

Summer 2009

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Medicare Secondary Payer Mandatory Reporting

By Jeana Wines

You should be aware Medicare has new mandatory reporting requirements concerning liability insurance (including self-insurance), no-fault insurance and workers' compensation. Penalties for non-compliance are stiff at **\$1,000 per day!** You must take steps to address these changes now. This summary is not exhaustive, but will assist you in understanding these changes and provide you with resources to get started.

Who: The new provisions affect "Responsible Reporting Entities" (RRE), which includes the fiduciary or administrator of laws and plans for:

1. Liability insurance (including self-insurance);
2. No fault insurance; and
3. Workers' compensation.

What: RREs must report the identity of a Medicare beneficiary whose illness, injury, incident or accident is at issue. In other words, if you have a claimant who is or may become a Medicare beneficiary, you must report that claimant's identity to Medicare.

Why: Medicare does not want to pay for medical services if they do not have to. If your claimant is a Medicare beneficiary, Medicare wants billing for claim-related services to go directly to the claim administrator.

How:

1. An RRE should designate a person to report the requested data on behalf of the RRE.
2. That person needs to register the RRE by 09/30/09 on a secure website that will be used to transmit the data.
3. Once the RRE's registration is complete, the CMS Coordinator of Benefits Contractor (COBC) will begin working with the RRE to set up the data reporting and response processes. Tech support should also be designated to assist through this process.

Continued

If claimant provides the RRE with an incorrect Social Security number, if there is a transcription error, if you were simply unaware claimant became eligible for Medicare, the RRE will be subject to penalties of \$1,000 per day!

When: Register electronically by **09/30/09**. A testing period will follow registration. Each RRE will be assigned a quarterly reporting schedule beginning Spring 2010.

Notes:

1. Your reporting responsibility continues as long as you may be responsible for medical services for an individual. You need to have a system for continually determining claimant Medicare eligibility.
2. Reporting is also required for some settlements as well.
3. The RRE's responsibility for reporting cannot be shifted to the claimant. The website will have a query screen where you can determine your claimant's Medicare status. If claimant provides you (the RRE) with an incorrect Social Security number, if there is a transcription error, if you were simply unaware claimant became eligible for Medicare, you will be subject to penalties of \$1,000 per day!

More Information:

1. Read the User Guide, most recently updated July 31, 2009:

<http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf>

2. Determine if your organization is an RRE. If so, register now: www.section111.cms.hhs.gov/MRA.
 3. Alerts and more detailed information will be posted periodically, and you can sign up to receive alerts by email: www.cms.hhs.gov/mandatoryinsrep.
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OREGON WORKERS' COMPENSATION

by Jennifer Roumell

Practical Tips for Processing Own Motion Claims

First, be certain there is an Own Motion claim to be processed. A denial for medical services, current condition and/or “post-aggravation rights” new/omitted medical condition claim that has *not* been set aside by a litigation order does not trigger processing for an Own Motion claim. *ORS 656.278*.

Your responsibility to process an Own Motion claim starts when a “worsened condition” or “post-aggravation rights” new/omitted medical condition has been found compensable. Once a compensability determination has been made, your responsibility starts. You have 30 days to process the Own Motion claim by either voluntarily reopening the claim or submitting a “Carrier’s Own Motion Recommendation” for or against reopening. *See OAR 438-012-0030(1)*.

When voluntarily reopening claims, submit Form 3501 (instructions are found in Bulletin 195) to the Workers’ Compensation Division (WCD). The form should not be filed with the Board.

When submitting the “Carrier’s Own Motion Recommendation,” the submission should include: (1) a “cover letter” summarizing the position regarding claim reopening and (2) the information specified in OAR 438-012-0030, including claim processing documents, chart notes, medical reports and any other written documentation regarding the current claim. Those materials should also be arranged in chronological order, be numbered as exhibits, and submitted with an exhibit list.

Your responsibility to process an Own Motion claim starts when a “worsened condition” or “post-aggravation rights” new/omitted medical condition has been found compensable.

Oregon Workers’ Compensation Board Decisions

Employer conveyance exception to the going and coming rule not applied.
Lorena Alvaraz-Rubio, 61 Van Natta 1646 (2009).

