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See page 3

Tips to Minimize Medicare Secondary Payer Reporting Liabilities

by Eli Poliakoff

As noted in the Spring 2010 issue of *DefenseLine*, Section 111 of the Medicare, Medicaid and SCHIP Extension Act ("Section 111") requires defendants to report to the federal government certain settlements with Medicare beneficiaries. This article suggests ways to mitigate potential liabilities associated with Section 111 reporting.

Section 111 Reporting

Non-compliance with the Section 111 reporting obligations can result in \$1,000 per day, per claim penalties, regardless of the amount of settlement. Penalties can result from a variety of mistakes, such as a failure to timely register for the reporting program; confusion over whether the defendant or its insurer has the reporting obligation; an incorrect determination that a plaintiff was not a Medicare beneficiary or that a specific settlement arrangement was not reportable; or due to another entity's delay (for instance, a reporting vendor). Additionally, penalties could arise due to inaccurate reported information.

To reduce the likelihood of reporting mishaps, settling defendants and their insurers should identify which entity is legally responsible for reporting (the Responsible Reporting Entity, or "RRE"). As noted in the prior article, the RRE designation depends on the settlement amount and insurance arrangement. Insureds and insurers should also identify which entity will administer the reporting (RREs can contract with other parties to oversee their Section 111 submissions). The RRE remains responsible for reporting penalties regardless of such arrangements; accordingly, vendor contracts should allocate responsibility for reporting penalties.

Entities that have a reasonable expectation of reporting should register by September 30, 2010 to allow for the required calendar quarter of testing before reporting begins in the first quarter of 2011. The agency that administers Medicare and runs the Section 111 program (the Centers for Medicare and Medicaid Services, "CMS") has indicated that a good faith effort to comply with the registration, testing and reporting deadlines is a defense against a penalty assessment. However, CMS has suggested that little sympathy will be accorded to entities that ignore the deadlines or fail to make alternate arrangements.

Most importantly, RREs should integrate the reporting requirements into the claims evaluation

and resolution process. CMS has provided an official form for use in obtaining Social Security and Medicare identification numbers, without which RREs cannot report. Discovery can also elicit certain information for reporting. Defendants may want to work with plaintiff's counsel to identify reportable information through fact sheets or other written agreements. Ultimately, the defendant/insurer is responsible for the content and timing of the report.

Plaintiff's counsel have incentive to cooperate with efforts to report accurate information. Section 111 reports include diagnosis codes that identify the injury or illness underlying the settlement. CMS will use the reported code (with other information) to connect the settlement to prior medical expenses made on behalf of the beneficiary (if any). If not accurately reported, CMS's recovery demand may inadvertently include past expenses that are unrelated to the injury covered in the settlement – thus hampering both parties' efforts to close out the case.

Section 111 Data Use Agreement

As discussed in the prior article, RREs must complete a Data Use Agreement ("DUA") when registering for the Section 111 program. The DUA imposes data security obligations and requires the RRE to protect the confidentiality of data and establish safeguards against unauthorized use and disclosure of information exchanged with CMS. Since the DUA alludes to "civil and criminal penalties for noncompliance contained in applicable Federal laws," RREs should revise information security policies and procedures to incorporate the DUA's requirements. The DUA holds RREs responsible for the acts of third party vendors; accordingly, RREs should ensure that vendor contracts address the DUA's requirements and penalties.

Medicare Secondary Payer Program

The Medicare Secondary Payer ("MSP") program is a voluminous combination of statutory provisions, federal regulations and private contractor guidelines. A thorough review of the MSP program is beyond the scope of the article. However, Section 111 reporting and the MSP program are intertwined processes. Section 111 reporting identifies settlements for the Medicare Secondary Payer Recovery Contractor's

Continued on middle of page 34

ARTICLE
CONT. FROM
PG. 25

Punitive Damages in South Carolina cont.

