
“Mandatory Insurer Reporting – Are You Ready?”



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Introduction

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- Mandatory Insurer Reporting (MIR) has turned into a very complex topic
 - The following information is intended as a starting point
 - There are no answers for many of the questions that have arisen or which will continue to arise as the law is implemented
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Introduction

- To fully appreciate the background and impact of Mandatory Insurer Reporting the information must be placed into the context of the Medicare As Secondary Payer Act (MSPA)
 - Since 1980 federal law has mandated that Medicare's liability must be considered secondary to the liability of virtually every other medical payer
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Introduction

- Although it was not enforced until 2001, and then only in workers' compensation cases, it applies equally to all types of liability claims and to group health plans
 - The acknowledgment of the law in the context of liability cases usually only involved dealing with Medicare "liens" but rarely involved any efforts to protect Medicare's future interests
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Introduction

- MSPA creates both an obligation to reimburse Medicare for those payments that have already been made and
 - May require a primarily liable payer to protect Medicare's future interests through the vehicle of a Medicare Set-Aside trust (MSA)
 - Failure to comply carries penalties for both the employer or insurer (double damages, fees) and for the claimant (loss of Medicare benefits)
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Introduction

- The Centers For Medicare & Medicaid Services (CMS) is a division of the Department of Health & Human Services (HHS)
 - Medicare acts, for the purpose of MSPA compliance, through CMS
 - And CMS through a series of Coordination of Benefits Contractors (COB's)
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Introduction

- The right to reimbursement is beyond a lien but is instead an independent right of recovery that can be pursued against any party or even a party's attorney
 - The Medicare Secondary Payer Recovery Contractor (MSPRC) handles the collection of conditional payments
 - Other COB's handle other CMS functions such as reviewing MSA allocation proposals
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Introduction

- CMS uses "claimant" to refer to the injured party whether they are identified as a claimant, plaintiff, petitioner or otherwise under state or other federal law
 - There are instances though where the claimant is not the injured party (such as in wrongful death or other survivor actions)
 - Other definitions that CMS uses may not be consistent with those used by industry
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Introduction

- In particular, CMS' definition of "self-insurance" is broader than is generally used in the business community
 - Even the reference to "insurer" or "insurance" is problematic since the process applies in the absence of traditional insurance coverage
 - The basic concept is who carries the risk
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Introduction

- Not everyone is, or will become, Medicare eligible
 - Medicare is only available to those who are 65 or older and who are eligible for retirement benefits (SSR) upon attaining their regular retirement age (RRA) or
 - Who are on Social Security Disability Insurance (SSDI)
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Introduction

- The tests for SSDI eligibility are the same as those for SSR except that eligibility is predicated on disability
- The benefit for indigents is Supplemental Security Income (SSI) which carries with it Medicaid eligibility (in MO, now know as MO HealthNet)
- The MSPA does not apply to Medicaid but be wary of Medicaid liens under state law

Introduction

- Approach these laws with several truths always in mind:
 - It is not about the retirement or disability payments but about the Medicare coverage that will eventually be extended
 - If Medicare is not potentially liable to pay benefits, they could care less about the claim
 - It involves an administrative process in which CMS makes all of the rules and appears to have all of the power

MMSEA of 2007

- The Medicare, Medicaid and SCHIP Extension Act of 2007
- It is an adjunct to the MSPA
- It DOES NOT change any of the existing reporting requirements under MSPA
- It is intended though to increase compliance with MSPA
- The process is now generally referred to as “Section 111 Reporting” or “MIR”

MMSEA of 2007

- Mandatory insurer reporting is intended to guarantee compliance with MSPA by requiring the reporting, to CMS, of any “payment” made to or on behalf of a Medicare beneficiary including the assumption or termination of liability
- For the purpose of facilitating CMS’ collection efforts and the coordination of benefits generally

MMSEA of 2007

- Virtually every entity that may be called upon to make a payment for a personal injury or disease will have the requirement to register and report
 - Applies equally to public and private entities
 - Claims are excluded if they don't involve personal injury (property damage only, employment discrimination, etc.)
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MMSEA of 2007

- The penalty for failure to report is \$1,000 per day per claimant
 - The penalty is additive to those provided for under the MSPA proper
 - In workers' compensation cases, it is less of a threat than a major nuisance
 - In all other cases it raises the concern of having to comply with MSPA in all types of liability cases
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MMSEA of 2007

