The Medicare Secondary Payer Act & Mandatory Insurer Reporting

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Representing someone who is Medicare eligible automatically triggers concerns over the implications of compliance with the Medicare Secondary Payer Act (hereinafter MSP). A client who is a current Medicare beneficiary or reasonably expected to become one within 30 months should be educated about the MSP and protected from the ramifications of non-compliance. The MSP is a series of statutory provisions[1] enacted in 1980 as part of the Omnibus Reconciliation Act[2] with the goal of reducing federal health care costs. The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay.[3] The regulations that implement the MSP provide "[s]ection 1862(b)(2)(A)(ii) of the Act precludes Medicare payments for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following" (i) Workers' compensation; (ii) Liability insurance; (iii) No-fault insurance.[4]

There are two issues that arise when dealing with the application of the MSP: (1) Medicare payments made prior to the date of settlement (conditional payments) and (2) future Medicare payments for covered services (Medicare set asides). According to CMS, both are obligations in terms of compliance with the MSP which extends to both prior to settlement and into the future. The passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)[5] has triggered heightened concerns of all parties to a settlement involving a Medicare

[1] The provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 U.S.C. § 1395y(b)(6) (2007).
[2] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (Dec. 5, 1980).
[3] 42 CFR § 411.20(2) Part 411, Subpart B, (2007).
[4] *Id.*
[5] Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

beneficiary. Part of this Act, Section 111[6], extends the government's ability to enforce the Medicare Secondary Payer Act. As of April 1, 2011, a Responsible Reporting Entities/insurers (hereinafter RRE), (liability insurer, self-insurer, no-fault insurer and workers' compensation carriers) must determine whether a claimant is a Medicare beneficiary ("entitled") and if so provide certain information to the Secretary of Health and Human Services (hereinafter "Secretary") when the claim is resolved. This is the so-called Mandatory Insurer Requirement, MIR for short.[7]

Under MMSEA, the RRE must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim. Failure of an applicable plan to comply with the reporting requirements potentially exposes them to a civil money penalty for each day of noncompliance with respect to each claim.[8] These reporting requirements make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties and potentially deny future Medicare covered services related to the injuries suffered.

The advent of MIR causes some very real and difficult problems for lawyers handling claims involving Medicare beneficiaries. For example, the biggest problem with the reporting requirement is the required disclosure of ICD medical diagnosis codes which identify the medical conditions that are injury related. These ICD codes can form the basis for the care potentially rejected by Medicare in the future. If the plaintiff and plaintiff counsel are unaware of the conditions disclosed by the defendant/insurer through the reporting process, there could be

[6] 42 U.S.C. § 1395y(b)(7)-(8)
[7] *Id.*
[8] *Id.*

some serious problems when the plaintiff seeks medical care from Medicare in the future. For example, a plaintiff sustained back and neck injuries which were claimed as a part of their lawsuit. The plaintiff had pre-existing neck problems. The case is ultimately settled with the defendant paying nothing for the neck injury because they determined that the neck injury was primarily due to a pre-existing condition. Now the defendant/insurer reports the settlement and lists the ICD-9 codes related to the neck injury even though they paid no settlement dollars towards that injury and rejected that part of the claim. The neck care could be rejected by Medicare in the future leaving the client with no set aside funds to pay for that care and no Medicare coverage either. Worse yet, your ability to negotiate a conditional payment made by Medicare may be complicated by including care that is unrelated. This issue is further exacerbated by the reporting data being submitted by outside reporting agents who are only providing initial case information without involvement of plaintiff counsel.

Another example is when the date of accident that is reported doesn't match up with what the plaintiff reports. The MIR requirements don't relieve the personal injury lawyer's obligation to report through the BCRC and resolve the conditional payment. If the defendant insurer reports a date of accident that doesn't match with what was reported by plaintiff counsel, it could trigger a second and new conditional payment demand from Medicare. This often leads to frustration and complication in resolving the conditional payment obligation.

Every time I am consulted by other lawyers about this issue, I suggest that the parties should be collaborating on this aspect of the Medicare settlement process. If the plaintiff does not know what is being reported, then the scenarios above could easily occur. The practical problem is that defense counsel typically is unaware of what is being reported and the ICD codes aren't included in the release. Accordingly, there are no guarantees that even if the parties

discuss this aspect of the reporting conundrum that the right codes will be reported. However, it still bears emphasis and discussion. Without focusing on this issue as part of the settlement process, a plaintiff, plaintiff lawyer or an elder law attorney involved in the case may find there are serious unintended repercussions that result.

MMSEA/MIR Release Language

In this new age of hypervigilance surrounding Medicare Compliance as a result of MIR, release language about protecting Medicare can be longer than the release itself. This language is frequently inaccurate or wholly inapplicable. In practice, I have seen language that mandates that the personal injury victim will not apply for Medicare or even Social Security Disability benefits. Equally as bad, language is frequently included that places a burden on the plaintiff to comply with requirements that aren't mandated by any law. Most of the language improperly cites statutes or regulations that don't say anything relevant to the issues at hand.

Therefore, great care needs to be taken by the personal injury practitioner in terms of what is agreed upon and included in the release. Technically, there is nothing required by any law that needs to be addressed in the release as it relates to the MSP. Practically speaking though, language has to be there to placate the other side's misinformation about their own liability regarding many of the MSP related issues. It is simple to address these issues concisely and in a way that doesn't place any onerous obligations upon the plaintiff. Every case is different, and the facts dictate the use of different language each time but there is a core set of provisions that can be done in one simple paragraph to deal with the Medicare related issues at hand.

MMSEA/MIR and Conditional Payments

The stated intent of the new reporting requirements was to identify situations where Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The Medicare Secondary Payer Act (MSP) prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no fault insurance or a group health plan.[9] However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or can't be expected to be paid promptly.[10] These "conditional payments" are made subject to being repaid when the primary payer pays.[11] When conditional payments are made by Medicare, the government has a right of recovery against the settlement proceeds.[12]

The Medicare Secondary Payer Act and the Mandatory Insurer Reporting requirements form a complex set a of issues that personal injury lawyers must deal with. As a result, realizing that every settlement with a Medicare beneficiary of one thousand dollars or more will be reported along with a variety of data points is critically important. Working collaboratively with the other side when it comes to these issues is recommended. Having incorrect or inaccurate information reported can cause both your client and your law firm issues.

[9] 42 CFR § 411.20(2) Part 411, Subpart B, (2007).
[10] 42 U.S.C.S. § 1395y(b)(2)(B)
[11] *Id.*
[12] 42 U.S.C.S. § 1395y(b)(2)(B)(iii)