

## CMS RELEASES

# “REVISED” INTERIM RECORD LAYOUT (12/05/08 Version) FOR REPORTING UNDER SECTION 111 OF THE MMSEA

By: Mark Popolizio, J.D.

On December 9, 2008, the Centers for Medicare and Medicaid Services (CMS) released its “Revised” *Interim Record Layout (12/05/08 Version)* as part of the agency’s Mandatory Insurer Reporting (MIR) requirements under Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA). A copy of CMS’ “Revised” *Interim Record Layout (12/05/08 Version)* can be obtained at <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterim120508.pdf>.

CMS’ “Revised” *Interim Record Layout (12/05/08 Version)* significantly amends the *initial* and *updated* versions of the *Interim Record Layout* released in October and November, 2008, respectively. A copy of these prior versions of the *Interim Record Layout* can be obtained at [http://www.nqbp.com/rl\\_cms\\_memos.shtml](http://www.nqbp.com/rl_cms_memos.shtml).

The proposed guidelines contained in the “Revised” *Interim Record Layout (12/05/08 Version)* relate exclusively to “liability insurance (including self-insurance), no-fault insurance and workers’ compensation” which is often collectively referred to under the MIR as “Non-Group Health Plans” (non-GHP or NGHP).<sup>1</sup>

The “Revised” *Interim Record Layout (12/05/08 Version)* represents the sixth set of written proposals issued by CMS since August in relation to the agency’s continuing implementation of Section 111.<sup>2</sup> In addition, CMS held Open Forum teleconference calls on October 1, 2008, October 29, 2008 and December 11, 2008 during which it discussed various aspects of its MIR proposals and addressed questions from the public related thereto.<sup>3</sup> Responsible Reporting Entities (RREs)<sup>4</sup> and other inter-

ested parties should review each of CMS’ written directives issued to date and the information discussed by CMS as part of its Open Forum teleconference calls in developing their Section 111 compliance programs.

This article outlines the information contained in the “Revised” *Interim Record Layout (12/05/08 Version)* and directs the reader to pertinent sections of the document for further examination.

### General Overview of CMS’ “Revised” Interim Record Layout (12/05/08 Version)

Through the “Revised” *Interim Record Layout (12/05/08 Version)*, CMS makes format modifications to the layout document itself and substantive changes to its proposed MIR guidelines. The revised layout now consists of 77 pages (the November update had 63 total pages).

With respect to format, CMS divides its written guidelines into several different categories marked by title headers and makes other modifications which render the document more “reader friendly.” On the substantive side, CMS provides more detailed written directives regarding key guidelines previously announced, memorializes several important points discussed orally at the recent Open Forum teleconference calls, and makes several changes to the actual data layout replica.

Unlike the November update, CMS actually alerts the reader to *some* of the changes made by the revised layout.

In this regard, page one of the “Revised” *Interim Record Layout (12/05/08 Version)* states the following:

Note: This is a revised version of the Interim Record Layout dated November 17, 2008. The version date is shown in the footer on the cover page for each version. Note that the date for this version, as shown below, is December 5, 2008.

Revisions:

- Added detailed information regarding: “Who Is the Responsible Reporting Entity (RRE)?”, “General Rules for Agents”, “High Level File Submission Rules”, and “What Triggers Reporting?”
- Revisions to the File Layout include but are not limited to the following: elimination of some fields associated with no-fault insurance; delay in requiring the reporting of certain fields; re-naming the “Policyholder” information as “Self-Insurance” information (with the applicable information requested only for self-insurance); and optional use of free form text for a limited time period in lieu of providing the WCIO Nature of Injury Code and the WCIO Cause of Injury Code and either an ICD-9 Code or WCIO Body Part Code. See page 15 for a more detailed listing of revisions to the File Layout.

With this general understanding under our belts, a “section by section” survey of the “Revised” *Interim Record Layout (12/05/08 Version)* is hereby provided as follows:

## Overview (p. 2-3):

This section provides CMS’ general summary of Section 111 and its MIR guidelines similar to that as contained in CMS’ initial and updated *Interim Record Layouts*.