- It covers “applicable plans” defined as liability insurance (including self-insurance), no-fault insurance and workers’ compensation plans
 - “Liability” includes homeowners, auto, products liability, medical malpractice, uninsured and underinsured motorists insurance
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MMSEA of 2007

- Applies to all types of self-insurance
 - Applies to both state and federal workers’ compensation plans
 - The term “plan” is being interpreted to encompass all conceivable types of personal injury and workers’ compensation claims
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MMSEA of 2007

- The obligation to report has NOTHING TO DO with a payer's possible obligations under MSPA
 - The reporting requirements are driven by the claimant's Medicare status at given points in time
 - The Responsible Reporting Entity (RRE) is the entity which is liable to pay medical benefits to or for the injured party
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MMSEA of 2007

- MMSEA actually states that the RRE must:
 - Determine if the claimant is entitled to Medicare benefits under the Social Security Act
 - If entitlement is found, to report certain required information to the Secretary (of HHS)
 - To be reported in the manner, and within the time frame, that the Secretary has specified
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Compliance = Four Step Process

- RRE Registration
 - RRE Testing Period
 - RRE Live Reporting
 - RRE Query Function Registration
 - Query function reporting is not the last step but should be done as early as possible so queries can be made as needed on current claims
 - RRE registration is a prerequisite to registering for and using the Query Function
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Compliance Timeline

- All RRE's must be registered by 9/30/2009
 - The testing period has now been extended to 3/31/2010
 - Live reporting can begin 4/1/2010
 - All RRE's must be in full live reporting mode by 7/1/2010
 - Note: no report can be filed until registration has been completed and the RRE has "passed" the testing
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Registration

- Four possible entities either must be, or can be, involved in the registration and reporting process
 - Authorized Representative (live person, must have the ability to legally bind the RRE, can not report, has ultimate accountability - required)
 - Account Manager (live person, will interact with their counterpart at CMS, has primary reporting responsibility, can be an Agent - required)
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Registration

- Account Designee (designated by the Account Manger, must be assigned an I.D.#, can be a designee for more than one RRE, can be an Agent – optional)
 - RRE Agent (can not register for the RRE, can be a TPA or other vendor, can be an Agent for more than one RRE under separate ID's, is never the RRE and appointing an Agent does not transfer compliance responsibility to the Agent – optional)
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Registration

- All steps in the process, from registration through live reporting, involve electronic data exchange
 - All takes place over the Coordinator Of Benefits Secure Website (COBSW)
 - All information exchange is between the RRE and a COBC that CMS has dedicated to MMSEA
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Registration

- Most frequently issue encountered initially is that of identifying the correct RRE
 - CMS has published guidelines that address this issue but they are not all encompassing
 - Options may exist within an organization to register as a single RRE or multiple RRE's where there are subsidiaries
 - Identifying the correct RRE is particularly difficult in deductible situations
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Query Function

- Created to allow RRE's to determine the claimant's Medicare status
 - Not often an issue in a workers' compensation context
 - The claimant's S. S. N. is always known
 - A claimant will seldom, if every, attempt to protect or hide status information
 - Claimants understand that this determination is an integral part of the settlement process
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Query Function

- In liability situations though, even obtaining the claimant's S. S. N. can be a challenge
 - Requires claimant's S. S. N. or H. I. C. N., the first letter of the first name, the first 6 letters of the last name, DOB and gender
 - Exact match on S. S. N. or H. I. C. N. is required then matches on 3 of the 4 other data elements
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Query Function

- Once the necessary information is collected, the query can be submitted but
 - The response is only as good as the information inputted is accurate
 - An initial negative response will not protect you if the claimant qualifies for Medicare later
 - Thus, repeated queries may have to be made
 - A query can only be made once per calendar month per RRE I. D. # and CMS will respond within 14 days
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Reporting

- The purpose of reporting is to alert CMS that claims payments are being made, or have been made, to a Medicare beneficiary
 - The “Reasonable Expectation” rules under MSPA do not apply
 - The “let’s report everything” approach will not be tolerated by CMS, they will reject any report if they cannot confirm that the claimant is a Medicare beneficiary
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Reporting

