New Medicare Reporting Requirements for Entities Paying Settlements or Judgments To Personal Injury Plaintiffs Who Are Medicare Beneficiaries

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Introduction

On October 1, 2010 Section 111 of the Medicare, Medicaid, and SCHIP\(^1\) Extension Act of 2007 (MMSEA) will become effective.\(^2\) Section 111 of the Act imposes new reporting requirements upon all entities that pay settlements or judgments to any personal injury plaintiff who is a Medicare beneficiary.\(^3\) The information collected through the reporting requirements will be used by the Centers for Medicare and Medicaid Services (CMS)\(^4\) to process claims billed to Medicare. It will also to be used to assist in the 1980 Medicare Secondary Payer statute (MSP) recovery program.\(^5\)

The new reporting requirements now place the attorney handling a personal injury matter in a new and unique position. Not only must the attorney serve as counsel to his client, but also as investigator to ensure that all statutory mandates are met. Failure on the party of the reporting party to provide all required information can result in civil penalties and damage claims.

Background

Medicare, established and signed into law on July 30, 1965 by President Lyndon B. Johnson, is a Federal program instituted to pay for certain health care for qualified enrolled individuals. Eligible individuals are those aged 65 and older, those with specified disabilities, and individuals with permanent kidney failure.\(^6\) Until 1980, Medicare was the primary payer in all cases involving its beneficiaries. The only exceptions were those cases involving workers’ compensation or care that was the responsibility of another government entity.

In the 1980s, Congress amended the Social Security Act to include the Medicare Secondary Payer Act (MSP)\(^7\) to help curb the out of control costs of the Medicare

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1 State Children’s Health Improvement Program.
2 42 U.S.C. §§ 1395y(b)(7) & (b)(8).
3 The dates for implementation of all requirements were delayed in an effort to allow the CMS to set in place the infrastructure needed to handle all reporting.
4 CMS is the referral agency that administers Medicare, Medicaid, and the Children’s Health Insurance program. CMS is a division of the United States Department of Health and Human Services. Medicare claims filed on behalf of beneficiaries who have received medical services, equipment or items are reviewed by and paid by CMS contractors, whether Part A “fiscal intermediaries” or Part B “carriers.”
5 MSP claims for reimbursement of conditional payments made by the Medicare program are handled by a single contractor known as the Medicare Secondary Payor Recovery Contractor (MSPRC).
7 42 U.S.C. § 1395y(b).
The MSP provisions required certain “primary plans,” including liability insurance, self-insurance, and no-fault insurance plans, to be the primary payer for items and services provided to Medicare beneficiaries. This left Medicare to provide benefits only as a “secondary payer.” The savings to the Medicare Trust Funds from the liability and no-fault insurance provisions alone is approximately $500 million per year, with an overall savings from all plans of about $6 billion per year.

The provisions utilized two methods to protect Medicare funds and to ensure that Medicare is the secondary payer. First, the provisions prohibit Medicare from making any payments for medical equipment or items and an estimated 40 services that are otherwise reimbursable by Medicare, if a payment has already been made or can reasonably be anticipated to be made by another source that has primary payer responsibility. Second, and conversely, the provisions authorize Medicare to make payments only if a primary plan has not made or cannot reasonably be expected to make payment promptly. This provision seeks to minimize any concerns over continuity of care issues that might present due to a delay in payment of medical bills. However, such payments must be reimbursed to the Medicare Trust Funds.

