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## Medicare Reporting Program Underway For Entities Required To Report Payments

**Under the Medicare Secondary Payer Act (MSP)**, Medicare is entitled to reimbursement of amounts paid to personal injury victims where another entity is primarily responsible for the payment. Such entities typically include civil defendants and their insurers. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA or the "Act") amended the MSP by requiring all primary payers to report to the government any payment or expectation of payment to a Medicare beneficiary. To that extent, the MMSEA creates a roadblock to settlement in personal injury cases. Medicare may recover payments from civil defendants and their insurers regardless of whether the payer is at fault or has already paid the Medicare beneficiary. Thus, entities that ignore the MMSEA may literally pay double for it.

Parties on all sides are confused by the MMSEA's complicated requirements, resulting in several extensions of the various compliance deadlines. However, entities required to register under the Act should have done so by now. This reminder reviews the major post-registration requirements of the MMSEA and their corresponding deadlines.

### **Basics of The Act**

Generally, the MMSEA requires all Responsible Reporting Entities (RREs) to determine and continually re-verify whether a claimant in a case is a Medicare beneficiary, and to report to the Centers for Medicare & Medicaid Services (CMS) any payment or reasonable expectation of payment to that beneficiary. RREs should submit a report to the CMS prior to reaching any settlement in a case involving a Medicare beneficiary.

To do this, RREs must enroll in the CMS reporting program. Any entity covered by the Act should have registered with the CMS by September 30, 2009, and those entities who missed the deadline should register immediately. After registration, RREs must "test" the reporting system between January 1, 2010 and March 31, 2010. Beginning in the second quarter of 2010 (April – June), RREs will submit live files to the CMS four times per year. RREs must make these submissions during a quarterly seven-day window, which the CMS will assign to the RRE. Reports must be made with respect to any claim filed on or after July 1, 2009 or January 1, 2010, depending on the type of payment

to the Medicare beneficiary, and initial reports will be retroactive to these dates.

Failure to comply with the MMSEA's requirements will result in a penalty of \$1,000 for each day of noncompliance, and this penalty applies separately for each individual Medicare beneficiary. An RRE may not contract away or otherwise escape its responsibility under the Act, so entities should understand clearly whether they are an RRE and what that status requires of them.

### **Are you an RRE under the Act?**

Under the Act, an RRE is any entity that pays, in whole or in part, any settlement, judgment, award, or other sum to a Medicare beneficiary. RREs potentially include insurers with respect to liability, no-fault insurers, workers' compensation insurers, and self-insurers.

An entity will not be considered an RRE and will face no reporting requirement in cases where it merely reimburses another entity that has made payments to a Medicare beneficiary. An exception to this rule occurs, though, when the third party acts solely as a third-party administrator or the payment stems from a private settlement, in which case the reimbursing entity will still be an RRE and must report the payment. Otherwise, the third party will shoulder the full reporting burden. Even when a third party is solely responsible for reporting, the reimbursing entity may avoid delays in case resolution by making its own report or by ensuring that the third party makes the report.

Entities that do not currently qualify as RREs but that may become RREs in the future should initiate registration now. The process can be lengthy, and failure to register before a reporting need arises will certainly cause delays in the resolution of cases involving Medicare beneficiaries.

### **MMSEA Timeline**

As the September 30, 2009, registration deadline has passed, any entity not registered with the CMS must do so immediately by visiting the CMS's registration website at <https://www.section11.cms.hhs.gov/MRA/Login.action>. The site contains a "How To" link at the top of the web page with registration instructions. The instructions provide detailed steps to help RREs initiate registration and select the necessary Authorized Representative (to complete the registration process) and Account Manager (to handle reports). Although most RREs will designate an agent as the Account Manager to make reports, only the RRE may perform the actual registration. After registering, RREs will receive their designated seven-day window for reporting within each quarter. RREs will also receive a User Guide explaining how to "test" the reporting system, how to report and what to include in reports.

Most RREs have completed the registration step of the process and are now wondering how to proceed with testing the reporting system and making live reports. The deadlines for these actions have constantly changed and have increased already-existing confusion over the Act. As of today, the MMSEA timeline post-registration is as follows:

- January 1, 2010: Claim Input File Testing Begins
- March 31, 2010: Deadline for Testing of Claim Input
- April 1, 2010 – June 30, 2010: First Quarter of Live Claim Input

After registration, RREs must spot situations that trigger the reporting requirement by determining whether each personal injury case involves a Medicare beneficiary. The deadlines differ slightly for claims that involve a one-time settlement and claims that involve ongoing payments for medical treatment. For cases involving an ongoing responsibility for payment of medical treatment, reports must be made for claims filed as of July 1, 2009. For one-time settlements, however, the reporting requirement begins on January 1, 2010, and is triggered by certain threshold amounts, which will decrease over the next three years. For the period of January 1, 2010, through December 31, 2010, RREs must report any one-time payment to a Medicare beneficiary of \$5,000 or more. For the year 2011, that threshold amount is reduced to \$2,000, and in 2012, the amount is further reduced to \$600. Consequently, when an RRE first makes a live report in the second quarter of 2010, it must report retroactive to either July 1, 2009, or January 1, 2010, depending on the type and amount of payment involved.