- MMSEA requires that RRE's implement a procedure within their claims handling process directed at determining if an injured party is a Medicare beneficiary
- However, CMS has granted a limited reporting extension where the claim pre-existed the implementation of the Act but will involve reporting post-implementation

Reporting

- Two categories of payments or events have been created or identified by CMS:
 - Total Payment Obligation To Claimant (TPOC)
 - Ongoing Responsibility For Medical (ORM)
 - TPOC's are usually settlements or other payments that terminate an RRE's obligation to pay medical but may also be interim payments
 - Independent medical evaluations (IME's) are not ORM's

Reporting

- ORM's are either actual payments or simply the act of determining that ongoing medical liability is being accepted
 - Lost time payments that under state law cannot include payments for medical are not ORM's but can be TPOC's
 - CMS assumes that ORM's are only made in workers' compensation or no-fault cases but that does not mean they can not exist in other claims
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Reporting

- CMS has decided that TPOC's do not have to be reported unless they take place on or after January 1, 2010
 - ORM's however must be reported if the payment was made, or action taken, on or after July 1, 2009
 - Once ORM is initially reported each successive payment does not have to be reported
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Reporting

- Monetary TPOC payment thresholds have now been established but they are quite modest:
 - \$0-\$5,000 7/1/2009 through 12/31/2010
 - \$0-\$2,000 1/1/2011 through 12/31/2011
 - \$0-\$600 1/1/2012 through 12/31/2012
 - They are cumulative
 - A special \$750 minimum applies only to workers' compensation "medical only" cases
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Reporting

- The workers' compensation "medical only" exception applies only if:
 - The payments are medical payments
 - All payments are made directly to a medical provider and do not exceed \$750 in total
 - Lost time not to exceed 7 days (but the payment of any lost time benefits nullifies the exception)
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Reporting

- The term “payment” is loosely defined
 - Included both a payment or an act that initiates or terminates the RRE’s ORM
 - Any payment, no matter how characterized or constituted, that closes out the RRE’s medical liability is reportable
 - ORM’s can follow TPOC payments if there is ongoing liability for medical post settlement, award or judgement
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Reporting

- Even if a settlement, award or judgment is only intended to cover non-medical damages, it is reportable if it has the effect of terminating the RRE’s medical liability
 - Understanding the TPOC and ORM concepts and their practical applications is in and off itself a daunting task
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Reporting

- To illustrate, is a write-off, write-down or adjustment a payment for reporting purposes
 - CMS's current position is that these are reportable but that determination is under review
 - Reporting will be on a quarterly basis
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Reporting

- Every RRE will be placed in a group numbered from 1 through 12
 - The number refers to 1 week of the 12 calendar weeks in each quarter
 - Reporting must take place within that designated week
 - The initial report will have to collect all data back to when compliance began
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Reporting

- Note the following special rules:
 - The claim need not be reported if the claim was actually closed or removed from the RRE's active claims records prior to 1/1/2009
 - ORM can be reported as terminated if a signed statement from the treating M. D. states that here is no need for ongoing treatment even in life-time medical states but the file may be subject to re-opening for further reporting if additional treatment is required

What Does This Mean To Me?

- Assume that any claimant who is 65 years of age or older is a Medicare beneficiary
- Assume that any claimant who is on SSDI is a Medicare beneficiary
- Recognize that if the claimant has end-stage renal disease (ERD) that they automatically qualify for Medicare

What Does This Mean To Me?

- In workers' compensation cases Section 111 reporting will mean:
 - More cases will need to be reported to CMS in anticipation that all conditional payments will come to light
 - Even greater attention will have to be paid to protecting Medicare's future interests
 - Investigating a claimant's Medicare status must be done as early as feasible
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What Does This Mean To Me?

- Determining a claimant's Medicare status must take place in the context of the quarterly reporting requirements
 - Late reporting is by far preferable to not reporting at all.
 - Penalties will likely focus, at least initially, on complete non-compliance
 - CMS has stated that they are most interested in data collection not imposing fines - but don't bet on it
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What Does This Mean To Me?

- In liability cases, the implications are staggering:
 - How do I collect the minimum information necessary just to use the Query Function
 - Is it still feasible to use interim payments or write-offs as a tool to discourage litigation if they will trigger responsibility to report
 - What effect could the reporting requirement have on setting medical reserves
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What Does This Mean To Me?

