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MEMBER BRIEFING

**REGULATION, ACCREDITATION,
AND PAYMENT PRACTICE GROUP**

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Medicare Secondary Payer Mandatory Reporting: Compliance Strategies for Healthcare Providers

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The Medicare Secondary Payer (MSP) program has long suffered from inadequate mechanisms to identify settlements and payments that may be subject to recovery efforts. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)¹ dramatically changes the status quo effective January 1, 2011 by forcing third-party payors to self-disclose settlements, payments, and other awards with or to Medicare beneficiaries. Healthcare providers, like other entities that may settle or pay reportable claims, are subject to Section 111's mandatory reporting requirements and the \$1000 per-day penalty for non-compliance. (Reporting is not limited to insurers.) This article briefly summarizes reporting obligations applicable to healthcare providers and identifies ancillary issues that healthcare providers should address in developing a Section 111 program.

Section 111 Reporting—Five Factors

Section 111 requires healthcare providers to: (1) determine if a settlement or payment is reportable; (2) confirm whether a claimant is a Medicare beneficiary; (3) identify whether the provider or its insurer has the reporting responsibility; and (4) collect and submit information on reportable settlements. In general, the following five factors determine whether a settlement or award is reportable:

¹ 42 U.S.C. § 1395y(b)(8). The Centers for Medicare & Medicaid Services (CMS) has issued several User Guides and hosted dozens of teleconferences on Section 111 compliance. The CMS Section 111 website—www.cms.hhs.gov/mandatoryinsrep/—includes updated User Guides, teleconference transcripts, reference manuals, and other material.

Reporting Responsibility

Reporting obligations apply to traditional lawsuit settlements, court-ordered judgments, awards, and "other payments."² A healthcare provider's reporting duty will generally arise in two circumstances.

First, settlements or payments resolving claims against providers for professional liability or other lawsuits must be reported. Insurers will generally incur the reporting responsibility when the insured's settlement amount is limited to its deductible. However, insured healthcare providers are responsible for reporting if the insured pays the settlement without recourse to insurance, or if the insured's settlement share exceeds the deductible. An insured must also report if it pays the settlement directly to the claimant then seeks reimbursement from its insurer under a policy that provides for coverage beyond a certain limit (such as re-insurance, excess, umbrella, or stop-loss policies). In these instances, the insured provider—not the insurer—is the Responsible Reporting Entity (RRE) that must submit the Section 111 report.

Second, the Centers for Medicare & Medicaid Services (CMS) has indicated that hospitals may need to report write-offs and other risk management or goodwill gestures. CMS interprets write-offs as an indication of payment responsibility analogous to a settlement. CMS has expressed concern with the variety of situations in which write-offs can be used, such as proactive efforts to preclude a claim or reactive efforts to address a claim. Similarly, CMS has indicated that sponsors of clinical trials may need to report agreements to pay medical expenses of trial participants.

In the latest Section 111 User Guide issued February 26, 2010, CMS said that Responsible Reporting Entities (RREs) do not need to report information related to hospital write-offs or clinical trials until "forthcoming guidance" is published. However, CMS noted that RREs "should continue to identify related claims and/or payments so that they can be reported as prescribed by the general Section 111 requirements and the further guidance." Accordingly, providers should identify and track write-offs and

² Third-party administrators or insurers of Group Health Plans (GHP) that provide coverage to Medicare beneficiaries and defendants/insurers that assume responsibility for ongoing medical expenses (ORM), typically in the workers' compensation context, are subject to similar reporting obligations. GHP and ORM reporting are beyond this article's scope.

clinical trial agreements with the expectation that at least some information related to these arrangements will need to be reported.

Providers should note that Medicare's refusal to pay for a claim (i.e., never events or certain hospital-acquired conditions) does not negate the reporting obligation. Unlike the typical lawsuit defendant, a healthcare provider may have direct knowledge of whether Medicare was billed or if it paid expenses related to the claim. However, whether Medicare actually paid for a specific claim is not a factor in determining if a settlement or payment is reportable. Even if the provider knows that Medicare was not billed, the settlement or payment related to that claim may still need to be reported if it meets the other Section 111 criteria.

Date of Settlement

Settlements, judgments, awards, or other payments finalized on or after October 1, 2010, must be reported. Reporting duties arise when the settlement is signed or approved by a court. If there is no written agreement or settlement, the reporting obligation arises with the payment.

Claimant's Medicare Status

The reporting rules apply if the claimant is a Medicare beneficiary. Upon submission of a Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN), the CMS Coordination of Benefits Contractor (COBC) will confirm whether a claimant is a Medicare beneficiary.

