

MSP Compliance Update: Impact of Latest Medicare Secondary Payer Compliance Developments on Claims Handling

Presented by
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Topics of Presentation

- Medicare Conditional Payment Recovery
- Medicare Set-Asides
- Section 111 Mandatory Insurer Reporting

Medicare Secondary Payer Act



- The MSP Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under liability insurance (including self-insurance), no-fault insurance or workers' compensation.

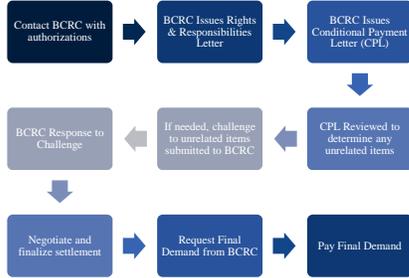
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How does Medicare enforce the MSP?



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Resolving Medicare Conditional Payments Process



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The Medicare Secondary Payer Recovery Portal (MSPRP)

Allows for:

- **Submit Proof of Representation or Consent to Release documentation** - Instead of mailing in an authorization, you can upload authorizations through the portal.
- **Request conditional payment information** - Requesting an updated conditional payment amount or a copy of a current conditional payment letter can be requested through the portal.
- **Dispute claims included in a conditional payment letter** - You are able to view the claims listed on the conditional payment letter and dispute unrelated claims through the portal.
- **Submit case settlement information** - You are able to input settlement information and upload a copy of the settlement documentation through the portal.

BCRC Contact Information

- By telephone
 - 1-855-798-2627 (Hours of Operation: Monday -Friday 8am-8pm(ET))
- By fax
 - 1-405-869-3309
- By mail
 - NGHP
 - PO Box 138832
 - Oklahoma City, OK 73113
- Latest Contact Information:
 - <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html>

Liability - \$1,000 Threshold on Conditional Payment Recovery

- **As of 2/18/2014. Further criteria:**
 - Medicare will not attempt to recover conditional payments on a \$1,000 or less liability settlement
 - Settlement is related to an alleged physical trauma-based incident, not an alleged exposure, ingestion, or implantation, and
 - Claimant has no additional settlements related to the same alleged incident

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Liability - Fixed Percentage Option for Medicare's Recovery Claim

- On 11/7/2011 Medicare implemented an option to pay a fixed 25% of a settlement to Medicare in resolution of the recovery claim. Further criteria:
 - Settlement is related to an alleged physical trauma-based injury, not an alleged exposure, ingestion, or implantation;
 - Settlement is \$5,000 or less
 - No demand letter has been issued.
 - Claimant has no additional settlements related to the same alleged incident.
 - Claimant elects this option "within the required timeframe."

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SMART Act Changes

- **Pre-Settlement Final Conditional Payment Determination:** Process by which the Final Demand from Medicare can be obtained shortly before final settlement rather than after.
- **Quicker Turnaround Time on Conditional Payment Challenges:** CMS has 11 business days to review challenges to conditional payments, i.e. payments unrelated to injury.
- **Minimum Thresholds for Conditional Payment Recovery:** With some exceptions, CMS must annually set a minimum threshold for conditional payment recovery in liability cases (Currently \$300). Optional for WC.
- **3 Year Statute of Limitations:** Puts in place a 3 year statute of limitations on Medicare conditional payment recovery. Effective as of 7/10/2013

Case Law Updates

- **Private Right of Action under MSP by Medical Providers against carrier:** *Michigan Spine and Brain Surgeons, PLLC, v. State Farm* (USCA 6th Circuit, July 16, 2014)
- **Medicare Advantage Plan Recovery under MSP:** *Humana Medical Plan v. Glaxo Smith Kline, LLC* (USCA 3rd Circuit, June 28, 2012).
 - *Humana Ins. Co. v. Farmers Texas County Mutual Ins.*, Order on Report and Recommendation (USDC, September 24, 2014)

3 Primary Components to a Medicare Set-Aside Arrangement

1. Medicare Set-Aside Allocation

A Medicare Set-Aside Allocation is a projection of reasonably probable Medicare covered future medical treatment and prescription medication related to the injury.

- > Priced over claimant's life expectancy
- > WC fee schedule used if available
- > Possibility of non-Medicare covered expenses

2. Method of Funding the MSA Account

The arrangement can be funded via lump sum or structure

3. Method of Administering the MSA Account

The arrangement can be professionally or self administered

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Workers Compensation MSA Review Thresholds



- **Thresholds:** CMS will review and approve MSAs that meet the following thresholds:
 - The claimant is Medicare eligible at the time of settlement and the total settlement payout value, is greater than \$25,000.
 - The claimant is reasonably expected to become Medicare eligible within 30 months of the settlement date and the total settlement payout value is greater than \$250,000.
- **Under threshold cases must still consider Medicare's interests.**

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CMS Publication of first-ever WCMSA Reference Guide

- Most recent version 2.2 released: 5/29/2014
- **Review is voluntary:** *There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval. (8.0)*
- **Review philosophy:** *Medical pricing may vary based on injury, age, location, and other factors. Each submission is reviewed independently of other submissions for claimants with the same injury and age. This accounts for any differences in WCMSA amount determination. (9.4.3)*

