



Alert

Health Care and Life Sciences Practice

To: Our Clients and Friends

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Defendants in Civil Lawsuits and Their Insurers Must Report Medicare Beneficiary Information

Under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”), liability insurance including self-insurance, no-fault insurance, workers compensation, and group health plans (“Responsible Reporting Entities,” or “RREs”) must report the identities and certain other information of Medicare beneficiaries after a claim is resolved through a settlement, judgment, award, or other payment. The purpose of reporting these payments is coordination of benefits; that is, so that the Centers for Medicare and Medicaid Services (“CMS”), which administers the Medicare program, may ensure that Medicare does not pay for items and services that should be paid by other insurers. If an RRE fails to report as required, the entity may be required to repay any amounts CMS determines were improperly paid by Medicare on the beneficiary’s behalf, and may be subject to penalties as described below.

The changes included in MMSEA represent a significant shift in the government’s approach to payment recovery. Prior to MMSEA, laws known as “Medicare Secondary Payer” laws (“MSP”) required that Medicare be considered secondary to all other types of insurance that could be liable for payment. Health care providers were required to inform Medicare beneficiaries that services must be paid by their private insurance before Medicare could be obligated to pay, and Medicare beneficiaries, not insurers, were required to report payment information to CMS following a settlement or other payment. These laws remain in effect, and have, in the past, been applied to require providers to repay to CMS amounts improperly paid by Medicare when other insurance was available. The new reporting requirement will mean that RREs, like providers, can be liable for repayment to CMS for items and services improperly paid by Medicare, even if the RRE has already paid the Medicare beneficiary.

To comply with the new requirements, civil defendants and their insurers should (1) immediately determine if they are or could become RREs; (2) enroll in the reporting program; (3) track and report payments to Medicare beneficiaries on a schedule and using the methods established by CMS; and (4) reimburse Medicare for its payments to Medicare beneficiaries for injuries or medical expenses. RREs can register at <https://www.section111.cms.hhs.gov/MRA/Login.action>. Although a third-party administrator or agent can report to Medicare on an RRE’s behalf, RREs are solely accountable for reporting. Failure to comply with MMSEA could result in a civil penalty of \$1,000 for each day of noncompliance for each recipient.

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After Medicare receives notice of a judgment or settlement payment (whether or not liability is admitted), a Recovery Contractor will send a Formal Recovery Demand Letter asking the RRE to pay Medicare the amount of relevant benefits that Medicare paid to the beneficiary. Interest accrues from the date of the letter, but is waived if the RRE pays within the specified time. Failure to reimburse may subject the RRE to double damages and attorney's fees. RREs may be required to reimburse Medicare even if they have already paid the beneficiary. To avoid double payments, RREs should notify Medicare early in the settlement process and before releasing any settlement funds or paying damages awards.

What, When, and How to Report

RREs can no longer rely on a claimant's word to determine whether he or she is Medicare eligible. Medicare offers an electronic query system by which registered RREs can verify and re-verify Medicare eligibility using a Social Security Number or Medicare Health Insurance Claim Number. (Re-verifying Medicare eligibility is important. The duty to determine a claimant's eligibility continues until the date of settlement or judgment. If an RRE checks beneficiary status before a claimant becomes a beneficiary and fails to re-verify, the RRE could incur reporting and payment penalties.)

CMS categorizes payments as Ongoing Responsibility for Medicals ("ORM") and Total Payment Obligation to the Claimant ("TPOC"). Beginning July 1, 2009, ORM payments must be reported, regardless of their amount. Beginning January 1, 2010, all other settlements, judgments, awards, and other non-ongoing payments for personal injuries or medical expenses must be reported if they exceed \$5,000 in 2010, \$2,000 in 2011, \$600 in 2012. After 2012, all TOPC payments must be reported, regardless of the amount.

These rules are not set in stone. CMS has made several changes and anticipates more. Additional information, including a user guide and CMS updates for MMSEA and MSP requirements, can be found at <http://www.cms.hhs.gov/MandatoryInsRep/>.

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