

ANOTHER STEP TO CLAIM RESOLUTION WITH A MEDICARE CLAIMANT

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Introduction

On December 29, 2007, former President George W. Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007, or the MMSEA. The MMSEA amends the Medicare Secondary Payer provisions of the Social Security Act thereby securing Medicare's place as a secondary payer. The reporting requirements contained within Section 111 of the MMSEA could lead to civil penalties and fines if not followed.

CMS' Oversight

The Center for Medicare and Medicaid Services (CMS) is an agency of the federal government that is part of the Department of Health and Human Services. CMS is responsible for the oversight of Medicare and the implementation of the MMSEA. CMS has a statutory lien on liability claims made by Medicare beneficiaries. This statutory lien confers on CMS the right to be reimbursed for medical expenses it paid on behalf of a Medicare beneficiary who recovers those expenses in a liability claim. It may also afford CMS some protection from the cost of future medical care. While the MMSEA does not change any statutory provisions or regulations, it does add a reporting requirement that, if not complied with, may result in some significant fines and penalties to those responsible for reporting. The Medicare beneficiary may be penalized through the termination of all benefits if Medicare is not protected as a secondary payer.

Does The MMSEA Apply To Your Case?

The MMSEA requires all liability insurers, including self-insurers, no fault insurers and workers' compensation insurers, to determine whether the claimant/plaintiff is Medicare eligible. A Medicare eligible plaintiff or claimant is someone who is 65 years of age or older, someone who is under the age of 65 with certain disabilities or someone suffering from end-stage renal disease.

Who Is Required To Report?

Responsible Reporting Entities (RRE) includes all liability insurers, self-insurers, no fault insurers and workers' compensation insurers. RREs are required to keep CMS apprised throughout claim settlement and litigation. The reporting entities are responsible to not only determine the Medicare eligibility status for the claimant/plaintiff but to report on every case where payment under a settlement, award, judgment or other payment is made that involves a Medicare beneficiary. RREs are ultimately responsible for complying with the reporting process including ensuring the accuracy of all reported information. While RREs may not contract away their obligation under this law, they may elect to use an agent for reporting purposes. All Responsible Reporting Entities must electronically register with CMS before September 30, 2009 to show intent to comply with this law.

Regardless of the number of defendants in a matter, each RRE is responsible for its own reporting. If there are multiple settlements involving the same claimant/plaintiff, each RRE must report separately. In cases involving multiple defendants, there may be multiple records submitted for the same claimant/plaintiff, but they will be cumulative rather than duplicative.

What Must Be Reported?

The Responsible Reporting Entity is required to input either a Medicare Health Insurance Claim Number (HICN) or the injured party's Social Security Number. While the RRE may submit either the HICN or the SSN, it is preferable to submit both to ensure a match if the claimant/plaintiff is in the system. In addition to the HICN and the SSN, the RRE is required to submit the first six characters of the Medicare beneficiary's last name, his/her date of birth, and gender. Other relevant information may include the nature and extent of the injury or illness, the facts about the incident giving rise to the injury or illness, information sufficient to assess the value of reimbursement and information sufficient to assess the value of future care planning.

The Coordination of Benefits Contractor (COB) will use the created files to determine if an injured party can be identified as a Medicare beneficiary based upon the information submitted and whether the beneficiary's entitlement for Medicare continued or commenced on or after the date of incident as defined by CMS. To determine whether an injured party is a Medicare beneficiary, the COB matches the RREs' data to Medicare's data.

Reporting Requirements

RREs must report settlements, judgments, awards, or other payments regardless of whether or not there is an admission or determination of liability.

These reporting requirements will result in not only added infrastructure costs (personnel and systems) for RREs, but more steps in legal claim resolution by mandating verification of CMS' benefits throughout litigation until resolution. In order to avoid lengthy delays, it is best to begin investigating a person's Medicare beneficiary status as soon as a questionable claim reaches your desk.

In cases involving more than one defendant, if more than one RRE has assumed responsibility for ongoing medicals, Medicare would be secondary to each such entity.

If the claimant/plaintiff was not a Medicare beneficiary at the time an RRE assumed ongoing responsibility for future medical care, the RRE must continue to monitor the claimant's/plaintiff's Medicare status because it may change over time. If the claimant/plaintiff becomes a Medicare beneficiary, any responsibility for ongoing medical care or payment of claim must be reported to CMS. If the reporting entity's responsibility for future medical costs terminates before the claimant/plaintiff becomes a Medicare beneficiary, then there is no reporting requirement.

