CENTERS for MEDICARE & MEDICAID SERVICES

Office of Financial Management/Financial Services Group

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Implementation of Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
(See 42 U.S.C. 1395y(b)(7) & (8))

ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation – Reporting Timeframe

Note: Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are often collectively referred to as "non-Group Health Plan" or "NGHP."

"Timeliness" of reporting -- NGHP TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met:

- The alleged injured/harmed individual to or on whose behalf payment will be made has been identified.
- The TPOC amount for that individual has been identified.

Where these criteria are not met as of the TPOC date, retain documentation establishing when these criteria are met.

Example:

- There is a settlement involving an allegedly defective drug.
- The settlement contains/provides a process for subsequently determining who will be paid and how much. Consequently, the fact that there will be payment to or on behalf of a particular individual and/or the amount of the settlement, judgment, award or other payment to or on behalf of that individual is not known as of the TPOC date.
- Timeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the date there is a determination both that payment will be made to or on behalf of that beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of that beneficiary.

The content of this ALERT will be incorporated in a future revision to the User Guide.

CMS will implement a system change to prevent erroneous late compliance flags in this situation. RREs should ignore erroneous late compliance flags received in this situation until the correction can be made.