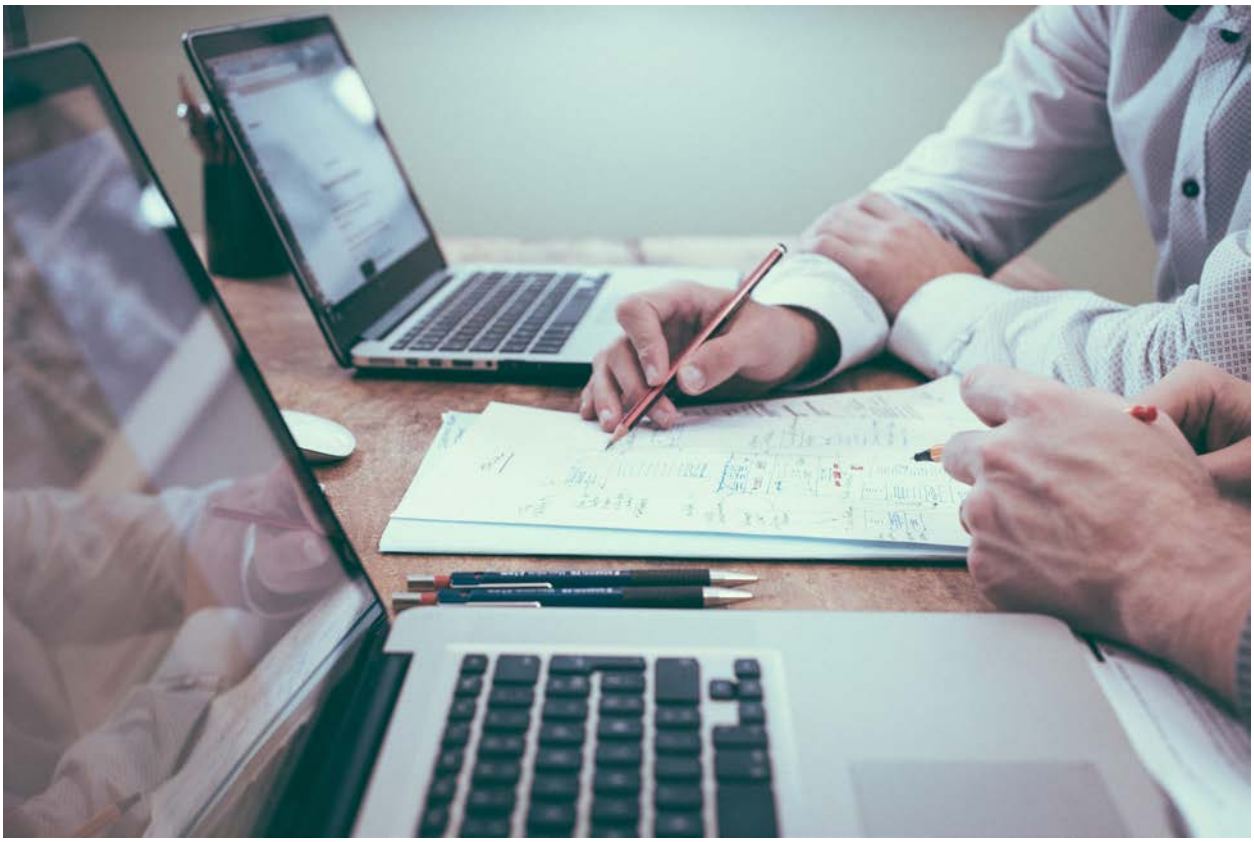
How the Advent of the Mandatory Insurer Requirement Causes Problems for Lawyers



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The following is adapted from The Art of Settlement.

Any time a personal injury lawyer represents someone who is Medicare eligible, it automatically triggers concerns over the implications of compliance with the Medicare Secondary Payer Act (MSP). The passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) has triggered heightened concerns of all parties to a settlement involving a Medicare beneficiary. Part of this Act, Section 111, extends the government's ability to enforce the Medicare Secondary Payer Act.

As of April 1, 2011, a Responsible Reporting Entities/insurers (RRE), (liability insurer, self-insurer, no-fault insurer, and workers' compensation carriers) must determine whether a claimant is a Medicare beneficiary ("entitled") and if so, provide certain information to the secretary of Health and Human Services (hereinafter "secretary") when the claim is resolved. This is the so-called Mandatory Insurer Requirement, MIR for short.