Claimant supervisor was provided a company car as a “perk” and was injured in an MVA when driving home. She was restricted from using the vehicle for personal purposes. While the employer testified there were adequate parking



spots, claimant testified there were not. She asserted the employer benefited when she did not drive her own car to work since there were only 15 parking spaces and 25 employees. Members Langer and Herman found *Dehiay v. Spencer*, 221 Or App 539 (2008) to be distinguishable because there the employee was commuting per employer instructions between work and a designated employee residence used while working for the employer during the week. In the instant case, claimant was neither paid for her travel time nor was she furthering the employer's business. Use of the car was also optional. Member Weddell dissented, citing *William B. Ford*, 48 Van Natta 581 (1994). *Ford* had involved parking shortages that required employees to drive vans home at night to avoid vandalism within the context of several vans being vandalized before the policy was instituted.

Use of the word “ceases” in a denial makes it a current condition denial. *Jose P. Vellegas*, 61 Van Natta 626 (2009).

Employer accepted a non-disabling right lumbar strain. At that time, claimant was also diagnosed with spondylosis and DDD. Ten months later, employer issued a partial denial of claimant's “current condition,” stating the accepted condition “ceased to be” the major cause of the current condition and need for treatment. The denial specifically said it was not a back-up denial. A later amended denial also denied DDD. The Board said ORS 656.262(6)(c) and the use of the word “ceases” demonstrated a combined condition denial and was invalid since there had been no combined condition acceptance as claimant had not made a new medical condition claim for DDD and the submission of bills does not constitute a claim; denial number two was precautionary and a nullity.

Consequential condition needs to establish subsequent or superseding event. *William T. Pepperling*, 61 Van Natta 186 (2009).

SAIF argued MRSA infection after accepted laceration should be analyzed as a consequential condition and, hence, major contributing cause standard to establish compensability. The Board disagreed and found MRSA infection was caused by the injury, so the material contributing cause standard applied. The Board relied upon evidence that infection developed once the skin was broken by the laceration and so arose directly from the injury. They did not find a subsequent or superseding event that caused the infection to establish a consequential condition.

Attending physician statement: “Return to full duty with no limitations” does not establish release to “regular work.” *Jason Monaghan*, 61 Van Natta 1308 (2009).

To prevent a work disability award, the attending physician should review the job description of the regular work and clearly state claimant is released to a job without limitations. In this case, the Board held claimant was entitled to a work disability award because it was uncertain the attending physician had an accurate understanding of the work activities despite the attending physician reporting return to full duty without limitation.

Upcoming SBH Events

9/18/09 – Work Injury Management Association of Oregon Presents:

Location: Wellspring Medical Center (Oak Room), 1475 Mount Hood Ave., Woodburn, OR

Time: 1:00 p.m. – 5:00 p.m.

Cost: \$40.00 payable at the door

Register: jnoland@cciservices.com to reserve your spot
Krishna Balasubramani is a speaker.

9/18/09 – 2009 Workers’ Compensation Seminar

Presented by the Oregon Law Institute

Location: Oregon Convention Center

Deborah Sather, Rebecca Watkins and Steve Verotsky are speakers.

10/7/09 – DMEC Annual Fall Conference

10/13/09 – WCCA Fall Conference

10/28/09 – SBH Annual Claims Professional Workshop at the MAC

11/4/09 - 11/6/09 – OSIA Annual Meeting – Welches, Oregon

12/9/09 - 12/10/09 – BOLI 25th Annual Employment Law Conference

For More Information

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SBH HAPPENINGS

Congratulations!

In May 2009, Deborah Sather was awarded the Douglas W. Daughtry Award of Merit by the Oregon State Bar, Workers' Compensation Section, for commitment to the highest standards of professionalism, honesty, integrity and willing adherence to the highest ethical standards while making outstanding contributions to the Workers' Compensation Section and the hearing process.



About our Newsletter...

The information contained within this newsletter is not legal advice, but a resource to help you stay informed about legal developments affecting your job. If you have a specific issue or concern, please contact your attorney for advice. SBH is a specialized firm offering comprehensive litigation and consultation services to employers, insurers, and adjusters in the Pacific Northwest. SBH assists with workers' compensation, employee policies & records, return to work programs, leave administration, OSHA compliance, discrimination, longshore, claims processing, hiring & firing, wage & hour, and more.