

Mandatory Medicare Secondary Payer Reporting

Penalties Can Be Severe, but Wortham's Medicare Reporting Liability Insurance Product Can Protect You

Many employers have made a conscious decision to reduce their overall cost of risk by maintaining a deductible on their workers compensation insurance policies or "self administering" smaller workers compensation claims to reduce the impact on the company's experience modifier. The Texas Workers Compensation statute certainly allows for this flexibility as long as it does not involve an occupational disease or involves the "absence of an employee of that employer from work for more than one day" (See TDI DWC Rules: <http://www.statutes.legis.state.tx.us/Docs/LA/htm/LA.409.htm#409.005>) Handling of claims in this manner has created few problems for employers as long as they maintained appropriate records in the event the injury becomes more serious and later becomes a lost time injury. However, new reporting requirements stipulated in Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) have dramatically changed this process for not only workers compensation claims, but any claim involving medical payments for an injured person who potentially could receive Medicare benefits. Failure to comply will subject employers to major fines.

The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act was put into law in 2007, and is an amendment to the Medicare Secondary Payer Act (MSP). MMSEA mandates new mandatory insurer reporting requirements. Effective January 1, 2010, the Centers for Medicare and Medicaid Services (CMS) began enforcing this statute and will require reporting of specific information on Medicare beneficiaries who receive any payment, settlement, judgment or award whether it is from a workers' compensation, no fault, personal injury, employment, tort, etc. The information on those claims must be sent to the CMS per the guidelines outlined in the statute (<http://www.cms.hhs.gov/mandatoryinsrep>).

Fortunately, in most instances, your insurance company is considered the Responsible Reporting Entity (RRE) as defined by CMS for their policyholders on claims they pay and handle. Many insurance companies have gone to great effort to ensure that they are compliant with these federal requirements. It should be noted, that there are a few carriers that have opted not to report liability claims if within a retention program. All policyholders should evaluate their insurance programs with retentions to ensure the proper reporting is taking place. Consideration should be given to retaining a consulting organization with specialized MMSEA and MSP expertise.

The real problem lies with the claims that fall within the deductible or those claims which are self administered that the carrier has no knowledge. Further, private payments and bill write-offs must be reported. If you as the employer fail to report a claim and/or self pay any portion of that claim, then you as the policyholder become the RRE and **are** subject to the Section 111, along with the associated Federal fines for non-compliance.

Policyholders who decide to pay all or any portion of a medical claim under an insurance plan, such as Workers' Compensation, that may involve a Medicare beneficiary, are considered by the CMS as involving self-insurance, and subject to the reporting requirements. Failure to report may result in fines of up to \$1,000 per day, per claim in addition to other fines and penalties presented by MSP.

You cannot always tell who qualifies as a Medicare beneficiary and the dollar amount changes each year between now and 2013 (see table below). For the coming year, unless you are paying the medical provider direct and it is under \$600, you should report the claim. By 2013, all claims must be reported regardless of cost.

What is the reason for these new reporting requirements? In a word - MONEY. The government (via Medicare & Medicaid) does not want to pay for medical services that are covered under a primary insurance program. The mandatory reporting requirements will provide information on claims to avoid duplicate payments and reduce the outlay from Medicare and Medicaid.

The Mandatory Insurer Reporting (MIR) program is continuously changing and definitely considered a work in progress. The bottom line is that Medicare does not want to be responsible for any medical bills that it should not, as a taxpayer we should applaud this effort. But, as it seems with every governmental agency the regulations and logistics for compliance are going to be quite overwhelming.

Wortham's Medicare Reporting Liability Coverage Product

John L. Wortham & Son, L.P. is pleased to announce the availability of a NEW insurance product and related consulting services designed to protect clients from financial loss as a result of the enforcement of the Medicare compliance requirements.

It is our belief that government agencies will escalate their enforcement actions and the collection of fines and penalties over both the short and long-term in view of budgetary constraints and deficit financial positions. In fact, the Office of the Inspector General identified close to \$3 billion in potential recoveries through various enforcement actions on behalf of Medicare during the first six months of fiscal 2010. As respects Section 111, CMS is prepared to identify noncompliant entities. CMS has engaged various Recovery Audit Contractors (RACs) who have subcontracted to other RAC auditors in the five districts who will be paid on a contingency basis – collecting a percentage of the fines and penalties they recover in the same manner that a plaintiff attorney is paid on a contingency basis as a percentage of the settlement or judgment they obtain for their client. The ability to perform a RAC audit resets over 30 days so we believe there will be significant activity as these auditors seek to capitalize on this opportunity and the federal agencies seek to bolster their financial position. It is understood that CMS may seek recoveries back to 1980 when the MSP Act, the enabling legislation, was first enacted.

The Wortham suite of Medicare Compliance products services is the only one to include a robust insurance product available in the marketplace addressing all of the new exposures. Since its introduction, we have found that many of the most sophisticated organizations across the United States, including those in the healthcare sector, are not fully prepared for the implementation of Section 111. Many of these organizations are not aware of the punitive penalties and fines that can be levied against the RRE in the enforcement of this legislation. The insurance coverage is written on a modified claims-made coverage format. So, a number of organizations have applied for the coverage in anticipation of the October 1, 2010 effective date.

Many organizations have engaged Wortham to perform a Variance Analysis, a process through which your policies, procedures and protocols are evaluated relative to both MSP and the Section 111 reporting requirements from a compliance, accounting, IT systems, protocols, procedures, training, actuarial and legal perspective. We have contracted with national accounting, actuarial and law firms to perform these services. At your option, our findings can include a qualified legal opinion.

It may be in the best interest of your organization to explore the compliance consulting service, variance analysis and insurance coverage with the brokers and technicians from Wortham's healthcare practice. An initial application for coverage can be accessed through the Wortham website homepage www.worthaminsurance.com.

Current Reporting Information:

1. For no-fault insurance, there is no minimum dollar threshold for reporting the assumption/establishment of ORM (**Ongoing Responsibility for Medical**) or for reporting TPOC (**Total Payment Obligation to Claimant**).
2. For liability insurance (including self-insurance), there is no minimum dollar threshold for reporting the assumption/establishment of ORM.
3. For workers' compensation ORM, claims meeting the **all** of following criteria are excluded from reporting for file submissions due through December 31, 2010:
 - Medicals only
 - Lost time of no more than 7 calendar days.
 - All payment(s) has/have been made directly to the medical provider.
 - Total payment does not exceed \$600.00
 - Currently the obligation for MSA reporting for worker's compensation is \$25,000.
4. For liability insurance (including self-insurance) and workers' compensation TPOCs, the following dollar thresholds apply:
 - September 30, 2009 - December 31, 2010, TPOC amounts up to \$5,000.00
 - January 1, 2011 – December 31, 2011, TPOC amounts up to \$2,000.00
 - January 1, 2012 – December 31, 2012, TPOC amounts up to \$600.00
 - January 1, 2013 going forward, TPOC amount \$0
 - If there is a claimant with multiple TPOCs reported, then the TPOCs must be combined in order to determine whether or not the reporting exception threshold is met.

If you have other questions a good resource is: <http://www.cms.hhs.gov/mandatoryinsrep/>