Medicare Compliance Review

IDCA Annual Meeting and Seminar

September 17, 2015
Part I: Medicare Secondary Payer Act (MSP)
Medicare Secondary Payer Statute (MSP)

• What is the Medicare Secondary Payer Statute?

• Collection of statutory provisions
  – Created by the Omnibus Reconciliation Act of 1980
  – Enacted by Congress in 1981

• Congress enacted the MSP in order to reduce spending and preserve the fiscal integrity of the Medicare program

• Basic premise:
  – No burden shifting of medical expenses to the Medicare program
  – MSP premise is the cornerstone of Medicare claims compliance
Medicare Landscape Review

Medicare Secondary Payer Act

- **Mandatory** insurer reporting (Section 111)
- **Mandatory** repayment to Medicare (conditional payments)
- **Discretionary** post-settlement medical allocation (MSAS)

The only two express goals of the MSP

- Coordination of benefits (prevention of payment by Medicare)
- Recovery (recovering Monday paid by Medicare that should have been paid by another responsible party)
The Basics of Medicare

Since 1965, Medicare has been the Federal health insurance program that provides medical benefits in certain situations:

- **Age**: Anyone over 65 (with sufficient work quarters)
- **Disability**: You must receive 24 months of SSDI benefits
- **Disease**: ESRD
- **Special consideration**: If you have ALS (Lou Gehrig’s Disease) you don’t have to wait the 24 months after getting SSDI

Medicare is compromised of 4 parts:

- **Part A** (in-patient hospitalization)
- **Part B** (outpatient)
- **Part C** (Medicare Advantage)
- **Part D** (RX)
Part II: Conditional Payments
What is a Conditional Payment?

Payments of medical bills made by Medicare are made under the condition that the primary plan will repay Medicare once it is demonstrated the primary plan is responsible for the payments (42 U.S.C. 1395y (b)(2)(B)(ii)).

- Demonstrated through a settlement or other payment to or on behalf of the beneficiary

Allows beneficiary to receive medical treatment when no other insurance is available

Allows medical care providers to get paid
What is a Conditional Payment?

| Concept | Medicare should not pay for services if another primary payer is available (or required) to pay.  
|         | However, if a primary payer will not pay, then Medicare will make the payment “conditioned” on it being reimbursed. |
| Medicare’s Reimbursement Right | Medicare will demand reimbursement after a WC settlement.  
|                                  | Medicare must be repaid within 60 days of final demand letter regardless of whether the amount is disputed or is being appealed or interest begins to accrue (Haro v. Sebelius) |
| Exposure | Medicare can recover / bring suit against any or all involved.  
|          | Interest accrual.  
|          | If not repaid, file can be referred to US Department of Treasury as a debt.  
|          | Private c/a filed by plaintiffs are becoming more common. |
What do you do with Conditional Payments?

1. Identify the issue
2. Obtain a Conditional Payment figure
3. Investigate and dispute
4. Pay **ONLY** the amount you owe **AFTER** the settlement is finalized
Medicare Contractor Changes

July 2015 CMS Announcement

• Effective October 5, 2015, two different contractors will perform NGHP recovery:
  – BCRC (incumbent)
  – Commercial Repayment Center (CRC)

• CRC will perform recovery against NHGP insurers—a new process for insurers.

• CRC will begin recovering in ORM situations: pre-settlement in WC and no-fault (Section 111 Reporting)
Medicare Contractor Changes

• “Rolling Recovery” - CMS’ ability to seek recovery on an ongoing basis pre-settlement

• CMS may no longer use settlement as the trigger for issuing a conditional payment demand

• Instead - ORM = Conditional Payment Notice (CPN) from CMS

• Impact on claims handling:
  – TX, MA, NH, NJ - cases not typically settled on a full and final basis; anticipate recovery to begin after ORM has been reported and Medicare makes a payment
  – What does this mean for Section 111 reporting?
Medicare Contractor Changes

• CPN gives insurers 30 days to object or face a final demand

• Critical for insurers to respond to CPNs in a timely fashion to avoid unwarranted demands

• Corollary: Effective October 1 CMS will begin referring delinquent debts to Dept. of Treasury after 4 months instead of six

• Keep in mind per SMART Act demands must be appealed within 120 days (primary payer appeal rights)
Medicare Contractor Changes

• Current claims with the BCRC remain with the BCRC

• Former conditional payment process will remain in place

• BCRC Process:
BCRC Conditional Payment Compliance

- Ensure that an MSP case is properly set-up with the MSP contractor – the BCRC

Identify
- Obtain CPL from BCRC

Dispute
- Engage BCRC in a dispute, where applicable, to mitigate cost/exposure

Resolve
- Notify BCRC of resolution of claim and obtain Final Demand and reimburse Medicare
What Is Medicare Advantage?

Medicare Advantage is offered by private insurers Medicare coverage – plus more services.

Key differences

• Medicare was created 1965. MA has been around as a concept since 1997.

• Medicare is run by federal government. MA is run by private insurers.

• Medicare has 39 million beneficiaries. MA has about 16 million enrollees (and growing).
Key Question

If MA plans are all private companies, can they directly recover from insurers and obtain double damages (just like Medicare)?

An answer in 3 parts

• The Medicare Act does afford some ability for MA plans to ask for money back.

• CMS asserts the MA plan has rights as well.

