



COORDINATION OF MEDICARE SET ASIDE ARRANGEMENTS AND MMSEA SECTION 111 REPORTS

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Introduction

Medicare's Secondary Payer Statute (42 U.S.C. §1395y) has existed in some form since the inception of the Medicare program in 1965. While the statute has been amended several times since then, the most significant amendments occurred in 1980, when the list of primary payers was expanded from workers' compensation only to also include liability, automobile and no-fault insurance; and in 2007, when the Medicare, Medicaid, & SCHIP Extension Act of 2007 (MMSEA) imposed significant reporting requirements on workers' compensation, liability and no-fault plans (including self-insured plans).

The 1980 revisions have, themselves, undergone changes over the years, but the following provision of the Medicare Secondary Payer statute has been in existence in substantially the same form since December, 1980:

Payment under [Medicare] may not be made . . . with respect to any item or service to the extent that . . .

(ii) payment has been made or can reasonably be expected to be made under a *workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.*¹

¹ 42 U.S.C. §1395y(b)(2)(A)(ii) (emphasis added).

CMS interprets this language as providing that *any* settlement that closes out future medical expenses in a claim against a primary payer represents a situation in which "payment has been made" for an item or service otherwise covered by Medicare, precluding future Medicare coverage for those items or services until the payment has been exhausted on future medical expenses related to the injury. This provision of the Secondary Payer Statute gave rise to the use of first Medicare Set-Aside Arrangement (MSA) in a workers' compensation settlement in 1995. This same provision also forms the basis for statements from several representatives of CMS over the past four years that Medicare's interests as secondary payer must be reasonably considered in liability settlements, just as they must be in workers' compensation settlements. As a result, the use of MSAs in liability settlements is becoming more and more common.

The 2007 amendment to the Secondary Payer Statute, contained in Section 111 of the MMSEA, adds 42 U.S.C. §1395y(b)(8), which imposes strict information reporting requirements on liability insurance plans, no-fault insurance plans and worker's compensation plans, (including self-insurance), referred to collectively by the Centers for Medicare and Medicaid Services ("CMS") as "Required Reporting Entities" or "RREs".

According to MMSEA Section 111, RREs have the responsibility to:

1. determine whether a plaintiff/claimant is entitled to Medicare benefits on any basis; and
2. upon settlement of a Medicare beneficiary's claim, submit all information required by CMS with respect to the claimant to CMS.

While MMSEA Section 111 became effective on July 1, 2009, actual reporting under MMSEA Section 111 has been delayed until April 1, 2010 with regard to claims involving existing Medicare beneficiaries where there is a settlement, judgment or award on or after January 1, 2010.

At that time, RREs will be required to submit required information on a quarterly basis. Penalties for non-compliance are stiff: \$1,000 per claimant for each day that the RRE is out of compliance. This penalty is in addition to any Medicare Secondary Payer claim for which the plan, as primary payer, may be liable.

The information that RREs will be required to submit is strikingly similar to the information currently required for submission and CMS review of MSAs in connection with WC

settlements.² This is a fairly clear indication that CMS intends to gather information to identify situations in which Medicare is secondary payer and ensure that Medicare's interests as secondary payer are reasonably considered in *WC and* liability settlements.

As a result, RREs are already instituting internal procedures for compliance with the new reporting laws, including procedures for determining the Medicare status of every claimant; collecting identifying information on all claimants when their claims are opened; and complying with the actual reporting requirements for claims that settle.³ RREs are also taking steps to ensure that, as primary payers, they reasonably consider Medicare's interests under the Secondary Payer Statute in any settlement involving a Medicare beneficiary.

A great deal of misinformation exists regarding the effects of MMSEA Section 111 on the use of MSAs in liability settlements. Some "experts" have stated that MMSEA Section 111 requires MSAs in liability settlements, effective July 1, 2009. Others have stated that MMSEA Section 111 says nothing about MSAs in liability settlements and, therefore, MSAs are not needed in liability settlements. Both statements are incorrect. The Secondary Payer provisions that give rise to the use of MSAs in liability and workers' compensation settlements have existed for over twenty-eight years. The new Secondary Payer provisions in Section 111 of the MMSEA provide a powerful tool by which CMS can now better enforce its existing rights as secondary payer.

Coordination of MSAs with MMSEA Reporting

Medicare Set-Aside Arrangements (MSA) and the new reporting requirements of Section 111 of the Medicare, Medicaid, & SCHIP Extension Act of 2007 (MMSEA) are important elements of the Medicare Secondary Payer Statute as the Centers for Medicare and Medicaid Services (CMS) endeavors to achieve the long-term financial viability of the Medicare system. The utilization of MSAs has been required for quite some time in Workers' Compensation claims. Although the Section 111 reporting provisions do not require use of MSAs in the liability setting, it is recommended by the authors that regular implementation of MSAs be adopted in

² Details regarding the particular information required from RREs can be found in CMS' "NGHP User's Guide" and updates, available on CMS' web site:
http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage

³ Additional information is available through CMS' Mandatory Insurer Reporting web site:
<http://www.cms.hhs.gov/MandatoryInsRep>

the case resolution process immediately in order to be certain that it can be demonstrated that reasonable efforts were made to protect Medicare's interests in a settlement. Further, we certainly can anticipate that at some point, MSAs will indeed be required in the liability setting in any event. The intrinsic complexity of each function -MSA and Section 111- as well as the critical interrelationship between them, leads to a clear conclusion that coordination and consistency are important.

