required under Section 111 if the date of incident *as defined by CMS* was prior to December 5, 1980.

On their face, CMS' directives regarding "closed" and "inactive" files and claims with older incident dates harbor the potential for requiring reporting on a large number of dormant or older claims. In this regard, CMS' consideration of some type of reporting cut off period would be helpful to RREs in reducing the number of potential reportable claims under Section 111 and alleviating the administrative burden to address these claims.

Conclusion

CMS' announcement of a NGHP "Query Access" system at the January 22, 2009 Town Hall teleconference represents a major and welcomed change to CMS' MIR directives. Furthermore, through the teleconference and follow up Q/A session CMS provided additional explanation of several previously outlined MIR requirements and gave the industry some indication as to where the agency stood in relation to other outstanding MIR features.

As noted above, CMS' long awaited *NGHP User Guide* is expected to be released sometime in February, 2009. In addition, CMS indicated that additional updates to the *"Revised" Interim Record Layout* (12/5/08 Version) may be forthcoming. In the interim, all RREs and other interested parties should continue to regularly monitor CMS' dedicated website www.cms.hhs.gov/MandatoryInsRep for the release of these documents, as well as for any other new MIR guidelines.

Likewise, close attention should be afforded to CMS' upcoming Town Hall teleconferences. Future Town Hall conferences for NGHP are scheduled for: *February 25, 2009; March 24, 2009; and April 22, 2009.*

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.

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Endnotes

[1] CMS' prior teleconferences were held on October 1, 2008, October 29, 2008 and December 11, 2008.

A copy of summaries of CMS' October 1, 2009 and October 29, 2008 teleconference calls can be obtained at http://www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage.

In addition, CMS recently released an audio version of its October 1, 2008 teleconference call and published an actual transcription of the October 29, 2008 teleconference call which can be obtained at http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage.

At the time this article was drafted, CMS had not released an audio version or transcript of the December 11, 2008 teleconference.

[2] 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, with noted exceptions to references to the GHP "Query Access" system in accordance with CMS' referral to same in relation to its explanation of the operating features of the forthcoming NGHP "Query Access" system discussed herein.

[3] Under CMS' MIR guidelines, the party responsible for placing Medicare on notice and submitting the required "production files" is referred to as the "Responsible Reporting Entity" (RRE). CMS' definition of what constitutes a RRE is contained in CMS' *Supporting Statement* at pages 13-15 and CMS' *"Revised" Interim Record Layout (12/5/08 Version)* at pages 3-5. Copies of the referenced CMS documents may be obtained as outlined below in endnote 4.

The author provided an overview of the issues regarding RREs and Agents in his article entitled *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, at pages 2-3.

[4] CMS' previously released MIR proposals consist of the following documents which are accompanied by references to the author's articles addressing same:

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.

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.

[5] 42 U.S.C. § 1395y(b)(8)(A).

[6] See, CMS' *"Updated" Interim Record Layout (November, 2008)* at p. 5.

[7] The fact that the "Query Access" system will not provide information regarding social security status is significant as procuring this information may be necessary in certain situations to determine whether a Medicare Set-Aside (MSA) could be applicable.

While a positive determination of Medicare entitlement is the linchpin that "triggers" Section 111 reporting, this determination and the corresponding obligations emanating there from address only one component of Medicare compliance. In this regard, it must be remembered that protecting Medicare's interests in the MSA context is not only dependent on a claimant's Medicare entitlement status; whether or not the claimant has applied for social security disability and the status of said application are separate and important considerations that must also be addressed. In addition, the claimant's age and whether or not he/she has End Stage Renal Disease are other relevant factors. Thus, while the "Query Access" system will provide helpful information with regard to Section 111 compliance, it will not necessarily provide all the information needed to address *every* aspect of Medicare compliance. Specifically, a separate request to the Social Security Administration to obtain social security status information and procurement of other relevant information will still be necessary in certain instances to address MSA compliance issues.

[8] See the author's article entitled *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, at p. 6.

[9] *CMS' "Revised" Interim Record Layout (12/05/08 Version)*, p. 13; Emphasis Added.

[10] The concept of "on going responsibility for medicals" relates to one of CMS' current "triggers" for reporting. An examination of the reporting "triggers" and the various issues related thereto is beyond the scope of this article.

CMS' reporting "triggers" are outlined in *CMS' "Revised" Interim Record Layout (12/05/08 Version)* on pages 7-8 (bullet points 9-11) and pages 9-14 (25 separate bullet points). The author addressed the reporting "triggers" in his article entitled *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, at pages 5-7.

[11] *CMS' "Revised" Interim Record Layout (12/05/08 Version)*, p. 12-13; Emphasis Added.