WORKERS' COMP NEWS

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Medicare reporting requirements

Employers, insurers brace for impact

Employers, insurers, and TPAs still getting used to the intricacies of Medicare Set-asides have a new challenge on their hands: understanding the intricacies of Medicare's recent reporting requirements.

As widely reported, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) imposes new mandatory reporting requirements on insurers and self-insurers in group health plans, liability insurance, no-fault insurance, and workers' compensation.

Businesses subject to the Act must report extensive information about the Medicare beneficiary, the claim, and the business itself once there has been a settlement, judgment, award or other payment. These reports must be submitted electronically on a quarterly basis.

The purpose of the requirement is to enable the Centers for Medicare & Medicaid Services to track payments to or on behalf of Medicare beneficiaries, so CMS can ensure Medicare remains a secondary payer and is not billed for charges that should be the responsibility of other parties.

Jessica Silinsky, an attorney in the Birmingham office of Carr Allison, notes three important points about the new reporting requirements:

- Only claims involving Medicare beneficiaries must be reported
- Huge penalties for non-compliance - $1,000 per day, per claimant. Since the reporting is quarterly, an employer who misses a deadline for reporting a claim could potentially face as much as $90,000 in fines because of one missed deadline.
- Responsible Reporting Entities (RREs) should do their homework

"Medicare will now be able to identify parties from which it can recover and, therefore, Responsible Reporting Entities should expect to receive conditional payment letters. It is important to begin the conditional payment claim research as early as possible in order to consider that amount in the parties' settlement negotiations," she adds.

Ms. Silinsky spoke on the subject at the recently held General Membership Meeting of the South Carolina Self-Insurers Association, Inc. She emphasized that in contracting with companies to handle the reporting to Medicare, RREs should be aware they are also binding themselves to contracts that will allow the companies to do MSAs in cases that do not warrant them.

"These agreements will likely result in high allocations that may unnecessarily hinder or prevent settlements. RREs should read those contracts carefully and strike language which would allow the company to prepare a Medicare Set-aside allocation report in any case that fits within the company's defined guidelines," she advises.

Ms. Silinsky notes there is some confusion among employers and others over Medicare's new reporting requirements and the agency's guidelines for Medicare Set-asides. "The reporting requirements are an entirely separate issue from the requirement to protect Medicare's interests with regard to future medical treatment," she points out.

Another misconception concerns what triggers reporting. For claims involving ongoing responsibility for medicals, an RRE must report to Medicare when it has assumed responsibility for medical care, and not upon or after the first payment for medical care, she says. Reporting is required for claims involving a Medicare beneficiary if ongoing responsibility for medicals was assumed on or after July 1, 2009.

"Also, the other category of claims that must be reported involve the so-called Total Payment Obligation to the Claimant (TPOC) without regard to ongoing medical services. Subject to certain exceptions and thresholds, all claims involving a Medicare beneficiary with a TPOC date of January 1, 2010 or subsequent, must be reported," she adds.

Although Medicare has been the secondary payer to other insurance for many years, the agency had been handicapped until recently because it did not have all the information needed to track potential payers. With an estimated 80 million or so baby boomers soon expected to be eligible for Medicare, the agency is determined to improve what in effect had been a "pay and chase" policy. ■

What's Inside

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APPEALING* RESULTS

By Sam Painter

Listed below are brief summaries of points of law made by South Carolina appellate courts in recent decisions that are of general interest to workers' compensation self-insurers:

