

***Alert! MEDICARE SECTION 111 REPORTING UPDATES Alert!***  
***Alert! MEDICARE LIEN MANAGEMENT UPDATE Alert!***

**In our effort to keep you current regarding developments in the Medicare Section 111 Mandatory Reporting process and Medicare Secondary Payer requirements, the following is a brief overview summarizing some of the most recent developments.**

### **New Option for “Small Reporters”**

“Small Reporters” (500 or less reports/year) may opt to submit MMSEA Sec. 111 claim data on the COBSW manually one claim at a time by registering starting October 1 (or changing present reporting election on or after Oct. 4). Considerations:

- Start reporting Jan. 3, 2011
- Report any required 2010 claims within first quarter 2011
- No testing required
- No 7 day reporting window
- One claim reported at a time
- Submit 2011 claims within 45 days of TPOC/ORM
- No query available
- Same data elements required

### **Write-Off Reporting Rule Announced**

1) Risk management/good will reduction of charge by physician/provider/supplier must be reported in billing to Medicare as payment from liability insurance, so there is no section 111 reporting as a TPOC.

2) Physician/provider/supplier (and all other entities) providing property of value as risk management tool must report as Sec. 111 TPOC if value meets threshold and there is “evidence” or “reasonable expectation” beneficiary has or may seek further medical treatment as a consequence of underlying incident.

### **Reporting of Periodic Payments**

Workers comp and No-fault plans that are required to make periodic payments by statute for obligations other than medical expenses do not need to report these payments if there is a separate assumption of ORM and the ORM is reported under MMSEA Sec. 111. Otherwise, the RRE must report the periodic payments as ORM.

### **Reporting of Deductibles Clarified**

Although a deductible continues to be considered by CMS as “Self-Insurance”, if there is a report being submitted by an insurer for a particular claim where the deductible is paid as well, then the insurer must report the total payment including the deductible. The entity paying the deductible does not need to report the claim under MMSEA Sec. 111.

### **Health Reimbursement Accounts (HRA)**

Group Health Plan (GHP) reporting under MMSEA Sec. 111 requires reporting regarding health reimbursement accounts with an annual benefit of \$1,000 or more. You may be aware that reporting of these arrangements is to commence in the 4<sup>th</sup> quarter of 2010 or 1st quarter 2011 depending on the effective date of the arrangement. In a recent alert from CMS, the reported termination date for such plans was clarified to reflect the date when the beneficiary loses or cancels the coverage not when the annual benefit is reached.

# MEDICARE INSIGHTS

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## **Provider Billing Time Limit Change**

With the changes required by the Patient Protection and Affordable Care Act, Sec. 6404, Medicare claims must be submitted within one year of the date of service. This will ease the collection of MSP conditional payments for which Medicare has a right of reimbursement in liability claims (under the old time limit, bills could be submitted up to 27 months after service). Still be watchful for any significant care that is not reflected as paid by Medicare in the conditional payment letter.

## **Medicare Secondary Payer Enhancement Act Status**

You will recall we had reported the introduction of this bill, HR 4796, a few months ago. The bill seeks to simplify the rules for dealing with CMS with regard to managing Medicare's right of reimbursement from liability settlements and judgments. The bill has been referred to the House Ways and Means Committee and the House Energy and Commerce Committee. No news has come out of these committees as to whether they will consider the bill at this time. R. David Camp (MI) is the ranking member of the Ways and Means Committee. This bill seems to have support on both sides of the litigation bar so far.

## **Medicare Advantage Not Covered by MSPRC Recoveries**

In a recent Medicare Secondary Payer Recovery Contractor (MSPRC) town hall meeting, CMS advised that the private pay Medicare advantage plans are not covered under the auspices of the MSPRC recovery of conditional payments. However, Medicare Advantage plans can assert the same conditional payment rights historically available to Medicare Parts A and B covered by the MSPRC. As a result, be careful when evaluating settlements and judgment payments to ensure that Advantage plans if any, are properly considered and protected for reimbursement.

## **Medicare Part D Subject to Coordination of Benefits!**

Some Part D prescription drug carriers are also seeking reimbursement under the Medicare Secondary Payer act. Regulations governing Part D mandate that Part D sponsors are to seek reimbursement for payments made conditionally on behalf of beneficiaries to the extent there is a secondary payer through settlement or judgment. As above with the Advantage plans, this recovery effort is separate and distinct from the MSPRC conditional payment recovery and will not be reflected in the conditional payment letter. Watch for drug coverage expenses when evaluating liability case values.

## **Closing Note**

While we are hopeful this information is of use, it does not substitute for legal advice. We remain positioned to work with you toward your ultimate compliance.

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