Traditionally, matters regarding Medicare Secondary Payer (MSP) compliance, such as Medicare Set-Aside (MSA) allocations, have been the responsibility of claims managers and supervisors. However, the nation’s current economic and political climate has thrown a harsh light on the critical state of the Medicare Trust Fund, leading to industry-wide concern. Mandatory Insurer Reporting (MIR) is making the process typically associated with managing cases though settlement more difficult, impacting business operations and technology.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) establishes MIR as a requirement for group health, liability, no fault and workers’ compensation insurers/plans — designated as Responsible Reporting Entities (RREs). According to MIR requirements, RREs must report certain claims information for Medicare beneficiaries to the Secretary of Health and Human Services. Through MIR, the Centers for Medicare & Medicaid Services (CMS), the agency managing MSP and MIR compliance, receives a list of claims where Medicare’s interests should be protected as a secondary payer. Additionally, open claims where a primary payer exists are to be reported to prevent erroneous payments by Medicare. Overall, MIR is meant to assist CMS by simplifying the recovery process and easing verification of MSP compliance.

The MIR process is complex, affecting multiple points within the claims management process. To accurately complete this reporting, specialized expertise is needed. The increased risk and cost of achieving compliance with MIR requirements has escalated this issue to the senior level of payer organizations. Additionally, many RREs are encountering challenges meeting MIR requirements due to inefficient or inaccurate reporting systems or partners.

The challenges of the MIR process include significant complexity regarding data validation, application of reporting rules, aggregation of data, sharing data with other providers and technological connectivity. As a result, eligible claims may not be reported or ineligible claims may be unnecessarily reported to CMS. These issues are indicators of inefficient and inaccurate reporting systems and significantly increase risk for payers. Data reported with errors can result in temporary suspension of reporting with CMS, increasing the risk of non-compliance penalties.

The RRE is accountable for compliance even when a Reporting Agent has been selected by the RRE to handle the data transmission process. Failure to comply may result in fines up to $1,000 per day, per claim.
For payers that partner with a Third Party Administrator (TPA) for claims management, the payer should expect the TPA to help properly manage reporting requirements. However, CMS has been clear — a TPA is never an RRE for Non-Group Health Plan (NGHP) MMSEA Section 111 Reporting. In the end, the RRE is ultimately responsible for compliance and holds primary accountability for the reporting of claims. As a result, RREs should expect their reporting solution to clearly and accurately deliver the appropriate information to ensure compliance with MMSEA Section 111 requirements.

**Mitigating risk through MIR management**

While complex, MIR compliance can be achieved through the efforts of a Reporting Agent that possesses the necessary expertise. When considering Reporting Agents, it’s important to recognize a few key facts about the reporting process:

**1. Not all claims are reportable**

Only claims for Medicare beneficiaries must be reported. You must first identify which claimants are Medicare beneficiaries and then apply CMS-defined rules to each of these claims. Doing this focuses attention on only those claims that require reporting. Many Reporting Agents stop here, reporting all Medicare beneficiaries, whether or not they meet thresholds outlined in the CMS User Guide. Matching the Medicare beneficiaries to the CMS-defined rules streamlines the process so the focus is on preparing only those claims that require reporting and ensuring that the appropriate data is submitted.

**What to look for:** A reporting system with automated checking of claims against all applicable reporting criteria that quickly checks if claims require reporting and indicates claims at-risk for non-compliance. This helps adjusters focus on the appropriate claims, reduce submission errors and more efficiently manage their workload.
2. **Data must be error-free before submission**

Invalid and incomplete submissions will slow down the reporting process and create additional delays in productivity. While organizations of any size can be challenged to ensure the accuracy of required data elements, payers that rely on data from multiple source systems face additional complications.

Reporting is about accuracy. Optum® found about half of the reportable claims we received contained invalid values in required fields, which had to be corrected in order to be accepted by CMS. If you have an error rate higher than 20%, your Reporting Agent may not be scrubbing your data before submission. Reporting erroneous data could trigger a temporary suspension of report review and response by CMS. This could put you out of compliance with your reporting requirements and expose you to potential fines.

**What to look for:** A reporting system with the ability to aggregate data from several sources and scrub data for reporting accuracy. The reporting system should identify potential problems and escalate that to the adjuster, thus, minimizing actual submission errors.

3. **Legacy systems will not be able to handle the reporting requirements**

The complexities involved in the reporting process require a robust reporting system and sophisticated technology. There are over 250 data fields included in the file specifications for submissions to CMS, with many of the fields being required. More importantly, there is significant complexity surrounding this data with additional fields moving from optional to required based on other entries within the claim. Most legacy systems cannot handle this without a significant rebuild. The system must have capabilities to pull data from multiple source systems, automate all of the validations and monitor data management.

As reporting continues, processes and data element submission criteria will be further refined by CMS, requiring consistent monitoring of agency announcements to ensure reporting processes are adjusted accordingly.

**What to look for:** A reporting system that supports all of the data elements required for reporting, easily adapts to changes in CMS rules and guidelines, provides flexible transmission options and delivers reports that provide a clear understanding of your level of compliance.

