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Client Alert

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CMS Issues Guidance on Reporting Requirements for Liability Insurers

On May 26 and 27, 2010, the Centers for Medicare & Medicaid Services (CMS), issued four alerts containing new guidance for liability (including self-insurance), no-fault and worker's compensation plans (collectively referred to as non-group health plans or NGHPs) regarding their reporting obligations under the Medicare Secondary Payer Act (MSP) and Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA).

The MSP and Section 111 of the MMSEA

In the early 1980s, Congress passed the MSP to make clear that the federal Medicare program is a secondary payer to other insurance or coverage. In practical terms, the MSP provides that, although CMS may initially pay a provider for performing services for Medicare beneficiaries, if it is later discovered that the patient has another source of coverage for those healthcare services, Medicare will recoup funds from the other source. Under MSP, CMS may bring an action against any or all entities that are or were required to make payment with respect to the same item or service under a primary plan. Alternatively, CMS may recover from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. Essentially, under the MSP, the government can recover from any entity associated with a personal injury settlement—attorneys, insurance carriers, third-party administrators, and virtually anyone who handles settlement proceeds and/or receives them as payment could have MSP liability to CMS.

Although the MSP laws have been in place for some time, CMS has had difficulties identifying those situations in which another payer is responsible for the beneficiary's healthcare costs. Therefore, on December 29, 2007, President George W. Bush signed into law the MMSEA, which includes a provision amending the notice and reporting requirements under the MSP relating to workers' compensation, liability (including self-insurance) and no-fault cases. Essentially, the law requires Responsible Reporting Entities (RREs), as defined by CMS, to report settlements involving payment for healthcare services for Medicare beneficiaries. CMS will then use this database as part of its claims payment process—if a Medicare beneficiary has received a reported settlement for his or her healthcare costs, then CMS either will not reimburse the provider for the billed amounts or will seek recovery for amounts already conditionally paid.

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These new reporting requirements, though still being finalized by CMS, became effective July 1, 2009, and CMS will require submission of electronic test claims beginning January 1, 2011, and actual quarterly data reporting beginning April 1, 2011. Importantly, under the new laws, failure to report can result in a fine of $1,000 per day, per claim, for the RRE—the insurer or entity responsible for the payment. Thus, to avoid MSP liability and fines, the RRE must ensure that CMS has the data required.

Recent Clarifications to Section 111 Reporting

CMS recently clarified reporting issues concerning Section 111 reporting for "write-offs," clinical trial payments, workers compensation and self-insured deductibles.

- **Write-offs**
  Write-offs refer to a common risk management tool by healthcare providers of either reducing certain charges or offering something of value (gift certificates, etc.) to a patient in response to pre-litigation and minor complaints, where no specific demands are made and counsel has not yet been retained. CMS had previously indicated that writing off charges and/or offering items of value could be a form of "self-insurance," triggering Section 111 reporting obligations. However, while CMS's recent alert clarifies that reductions in the amount due on a medical bill and other efforts at offering something of value constitutes self-insurance for purpose of the MSP, whether actual Section 111 reporting is required depends on the factual situation, as follows:
  1. **No Report Required:** Where the entity is a physician, provider or supplier and has reduced its charges or written off a portion of the charge to a Medicare beneficiary as a risk management tool, the provider, physician or other supplier must submit a claim to CMS reflecting the unreduced permissible charges (e.g., limiting charge) and showing the amount of the reduction provided or write-off as a payment from liability insurance (including self-insurance). CMS reasoned that no Section 111 reporting was necessary because this billing procedure adequately protected its interests.
  2. **Reporting Required:** When a provider, physician, or other supplier has provided property of value to a Medicare beneficiary as a risk management tool when there is evidence or a reasonable expectation that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity must report the write-off or value of the property provided as a Total Payment Obligation to Claimant (TPOC) from liability insurance (including self-insurance).[1] However, no reporting is required if the value of the property provided is less than the certain reporting thresholds.[2]

1 This reporting requirement also applies to entities other than providers, physicians or other suppliers who reduce charges and/or provide property of value to a Medicare beneficiary as a risk management tool if there is evidence or a reasonable expectation that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk. The entity is required to report both write-offs and property contributions unless the write-off or the value of the property provided is less than the TPOC reporting threshold.

2 CMS has instituted minimum reporting thresholds before Section 111 requirements are triggered. Liability claims and workers compensation claims that exclude ongoing responsibility for medicals must exceed the following thresholds to warrant reporting:

(Footnote 2 continued on page 3)

CMS's alert makes clear that, for Section 111 reporting, providers, physicians and other suppliers must determine whether claims submitted to CMS reflect the unreduced permissible charge and show the amount of the reduction provided or written off. These deductions or discounted services must be reflected in the provider's original billing and are therefore not subject to reporting. In instances where a provider, physician or other supplier provides property of value (in excess of reporting thresholds) to a beneficiary, the critical inquiry in evaluating whether a report will be required concerns whether there is a "reasonable expectation the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk."

- **Clinical Trials**
  CMS clarified that payments made by sponsors of clinical trials for complications or injuries arising out of the trials are considered to be payments by liability insurance (including self-insurance) and are subject to Section 111 reporting by the appropriate RRE.

- **Deductibles**
  CMS revised language in the *NGHP User Guide* concerning the reporting requirements for insurance deductions. CMS's position has been that in situations where a deductible is paid to the insurer for subsequent distribution to a claimant (as opposed to paying the settlement directly to the claimant) then the insurer must include the amount of those deductibles in the amounts it is reporting for Section 111 purposes. CMS's alert clarifies that in all instances (regardless of to whom the deductible is paid), the insurer is responsible for reporting both the deductible and any excess paid to the claimant.

- **Worker's Compensation**
  CMS clarified that in situations where the applicable worker's compensation or no-fault state law requires an RRE to make regularly scheduled periodic payments to the claimant, for obligations other than medical expenses (i.e., indemnity payments for lost wages), the RRE is not required to report these periodic payments provided that the RRE is already reporting ongoing responsibility for medicals.

(Footnote 2 continued from page 2)

Time Frame	Threshold to Warrant Reporting
July 1, 2009 – December 31, 2010	$5,000
January 1, 2011 – December 31, 2011	$2,000
January 1, 2012 – December 31, 2012	$600.00

For workers compensation claims, when ORM has been assumed, RREs must report most claims. The RRE must report unless the claim is (i) medicals only; (ii) lost time was no more than seven days; (iii) all payments were made directly to the provider; and (iv) total payments do not exceed $600.

CMS officials also disclosed that they will issue an updated version of the *NGHP User Guide* in July 2010 to further assist in implementing Section 111. Keeping abreast of CMS's ongoing announcements of the agency's Section 111 reporting guidelines is imperative for understanding the requirements of Section 111 and to assure that all necessary measures are taken as part of the claims handling and settlement process.