Reporting Malpractice Claims to the Government

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As many of our readers may be aware, the federal government recently passed legislation requiring that liability insurers, such as OMIC, report to the Centers for Medicare & Medicaid Services (CMS) the resolution of claims (by settlement, judgment, award, or other payment) by Medicare beneficiaries for bodily injury and medical payments. OMIC is registered with CMS and is gearing up for submission testing and eventual reporting.

The purpose of this "Section 111" reporting (referring to Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007)[1] is to ensure that Medicare makes payments in the proper order or recovers payments when another entity (such as an insurer) is required to pay for covered services before Medicare does. Section 111 requires that OMIC determine whether a claimant or a potential claimant for damages due to bodily injury or medical payments is entitled to receive Medicare benefits. If so, OMIC must report the identity of the Medicare beneficiary whose illness, injury, incident, or accident is the subject of the claim, and provide other information that will enable CMS to appropriately coordinate benefits. The law sets forth procedures that Medicare can use to bring legal action against various parties, including a liability insurer, for failure to make proper reimbursement, and subjects responsible reporting entities (RREs) to fines for noncompliance.

This Section 111 reporting is separate from and in addition to the reports OMIC already sends to the National Practitioner's Data Bank (NPDB), under another federally mandated reporting scheme. OMIC is required to submit NPDB reports when OMIC makes a payment for the benefit of an ophthalmologist or other health care provider in the settlement or satisfaction of a claim or judgment. (Insureds may have their own reporting responsibilities to the NPDB, as well. See the OMIC **Risk Management Recommendations** letter titled "Responding to Unanticipated Outcomes" found on OMIC's web site at http://www.omic.com/resource/risk_man/recommend.cfm#responding.)

In order to trigger OMIC's reporting responsibility, there must be an exchange of money resulting from a written complaint or claim demanding monetary payment based on the provision or failure to provide health care services. Per the NPDB requirements, OMIC sends a copy of the NPDB report to the appropriate state licensing board. The Health and Human Services Office of Inspector General (OIG) has the authority to impose civil money penalties if these reporting requirements are not met. Whenever the Data Bank receives an NPDB report, it sends a Subject Notification Document to the subject of the report (the OMIC insured ophthalmologist or other health care provider, not the patient).

In addition to this federally mandated Section 111 and NPDB reporting, many states also are seeking reporting of the same or additional claims information through their departments of insurance, departments of health, boards of medicine, or other state agency or department.

OMIC was formed as a risk retention group under the federal Liability Risk Retention Act of 1986 (LRRA) to insure the liability risks of American Academy of Ophthalmology members.[2] As a risk retention group, OMIC is governed by only one state, its state of domicile, which is Vermont. This eliminates the need for redundant regulation.[3]

When these state-specific claims data calls were infrequent and the data sought was minimally burdensome to acquire, OMIC voluntarily complied with the requests. Over the past several years, however, the requests have multiplied and the data sought has increased dramatically. For this reason, OMIC has begun to respectfully decline these requests from the various states. To provide the federally required CMS and NPDB reports, plus detailed closed claims reports in every state, each requiring reporting in a different manner and on different time frames, would be extremely burdensome. This runs contrary to the intent of the LRRA, which is to increase the availability of commercial liability insurance by allowing RRGs to offer insurance nationwide while avoiding regulatory redundancy.

It is OMIC's position that voluntarily completing such reports would pose a substantial administrative burden, the cost for which would ultimately be borne by our insureds. We are also concerned that our members' confidential claims data could be subject to potential disclosure under state freedom of information acts, which could be detrimental to our insureds' interests.

In some states, this may mean that OMIC's insureds must report claims data that is not on the NPDB report to the licensing agency, department of insurance, or other state governmental entity, as provided by state law. We apologize for any inconvenience this may cause to our insureds, but believe it is in our policyholders' best interest to resist this encroachment by state agencies outside of Vermont. OMIC, via your appointed defense counsel or claims representative, will be happy to assist you with obtaining the necessary information for the report (for example, the plaintiff's address or date of birth).

1. 42 USC § 1395y(b).

2. 15 USC § 3901 et. seq.

3. National Association of Insurance Commissioners. *Risk Retention and Purchasing Group Handbook.* Rev. June 1999, p. II-2.