Nature of Claim

A settlement of a claim for medical expenses or one that releases potential liability for such expenses is subject to the reporting rules. Reporting cannot be avoided by joint agreements that the settlement does not cover medical expenses.

Settlement Threshold

Liability settlements finalized before December 31, 2011, are exempt from reporting if less than \$5,000. The exemption reduces to \$2,000 between January-December 2012, and to \$600 between January–December 2013.

Reports are submitted quarterly in electronic format to the COBC and include up to 100 detailed data points on the claimant, defendant/insured, and settlement.

Section 111 Safe Harbor

A reporting entity can submit a claimant's SSN or HICN to determine Medicare status; and if the claim is reportable, the reporting entity must subsequently submit the identifiers in the Section 111 report. A reporting entity cannot fulfill its Section 111 reporting duties without at least one of these numbers.

CMS has issued a Safe Harbor form for entities to use in obtaining these identifiers from claimants. If a claimant refuses to provide the information, CMS will still consider the reporting entity compliant with the Section 111 requirements if the claimant signs the form acknowledging their refusal to provide their identifying numbers. Unfortunately, this exception does not apply if the reporting entity has actual knowledge that the claimant is a Medicare beneficiary. Healthcare providers that have a claimant's HICN or otherwise know that a claimant is a Medicare beneficiary cannot take advantage of the reporting Safe Harbor.

Executing the Safe Harbor form requires the claimant to acknowledge that his or her refusal to provide the information potentially constitutes a violation of Medicare coordination of benefits requirements; therefore, few claimants can be expected to cooperate. CMS recognizes that this potential scenario puts reporting entities at risk of non-compliance for no fault of their own. Therefore, CMS suggests that reporting entities develop a process to obtain the information and carefully document all correspondence with claimants to obtain a signed Safe Harbor form, including proof-of-receipt documents. CMS has not clarified what steps should be taken in this regard to meet the Safe Harbor requirements, and additional guidance is expected.

Because of the Safe Harbor's limitations, healthcare providers' knowledge about a claimant's medical history and Medicare status puts them at a disadvantage compared with other reporting entities (for example, auto manufacturers). Healthcare providers should carefully consider whether the Safe Harbor is available for a given claimant on a case-by-case basis.

Confidentiality Considerations

The Section 111 reporting process includes electronic exchange of information between the reporting entity and the COBC, including the claimant's name, SSN, date of birth, ICD-9 codes for the alleged cause of injury and diagnosis, and the settlement amount. Accordingly, healthcare providers should recognize the confidentiality issues Section 111 reporting implicates.

Data Use Agreements

During Section 111 registration, reporting entities must sign a Data Use Agreement with CMS that requires implementation of safeguards to protect data confidentiality and limits on the use, access, and disclosure of the subject information. Reporting entities must agree to let CMS access the premises where the Medicare data is kept to inspect arrangements regarding compliance with Data Use Agreement security requirements, and must advise personnel who have access to the data of the civil and criminal penalties for noncompliance with "applicable federal law." As such, healthcare providers should ensure that existing Health Insurance Portability and Accountability Act (HIPAA) policies and training programs address the Data Use Agreement's requirements.

The Agreement also requires RREs to ensure that third-party vendors (such as consultants used to assist in reporting) establish appropriate safeguards to protect the exchanged information, and limit access and segregate information when serving multiple RRE clients. Healthcare providers should incorporate these Data Use Agreement obligations into the service contracts or Business Associate Agreements with reporting agents. These contracts should also allocate responsibility for Section 111 penalties and costs related to compliance with applicable breach notification obligations.

Breach Notification Considerations

Section 111 reporting requires healthcare providers (even if they are not the reporting entity) to process and disclose significant amounts of patient information. Healthcare providers should recognize and anticipate the opportunities for inadvertent use, access, and disclosure in the reporting process, especially in light of the notification obligations under HIPAA, the Health Information Technology for Economic and Clinical Health Act, and state information security laws.

Confidential Settlements and FOIA

Many settling defendants, including healthcare providers, require that settlement terms remain confidential. However, Section 111 mandates disclosure of the amount, identity of the claimant, and circumstances of the claim (among other factors). CMS contends that it is entitled to the settlement information regardless of any confidentiality agreement between the parties since Section 111 serves a coordination-of-benefits purpose.³ Accordingly, healthcare providers and other reporting entities should be aware that Section 111 information will be maintained in a government database. It seems unlikely that such information would be released under the Freedom of Information Act (FOIA) because of the FOIA exemption for requests that intrude on personal privacy.⁴ CMS agrees, noting that federal privacy restrictions would likely preclude requests for information on individual settlements. However, it is unclear whether federal privacy limitations would prohibit disclosure of de-identified, aggregated settlement information—for example, the total amount written off or settled by a provider in a given year, or related to a specific procedure. CMS contends that logistical challenges render such disclosure unlikely since the information is not organized in aggregated form. However, such information will be used by CMS to identify secondary payor circumstances and facilitate recovery efforts.