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CMS Publication of first-ever WCMSA Reference Guide

- **Medical Records:** Treatment records required for the last two years of treatment, and dated within six months of the submission date. Whether the treatment was paid by WC carrier is irrelevant. (9.4.4)
- **Prescription History:** Prescription history must be updated and clearly indicate dosage and frequency. If no prescription history then clear statement from doctor. (9.4.4)
- **Apportionment:** *The WCRC will always price the case at 100% of the future costs related to the work injury. CMS does not recognize any apportionment of future medical items and services or prescription drug costs related to the work injury. (9.4.5)*
- **State Law:** *CMS will recognize or honor any state-mandated, non-compensable medical services and will separately evaluate any special situations regarding WC cases. (9.4.5)*

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CMS Publication of first-ever WCMSA Reference Guide

- **Prescription Pricing Methodology:** *The WCRC allocates drugs into WCMSAs based on whether the drug is used for a condition related to the workers' compensation injury, is considered a Part D or Part B drug, and is used for a medically accepted indication. Further, when evaluating drug use, the WCRC reviewers assess the drug dosage, frequency, formulation, patents expiring, newer more expensive drugs, and use of brand-name versus generic drugs. (9.4.6.1)*
- **CMS policy on the following:** Off-label use of medications, Compounded drug products, As-needed drugs, Physician dispensed drugs, Drug weaning/tapering and Drug Contraindications, warnings and precautions. (9.4.6.2).

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CMS Publication of first-ever WCMSA Reference Guide

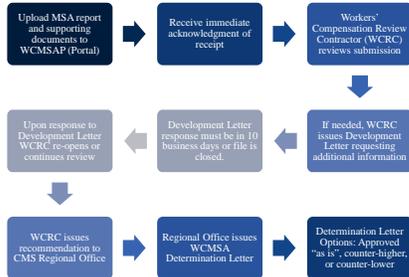
- **Re-Reviews (Reconsiderations/Appeal): Criteria**
 - (1) you believe CMS' determination contains obvious mistakes (e.g., a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, that has already occurred); or
 - (2) you believe you have additional evidence, not previously considered by CMS, which was dated prior to the submission date of the original proposal and which warrants a change in CMS' determination.
- (6.0)

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Solutions to Cost Drivers

- **Pre-MSA**
 - Case Management/Pharmacy Management
 - Medical Cost Projection
 - Adjuster/Claimant Attorney/Defense Attorney working together to obtain documentation
- **Medicare Set-Aside**
 - **MedAllocators/ECS Prescription and Treatment Addendum:**
 - Advises the client that without additional documentation to support the limiting of future medical treatment and medication, CMS will likely increase the MSA amount upon approval (**Counter-higher**) or issue a development letter
 - Provides specific recommendations for issues to address prior to submission.

CMS WCMSA Submission and Approval Process



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6 CMS Regional Offices for WCMSAs



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Pros and Cons of WCRC – *Provider Resources*

Positives

- More experienced and knowledgeable reviewers
- Quick TAT – Average is 30 days when no Development Letter
- Better explanations as reasons for Development Letters and Counter-Highers
- Bit more open on reconsiderations

Negatives

- More subjective reviews than prior WCRC.
- More variances in pricing than prior WCRC.
- Continued pricing of medications over life expectancy.
- In most cases strict requirement for medical records/Rx history within 6 months of submission.

WCMSA Self-Administration

- Claimant self-administering an MSA has specific obligations in holding the funds.
- CMS provides the following to assist:
 - Self-Administration toolkit
 - Account Expenditure form
 - Transaction record sample
- <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Self-Administration.html/>

Contact information

- **WCMSA information:**
<http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/>
- **WCMSAs by mail:** Coordination of Benefits Contractor (COBC), P.O. Box 660, New York, New York 10274-0660
Fax for Development Letter Responses and Reconsideration Requests (Less than 10 pages): (646)458-6745
- **WCMSA by Portal:**
<https://www.cob.cms.hhs.gov/WCMSA/login>
- **WCRC:** 855-280-3550

Do you need to consider a Medicare Set-Aside in a Liability Claim?

- **Statute:** Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability or no-fault insurance.
- **Regulation:** CMS changed its MSP User Manual in 2009 to acknowledge the existence of Medicare Set-Asides (MSAs) in Liability and No-Fault cases.
- **Reporting:** Some settlements post 10/1/11 will be reported to CMS

Do you need to consider a Medicare Set-Aside in a Liability Claim?

- **Review Policy:**
 - Regional Offices: CMS has authorized its regional offices to review and approve these MSAs at their discretion.
 - 9/30/11 CMS Memo on when CMS will not Review:
 - Claimant's treating physician certifies in writing that injury related treatment has been completed as of the date of settlement.
 - Treating physician further certifies that future medical items and/or services for the injury will not be required.
 - If the certification is obtained CMS considers its interest, with respect to future medicals for the particular settlement to be satisfied.
 - CMS will not provide a confirmation letter that its interests have been satisfied.
 - CMS states beneficiary and/or their representative should keep a copy of physician's certification.

