

CMS RELEASES “NGHP USER GUIDE” & SUPPLEMENTAL “ALERTS” REGARDING SECTION 111 REPORTING

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On March 17, 2009, the Centers for Medicare and Medicaid Services (CMS) released its long awaited “**User Guide, Version 1.0 – March 16, 2009**” (hereinafter “**User Guide**”) pertaining to “liability insurance (including self-insurance), no-fault insurance and workers’ compensation” which are collectively referred to as “Non-Group Health Plans” (non-GHP or NGHP) under CMS’ Mandatory Insurer Reporting (MIR) directives per Section 111 of the Medicare, Medicaid & SCHIP Extensions Act (MMSEA).¹ A copy of the User Guide can be obtained at http://www.nuquestbridgepointe.com/news/uploads/nghp_mir_user_guide.pdf.

On March 23, 2009, CMS released a **Supplemental Alert** (dated March 20, 2009) to the User Guide (hereinafter **March-Alert**). A copy of the **March-Alert** can be obtained at http://www.nuquestbridgepointe.com/news/uploads/alert_nghpuserguide_v1_0.pdf.

On April 9, 2009, CMS released a **second Supplemental Alert** (dated April 7, 2009) to the User Guide (hereinafter **April-Alert**). A copy of the **April-Alert** can be obtained at <http://www.nuquestbridgepointe.com/news/uploads/nghpalerttpoc.pdf>.

In addition, CMS held “**Town Hall**” teleconferences on **March 24, 2009 and April 9, 2009** to discuss this newly released information and entertain questions from the industry regarding same.²

The User Guide and Alerts represent CMS’ latest and most significant MIR releases to date in relation to its

implementation of Section 111. These documents introduce additional MIR directives and serve to update and revise information contained in CMS’ previously released MIR documents, most notably the “Revised” Interim Record Layout (12/5/08 Version).

In conjunction with the release of this information, CMS also extended the “data testing” period through the end of 2009, and pushed back the “production live date” for Section 111 reporting until the first quarter of 2010. (CMS’ updated MIR timelines are outlined in Part I below).

The User Guide and Alerts contain detailed information and requirements regarding numerous general and technical MIR aspects. The purpose of this article is to provide a *basic* outline of particular MIR components contained in these newly released documents. As such, this article is designed to serve as a collaborative aid to the reader’s complete examination of the actual User Guide and Alert documents.

As part of the author’s aim of putting Section 111 into focus, this article has been divided into the following six parts:

- Part I: User Guide & Alert Overviews
- Part II: Who Must Report?
- Part III: Determining Medicare Status – *CMS’ Query Process*
- Part IV: Reporting Triggers, Exceptions & Special Reporting Extension
- Part V: What Information Must Be Reported?
- Part VI: Registration/Account Set Up & Other Matters

PART I:

USER GUIDE & ALERTS -OVERVIEW

CMS' NGHP User Guide -Overview

Prior to the release of the User Guide, the major general and technical MIR directives were essentially contained in the *Interim Record Layout*. The initial layout was released in October, 2008. An "updated" version of the layout was issued a few weeks later in November, 2008. In December, CMS released its "*Revised*" *Interim Record Layout (12/5/08 version)* which had basically been serving as the operative MIR compliance blueprint prior to release of the User Guide.³

The User Guide now expands upon the *Revised Layout* in several key respects and provides important directives and guidance in a number of areas. The User Guide's place in the larger unfolding MIR process is manifested in the following statement by CMS:

The December 5, 2008, Interim Record Layout was generally limited to the record layout, high level file submission information, basic information concerning who is an RRE/what triggers reporting. This User Guide goes beyond this by adding overview information on several topics, as well numerous sections of detailed technical information regarding registration, testing, file submission, response files, etc. A complete reading of this User Guide is advised. Now that there is a full User Guide, any future revisions (including additions or deletions) will be specifically identified.⁴

CMS' use of the phrase "initial version" in the User Guide's title is important as it indicates that "subsequent versions" of the guide are contemplated. Along these lines, CMS states the following:

Please note that the Centers for Medicare & Medicaid Services (CMS) is implementing the Section 111 requirements in phases. As time passes and we gain experience with Section 111 reporting, the data exchange requirements will continue to be refined and new processes added when necessary. CMS will issue revised versions of this Section 111 User Guide from time to time. Section 111 RREs will be notified when new versions are available. Please check the CMS Section 111 Web page often at

www.cms.hhs.gov/MandatoryInsRep for the latest version of this guide and for other important information.⁵

The User Guide also provides a glimpse of how Section 111 will relate to the overall aim of ensuring Medicare's secondary payer status in the claims context under the Medicare Secondary Payer Statute (MSP). In this regard, CMS indicates the following:

The data collected under Section 111 reporting will be used by CMS in processing claims billed to Medicare for reimbursement for items and services furnished to Medicare beneficiaries and for MSP recovery efforts, as appropriate.

The Section 111 reporting responsibilities are an additional, more comprehensive method for obtaining information regarding situations where Medicare is appropriately a secondary payer. They do not replace or eliminate existing obligations under the MSP provisions for any entity. For example, Medicare beneficiaries who receive a liability settlement, judgment, award, or other payment have an obligation to refund associated conditional payments within 60 days of receipt of such settlement, judgment, award, or other payment. The Section 111 reporting requirements do not eliminate this obligation.⁶

As for the actual format of the User Guide, the document consists of 180 pages. The first 82 pages are divided into 20 specific sections which contain detailed information concerning several general and technical MIR aspects.

This is followed by a series of appendices addressing data layout requirements and important information regarding the determination of reporting responsibilities as follows:

- Appendix A: Claim Input File
- Appendix B: TIN Reference Layout
- Appendix C: Claim Response File Layout
- Appendix D: Query File Input and Response File Layouts
- Appendix E: Disposition, Error and Compliance Flag Codes
- Appendix F: MMSEA Section 111 Statutory Language
- Appendix G: MMSEA Section 111 Definitions and Reporting Responsibilities

CMS’ “March Alert” – MIR Timeline Extensions

A few days after the User Guide was issued, CMS released its *March-Alert*.

Through the *March-Alert* CMS extended the MIR timelines for the “testing period” and projected “production live date” as follows:

- 5/1/09-6/30/09: Section 111 registration (no change).
- 7/1/09-12/31/09: Data testing period. The initial testing period end date was 9/30/09.
- 1/1/10-3/30/10: The “production live date” (the date a particular RREs “official” Section 111 reporting is to commence). RREs are required to begin live production submission no later than their assigned submission window in the January – March quarter of 2010. However, if RREs complete testing before January 2010, they may begin submitting live production files in the October - December quarter of 2009.

In addition to these time extensions, the *March-Alert* outlined certain reporting “exceptions” and “exemptions” which are more fully discussed below. The *March-Alert* also updates and corrects other information contained in the User Guide.

CMS’ “April Alert” – Reporting Multiple TPOC Amounts & Dates

Through the *April-Alert*, CMS modified certain requirements for the reporting of multiple TPOC amounts. TPOC refers to the “Total Payment Obligation to the Claimant” and relates to one of CMS’ “reporting triggers.” For a discussion of the “reporting triggers,” see Part IV below.

With this general outline of the User Guide and Alerts under our belts, attention will now center on certain key aspects of the MIR directives and process:

PART II: WHO MUST REPORT?

SECTION 111 – APPLICATION

Per Section 111, “applicable plans” are the entities required to comply with the “notice and reporting” requirements. The statute defines “applicable plans” as follows:

“APPLICABLE PLAN- In this paragraph, the term ‘applicable plan’ means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

- (i) Liability insurance (including self-insurance).
- (ii) No fault insurance.
- (iii) Workers’ compensation laws or plans.”⁷

A copy of the actual statutory text of Section 111 is attached as Appendix F to the User Guide (p. 175). **Section 111 is effective 7/1/09 in the NGHP context.**

Responsible Reporting Entities (RREs)

The party required to report under Section 111 is referred to by CMS as the “Responsible Reporting Entity (RRE).”⁸ Determining RRE status is an important first step in assessing Section 111 reporting responsibilities.

