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## **CLIENT ALERT:** **MEDICARE'S SECTION 111** **MANDATORY REPORTING PROGRAM**

### **Overview**

Pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), beginning January 1, 2010, insurers and self-insured entities will be required to report claims made by Medicare-eligible claimants to the Centers for Medicare and Medicaid Services (CMS) and will be subject to a \$1,000 daily fine for late reporting. The same entities will be subject to double damages if they fail to satisfy Medicare's "lien"<sup>1</sup> when monies are paid to a claimant through settlement, judgment or otherwise.

By imposing this mandatory reporting requirement on Responsible Reporting Entities (RREs),<sup>2</sup> Medicare hopes to increase its ability to identify individuals who received Medicare payments and to recoup an estimated \$1.74 billion of benefits that RREs should have paid. While this practice has been required in workers' compensation matters for decades, its application to civil cases has dramatic implications. Counsel for self-insureds, insureds, and plaintiffs must remember that Medicare is a secondary payer for any medical care and has an absolute right to reimbursement from RREs that should have paid such expenses. These new requirements will complicate the consummation of settlements and present a possible risk of future liability against all parties, including counsel, if Medicare's lien is not satisfied.

### **The New Process**

As discussed below, the MMSEA imposes enhanced and expanded reporting obligations on insurers and self-insureds, not new ones. The new reporting obligations consist of three new steps.

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The first step is **registration** which includes account setup and training. Every RRE must register with CMS via the Coordination of Benefits Contractor Secure Website (COBCSW), set up an account, identify authorized users and satisfactorily test the data exchange process before submitting production files. Registration runs from May 1, 2009 through September 30, 2009 and testing begins on January 1, 2010.<sup>3</sup>

After successful registration and training, RREs will undergo an **initial one-time only reporting** process. RREs will submit their initial files which will contain information for all liability insurance (including self-insurance), no fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award or other payment date is on or after January 1, 2010, and which meet or exceed the threshold reporting amounts.

The third step in the process is **quarterly reporting**. RREs will be assigned a quarterly file submission time-frame (a 7-day window) during which they are to submit files (*i.e.*, four one-week periods). These quarterly file submissions are to contain only new or changed claim information. Quarterly files must contain resubmission of any corrected records found in error on a previous submission. The Coordination of Benefits Contractor (COBC) processes the data in the RRE's input file and determines whether the submitted information identifies the injured party as a Medicare beneficiary. Other insurance information for Medicare beneficiaries derived from the input file is posted to other CMS databases by the COBC. This is then used by other Medicare contractors for claims processing to ensure Medicare pays secondary when appropriate and/or is passed to the CMS Medicare secondary payer recovery contractor for recovery efforts. When this processing is completed, the COBC electronically transmits a response file back to the RRE (generally within 45 days). The response file will include notice of any errors found, and other information and instructions for the RRE.

### ***Determining a Claimant's Medicare Status***

Until now, insurers and self-insurers wishing to comply with CMS policy were often at the mercy of a plaintiff or claimant for information concerning Medicare entitlement. Often, the only way that information was available to an insurer or self-insurer was through a signed consent form from the claimant. Anticipating the burden of the new reporting requirement, CMS has developed a "query process" whereby an RRE will be able to determine a claimant's Medicare status electronically—and without authorization—as long as an RRE has access to the claimant's name, date of birth, gender and Social Security Number. The query process will streamline compliance for insurers and self-insurers, and will arm the defense with Medicare entitlement information early in the claim process. There is no safe harbor for an RRE who submits erroneous information during the query process, even where the claimant purposely provided the RRE with false information regarding his or her identity.

### ***CMS' Enforcement Rights***

Based on the law, primary payers must notify Medicare as of January 1, 2010 of claimants

who are entitled to Medicare benefits and have received or will receive payments from the primary payers. The information must be submitted “after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).” A failure to make a timely report can result in penalties, including a fine of \$1,000 for each day of noncompliance. There is no cap on the fine. Not all claims must be reported. CMS has created certain thresholds for certain time periods.<sup>4</sup>

Medicare has a direct right of action and a subrogation right for its conditional payments against *any* party, including a primary payer that has already paid a plaintiff or a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received a primary payment. Medicare’s right to reimbursement does not accrue until a plaintiff or claimant receives money in a liability case. If reimbursement is not forthcoming, CMS has several methods of recovery at its disposal including: (a) an offset of the amount of its reimbursement against any monies it owes to an RRE; (b) double damages; (c) a subrogation right; (d) a right of intervention in any action related to the events giving rise to the need for Medicare; and (e) an offset of the amount of its reimbursement against the claimant’s social security benefits.

### ***Future Medicals & Medicare Set Asides (MSAs)***

While Medicare has a right of recovery for past medical bills up to the date of the settlement, Medicare is opposed to any settlement that results in a contrived shift of a claimant’s *future medical care* to Medicare. In other words, CMS is not bound by an allocation for future medicals made by the parties in a settlement agreement. The solution to the problem of burden-shifting is to establish a Medicare Set-Aside Arrangement (MSA), which is designed to pay all the medical costs of the claimant’s injury over the remaining lifetime of the injured claimant. While historically they have applied to workers’ compensation settlements, they have not traditionally been used for liability settlements. While there are currently no rules or regulations to guide MSAs in the liability setting, the prudent course is to follow the rules in workers’ compensation cases.