MSAs, of course, are the product of a meticulous review of the medical records by trained professionals who are then able to put the totality of the medical circumstances into context and thus to use that as the foundation for a well-reasoned, fair, and ultimately successful submission for approval to CMS. The primary goal of a proper MSA proposal to CMS is to limit the exposure of settlement proceeds to exhaustion on the plaintiff/claimant's future medical expenses. Thus, an MSA will segregate the projection for future, injury-related medical services and prescription drugs of the type covered by Medicare and use the projected costs for such items and services to arrive at a reasonable MSA funding amount. This information, with supporting documentation, is required for any CMS review of a proposed MSA.

Likewise, the prudent approach to fulfillment of Section 111 reporting protocols is to review substantively each of the variable data elements in order to accomplish accurate reporting and thus to diminish potential exposure to ancillary risk issues, separate and apart from the well-publicized Civil Penalties.

In each case, inadequate or inaccurate completion of an MSA and a Section 111 report can lead to a denial of benefits for a Medicare beneficiary and can lead to unwanted and perilous litigation. Since the information required for submission of an MSA for CMS approval is also required as part of the information in a Section 111 report, the necessity for the MSA documents to be consistent and parallel with the Section 111 report is self evident.

For example, one of the core elements required for submission of both an MSA and a Section 111 report is the description to CMS of the ICD-9 codes that are applicable to the beneficiary as a result of the injuries giving rise to the settled claim. Although it is possible to contemplate that the codes could differ, we would see that scenario as an extraordinarily rare and unique situation. Thus the overwhelming numbers of claims resolutions should have identical codes on the MSA submission and the Section 111 report. However, there is a logistical barrier that is created if the Responsible Reporting Entity (RRE) has failed to ensure coordination in the typical instance in which an MSA is produced by one entity and the Section 111 report is produced elsewhere, i.e., via internal resources or through the use of an Agent. This functional separation and absence of coordination can lead to obvious instances of inconsistent data being submitted to CMS on the same claim, the gravamen of which obviously arose from the identical set of circumstances.

This is particularly the case if a simple data transfer protocol has been adopted to fulfill Section 111 reporting. Mere data transfer, without substantive analysis of data elements (typical in Section 111 reporting services that are offered as ostensibly “free”), enhances the potential for a perfunctory download of superfluous and unnecessary ICD-9 codes. This heightens the risk and exposure. Taken together, the absence of coordination is a pathway to a predictable, negative outcome for the beneficiary and thus it has risk exposure for the RRE.

If the data submitted to CMS in connection with an MSA proposal with respect to a particular claim differs from the data submitted to CMS by the RRE in its Section 111 report for that same claim, potentially serious problems could arise. If the RRE’s quarterly report contains ICD-9 codes for injuries not related to the plaintiff/claimant’s workers’ compensation or liability claim, CMS could improperly deny Medicare coverage for medical care unrelated to the plaintiff/claimant’s injuries. If the plaintiff/claimant’s MSA is still under review at the time the RRE files its quarterly reports, the inclusion of ICD-9 codes unrelated to the injury could result in a significant increase in the amount CMS may require to fund the MSA. Finally, a significant difference between the data submitted with an MSA approved by CMS and data submitted by the RRE after the MSA has been approved could lead CMS to withdraw its approval of the original MSA submission and withhold Medicare coverage for injury-related care until the entire settlement has been expended on the plaintiff/claimant’s injury-related medical expenses. Since there is currently no appeal process applicable to MSA submissions, these types of errors would be difficult, if not impossible to correct.

We would suggest that exposure would also be extant in the foregoing scenario for the attorneys involved in the claim—plaintiff and defense—as well as the MSA professional and the Section 111 reporting Agent if their actions are seen to have contributed to an unfavorable result to the plaintiff/claimant. This is because each of these participants in the process would almost certainly have a legal duty to the plaintiff/claimant to use reasonable care to ensure that the above scenario does not occur. Moreover, this example of the interrelationship between the data on an MSA and the Section 111 report is based upon the example of just one of the data fields. Obviously, both an MSA and a Section 111 report contain many other variable elements and thus there are many pitfalls that can arise from the absence of an acknowledgment of the interrelationship between MSA and Section 111 obligations and the failure to implement appropriate coordination protocols.

Conclusion

Analysis of the requirements of the different facets of the Medicare Secondary Payer Statute indicate unequivocally that the MSA and Section 111 reporting functions do not exist in a vacuum and thus must be addressed via an organic approach as part of an integrated claims resolution system. As part of such a system, it is absolutely essential that both the RRE or its

agent and the professional responsible for submission of the MSA communicate with each other. If the RRE or agent has already submitted its Section 111 report on a particular claim, the information submitted must be made available to the entity responsible for submission of the MSA. Conversely, if the MSA has already been submitted, the RRE or its agent should be provided with a copy of the MSA proposal before submitting any Section 111 report with regard to the same claim. Only in this way can both the MSA professional and the RRE or its agent ensure that their respective duties are completed properly and coordinated so that no significant inconsistencies in data exist which may cause unnecessary damage to the plaintiff/claimant.

This application of a prudent and measured response to the requirements of CMS will not only assist with the fundamental and worthwhile goal of contributing to the viability of Medicare and the well-being of its beneficiaries, but also will reduce financial exposure to the RRE. Therefore, expert assistance at every step is essential to minimize potential risk exposure.

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