CMS’ directives and discussion concerning RREs can be found at pages 19-20 and Appendices F and G of the User Guide. The reader should carefully review these sections to become fully apprised with CMS’ RRE definitions and directives.

In terms of determining RRE status, CMS states as follows:

[Y]ou must use the applicable statutory language in conjunction with “Attachment A – Definitions and Reporting Responsibilities” to the Supporting Statement for the Paperwork Reduction Act (PRA) Notice published in the Federal Register in order to determine if you are a RRE for purposes of these new provisions. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments

are all available as downloads at www.cms.hhs.gov/MandatoryInsRep. “Attachment A – Definitions and Reporting Responsibilities” to the Supporting Statement provides details on definitions and exactly which entities must report. Attachment A can also be found in Appendix G of this guide.⁹

Under the MIR, it is imperative to note that CMS’ definitions regarding specific terms control, even if CMS’ definitions differ from those commonly used by the industry. For example, CMS notes that its definitions of “no-fault” and “self-insurance” differ from how those terms may be typically used in the industry. Regardless, CMS’ definitions govern in terms of Section 111.¹⁰ This important fact has particular applicability with respect to determining RRE status.

Taking this into consideration, in general potential RREs under the MIR include, but are not necessarily limited to, insurers (carriers), self insureds, self insurance pools and Federal/state assigned claims funds or related agencies.

The author hereby highlights the following considerations with respect to RRE determination as specifically outlined by CMS in the User Guide:

Workers’ Compensation Law or Plan

Under the MIR, CMS defines a “workers’ compensation law or plan” in Appendix G (p.180) as follows:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), a workers’ compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses.

The term includes a similar compensation plan established by an employer that is funded by such employer directly or indirectly through an insurer to provide compensation to a worker of such employer for a work-related injury or illness. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8).

CMS provides additional information regarding its definition and use of this term in Section 5.2 of the User Guide (p.13). The author *strongly encourages* the reader to closely examine this section.

Insurer (Liability & No-Fault)

Under the MIR, CMS defines a “liability insurer” in Appendix G (p.179) as follows:

For purposes of the reporting requirements for 42 U.S.C. 1395y(b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.

In Section 5.1 of the User Guide (p.11-12), CMS provides additional information regarding how it defines and uses this term (and related matters related thereto) and provides examples of the type of coverages included. The author *strongly encourages* the reader to closely examine this section.

Self-Insurance

Under the MIR, CMS defines “self-insurance” in Appendix G (p.179) as follows:

42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers’ compensation law or plan) for a business, trade or profession. See also 42 C.F.R. 411.50.

Section 5.1 of the User Guide (p.11-13) provides additional information and examples of constitutes “self-insurance” under the MIR and the author strongly encourages the reader to examine these sections.

With respect to self insurance, the payment of deductibles is a factor to be considered in determining reporting responsibilities. In this regard, CMS states the following:

Self-Insured Deductible Payment

On page 19 of the User Guide, CMS states:

Where an entity is self-insured for a deductible but the payment of that deductible is done through the insurer, then the insurer is responsible for including the deductible amount in the amount it reports as a settlement, judgment, award or other payment.

The issue is also referenced on page 180 of the User Guide as follows:

Special Considerations where liability self-insurance which is a deductible or co-payment for liability insurance, no-fault insurance, or workers' compensation is paid to the insurer or workers' compensation entity for distribution (rather than directly to the claimant):

As indicated in the definition of "liability self-insurance," such deductibles and co-payments constitute liability self-insurance, and require reporting by the self-insured entities. However, in order to avoid two entities reporting where the deductibles and/or co-payments are physically being paid by the insurance company or workers' compensation rather than the self-insured entity, CMS has determined that the liability insurance company, no-fault insurance company, or workers' compensation, as appropriate, must include the self-insurance deductible or co-pay in the amount it reports. Note that this rule only applies where the self-insurance deductible or co-pay is paid to the insurer for distribution rather than directly to the claimant.

Reinsurance, Excess/Umbrella Coverage & Other Coverage Forms

In certain circumstances other forms of insurance, such as re-insurance, excess/umbrella coverage and guaranty funds could have reporting responsibilities under the MIR. CMS' directives indicate the following:

For re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient

compensation funds, etc. which have responsibility beyond a certain limit -

The key in determining whether or not reporting for 42 U.S.C. 1395y(b)(8) is required for these situations is whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment being made to self-insured entity to reimburse the self-insured entity. Where payment is being made to reimburse the self-insured entity, the self-insured entity is the RRE for purposes of the payment made to the injured individual and no reporting is required by the insurer reimbursing the self-insured entity.¹¹

Liability and WC Self Insurance Pools

Through the User Guide, CMS announced several newly released directives regarding RRE determination pertaining to self insurance pools. In large part, RRE determination regarding self-insurance pools hinges on the "legal status" of the pool and the degree of control over claim payment and resolution between the pool and participating entity.

With respect to liability self-insurance pools, CMS' directives provide as follows:

RRE for liability self-insurance pools –

Entities self-insured in whole or in part with respect to liability may elect, where permitted by law, to join with other similarly situated entities in a self-insurance pool (e.g., joint powers authority).

If the self-insurance pool (1) is a separate legal entity (2) with full responsibility to resolve and pay claims using pool funds (3) without involvement of the participating entity, the self-insurance pool is the responsible reporting entity. If all three aforementioned characteristics are not applicable to the self-insurance pool, the participating self-insured entity is the responsible reporting entity.¹²

CMS' directives in the WC setting are similar:

Where the applicable law or plan authorizes employers to join with other employers in self-insurance pools (e.g., joint powers authorities) and the self-insurance pool (1) is a separate legal entity (2) with full responsibility to resolve and pay claims using pool funds (3) without involvement of the participating employer, the self-insurance pool is the RRE.

Where the applicable law or plan authorizes employers to join with other employers in self-insurance pools but any of the above delineated requirements are not satisfied, the participating employer is the RRE.

Where the applicable law or plan establishes a State/Federal agency with sole responsibility to resolve and pay claims, the established agency is the RRE.¹³

Federal/State “Assigned Claims Funds” & Agencies

Through the User Guide CMS also issued new directives regarding RRE determination related to Federal or State “assigned claims funds” and related agencies. In this setting, RRE determination relates primarily to the source of funding and the degree of control over claim payment and resolution between the fund and the carrier assigned to administer the underlying claim (if applicable).

With regard to assigned claims funds in the *automobile accident* context, CMS’ stated directives are as follows:

RRE for a State established “assigned claims fund” which provides benefits for individuals injured in an automobile accident that do not qualify for personal injury protection/medical payments protection from an automobile insurance carrier:

Where there is a State agency which resolves and pays the claims using State funds or funds obtained from others for this purpose, the established agency is the RRE.

Where there is a State agency which designates an authorized insurance carrier to resolve and pay the claims using State-provided funds without State agency review and/or approval, the designated carrier is the RRE.

Where there is a State agency which designates an authorized insurance carrier to resolve and pay the claims using State-provided funds but the State agency retains review or approval authority, the State agency is the RRE.¹⁴

In the *workers’ compensation* context, CMS’ directives to determine RRE status in situations where a Federal or State agency is involved in claim administration are as follows:

Applicable law or plan authorizes employers to self-insure or to purchase insurance from an insurance

carrier and also establishes a State/Federal agency to assume responsibility for situations where the employer fails to obtain insurance or to properly self-insure —

Where such State/Federal agency itself resolves and pays the claims using State/Federal funds or funds obtained from others for this purpose, the established agency is the RRE.

