A Perfect Storm

by Kathleen Shannon Glancy

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The aggressive enforcement by the Center for Medicare and Medicaid Services (CMS) of Medicare's priority as a secondary payer against all other conceivable sources of payment for health care services for Medicare beneficiaries is not news.[1] Since 1982, Medicare has been precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."[2]

Except for the recovery of past Medicare conditional payments, however, Medicare's enforcement of their super lien status was inconsistent at best and enforcement was dependent on CMS having adequate information to identify a claim as a conditional payment. In the past, identification of conditional payments was made by individual reporting by Medicare beneficiaries, medical providers, and a smattering of data sharing agreements with state workers' compensation agencies and large group health plans. Then the soaring costs of health care, the economic pressure due to increased cost of Medicare funding, and the information revolution of the modern internet converged to create a perfect storm. The road to sharing of claims information was paved by the passage in 1996 of the Health Insurance Portability and Accountability Act, or HIPAA.

While HIPAA[3] was touted as an individual privacy protection bill, an overriding purpose of HIPPA was to legalize the sharing of health-related information for the purpose of billing and claims management.[4] To improve the efficiency and effectiveness of the health care system, HIPAA was designed to require national standards for coding and storing of electronic health care transactions including codes for treatment, diagnosis, and billing. In essence HIPAA mandates a nationalized system of coding that is a prerequisite for the electronic transfer and sharing of the patients' "unique health identifiers." At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.

Medical care providers now routinely require patients to sign HIPPA notices or releases as a prerequisite to treatment. The HIPPA release allows disclosure of health claim information to other entities for care and "other" purposes, i.e. billing. The access to health information for "claims" purposes paves the way for the exchange of claims information using universal codes between patient, provider, and payer, including CMS, as the largest secondary payer.

In the workers' compensation world, July 2001 was a watershed moment due to the now infamous Patel Memorandum that established the "Medicare Set Aside" (MSA). CMS then established guidelines for development of the MSAs through a series of "policy memos" outlining the suggested process to "reasonably consider Medicare's interests" with respect to its status as a secondary payer to all other applicable entities that may be responsible for the payment for both past and *future* medical services for current and soon to be Medicare beneficiaries. Then enforcement stepped up by putting all stakeholders on notice that CMS intended to secure compliance with enhanced reporting requirements and imposition of penalties against any and all stakeholders for failure to adequately protect their interests. But despite these enhanced enforcement efforts, CMS realized that without access to all claims records many conditional payments went undetected.

Then in 2007 Congress passed the Medicare, Medicaid, and SCHIP Extension Act, commonly now known as MMSEA.[5] Section 111 of the Act refers to Mandatory Medicare Secondary Payer Reporting requirements.[6] Medicare Secondary Payer (MSP) refers to situations where another entity is required to pay for covered services be-

fore Medicare does, and must do so without regard to a patient's Medicare entitlement. This bill enacted mandatory claims reporting requirements on liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers, referred to collectively as "Responsible Reporting Entities" or RREs.[7] These entities are responsible to the Medicare beneficiary for medical payments and such payment responsibility is primary to the Medicare's responsibility to pay for such treatment.

This reporting obligation first became effective on May 1, 2009, and requires the primary insurer (RRE) to notify Medicare when a Medicare beneficiary receives a settlement, judgment, award, or other payment.[8] The new Section 111 reporting requirements are in addition to—not instead of—existing CMS processes such as MSA submissions or the conditional payments recovery process.[9] In order to manage the huge volume of MMSEA Section 111 data, CMS engaged a Coordination of Benefits Contractor (COBC) to receive, process, and manage the data exchange.

What must be reported?

Section 111 requires reporting entities to report claim information for Medicare beneficiaries after the insurer has assumed ongoing responsibility for medicals (ORM) or after paying the total payment obligation to the claimant (TPOC) in the form of a settlement, judgment, award, or other payment.[10] In order to satisfy this reporting requirement, the reporting entities must first determine whether a claimant is a Medicare beneficiary or not and if yes, then report the required information, regardless of whether or not there is a determination or admission of liability.[11] The Act vests in the Secretary [of Health and Human Services] the discretion to specify the information to be reported in order to "enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim."[12] CMS has determined that part of the information sought is the relevant ICD- 9-CM codes (International Classification of Diseases Ninth Revision, Clinical Modification).[13]

Practical Implications

Transparency is here. The Act is designed to capture medical payment claim information on injured parties who are also Medicare beneficiaries. The reporting requirement was enacted at the request of CMS based on the historical poor compliance with the Medicare Secondary Payor Act and the regulations. CMS is seeking the claim information (due to an illness, injury, incident, accident, or exposure) for all individuals who have been identified as Medicare beneficiaries, regardless of whether the is a determination or admission of liability.

