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## Medicare Reporting — Those Who Hesitate Are Lost

*Law360, New York (October 09, 2009)* -- Nearly two years after its enactment, implementation of the reporting scheme established by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (“MMSEA-111”) is finally under way.

The statute has serious teeth and, as interpreted by the federal Centers for Medicare and Medicaid Services (“CMMS”), creates onerous burdens. Unless you and your clients have already begun the complex and extensive preparations required for compliance, you may find yourself unable to avoid severe civil penalties and other liability.

### **What is MMSEA-111?**

MMSEA-111, codified at 42 U.S.C. § 1395y (b) (7)-(8), is a reporting scheme added to the Medicare Secondary Payer Statute (“MSPS”) in 2007. The MSPS was enacted in 1980 to reduce the costs of Medicare by making Medicare a “secondary payer” and placing the “primary” payment obligation for a Medicare beneficiary’s care on any other “responsible” entity. See 42 U.S.C. § 1395y (b).

In practice, this means that Medicare payments are “conditional” and must be reimbursed to Medicare if it is established that another entity, called a “primary plan,” was responsible for the medical services rendered. *Id.*

Although a detailed exploration is beyond the scope of this article, the MSPS and associated regulations require Medicare beneficiaries who receive compensation for Medicare-provided medical expenses to reimburse Medicare for its conditional payments and, if they do not, authorizes Medicare to obtain reimbursement (and, in certain circumstances, double damages) directly from the primary plan even if the primary plan has already paid the beneficiary.

Primary plans include private health insurance, workers’ compensation programs, no-fault insurance, liability insurance and self-insured businesses.

The purpose of the MMSEA-111 reporting scheme is to assist Medicare in its MSPS recovery efforts.

As discussed more fully below, MMSEA-111 requires “Responsible Reporting Entities” to determine whether a personal injury claim involves an injury to a Medicare beneficiary and, if so, to report numerous categories of information to Medicare in the event the “Responsible Reporting Entity” becomes obligated (e.g., through a judgment or settlement) to make a payment on the claim.

Compliance with MMSEA-111 is no simple task and failure to comply carries serious consequences.

### **Who Must Report?**

To varying degrees, MMSEA-111 will affect every player in the personal injury context, including defendants, liability insurers, third-party administrators and counsel on both sides. As stated above, the MMSEA-111 reporting requirements apply to “Responsible Reporting Entities” (commonly abbreviated as “RREs”).

The process of determining whether one is an RRE is detailed in the MMSEA “User Manual” available on the CMMS Web site. In essence, an entity that pays any portion of the judgment or settlement on a claim involving injury to a Medicare beneficiary is an RRE (with the exception that a third-party administrator is never the RRE).

A business that pays claimants directly (or through a third-party administrator) is the RRE even if all or a portion of the payment is later reimbursed by an insurance carrier.

On the other hand, if a business pays a deductible to its insurance carrier, which pays the claimant, the insurance carrier is the RRE.

Although an RRE may contract with a third-party administrator or other agent to conduct the reporting required by MMSEA-111, it remains the RRE and, accordingly, remains liable for any noncompliance with the statute.

### **What Must be Reported?**

The CMMS divides the matters that must be reported pursuant to MMSEA-111 into two classes. First, where an RRE enters into a traditional settlement or suffers a judgment, the settlement or judgment is considered a “Total Payment Obligation to Claimant” (“TPOC”).

Second, where an RRE assumes responsibility for a claimant’s future medical care, the obligation is considered an “Ongoing Responsibility for Medicals” (“ORM”). ORMs are primarily encountered in the context of workers’ compensation plans or no-fault insurance.

The statutory language of MMSEA-111 provides that its reporting requirements are effective July 1, 2009. 42 U.S.C. § 1395y (b) (8) (A). The CMMS has delayed the effective date for TPOCs, however, to Jan. 1, 2010.

The effective date for ORM reporting is unchanged and, accordingly, any ORM established or in effect after July 1, 2009, must be reported. The focus of this article is on TPOCs, which are more common in the liability context.

For TPOCs established on or after Jan. 1, 2010, an RRE must determine whether the claim involves a Medicare beneficiary and, if so, must report the TPOC and several categories of information to Medicare.

There are two exceptions. The first exception is that claims involving injuries occurring prior to the MSPS effective date, Dec. 5, 1980, need not be reported.

The primary significance of this exception is in the latent disease context because, according to the CMMS User Manual, TPOCs need not be reported if all exposures contributing to the disease occurred prior to Dec. 5, 1980.