Where such State/Federal agency designates an authorized insurance carrier to resolve and pay the claim using State/Federal-provided funds without State/Federal agency review and/or approval, the designated carrier is the RRE.

Where such State/Federal agency designates an authorized insurance carrier to resolve and pay the claim using State/Federal-provided funds but State/Federal agency retains review or approval authority, the State/Federal agency is the RRE.¹⁵

Third Party Administrators (TPAs)- Limited RRE Status

CMS’ directives regarding RRE status and TPAs is as follows:

Third party administrators (TPAs) as defined by CMS for purposes for 42 U.S.C. 1395y(b)(7) & (8) are never RREs for purposes of 42 U.S.C. 1395y(b)(8) [liability (including self-insurance), no-fault, and workers’ compensation reporting] **based solely upon their status as this type of TPA.** (Note that for purposes of 42 U.S.C. 1395y (b)(7) reporting for group health plan arrangements, this type of TPA is automatically an RRE.)

However, while entities which meet this definition of a TPA generally only act as agents for purposes of the liability insurance (including self-insurance, no-fault insurance, or workers’ compensation reporting they may, under specified circumstances, also be an RRE. See, for example, the discussion of RREs for workers’ compensation.¹⁶

Accordingly, under the MIR TPAs are not and cannot be RREs, except to the extent that they may self-insure its own WC and liability exposures.

It is anticipated that CMS will be releasing additional information, examples and directives pertaining to RRE determination in other contexts not specifically referenced in the User Guide.

SECTION 111 REPORTING “AGENTS”

A RRE may use an Agent for reporting purposes under Section 111. CMS does *not* “sponsor” any entities as Agents and has no “approved list of agents.”¹⁷

CMS has outlined several important directives regarding the use of Agents that must be considered. **CMS’ directives concerning Agents can be found at Section 7.2 (p. 21) of the User Guide.**

Under the MIR, Agents are not, and cannot be, RREs. Even if a RRE decides to use an Agent, the RRE remains ultimately liable for Section 111 compliance and for the accuracy of the data submitted.¹⁸ A RRE “may not shift its Section 111 reporting responsibility to an agent, by contract or otherwise.”¹⁹ Furthermore, the RRE (not the Agent) is the party responsible for registering with CMS under the MIR registration process.

Regarding technical reporting aspects, the following directives regarding Agents are noted:

- Agents must exchange separate files for each RRE ID that they represent.
- Agents must test each RRE ID file submission process separately.
- Agent representatives may be Account Managers and Account Designees for the RRE on the COB Secure Web site (COBSW). However, agents may not be named as the RRE’s Authorized Representative.
- All communications regarding Medicare recovery will be directed to the RRE, not the agent.²⁰

PART III:

DETERMINING MEDICARE STATUS CMS’ QUERY PROCESS

Query Process – In General

Determining a claimant’s Medicare status is a core requirement under Section 111 which has a direct impact on a RRE’s reporting obligations. To appreciate this important aspect of Section 111 and the current state of affairs under the MIR regarding same, a brief overview may be helpful.

The actual statutory text of Section 111 provides that “applicable plans” 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.²¹

It should be noted that the actual statutory text of Section 111 uses the word “entitled.” However, in the User Guide CMS primarily uses the word “beneficiary,” while at other times it uses “entitled” or “enrolled” in this context. CMS seems to use these terms interchangeably.

Under the MIR, RREs are responsible for developing their own procedures to determine a claimant’s Medicare entitlement status; including performing follow up status checks to ascertain whether a claimant who was *initially* determined *not* to be Medicare entitled subsequently becomes entitled to Medicare.

Significantly, the actual statutory provisions of Section 111 do *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 a specific process regarding this core component of Section 111 has raised legitimate concerns from the very beginning of the MIR process. 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 (e.g. refusal to execute an authorization allowing the RRE to submit a request to the SSA), inability to locate the claimant, or other reasons. In these situations, determining Medicare entitlement status may be difficult or impossible.

CMS acknowledged this potential problem in its first Town Hall teleconference in October, 2008. At that time, the agency advised that it would determine whether a designated system could be developed to rectify this problem.

After several months of consideration, CMS at its January 22, 2009 Town Hall teleconference announced the establishment of a “Query Access” system (now being referred to as “Query Process”) to assist RREs in determining Medicare entitlement status. At that time, CMS provided *oral* information regarding the expected operating parameters of this system and advised that the forthcoming User Guide would outline the exact operating directives.²²

The User Guide now provides specific written directives and information regarding the “Query Process” system which are located at Section 13 (p.67) of the User Guide.

CMS describes the Query Input File to be used as the “dataset transmitted from a Section 111 RRE to request information regarding whether a particular injured party is a Medicare beneficiary (is or was entitled and enrolled in Medicare) prior to submitting the claim.”²³ The “Query Process” system is optional.²⁴

Under the “Query Process” system, requests may be submitted “up to once per calendar month per RRE ID”²⁵ and do not have to be submitted during a specific submission timeframe. CMS states that a response will be returned “within 14 days.”²⁶

Importantly, use of the information received from the “Query Process” system is limited per the terms, conditions and restrictions regarding access and use of Section 111 data as contained in the Section 111 Data Use Agreement.²⁷

The following informational elements need to be provided:

- Social Security Number (SSN) or Health Identification Number (HICN)
- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender

It is important to note that the SSN or HICN are required informational elements. The Coordination of Benefits Contractor (COBC) must find an “exact match” on the SSN or HICN. Then, at least three out of the four remaining criteria must be matched exactly.

CMS advises that if a match is found, the user will be returned to the correct HICN and that same should be stored and used on future transactions. CMS indicates

that this number is “CMS’ official identifier for the beneficiary and will be used by the COBC when matching claim records to Medicare beneficiaries when submitted.”²⁸

Section 13.2 addresses software availability and other technical requirements. In general, Query Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set. Alternatively, RREs may use their own translator software, or the HIPAA Eligibility Wrapper (HEW) software (provided by the COBC) to submit a Query Input File and process the Query Response File.²⁹ A RRE must request a copy of the HEW software during registration which will be available in mainframe and PC/server versions.

Section 13.1 contains additional requirements regarding information received from the “Query Process” system. In addition, Section 13.3 contains related “general” reporting requirements. Detailed examination of these sections is beyond the scope of this article. All RREs and interested parties should review these sections carefully to ensure that the corresponding requirements are incorporated into their Section 111 reporting programs.

Query Process – Issues & Considerations

It is important to note CMS has stated that the “Query Process” system is not a “safe harbor” with respect to a RRE’s obligations under Section 111. In this respect, 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.”³⁰

Another important consideration relates to the limited information that the “Query Process” will provide. Specifically, the “Query Process” system will *not* provide the *basis* or *date* of individual’s Medicare entitlement 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. This could have implications with respect to Medicare compliance issues *outside* of Section 111.³¹

On a related note, a question raised at a recent Town Hall teleconference concerned 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). In response, CMS only indicated that it was still considering establishing a “model

form” to assist in determining a claimant’s SSN.³² In the author’s view, it is unlikely that CMS will provide a “safe harbor” in this context in keeping with its refusal to do so in relation to the “Query Process” system.

PART IV:

“REPORTING TRIGGERS,” EXCEPTIONS & SPECIAL REPORTING EXTENSION

CMS has established two “reporting triggers” which, if either is met, require the claim to be reported via CMS’ electronic reporting process, accompanied by the production of specific information as required under the MIR. Reporting will be on a quarterly basis.

The two triggers are referred to as (1) TPOC and (2) ORM which are more fully explained in this section. Under the MIR, multiple reporting (including reporting under each of the reporting triggers) may be applicable in a particular case based upon certain relevant circumstances and specific facts.

