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SMART Act aims to ease Medicare disputes

Insurers, self-insurers, and healthcare providers are pleased President Barack Obama recently signed into law the Strengthening Medicare and Repaying Taxpayers (SMART) Act, which had passed Congress with bipartisan support.

"This commonsense legislation, which passed as part of H.R. 1845, the Medicare IVIG Access Act, makes it more efficient for patients, healthcare providers, and insurers to settle disputes and lawsuits," says Sen. Rob Portman (R-Ohio), who introduced the legislation in 2011 with Sen. Ron Wyden (D-Or). The Congressional Budget Office estimates the act will save taxpayers $45 million over ten years.

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The SMART Act addressed several problems in the Medicare Secondary Payer system. For one, the federal government did not provide Medicare repayment amounts until after parties had settled their disputes or lawsuits. Coupled with complicated reporting and reimbursement obligations, this inefficiency made it difficult for parties to reach a settlement.

As various observers have reported, the SMART Act does the following:

- Establishes a 3- year statute of limitations for Medicare conditional payment claims;
- Allows parties to obtain a final conditional payment claim amount prior to a settlement, judgment or award;
- Removes the requirement for social security numbers for Section 111 Reporting;
- Provides a right of appeal for insurance companies and self-insureds or conditional payment claims/liens;
- Makes issuance of Section 111 penalties discretionary; and
- Establishes minimum thresholds for Medicare to seek recovery.

The American Health Lawyers Association notes the SMART Act will streamline the process because of better reporting and reimbursement requirements, and focuses on strengthening tools for determining liability for conditional payments made by Medicare.

The group adds among other provisions, the SMART Act:

- Accelerates the processing of Medicare conditional payment reimbursement by requiring the Centers for Medicare & Medicaid Services to provide the Medicare reimbursement amount within 65 days of a request (though a 30-day extension applies at the Secretary's discretion).
- Removes the automatic imposition of a $1,000-per-day civil monetary penalty for non-compliance, and instead vests the Secretary with discretionary authority to impose a penalty "up to" that amount.
- Requires the Secretary to establish a website through which beneficiaries and plans can access up-to-date Medicare claims and payment information and download a "statement of reimbursement amount" on payments for MSP claims. A statement of reimbursement obtained from the website during a "protected period" can be relied upon by the beneficiary/plan as the final conditional amount subject to recovery by CMS.

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CASE LAW UPDATE

By Joe Austin

Exclusive Remedy

It is well-settled that the Workers' Compensation Act provides the "exclusive remedy" for employees to pursue claims against their employers for injuries which arise out of the employment relationship. As a result, an employee who has been injured at work is limited to recovery of workers' compensation benefits, and may not pursue other claims against his employer.

Two recent cases discuss the extent to which the exclusive remedy provisions of the Act can be asserted by entities other than the employer as a shield against lawsuits on behalf of injured employees. In the first of these cases, *Gregory v. Pearson,* the employee was killed while working at a public landfill in Cleveland County. The county had arranged for the landfill's personnel to be provided by a staffing agency, and as part of the arrangement, the agency was responsible for providing workers' compensation benefits. The employee died as a result of injuries sustained when a county employee ran over him at work, and his estate filed a wrongful death action against the county. A Superior Court judge dismissed suit on the grounds that the Workers' Compensation Act provided the exclusive remedy for the estate, but the Court of Appeals reversed, ruling that the county was not entitled to the protections of the Workers' Compensation Act since it had contracted to transfer workers' compensation liability to the agency. As a result, the estate was entitled to proceed with its wrongful death action against the county. Thus, a business that uses agencies to staff certain operations may potentially be sued for negligence by employees of the agency who are injured at work.

The second case deals with claims against co-workers. As an extension of the exclusive remedy provisions of the Act, North Carolina courts have ruled that co-workers are immune from liability for acts of negligence, but not for intentional or reckless conduct.

As an illustration, in the recent case of *Trivette v. Yount*, a secretary in a middle school filed a civil action against the principal of the school. According to the secretary's complaint, the principal had been joking around, recklessly pretending to spray the secretary with a fire extinguisher, when it suddenly discharged, resulting in a pulmonary injury. The principal filed a motion to dismiss the action, claiming that the employee's exclusive remedy was under the Workers' Compensation Act, and a motion for summary judgment, contending that the employee had not produced enough evidence to go to trial, both of which were denied.

On appeal, the Supreme Court of North Carolina reversed the ruling on summary judgment. Although the court agreed that the secretary's allegation of recklessness was sufficient to assert a claim for which the exclusive remedy provisions of the Workers' Compensation Act did not protect the principal from liability, it ruled that the secretary had not come forth with sufficient evidence to go to trial. In reaching its decision, the Supreme Court reasoned that, unlike prior cases in which recklessness had been established, such as co-workers who disabled safety guards and who performed excavations without safety gear, the principal's conduct did not rise beyond the level of ordinary negligence. As a result, the principal did not have to defend the suit at trial.

Injuries During Breaks

It is not at all uncommon for employees to be injured while on break, but claims for such injuries are frequently the subject of litigation. For example, in the case of *Mintz v. Verizon Wireless*, the employer required the employee to take an unpaid lunch break. On one occasion, the employee went to the ground floor of her building during the lunch break. At the end of her lunch break, the employee was leaving a restroom on the ground floor, as she was returning to her work area (on another floor), when she slipped and fell. Although the restroom was located in a common area of the building, the building was not open to the public, and access to the building was limited to employees and service providers of the employer.

