

Recent Medicare Reporting & Reimbursement Requirements by Jonathan M. Spiegel

A fair amount has been written and will continue to be written on Medicare reporting and reimbursement as the United States Government—specifically Medicare, operating through the Centers for Medicare and Medicaid Services (CMS)—insurance carriers, counsel and the courts sort through various provisions of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). This article will provide some background context, highlight key provisions of Section 111 of the MMSEA and will close by offering some compliance tips for the practitioner and insurance carrier.

Background

Established by Congress in 1965, Medicare provides benefits to persons at least 65 years old and, regardless of age, covers those receiving Social Security Disability benefits for at least 24 months, and those medically determined to have end-stage renal (kidney) disease. *See* 42 U.S.C. § 1395c. In 1980, Congress passed the Medicare Secondary Payer Act (MSPA). 42 U.S.C. § 1395y(b)(2).

As the name suggests, the MSPA was intended to make Medicare the *secondary* payer of health/medical-related benefits. Thus, where the beneficiary had a health insurance plan, or where the beneficiary's medical expenses should have been paid by a tortfeasor or its insurance carrier, Medicare would be reimbursed, when applicable, for payments it made on behalf of that beneficiary. Medicare's initial payments are referred to as "conditional, primary payments." To recoup *billions* of dollars in lost, unreimbursed Medicare payments made each year, Congress passed Section 111 of the MMSEA to put some real "teeth" into the MSPA. *See* 42 U.S.C. § 1395y(b)(7) & (8).

Key Provisions of Section 111

CMS requires that any settlement, judgment or other award to a Medicare beneficiary be reported so that Medicare can seek reimbursement for any conditional, primary payments it has made. The reporting and reimbursement requirements apply to both current Medicare participants, as well to workers' compensation beneficiaries who have incurred at least \$250,000 in medical benefits, have a Medicare Set-Aside in place for any future medical benefits, and are within 30 months of Medicare-eligibility. Those required to report required information to Medicare are referred to as "Responsible Reporting Entities," or RREs. They include group health plans, as well as liability, no-fault, and workers' compensation insurers and self-insureds.

If an RRE fails to timely report the required information, *the RRE can be fined \$1000 per claim, per day*, from the date of the noncompliance. Understandably, this particular provision has been followed most closely by the insurance industry.

Legislation is currently pending in Congress to take some of the "bite" out of Section 111. *See* H.R. 4796 introduced in the U.S. House of Representatives in March of this year. The proposed changes include softening the penalty to "up to \$1000.00" per day; creating a three-year statute of limitations for Medicare's right of reimbursement; and only allowing reimbursement for claims totaling at least \$5000.00. However, it is likely that Section 111 will survive with most of its enforcement provisions intact in light of public policy considerations.

Failure to timely reimburse Medicare for any payments it has "fronted" for the Medicare beneficiary can also have negative financial consequences. Defendants, health care providers,

claimants/plaintiffs and plaintiff's counsel that have received a financial benefit as a result of Medicare having first paid otherwise reimbursable medical benefits can suffer double damages for any non-reimbursed Medicare payments. *See* 42 U.S.C. §1395y(b)(7) & (8).

The U.S. Department of Justice recently filed a suit on this precise issue in the United States District Court for the Northern District of Alabama. In *U.S. v. Stricker*, Civil Action No. 1:09-cv-02423-KOB, several attorneys, corporations and insurers settled a large class action involving 907 Medicare beneficiaries, but the payments were not reimbursed. The class action was settled for approximately \$300 million and the DOJ is now seeking double damages against all parties as a result of the failure to reimburse Medicare.

Compliance Tips

In light of the serious consequences and penalties for failure to timely report and reimburse Medicare conditional payments, counsel should contact and report to the local Regional CMS office early and as often as necessary in the claim/suit process. Moreover, because Section 111 enforcement and reporting timetables have changed several times since their original enactment in 2007, consult the CMS website (www.cms.gov/mandatoryinsrep/04_whats_new.asp) for the latest CMS missives on enforcement and reporting. This website also has many other helpful Medicare-related links and resources.

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