In terms of general reporting principles, reporting is required under the triggers if the “injured party is/was a Medicare beneficiary”³³ and is required “regardless of whether or not there is an admission or determination of liability.”³⁴ There is no Medicare beneficiary age threshold for reporting and “geographic location of the incident, illness, injury is not determinative for Section 111 reporting.”³⁵

Importantly, CMS states that “notice to CMS of a pending claim or other pending action by an RRE or any other individual or entity does not satisfy an RRE’s reporting obligations with respect to 42 U.S.C. 1395y(b)(8).”³⁶ On this latter point, CMS appears to be indicating that the claim must be “ripe” for reporting under the established reporting triggers for proper Section 111 compliance. Furthermore, the parties’ allocation of settlement proceeds (even if a Court has approved same) does not affect a RRE’s obligation to report under Section 111.³⁷

Under the MIR, “each RRE reports its ongoing medical responsibility and/or settlement/judgment/award/other payment responsibility without regard to ongoing medicals. Each RRE would also report any responsibility it has for ongoing medicals on a policy-by-policy basis.”³⁸

Likewise, with respect to multiple settlements involving the same individual CMS states that “each RRE must report appropriately” with the agency viewing the submission of multiple records for the same individual as being “cumulative rather than duplicative.”³⁹

Against this general backdrop, CMS’ current “reporting triggers” can be outlined as follows:

Reporting Trigger # 1 – “TPOC” Reporting

Reporting required upon claim resolution (or partial resolution) via a settlement, judgment, award or other payment on or after July 1, 2009 – (TPOC)

CMS refers to this reporting trigger as “TPOC” – Total Payment Obligation to the Claimant which is defined “as the total payment obligation to the claimant without regard to ongoing medicals.”⁴⁰ TPOC reporting is viewed by CMS as essentially involving a single payment obligation via lump sum payment or via structured/annuity payment.⁴¹ CMS states “that a single payment obligation is reported only once regardless of whether it is funded through a single payment, an annuity or a structured settlement.”⁴²

TPOC reporting is applicable in both liability and workers’ compensation contexts as may be required under the circumstances. CMS views the TPOC trigger to be the likely main reporting basis in the typical liability claim (no-fault excluded) as in this setting the applicable plan’s main payment is typically issued as part of a “single payment” obligation as described by CMS. In contrast, in the workers’ compensation and no-fault arenas, the applicable plan typically provides or pays for medical services which could, in the Section 111 reporting context, require reporting under the “on-going responsibility for medicals (ORM)” trigger (discussed below).

The TPOC date is the date “the obligation is established” which is defined as follows:

This is the date the obligation is signed if there is a written agreement unless court approval is required. If court approval is required it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement it is the date the payment (or first payment if there will be multiple payments) is issued.⁴³

The TPOC amount is referenced as:

Dollar amount of the total payment obligation to the claimant. If there is a structured settlement, the amount is the total payout amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity. For annuities base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount (if there is a minimum payout), whichever calculation results in the larger amount.⁴⁴

Under TPOC, RREs must report the full amount of any settlement, judgment, award or other payment amount (the TPOC amount) without regard to any amount separately obligated to be paid as a result of the assumption/establishment of responsibility for ongoing medicals.⁴⁵ In addition, at the March 24 teleconference CMS stated that the amount of any Medicare Set-Aside should be included as part of the TPOC calculation.⁴⁶

Under the MIR, there may be multiple TPOCs for the same individual for the same claim. Through CMS' *April-Alert*, the agency has announced special requirements pertaining to the reporting of multiple TPOC amounts and dates which should reviewed by all RREs and interested parties. (A copy of said Alert may be obtained by using the link provided as referenced in the introduction to this article).

TPOC Reporting Exemptions –

CMS' *March-Alert* established TPOC “monetary reporting exemptions” below which reporting is *not* required.

CMS' TPOC monetary threshold exemptions apply only to liability insurance (including self-insurance) and workers' compensation case; they do not apply to no-fault. CMS' current TPOC monetary threshold reporting exemptions are as follows:⁴⁷

- TPOC dates of 7/1/09-12/31/10:
TPOC \$0.00 - \$5,000.00 reporting exemption*
- TPOC dates of 1/1/11-12/31/11:
TPOC \$0.00 - \$2,000.00 reporting exemption*
- TPOC dates of 1/1/12-12/31/12:
TPOC \$0.00 - \$600.00 reporting exemption*

*Exception: Where there are multiple TPOCs reported by the same RRE on the same record, the combined TPOC amounts

must be considered in determining whether or not the reporting exception threshold is met. For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the threshold applies to the total of these two figures.

Reporting Trigger # 2 – “ORM” Reporting

Reporting required in situations where the RRE has assumed “ongoing responsibility for medical payments (ORM)” including claims where ORM was assumed prior to July 1, 2009 and continues as of that date regardless of an initial resolution (partial resolution) date prior to July 1, 2009.

Reporting Under ORM- In General

Reporting under the ORM trigger requires two reportable events: (a) when the RRE assumes “ongoing responsibility for medical payments (ORM)” and (b) when ORM terminates.⁴⁸

Under the MIR, “*the only exception to two claim reports for ORM ... will be when assumption and termination of ORM are reported in the same record or when the RRE needs to update or delete previously submitted information and correct records due to a change in important information sent on the prior record.*”⁴⁹ In this regard, CMS states the following:

If ORM is started and ended within the same calendar quarter or prior to the current reporting quarter before the initial report of ORM was made, all of this information may be reported on one record. For example, suppose a workers' compensation claim is opened for an employee/injured party who is a Medicare beneficiary in January and the injury is relatively minor such that ORM terminates in February. Depending upon its specific quarterly submission date, the RRE may end up only needing to report the claim once if the claim is closed and ORM has ended.⁵⁰

From CMS' view, the ORM trigger will “*typically only [apply] to no-fault and workers' compensation claims.*”⁵¹ This is so because in these settings it is very common for RREs to provide or pay for medical services as part of normal claim administration per statutory or contractual obligation. However, ORM reporting could be required in the liability setting in certain circumstances.

It is important to note that if the claimant was not a Medicare beneficiary at the time ORM was assumed, “the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary unless responsibility for [ORM] has terminated before the individual becomes a Medicare beneficiary” or otherwise terminated per an ORM reporting exception.⁵²

Under the ORM trigger, reporting it is not required each time a RRE pays for a medical service.⁵³ Likewise, the RRE does not need to report the same claim information each quarter.⁵⁴ Per CMS, once the RRE makes the first report and receives a positive response that the record was accepted reporting is not required again until ORM has terminated.⁵⁵

ORM—“Assuming” Responsibility

Under the ORM framework, a central determination involves exactly what constitutes (or may constitute) ORM in terms of Section 111 reporting. From the author’s perspective, the User Guide does not necessarily provide an encompassing definition or definitive guidance on this point. On page 7 of the User Guide, CMS states the following regarding ORM:

Ongoing responsibility for medicals (ORM) refers to the RRE’s responsibility to pay, on an ongoing basis, for the injured party’s (Medicare beneficiary’s) medicals associated with a claim. This typically only applies to no-fault and workers’ compensation claims. Please see Section 11.6 for a more complete explanation of ORM.

Legitimate questions may arise as to when or what type of payments are sufficient to establish ORM in light of the various contexts and manners in which payments can be made in the claims context. In this regard, notwithstanding CMS’ above statement, the current directives do not really provide guidance regarding the varying situations that may arise. Two examples that are actually contained in the User Guide relate to payments issued during an investigatory period and in relation to a defense evaluation.

Under the MIR, payments made “pending investigation” triggers ORM reporting which may be terminated upon completion of the investigation if ORM is terminated.

