



# CARR ALLISON

## MEDICARE COMPLIANCE NEWSLETTER

June 9, 2010

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### **CMS Publishes New Alerts Regarding Section 111 Reporting**

CMS recently published alerts offering guidance on several outstanding issues concerning mandatory reporting for liability insurance, self-insurance, no-fault insurance and workers' compensation entities. Links for the alerts can be found in the "What's New" section of the Mandatory Insurer Reporting website.  
[http://www.cms.gov/MandatoryInsRep/04\\_Whats\\_New.asp](http://www.cms.gov/MandatoryInsRep/04_Whats_New.asp)

### **Direct Data Entry for Section 111 Reporting**

The first alert dated May 25, 2010 provides information regarding the direct data entry (DDE) option for RREs who will only submit 500 or fewer claims per year. RREs must register in order to use the DDE option beginning October 1, 2010 and will be able to use the option by January 3, 2011. If an RRE has registered using the current file transmission methods and wishes to utilize the DDE option, the Account Manager will need to log into the COB secure website and change the method of transmission for the RRE ID.

Claims will be reported using the DDE option by logging into the Section 111 COB secure website and manually entering the required data. No testing is required for the DDE option and RREs will not receive an assigned timeframe to submit claims.

A separate query function will not be available for the DDE option. If an injured party's information does not provide a match as a current Medicare beneficiary it will count against the RREs limit of 500 claims per year. Therefore it would be wise to have a process in place to verify a claimant's status beforehand. Claim records will be submitted one report at a time. Users of the DDE option can save a claim record in progress for 30 calendar days.

### **Clinical Trials**

CMS has stated the following regarding Section 111 policy for reporting clinical trials.

"When payments are made by sponsors of clinical trials for complications or injuries arising out of the trials, such payments are considered to be payments by liability insurance including self-insurance and must be reported. The appropriate responsible reporting entity should report the date that the injury/complication first arose as the date of incident. The situation should also be reported as one involving ongoing responsibility for medicals."

<http://www.cms.gov/MandatoryInsRep/Downloads/May27NGHPTeleconference.pdf>

Alabama State Bar Association rules require the following disclosure: "No representation is made that the quality of legal services to be performed is greater than the quality of legal services performed by other lawyers."

## **Write-offs**

As CMS has previously stated, risk management write-offs constitute liability self-insurance for purposes of Section 111 reporting. In order to minimize the risk of a potential liability claim, entities may reduce the amount due for items and services (write-off) or provide something of value (e.g., cash, gift card, etc) to a claimant. In certain situations, these actions can create a reporting obligation. The below examples issued by CMS identify whether a write-off action triggers an obligation to report.

- In instances where a provider, physician or other supplier has reduced its charges or written off some portion of a charge to a Medicare beneficiary as such a risk management tool, the provider, physician or other supplier is expected to submit a claim to Medicare reflecting the unreduced permissible (e.g., limiting charge) charges and showing the amount of the reduction provided or write-off as a payment from liability insurance (including self-insurance). Medicare's interests with respect to this particular TPOC amount have been protected through this billing procedure; the provider, physician or other supplier shall not report the write-off or value of property provided as a TPOC.
- In instances where a provider, physician, or other supplier has provided property of value to a Medicare beneficiary as such 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 shall report the write-off or value of the property provided as a TPOC from liability insurance (including self-insurance). If the value of the property provided is less than the TPOC reporting threshold, it need not be reported under Section 111.
- In instances where any other entity has reduced its charges or provided property of value to a Medicare beneficiary as such 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 shall report the write-off or value of the property provided as a TPOC from liability insurance (including self-insurance). If the amount of the write-off or value of the property provided is less than TPOC reporting threshold, it need not be reported under Section 111.

We are certain that the alert on this issue will create a lot of concern within the insurance industry. We will continue to provide you with any new information on this and other topics.

## **Periodic Workers' Compensation Payments**

The current language in the User Guide regarding periodic payments in workers' compensation and no-fault situations will be updated as follows.

"In situations where the applicable workers' compensation or no-fault law or plan requires the RRE to make regularly scheduled periodic payments, pursuant to statute, for an obligation(s) other than medical expenses, to or on behalf of the claimant, the RRE does not report these periodic payments as long as the RRE separately assumes/continues to assume ongoing responsibility for medicals (ORM) and reports this ORM appropriately. Otherwise, such scheduled periodic payments are considered to be part of and are reported as ORM."

<http://www.cms.gov/MandatoryInsRep/Downloads/AlertPeriodicWCPaymentsUpdateNGHP052710.pdf>

## **Revision to February 24, 2010 Alert**

Revised language regarding who must report can be found in Appendix G under the liability self-insurance heading. The revised language reiterates what was previously stated in the alert. In situations where the liability self-insurance is a deductible, the insurer remains responsible for reporting both the deductible and any amount in excess of the deductible.

## Case Law Update

by Matt Dorius, J.D. and Jennifer Smith, J.D.

In the case of *Seger v. Tank Connection, L.L.C., et al.*, No. 8:08CV75, 2010 U.S. Dist. LEXIS 49013 (D. Neb. April 22, 2010), the U.S. District Court for the District of Nebraska held that the plaintiff was required to provide either his Medicare Health Insurance Claim Number (HICN) or his Social Security Number (SSN) in response to a defendant's discovery request. The defendant sought this information in order to be able to comply with Section 111 reporting requirements following judgment, as well as to assess the plaintiff's damages by determining the amount of conditional payments Medicare had made. The plaintiff ignored the defendant's discovery request, arguing various evidentiary issues and that the defendant did not need the information to comply with Section 111 until judgment had been issued. The court ordered the plaintiff to provide his HICN or SSN, as the information "could reasonably bear on issues in the case" and the plaintiff had not established that providing it was unduly burdensome. *Id.* at \*19.