**An important addition made to this section relates to CMS providing a definition of the term “claim” as that term is to be used in the context of Section 111.** CMS defines this term as follows:

For purposes of RRE submissions, the term “**claim**” is used to refer to the overall claim for liability insurance (including self-insurance), no-fault insurance or workers’ compensation rather than a single claim for a particular medical item or service.<sup>5</sup>

## Who Is the Responsible Reporting Entity (RRE)? (p. 3-5)

In this section, CMS discusses the definition of the term “Responsible Reporting Entity” (RRE) and advises that the reader must use the statutory definition of “applicable plan” as contained in 42 U.S.C. § 1395y(b)(8) in conjunction with the definition of “RRE” as outlined in the Federal Register and CMS’ “Supporting Statement.”<sup>6</sup>

In addition, CMS recognizes that there may be differences between how the industry and CMS may define certain terms. In this instance, CMS advises that that the agency’s definitions control in terms of Section 111 compliance. CMS states the following:

CMS is aware that the industry generally does not use the term “plan” or some other CMS definitions such as the definitions for “no-fault insurance” or “self-insurance.” However, CMS is constrained by the language of the applicable statute and CMS’ regulations. It is critical that you understand and utilize CMS’ definitions for purposes of Section 111 when reviewing and implementing Section 111 instructions.<sup>7</sup>

In this section CMS also reiterates that third party administrators (TPAs) are “never” RREs under Section 111 and that the RRE may not limit via contract or otherwise its reporting responsibility; although a RRE may use a TPA or other party as an “Agent” for reporting purposes. On this important point, CMS states the following:

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] and only act as agents for such reporting. The RRE is limited to the “applicable plan” and may not by contract or otherwise limit its reporting responsibility although it may contract with a TPA or other entity for actual file submissions for reporting purposes. The applicable plan must either report directly or contract with the TPA or some other entity to submit data as its agent. (Where an RRE uses another entity for claims processing or other purposes, it may wish to consider contracting with that entity as its agent for reporting purposes).<sup>8</sup>

CMS also provides important guidelines related to several other key points regarding RRE status as follows:

- 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.
- Where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurers issue any payment in obligation of a settlement, judgment, award or other does not shift RRE responsibility to the entity issuing the payment. All RREs involved in the settlement remain responsible for their own reporting.
- RRE in bankruptcy – CMS is considering whether or not special provisions must be made for this situation.
- Re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds which have responsibility beyond a certain limit, etc. — 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.<sup>9</sup>

## General Rules for the Use of Agents for Section 111 Reporting (p. 5)

In this section, CMS outlines its guidelines regarding “Agents” in relation to Section 111 and the MIR which, in general, include the following;

- Agents are *not* considered RREs under Section 111; although an RRE may use an Agent for reporting purposes.
- Agents may include (but are not necessarily limited to) data service companies, consulting companies or similar entities.
- **RREs must complete the registration and file submission processes with the COBC; an Agent may not register on behalf of the RRE.** (Note: If an RRE

will be using an Agent for reporting purposes, it will designate said Agent during the registration process).

- RREs may not shift reporting responsibility under Section 111 to an Agent by contract or otherwise. On this point, CMS further states that *“the RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of data submitted.”*<sup>10</sup>
- CMS does not sponsor, endorse or approve any entities that will or may serve as Agents. Furthermore, entities that may serve as Agents do not register with CMS or pay a “fee” to become an Agent.

## High Level File Submission Rules for Section 111 Reporting (p. 5-6)

This section outlines several important technical aspects of the reporting and file submission process contained in eight separate bullet points which should be closely reviewed. In the meantime, CMS’ requirements in relation thereto can be summarized by topic as follows:

- “Mixing” GHP and Non-GHP data is precluded;
- Allowing a single submission if a RRE “has responsibility for multiple lines of business” if the RRE desires to do so;
- Reporting the assumption and termination of “ongoing responsibility” and one time reporting of payments where on-going responsibility is not assume;
- Information regarding the frequency of submissions per quarter;
- Allowing a RRE to separately register “different lines of business and/or different client bases (including indentifying a different Agent for data submission for each registration)” which could include “registering at the parent company level vs. registering at the subsidiary level;”
- Agents are prohibited from mixing data for multiple RRE clients; and
- All reporting to be accomplished via electronic file exchanges without exception; CMS states that it has “no plans for direct data entry by RREs.”