Do you need to consider a Medicare Set-Aside in a Liability Claim?

- On June 15, 2012 CMS Issued an Advanced Notice of Proposed Rulemaking. What does this mean?:
 - CMS has claimed that in liability cases it has a right of subrogation and direct right of action for injury related medical costs occurring post-settlement, i.e. future medicals and can deny payment for injury related treatment.
 - Given the above right, CMS has initiated the process of making rules as to how its interests in future medicals are to be protected in liability settlements.
 - The Notice provides several proposed options for which CMS requests comment.
 - There is no timeline for when the actual proposed rules will be issued.

Medicare Approval Process for Liability Cases

- No formal review process as there is in WC cases
- CMS allows its Regional Offices to determine whether they review liability MSAs.
 - 5 of 10 offices have some policy on reviews.
- MSA approval is voluntary
- Review by regional office usually takes 3 months or less.
- Review by regional office is less stringent than the WC review process.
- Regional Office to utilize for review is determined by the claimant's state of residence

Liability MSAs

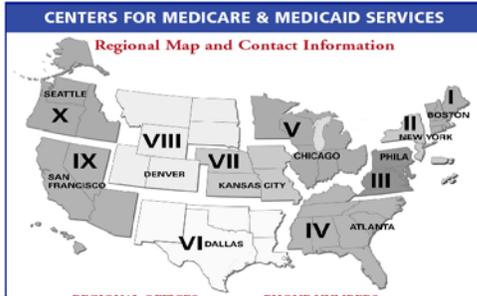
Regional Offices Reviewing MSAs:

Boston Office (Depends on workload) - CT, ME, MA, NH, RI, VT
New York Office - NJ, NY, PR, VI
Philadelphia Office - DE, MD, PA, VA, WV, DC
Chicago Office - IL, IN, MI, MN, OH, WI
Seattle Office (Limited to high value settlements) - AK, ID, OR, WA

Regional Offices Not Reviewing MSAs:

Atlanta Office - AL, FL, GA, KY, MS, NC, SC, TN
Dallas Office - AR, LA, NM, OK, TX
Kansas City Office - IA, KS, MO, NE
Denver Office - CO, MT, ND, SD, UT, WY
San Francisco Office - AZ, CA, HI, NV, GU, MP, AS, FM, MH, PW

CMS Regional Offices



CMS Regional Offices – Contact Information

- Boston: (617) 565-1318
- New York: (212) 616-2205
- Philadelphia: (215) 861-4178
- Atlanta: (404) 562-7150
- Chicago: (312) 886-5350
- Dallas: (214) 767-6402
- Kansas City: (816) 426-5233
- Denver: (303) 844-7481
- San Francisco: (415) 744-4907
- Seattle: (206) 615-2385

Mandatory Reporting Overview

- Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111).
- The law requires that claims involving Medicare beneficiaries must be reported to Medicare.
- This applies to workers' compensation, general liability, and no fault cases.
- **Purpose:** Prevent Medicare from making payments for treatment that should be paid by a primary payer and to enforce Medicare liens.

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Mandatory Reporting Overview

- **Responsibility for reporting:** This rests with what Medicare terms Responsible Reporting Entities (RREs).
 - Generally the RRE is a self-insured company or subsidiary or the insurance company. It is not a third party administrator (TPA).
- **Who does the reporting?:** The RRE can do it in-house, assign to a TPA or assign to a vendor.
- **Penalty:** \$1,000 per day, per claimant penalty for not properly reporting.
- **MSAs:** Section 111 reporting requirement does not discuss Medicare Set-Asides.

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Reporting Trigger: Ongoing Responsibility for Medical (ORM)

- All cases in which there was an ongoing responsibility (ORM) for medical on January 1, 2010 or later must be reported.
- Exclusion: Workers compensation cases meeting all the following criteria are excluded from reporting through December 31, 2012
 - Medicals only
 - Lost time of no more than 7 days
 - All payments made directly to medical provider.
 - Total payment does not exceed \$750.00.

Reporting Trigger: Total Payment Obligation to the Claimant (TPOC)

- Total payment obligations to the claimant, TPOCs, (defined as settlements, judgments, awards or other payments) involving Medicare beneficiaries
- Threshold for reporting as of 10/1/2014: \$1,000
- Further information on Section 111 Reporting: <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html>

SMART Act Changes to Section 111 Reporting

- **Reporting Penalties Clarified:** Changes Section MIR Reporting penalty provisions from mandating a \$1,000/day penalty for non-compliance to making it discretionary.
 - Final regulations not released
- **Optional use of SSNs/HICNs for Section 111 Reporting:** Mandates CMS find an alternative method to using Social Security and Medicare numbers for Section 111 reporting.
 - As of 1/5/2015 five digit SSNs allowed under certain circumstances.

Other tips

- Sign-up for e-mail updates and notifications for Section 111 reporting, BCRC and WCMSAs.
- For Section 111 reporting CMS has computer-based training on all components.
- Sign-up for blogs and newsletters on MSP compliance.

Questions/Contact Information



For further information please contact:

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