**DEPARTMENT OF INDUSTRIAL ACCIDENTS**
**WORKERS' COMPENSATION TRUST FUND**
**ADMINISTRATIVE BULLETIN NO. 1**

TO: All Interested Persons

FROM: Holly B. Anderson, Esq., Director, Workers' Compensation Trust Fund

RE: Trust Fund Reporting Obligation to Medicare – New Data Collection Process

DATE: March 21, 2024

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Medicare has been a secondary payer to Workers' Compensation since Medicare's enactment in 1965. When the Trust Fund acquires ongoing responsibility for the medical care of an employee who is also receiving Medicare or resolves a claim in a manner that requires a payment to a Medicare recipient, it must in most cases report to the Centers for Medicare and Medicaid Services ("CMS") information that will allow CMS to coordinate benefits and/or address conditional payments previously made on behalf of the claimant/payee.[1] A final rule published in the Federal Register on October 11, 2023, effective December 11, 2023, imposes substantial civil money penalties on entities like the Trust Fund in the event of untimely reporting.[2]

As a first step to compliance—and to establish safe harbor when necessary—the Trust Fund must make a "good faith effort," specified at 42 C.F.R. § 402.1(c)(22)(ii)(A), to gather basic information needed to ascertain a claimant/payee's Medicare status. Accordingly, effective immediately, in every Trust Fund claim (presently active or otherwise), Trust Fund staff will seek to collect and/or resolve any questions regarding the following claimant/payee data:

- Name (first, last and middle);
- Date of birth;
- Gender;
- Social Security Number to at least the last *five* digits; and
- Medicare Beneficiary Identifier number.

Trust Fund staff will follow the below steps in order until all data is collected/confirmed, a *written* response is received clearly and unambiguously declining to provide data (in whole or in part), or all steps are completed:

1) A written request for data, including a letter explaining the need for the information and the attached CMS-approved data form, will be sent to the claimant and their counsel of record, or other legal representative. Email will be used at this stage when possible.
2) A second-attempt letter and the same data form will be sent to the claimant and their counsel of record, or other legal representative (if any), by U.S. mail.
3) A series of telephone calls will be placed, first to claimant's counsel of record, then to claimant's other legal representative, if any, and then directly to the claimant. If a call is placed directly to the claimant, a notice with basic information regarding the call will be sent to the claimant and to claimant's counsel of record, or other legal representative, if any.

Trust Fund staff will wait at least 10 business days between steps for a complete response unless waiting would place the Trust Fund at risk of civil money penalties. The Trust Fund's email address for the above-described data requests, and all responses to such requests, is WCTFM111@mass.gov. Please save it as a known contact.

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[1] *See* Section 1862(b)(8)(F) of the Social Security Act, as amended by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

[2] The entire final rule is available at https://www.govinfo.gov/content/pkg/FR-2023-10-11/pdf/2023-22282.pdf?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov

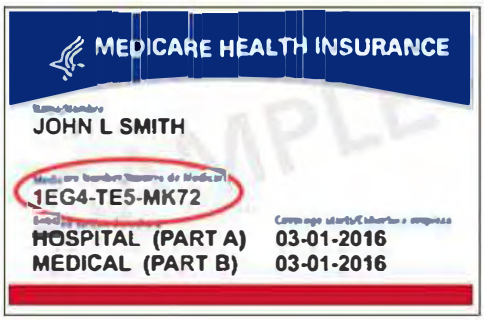
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to help CMS to properly coordinate payment of benefits among plans so that your medical claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

**Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.**

**Please note the Medicare Number located on this card.**




## Section I

| | | |
|---|---|---|
| *Are you presently, or have you ever been, enrolled in Medicare?* | ☐ Yes | ☐ No |
| *If yes, please complete the following. If no, proceed to Section II.* | | |
| ***Full Name:** (Please print the name exactly as it appears on your SSN or Medicare card if available.)* | | |
| **Medicare Number:** | **Date of Birth (Mo/Day/Year)** / / | |
| ****Social Security Number:** (If Medicare Number is Unavailable) - - | **Sex** ☐ Female | ☐ Male |

** Note: If you are unable to provide your Medicare Number **and** uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last **5** digits of your SSN in the section above.

## Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____

**Claimant Name (Please Print)**

_____

**Name of Person Completing This Form If Claimant is Unable (Please Print)**

_____ _____

**Signature of Person Completing This Form** **Date**

*If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.*

## Section III

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**Claimant Name (Please Print)**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

**Reason(s) for Refusal to Provide Requested Information:**

_____

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_____ _____

**Signature of Person Completing This Form** **Date**

Please return both pages of this form to the Trust Fund by either email (preferred) or U.S. Mail.

Email: WCTFM111@mass.gov
U.S. Mail: Department of Industrial Accidents, Attn: Trust Fund M111 Unit
2 Avenue de Lafayette, Boston, MA 02111