- How do I close a file with a future medical issue without getting clearance from CMS
 - Will CMS entertain a proactive approach such as submitting a liability MSA proposal
 - Conversely, in liability will this reporting process evolve into a MSPA compliance program similar to that which applies to workers' compensation cases
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What Does This Mean To Me?

- In settlement, should I now allocate for future medical to protect myself in case CMS demands a MSA at some point in the future
 - Knowing that CMS takes the position that they are not bound by an allocation made between the parties, what good will an allocation do!
 - Will a court approved allocation carry any weight with CMS
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What Does This Mean To Me?

- Will a judge's or jury's allocation of damages or fault be necessary to protect me in the future
 - How will this effect settlement negotiations, particularly with respect to future medical issues
 - Will settlement documents need to be changed in light of Section 111 reporting and the threat of future action by CMS
 - Can I enlist a court's aid in compelling a claimant to assist in compliance
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What Does This Mean To Me?

- It seems certain though that ignoring Medicare in the claims handling process, in workers' compensation cases and now in liability cases, is unwise
 - Medicare will always assume that if you ignore them that you did so intentionally and for the purpose of either defeating their right of recovery or in order to avoid having to protect Medicare's future interests
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Additional Questions and Issues

- The following is a non-exhaustive list of questions and issues that quickly come to mind now that MIR is in place
 - Many, perhaps most, of these have not yet been answered or even addressed by CMS
 - CMS, for instance, has not even promulgated reporting policies applicable to mass tort litigation
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Additional Questions and Issues

- Clearly, CMS does not have the prior experience to fathom the myriad issues that Section 111 reporting raises, particularly in the liability area
 - They are trying though to understand and adapt
 - It is not too late to address an issue to CMS through various means
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Additional Questions and Issues

- What if I settle closing medical?
 - What if I settle and leave future medical open?
 - What if the claim is tried and future medical is either awarded or denied?
 - When can CMS' record and my file be closed?
 - Is there any way that I can protect myself against a later discovered Medicare "lien"?
 - How are structured settlements reported?
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Additional Questions and Issues

- The International Classification of Diseases, 9th Revision codes (ICD9's) drive the MSA allocation system
 - How can coding issues come back to haunt me
 - Codes are used to distinguish between injury related and pre-morbid, co-morbid or post-morbid conditions for Medicare “lien” purposes
 - Listing both diagnosis codes and causation codes (“E codes”) will be required

Additional Questions and Issues

- Can the codes be used, in essence, as an admission against my interests later
- CMS has clearly stated that detailed coding is required in order to facilitate their coordination of benefits activities
- This means that they want the information to use to deny medical benefits for certain injuries/conditions in pending claims

Conclusion

- MMSEA is here and cannot be ignored
- It is one more cost driver in the business of claims handling
- It requires vigilance on the part of all entities involved in the process
- It may not factor in to the majority of claims, but it certainly will in many

Caveat

- COMPLIANCE WITH MMSEA IS A WORK-IN-PROGRESS IN WHICH THE GROUND RULES HAVE CHANGED FREQUENTLY. THAT WILL CONTINUE TO HAPPEN. THUS, IT IS A CONTINUING EDUCATION PROCESS FOR ALL OF US.

Resources

- CMS's main website is www.cms.hhs.gov
 - The Section 111 website is www.cms.gov/MandatoryInsRep/
 - Sample links within that website are
 - “Overview’
 - “Group Health Plan (GHP)”
 - “Liability Insurance, Self-Insurance, No-Fault Insurance and Workers Compensation” (Non GHP)
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Resources

- “MMSEA 111 What’s New”
 - “Computer Based Training (CBT)”
 - “NGHP Transcripts”
 - A listing of past and future NGHP “Town Hall Conferences”
 - Frequent periodic updates
 - See particularly the 7/31/2009 Alert re: identifying RRE’s, deductible arrangements, excess insurance, bankruptcy, etc.
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Resources

- Of particular importance is the MMSEA User Guide that can be reviewed and printed as necessary
 - Version 2.0 is 225 pages
 - Has all things related to Section 111 reporting
 - Shows what form reporting will take
 - First version published on 3/16/2009 then updated on 7/31/2009
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Questions?

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