Medicare Payment

Medicare beneficiaries who receive a liability settlement, judgment, award, or other payment have an obligation to "pay back" any conditional payments paid by Medicare within 60 days of receipt of such funds. Conditional payments must be verified and resolved by all participants in a matter in order to avoid the steep penalties.

As far as payment for future medical care is concerned, it is important to remember that the purpose of Section 111 was to add a reporting requirement and CMS has yet to give any guidance as to liability Medicare Set-Asides. A Medicare Set-Aside (MSA) is money set-aside from any settlement, judgment or award for any future medical expenses. While Section 111 does not specifically require Set-Asides, they are often the best practice for protecting Medicare's interest as a secondary payer. While there is no threshold amount or specific requirement for a Set-Aside, many companies are setting them up in cases involving future medical care for a Medicare beneficiary so as to avoid any possible fines or penalties.

The typical funding mechanisms of an MSA are in the form of a structured annuity or lump sum. The money often goes into a trust that can be professionally or self-administered, but the administrator is responsible for an annual accounting. In addition, the administrator of the account must show the account has been properly exhausted before claiming any Medicare benefits for services related to the injury. The best practice is to have CMS approve this allocation for future care.

CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. However, CMS does normally defer to an allocation made through a jury verdict or after a hearing on the merits. This issue is relevant to whether or not CMS has a recovery claim with respect to a particular settlement, judgment, award, or other payment and does not affect the RREs' obligation to report.

Fines and Penalties

This law has many attorneys, beneficiaries and insurers scrambling to comply because the penalties for non-compliance are steep. Insurers can face penalties of up to \$1,000 per day per claimant/plaintiff whose Medicare status is not fully reported to CMS. The penalties Congress gave CMS also include both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from "any or all entities that are or were required to make payment." The government is also entitled to seek to recover double damages if it brings an independent cause of action.

To avoid being penalized, the ultimate goal for RREs, attorneys, and beneficiaries is to understand when there is coverage primary to Medicare, to notify Medicare of such coverage, and to pay Medicare when appropriate.

Insurers need to be mindful of the following three concepts: 1) Responsible Reporting Entities must **REPORT** to CMS payments made on behalf of Medicare-eligible claimants/plaintiffs; 2) Responsible Reporting Entities should determine whether there are medical expenses in the **PAST** for which CMS seeks reimbursement; and 3) Responsible Reporting Entities should assess what Medicare-covered medical expenses may be incurred in the **FUTURE** due to the injury or illness. One last caveat to consider is the fact that CMS has the right to reject settlements that do not protect Medicare's interest. Therefore, while perhaps time consuming, it is best to voluntarily get pre-approval of settlements from CMS directly.

While the monetary penalties for an RREs' non-compliance are steep, attorneys and Medicare beneficiaries are also subject to penalty. Attorneys are now exposed to increased legal malpractice as ethical rules may be violated by failing to notify and honor CMS' reimbursement right even if the attorney was not aware of CMS' interest since the attorney "should have known" that Medicare would have a lien. Attorneys can protect themselves by reporting all settlements to CMS, putting Medicare's name on settlement drafts, and getting written confirmation that Medicare's interests have been protected. Also important to note is that indemnity clauses on settlement agreements will not protect you because CMS, as a governmental entity, has a super lien. A Medicare beneficiary risks termination of all benefits if he/she fails to protect Medicare's place as a secondary payer. It is important to make sure all claimants/plaintiffs are aware of this law and the risks associated with non-compliance.

Where Do We Go From Here?

In order to prepare for this law, all RREs should track developments on CMS' website at www.cms.hhs.gov/MandatoryInsRep/. After registering with CMS, an RRE should also track the associated dates for compliance and reporting, revise protocols for claims assessment and handling, allocate sufficient resources and expertise for maintaining compliance, and revise all paperwork as necessary.

As daunting as this new law may seem, CMS is making an effort to make compliance manageable. In addition to keeping up-to-date with developments on CMS' website, there have been numerous broadcasted town hall meetings as well as a User Guide that has been published to help walk you through the compliance requirements. If all else fails, protect yourself by assessing all claimants/plaintiffs for Medicare eligibility, reporting those individuals to CMS, identifying whether any

conditional payments have been made, obtaining an estimate of future medical expenses, clearly identifying settlement funds allocated for future medical expenses, and drafting all settlement documents in such a way as to indicate Medicare's interests have been addressed.

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