On this point, CMS states:

Where payment is made pending investigation, the RRE must report this as an assumption of ongoing responsibility for medicals. If ORM terminates upon completion of the investigation, the termination of ORM must be reported.⁵⁶

Conversely, a “one time payment for defense evaluation” does *not* trigger reporting if it falls under CMS’ precise guidelines as follows:

One time payment for defense evaluation - A payment made specifically for this purpose directly to the provider or other physician furnishing this service does not trigger the requirement to report.⁵⁷

A question that would seemingly arise in the second instance is what happens in a situation where there is *more than one* defense evaluation? From the author’s experience, more than one “defense evaluation” is commonplace in defending claims and/or addressing the claimant’s specific injury claims or request for medical benefits. Further clarification from CMS on this point may be necessary.

In many respects, the current MIR directives do not necessarily provide clear bases or other benchmarks to delineate when payments would be considered ORM in all instances. Is one payment enough? Is the “amount” or nature of the payment a determinative factor? What does CMS mean by “consistent?” Exactly what constitutes “on going?” As an example, if the RRE in a liability case decides to pay a single bill is this ORM? What if a workers’ compensation RRE makes a “mistaken payment” during the course of a denied claim? Typically, “mistaken” or even “voluntary” payments in and of themselves are not sufficient to establish liability under most workers’ compensation statutes. However, are some sufficient to establish ORM under the MIR? Undoubtedly, the reader likely has a few scenarios of his/her own to toss into this ring.

From the author’s view, this uncertainty could have a significant impact on determining reporting obligations. Absent more definitive directives, a conservative approach erring in favor of reporting may be the most prudent path for RREs at this time.

ORM Reporting – “Terminating” Responsibility

On a related front, the “reach” of Section 111 has direct affect on the issues of when reporting is required and when a RRE may file a “termination” report under the ORM trigger. In the first instance, the question is just how far back is the obligation to report under Section 111?⁵⁸ Once it is determined that Section 111’s “reach” requires reporting under ORM, the question becomes when can a RRE properly submit a “termination” report?

Understanding the possible scope of Section 111 in this regard is important not only to assess potential reporting responsibilities, but to also comprehend CMS’ recently announced ORM reporting exceptions.

The starting point in this analysis is to understand that under the written MIR directives the potential “reach” of Section 111 regarding workers’ compensation cases dates back to the inception of the Medicare program in 1965, as workers’ compensation has been primary to Medicare since the program began. The situation is different for liability (including self-insurance) and no-fault cases which are governed by the December 5, 1980 effective date of the MSP. With regard to these claims, reporting is *not* required under Section 111 if the date of incident *as defined by CMS* was prior to December 5, 1980.⁵⁹

Section 111’s potential reach has raised particular concern in the workers’ compensation arena (and in jurisdictions with “life long” medical provisions for no-fault) where it is common for primary payers to administratively “close” files due to inactivity or based on the fact that the claimant returned to work. In these instances, the claim is closed from an *administrative* perspective, but not necessarily from a legal standpoint.

Under the MIR, the general rule is where ORM has been assumed by the RRE, the RRE may *not* automatically submit a “termination report” based on the fact that it has administratively “closed” a file (or deems same inactive) *if* ORM is “subject to reopening or otherwise subject to a further request for payment.”⁶⁰

In these situations, CMS states that “*the record submitted for ORM should remain open.*”⁶¹ CMS notes further that “[f]or certain states which require a workers’ compensation claim be left open for ORM indefinitely, the second report may never be submitted.”⁶²

A strict application of CMS’ directives potentially places a considerable number of older claims within Section 111’s reporting ambit.⁶³ Accordingly, the MIR directives regarding “closed” and “inactive” files, and claims with older incident dates harbor the potential for reporting on a large number of dormant or older claims. Likewise, with respect to more recent claims, RREs may need to keep some opened indefinitely into the future despite the fact that the claim otherwise becomes dormant or inactive. In either scenario, the RRE faces a potentially significant administrative burden.

In recognition of this potential burden, CMS has issued the following three exceptions regarding ORM reporting:

ORM REPORTING EXCEPTIONS

ORM Reporting Exception #1: “Special Exception” – ORM Termination

The User Guide provides a “Special Exception” related to the “termination” aspect of ORM reporting. CMS’ “Special Exception” provides as follows:

RREs may submit a termination date for ORM if they have a signed statement from the injured individual’s treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or a claim for further payment.

If, in fact, there is a subsequent reopening of the claim and further ORM, the RRE must report this as an update record with zeroes in the ORM Termination Date (Field 99).⁶⁴

The key to this exception is obtaining a signed statement from the claimant’s treating physician that no additional “medical items” or “services” are required in relation to the claimed injuries. By way of note, the term “treating physician” is not defined in User Guide which could present interpretational issues in certain instances.

Importantly, even if this exception applies, reporting would be required at a later time “*if there is a subsequent reopening of the claim and further ORM.*” Accordingly, RREs will need to account for this contingency as part of the claims handling process.

ORM Reporting Exception #2: Qualified Exception

The User Guide also outlines a “Qualified Exception.” CMS’ Qualified Exception provides as follows:

[F]or ORM assumed prior to July 1, 2009, if the claim was actively closed or removed from current claims records prior to January 1, 2009, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to July 1, 2009. If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original DOI (as defined by CMS).⁶⁵

The key to this exception is determining whether the claim “was actively closed or removed from the claims records prior to January 1, 2009.” The User Guide does not define this phrase. It is uncertain exactly how broadly CMS will be interpret and apply this exception in practice. It is possible that this exception could end up having the most “muscle” of the three ORM exceptions depending on how same is interpreted and applied by CMS.

However, it must be remembered that reporting would be required if the claim was “later subject to reopening with further ORM.” Accordingly, RREs will need to account for this contingency as part of the claims handling process.

ORM Reporting Exception #3: Workers’ Compensation Exception

Through the *March-Alert*, CMS announced a specific reporting exception relating *only to workers’ compensation cases* based on a combination of claim factors and limited to a specific monetary threshold. The terms of this exception are as follows:⁶⁶

For workers’ compensation ORM, claims meeting **ALL** of the following criteria are excluded from reporting for file submissions due through December 31, 2010:

- a. “Medicals only.”
- b. “Lost time” of no more than 7 calendar days.
- c. All payment(s) has/have been made directly to the medical provider.
- d. Total payment does not exceed \$600.00.

As will be noted, this exception is limited to workers’ compensation and only with respect to “file submissions

due through December 31, 2010.” From the author’s experience, it is unlikely that this exception will have significant applicability. It must be noted that there is no low dollar threshold reporting exception for liability (including self-insurance) or no-fault in the ORM context.

CMS’ Exceptions – Special Considerations

It is important to note that CMS’ above discussed reporting exceptions “do not act as a ‘safe harbor’ with respect to any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions.”⁶⁷

This statement warrants particular attention as same indicates that just because reporting may not be necessary under Section 111, this *would not* serve to vitiate any other obligations or responsibilities under the MSP. For example, although reporting may not be required under the MIR, the issue of conditional payment reimbursement under the MSP must still be addressed.

In addition, CMS indicates that its monetary thresholds as “interim thresholds” with the agency “reserving the right” to change same. In this regard, CMS acknowledged that it is “still actively soliciting data relevant to determining reporting thresholds, including for the purposes of a more liberal threshold for workers’ compensation ORM.”⁶⁸

ORM REPORTING “EXTENSION”

Under the “Special Reporting Extension,” a RRE may delay reporting until the third quarter of 2010 for certain claims where ORM was assumed prior to July 1, 2009 and continues as of that date.

CMS’ directives regarding the *Special Extension to ORM reporting* are located at Section 11.7 (page 52) of the User Guide and are as follows:

Special Reporting “Extension” for ORM Assumed Prior to July 1, 2009 Where Such ORM Continues as of July 1, 2009.

