CIVIL MONETARY PENALTIES & OTHER DEVELOPMENTS IMPACTING STRATEGIC MEDICARE COMPLIANCE FOR CASUALTY PROGRAMS, CLAIMS & LITIGATION MANAGEMENT

Thomas S. Thornton, III Carr Allison

OVERVIEW

Dan Millman once wrote in Way of the Peaceful Warrior: A Book that Changes Lives: "The secret of change is to focus all of your energy not on fighting the old, but on building the new!" This article will provide a high-level overview of recent changes in the regulatory, procedural, and judicial framework which will impact the liability and workers' compensation sides of a Casualty Program.

CIVIL MONETARY PENALTIES (CMPs) - THE SHOE HAS FINALLY DROPPED

Since the implementation of Section 111 Reporting in 2007, industry has raced to develop and implement proficient methods of data collection and reporting in order to comply with the Medicare Act and avoid the potential civil monetary penalties of $1,000 a day, per file, for non-compliance. The passage of the SCHIP and SMART Act in 2013 addressed certain constitutional concerns with the original statutory language and required Medicare to provide a more rational penalty and appellate process.

On October 11, 2023, CMS published its final rule and regulation in 42 CFR 402, with an effective date of December 11, 2023. It is this author's opinion that the initial Final Rule is a soft rollout of CMPs to ensure each organization defined by CMS as a Responsible Reporting Entity (RRE) is registered and has a systematic system in place to submit accurate and timely reports.

CMS announced that its initial focus relating to the application of CMPs will be limited to the timeliness of the submission of bodily injury and/or workers' compensation settlements, and it will not apply an error threshold as relates to individual reports. Further, as opposed to auditing individual RREs, CMS will randomly select up to 250 new records (reports) per quarter. The auditing will not begin until the first quarter of 2026. October 11, 2024, is the date upon which the 365-day window to submit a Section 111 Report begins to run for ascertaining the timeliness of records submitted. Additional important factors for RREs to know include, but are not limited to:

- CMPs will only be prospective and not retrospective.
- RREs will be apprised of potential forthcoming CMPs and have an opportunity to present evidence to defend and mitigate any CMPs informally and formally.
- There will be a tiered approach to the monetary amount of the penalties based on the length of delinquency vs timely reporting.
- 5-year applicable Statute of Limitation.

Medicare also clarified and provided a formal safe harbor relating to the industry's efforts to obtain the Big 5 (First and last names, DOB, SSN, gender) from claimants and empowered them to submit a query and, potentially, a subsequent Section 111 Report. Specifically, an RRE should create a system that will document the entity's attempts to obtain an individual's Big 5 at least twice in writing, once by email and once by mail, and one additional time by phone or other means in the absence of successful written communication. Documentation of those efforts must be maintained for at least five years. Medicare also provided that if a claimant, or a claimant's attorney, certifies in writing that they refuse to provide their Big 5/SSN, all further efforts may cease. After that, CMPs against the RRE cannot be assessed for failure to report under Section 111 if the information cannot be otherwise obtained.

- **Best Practice** - All releases should attempt to require the Releasor(s) to verify that they are not a past or current Medicare beneficiary as of the date the release is signed.

CHANGES TO SECTION 111 REPORTING

There have been two primary changes to Section 111 reporting requirements, which will impact the casualty program and litigation industry.

First, pursuant to 42 U.S.C §1395y(b)(8), until recently, an RRE was responsible for submitting a Section 111 Report for any and all claims where:

1) Consideration paid is in excess of $750.
2) Medicals were claimed or released, or the settlement, judgment, award or other payment had the effect of releasing medicals (actual bodily injury and/or medical treatment paid by Medicare was irrelevant).
3) Releasor is a past or current Medicare Beneficiary.

In cases where the claims asserted would typically require a release of medicals, but the alleged incident did not actually have associated medical care, such claims were still reportable. However, instead of reporting diagnosis codes, the code NOINJ would be reported in Field 18 to indicate that no injury was involved. These claims typically involved loss of consortium, E&O, D&O or other similar claims resulting in wrong action relating to a Releasor employment status. Medicare has now stated that in such situations where a claimant attests that they have no alleged damages involving medical care or a physical or mental injury, then the RRE does not have to submit a Section 111 Report. (Medicare Secondary Payer Mandatory Reporting Liability Insurance, No-Fault Insurance and Workers' Compensation User Guide

Chapter IV: Technical Information Version 7.2, pp 29-30 Section 6.2.5.2). In general, where a Section 111 Report is not submitted, the risk associated with a conditional payment claim being asserted is significantly diminished.

- **Best Practice** - Release language should be included in Loss of Consortium or other Professional Liability Claims requiring the Releasor(s) to specifically attest to the lack of any injury requiring medical care in order to document the basis for non-submission of a Section 111 Report.