The MSP statute is clear that a primary plan, entities that make payment on behalf of a primary plan, and an entity that receives payment from a primary payer must reimburse Medicare for any such payments made for an item or service if it is shown that such primary payer has or had the responsibility to make payment for such item or service. The existence of a judgment or a payment conditioned upon a recipient’s compromise or release as to what is claimed or released for the primary plan is sufficient to demonstrate a responsibility to make such a payment. Medicare is to be reimbursed within 60 days of payment by the primary plan, and interest may be imposed if payment is not timely paid. Additionally, if a primary plan learns that Medicare has made a payment, it must then notify Medicare, describing the circumstances surrounding the payment, and repay Medicare. Failure to reimburse Medicare for conditional payments made on behalf of a beneficiary may result in one of three actions being taken by the United States. First, the payments may be recovered “by direct collection or by offset against any monies [it] owes the entity responsible for refunding the conditional payment.” Second, the United States “may bring an action against any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service . . . under a primary plan.” Under this provision, the United States may sue the primary payer for

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9 Primary plans are defined at 42 U.S.C. § 1395y(b)(2)(A). See also 42 C.F.R. §411.21.
10 Id.
13 Id.
15 See 42 C.F.R. §§ 411.25, 411.22.
16 42 C.F.R. § 411.24(d).
double damages.\textsuperscript{18} Lastly, the United States may bring a direct action against “any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.”\textsuperscript{19} An entity is described as including a “beneficiary, provider, supplier, physician, attorney, State agency or private insurer.”\textsuperscript{20} “The United States shall also be subrogated . . . to any right under this subsection of an individual or any other entity to payment with respect to such item or services under a primary plan.”\textsuperscript{21}

Most courts that have interpreted the MSP have held that its provisions applied only to insurers, not to tortfeasors who paid claimants directly.\textsuperscript{22} However, the government has continued to rely on an interpretation of the MSP as including tortfeasors who settle with injured plaintiffs. The United States Court of Appeals for the Fifth Circuit indicated that “every court that has heard its arguments on this issue . . . has rejected the government’s expansive interpretation of the MSP statute.”\textsuperscript{23}

As a result of the continued disconnect between the interpretations, Congress amended the MSP in 2003 to expand the definition of the term “self-insured plan.” The new definition included any “entity that engages in a business, trade, or profession . . . if it carries its own risk in whole or in part.”\textsuperscript{24} Medicare interprets the amendments to the MSP to establish that “individuals/entities engaged in a business, trade, or profession are self-insured to the extent they have not purchased liability insurance coverage,” which “includes responsibility for deductibles.”\textsuperscript{25} Therefore, any business or entity that either pays a settlement or judgment to a tort claimant or pays a deductible toward the defense of a claim is self-insured under the MSP and is subject to its requirements. Further, any entity subject to the provision above is now subject to Section 111 of the MMSEA and must register as a “responsible reporting entity (RRE) in order to provide the required information to CMS.”\textsuperscript{26} This includes liability insurance programs, worker’s compensation

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\textsuperscript{18} Id.
\textsuperscript{19} 42 U.S.C. § 1396y(b)(2)(B)(iii).
\textsuperscript{20} 42 C.F.R. § 411.24(g).
\textsuperscript{21} 42 U.S.C. § 1395y(b)(2)(B); See also 42 C.F.R. § 411.24(a). (It is noted that the Medicare regulations also empower Medicare to “join or intervene in any action related to the events that gave rise to the need for services for which Medicare is paid.” 42 C.F.R. § 411.24(b). Most of the underlying tort litigation takes place in state courts and since such courts lack jurisdiction over the Medicare program, CMS does not normally intervene in such actions. See Hoste v. Shanty Creek Mgmt., Inc., 246 F. Supp. 2d 784, 788-89 (W.D. Mich. 2002); Mitchell v. Health Care Serv. Corp., 633 F. Supp. 948, 949 (N.D. Ill. 1986)).
\textsuperscript{23} Thompson, 337 F.3d at 494.
\textsuperscript{24} 42 U.S.C. § 1395y(b)(2)(A).
\textsuperscript{26} Id. at 19.
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programs, self insurance programs, group health programs, and no-fault insurance programs. This would also include captive insurance programs, risk retention groups, and other entities that may be or become responsible under MMSEA for a primary payment made to an injured patient.

