Paying it back

Understanding the new Medicare/Medicaid reimbursement law

With the ongoing debate over national health care, employers may have overlooked a new law that requires group health plan insurers and self-insurers, workers' compensation and no-fault insurers, and third-party administrators and plan administrators to report information to the secretary of Health and Human Services regarding injured employees or other claimants.

The Medicare Secondary Payor Act (MSP) of 1980 requires primary payer programs to pay for medical benefits ahead of Medicare, but it hasn't worked as designed.

"The Medicare program has continued making payments that should have been made by primary payers and the MSP's success rate in recovering these 'double payments' has been less than stellar," says Mark E. Morley, a senior partner at Secrest Wardle and co-chair of the firm's Executive Committee.

Smart Business spoke with Morley about the new Mandatory Insurer Reporting Law, also referred to as the Medicare, Medicaid & SCHIP (State Children's Health Insurance Program) Extension Act of 2007 (MMSEA), designed to end the miscues of the past while imposing a $1,000 per day penalty on those who ignore its requirements.

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How can employers avoid the penalty?

Compliance. The days of waiting for a call from Medicare seeking reimbursement appear to be over. The Centers for Medicare and Medicaid Services (CMS) issued an alert advising that employer-sponsored medical plans, no-fault and workers' compensation insurers, liability insurers and self-insured plans must proactively collect information, such as Social Security numbers, health care insurance claim numbers and Employer Identification Numbers and report to Medicare. This lets Medicare coordinate its payments with other insurance to avoid unnecessary depletion of the Medicare Hospital Trust Insurance Fund.

Are past and future medical expense payments affected?

Yes, the statute requires reimbursement to Medicare when it has made payments for medical expenses that are covered by another insurer. For example, in a workers' comp case where Medicare payments were made, the CMS is authorized to initiate recovery for payments as soon as it learns that payment 'has been or could be made.'

The same applies to a no-fault insurer, according to the Code of Federal Regulations. The recipient of benefits is required to reimburse Medicare within 60 days of receiving payment. And the CMS can seek reimbursement directly from the involved insurer or employer-sponsored plan, even though it has already reimbursed the beneficiary.

Are there limitations on the recovery of conditional Medicare payments?

When making a conditional payment, CMS has a right of subrogation from any individual or entity, including a beneficiary, physician or attorney. Additionally, CMS has a direct right of recovery against any entity responsible for making primary payment for services received by the Medicare recipient/beneficiary.

The law states that CMS cannot recover payment for particular services unless it has filed a claim for recovery by 'the end of the year following the year in which … [it] has notice that the insurer is a primary plan to Medicare for those services.' By comparison, the U.S. Code creates a three-year period beginning on the date on which the item or service was furnished, within which CMS may seek to recover conditional payments if, within that time frame, it has submitted a request for payment to the primary payer. So, there appears to be some discord within the federal statutes concerning when a claim must be made by CMS to recover conditional Medicare payments.

How will CMS present its claims for reimbursement?

In 2006, the government selected Chickasaw Nation Industries Inc. as the national Medicare Secondary Payer Recovery Contractor (MSPRC). When Medicare learns of the identity of an entity that may be the primary payer on a claim, MSPRC will send a 'Pre-Demand Letter' indicating that Medicare may have made a conditional payment in error to the recipient and asserting its lien on future payments or settlements.

The primary payer is required to check its records to determine if it is the proper primary payer and reimburse Medicare accordingly. Otherwise, the MSPRC may send a demand letter advising the specific amount of money due. The primary payer may dispute the claim, but Medicare will decide if the rebuttal is a valid, documented defense. A primary payer can also submit payment pending a decision to stop the running of statutory interest. The downside is waiting for a refund from Medicare should it later decide in favor of the payer.

What are the current deadlines for reporting?

The mandatory requirements for MMSEA are a moving target. The July 1, 2009, reporting deadline was pushed to Sept. 30, 2009, since the onerous nature of the new mandates was not fully appreciated by Congress. The burden is on the responsible reporting entity (RRE) to determine the Medicare status of its claimants and report only those claims or settlements where the injured party is entitled to (although not necessarily enrolled in) Medicare. Although the requirement itself is simple, the implementation is not as easy as CMS envisioned.

The deadline for testing of the reported information has been delayed until March 31, 2010, and the first live reporting is now scheduled for sometime during the second quarter of 2010, despite the July 1, 2009, effective date. As the MSP seeks to shift the Medicare burden onto the private sector, the federal government appears to have little appreciation for the complexity of the insurance market and the impact of this recovery program.

Employers can stay current with CMS policy regarding its MSP program by visiting www.cms.hhs.gov/Manuals/IOM and www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf. <<

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