The second exception is that TPOCs established prior to Jan. 1, 2011, need not be reported pursuant to MMSEA-111 unless the amount of the TPOC is \$5,000.00 or more. After Jan. 1, 2011, the reporting threshold for TPOCs will decrease.

As indicated above, an RRE's MMSEA-111 reporting responsibility is two-fold. First, the RRE must determine whether the claim involves a Medicare beneficiary.

Second, if it does and the RRE settles the case or suffers a judgment, the RRE must report certain specified categories of information to Medicare. The information that must be reported is outlined in the CMMS User Manual and is too extensive to list here.

In general terms, the RREs must report the amount of the TPOC and various details regarding the nature of the claim and the Medicare beneficiary's injury, the identity of the injured Medicare beneficiary, the identity of the claimant (if different from the Medicare beneficiary), and certain details regarding the claimant's counsel, if any.

The purpose of this data collection is to permit Medicare to more efficiently enforce its secondary payer reimbursement rights.

### **How Does the Reporting Work?**

CMMS has established an electronic reporting system for purposes of the MMSEA-111 reporting scheme. RREs in the liability context (i.e., liability insurers and self-insured businesses) were required to register with the CMMS electronic reporting system by Sept. 30, 2009.

Once registered, RREs can submit “queries” to CMMS to determine whether the injured person with respect to a given claim is a Medicare beneficiary.

The query results merely indicate whether Medicare recognizes the injured party as a beneficiary, however, and it does not appear that the query results provide any “safe harbor” if it later turns out that the claim did involve a Medicare beneficiary.

Registration is followed by a lengthy data submission testing process during which the RRE, or its designated agent, will exchange data with the CMMS electronic reporting system to eliminate errors prior to the start of live reporting.

Live reporting is scheduled to begin April 1, 2010, but will include TPOCs established on or after Jan. 1, 2010 (and ORMs established or in effect on or after July 1, 2009).

Reporting does not occur on a rolling basis. Instead, each RRE will be assigned a quarterly seven-day “file submission period” during which it must submit all required reports.

The data that RREs are required to report is extensive and collecting the required data in advance of the short quarterly reporting window will require meticulous planning on the part of the RRE.

### **What Potential Liabilities are Associated with MMSEA-111?**

Congress included considerable penalties to ensure compliance with the burdensome MMSEA-111 reporting scheme.

An RRE that fails to report in accordance with MMSEA-111 is subject to civil penalties of \$1,000.00 per day as to each claim for which it has failed to meet the reporting requirements.

An entity that receives a large number of personal injury claims and is unprepared to comply with the MMSEA-111 could incur catastrophic civil penalties in a short amount of time.

It should also be noted that MMSEA-111 does not alter an entity’s responsibilities under the pre-existing provisions of the MSPS and associated regulations.

These pre-existing provisions include a separate obligation on the part of primary payers (which, since at least 2003, has included self-insured businesses) to report any payments made to a claimant if it has actual or constructive knowledge that the claimant is a Medicare beneficiary. See 42 C.F.R. § 411.25.

In addition, they empower Medicare to recover its conditional payments directly from the primary payer if the beneficiary fails to provide reimbursement. See 42 C.F.R. § 411.24(i).

The MMSEA-111 reporting scheme is designed to strengthen the ability of Medicare to enforce its reimbursement rights.

In other words, the information reported pursuant to MMSEA-111 will increase the likelihood that, if the claimant fails to reimburse Medicare for its conditional payments, your client may be required to pay the judgment or settlement twice — once to the claimant and again to Medicare.

### **Proactive Steps are Required and Time is Running Out**

Extensive preparation and organization is required in order to comply with the MMSEA-111. The registration and testing phase of the CMMS electronic reporting system is lengthy and complex and an RRE that has yet to register is already falling behind.

In addition to these tasks, entities must take careful inventory of the processes they currently utilize for handling litigated and non-litigated personal injury claims to ensure that they are collecting the information necessary to determine the Medicare status of each injured person and, if necessary, to report all required information to Medicare.

This will likely require that changes be made to form discovery and, especially in the case of a pro se claimant, procedures will need to be developed to inform the claimant of the new reporting requirements and to ensure that the necessary information is received before the claim is resolved.

These preparations are fraught with difficulties due to the unsettled nature of the administrative implementation of MMSEA-111.

Although the reporting will not apply to TPOCs established this year, new data collection procedures must be implemented immediately because many of the personal injury claims currently pending, and certainly many of the claims received over the course of the next three months, will not be resolved until 2010 and, therefore, will give rise to MMSEA-111 reporting obligations.

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