### ***The Impact on Litigation***

Given the new reporting requirements, discovery in liability litigation must be tailored to obtain key information from plaintiffs including: (a) whether the plaintiff is a Medicare beneficiary; (b) whether the claimant is eligible for Medicare benefits; (c) whether the claimant has ever received Medicare benefits; and (d) the claimant’s Social Security Number,<sup>5</sup> full name (including use of other names and aliases), Medicare Health Insurance Claim Number (HICN) (if one exists), date of birth, gender, date of incident, and description of incident. Requests for production should seek a copy of the plaintiff’s Social Security Card and Medicare Beneficiary Card. As with any litigation discovery, you should try to ascertain early what the potential damages are from a medical standpoint in order to start thinking about resolution, especially if Medicare is involved.

Likewise, both pre-trial and post-trial procedures must be tailored toward the new law. For example, verdict forms should apportion the amount of the award between medical benefits (future and past) and non-medical benefits (*e.g.*, lost wages). Because judgment proceeds cannot be

released until Medicare notifies the parties of its right of reimbursement, defendants should carefully consider using interpleader to deposit the funds into the court's registry since they have twenty (20) days to pay under Florida law.

The new reporting requirements and Medicare's broad right to enforce its right to reimbursement will require RREs to protect themselves from liability to Medicare if the claimant does not reimburse Medicare. Some tools suggested by practitioners include: (a) using multi-party settlement drafts which require the Medicare beneficiary, private payees, and Medicare to endorse the check; this should be negotiated as a condition of settlement since it may substantially delay the plaintiff from receiving any money given Medicare's processing time; (b) issuing multiple checks—a multi-party check to cover the anticipated Medicare recovery amount and another one to the beneficiary and his or her representative; (c) issuing a separate check to Medicare; and (d) demanding that claimant agree to hold harmless and indemnify the RRE for any Medicare liens as well as escrow the settlement funds until Medicare's lien has been satisfied (this may only insulate the RRE from the single damages not the double damages that can be recovered by Medicare).

### ***Conclusion***

Section 111 of the MMSEA will present new challenges to liability insurers and their counsel. However, by being proactive and creating a uniform set of guidelines and procedures to govern cases involving Medicare eligible individuals, they can overcome these challenges.

## ENDNOTES

1. Technically speaking, Medicare's interest is not a "lien." Medicare's right is superior to a lien and the courts have recognized that Medicare's right to reimbursement is paramount to any other claim.
2. RREs are any organization that funds and pays, in whole or in part, a settlement, judgment, award or other payment to a Medicare beneficiary. An entity is not considered an RRE simply because it reimburses another entity that has paid a settlement, judgment, award or other payment on its behalf, unless that reimbursement is to a third-party administrator or results from a private settlement agreement. When deductibles are involved, who the RRE is will depend on whether the claim is resolved within or in excess of the deductible.
3. CMS has released the following timeline for liability insurers which includes self-insurers, no fault insurers and workers' compensation carriers:  
  
05/01/2009 - 09/30/2009 Electronic registration via the COBCSW for all liability insurance RREs.  
  
07/01/2009 Test and production query functions will be available for those RREs who have completed registration and are in testing status.  
  
01/01/2010 - 03/31/2010 Claim Input File testing period for all liability insurance RREs.  
  
04/01/2010 - 06/30/2010 All liability insurance RREs submit their first Section 111 production Claim Input Files based upon a predetermined schedule with the Coordination of Benefits Contractor (COBC).  
  
07/01/2010 All liability insurance RREs will be submitting their Section 111 production Claim Input Files.
4. From January 1, 2010 through December 31, 2011, claims where the Total Payment Obligation to Claimant (TPOC) is over \$5,000 must be reported. From January 1, 2012 through December 31, 2012, claims where the TPOC is over \$2,000 must be reported. From January 1, 2013 through December 31, 2013, claims where the TPOC is over \$600 must be reported. After January 1, 2014, all amounts will be reportable.  
  
TPOC refers to the dollar amount of a settlement, judgment, award or other payment obligation—generally a “one-time” or “lump sum” payment—to or on behalf of the injured party, separate and apart from ORM. ORM or “Ongoing Responsibility for Medicals” refers to the RRE's responsibility to pay, on an ongoing basis, for the injured party's medicals associated with the claim. This typically only applies to no-fault and workers' compensation claims.
5. The Social Security Number or Health Insurance Claim Number is essential to the administration of the Medicare program. Collection of the SSNs for the purposes of coordinating benefits with Medicare is a required, legitimate and necessary use of the SSN under Federal Law and is thus permitted by HIPAA. CMS also takes the position that the Section 111 program takes precedence over any conflicting state law that would otherwise purport to limit when SSNs can be collected and used. Furthermore, CMS maintains that the query process and exchange of information for Section 111 purposes does not require the claimant's signed release or authorization.