## General Requirements for File Submission (p. 6-9)

In this section, CMS lists very detailed requirements contained in 23 separate bullet points. A detailed review of each the topic addressed per bullet point is beyond the scope of this article.

The reader should closely examine each of these requirements within the actual revised layout. In the interim, the author wishes to spotlight the following three requirements which he believes warrant particular attention:

### RRE Registration:

CMS states the following with respect to RRE registration on the COB Secure Web site (COBSW):

RREs must register on the COB Secure Web site (COBSW) by June 30, 2009, and complete testing prior to submission of production files. (The earliest date for registration is May 1, 2009.) After the registration has been processed by the COBC, the RRE will receive an e-mail with a Profile Report. The Profile Report will contain information submitted during registration for verification purposes, the assigned 7-day file submission timeframe, and the assigned Section 111 Reporter ID (RRE ID). The last page of the Profile Report must be signed by the RRE and returned to the COBC before testing can begin.<sup>11</sup>

### IT/Technical Requirements:

In addition to the actual reporting requirements, it is important that CMS' IT and technical requirements be considered. On this point, CMS' guidelines provide as follows:

Files may be submitted via the COBSW using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) or Secure File Transfer Protocol (SFTP). As an alternative, RREs with large amounts of data may submit via Connect: Direct (formerly known as NDM) via the AT&T Global Network System (AGNS). To use the AGNS method, RREs must first establish an AGNS account in order to send files directly to the COBC over AGNS. RREs that currently do not have an existing AGNS account should contact one of the well-established resellers of AT&T services to obtain a dedicated or a dial-up access line to the AGNS VAN. ***RREs are encouraged to do this as soon as possible since this set up can take a significant amount of time.***

Files submitted via HTTPS or uploaded via SFTP to the COBC secured web site should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

Files transmitted directly to the COBC mainframe using Connect: Direct will be automatically converted to EBCDIC.<sup>12</sup>

Accordingly, all RREs and other interested parties should be working with their IT departments *at this time* to assure that their Section 111 compliance programs meet CMS' technical requirements.

### Determining Medicare Entitlement

A core component of Section 111 is the obligation of the "applicable plan" to determine if a claimant is "entitled" to Medicare. Under 42 U.S.C. § 1395y(b)(8)(A), an "*applicable plan shall determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis.*"

Remarkably, neither Section 111 itself nor CMS' proposed MIR guidelines provide a procedure to "determine" Medicare entitlement status. Likewise, neither provides an implied consent provision allowing Medicare entitlement status to be obtained without an authorization; nor requires a claimant to execute an authorization allowing a request to be made to the Social Security Administration (SSA) to obtain this information.

**Under the MIR, a RRE is responsible for devising its own procedures to determine a claimant's Medicare entitlement status, including establishing a procedure to perform follow up status checks to ascertain if a claimant who was *initially* determined *not* to be Medicare entitled subsequently becomes entitled to Medicare.**

CMS states the following regarding the RREs' obligation to determine Medicare entitlement:

RREs must implement a procedure in their claims resolution process to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) for the injured party on all Input Claim File detail records.<sup>13</sup>

If the individual was not a Medicare beneficiary at the time responsibility for ongoing medicals was assumed, the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary unless responsibility for ongoing medicals has terminated before the individual becomes a Medicare beneficiary.<sup>14</sup>

During the recent Open Forum teleconference calls, legitimate concerns were raised regarding the prospect of a RRE being unable to determine Medicare entitlement status due to 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 a request to the SSA), inability to locate the claimant, or for other reasons.

In recognition of this potential problem, CMS is in the process of determining whether a “query access” system could be devised to assist RREs.<sup>15</sup> However, it is unknown if a “query access” system will be (or could be) ultimately established by CMS. Thus, at this time all RREs and interested parties should continue to develop their procedures and practices to determine and monitor a claimant’s Medicare entitlement status. Along these lines, it would appear prudent for RREs to start contemplating what, if any, measures could be taken in the event it encounters difficulty in determining Medicare entitlement status. For example, in the context of a litigated claim, a motion to the Court to compel the claimant to execute an authorization allowing a status determination request to be submitted to the SSA may be an option.

