



KOPKA PINKUS DOLIN & EADS, LLC

Legal Advisory

MEDICARE MANDATORY INSURANCE REPORTING REFERENCE GUIDE

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1. The “Medicare, Medicaid and State Children’s Health Insurance Program (SCHIP) Extension Act” (MMSEA) is being implemented in phases.
2. Although the overall name of the new law includes reference to the state-operated programs of Medicaid and SCHIP, the mandatory reporting requirements found in Section 111 of MMSEA, 42 U.S.C. §1395y(b)(8), pertain only to claimants eligible for Medicare or who will be eligible for Medicare during the time they receive future medical treatment that is covered by the settlement, judgment, award, or ongoing medical payments in the injury case.
3. Medicare beneficiaries include not only persons 65 or older, but also persons of any age who:
 - a. Have end stage renal disease (kidney disease/dialysis patients)
 - b. Apply or will potentially apply for Social Security Disability Insurance (SSDI) (which could include work comp claimants who are permanently and totally disabled)
4. Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers compensation.
5. The purpose of MMSEA is to provide verification that Medicare’s interests are being considered during the claims process so that a claimant does not receive Medicare benefits when the expense should have been covered by other insurance.
6. The new law will better enable Medicare to recover its “conditional payments” which must be reimbursed from the proceeds of an award or settlement of an injury claim.
7. MMSEA has a separate section pertaining to group health insurance which has different rules and implementation dates.
8. The information will be sent **by the insurer** via a secure Internet connection or other approved electronic means. (There are certain procedures on deductibles for self-insureds.)
9. The reporting of settlements, judgments or awards (referred to as “TPOC” which is Total Payment Obligation to Claimant) is for **cases that have settlements, judgments or awards on or after January 1, 2010**. (The TPOC thresholds are in item #12 below.)



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10. Insurers may start inputting the information on January 1, 2010 but the deadline for the actual electronic reporting of injury claim information by liability, no-fault and workers compensation insurers (as well as self-insureds) takes effect April 1, 2010.
11. The reporting will also need to be done for claims where there is Ongoing Responsibility for Medical (ORM) which typically applies to no-fault, work comp claims, PIP and auto med pay. **ORM reporting applies to claims where ORM exists on or after July 1, 2009 regardless of the date of initial acceptance of responsibility for ongoing medical.** Therefore, if a case settled in December 2009 but there was ongoing responsibility for medical at any time during the second half of 2009, the ORM would have to be reported. ORM is only reported twice -- at the beginning of the responsibility and then when there is a determination of no further medical treatment. ("Ongoing Responsibility" does not equate to ongoing reporting.)
12. Except for small work comp claims (explained at the end of this memo), **all Ongoing Responsibility for Medical must be reported, regardless of the amount.** Settlements, judgments and awards should not be reported if they are equal to or less than the following amounts in the following years:
 - (a) 2010 – 2011: \$5,000
 - (b) 2012: \$2,000
 - (c) 2013: \$600
 - (d) After 1/1/2014: All settlements, judgments and awards must be reported.

Therefore, if in 2010 or 2011 there is a settlement of \$5,000 which never involved Ongoing Responsibility for Medical, the settlement will not need to be reported. (The system will supposedly reject TPOC amounts of \$5,000 or less).
13. After the initial information is sent to Medicare, the information will need to be updated quarterly if there is a change in circumstances (such as a settlement, judgment, name change, etc.)
14. MMSEA adds reporting rules but does not change existing law with regard to Medicare's rights to recover third party payments, 42 U.S.C. § 1395y(b)(2). This was once referred to as the "Medicare Super Lien." While the term "lien" is no longer advisable for Medicare's right of recovery, the statute allows Medicare to recover payment from a liability insurer (even though it already reimbursed the Medicare beneficiary or other party) or from an attorney or physician who has received a primary payment. 42 C.F.R. 411.24(g)(i).
15. Release language is not binding on Medicare. You don't try to "Medicare-proof" the release. Instead, you make sure that Medicare will be reimbursed.
16. MMSEA also does not change laws affecting Medicare Set-Asides.
17. Claim representatives should flag claims of persons in their early 60's so that if the pendency of the claim or the Ongoing Responsibility for Medicals (ORM) extends past age 65, the insurer or self-insured will properly and promptly report the information to the Centers for Medicare and Medicaid Services (CMS).



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18. The “query function” – Insurers who are registered with CMS can input the following data to determine if a person is a Medicare recipient:
 - (a) Name
 - (b) Date of Birth
 - (c) Social Security Number or Medicare Health Insurance Claim Number (HICN)
 - (d) Gender

19. **Penalties**
 - a. Failure to comply with the reporting requirements can result in a fine of \$1,000 per day per claim file.
 - b. If Medicare institutes an action to recover funds, it can recover double the amount.
 - c. Medicare benefits can be terminated if Medicare’s recovery rights are not protected.

20. **Other noteworthy items about this legislation:**
 - One time payment for defense medical evaluation – A payment made specifically for this purpose directly to the physician or other provider furnishing this service does not trigger the requirement to report.

 - The geographic location of the incident, illness, injury is not determinative of the reporting responsibility as Medicare beneficiaries who are injured outside the United States often return to the U.S. for medical care.

 - As long as the claim remains open in the insurer’s system, if the claim represents ongoing responsibility for medicals, then you must continue to monitor the status of the injured party to determine if and when the injured party becomes entitled to Medicare.

 - Settlements, judgments, awards, or other payments must be reported regardless of whether or not there is an admission or determination of liability.

 - After January 1, 2010, it may be difficult to settle out of a multi-defendant case involving a potential Medicare beneficiary because the settling defendant might end up being liable for the entire Medicare obligation.

 - Don’t over-allocate to loss of consortium because Medicare is not bound by the release language.

 - Don’t allocate the settlement to punitive damages because this will not successfully evade the Medicare responsibility (although it remains to be seen if a special verdict form will work because there would at least be a judicial determination that the money was punitive damages rather than medically-related damages).

 - If the settlement documents identify the injury by ICD-9 codes, that would be beneficial now and will be essential in 2011. After January 1, 2011, insurers will be required to input ICD-9 codes in their reports to Medicare.



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Workers' Compensation ORM for Minor Incidents

For workers' compensation ORM, claims meeting **ALL** of the following criteria are excluded from reporting for file submissions due through December 31, 2011:

- The claim is for "medicals only" and
- The associated "lost time" for the worker is no more than the number of days permitted by the applicable workers' compensation law for a "medicals only" claim (or 7 calendar days if the applicable law has no such limit) and
- All payment(s) has/have been made directly to the medical provider and
- Total payment for medicals does not exceed \$750.

Additional Resources

Further information can be found in the User Guide at the following web address: <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf> but one should always check for updates at <http://www.cms.hhs.gov/MandatoryInsRep>

**For more information on the details of this advisory contact
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