

LEGAL ALERT

February 2010

What Insurance Carriers Need to Know About the New Medicare Reporting Requirements

On December 29, 2007 President Bush signed into law the “Medicare, Medicaid and SCHIP Extension Act of 2007” (“MMSEA”). Said law became effective July 1, 2009 and significantly changed the Medicare Reporting Requirements. Medicare reporting requirements have been in place but not frequently enforced since 2003 when the court in *U.S. v. Baxter International*, 345 F.3d 866 (11th Cir. 2003) determined that a primary payer (defendant) has a duty to inquire whether a claimant is eligible for Medicare for purposes of determining whether there was a likelihood that Medicare may have made payments that were the responsibility of the primary payer. Pursuant to Section 111 of MMSEA (P.L. 110-173) effective January 2010 liability insurance carriers are required to comply with new mandatory reporting set forth below.

The actual implementation of procedures is being spearheaded by the Centers for Medicare and Medicaid Services (“CMS”). CMS has been charged with the development of procedures and systems to assist Responsible Reporting Entities (“RREs”) in carrying out the required mandate. The following is a brief summary of upcoming deadlines, reporting requirements, and method of reporting.

Upcoming Deadlines:

January 1, 2010 – March 1, 2010: Training/Testing Period for registered RREs.

April 1, 2010: Deadline for RREs to Commence Reporting.

Who must comply?

RREs: liability insurance carriers (including self-insureds), no-fault insurance carriers; and workers’ compensation plans.

How to determine whether your case requires reporting?

- Determine whether a claimant is entitled to benefits under Medicare;
- Determine whether there is an Ongoing Responsibility for Medicals (“ORM”) under workers’ compensation or no-fault plan; and
- Determine there is a Total Payment Obligation to the Claimant (“TPOC”), i.e., settlement, judgment or award.

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If you determine the claimant is entitled to benefits you must submit the information outlined below.

How to determine Medicare status?

- Obtain a benefit statement from Social Security Administration (“SSA”). SSA is the agency in charge of determining a person’s Medicare eligibility.

Note: The only conclusive method of determining whether a claimant is a Medicare beneficiary is to obtain a determination by SSA. SSA will only issue a determination upon receipt of a signed Social Security Consent form (SSA-3328) from the claimant.

- Check the CMS Query System available at www.cms.hhs.gov. You will need the following minimal information to conduct your query:
 - Claimant’s Social Security Number;
 - First letter of claimant’s name;
 - First six letters of claimant’s last name;
 - Claimant’s date of birth; and
 - Claimant’s gender.

Once a determination of Medicare status has been made the reporting requirement is triggered upon resolution of the matter either by settlement, judgment, award or other payment.

What must be reported?

- Claimant’s name, address, DOB, gender, SSN or HCIN;
- Reporter's name, address, type of policy (*i.e.*, workers’ compensation, liability, no-fault), tax identification number, policy number, claim number, policy limits, if applicable, and whether self-insured;
- Name of insured;
- Name, address, telephone number of claimant’s attorney;
- Date of incident, nature of injury, cause, body part affected, ICD-9 diagnostic code and whether claim involves product liability;
- Settlement date, amount, contested or uncontested, whether there is ongoing liability and whether Medicare right to recovery was considered.

Are there any thresholds for what needs to be reported?

There are no thresholds. However, the following temporary exclusions have been implemented:

- Workers’ Compensation Plans are excluded from reporting through December 31, 2010 if,

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- Payments are for medicals only;
 - The claim involves lost time of no more than 7 days;
 - All payments have been made directly to the medical providers; and
 - The ongoing medical responsibility does not exceed \$600.
- Workers' Compensation Plans and Liability Plans are excluded from reporting Total Payment Obligations to Claimant ("TPOC") if,
 - TPOC is under \$5,000.00, excluded through December 31, 2010;
 - TPOC is under \$2,000.00, excluded from January 1, 2011 to December 31, 2011; and
 - TPOC is under \$600.00, excluded from January 1, 2012 to December 31, 2012.

How to report the required information?

All required information must be submitted digitally over the Internet at the Coordination of Benefits Secure Website (COBSW). You may contact CMS to obtain the necessary software and training to allow you to submit the required information.

What happens if you fail to report?

Penalties for non-compliance include a \$1,000 fine for each day of non-compliance per claimant for whom reporting was required. Enforcement of penalties is scheduled to commence April 1, 2010.

This legal alert is meant to advise you of the key components of Section 111 Medicare Reporting Requirement. For more detailed information regarding the new reporting requirements for liability insurance see 42 U.S.C. 1395y(b)(8).

If you have questions about these new requirements, please contact Rosevelie Marquez Morales at (212) 313-5458 or rmarquez@harrisbeach.com, or Brian A. Bender at (212) 313-5405 or bbender@harrisbeach.com, of the Harris Beach Insurance Litigation & Product Liability Defense Practice Group.

This legal alert does not purport to be a substitute for advice of counsel on specific matters.

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