TUCKER ELLIS LLP

MEDICARE REPORTING AND RECOVERY UPDATE

MMSEA SECTION 111 REPORTING

RREs NOT LIMITED TO QUARTERLY REPORTING

Responsible Reporting Entities (RREs) were previously required to submit only one Section 111 claim file per quarter. That restriction was lifted in a CMS Alert dated May 1, 2012 announcing that RREs may submit multiple claim files within a single quarter. However, two limitations apply: (1) CMS will only process one claim file at a time; therefore, RREs should wait to receive a response from one submission before submitting a new claim file for processing; and (2) RREs may not submit a claim file more frequently than once every 14 days.

The increased frequency of reporting is optional. RREs are not required to send more than a single claim file each quarter, but they must submit at least one claim file per quarter within the submission timeframe previously assigned.

MMSEA USER GUIDE 3.4 NOW AVAILABLE

The latest edition of the MMSEA Section 111 User Guide (issued July 3, 2012) is now available for download from the CMS Section 111 website (www.CMS.gov/mandatoryinsrep). This edition, nicely reorganized into five main chapters for easy access, incorporates previous alerts to the Section 111 reporting program and also includes a new reporting option for workers' compensation TPOCs, various technical updates, and guidance on such topics as: "Who Must Report" and "Reporting Thresholds."

REMINDER: DELAYED REPORTING PHASING OUT, BUT INTERIM THRESHOLDS EXTENDED

Last fall CMS offered RREs the option to delay Section 111 reporting for certain TPOC settlements, judgments, awards, or other payments. The phased-in schedule allowed RREs to ease into reporting starting with TPOCs over $100,000 beginning January 1, 2012. Over the course of the year, the optional TPOC threshold has gradually lowered. Currently, all TPOC amounts over $25,000 with a TPOC date on or after July 1, 2012 must be reported in Q4 (starting October 1, 2012). TPOCs over $5,000, having a TPOC date on or after October 1, 2012, will be subject to reporting in Q1 2013.

NEW: On June 20, 2012, CMS released an **Alert** to announce that the minimum threshold will remain at $5,000 through 2013. The threshold will drop to $2,000 for reporting in 2014 and $300 for reporting in 2015. The mandatory TPOC thresholds for workers' compensation have also been revised. The revised reporting thresholds are available on the Section 111 website.

SECTION 111 REPORTING TIPS AND REMINDERS

Tendered Cases and Claims – A defendant that tenders its defense to another entity retains a Section 111 reporting obligation if the tendering company is still named as a party at the time the case is settled with (or a judgment is paid to) a Medicare beneficiary. Companies are therefore urged to review their records of past tendered cases to establish with their tender partners if a reporting obligation exists. Going forward, companies should consider including in their tender agreements: (1) a request to keep the tendering party informed of any potential settlement or payment; (2) an obligation that the party accepting the tender also serve as the Section 111 reporting agent; and (3) indemnification provisions to protect against any MMSEA reporting errors or penalties.

ICD-9 Accuracy – CMS has seen a surge of wrongful denials of provider claims for reimbursement for services in recent months. The timing coincides with the uptick in Section 111 reporting since the beginning of the year. CMS reminds RREs to ensure that claim records are submitted with ICD-9 Codes that are as specific as possible, using only those ICD-9 Codes that are directly linked to the injuries for which the RRE is responsible. When reporting ORM, use the diagnosis codes associated with the conditions for which the RRE has agreed to pay; when reporting a TPOC, include the diagnosis codes associated with the conditions claimed and released. In death cases, use the ICD-9 Code corresponding to the injury or illness sustained which led to the death, not a code for the death itself.

In Cases Involving Deceased Beneficiaries – The RRE should report the claimants' identifying information such as name, address, and social security number. If the claimant is an estate, report its tax identification number (TIN). Please note that the Section 111 report form can accommodate information for no more than four claimants. Therefore, prioritize the reporting to include information on the estate, as well as the claimants and heirs who are expected to receive the greatest share of the distributions from the proceeds of the settlement. In cases where the claimants and/or counsel refuse to share claimant information despite repeated and documented requests, the RRE is advised to report the settlement as though the beneficiary is, in fact, still alive, using the injured party's name and the plaintiff's attorney's information for contact purposes.