The Industrial Commission found the employee's claim to be compensable. The Court of Appeals affirmed, concluding that any injury occurring during a break on premises under the control of the employer would be compensable, regardless of whether the break is paid or unpaid.

Joe Austin is a senior attorney at Young Moore and Henderson in Raleigh. A graduate of Davidson College, he received his law degree from Wake Forest University.

President's Note

A big year?

We are putting the final touches to the program for our 2013 annual conference and plan to have it out to you within the next few days. As in years past, registration fees will remain at $225 for members and $400 for non-members; exhibitor fees will be $650 for members and $800 for non-members.

Two developments may make for an interesting year. There is a small, but real, possibility workers' compensation could be more than a side issue in this legislative session. As we report elsewhere in this newsletter, legislators will have to resolve disagreements this session over as many as 30 rules pertaining to the 2011 workers' comp reform legislation.

This is also the year healthcare reform comes home or hits home. Informed observers note the American public seems to have snoozed through the ground-shifting provisions passed by Congress in the 2010 Affordable Care Act perhaps because the changes were a few years away. But now that major changes are at the doorstep, the public is likely to wake up with a roar.

For one, many employers are likely to decide this year it will be cheaper for them to stop providing health insurance because the financial penalty for doing so is not that steep. "If you think workers will be surprised when their coverage disappears, just wait until they discover they'll be violating federal law if they don't buy health insurance on their own" reports *Fortune* magazine.

Technically, low-paid workers can get subsidies for the coverage they'll have to buy through state insurance exchanges. But good luck with that. "The exchanges are scheduled to open for enrollment on Oct. 1. But so far only 20 states are setting them up. Many of the other states' exchanges will have to be run by Washington, and it still isn't clear how they will work," the publication notes.

Workers' comp has long occupied its own niche in healthcare. But rising healthcare costs are a universal worry and it is unlikely workers' comp can stay isolated from the broad changes sweeping across healthcare.

With very best wishes,

Jay Norris

2011 Comp Reform

Some provisions still up in the air

The North Carolina General Assembly will have to resolve disagreements this session over as many as 30 rules pertaining to the 2011 workers' comp reform legislation.

Employers, carriers, and medical providers are not pleased with some of the rules proposed by the Industrial Commission and have asked for legislative review. At the same time, the plaintiffs' side seems satisfied with the commission's proposed rules and may lobby against extensive changes by legislators.

"While a great deal of compromise took place two years ago, there are still things that are not settled. There is a potential here for some quarrels this year," notes Larry Baker chair of the workers' compensation section of the North Carolina Association of Defense Attorneys.

At issue are nearly 30 rules out of the nearly 150 rules drafted by the Industrial Commission. The reform legislation, which brought the commission under the Administrative Procedures Act, required the agency to review its entire rules, and the objections came when the commission opened its procedures for public comment.

Given the disagreements over so many measures, the commission has decided to put off implementing the newly proposed rules, with two exceptions. The commission still requires employers to post proof of workers' compensation coverage at the worksite, and the agency has approved a new methodology for paying hospitals.

The net import is the General Assembly expected a final set of rules by the end of 2012 and now it appears it may be mid-year or so before the rules will be in place. Baker says the delay is not having a material impact on the system as substantive procedures are not affected.

coming up

March 20–22, 2013
NC Association of Self-Insurers' Annual Conference. Holiday Inn Resort, Wrightsville Beach.

April 10–12, 2013
Members-Only Forum, SC Self-Insurers Association. Litchfield Beach & Golf Resort

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- Requires the Secretary to modify MSP reporting requirements to provide that "applicable plans" are permitted but not required to access or report beneficiary social security numbers or health identification claim numbers.

The American Health Lawyers Association concludes "on the whole, the SMART Act appears to improve MSP efficiencies and has the potential to improve the predictability of MSP liabilities by ensuring that affected parties have accurate, up-to-date information and limiting the number of years Medicare can look back to achieve MSP recoveries."

Roy Franco

The group adds the law also will likely reduce costly penalties associated with the MSP program and will permit an avenue to appeal Medicare determinations with respect to plan liability for conditional payments.

Roy Franco, chief legal and compliance officer for Franco Signor LLC, says one issue prompting groups to press for change was Medicare's refusal to issue a final reimbursement amount before a settlement, judgment, award, or other payment. "Medicare's position caused problems as the final Medicare number was usually larger than what parties had expected," he adds.

"Another issue that surfaced was the inability by an insurance carrier or self- insured plan to refute a final number presented by Medicare without approval of the Medicare beneficiary. If the final number were available near or at the time of resolution, this may not have been such a huge issue, but Medicare usually presented claims months, if not years, after the claim was resolved," he notes.

Franco serves as co-chair of the Medicare Advocacy Recovery Coalition, which was prominent among those advocating improvements. He says yet another reason for the momentum for a change was no one really knew how long Medicare had to present a claim against an insurance carrier or a self -insured plan. Was it 3, 6 or 10 years? When did the clock start ticking?

He says the SMART Act will bring relief to insurers and self-insurers but it will likely be several months before all the changes are adopted.