In *Mixon v. U.S. Agencies Casualty Insurance Company*, 2010 U.S. Dist. LEXIS 32039 (E.D. La. March 31, 2010), the plaintiff, a Medicare beneficiary, received a sum of \$11,173.47 from the defendant as a result of a vehicular accident. The United States moved the court to, and the court subsequently did, order that the funds be deposited into the registry of the court. Importantly, Medicare had issued conditional payments to the plaintiff in the amount of \$43,350.61 for medical services related to the underlying vehicular accident. The court noted that Medicare is statutorily authorized to make conditional payments for medical care and services and then seek repayment for the same in a position superior to all other claimants. This superior interest entitles Medicare to obtain reimbursement from the primary insurer, the defendant in this case. The court held that, because the amount of the conditional payments by Medicare (\$43,350.61) exceeded the amount received by the plaintiff (\$11,173.47), the United States was entitled to the full amount held in the registry of the court.

In *Haro v. Kathleen Sebelius*, 2010 U.S. Dist. LEXIS 38620 (D. Ariz. April 12, 2010), the plaintiffs challenge procedural and policy decisions implemented by Medicare as exceeding the authority of the Medicare Secondary Payer Statute and violating their rights under the Due Process clause of the United States Constitution. Specifically, plaintiffs argue that (1) Medicare can not require repayment of a recovery claim before the amount is determined through the administrative appeal procedures, and (2) Medicare can not make plaintiffs' attorneys financially responsible if they do not hold or immediately turn over to Medicare their clients' litigation proceeds. In *Haro*, the defendant filed a motion for summary judgment claiming that the court lacked jurisdiction over the claims of those plaintiffs who had not exhausted the administrative appeals process. The court denied the defendant's motion, explaining that the administrative review provisions provided in 42 U.S.C. § 405(h) do not provide a mechanism to review the procedural and policy decisions implemented by the Secretary. Further, the court noted that the issue at hand was one purely of statutory construction that did not require consideration of individual MSP claims, nor the agency's expertise. Using the same grounds set forth in its motion for summary judgment, the defendant challenged the scope of discovery, arguing that discovery should be limited to the administrative record for each individual plaintiff. The court denied this motion for the same reasons that it denied the defendant's motion for summary judgment. This case is currently in the discovery stage of the proceedings.

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# CARR ALLISON

## MEDICARE COMPLIANCE DEPARTMENT

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### ABOUT US

The Medicare Compliance Group at Carr Allison is dedicated to assisting clients across the country with Medicare Secondary Payer issues including Section 111 Reporting, Conditional Payment Claim issues and Medicare Set-asides. Our number one priority is and has always been providing exceptional client service. We are truly dedicated to serving our clients well and ensuring compliance with complex federal laws while saving clients as much money as possible. Every client receives individualized, personal attention from experienced attorneys and staff who are familiar with the details of each file. Our medical personnel are readily available to answer medical questions about allocation reports and our attorneys are eager to discuss claims and provide sound, quality legal advice. We believe in complete accountability and frequently provide detailed status updates to our clients on every file. We view our clients as partners and friends, not simply as file numbers or sources of revenue.

In an area that is constantly changing, we make complete Medicare compliance as simple and worry-free as possible. We stay informed of recent and upcoming changes and issues involving the Medicare Secondary Payer Act and make certain that our clients stay informed as well. We welcome the opportunity to serve you and look forward to demonstrating why Carr Allison is the right choice for your organization.

### CARR ALLISON SERVICES

- Preparing Cost-Effective, Accurate Medicare Set-aside Allocation Reports
- Assisting with Medicare Issues in Workers' Compensation and Liability Cases
- Preparing Life Care Plans
- Prescription Drug Reviews
- Verifying Claimants' Public Benefits Status
- Providing Sound Legal Advice and Representation
- Obtaining CMS Approval of Settlements in Appropriate Cases
- Researching and Resolving Conditional Payment Claims
- Conducting Free Training for All Clients
- Section 111 Medicare Reporting Consultation
- Competitive Flat Fee Rates
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- And Much More

### Medicare Compliance Group Attorneys

<b>Name</b>	<b>Telephone</b>	<b>Email</b>
Ben Pugh, Partner/Co-chair	(205) 949-2940	bpugh@carrallison.com
Melisa Zwilling, Partner/Co-chair	(205) 949-2949	mzwillling@carrallison.com
Adrienne Sawyer	(205) 949-2902	asawyer@carrallison.com
Jessica Silinsky	(205) 949-2981	jsilinsky@carrallison.com
Joe Isbell	(205) 949-2931	jisbell@carrallison.com
Kristi Hobbs	(205) 949-2975	khobbs@carrallison.com
Matt Dorius	(205) 949-2923	mdorius@carrallison.com
Jennifer Smith	(205) 949-2974	jsmith@carrallison.com

### **Carr Allison**

**100 Vestavia Parkway, Birmingham, Alabama 35216**

**205-822-2006 phone 205-822-2057 fax**

**[www.carrallison.com](http://www.carrallison.com)**

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