Second, on February 23, 2024, CMS issued an Alert adding/changing fields to be utilized for a workers' compensation settlement (TPOC) with a date on or after April 4, 2025. Specifically, Medicare is now requiring that the following additional information be submitted as it relates specifically to WCMSAs:

- MSA Amount
- MSA Period
- Lump Sum or Annuity Payout Indicator
- Initial Deposit Amount
- Anniversary (Annual) Deposit Amount
- Case Control Number
- Professional Administrator EIN

The above must be provided beginning April 4, 2025, regardless of whether an MSA is submitted for approval or not. (February 23, 2024, MSP Mandatory Reporting Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 ((See 42 U.S.C. 1395y(b)(7) & (8) Technical Alert: Change to Workers' Compensation Report). It is important for an RRE to remember that a workers' compensation settlement that closes the right to indemnity and/or medical rights/benefits prior to the individual becoming a Medicare beneficiary is not reportable.

- **Best Practice** - See below.

DEVELOPMENTS RELATING TO MEDICARE SET ASIDES FOR LIABILITY AND WORKERS' COMPENSATION INDUSTRY (LMSA AND WCMSA)

It is important for the industry to remember that the term "Medicare Set Aside" does not exist in any specific federal statute or regulation, whether in the context of a workers' compensation or a liability matter. A reasonable interpretation of the law is that Medicare may only recover a conditional payment post-settlement and/or deny a claimant's rights to future Medicare payments after a reasonably allocated amount of the settlement proceeds and/or the total settlement proceeds have been exhausted (42 USC 1395 y(b)(2)(B), 42 CFR 411.46).

Liability Industry: There have been two published memoranda by CMS relating to the LMSA issue. One, dated May 25, 2011, is commonly referenced as the "Sally Stalcup Memo," named after the MSP Regional Coordinator of the Dallas Office at the time. The second is a September 29, 2011, memo from CMS directly relating to safe harbors for a then undefined procedural requirement for medical documentation in support of an assertion that no future accident-related care will be necessary. CMS first attempted to address LMSAs from a regulatory perspective in 2012 with the publication and release of proposed rulemaking. This proposal went through several iterations, with the opportunity for industry comments, the expectation being that the final rule would be released in late 2022/early 2023. In a move that surprised the industry, Medicare withdrew its proposed regulations, which it had attempted to finalize over the previous 10 years. No further action has been taken by CMS since that time.

- **Best Practice** - Whether, when or how to address Medicare's future interest in a liability matter pursuant to 42 USC 1395y(b) should be a decision made by the RRE/Defendant to a liability settlement, and that position should be conveyed to the claim handler/litigation defense counsel before the initiation of settlement negotiations.

Workers' Compensation: The Workers' Compensation Industry experienced confusion in early 2023 following a webinar and release of information related to non-submit WCMSAs. CMS attempted to clarify its position with the release of the WCMSA Reference Guide, Version 3.9, dated May 15, 2023. Specifically, Section 4.3 now clarifies CMS's position on non-submit WCMSAs as representing a potential attempt to shift financial responsibility to Medicare by not properly providing a reasonable relationship between the amount paid to release an indemnity claim and the amount to release the future medical rights of the claimant. The risk associated with a non-submit would now appear to be:

- CMS will deny coverage for treatment until proof that the proceeds allocated to fund an MSA are properly exhausted, assuming the amount is deemed reasonable either through pre-settlement submission to CMS or by subsequent review of the non-submit terms of settlement.
- If the amount allocated in a non-submit is subsequently deemed unreasonable, CMS will require the claimant to exhaust their net proceeds from the settlement before again providing coverage for medical care.

Medicare clarified that the above policy does not apply to WCMSAs that do not meet the review threshold. Unfortunately, the financial burden associated with the voluntary submission process, or even the involvement of a vendor to provide a traditional report, remains. This is because Medicare applies a strict liability analysis related to the future care included in the submission, based primarily upon the medical care provided/recommended by treating physicians and the associated payment of medical cost by the employer/RRE, without giving any consideration to liability or medical causation defenses. This could give rise to constitutional defenses but for the voluntary nature of the submission.

- **Best Practice** - An RRE's reliance upon a cookie-cutter process relating to WCMSA compliance and whether, when or how to involve a Medicare vendor will continue to have a significant negative impact on casualty programs and associated spending. While changes to the Section 111 WCMSA TPOC process will increase scrutiny, they do not take into account the lack of legal authority or available defenses.

FINAL BEST PRACTICES

The Medicare Act and the associated obligations placed upon the industry and practitioner create a tangled web with various intertwined risks and concerns. The claims and litigation industry appears to continue to move at a faster pace, with numerous parties involved and cases becoming litigated sooner. Without "timely" checks and balances in place with the various involved parties, compliance risks will slip through the proverbial cracks. The one primary constant, considering that over 95% of claims settle, is the Release. If you build it, compliance will come!

Thomas S. Thornton, III is a shareholder with Carr Allison. His litigation practice focuses on the defense of personal injury, premises liability, product liability, transportation, general liability and catastrophic workers' compensation matters. He also serves as National Medicare Compliance Counsel, advising businesses, carriers and TPAs on the development of claim-handling strategies and associated release language.