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Safeguarding Medicare's Interests: Strategies and Updates

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With increasing regulations surrounding Medicare compliance, it is critical for claims professionals to stay up-to-date on the latest Medicare Set-Aside (MSA) requirements and processes. Medicare compliance plays a crucial role in protecting Medicare's interests when settling claims involving future medical costs. Below, we explore the most recent updates and best practices in MSA preparation and Medicare compliance.

Protecting Medicare's Interests: Three Essential Steps

When settling a claim that involves a Medicare beneficiary, it's essential to ensure that Medicare's interests are protected. There are three main strategies to achieve this:

1. **Section 111 Reporting:** Payers are required to report claims involving Medicare beneficiaries under Section 111. This reporting process ensures that both Medicare and the insurer are aware of the individual's Medicare status, facilitating proper coordination of benefits.
2. **Resolving Medicare Conditional Payments:** Conditional payments occur when Medicare covers medical expenses that should be paid by another party. To avoid complications during settlement, it's crucial to identify and resolve these conditional payments early in the claims process.
3. **Medicare Set-Aside (MSA):** An MSA is a fund designated to cover future medical expenses related to the claim. By setting aside these funds, payers can ensure that the injured party has resources available for future treatments, reducing the risk of Medicare shouldering the costs.

Section 111 Reporting: Enhanced Penalties in 2024

Accurate Section 111 reporting is a key element of Medicare compliance. This process requires payers to report claims where they've accepted responsibility for medical care, ensuring that Medicare is aware of any settlements or awards involving a beneficiary.

Starting in 2024, penalties for non-compliance with Section 111 reporting will be enforced more strictly. Fines can range from \$250 to \$1,000 per day, depending on the severity and duration of the non-compliance. To mitigate these risks, payers should prioritize accurate reporting and maintain strong oversight of claims involving Medicare beneficiaries.

Resolving Medicare Conditional Payments

Conditional payments are made by Medicare when they cover medical costs that should be paid by another entity, such as an insurer. For example, in a workers' compensation case, if Medicare has paid for treatment related to the claim, the responsible party must reimburse Medicare.

Medicare's process for conditional payment resolution allows payers to address these payments before settlement. Payers can request a conditional payment letter from Medicare, which outlines any payments made on behalf of the beneficiary. If any payments are deemed unrelated to the claim, payers have the opportunity to dispute or appeal the charges. If no action is taken, Medicare will issue a demand letter, requiring reimbursement within 60 days.

Best Practices for Managing Conditional Payments

To ensure efficient handling of conditional payments, follow these best practices:

- **Start the process early:** Once it's determined that a claimant is a Medicare beneficiary, begin identifying any conditional payments as soon as possible to prevent delays.
- **Monitor payments regularly:** Since Medicare updates its records quarterly, it's important to check for conditional payments frequently, especially in long-running claims.
- **Be proactive:** Respond promptly to any communication from Medicare and provide supporting documentation when disputing payments.

Medicare Set-Asides (MSAs): Ensuring Future Medical Needs Are Covered

MSAs are designed to protect Medicare's interests by setting aside funds to cover future medical treatment related to a workers' compensation or liability claim. These funds ensure that Medicare is not responsible for medical expenses after a settlement.

While preparing an MSA is not mandated by law, doing so is considered best practice in cases involving Medicare beneficiaries. MSAs help payers protect themselves against future claims from Medicare, ensuring compliance with the Medicare Secondary Payer Act (MSP). The Centers for Medicare & Medicaid Services (CMS) offer guidelines for when an MSA should be submitted for approval. Generally, if the settlement is over \$25,000 and the claimant is a current Medicare beneficiary, submission is recommended. If the settlement exceeds \$250,000 and the claimant is expected to become Medicare-eligible within 30 months, submission is advised as well.

Key Changes for 2024

Several important changes are on the horizon for 2024, including:

- **Increased enforcement of Section 111 penalties:** Beginning in October, CMS will enforce civil monetary penalties for non-compliance with Section 111 reporting. Random audits will review a sample of claims annually to ensure proper reporting.

- MSA reporting through Section 111: By 2025, payers will be required to report the MSA amount, including the number of years it covers and whether it's a lump sum or annuity.

These updates emphasize the need for thorough recordkeeping and proactive compliance measures.

Overcoming Common Obstacles in MSA Preparation

The preparation of an MSA can be challenging due to several common obstacles. Here are the key issues payers should be aware of:

- **Lack of Current Medical Records:** Accurate, up-to-date medical records are critical for preparing an MSA. Payers should aim to provide two years of medical records for each claim included in the MSA.
- **High-Cost Prescription Medications or DME:** Medication and durable medical equipment (DME) can significantly impact the cost of an MSA. Having a detailed pharmacy log can help ensure that the MSA reflects the most accurate and cost-effective medication options.
- **Injured Party Consent Issues:** If the injured party refuses to sign the necessary consent forms, CMS will not review the MSA. Payers must ensure that all documentation is completed and properly signed to avoid delays.

While submitting an MSA for CMS review is voluntary, protecting Medicare's interests is required by law. Even if an MSA is not submitted, payers must demonstrate that they have considered Medicare's future interests as part of the settlement process. This can be done by creating and funding an MSA without submission, as long as the settlement clearly shows that Medicare's interests were considered.

Conclusion

As 2024 brings new compliance challenges, it's more important than ever for claims professionals to remain vigilant in protecting Medicare's interests. From ensuring accurate Section 111 reporting to resolving conditional payments and preparing MSAs, staying proactive is the key to avoiding penalties and ensuring smooth claims settlements. With the upcoming changes to CMS enforcement and MSA reporting, payers should review their compliance strategies and ensure that their processes are robust and up-to-date.



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