Where ORM was assumed prior to July 1, 2009, and continues as of July 1, 2009, the RRE must report this individual. As RREs may not have collected the necessary data elements for individuals (such as the SSN) for whom responsibility was assumed prior to July 1, 2009, CMS is permitting RREs to delay

reporting for these individuals until the RRE's assigned submission in the third calendar quarter (July – October) of 2010. The extension is intended to allow RREs time to go back and determine the Medicare status of individuals for whom there is pre-existing ORM which continues as of July 1, 2009.

This extension does not apply to claims which are addressed/resolved (partially addressed/resolved) on or after July 1, 2009. The extension applies only to claims where the RRE has accepted ongoing responsibility, for medicals with the claim potentially subject to further payment for items or services with dates of services on or after July 1, 2009, but the original resolution (partial resolution) date is prior to July 1, 2009.

If an RRE has the information that such a claimant is a Medicare beneficiary and the RRE has the SSN or HICN, it is to send the record with its initial production file. If the RRE does not have this information, it may delay reporting on these claims until its third calendar quarter 2010 file submission.⁶⁹

Accordingly, if an exception to reporting cases where ORM was assumed prior to July 1, 2009 is inapplicable, a RRE may have additional time to report these cases in accord with the above directive.

Other Information Regarding Reporting

Section 11.8.2 of the User Guide (p. 55) provides additional information regarding reportable claims and information regarding technical reporting aspects. The author provides a non-exhaustive outline of certain points contained under this section:⁷⁰

Reporting & Appeals

Under the MIR, appeals could affect the obligation to report under the TPOC and ORM triggers.

With respect to TPOC, CMS indicates if the applicable plan or the claimant is “*appealing or further negotiating the judgment/award/other payment*” TPOC reporting is required if payment is being made. Conversely, “if payment is *not* being made pending results of the appeals/negotiation, the TPOC is not reported until the appeal/negotiation is resolved.”⁷¹

With respect to ORM, the directives are similar. However, CMS' directives in this setting only reference the situation where the *applicable plan* is appealing whereas *both the applicable plan and the claimant* are

referenced in the TPOC context. The author is unsure if this is simply an oversight on CMS' part or was a deliberate omission. CMS' directives regarding ORM and appeals are stated as follows:

If there is an assumption of ORM due to a judgment or award but the liability insurance (including self-insurance), no-fault insurance, or workers' compensation is appealing this judgment or award: If payment is being made, pending results of the appeal, the ORM must be reported. If payment is not being made pending results of the appeals, the ORM is not reported until the appeal is resolved.⁷²

Other Considerations

The following are additional directives for consideration with regard to reporting noted under Section 11.8.2:

- Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc. Consequently, it is possible that an RRE will submit more than one record for a particular individual in a particular quarter's submission window.

For example, if there is an automobile accident with both drivers insured by the same company and both drivers' policies are making a payment with respect to a particular Medicare beneficiary, there would be a record with respect to each policy. There could also be two records with respect to a single policy if the policy were reporting a med pay (considered to be no-fault) assumption of ongoing responsibility for medicals and/or exhaustion/termination amount as well as a liability settlement/judgment/award/other payment in the same quarter.

- Policies or self-insurance which allege that they are “supplemental” to Medicare — By statute, Medicare is secondary to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. An insurer or self-insured entity cannot, by contract or otherwise supersede federal law.
- RREs are not required to report liability insurance (including self-insurance) settlements, judgments, awards or other payments for “property damage only” claims which did not claim and/or release medicals or have the effect of releasing medicals.

In addition, the reader may wish to consult Section 11.4 (p. 35) for specific guidance and examples regarding how to handle “initial” reporting for TPOC and ORM in specific situations.

PART V:

WHAT INFORMATION MUST BE REPORTED?

Once it is determined that reporting is required, the question becomes “*exactly what information must be reported to CMS?*”

Pages 83-175 of the User Guide contain the data record layout outlining the information that must be captured and reported under Section 111. A review of this information is outside the scope of this article and all RREs and other interested parties are encouraged to closely examine these data fields and corresponding instructions.

In addition, the User Guide contains several sections regarding important technical reporting requirements which should be reviewed. The author provides the following *non-exhaustive* listing of same:

- Section 1: Summary of Version 1.0 Updates (p. 5)
- Section 9: File Format (p. 27)
- Section 11: Claim Input File (p.30)
- Section 11.2: Data Elements (p. 32)
- Section 11.4 Initial File Submission (p.35)
- Section 11.5: Quarterly File Submissions (includes add, delete, updates and event table) (p.40)
- Section 11.8: Additional (Technical) Requirements (p. 52)
- Section 12: Claim Response File (includes, codes, errors and compliance flags) (p.60)
- Section 14: Testing Process (p. 70)
- Section 15: Electronic Data Exchange (p. 74)

On a related note, CMS has provided long awaited information regarding which code set is to be used regarding the “illness/injury/incident” data fields. On this point, the User Guide provides as follows:

CMS has made a final decision on which code set will be used to describe an illness/injury/incident. In connection with this:

The Alleged Nature of Injury, Incident, Illness and Body Part Codes 1-5 have been removed on the Claim Input Detail Record Layout.

The definition for the Alleged Cause of Injury, Incident, Illness (now Field 15) on the Claim Input Detail Record layout has been changed to direct RREs to use the ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) External Cause of Injury “E Code” describing the alleged cause of injury/illness. In addition, the definitions and requirements for the ICD-9 Diagnosis Codes and Description of Incident, Illness or Injury have been updated.

Additional ICD-9 Diagnosis Code fields have been added to be consistent with internal CMS databases.⁷³

PART VI:

REGISTRATION/ACCOUNT SET UP & OTHER MATTERS

Under the MIR, the required notice and data submission will be transmitted electronically. It should be noted that any attempt to provide “notice” outside of the established Section 111/MIR reporting process will *not* be recognized and will *not* satisfy the Section 111 mandates.⁷⁴

As part of the MIR process, all RREs must register with CMS and provide required information in relation thereto. Again, even if the RRE will use an Agent for Section 111 reporting, the RRE is the party that is responsible for registering under the MIR.

The Section 111 registration period is 5/1/09-6/30/09. RREs will register on the COB Secure Web site (COBSW) - www.Section111.cms.hhs.gov. The website is not yet available but the requirements for registration may be viewed at www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf.⁷⁵

At this time, a RRE may register for the NGHP CBT (Computer Base Training) courses by contacting the COBC’s EDI Department at 646-458-6740. An EDI representative will take the company name, company type (e.g. liability insurer [including self-insured entities], workers’ compensation, etc.) and the name, phone number and e-mail address for the individual(s) to be

registered for this training. Once the COBC has processed the request, the RRE will be registered for the training course. CMS indicates that while the NGHP curriculum is *not* currently accessible, registrants will be notified automatically as soon as NGHP CBT courses are available.⁷⁶

Regarding registration, it is important to note that even if a RRE determines that it has nothing to report at this beginning juncture of the MIR process, it may still wish to consider registering in the event that reporting becomes necessary in the future. On this point, CMS states:

Entities who are RREs for purposes of the Section 111 ... are not required to register if they will have nothing to report. For example, if an entity is self-insured (as defined by CMS) solely for the deductible portion of a liability insurance policy but it always pays any such deductible to its insurer, who then pays the claim, it may not have anything to report. However, those who do not register initially because they have no expectation of having claims to report, must register in time to allow a full quarter for testing if they have future situations where they have a reasonable expectation of having to report.⁷⁷

Once registration is completed, “testing” between the RRE (or its Agent) and the COBC will commence. **The “testing period” is 7/1/09-12/31/09.**⁷⁸

CMS’ current “production live” date is slated for 1/1/10-3/30/10. However, RREs which complete testing before January, 2010 may begin submitting live production files in the fourth quarter of 2009.⁷⁹

A detailed review of the registration, account set up and testing processes are beyond the scope of this article. All RREs and interested parties should closely examine the User Guide on these points. In the interim, the author provides the following *general* summary:

Registration/Account Set Up

The User Guide contains detailed information pertaining to the registration and account set up processes in Section 8 (p. 22-26). In addition, Section 6 (p. 15-17) provides helpful information regarding this area.

