NC Workers' Comp NEWS

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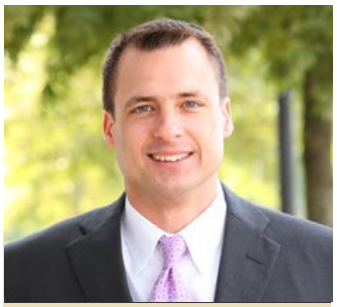

Medicare reporting requirements: Stiff penalties for non-compliance

by Gregg Newton

It bears emphasizing that 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.

Space does not permit a full airing here of this far-reaching legislation but the basics are simple. Businesses subject to the Act must report the names and Social Security numbers of every Medicare beneficiary who, after June 30, 2009, received a settlement, judgment, award, or other payment that constitutes payment or reimbursement for medical costs associated with a claim.

These reports must be submitted quarterly, electronically. Businesses that fail to comply may be fined up to $1,000 per day per Medicare beneficiary. 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 payor and is not billed for charges that should be the responsibility of other parties.

Medicare calls businesses covered by the Act ***Responsible Reporting Entities***. Such an entity may delegate its reporting to an agent but the Responsible Reporting Entity remains ***responsible*** for ensuring the reports are accurate and timely. RREs were to register with CMS by September 30, 2009.

Who is deemed a Responsible Reporting Entity? In most claims, the answer will be obvious—either the insurer or self-insured making payment on the claim. The answer may not be so obvious in cases involving TPAs, substantial deductibles, or retentions. CMS has made it clear that TPAs are never considered RREs for reporting purposes. Although a TPA can be a reporting agent for the RRE, the RRE, itself, has ultimate responsibility.

Beginning on January 1, 2010 and continuing through March 31, 2010, registered RREs are required to submit test reports and must pass the testing process prior to submitting "live production files, beginning with the second quarter of 2010. Businesses should ask themselves two basic questions: 1) is the Claimant a Medicare beneficiary? 2) does the claim need to be reported?

The most reliable way to determine Medicare eligibility is to query CMS. This requires one have the claimant's name, SSN, DOB and gender. RREs should develop systems to gather this information efficiently and keep track of claimants whose eligibility status needs to be determined or updated.

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President's Note

Speakers, exhibitors welcome

Please make plans to attend our 2010 conference, set for March 24-26 at the Holiday Inn Sunspree Resort at Wrightsville Beach, Wilmington. We expect to have the program nailed down by year's end and will update you immediately thereafter.

If you are interested in making a presentation or would like us to address a specific topic, please drop a note to our executive director Moby Salahuddin at msalahuddin@sc.rr.com. Please bear in mind that our audience mostly includes claims professionals, lawyers, rehab nurses, and surveillance specialists.

As in years past, we will make opportunities available for sponsors and exhibitors. At press time, all indications are the economy continues to improve and we are hopeful conditions will be much better by March next year than they were in 2009.

With very best wishes,

Jay Norris, *president*

CASE LAW UPDATE

By Joe Austin

Subrogation Liens

The Court of Appeals has re-affirmed that a Superior Court judge has discretion to eliminate an employer's workers' compensation lien. In Leggett v. AAA Cooper Transportation, the employee was injured in a motor vehicle accident and recovered $99,000.00 for his personal injury claim. Although the employer had paid $182,961.00 in workers' compensation benefits arising out of the accident, Judge Alma Hinton ruled that the employee was entitled to all of the proceeds from the personal injury claim, and eliminated the employer's lien. The Court of Appeals upheld the ruling, reasoning that the elimination of the lien was within the judge's discretion. As a practical matter, employers should always consider the prospect that a workers' compensation lien can be eliminated in negotiating with an employee over the disposition of the proceeds of a personal injury claim. Furthermore, employers should be aware that this issue can be negotiated prior to the resolution of a personal injury claim, and should be considered as a term to be included in a clincher agreement, which can be negotiated when the employer may have more leverage to obtain a favorable agreement for the distribution of any personal injury proceeds.

Attorney's Fees

In D'Aquisto v. Mission St. Joseph's Health System, the Court of Appeals held that the Commission has the discretion to order the employer to pay the employee's attorney for time spent fighting an appeal where the employer appealed the award of benefits to employee and the award was affirmed on appeal. The Court found that unlike an award of attorney's fees for an unreasonable defense, the Workers' Compensation Act allows the Industrial Commission to assess attorney's fees if the employer appeals an award and does not prevail. As a result, employers should be mindful of this potential additional cost when considering whether to appeal from an adverse award from the Commission.

Post-Injury Drug Testing

Once an employer presents competent evidence that an employee's impairment was a proximate cause of an accident, the employee is required to refute that evidence. In Moore v. Sulbark Builders, the Court of Appeals upheld the Industrial Commission's determination that the employer had failed to present competent evidence of intoxication, even through a post-injury urine sample demonstrated traces of marijuana. The Court held that the test that was administered did not provide the actual level of cannaboid concentration, and was therefore insufficient to show impairment. In light of this ruling, employers should consider obtaining detailed analysis for any substance that shows up as positive in a routine drug screen in order to preserve a viable intoxication defense.

