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CLIENT UPDATE **JUNE 2009**

MEDICARE'S SECTION 111 SECONDARY PAYER PROGRAM

JUNE UPDATE

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The Centers for Medicare & Medicaid Services (CMS) is charged with implementing the mandatory reporting provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42 U.S.C. § 1395y(b)(8)). The "Section 111 Secondary Payer Program" applies to group health plans and all liability insurance providers (including self-insurers), no-fault insurance and workers' compensation. The law requires detailed data submissions to CMS whenever a settlement, judgment or other payment is made to, or on behalf of, a Medicare beneficiary. *Click here for a detailed summary of the Section 111 law, including the FAQs, and Practical Tips, issued May 2009*.

With the new law now in effect, reporting entities should now be engaged in registration and training for the data entry and submission process. In response to the many substantive and technical questions regarding compliance with the new reporting requirements, CMS continues to provide guidance, updates, and clarifying instruction for liability providers and others.

On Tuesday, June 9, 2009, CMS hosted a teleconference to address policy and practice issues for Section 111 reporting with the liability insurance providers and their representatives.

Highlights of the June 9, 2009 session include:

Important issues still being considered

CMS is still considering what reporting obligations to impose in these situations.

- **Bankruptcy and litigation** – what happens when a responsible reporting entity is bankrupt or dissolved?
- **Clinical Trials –** CMS indicates they are working on language which is undergoing internal review and will be issued shortly.
- **Hospital write-offs** – CMS will meet with industry representatives shortly to understand what reporting obligations should attach to this service recovery practice which commonly occurs in hospital and healthcare settings.

- **Protection and Indemnity Clubs** – CMS will study this issue and the payment and reimbursement practices of Club members to develop appropriate reporting obligations.

- **Mass torts** – CMS invites interested parties to sign up for a mass tort working group to help CMS develop appropriate reporting guidelines for MDL, asbestos, product liability and other mass tort situations. TEW attorneys will seek to participate. Interested parties are invited to do the same. *Please contact TEW for more information about this opportunity to influence how the Section 111 program will affect industry groups.*

Watch for updates on these issues in future CMS Alerts posted on the website: www.cms.hhs.gov/MandatoryInsRep or in TEW Client Alerts.

Technical Update:

- CMS announced it will be reviewing all ICD-9 Codes and issuing a list of invalid codes that do not provide useful information to CMS. After issuance of the list, such invalid codes will be rejected from claims submissions.

CMS clarifies these reporting obligations:

- Any payment to, or on behalf of a Medicare beneficiary, whenever the file involves a claim for medicals or the release of medicals, must be reported. Besides tort and bodily injury type claims, CMS representatives made clear the reporting includes payments that arise in the context of employment litigation including discrimination claims.

- CMS reiterated that it is not bound by the parties' allocation of a settlement, award, judgment or other payment, but instead, will require reporting of gross amounts paid. For example, the Responsible Reporting Entity (RRE) must report attorneys' fees and costs when those amounts are paid by a claimant out of the gross settlement amount. If, as is the practice in some jurisdictions, fees and costs are carved out and paid separately, then those sums do not need to be reported.

How to report when multiple claimants, insurers or defendants are involved:

- If a claim is filed by an injured party and spouse and both are Medicare beneficiaries, and an award or settlement is made to both to resolve the personal injury and loss of consortium claims, CMS will require the reporting entity to submit two reports, one as to each claimant, and to report the full amount of the settlement on each report. The parties' allocation of payment as to the main injury claim and the derivative claim is not binding on CMS. Dual reports in the full amount of the settlement are required even if the claimants sign separate releases.

- If a single defendant/policyholder resolves a claim and the payment is made by multiple insurers, each contributing their obligated

amount, CMS will expect each insurer to report the full amount of the total settlement, and not just that insurer's proportionate share. CMS will allow each insurer to report their payment separately only if the release document separately names each insurer and the amount to be paid by each. Otherwise, CMS views the insurers' collective obligations to pay the claim as a situation of joint and several liability.

- If multiple defendants/tortfeasors resolve a claim for which they could have been held jointly and severally liable, then each separate defendant must report the full amount of the settlement and not just their proportionate share. CMS explained it wants to receive maximum claim and payment information on the "front end" and will then work with the beneficiary to clarify the exact amounts that were paid on the "back end" of the Medicare recovery efforts.

CMS clarifies who is to report:

- CMS is willing to consider ways to minimize the number of reporting entities that must register for the Section 111 Program. In that regard, CMS will issue guidance regarding the registration requirements for parent and subsidiary companies, including holding companies.

- **Role of TPAs:** RREs are required to register and identify an Authorized Representative who must be an RRE employee. But the RRE will also designate an Account Manager who is expected to have the most knowledge of the reporting processes and handle day to day contact and claims processing. The Account Manager is not required to be an employee of the RRE, and may be an agent or TPA. Confirming the helpful role TPAs may play in the Section 111 reporting process, should be welcome relief to many companies.

Practice tips:

- Be wary whenever a claimant or claimant's attorney says they have been in contact with CMS and have been told "there is no lien". CMS representatives caution such a report may be misunderstood and premature. If CMS is still paying claims for the beneficiary, a final lien status cannot be ascertained. Though CMS representatives will not give directives on its lien recovery practices, RREs are hereby advised to look for ways to protect their interests and assist the CMS recovery process. Including CMS's name on the settlement check(s) is one strategy to consider.

- CMS reiterates that Medicare beneficiaries are required to cooperate with Medicare and all other parties to facilitate the coordination of benefits and proper payment of medical claims. In that regard, beneficiaries should be reminded

of this legal obligation if they resist providing their social security number or Medicare identification number to the RREs during the claims handling process. Similarly, a RRE does not require a Medicare beneficiary's permission in order to conduct a good faith query of the individual's Medicare status. Per CMS, Medicare beneficiaries have, through regulation, consented to the release of this information for coordination of benefit purposes.

Resources:

- During the June teleconference CMS representatives encouraged any interested party to take the online computer based training course for the Section 111 Secondary Payer Program. These courses are free and can be taken by anyone at anytime. Signup is available via the CMS webpage www.cms.hhs.gov/MandatoryInsRep.

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