- A trustee of an electric co-op was not entitled to workers' compensation benefits when he was injured in a wreck while traveling to a conference related to co-op business because he was not an employee, even though the co-op paid him a per diem and reimbursed his expenses. *Shuler v. Tri-County Electric Co-op, Inc.* [Supreme Court].
- An inmate injured while serving time on the weekends may not combine wages to determine his average weekly wage under the applicable statute (§ 42-7-65). *Smith v. Barnwell County* [Supreme Court].
- An employee's false statement in an employment application will bar workers' compensation benefits when: (1) the employee knowingly and willfully made a false representation as to his physical condition; (2) the employer relied upon the false representation and this reliance was a substantial factor in the hiring; and (3) there was a causal connection between the false representation and the injury. *Brayboy v. Workforce* [Supreme Court]. *Also, Fredrick v. Wellman* [Court of Appeals, both cases citing *Cooper v. McDevett & Street*].
- Once a claimant files a claim, that claim encompasses all of the effects of that accident. Effects of that accident that are not claimed until more than two years after the accident will not be barred by the statute of limitations. *Hieronymus v. Hamrick* [Court of Appeals].
- An order which found that one portion of a claim was not compensable (a brain injury) and which remanded the claim for further findings with respect to other injuries was a final order with regard to the brain injury and was therefore appealable [i.e., it was not interlocutory]. *Canteen v. McLeod Regional Medical Center* [Court of Appeals].
- An order by a circuit court judge remanding a case to the Appellate Panel for the taking of additional evidence is interlocutory, or non-final, and not immediately appealable. *McCrea v. City of Georgetown* [Court of Appeals].
- It was error for the circuit court to reverse the full commission's denial of a heart attack on both evidence and notice grounds where there was substantial evidence in the record which supported the full commission's decision. *Watt v. Piedmont Automotive* [Court of Appeals].
- It was an abuse of discretion for the appellate panel and the single commissioner to deny the employer the opportunity to take the depositions of the claimant's supervisor and the claimant's physician when the employer's inability to take these depositions was not due to the fault of the employer (the supervisor was sick; the doctor was too busy). *Trotter v. Trane Coil Facility* [Court of Appeals].
- The Commission's determination that the claimant was entitled only to an award of 10% loss of the back (and not to an award of total disability) was supported by substantial evidence. *Fishburne v. ATI Systems International* [Court of Appeals].
- Where the appellate panel has made no factual findings with respect to an issue, the issue must be remanded for further findings. *Mungo v. Rental Uniform Service of Florence, Inc.* [Court of Appeals].

*And sometimes not so appealing. These points of law are presented subject to the following disclaimer: Fairly summarizing a point of law in a sentence or two is often difficult. Sometimes it is impossible. Before relying on any of the points of law discussed, you should review the entire decision, and check to see if the case has been subject to further appeal. ■

President's Column

Lingering questions about the SIF

David Keller

It is hard to believe the holiday season is almost upon us. That also means the legislative session for 2010 is only two months away. Luckily, with so many other issues on their plate legislators are not expected to tinker with workers' compensation.

Our association has been focused on dealing with issues related to the orderly winding down of the Second Injury Fund. On October 28, a group from the Association met with the director of the Fund to discuss the current formula for the agency's yearly assessment.

I have also asked Cliff Scott, one of our board members, to head up a group to look into how we might be helpful in formulating a winding-down strategy for the Fund. The statute gives the Workers' Compensation Commission and the Department of Insurance authority to advise the Budget and Control Board on how it might close the Fund.

In the next few months we will solicit ideas from you about how existing claims can be run off, with special emphasis on life time medical claims and claims involving Social Security beneficiaries. We are also interested in assisting the Commission in implementing long-postponed regulations required by the Reform Act of 2007.

Finally, please make plans to join us for our annual Members' Only Forum, set for April 21-23 at Litchfield Beach. This year's program promises to be the best ever!

Happy Holidays and a Happy New Year. ■

WORKERS' COMP NEWS

Workplace safety

Employers can expect more scrutiny from feds

A recently issued report by the U.S. Government Accountability Office charges physicians and nurses are often pressured by employers to conceal workplace injuries - even if it means providing inadequate medical treatment.

"From its survey of U.S. health practitioners, GAO found that over a third of them had been subjected to such pressure," the watchdog agency said in its report, titled Workplace Safety and Health: Enhancing OSHA's Records Audit Process Could Improve the Accuracy of Worker Injury and Illness Data.

The *Charlotte Observer* reported that in a survey of 504 occupational health practitioners - including company doctors and nurses - the GAO found:

- More than a third said they were asked to provide insufficient treatment to workers so that job-related injuries did not show up on company injury logs.
- More than half said they were pressured by company officials to downplay injuries or illnesses.
- More than two-thirds said they knew of employees who feared disciplinary action if they reported injuries.
- The GAO pointed to another factor that discourages reporting: programs that reward employees with prizes or bonuses if their plants go long periods without recordable injuries.

GAO was asked by Congress to determine (1) whether DOL verifies that employers are accurately recording workers' injuries and illnesses and, if so, the adequacy of these efforts, and (2) what factors may affect the accuracy of employers' injury and illness records.

Separately, the U.S. labor department announced in late October it would step up oversight of all state workplace-safety programs, "a signal of more-stringent enforcement following a report critical of Nevada's response to a string of workplace deaths," the *Wall Street Journal* reported.

"The action follows calls from unions and senior congressional Democrats -- including Senate Majority Leader Harry Reid of Nevada and U.S. Rep. George Miller of California -- for a tough response to 12 construction deaths that occurred on the Las Vegas Strip between December 2006 and June 2008 amid a building boom," the newspaper added.