Per Section 8 of the User Guide, CMS describes the registration/account set up process as a “five step” process which in general can be outlined as follows:

Step 1: RREs to identify an Authorized Representative, Account Manager and other COBSW Users

Under **Step 1** the registration process commences with the RRE naming an **Authorized Representative (AR)** who is the “*individual in the RRE organization who has the legal authority to bind the organization to a contract and the terms of MMSEA Section 111 requirements and processing.*”⁸⁰ CMS provides specific rules and restrictions on page 23 of the User Guide with respect to who may and may not serve as the AR and the role of the AR in the overall process that should be carefully reviewed. As examples, the **AR cannot** be a user of the COBSW and **cannot** be an Agent for the RRE.⁸¹

The RRE must also name an **Account Manager (AM)** who “*is the individual who controls the administration of an RRE’s account and manages the overall reporting process.*”⁸² Each RRE ID may have only one AM. The AM may be an RRE employee or agent. CMS provides detailed directives regarding the role, rights and function of the AM on page 23 of the User Guide which should be carefully examined.

As part of the process, the RRE may permit the AM to name “**Account Designees**” (**AD**) to assist the AM with reporting. CMS outlines important directives regarding AD’s on page 24 of the User Guide which should be carefully reviewed.

Step 2: RREs to determine “reporting structure”

Under **Step 2**, the RRE must determine its “reporting structure.” CMS states the following regarding same:

Before beginning the registration process, an RRE must also determine how the RRE will submit its Section 111 files to the COBC and how many Section 111 Reporter IDs (RRE IDs) will be needed. Only one Claim Input File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, claim system structures and agents that may be used for file submission, you may want to submit more than one Claim Input File to the COBC on a quarterly basis and therefore will need more than one RRE ID in order to do so.

For example, if an RRE will use one agent to submit workers’ compensation claims and another agent to submit liability and no-fault claims, the RRE must register on the COBSW twice to obtain two RRE IDs

that will be used by each agent respectively. You may name the same Authorized Representative and Account Manager for both accounts or use different individuals. Likewise, if you have two or more subsidiary companies that process workers' compensation claims using different claims systems and you will not combine the claim files for Section 111 reporting, you must register for each claim file submission to obtain separate RRE IDs in order to submit multiple claim files in one quarter.

You may **not** set up a separate RRE ID for submission of the Query Input File only. You **must** submit a quarterly Claim Input File for every RRE ID you establish.⁸³

Step 3: RREs to register on the COBSW

Under **Step 3**, the RRE (not an Agent) must have a company representative register on CMS' Section 111 COBSW URL (www.Section111.cms.hhs.gov). CMS directs this person to click on the "New Registration" button, complete and submit the registration for the RRE. All RREs should also consult page 25 of the User Guide to review the information required to be submitted with said application.

Once the COBC "validates" the registration application, it will send a letter to the AR (*via U.S. Mail*) containing a personal identification number (PIN) and the COBC-assigned RRE ID (Section 111 Reporter ID) associated with the registration. The AR must give this PIN and RRE ID to their AM to use to complete the account setup step. RREs needing more than one RRE ID, must repeat this step for each.

Step 4: RRE account set up on the COBSW-Account Manager

Under **Step 4**, the AM, on or after May 1, 2009, must go to the Section 111 COBSW URL (www.Section111.cms.hhs.gov) with the PIN and RRE ID and click on the "Account Setup" button. As part of this process, the AM will create a Login ID for the COBSW and provide other required information as more fully outlined on page 26 of the User Guide. This page also contains other important directives regarding the AM's role, rights and obligations.

Step 5: Authorized Representative to return signed "RRE profile report"

Under **Step 5**, the COBC will send the AR a "profile

report" (*via e-mail*) once the account set up has been successfully completed. The "profile report" will contain the following information:

- A summary of the information you provided on your registration and account setup;
- Important information you will need for your data file transmission;
- RRE ID that will need to be included on all files transmitted to the COBC;
- The RREs assigned "production live date" and ongoing quarterly file submission timeframe for the MSP Input File; and
- Contact information for your COBC EDI Representative who will support you through testing, implementation and subsequent production reporting.⁸⁴

Importantly, the AR must review, sign and return the profile report to the COBC. At that point, the RRE may begin testing Section 111 files. The COBC will send an e-mail to the AR and AM advising that testing can begin.

Data Use Agreement

CMS has included directives aimed at "safeguarding" and limiting access to Section 111 data. CMS states as follows:

Data exchanged for Section 111 is to be used solely for the purposes of coordinating health care benefits for Medicare beneficiaries between Medicare and Section 111 RREs. Measures must be taken by all involved parties to secure all data exchanged and ensure it is used properly.

In this regard, CMS has included a "Data Use Agreement" as part of the User Guide (p. 79). This agreement will be part of the RRE's "profile report" and the RRE's Authorized Representative must sign the last page of this agreement and return same to the COBC. In addition, it is indicated that "*all users must agree to similar language each time they log on to the Section 111 application of the COBSW.*"⁸⁵

All RREs and interested parties should carefully examine the directives and restrictions contained in the Data Use Agreement to ensure proper compliance under Section 111. The author highlights the following excerpt from

the agreement which provides a general idea of CMS' directives:

The Responsible Reporting Entity and its duly authorized agent for this Section 111 reporting, if any, shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the only entities authorized to have access to the data are CMS, the RRE or its authorized agent for Mandatory Reporting. RREs must ensure that agents reporting on behalf of multiple RREs will segregate data reported on behalf of each unique RRE to limit access to only the RRE and CMS and the agent. Further, RREs must ensure that access by the agent is limited to instances where it is acting solely on behalf of the unique RRE on whose behalf the data was obtained.

Furthermore, the agreement provides that the CMS shall be granted access to inspect the premises where the data is being maintained *“for the purpose of inspecting security arrangements confirming whether the RRE and its duly authorized agent, if any, is in compliance with the security requirements specified [in the Data Use Agreement].”*⁸⁶

Other Information

The User Guide also contains several other important sections which are beyond the scope of this article. These sections include, but are not limited to the following:

- Section 3: Section 111 Overview (p. 8)
- Section 4: Medicare Entitlement, Eligibility and Enrollment (provides summary of the various parts to the Medicare program) (p. 10)
- Section 5: MSP Overview (includes review of the roles of the COBC and MSPRC)(p. 11)
- Section 18: Customer Service (p. 80)
- Section 19: Training & Education (p. 81)
- Section 20: Checklist Summary (p. 82)

All RREs and interested parties should closely examine these sections, as well as any other sections not specifi-

cally outlined in this article, to ensure that all applicable directives and information are incorporated into their Section 111 compliance programs

Conclusion

It is important to keep in mind that the foregoing provides only a *general* summary of *certain* components regarding Section 111 and CMS' MIR directives. In many respects, this article really only “scratches the surface” of all the various MIR components. For example, issues dealing with the technical reporting aspects and the nuances and questions related to the actual data layout were, for the most part, left untitled in this article.

The User Guide and Alert documents certainly cover a lot of ground on many fronts. However, important questions regarding core MIR components remain. For example, questions regarding RRE determination in situations not addressed in the User Guide likely linger in many quarters. In addition, various issues regarding the reporting triggers may need further clarification.

It is also important to remember that CMS' overall implementation of Section 111 remains in a “work in progress” phase. For example, CMS is still working on finalizing its directives regarding mass torts, product liability, bankruptcy and RRE status, and its “model form.” CMS has also yet to release its directives regarding Section 111's “\$1,000 per day, per claimant” penalty provision for non-compliance. As such, the MIR remains a moving target that will continue to evolve through the upcoming months as the industry heads into the MIR registration and testing phases; and it will likely continue to be so even after official reporting commences as CMS and the industry obtain actual experience to draw upon.