## What Triggers Reporting? (p. 9-14)

Perhaps the most significant change made in the “Revised” *Interim Record Layout (12/05/08 Version)* relates to CMS’ outlining of very detailed information regarding what triggers the actual reporting requirements under Section 111.

CMS’ triggering events for reporting are contained on pages 9-14 (25 separate bullet points) in the section entitled *What Triggers Reporting?* In addition, there are references to the triggering events on pages 7-8 (bullet points 9-11) under the section “*General Requirements for File Submission.*” A complete examination and assessment of each point contained under these sections is beyond the scope of this article. In this regard, the author strongly recommends all RREs and other interested parties perform a detailed examination of these points

to be properly apprised of what triggers reporting under Section 111.

**In general, reporting under Section 111 is triggered upon (i) claim resolution (partial resolution) via a settlement, judgment, award or other payment on or after July 1, 2009<sup>16</sup> and (ii) situations where “the RRE has accepted Ongoing Responsibility for Medical payments,”<sup>17</sup> including claims for which “the RRE still has responsibility for ongoing payments for medical services as of July 1, 2009, regardless of an initial resolution (partial resolution) date prior July 1, 2009.”<sup>18</sup>**

In relation to the triggers, it is important to note that CMS states that:

RREs are to report once there has been a settlement, judgment, award or other payment. Notice to CMS of a pending claim or other pending action does not satisfy an RRE’s reporting obligations with respect to 42 U.S.C. 1395y(b)(8).<sup>19</sup>

This policy is directed against the idea of “shotgun” reporting; that is, the practice of simply putting Medicare on notice of *all* claims without necessarily determining if a claimant is entitled to Medicare, or which are not otherwise ripe for reporting under the established reporting triggers. This concept was raised in the October 1, 2008 Open Forum teleconference at which time CMS advised that RREs would only be considered compliant for Section 111 purposes if notice was submitted in accordance with the actual parameters of the established reporting triggers. CMS’ written policy as stated above is in accord with its previous oral statements.

CMS also reiterates what it refers to as its “special reporting extension” regarding “*ongoing claims resolved (partially resolved) prior to July 1, 2009.*” This extension relates to cases where the RRE assumed responsibility for medicals prior to July 1, 2009 with that responsibility continuing as of July 1, 2009. CMS introduced this limited extension in its initial *Interim Record Layout* in recognition of the fact that RREs may need additional time to determine a claimant’s Medicare entitlement status. **Cases qualifying under CMS’ “special reporting extension” do not need to be reported until the third quarter (July-October) 2010.** CMS’ policy on this point is as follows:

Where ongoing responsibility for medicals was

assumed prior to July 1, 2009, and continues on as of July 1, 2009, the RRE must report this individual. As RREs may not have collected the necessary data elements for individuals 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 ongoing payment responsibility which continues as of July 1, 2009. This extension does not apply to claims with resolution (partial resolution) dates of July 1, 2009, and subsequent. The extension applies only to claims where the RRE has accepted ongoing responsibility, with the claim potentially subject to further payment as of 7/1/09, but the original resolution (partial resolution) date is prior to 7/1/09. 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 file in fourth calendar quarter 2009. If the RRE does not have this information, it may delay reporting on these claims until its third calendar quarter 2010 file submission.<sup>20</sup>

It is important to note that the special reporting extension does *not* apply if the RRE actually has the requisite information. In that instance, the RRE must report as part of its initial filing in the fourth calendar quarter of 2009. Furthermore, as indicated above, the extension does *not* apply to claims with “resolution (partial resolution)” dates of July 1, 2009, and subsequent.”

**As for other matters, CMS has announced policies with respect to the following two issues which have been of particular interest and concern to the industry:**

### **Inactive & “Closed” Files**

A recurring question that many RREs have raised is the obligation to report cases under Section 111 that are considered inactive or “closed.” In this regard, it is common practice in the workers’ compensation arena (and in the no-fault context in jurisdictions with life long medicals) for the carrier or claims administrator to “close” a claim that has been inactive. In this context it is important to distinguish 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. In the former situation, the file is “closed” from an *administrative* perspective, but not necessarily from a legal standpoint.