> ***...The deaths in Nevada raised concerns about OSHA's monitoring of all state plans...***

"The safety of workers must be priority one, and the U.S. Department of Labor is stepping up review of state OSHA plans to ensure that is the case," said Labor Secretary Hilda Solis.

State OSHA plans are required to be at least as effective as the federal safety agency, but the federal government's ability and effort to enforce that is limited and varies by who is running the executive branch. The deaths in Nevada raised concerns about OSHA's monitoring of all state plans, putting pressure on the agency to strengthen its oversight of all such programs.

"Mr. Barab, the Labor Department's acting assistant secretary for OSHA, said OSHA would start more-rigorous state reviews immediately and hopes to have initial results in the spring. He said the agency wasn't targeting any particular states," the *Journal* reported. ■

Tips on managing expensive claims

Medical cost inflation in workers' compensation is nearly double that of medical cost inflation overall, which is projected to be twice as much as general inflation. All the more reason then for employers to focus on the many-headed monster that refuses to be tamed no matter how much employers throw at it.

"The conventional focus of insurers is to try to lower the cost of each individual unit of care, such as a diagnostic test or a physical therapy visit," notes Kevin Fleming, president of Paradigm Management Services, writing in the November 2009 publication of the National Council of Self-Insurers. A common strategy is to contract with medical provider networks that negotiate discounts with providers, he adds, but that approach is not working well either.

"What is needed is a more far-reaching cost containment approach," Mr. Fleming writes, in arguing for a multi-pronged approach that includes current cost-containment strategies combined with sharp focus on catastrophic, chronic, and pain-related cases. NCCI estimates 50% of medical spending in workers' compensation arises from 6.2% of claims.

Mr. Fleming suggests the following approach:

Sharpen your traditional tools

These include essentials such as utilization review, pharmacy benefit management, and an emphasis on benchmarking results

Contain chronic pain treatment

Chronic pain claims account for nearly half of total medical costs in workers' compensation. "Much of the treatment for chronic pain is controversial, expensive, very often ineffective, and even harmful to the patient," Mr. Fleming writes.

(Continued on page 4)

CALENDAR

December 10, 2009	NCCI's State Advisory Forum. Columbia Metropolitan Convention Center.
March 24–26, 2010	Annual Conference North Carolina Association of Self-Insurers. Wrightsville Beach.
April 21–23, 2010	Members Only Forum, SC Self-Insurers Association. Litchfield Beach & Golf Resort, Pawleys Island.
April 25–29, 2010	RIMS 2010 Annual Conference & Exhibition. Boston Convention & Exhibition Center.

Healthcare will change comp too

Employers can expect more scrutiny

(Continued from page 3)

Employers and insurers would do well to select a team of expert physicians and nurses to monitor such claims and keep abreast of treatment and prognosis. The nature of chronic pain claims is such that months and even years may elapse without the claimant experiencing sustained pain relief, he writes.

Carve out the management of catastrophic injuries.

Claims for severe burns, spinal cord trauma, and devastating brian injuries are also in a class by themselves. Medical treatment is complex, often involving multiple teams, and risk of complications is high. Employers and insurers should choose highly skilled practitioners for each type of injury.

Monitor care and costs of former catastrophic injury patients

Cases not managed well in the initial stages are prone to complications, two years or even 15 years later. Unless the claimant has returned to work, employers and insurers should remain vigilant.

Take-home message: Smart employers and insurers develop the expertise to discern "who is best to provide what care at what time in the course of treatment," Mr. Fleming concludes. ■

Although workers' compensation is not included in the ongoing efforts to reform healthcare, experienced observers note broad changes in healthcare would have an impact on workers' compensation.

"You can't fundamentally alter the national health care system and not affect workers' comp," said Dave North, president and chief executive officer of Sedgwick Claims Management Services Inc. in Memphis, Tenn. He was quoted in a story in Business Insurance.

One obvious area is medical errors. If initiatives foreseen in healthcare reform legislation – such as electronic health records and emphasis on evidence-based care - improve healthcare delivery, workers' comp would benefit as well given that healthcare costs account for nearly 60% of the total cost in workers' compensation

Similarly, observers say if prevention and wellness efforts can reduce obesity and diabetes that too would have a favorable impact as these two co-morbidities drive up cost of comp claims. In the same vein, changes in how providers are reimbursed could have spillover effects for workers' compensation.

Harry Shuford, chief economist at NCCI, says if the U.S. healthcare system moves from the current fee-for-service model to some sort of pay-for-performance compensation structure then workers' comp would follow suit. ■

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