**Achievable success**

While MIR requirements and MSP compliance are an industry challenge, it’s important to recognize that there are solutions to meet this challenge. Optum achieves a CMS acceptance rate of virtually 100%, once adjusted for errors defined by CMS in the User Guide as requiring “no correction necessary by the RRE.” We continually analyze responses from CMS to determine whether validations are providing the necessary guidance to ensure accurate submissions to CMS. This accuracy rate has been driven by strong regulatory and technical expertise that has adapted to the ever-changing requirements.

**The future of MIR compliance**

CMS has issued many updates to the NGHP User Guide since the beginning of production reporting, with the latest, version 4.5, published on February 2, 2015. Looking ahead, major updates to the NGHP reporting process will include implementation of ICD-10 coding along with changes to the TIN address structure with the addition of recovery agent information. CMS also responded to a requirement of the Smart Act by adding functionality to allow the use of the last five digits of the Social Security Number to query and report a claim.
Additionally, the industry is still waiting for an update to the rule-making process initiated in December 2013 for ANPRM-6061 regarding civil monetary penalties for reporting NGHP claims. Although CMS has received responses to their request for commentary, no additional progress has been seen towards issuance of a preliminary or final rule on this topic.

Case study
A large employer dramatically decreases their exposure and ensures compliance by changing to a third-party administrator who partners with Optum for MIR reporting.

Background
As a self-insured entity, a large national employer recognized their responsibility to report applicable claims under MMSEA Section 111, as well as the complexity of the processes involved to achieve full compliance. They understood the extensive technology and data scrubbing requirements and the need for timely submission of reportable claims. In addition, they knew that issues with data validation could increase risk, as data reported with errors can result in temporary suspension of reporting with CMS, increasing the potential risk of non-compliance penalties.

The employer registered as an RRE and, in 2009, selected a Reporting Agency to assist them with meeting MIR requirements. The Reporting Agent was chosen based on its advertised capabilities for MIR compliance, including timely submission of data to the Coordination of Benefits Center (COBC), training programs to prepare RRE staff for the MIR process, and support for individuals responsible for the claims management process.

Challenge
On January 1, 2011, the reporting required by CMS to fulfill MIR requirements began. The RRE was issued a reporting schedule of group one by the COBC. This meant that a quarterly claim input file should be submitted during the first week (first through seventh day) of January, April, July and October. After quarter one reporting, the RRE was concerned that their Reporting Agent was not handling their claims data properly and that reporting of required data to CMS was not occurring. Concerns on the part of the RRE regarding the accuracy of reporting by their designated agent were triggered by lack of available reports, unexpectedly low maintenance or clean up required for claims files, and absence of statistics confirming the results and overall success of the reporting process.

The RRE initiated a search for a new TPA and Reporting Agent. Their selection ended with a TPA using our MedicareConnect platform to report claims to Medicare. The new TPA took over all claims on March 28, 2011, only a few days prior to the RRE’s quarter two reporting deadlines, leaving limited time to fix any errors and increasing the risk for non-compliance.

First, the TPA requested that we review the RRE’s data to determine if there were any issues for the upcoming quarter two reporting. They also requested that we audit the quarter one submission to evaluate the RRE’s compliance.

Analytic approach
The data from the former TPA was provided to us for review. Upon examination, we determined that while the data appeared ready for query, many of the claims records had never been sent to CMS to determine beneficiary status. We began to work with the TPA and the RRE using MedicareConnect’s validation rules and error reporting capabilities to quickly identify and prioritize missing or incorrect data needed to clean up the claims prior to submission.
In the audit of quarter one reporting, we checked the file transmission history for the RRE via the COBC secure website. The site indicated there had only been one query submission from the original TPA. Upon closer investigation, we found that this query did not contain any records. In addition, we found that the quarterly claim input file had not been submitted to CMS in quarter one; therefore, no claims were reported. We worked diligently with the COBC supervisor and Electronic Data Interchange (EDI) Representative to receive a submission extension for this RRE.

Results and impact

By the beginning of June 2011, all of the RRE’s claims had been sent for query through MedicareConnect. Over 50% of the approximately 900 queried claims were identified as beneficiaries for which reporting is required. By quarter three, 350 of these claims were ready for submission and reported with a 0% error rate* with the remaining claims to be included in the quarter four reporting file.

The TPA and RRE are both satisfied with the level of service we provided. The RRE is pleased with the fast progression of the data through our validation processes and now feels comfortable about the status of their claims. With our suite of interactive reports available at both the TPA and RRE level, the RRE is able to monitor the progress the TPA is making in cleaning up the claim data for query and reporting submission. The RRE is now confident that their claims are actively managed and reported as required.

As a result of our efforts, the RRE and TPA confirmed that we will continue to act as the Reporting Agent for their claims. Now, with 16 quarters of error-free reporting with Optum, the RRE continues to achieve high compliance with their NGHP claims.

*Rate adjusted for disposition/error codes, which are CMS-related and do not require correction by the RRE, such as SP31 and disposition codes 50 and 5.

About Optum for Workers’ Compensation and Auto No-Fault

The workers’ comp and auto no-fault division of Optum collaborates with our clients to deliver value beyond transactional savings while helping ensure claimants receive safe and effective clinical care. Our innovative and comprehensive medical cost management programs include pharmacy, ancillary and managed care services from first report of injury to settlement.

Optum and its respective marks are trademarks of Optum, Inc. All other brand or product names are trademarks or registered marks of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.