Each RRE must maintain specific data related to the beneficiary, including patient name, Social Security Number, gender, date of birth, litigation information, and injury information. Additionally, each RRE must register with a coordination of benefits contractor (COBC). As new information becomes available the RRE is responsible for reporting such. Regardless of how a settlement is structured between a patient and the insurance entity, the RRE is responsible for reporting the same to CMS through the COBC. The CMS then uses the information to verify payments that may have been made prior to the settlement and ensure that repayment is made.27

As noted, prior to the enactment of the MMSEA, the government had the right to collect amounts it paid for medical expenses if those amounts should have been paid by a primary plan. In the event the government prevailed in such a lawsuit, it could collect double damages against the defendant. However, the MMSEA provides penalties. Any entity that fails to comply with reporting requirements “shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted.”28

Implication for Attorneys

Attorneys are not RREs and have no direct responsibility for reporting to the CMS. Likewise, personal injury attorneys representing Medicare beneficiaries have no fiduciary relationship with Medicare. However, any attorney representing RREs or a client with a legal obligation to reimburse Medicare has a legal obligation to ensure that Medicare is reimbursed for conditional payments subject of a recovery by the beneficiary. In order to obtain the information needed and protect the interests of the RRE and beneficiary, as well as their own, there are several steps that attorneys should perform in any case involving a plaintiff alleging any bodily injury:

Plaintiff counsel:

1. When representing a Medicare beneficiary, counsel should immediately contact the COBC and provide the beneficiary’s name, sex, date of birth, Social Security Number or Medicare Health Insurance Claim Number, date of incident, and a description of the incident.

2. After review of the information by the MSPRC, counsel should access the interim conditional payment information and communicate the same to the client.

3. Upon a settlement, judgment or award of the matter, counsel should notify in writing the MSPRC, including the date of such agreement or otherwise, amount recovered, any attorney’s fees or other procurement costs associated with same. A copy of the executed settlement, judgment or award should also be forwarded.

4. Upon receipt of a demand letter from the MSPRC, counsel should review with the client and submit an appeal or request a compromise if desired.

Defense counsel:

1. At the initiation of a suit, counsel should contact the RRE to determine if it has promulgated any forms to be completed related to the information to be obtained.

2. In the discovery phase of any case, the attorney should obtain all basic information pertaining to a plaintiff. Additionally, written discovery should include inquiries as to whether or not a plaintiff is a Medicare beneficiary, including the individual’s Social Security Number and Medicare health claim insurance number if there is one. This should be obtained as early in the litigation as possible and updated as applicable. The information as provided by the plaintiff should be verified or certified.

3. All information should be reaffirmed or reviewed in the deposition phase of litigation.

4. Upon payment of a settlement or judgment in a case, include language listed under Section IX, Representations and Warranties, Subsection 9 to release the defendant in a matter from all Medicare/Medicaid liens. In a case where the beneficiary fails to reimburse Medicare, if the settlement does not expressly release the defendant, CMS may seek reimbursement from the defendant or its insurer, even though it has already paid the beneficiary and even if liability is expressly denied.

Conclusion

It has long been felt that Medicare/Medicaid could not continue to sustain paying the amounts of money paid out in previous years to beneficiaries and expect to continue to survive. Section 111 of the MMSEA provides some relief in that it allows a recoupment by the agency of monies from those individuals who receive a settlement or judgment for an injury for which Medicaid/Medicare has already paid and/or will likely continue to pay benefits for the same. However, the obligation of all responsible reporting entities to obtain and report accurate information regarding these individuals also places a huge responsibility on counsel, whether defense or plaintiff oriented in a claim or suit. As such, all counsel involved in these matters must now formulate a system for gathering and reporting the information in order to avoid liability claims against themselves and
possible penalties. While great in theory and possible reimbursements to Medicaid/Medicare, this is just one more step in the lawyer’s paper chase. Good luck to us all.

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