Reporting Loss of Consortium for Spouses –Ascertain the Medicare status of the spouse and if s/he is a Medicare beneficiary, and if the wording of the Complaint or Release releases medicals for the spouse, then a separate Section 111 report will be due for the spouse's recovery. Depending on the beneficiary status of the plaintiffs, the loss of consortium claim may end up being reportable even if the main injury claim is not. In cases where the injured party is a Medicare beneficiary but the spouse with the loss of consortium claim is not a beneficiary, the full amount of the settlement must be reported for the injured Medicare beneficiary. Medicare cautions against attempts to allocate settlement funds to the spouse for whom there is no reporting responsibility.

Risk Management Write-offs – Providers, physicians, or other suppliers who write off some or all of their own charges will report these transactions to Medicare as part of their normal billing processes. They do not need to separately submit a Section 111 report. But if those providers, physicians, or other suppliers accept and pay the bills of others, then those transactions must be reported through Section 111 as ORM or TPOC, whichever applies. In situations where the provider also wants to assume the patient's co-payment obligation to ensure they have no out-of-pocket expense, they may do so by providing the patient a cash amount that is the equivalent of the co-insurance and/or deductible and then report that amount as a TPOC. But all providers are cautioned that the CMS rules in this area are complex and providers are urged to seek compliance guidance before engaging in a pattern or practice of waiving co-insurance and deductibles.

MSPRC SELF-SERVICE INFORMATION LINE

The Medicare Secondary Payer Recovery Contractor (MSPRC) has added a customer service line available to beneficiaries, defendants, insurers, and attorneys. This feature gives callers the ability to get the most up-to-date demand and conditional payment amounts for beneficiaries. The phone lines are open 24/7 and the information can be accessed entirely from the telephone keypad – callers will not be kept on hold waiting to speak with a customer service representative. Callers with multiple recovery cases can request information on an unlimited number of cases during one phone call. The MSPRC Self-Service Line is 1-866-677-7220. Callers must have the following information available when placing their calls:

- The 15-digit Case Identification Number (as found on MSPRC correspondence);
- Beneficiary's full name;
- Beneficiary's date of birth; and
- Beneficiary's social security number or HICN.

Helpful Tip: To obtain the case identification number, defendants should request MSPRC correspondence involving the injured party/beneficiary as part of their routine discovery or as a condition for entering settlement negotiations.

NEW TOOLS FROM MSPRC TO SIMPLIFY RECOVERY OBLIGATIONS

MSPRC has recently introduced three programs to help beneficiaries expedite the resolution of their repayment obligation to Medicare. These programs are available only in cases of physical trauma-based incident/injury/accident/ illness. These programs are not yet available in cases of alleged ingestion, implantation, or exposure-based injury.

(1) For TPOCs of $300 or less: no MSP recovery

Medicare will not recover against the beneficiary's settlement, judgment, award, or other payment if the TPOC is $300 or less, the beneficiary has not received and does not expect to receive any other settlements or payments related to the incident, and Medicare has not previously issued a recovery demand letter. This $300 threshold does not apply to cases involving ORM.

(2) For TPOCs of $5,000 or less: fixed percentage option for recovery

Beneficiaries who elect this option will be able to resolve Medicare's recovery claim by paying Medicare 25 percent of his/her total liability insurance settlement instead of using the traditional recovery process. This option is available if the total settlement, judgment, or award is $5,000 or less, the beneficiary has not received and does not expect to receive any other settlements or payments related to the incident, and Medicare has not issued a demand letter or other request for reimbursement related to the incident. The Fixed Percentage Option request must be submitted within the required timeframe (at or before the time settlement documentation is submitted or by the due date referenced in the Conditional Payment Notice).

(3) For TPOCs of $25,000 or less: option to self-calculate the final conditional payment amount

Qualifying beneficiaries can suggest their own repayment obligation prior to settlement. This option is available only if the date of incident occurred at least six month ago and the beneficiary demonstrates, through physician attestation or written certification, that treatment

has been completed. The beneficiaries will be asked to review their Conditional Payment Notice, identify the claims related to their case, and then self-calculate their conditional payment amount (CPA). MSPRC will respond within 60 days to let the beneficiary know whether it agrees or disagrees with the self-calculated amount. When the liability case settles, the beneficiary must report the amount of the settlement, total attorneys' fees, and costs, and MSPRC will then issue a Final Demand within 20 days.

