

Treatment Plan for the Unwary Our Patient: A Medical Group

By Glenn Simpson and Paul Masterson

Although the federal government has enacted legislation that will cause significant heartburn for many physicians, group practices, outpatient centers and other health-care providers that might settle a liability claim asserted by a Medicare beneficiary, it can be argued that perhaps a majority of those impacted are unwary of the impending *sequelae*. Examining the following record will shed light on the new reporting requirements.

Our hypothetical patient is a medical group that is insured for professional liability and is responsible for a self-insured retention of \$50,000, and estimates that it would have two to five reportable transactions per year. Our mythical patient, however, could be found in multiple other situations indeed.

CHIEF COMPLAINT/REASON FOR VISIT

Patient presents with potential exposure to financial liability for failure to comply with reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007.

HISTORY AND PHYSICAL

Medicare estimates that over \$43 billion was paid for medical expenses on behalf of beneficiaries in situations in which Medicare should have been considered to be a secondary payer. Medicare has been designated as a secondary payer in workers' compensation since the inception of the act in 1965, and since 1980 in claims involving payments in liability cases.

The purpose of the recent legislation is to enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. To assist with accomplishing this purpose, Section 111 adds mandatory reporting requirements for Medicare benefi-

ciaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. The reporting requirements apply to applicable plans that are broadly defined as follows:

- Any organization that is directly responsible for the payment of any claim (including write-offs) that involves a Medicare beneficiary. This includes claims of any type including professional/general liability, workers compensation, automobile, et al. "Direct responsibility" includes organizations that are insured yet have retentions that impose direct financial responsibility

Section 111 adds mandatory reporting requirements for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance.

on the organization.

The patient believes that this definition applies and thus the group is a Responsible Reporting Entity (RRE).

EXAMINATION

An examination of the entity indicates that its self-insured status might lead ultimately to resolution of a liability claim pertaining to a Medicare beneficiary, under the auspices of that program. It does not appear that the entity is fully insured via a carrier program. Were that the case, and absent considerations of self-insured retentions or deductibles, the carrier would likely be considered the RRE with the attendant report-

ing obligations. Further examination identifies several proactive goodwill gestures involving adjustments or write-offs of bills that are considered reportable events.

DIAGNOSIS

The patient is found to have heartburn caused by MMSEA, MSP, RRE, TPOC, COBC, ORM, COBCSW and the complexities of the law.

TREATMENT PLAN

- Advised patient that penalty for non-compliance is \$1,000 per day per claim.
- Patient will consult counsel or compliance officer to determine applicability.
- Patient will register with Coordination of Benefits Contractor (COBC) if RRE status confirmed.
 - Patient will design and implement data interface with COBC to commence testing process on Jan. 1, 2010.
 - Patient will complete testing and be approved for submission of live data on reportable claims.
 - Patient will prepare and submit reports on applicable claims on which a payment was made on or after Jan. 1, 2010 with appropriate header and trailer records on quarterly submission window established by COBC.
- Patient advised that compliance will require substantive analysis of elements of reportable claim and is not solely transmission or transposition of data.
- Patient advised regarding option to retain MMSEA Agent with substantive and procedural infrastructure already in place.
- Patient advised of increased risk of non-compliance caused by few reportable claims and general lack of understanding of law.

Glenn Simpson and Paul Masterson are principals with MGU Specialty Risk Services, an agent for RREs; www.MGUspecialtyriskservices.com