### **Spotting Medicare Beneficiaries**

MMSEA requirements apply only to cases involving payments to Medicare beneficiaries, so RREs should carefully distinguish Medicare and Medicaid recipients. An injured party is potentially Medicare-entitled if he or she is 65 years of age or older and has been dependent on Social Security Disability Insurance (SSDI) for 24 months. Medicaid, in contrast, covers a broader range of individuals who have limited income, including children.

In addition to identifying current Medicare recipients, RREs must identify any claimants that it “reasonably expects” may become Medicare recipients within 30 months. This may include individuals who: (1) are 62 ½ years of age or older, (2) have applied for SSDI, (3) may be expected to appeal a claim that has been denied, or (4) have end-stage renal disease. RREs should flag these individuals and submit reports for them to be safe under the MMSEA.

The reporting requirement applies until the termination of payments, so RREs must continually re-verify whether an individual satisfies the Medicare criteria. If an RRE initially determines that a claimant is not a Medicare beneficiary but fails to re-verify, and the claimant becomes a Medicare beneficiary at any time before payments terminate, the RRE will face penalties.

To verify whether an individual currently receives Medicare, RREs may submit a file once per month with each claim the RRE wants to check for Medicare beneficiary status. With this monthly request, the RRE must include each claimant’s name, date of birth, gender and Social Security Number. The CMS will then check the data in the government’s records and respond to the RRE within 14 days with a “yes” or “no” answer for each claimant in the file. For those claimants who have Medicare beneficiary status, the CMS will provide the RRE with a Health Identification Number to use in all future reports for that individual.

RREs must never rely on a claimant in making the Medicare beneficiary status determination for a few reasons. First, the obligations imposed by the MMSEA rest entirely on the RRE—Medicare beneficiaries and their representatives share no similar obligation. Second, the MMSEA contains no “safe harbor” provision for RREs who held erroneous but good faith beliefs that a particular claimant was not a Medicare beneficiary. The RRE will bear sole responsibility for any failure to report, so monthly verification with the CMS is a must.

Remember, individuals who do not meet the criteria of Medicare beneficiary at the time of a settlement or judgment may later become Medicare beneficiaries. Thus, although RREs will make the Medicare beneficiary determination prior to settlement or judgment, the RRE must continually to make the determination until payments end and the case file is closed.

### **The Report: Timing and Contents**

In cases where no payment will be made until settlement, no payment report is required until the time of the settlement, award, or other payment. In contrast, cases involving an ongoing responsibility for payment of medical treatment must be reported immediately. Regardless of whether the RRE has reached or is even negotiating a settlement, the RRE must report the start date of any ongoing payments and must monitor the claim until the payment obligation terminates. Upon termination of ongoing medical payments, the RRE must file a report with the CMS before closing out the file. Notwithstanding these rules for timing reports, all RREs should immediately report to the CMS any possibility of payment to a Medicare beneficiary. Involving Medicare in settlement negotiations will make for smoother case resolution and will, more importantly, help an RRE avoid paying double.

The information required for reports to the CMS is very specific and will likely change as we near 2010 and the CMS issues further guidance. Generally, a report for an individual claimant will require the claimant’s name, date of birth, and Social Security Number, as well as ICD-9 Event Codes and ICD-9 Diagnosis Codes. The CMS allows RREs to submit up to five ICD-9 Codes that characterize the claimant’s injuries. If an RRE includes incorrect data, the RRE will have one quarter to correct the mistake and will then face penalties for violations that result from the incorrect data.

Any data involved must be carefully protected. While the MMSEA requires collection of such sensitive data as Social Security Numbers, the Act does not protect the RRE from privacy liability. Consequently, RREs should implement safeguards to protect data as it is gathered and submitted to the CMS.

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### **Paying a Claimant and Closing the File**

Prior to any payment, the RRE should ensure that it will not be paying twice—once to the claimant and once to reimburse Medicare. RREs may seek the necessary assurance in one of several ways. First, the RRE might issue a two-party check payable to the CMS and the claimant. Second, the RRE may have the claimant execute a release agreement to secure indemnity for the RRE in the event that it becomes necessary, although obtaining indemnity from the claimant might not be too likely. The third and safest method of payment is to wait until the CMS has issued a reimbursement demand letter before releasing any funds. The disadvantage to this final method lies in the amount of time it may take the CMS to issue the demand letter, but securing a response from the CMS before paying a claimant is likely the most protective method with respect to the RRE's interests.

An RRE may not close a particular file with the CMS until the last payment has been made. Once payment is finally resolved and made, the RRE should report the final payment to the CMS and await notification that the file has been closed with the CMS before closing the matter within its own files.

### **Penalties for Non-Compliance**

Violations of the MMSEA will subject an RRE to penalties of \$1,000 per day for each late claim, and this penalty applies separately for every individual Medicare beneficiary. Remember, the penalty covers cases where the RRE made even a good faith error as to a claimant's status. In addition, the RRE may not contract away its liability under the MMSEA. While a third party may perform the required actions on behalf of the RRE, no attorney, agent, or other representative will bear the liability of non-compliance for the RRE.

Given the confusion over the Act, the ever-evolving guidelines and the number of changes in the deadlines, the CMS may, at first, be lenient in response to RREs' errors. The MMSEA provides no grace period, though, and RREs should not rely on the expectation of one. RREs should immediately ensure they have properly registered and read thoroughly the guidelines provided to them by the CMS. Even the guidelines are complicated, and many RREs will likely have questions.

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