It is now apparent that CMS is positioned to have a complete information set on any and all injury claims suffered by a Medicare beneficiary for which a third party has a potential obligation to pay for related medical treatment. This information transparency will ensure that CMS tags the Medicare claim number of the injured beneficiary to ensure proper scrutiny of submitted claims prior to payment under the Medicare program. CMS intends to use this claim information to make a determination on whether Medicare has paid any claims that can be recovered either from the party responsible for the primary payment or from the beneficiary after settlement funds have been distributed.

Once a Medicare beneficiary has been identified as a claimant under Non-group Health Plan (NGHP), defined as liability insurance, including self-insurance, no-fault insurance, and workers' compensation, CMS will issue a list of conditional payments associated with that beneficiary. Experientially, this initial list is an all-inclusive list of all Medicare payments ever made without any substantive elimination of non-injury related payments. **Absent a vigorous audit of the statement of conditional payments, primary payers and beneficiaries will be charged with repayment and denial of future claims until the full amount of the claimed conditional payments have been recovered or set off against claim denials on future medical care, whether the claimed conditional payments are related to the underlying NGHP claim or not.**

CMS has determined that the reporting entities are required to report the ICD-9 codes which are the disease classification codes for health care services. Importantly, it is the RRE who will initially determine and submit the relevant ICD-9-CM codes. These codes may or may not translate directly to the body parts that are causally related to the underlying injury as determined by the relevant medical evidence.

Any body parts that are covered by a claim or settlement agreement, whether admitted or denied, fall within the scope of the CMS claim of conditional payment. This is premised on the longstanding CMS policy that their claim of conditional payment is not predicated on their ability to prove a causal connection between the medical claim and the injury. CMS asserts that their position is predicated simply on the beneficiary's claim that a condition is related and the fact that the defending party is released from liability for that claim as a result of the settlement, award, or judgment. The CMS "claim of conditional payment" attaches to all conditions or claims made and for which, as a result of the settlement, liability of the employer and carrier is released. This position is now supported somewhat by the language of Section 111 reporting which states that the information must be reported within the timeframe of the Secretary, "(*regardless of whether or not there is a determination or admission of liability*).[14]

It is critical that the responsible reporting entity and the claimant confer and agree on the accuracy of the information reported pursuant to Section 111. For instance, in workers' compensation claims, MSA documents can be carefully scrutinized to ensure the accuracy of the crosswalk between conditions and body parts contemplated by the parties to be covered in the MSA and that this information has been accurately reported pursuant to Section 111 as well. As noted, Section 111 reporting is in addition to any other CMS process as to conditional payments and recovery processes. In the final analysis of the claim all parties must ensure careful and accurate reporting of the relevant ICD-9 CM codes.

In practice, CMS and their contractors

have been fairly liberal in their receptiveness to a disputed challenge or audit of the list of claimed conditional payments. Furthermore, the parties will not be bound by the initial ICD-9-CM designations. However, this is done on a case-by-case basis and requires the extra expense and time to collect the medical records associated with the disputed conditional payments in order to demonstrate that the disputed conditional payments are not covered by a primary payer and therefore do not qualify as a conditional payment.

In respect to their broad collection powers, CMS announced a new "Conditional Payment Notice" (CPN) in lieu of a Conditional Payment Letter in certain circumstances when a past settlement, award, judgment, or other payment has occurred. **The CPN notifies the beneficiary of conditional payment information and allows the beneficiary and or representative *only 30 days* for a response.** The response should include, proof of representation, proof of disputed conditional payments with a request that these disputed payments be removed from the list, settlement documentation, procurement costs and fees, statement of additional related pending settlements, and judgments awards or other related payments. **If no response is made, full demand will be made without regard to fees, costs, or for non-related charges.**[15]

CMS has issued a policy memorandum providing a limited exception to conditional payment recovery for cases where last injurious exposure occurred BEFORE December 5, 1980.[16] Effective November 7, 2011, CMS has implemented a new and simple fixed percentage recovery option for beneficiaries who receive certain types of liability insurance (including self-insurance) settlements of $5,000.00 or less.[17] In these limited circumstances CMS has announced that payment of 25 percent of the total liability settlement will resolve Medicare's recovery claim in lieu of using the current recovery process. Starting Sept. 6, 2001, an exclusion threshold was implemented for liability settlements of $300.00 or less. In these cases CMS will waive conditional payment recovery.