On the flip side, *Mitchell* seems to favor a plaintiff as well. For example, in *Mitchell*, potential damages are now a possible multiplier in fixing a punitive damages award, meaning a great deal more money can be awarded. In contrast, the Tort Reform threatens to top a punitive damages award off at a cap, rendering the multiplier and ratio guidepost moot points. The proposed legislation also reduces the overall liability a defendant can be exposed to, which means less compensatory damages and consequently a lesser punitive damages award if the issue is even reached at all. Yet, the Tort Reform is not all negative for a plaintiff. It does bring back the *Gamble* factors making it easier for a plaintiff to introduce evidence in support of a punitive damages award.

ARTICLE
CONT. FROM
PG. 26

("MSPRC") review. If applicable, the MSPRC will assert the "Medicare lien" on the settlement proceeds.

In general, Medicare will first seek to recover its expenses from the beneficiary/plaintiff. Under MSP regulations, if the beneficiary does not reimburse the government within 60 days of settlement, the government can recoup its payments from any entity that funded the settlement (for example, defendants or insurers) or received the settlement. The latter category most commonly includes beneficiaries and plaintiff's counsel, but might include defense counsel if settlement funds are conveyed to counsel for disbursement.

If the government does not have to file a recovery lawsuit, the settling defendant may be liable for the lesser of the lien amount or the settlement (both of

ARTICLE
CONT. FROM
PG. 32

all safety-based violations found during roadside inspections to formulate a carrier's safety rating (as well as continuing to use violations found in investigations); and, significantly, an adverse rating can issue based on only one deficient area. Currently, the three rating labels are Unsatisfactory, Conditional, and Satisfactory. The three new proposed labels – Unfit, Marginal, and Continue to Operate – especially the two more adverse of the three ratings, are arguably terms loaded with even more negative connotations for a fact finder. Also of note, while a carrier's fitness ratings are currently updated only when a compliance review is conducted, under the proposed rules a fitness rating will be updated monthly. While it is currently not anticipated that the new fitness determination and rating rules will be promulgated with the roll-out of CSA 2010, carriers and practitioners need to be aware that changes, whether in the current proposed form or as further modified in the rule-making process, are likely on the horizon.

Also, *Mitchell* adds an additional obstacle between a plaintiff and a punitive damages award by changing the post-judgment review to the de novo standard instead of just abuse of discretion.

Conclusion

In short, our courts and legislature are introducing significant change to the law of punitive damages in South Carolina. We will know by the end of this year's Session which side will have its way – the *Mitchell* Court or the 2010 Tort Reform. As it stands now, the Tort Reform will determine the fate of the *Gamble* factors, the multiplier, and the overall ability to recover larger punitive damages awards, but it will not affect *Mitchell's* de novo standard. Whatever the change, neither the plaintiffs nor defendants will be spared.

which can be further reduced to reflect the plaintiff's costs of procuring the settlement). However, if the government files a recovery lawsuit, the primary payer is liable for double the amount of the lien – regardless of the amount of the settlement.

While the MSP regulations suggest that a settling defendant's liability may accrue as soon as 60 days after settlement, MSPRC procedures for identifying the reimbursable amount can take several months. Under the latest MSPRC guidelines, it is unlikely that a defendant's liability would accrue sooner than approximately 150 days after settlement.

Interested parties should follow recent legislation introduced in Congress (the Medicare Secondary Payer Enhancement Act, H.R. 4796) that would significantly revise the MSP recovery process.

Conclusion.

In sum, CSA 2010 provides for a much more expansive program in monitoring carrier compliance and safety. The wide-ranging investigation and intervention processes under the CSA 2010 will require more on-line monitoring by carriers of their BASICs scores, underlying reporting, and data – and trucking defense attorneys likely will have a corresponding increased role in evaluating and responding to governmental assertions of regulatory violations and claims. Moreover, BASICs data, the underlying reporting, and documentation of investigations/interventions will no doubt provide new areas of discovery and potential fodder for plaintiffs in trucking cases. It will be important for trucking defense practitioners to gain an early understanding of the changes wrought by CSA 2010, so as to best advise clients with regard to compliance and the new landscape of investigation/intervention – as well as to best anticipate the role CSA 2010 will undoubtedly play in truck wreck litigation.