³ A Medicare beneficiary's filing of a Medicare claim constitutes an express authorization for "any entity . . . that possesses information pertinent to the Medicare claim to release that information to CMS" for "coordination of benefits purposes." 42 C.F.R. § 411.24(a); CMS, Medicare, Medicaid & SCHIP Extension Act Section 111 Teleconference Transcript, at 34 (Jan. 22, 2009) (CMS MMSEA Section 111 Teleconference Transcripts). "Coordination of benefits" broadly includes efforts to enforce Medicare's secondary payer status. Transcript available at www.cms.hhs.gov/MandatoryInsRep/Downloads/Jan22Transcript.pdf.

⁴ 5 U.S.C. § 552(b)(6) (2000).

Minimizing Penalties

A reporting entity that fails to comply with the Section 111 reporting requirements is subject to a civil money penalty of \$1,000 per day of noncompliance, per claim. For example, a provider's ten-day delay in submitting reports on five settlements could result in a \$50,000 penalty. CMS noted in 2008 that guidelines for penalty assessment (and presumably the standards and procedures for appeals) would be issued prior to enforcement; as of early March 2010, no such guidelines had been released. CMS concedes that there are no "bright lines" for enforcement but noted that penalty deliberations would take into account whether an entity "ma[de] the effort" to comply with the reporting requirements.⁵

CMS notes that reporting entities can "remain in compliance" by timely registering for the reporting process, completing the testing cycle, and submitting punctual and accurate reports; alternatively, communicating with the COBC as to why it cannot keep on schedule. Entities that have a "reasonable expectation of having claims to report" must register in enough time to allow a full calendar quarter for testing prior to submitting reports.⁶ In order to stay on schedule to adhere to the compliance guidelines, entities that expect to report should register by September 30, 2010, to allow for a calendar quarter of testing prior to first quarter 2011 reporting deadlines.

In the meantime, healthcare providers should revise release and settlement documents to reflect the reporting requirements, including indemnification provisions for penalties. Although not required by Section 111, developing MMSEA Fact Sheets to confirm the reportable information with plaintiffs may resolve future disagreements over accuracy—especially if Medicare commences recovery efforts against the beneficiary based on the report.

Section 111 does not change Medicare's existing authority under the MSP program to recover conditional payments from beneficiaries, plaintiffs' attorneys, and/or settling defendants. Section 111 reporting merely provides notice to Medicare of third-party

⁵ CMS MMSEA Section 111 Teleconference Transcript at 45 (Feb. 25, 2009), available at www.cms.hhs.gov/MandatoryInsRep/Downloads/Jan22Transcript.pdf.

⁶ CMS MMSEA 111 Alert—NGHP RRE Compliance (Feb. 24, 2010), available at www.cms.hhs.gov/MandatoryInsRep/Downloads/Jan22Transcript.pdf.

settlements with beneficiaries. However, the notice of settlements afforded by Section 111 combined with recent high-profile recovery lawsuits filed against plaintiffs attorneys and settling defendants suggests that the federal government is taking a more aggressive approach in exercising its rights under the MSP program.

Deadlines

Section 111 registration, testing, and reporting involves significant information technology issues as reports are submitted electronically; therefore, healthcare providers are advised to consult with Internet Technology Departments in developing a Section 111 program. Healthcare providers may wish to contract with third-party vendors to administer their reporting, which may be cost-efficient in light of the significant human and infrastructure resources necessary for reporting.

The initial Section 111 reports are due between January 1, 2011, and March 30, 2011, and must include information on settlements signed on or after October 1, 2010. Healthcare providers should take steps now to (1) determine the applicability of Section 111's requirements; (2) implement procedures to determine claimants' Medicare status; (3) ensure compliance with confidentiality obligations; (4) modify policies, training programs, contracts, and settlement documents to address Section 111's required actions; and (5) collect, confirm, and submit reportable information on time to avoid penalties and CMS scrutiny. Healthcare providers should also carefully review forthcoming Section 111 guidance from CMS, including guidelines for utilizing the safe harbor process and reporting write-offs and clinical trials.

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