In its first policy Memorandum addressing Liability Medicare Set-Asides (LMSA), CMS addressed the issue of how to "consider Medicare's interest" where future injury related medical treatment will not be required. CMS said that if the treating physician certifies in writing that no future medical treatment is required, Medicare will consider its interest satisfied and there is no need for CMS review.[18] When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that Medicare's interest with respect to future medicals for that settlement has been satisfied, but the parties are encouraged to maintain the physician's certification.[19]

Looking ahead

Future action promised by CMS includes the implementation of an option that allows for an immediate payment to Medicare for future medical costs that released by the settlement. CMS will continue to improve online access to information both for RREs and for beneficiaries and their representatives.

Online look up is now available to responsible reporting entities (RREs) to determine whether there is a match between claimant information submitted and a Medicare beneficiary. Access to match information is limited to RREs. As of September 30, 2011, Medicare Secondary Payer Recovery Contractor has implemented a self-service information feature to its customer service line. This feature gives callers the ability to get the most up-to-date Demand/Conditional Payment amounts and the dates those letters were issued.[20]

Beneficiaries and representatives should now have online access to this information and much more. The implementation of a MSPRC Web portal will allow a beneficiary or representative to obtain information about Medicare claim payments, demand letters, and input settlement and disputed claim information. This access will be critical to streamline the resolution process for all claims involving conditional payments. It is noteworthy that the current online access for RREs is simply a matching program. The Web Portal program will allow the beneficiary or their representative substantive access to medical claim information. We should be very mindful of looming privacy issues as to who is a representative because such status will allow broad access to beneficiary claim information.

Finally, on April 27, 2012, bi-partisan legislation known as the Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2012, was filed in the U.S. House of Representatives.[21] The legislation seeks to resolve the serious delays and confusion in the review of workers' compensation Medicare set asides by CMS. The coalition for Medicare Secondary Payer (MSP) reform, which includes representatives of injured workers, employers, and insurance carriers, has been working a number of years for reform in the processes and procedures used by CMS in its review of workers' compensation settlement agreements. The pending bill codifies the current $25,000 threshold for all workers' compensation settlements, establishes criteria for a qualified MSA, a safe harbor provision, time frames for approval and appeals, and allows an optional direct payment to CMS. ◆

1. Medicare has been a secondary payer to workers' compensation benefit payments since the inception of the Medicare program in 1965. Medicare as a Secondary Payer provisions were added in early 1980s and have been modified and expanded several times since then. These provisions were amended again by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007-the MMSEA Section 111 mandatory reporting requirements. 42 U.S.C. 1395y(b) (Section 1862(b) of the Social Security Act) and 42 C.F.R. Part 411.

2. 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act.

3. The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA).

4. The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes, i.e. billing.

5. 42 U.S.C. 1395y(b)(7)&(b)(8).

6. 42 U.S.C. 1395y(b)(8). In addition to Medicare being a secondary payer as to workers' compensation and liability claims, it is also secondary to selective category of group health plans (GHPs) who insure Medicare beneficiaries on the basis of employment (age 65 and older with GHP coverage based on an employer of at least 20 employees or under 65 years and disabled with GHP coverage based on an employer with 100 or more employees or for a limited 30 month period for beneficiaries who have end stage renal disease with GHP coverage on any basis.)

7. MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' compensation User Guide Version 3.2 August 17, 2011.

8. The implementation of the mandatory reporting has been delayed several times and was implemented in stages depending on the character of the NGHP type of claim involved and the manner of reporting. In January 2010 reporting of claims with ongoing responsibility for medicals (ORM) was implemented and in October 2010 reporting of the Total Payment Obligation to the Claimant (TPOC) became mandatory. Direct data entry reporting for NGHPs finally began July 2011. CMS Policy Memorandum Alert dated 2/14/2011.

9. MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Version 3.2 August 17, 2011.

10. 42 U.S.C. 1395y(b)(8).

11. 42 U.S.C. 1395y(b)(8)(C).

12. 42 U.S.C. 1395y(b)(8)(B)(ii).

13. MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Version 3.2 August 17, 2011.

14. 42 U.S.C. 1395y(b)(8)(C), emphasis added.

15. *See* 42 CFR 411.37; 42 CFR 411.47.

16. CMS policy memorandum dated 10/11/11.

17. MMSEA 111 *What's New Bulletin* from MMSEA111 web page.

18. CMS policy memorandum dated 9/30/11 and effective as of this date.

19. *Id.*

20. MMSEA 111 *What's New Bulletin* from MMSEA111 web page.

21. HR 5284.