***NOTE*:** With each of these programs, additional conditions attach, including giving up the right to appeal or request a waiver. For more information on these options, see the MSPRC website at www.msprc.info/.

LIABILITY MEDICARE SET-ASIDES: CMS POLICY MEMO AND ANPR

CMS has taken steps to respond to parties' requests for guidance on the MSP obligations associated with "future medicals" by issuing a Policy Memorandum (dated September 29, 2011) and, more recently, through an Advance Notice of Proposed Rulemaking ("ANPR") published in the *Federal Register* on June 15, 2012.

In the CMS Policy **Memorandum** from CMS Official Charlotte Benson (the so-called "Benson Memo"), CMS indicated that the agency will consider Medicare's interests regarding future medicals to be "satisfied" where the beneficiary's treating physician certifies in writing that treatment for the alleged injury has been completed as of the date of the "settlement" and that future medical items and/or services will not be required. The physician's certification does not need to be submitted to CMS for review but should be retained by the settling parties for future reference.

On June 15, 2012, CMS utilized the ANPR process to solicit comments on whether and how Medicare should implement an MSA process in liability insurance situations. Medicare outlined a series of options for addressing "future medicals" with some options available only to Medicare beneficiaries, while other options would be available to beneficiaries and non-beneficiaries alike. Seven options are set forth in the ANPR. Comments are due no later than 5 p.m. on August 14, 2012. The **ANPR** was published in the *Federal Register* Volume 77, Page 35917.

THIRD CIRCUIT HOLDS THAT MEDICARE ADVANTAGE PLANS HAVE A PRIVATE RIGHT OF ACTION UNDER THE MSP

On June 28, 2012, in a class action against GlaxoSmithKline LLC (the manufacturer and distributor of Avandia, a Type II diabetes drug), the Third Circuit Court of Appeals reversed the District Court's order of dismissal. The court held that Humana and other similarly situated Medicare Advantage organizations have a private right of action under the MSP and could bring suit for double damages against Glaxo for failing to set aside reserves to reimburse the Medicare Advantage plans for costs of treatment for its subscribers' Avandia-related injuries. In distinguishing the opinions of other courts that have considered this issue, the Third Circuit concluded that the Medicare Advantage organizations have the same right to recover against primary plans, as does the Medicare Trust Fund.

Just as the settlements with Medicare Advantage enrollees and original Medicare beneficiaries are each subject to Section 111 reporting, now the *Avandia* decision appears to give Medicare Advantage plans some of the same rights, remedies, and options for recovery available to original Medicare under the Secondary Payer statute. *In re Avandia Marketing, Sales Practices and Product Liability Litigation*, No. 11-2664, ____ F.3d ___, 2012 WL 2433508 (3rd Cir. June 28, 2012).

FROM THE NATION'S CAPITAL

On April 27, 2012, the bipartisan Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2012 (H.R. 5284) was introduced in the House of Representatives. The bill is intended to address the costly delays and inconsistencies often encountered with Medicare's approval process for Medicare set-asides in the workers' compensation arena.

This legislation follows on the heels of a Government Accountability Office (GAO) study released in March 2012 that (1) examined how Section 111 mandatory reporting has affected the workload and performance of MSP contractors and (2) identified key challenges within the MSP systems. In its recommendations, the GAO asked that CMS not require NGHPs to report on cases for which the agency will not seek recovery, suggested that CMS make the submission of ICD-9 Codes an optional component of Section 111 reporting, and urged the agency to improve communications with the NGHP community and with beneficiaries by launching an improved website and offering more effective guidance on MSP reporting and recovery issues. A complete copy of the **GAO report** is available on the GAO website (www.gao.gov).

ADDITIONAL INFORMATION

Tucker Ellis will continue to monitor developments in this area and provide updates and guidance for reporting and recovery obligations as available.

If you have any questions or would like to receive a compilation of select Medicare MMSEA-MSP cases, please contact:

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