Under MMSEA, the RRE must report the identity of the Medicare beneficiary to the secretary and other such information as the secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of a claim. Failure of an applicable plan to comply with the reporting requirements potentially exposes them to a civil money penalty for each day of noncompliance with respect to each claim.

These reporting requirements make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties and potentially deny future Medicare-covered services related to the injuries suffered.

But the advent of MIR causes some very real and difficult problems for lawyers handling claims involving Medicare beneficiaries—most notably, the required disclosure of ICD codes and the need for hypervigilant release language.

Required Disclosure of ICD Codes

The biggest problem with the reporting requirement is the required disclosure of International Classification of Diseases (ICD) medical diagnosis codes which identify the medical conditions that are injury related. These ICD codes can form the basis for the care potentially rejected by Medicare in the future.

If the plaintiff and plaintiff's counsel are unaware of the conditions disclosed by the defendant/insurer through the reporting process, there could be some serious problems when the plaintiff seeks medical care from Medicare in the future. For example, a plaintiff sustained back and neck injuries which were claimed as a part of their lawsuit. The plaintiff had preexisting neck problems. The case is ultimately settled with the defendant paying nothing for the neck injury because they determined that the neck injury was primarily due to a preexisting condition.

Now the defendant/insurer reports the settlement and lists the ICD-9 codes related to the neck injury even though they paid no settlement dollars toward that injury and rejected that part of the claim. The neck care could be rejected by Medicare in the future leaving the client with no Set-Aside funds to pay for that care and no Medicare coverage either.

Worse yet, your ability to negotiate a conditional payment made by Medicare may be complicated by including care that is unrelated. This issue is further exacerbated by the reporting data being submitted by outside reporting agents who are only providing initial case information without involvement of plaintiff's counsel.

The Need for Hypervigilant Release Language

In this new age of hypervigilance surrounding Medicare compliance as a result of MIR, release language about protecting Medicare can be longer than the release itself. This language is frequently inaccurate or wholly inapplicable. In practice, I have seen language that mandates that the personal injury victim will not apply for Medicare or even Social Security Disability benefits. Equally as bad, language is frequently included that places a burden on the plaintiff to

comply with requirements that aren't mandated by any law. Most of the language improperly cites statutes or regulations that don't say anything relevant to the issues at hand.

Therefore, great care needs to be taken by the personal injury practitioner in terms of what is agreed upon and included in the release. Technically, there is nothing required by any law that needs to be addressed in the release as it relates to the MSP. Practically speaking though, language has to be there to placate the other side's misinformation about their own liability regarding many of the MSP-related issues. It is simple to address these issues concisely and in a way that doesn't place any onerous obligations upon the plaintiff. Every case is different, and the facts dictate the use of a different language each time, but there is a core set of provisions that can be done in one simple paragraph to deal with the Medicare-related issues at hand.

Work Collaboratively with the Other Side

The Medicare Secondary Payer Act and the Mandatory Insurer Reporting requirements form a complex set of issues that personal injury lawyers must deal with. As a result, realizing that every settlement with a Medicare beneficiary of one thousand dollars or more will be reported along with a variety of data points is critically important. Every time I am consulted by other lawyers about this issue, I suggest that the parties should be collaborating on this aspect of the Medicare settlement process. Working collaboratively with the other side when it comes to these issues is recommended.

If the plaintiff does not know what is being reported, then the scenarios above could easily occur. Without focusing on this issue as part of the settlement process, a plaintiff, plaintiff's lawyer, or an elder law attorney involved in the case may find there are serious unintended repercussions that result. Having incorrect or inaccurate information reported can cause issues for both your client and your law firm.

For more advice on the Mandatory Insurer Requirement, you can find The Art of Settlement on Amazon.

Jason Lazarus is the founder and CEO of Synergy Settlement Services and the managing partner and founder of the Special Needs Law Firm, a boutique firm focused on special needs settlement planning and lien litigation. Jason received his BA from the University of Central Florida and his JD, with honors, from Florida State University. He also earned his LLM in elder law with distinction from Stetson University College of Law. As a Medicare Set-Aside Consultant (MSCC), Jason is certified by the International Commission on Health Care Certification.

To learn more about Jason Lazarus and his book Art of Settlement, visit his website and if you would like to learn more about Synergy Settlement Services, visit their website.