Taking all of this into account, all RREs and other interested parties should continue to regularly monitor CMS' dedicated website www.cms.hhs.gov/MandatoryInsRep for the release of additional MIR documents and information.

Likewise, close attention should be afforded to CMS' upcoming Town Hall teleconferences. Attached to this article is a listing of the currently scheduled Town Hall conferences for easy reference.

CMS' UPCOMING SECTION 111 "TOWN HALL" TELECONFERENCES FOR NON-GROUP HEALTH PLANS

As part of CMS' continuing implementation of its Mandatory Insurer Reporting (MIR) directives in regard to the "notice and reporting" requirements of Section 111 of the MMSEA, CMS will be holding a series of additional "Town Hall" teleconferences in the next several months.

These Town Hall teleconferences will address important aspects of CMS' MIR directives related to liability insurance (including self-insurance), no-fault and workers' compensation (referred to under the MIR as "non-group health plans/NGHP").

The following is a listing of CMS' currently scheduled Section 111 "Town Hall" teleconferences:

**All town hall teleconferences are held from 1:00pm to 3:00pm EST
unless otherwise noted by CMS.**

April 21, 2009	Liability (including Self-Insurance) and No-Fault, WC Questions only
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May 12, 2009	NGHP Registration Issues Only
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May 14, 2009	
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June 9, 2009	
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July 14, 2009	
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August 18, 2009	
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September 30, 2009	
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October 22, 2009	
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November 17, 2009	
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December 15, 2009	
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Please note that CMS may 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

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 CMS' prior teleconferences were held on October 1, 2008, October 29, 2008, December 11, 2008 and January 22, 2009, January 28, 2009 and February 25, 2009.

A. CMS' Published Information Regarding its Town Hall Conferences

Summaries of CMS' October 1, 2009 and October 29, 2008 teleconference calls can be obtained at http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage.

CMS 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.

CMS has released audio versions of all its prior Town Hall teleconferences with the exception of the December 11, 2008 teleconference and the "Question/Answer" session held on January 28, 2009. The available audio versions of CMS' Town Hall teleconferences can be obtained at http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage.

B. Author's Articles Regarding Section 111 and the MIR

The author has released several articles on Section 111 in relation 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.

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 For a review of the various *Interim Record* versions, see the author’s articles on same as outlined in endnote 2 above.

⁴ CMS’ NGHP User Guide (Version 1.0, March 16, 2009) at p. 5.

⁵ CMS’ NGHP User Guide (Version 1.0, March 16, 2009) at p. 6. (Emphasis added).

⁶ CMS’ NGHP User Guide (Version 1.0, March 16, 2009) at p. 11.

⁷ 42 U.S.C. 1395y(b)(8)(F).

⁸ CMS’ NGHP User Guide (Version 1.0, March 16, 2009) at p. 6.

⁹ CMS’ NGHP User Guide (Version 1.0, March 16, 2009) at p 18.

¹⁰ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 18.

¹¹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p.19.

¹² CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 19.

¹³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 20.

¹⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 19.

¹⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 20.

¹⁶ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 18.

¹⁷ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 21.

¹⁸ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 21.

¹⁹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 21.

²⁰ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 21.

²¹ 42 U.S.C. 1395y(b)(8)(A).

²² See the author's article entitled, *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. This article can be obtained per the instructions contained at the end of endnote 2.

²³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 67.

²⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 67.

²⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 69.

²⁶ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 69.

²⁷ For a discussion regarding the Data Use Agreement, see Part VI below.

²⁸ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 67.

²⁹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 68.

³⁰ See the author's article entitled, *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. This article can be obtained per the instructions contained at the end of endnote 2.

³¹ 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 resulting there from address only one

component of Medicare compliance. For example, 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 outside the Section 111 context 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 Section 111 "notice and reporting" requirements, 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. On another front, obtaining the date a claimant became entitled to Medicare may be helpful with respect to addressing issues related to conditional payment exposure and reimbursement. These issues are outside the scope of Section 111 and this article.

³² See the author's article entitled, *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. This article can be obtained per the instructions contained at the end of endnote 2.

³³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

³⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 57.

³⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 56

³⁶ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 56.

³⁷ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 57.

³⁸ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 56.

³⁹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 56.

⁴⁰ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁴¹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 36 and 50.

⁴² CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 58.

⁴³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 110 (Field 100).

⁴⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 111 (Field 101).

⁴⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 57.

⁴⁶ Per CMS statement made at the March 24, 2009 Town Hall teleconference.

⁴⁷ CMS' "Supplemental Alert" (March 23, 2009) at p. 2.

⁴⁸ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁴⁹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁵⁰ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁵¹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 49.

⁵² CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 51.

⁵³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁵⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁵⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 50.

⁵⁶ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 52.

⁵⁷ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 57.

⁵⁸ See the author's article entitled, *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. This article can be obtained per the instructions contained at the end of endnote 2.

⁵⁹ With respect to liability claims, reporting under Section 111 is not required under Section 111 for dates of incident prior to December 5, 1980 (as defined by CMS). In this regard, CMS' directives provide:

Liability Claims – DOI Prior to 12/5/80

RREs are not required to report liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the date of incident (DOI) **as defined by CMS** was prior to December 5, 1980.

For claims involving "exposure", this means that there was no exposure on or after December 5, 1980, alleged, established, and/or released. If any exposure for December 5, 1980 or a subsequent date was claimed and/or released, then Medicare has a potential recovery claim and the RRE must report for Section 111 purposes.

For example, if the date of 1st exposure is prior to December 5, 1980, but that exposure continues on or after December 5, 1980; Medicare has a potential recovery claim.

Additionally, please note that application of the December 5, 1980, is specific to a particular claim/defendant. For example, if an individual is pursuing a liability insurance (including self-insurance) claim against "X", "Y" and "Z" for asbestos exposure and exposure for "X" ended prior to December 5, 1980, but exposure for "Y" and "Z" did not; a settlement, judgment, award or other payment with respect to "X" would not be reported.

The liability insurance (including self-insurance) and no-fault insurance MSP provisions were effective December 5, 1980. CMS has determined as a matter of policy that it will not recover under the MSP provisions with respect to liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the DOI **as defined by CMS** was prior to December 5, 1980.

⁶⁰ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 51.

⁶¹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 51.

⁶² CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 51.

⁶³ A similar concern could seemingly surface prospectively with regard to claims arising after July 1, 2009 which under the MIR directives may require the RRE to keep an "open" ORM filing on record despite the fact that the file becomes dormant or inactive as the years progress.

- ⁶⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 51.
- ⁶⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 52.
- ⁶⁶ CMS' "Supplemental Alert" (March 23, 2009) at p. 2.
- ⁶⁷ CMS' "Supplemental Alert" (March 23, 2009) at p. 2
- ⁶⁸ CMS' "Supplemental Alert" (March 23, 2009) at p. 2
- ⁶⁹ Emphasis supplied by the author.
- ⁷⁰ This section was summarized from CMS' NGHP User Guide (Version 1.0, March 16, 2009), p. 55-59.
- ⁷¹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 59
- ⁷² CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 59.
- ⁷³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 52.
- ⁷⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 52.
- ⁷⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 22.
- ⁷⁶ http://www.cms.hhs.gov/MandatoryInsRep/05_Computer_Based_Training.asp#TopOfPage
- ⁷⁷ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 22 (emphasis added).
- ⁷⁸ See, CMS' *March-Alert*.
- ⁷⁹ See, CMS' *March-Alert*.
- ⁸⁰ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 23.
- ⁸¹ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 23.
- ⁸² CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 23.
- ⁸³ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 24 (emphasis added).
- ⁸⁴ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 26.
- ⁸⁵ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 79.
- ⁸⁶ CMS' NGHP User Guide (Version 1.0, March 16, 2009) at p. 79.