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Resolution of Claims Involving Medicare Beneficiaries under the MMSEA

New Reporting Requirements and Significant Penalties for Failing to Protect Medicare's Interests

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Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), codified at 42 U.S.C. § 1395y(b)(8), establishes mandatory reporting requirements with respect to Medicare beneficiaries who receive settlements, judgments, awards, or other payment from liability insurance programs, including self-insurers, no-fault insurance, or workers' compensation programs. The Centers for Medicare & Medicaid Services (CMS) requires its interests to be protected prior to any settlement of the medical portion of a claim involving a Medicare beneficiary. All insurers with respect to liability, no-fault, and workers' compensation, including self-insurers, are responsible reporting entities (RREs) and will be required to determine whether a claimant is entitled to Medicare benefits. All RREs must provide their first Claim Input File no later than June 30, 2010, however, the retroactive date for claim payment reporting is January 1, 2010, and January 1, 2009, if the claim involves ongoing responsibility for medicals (ORM). The penalty for non-compliance is \$1,000 per day, per claim, for each day the responsible party is out of compliance.

Section 111 of the MMSEA significantly amends the notice and reporting requirements under the Medicare Secondary Payer (MSP) statute relating to liability insurance programs, including self-insurers, no-fault insurance, and workers' compensation programs. The purpose of the Section 111 reporting requirements is to enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. The requirements relating to group health plans are treated separately under Section 111. This alert does not address the requirements of Section 111 in relation to the group health context.

Overview of Medicare Secondary Payer Statute

In order to understand the new reporting requirements of Section 111, a brief discussion of the MSP statute is warranted. The MSP provisions, codified at 42 U.S.C. § 1395y, were enacted in 1980 to control the rising costs of the Medicare program. The MSP provisions have been amended several times since their enactment and were amended again by Section 111 of the MMSEA. Since the MSP provisions were enacted, Medicare has been a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation programs. The MSP provisions aim to assure that primary payers assume the responsibility for medical treatment for accident-related injuries. Under the MSP statute, Medicare has a direct right against all primary payers responsible for making payment and any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer. See 42 C.F.R. § 411.24(g). Medicare also has a subrogation right, as well as rights of joinder and intervention. See 42 C.F.R. § 411.26.

Medicare Conditional Payments

Primary payers are obligated to reimburse Medicare for conditional payments. "Conditional payment" is defined as a "Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed." 42 C.F.R. § 411.21. Primary payers are obligated to reimburse Medicare for conditional payments when it is demonstrated that a primary plan "has or had a responsibility" to make payment. A primary plan's "responsibility" may be "demonstrated" by a "judgment" or "a payment conditioned upon a recipients' compromise, waiver, and release." 42 U.S.C. § 1395y(b)(2)(B)(ii). A "settlement," "award," or "contractual obligation" is indicative of "responsibility" under the MSP. See 42 C.F.R. § 411.22(b)(3).

Section 111 Contains New Mandatory Insurer Reporting Obligations

All insurers with respect to liability, no-fault, and workers' compensation, including self-insurers, are termed RREs. Section 111 requires RREs, whenever there is a settlement, award, judgment, or other similar payment, to: (1) determine if a claimant is entitled to benefits from Medicare on any basis and (2) notify Medicare of said entitlement. See 42 U.S.C. §

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1395y(b)(8)(A). RREs have a duty to report to CMS within the time specified by the Secretary of the Department of Health and Human Services after the claim is addressed/resolved through a settlement, judgment, award, or other payment, regardless of whether there is a determination or admission of liability. Where there are multiple defendants involved in a settlement, all RREs involved in the settlement remain responsible for their own reporting. The obligation to identify the Medicare beneficiary lies solely with the RRE.

What Must Be Reported?

Under 42 U.S.C. § 1395y(b)(8)(B), the information to be reported includes the “identity of the claimant” and “such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.” RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary and gather the information necessary for Section 111 reporting. CMS has released its Claim Input File Detail Record which outlines the information to be reported and the format to be utilized. The reporting data elements include, but are not limited to, the injured party’s name, SSN or HICN (Medicare Health Insurance Claim Number), gender, date of birth, RRE’s information, litigation information to include name of attorney or representative, information regarding ongoing responsibility for medicals payment, injury/incident/illness information, insurer information, and additional claimant information, if applicable.

Process for Section 111 Mandatory MSP Reporting

Data reported for purposes of Section 111 by RREs will be submitted electronically to CMS’ Coordinator of Benefits Contractor (COBC). RREs are required to **register online through CMS’ secure website**. Once the RRE has completed the registration process, the COBC will work with the RRE to set up the data reporting and response processes. The COBC coordinates the activities that support the collection, management, and reporting of other insurance or workers’ compensation coverage for Medicare beneficiaries. The COBC does not process claims, answer claims specific injuries, or handle MSP recoveries. The COBC updates the CMS systems and databases used in the claims payment and recovery processes.

The Initial Claim Input File must include single settlement claims, i.e., one-time payment with no further responsibility to the claimant, for any claim for a Medicare beneficiary if the settlement, payment, judgment, or award occurred on or after January 1, 2010. The Initial Claim Input File must also include any claim for a Medicare beneficiary where the RRE has ORM as of January 1, 2009. ORM refers to the RRE’s responsibility to pay, on an ongoing basis, for the injured party’s medicals associated with a claim. This typically only applies to no-fault and workers’ compensation claims.

When Must Reporting be Done?

RREs are required to make quarterly reports and must report new claims for Medicare beneficiaries that received settlements, judgments, awards, or medical payments during the quarterly reporting period. RREs further have an obligation to report any changes or corrections to claims that were previously reported and final notification on any previously reported claims if the ORM has ended.

Implementation Timeline, as of May 12, 2009

All RREs are required to submit their first Section 111 production Claim Input Files no later than June 30, 2010. Beginning July 1, 2009, the test and production query function will be available for those RREs who have completed registration and are in testing status. January 1, 2010, through March 31, 2010, is a Claim Input File testing period for all liability insurance (including self-insurance), no-fault insurance, and workers’ compensation RREs. From April 1, 2010, through June 30, 2010, all liability insurance (including self-insurance), no fault insurance, and workers’ compensation RREs are required to submit their first Section 111 production Claim Input Files based upon a predetermined schedule with the COBC.

Penalties for Non-Compliance?

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Under 42 U.S.C. § 1395y(b)(8)(E), the penalty for non-compliance is \$1,000 per day, per claim. This amount is in addition to any other penalties available at law. The MSP statute provides for a private cause of action against a RRE that fails to reimburse Medicare or otherwise make primary payment. See 42 U.S.C. § 1395y(b)(3)(A).