Joe Austin leads the workers' compensation practice group at Young Moore and Henderson in Raleigh. A graduate of Davidson College, Joe received his law degree from Wake Forest University.

At the NC Industrial Commission

Budget cuts force new fees at the Commission

by Amy L. Pfeiffer

The safety department at the North Carolina Industrial Commission is now fee-based, meaning the department will implement fees for its services. The department has to support itself from fees or risk being phased-out entirely.

The change is expected to save approximately $2.5 million per year. Also, two Deputy Commissioner positions and three legal specialists (law clerk) positions in the Commissioners' offices will no longer be supported by the general fund, and instead must be supported by fees generated specifically by the Commission.

The intent is to save the state about $370,000 per year for these five positions. Which means in order for these positions to survive the Commission will have to raise as much in fees and specifically allocate the money towards these positions.

Consequently, as of October 1, the Commission raised the processing fees for reviewing clincher agreements from $250 to $375. Also, as of October 1, the agency requires processing fees for clincher agreements, Form 24 applications, and Form agreements (21, 26 and 26A) be submitted with the documents, rather than invoicing defendants after the documents have been processed.

Please note for Forms 21, 26, and most significantly Forms 26A, the Commission requires the processing fee check or money order ($125) be mailed or hand-delivered to the Commission along with the agreement, or the Commission will return the agreement without reviewing it. However, when this payment option is not feasible (as can be the case when checks are processed out of a different office), you may contact Keischa Lovelace, Claims Director (919-807-2592), and, with her approval, work out alternate arrangements, such as submitting a certification of payment with the form agreement instead of the check/money order itself.

Form agreements are still to be sent to the Claims Department. Checks should be made payable to the NC Industrial Commission and must include the following information: IC file number, claimant name, and type of processing fee being paid.

For Form 24 applications, the Commission anticipates that in most cases the form will be submitted for review in hard copy format, and therefore must include the processing fee check/money order ($60). However, if Form 24 is sent electronically, it is acceptable to send with the electronic copy a certification of payment. The Commission has adopted a certification form which is different from the clincher and the form agreement certifications.

Please check the Commission website to see if the certification has been posted. Until then, the processing fee should be sent with the Form 24 application. Again, the Commission will not accept the form for filing without payment or a certification. Forms 24 are still to be sent to the Executive Secretary's office for processing.

Finally, regarding clincher agreements, ($375) these agreements are, for the most part, to be submitted electronically. The Commission allows the submission instead of a certification of payment which should be sent along with the clincher agreement. The certification form is posted on the NCIC website.

While it is not absolutely mandatory that the check go out on the same day the clincher is sent for review, the Commission will expect the payment within three to five days. Clincher processing fees are also made payable to the NCIC and must include the IC file number, claimant name, and type of processing fee being paid. Checks should be sent c/o Carolyn Wall and mailed to 4340 Mail Service Center, Raleigh, 27699-4330.

Amy Pfeiffer is an associate at Cranfill Sumner & Hartzog in Raleigh. She is a graduate of North Carolina State University and Columbus School of Law, Catholic University of America in Washington, DC. Amy served as a Deputy Commissioner at the North Carolina Industrial Commission from 1997-2003.

coming up

March 24-26, 2010
North Carolina Association of Self-Insurers Annual Meeting & Educational Conference Holiday Inn Sunspree Resort, Wrightsville Beach

April 21-23, 2010
Members-Only Forum, SC Self-Insurers Association. Litchfield Beach and Golf Resort

April 25-29, 2010
RIMS 2010 Annual Conference & Exhibition Boston Convention & Exhibition Center.

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Association of Self-Insurers
The employers' voice in workers' comp

Medicare reporting requirements (Ctd. from page 1)

The second step in complying is to determine whether the claim needs to be reported, and specifically whether either of two triggering events have occurred. These are referred to as Total Payment Obligation to Claimant and Ongoing Responsibility for Medicals. A complete understanding of them is critical for compliance.

Finally, CMS has established interim reporting thresholds. Subject to exceptions, TPOC for both liability and workers' compensation claims incurred between January 1, 2010 through December 31, 2011, need not be reported if it is under $5,000. CMS has noted that these are "interim" thresholds and may change.

Gregg Newton is an attorney with Cranfill Sumner & Hartzog.

NC Rate Bureau files for a 9.6% loss cost decrease

The North Carolina Rate Bureau has filed for a 9.6% overall loss cost decrease, effective April 2010 for new and renewal policies. If approved by the department of insurance, the filing would mean more than $119 million in annual savings for North Carolina employers, the **Raleigh News & Observer** reported.

Loss costs decreased most substantially for office and clerical workers. Here is the breakdown, as reported by the rate bureau:

- Manufacturing -12.0%
- Contracting -9.5%
- Office & Clerical -18.4%
- Goods and Services -7.2%
- Miscellaneous -2.7%
- Overall – 9.6%

One reason behind the decrease in the loss costs was a 2% drop in claims, according to the rate bureau. The bureau's filings are based on historical data through the end of 2007.

The rate bureau filed its request in early September. The insurance department has 60 days from the day of filing to make a decision.