CMS’ guidelines recognize this distinction and state the following with regard to cases that RREs may consider “closed:”

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.<sup>21</sup>

Based on the above, RREs should note that reporting under Section 111 *may still be required* 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.

### **Claims Pre-Dating 12/05/80**

**Another important question that has surfaced concerns the “reach” of Section 111. That is, just how far back is the obligation to report under Section 111?** This question is of particular concern to RREs with a large book of older claims. The question involves whether there is an obligation to report claims pre-dating the enactment of the Medicare Secondary Payer (MSP) Statute on December 5, 1980.

CMS states its policy regarding this point as follows:

“Date of Incident” prior to December 5, 1980 – The date of incident does not affect the RRE’s reporting responsibilities for workers’ compensation. Medicare has been secondary to workers’ compensation from the inception of the Medicare program. However, the lia-

bility 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 settlements, judgment, or awards where the date of incident **as defined by CMS** was prior to December 5, 1980. Consequently, the RRE is not required to report liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the date of incident 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 12/5/80 or later was claimed and/or released, then Medicare has a potential recovery claim and the RRE must report for Section 111 purposes.<sup>22</sup>

Based on the above, Section 111 could apply to workers’ compensation cases with a date of incident *prior* to the enactment of the MSP in 1980. As stated, this is based on the fact that Medicare has been secondary to workers’ compensation since the inception of the Medicare program back in 1965. The situation, however, could be different for liability (including self-insurance) and no-fault which are governed by the December 5, 1980 effective date of the MSP. In regard to these claims, CMS provides that reporting is *not* required under Section 111 if the date of incident *as defined by CMS* was prior to December 5, 1980. Obviously, all RREs and other interested parties need to closely examine CMS’ definition regarding “date of incident” in this context (and may need to seek to further clarification of same from CMS) in order to determine their obligations.

**Other important components related to the triggering events outlined by CMS include, but are not limited to, the following:**

- RREs are to report only with respect to Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, award or other payment) (p. 9).
- Situations where the reported individual is not a Medicare beneficiary or CMS is unable to validate a particular SSN or HICN based upon the submitted information (p. 9).
- The possibility that RREs will need to submit more than one record for a particular quarter’s submission window (p. 10).

- Joint settlements, judgments, awards or other payments (p. 10).
- Multiple settlements involving the same individual (p. 10).
- Re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds which have responsibility beyond a certain limit, etc. (p. 10).
- One time payment for defense evaluation (p. 10).
- When payment is made “pending investigation” (p. 11).
- Situations where the claimant is *not* a Medicare beneficiary and there has been no establishment/acceptance of responsibility for on going medicals at the time of a settlement, judgment, award or other payment (p. 12).
- RREs must report settlements judgments, awards, or other payments **regardless of whether or not there is an admission or determination of liability**. Reports are required with either partial or full resolution of a claim. (p. 12; Emphasis by CMS).
- No exception for alleged de minimus or “nuisance” settlements, judgments, awards or other payments (p. 12).
- If medicals are claimed and/or released, the settlement, judgment, award or other payment must be reported regardless of any allocation made by the parties or a determination by the court (p. 12).
- “Property damage only” claims (p. 12).
- No age threshold for reporting (p. 13).
- Policies or self-insurance allegedly “supplemental” to Medicare (p. 13).
- Geographic location of the incident, illness or injury is not determinative of a RRE’s responsibility since beneficiaries injured outside of the U.S. often return to the U.S. for treatment (p. 13).
- Mass tort or Multi District Litigation (MDL) (p. 14).

## Interim Record Layout Replica (p. 15-77)

Pages 15-77 of the “Revised” *Interim Record Layout (12/05/08 Version)* contain an actual replica of the proposed data layout and other information to be reported, broken down by several specific reporting sections and subcategories. This data layout replica was previously outlined in pages 8-63 of the “Updated” *Interim Record Layout* (November, 2008 version).

**The data fields and related instructional directives contained in the data record layout outline the exact data and other information that RREs will need to capture and report under Section 111.** Close attention should be afforded in particular to the “Description” fields as this section contains important information and directions regarding several key reporting aspects under the MIR.

CMS provides the reader with an outline of the changes made to data layout replica on page 15 of the “Revised” *Interim Record Layout (12/05/08 Version)*. **All RREs and interested parties should closely examine the data layout replica and the changes thereto as noted on page 15 of the revised layout to assure that they have a complete understanding of the data and information that must be reported under Section 111.**

## Conclusion

CMS’ “Revised” *Interim Record Layout (12/05/08 Version)* substantially modifies the initial and updated versions of the *Interim Record Layout*. The revised layout provides expanded and detailed directives regarding several key aspects of CMS’ proposed MIR guidelines. All RREs should incorporate the informational directives outlined in the revised layout, including the changes made to the data layout replica into their Section 111/MIR compliance programs.

This is an important reminder that CMS may make further changes to the *Interim Record Layout*. Thus, all RREs and other interested parties should continue to regularly monitor CMS’ dedicated website [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep) to determine if CMS issues new proposed guidelines or otherwise makes modifications to the proposed record layout or other aspects of the MIR.

Likewise, close attention should be afforded to the information discussed and announced by CMS in conjunction with its Town Hall Teleconference Meetings. Future Town Hall conferences for non-GHP are scheduled for: *January 22, 2009; January 28, 2009; February 25, 2009; March 25, 2009; and April 22, 2009.* Information regarding the time of each conference and corresponding dial-in numbers has not been released to date.

## About the Author

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## Endnotes

<sup>1</sup> Section 111 of the MMSEA is codified at 42 U.S.C. § 1395y(b)(7) and (8). Subsection (7) pertains to Group Health Plans which are not addressed as part of CMS' Interim Record Layout (all versions) or by the author in this article. Subsection (8) concerns liability insurance (including self insurance), no-fault insurance and workers' compensation which are commonly referred to in the Section 111 context as non-Group Health Plans (non-GHP). CMS' "Revised" *Interim Record Layout* (12/05/08 version) and this article relate to non-GHP requirements under Section 111.

<sup>2</sup> CMS' previously released MIR proposals consist of the following 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 Version– 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 Version– November, 2008):**

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

**Each of the referenced articles can be obtained by logging onto [www.NQBP.com](http://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](http://www.nqbp.com/rl_cms_memos.shtml).**

<sup>3</sup> A copy of summaries of CMS' October 1, 2009 and October 29, 2008 Open Forum teleconference calls can be obtained at [http://www.cms.hhs.gov/MandatoryInsRep/03\\_Liability\\_Self\\_No\\_Fault\\_Insurance\\_and\\_Workers\\_Compensation.asp#TopOfPage](http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.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](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 Open Forum teleconference.

<sup>4</sup> 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. See also, pages 2-3 of this article.

<sup>5</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 3.

<sup>6</sup> See, 73 Fed. Reg. 45013 (August 1, 2008). Also, a copy of CMS' Supporting Statement can be obtained as outlined in endnote number two above.

- <sup>7</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 4.
- <sup>8</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 4.
- <sup>9</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 4-5.
- <sup>10</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 5; Emphasis added.
- <sup>11</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 7.
- <sup>12</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 7; Emphasis by CMS.
- <sup>13</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 7.
- <sup>14</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 11. As part of the December 11, 2008 Open Forum teleconference CMS provided no guidance as to how often a RRE should follow up to determine a claimant's Medicare entitlement status. CMS advised that RREs need to make this determination.
- <sup>15</sup> CMS discussed the possibility of establishing a query system at the October 1, 2008, October 29, 2008 and December 11, 2008 Open Forum Teleconference calls.
- <sup>16</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 7 and p. 10.
- <sup>17</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 8 and p. 11.
- <sup>18</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 7 and p. 11.
- <sup>19</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 10.
- <sup>20</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 11.
- <sup>21</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 13; Emphasis Added.
- <sup>22</sup> CMS' "Revised" Interim Record Layout (12/05/08 Version), p. 12-13; Emphasis by CMS.