• Just what the rights are and how those rights are enforced is the subject of several important court cases.
Refresher: What Can Medicare Do?

Medicare can sue insurers in federal court and obtain double damages. MSP private cause of action:

42 USC 1395y(b)(3)(A)

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

What about MA Plans? Can they also do this?
What Have Courts Said?

Do Medicare Advantage Plans have private cause of action rights under the MSP?

“Game changer” case:
In re Avandia, 685 F.3d 353 (3rd Cir. 2012)

- **Humana**: Medicare statute and MA regs. give us the right to sue in federal court for double damages

- **Court**: Agrees
Post-Avandia

What does Avandia mean?

• Medicare Advantage plans have an open door to federal court

• MA plans can sue insurers for payments that they make that are related to the underlying property/casualty claim

• Applicable only in the 3rd Circuit (PA, DE, NJ, and US VI)
Post-Avandia

How are other courts handing this issue?

- Courts are all over the map on this issue
- Texas, Florida, Louisiana: key states to watch
  - Court finds settlement agreement “demonstrates [insurer’s] responsibility” to reimburse Humana
  - Court finds that as primary payer, Western Heritage must pay double damages under P.C.A. provision
  - Under appeal
Post-Avandia

How are other courts handing this issue?

• But see

• Another key case: *Parra v. Pacificare of Arizona*, 715 F.3d 1146 (9th Cir. 2013)
  – Case involves question of whether plan can sue an MA enrollee’s survivors (following accidental death)
  – *Pacificare* – Among other things, MA plans have P.C.A. pursuant to Medicare Act
  – Court rejects *Pacificare*’s claim
Where Does That Leave Us?

http://www.verisk.com/claimspartners-v/medicare-advantage/
Part III:

Section 111 Reporting
Under CMS’ directives, “Responsible Reporting Entities (RREs)” are the parties required to report.

RREs are insurers and self-insureds – risk bearing entities

Claimants/Plaintiffs and their lawyers are never responsible
There are two Section 111 reporting triggers:

1. **TPOC**: Total Payment Obligation to the Claimant
2. **ORM**: On-Going Responsibility for Medicals

**TPOC** involves the reporting of certain settlements, judgments, awards and other payments.

- Different TPOC dates and monetary threshold amounts for WC and liability claims.
- There is no monetary threshold for NF claims.

**ORM** involves the reporting of claims when the RRE “accepts on going responsibility for medicals.”

- Typically will involve WC, NF and Med Pay claims.
Section 111 Reporting Thresholds:
Liability

- CMS Alert dated 2/28/2014
- Liability Settlements:
  - 10/1/2014- Settlements greater than $1,000
Section 111 reporting Thresholds – Workers’ Comp

- CMS Alert dated 2/28/2014

- Workers’ Compensation Settlements:
  - 10/1/13-9/30/14- Settlements greater than $2,000
  - 10/1/2014- Settlements greater than $300
Part IV: Medicare Set Asides
What is a Medicare Set-Aside?

A Medicare Set-Aside is a fund of money segregated out of a person’s WC settlement.

The money should only be used to pay for WC-related medical needs after the settlement.

Medicare will review MSA proposals and approve the amount to be set aside, providing a layer of protection against future enforcement.
# Know the WCMSA Thresholds

## WCMSA Review Thresholds

<table>
<thead>
<tr>
<th>WCMSA Threshold #1</th>
<th>WCMSA Threshold #2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Beneficiaries</strong></td>
<td><strong>Non-Medicare Beneficiaries</strong></td>
</tr>
</tbody>
</table>
| Claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is > $25k | Claimant is NOT a Medicare beneficiary at the time of settlement, **but**:
| | i. The total settlement is > $250k; **AND**
| | ii. The claimant has a reasonable expectation of Medicare enrollment w/in 30 months of the settlement. |
Review Threshold “Definitions”

**Total Settlement Amount**

- Total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present value of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement.

**Reasonable Expectation of Medicare**

- Includes, but is not limited to, the following situations where the claimant:
  - Has applied for SSD;
  - Has applied for SSD, was denied, but anticipates appealing or re-filing for SSD;
  - Is in the process of appealing or re-filing for SSD;
  - Is 62.5 years old; or
  - Has End Stage Renal Disease but does not yet qualify for Medicare.
MSA thresholds (Workers’ Comp)

Class III

• Problem:
  – CMS has stated that these (Class I AND Class II) are only “workload review thresholds.”
  – CMS has also stated that parties must “consider and protect Medicare’s interests when settling any workers’ compensation case (Class III); even if review thresholds are not met, Medicare’s interest must always be considered.”

• Solution:
  – Review each file with a uniform approach at compliance
    • Medicare Status, Lost Time, Return to Work, Age, Medical reserves, Dollar Amount, Type of Settlement
Successful Reconsideration Requests

Two criteria for submitting a reconsideration request to CMS: Clear Error or New Information not previously considered

**Clear Error**
- Easier argument to make, does not require additional information.
- Example would be CMS allocated Fentanyl 1x a day although the pay history and medical records clearly state 10 patches a month.

**New information not previously considered**
- Misleading because CMS only accepts “new information” if it pre-dates the date of the CMS submission.
- This is why it is always better to issue spot early and get supporting documentation ahead of time.
Liability Cases & “Future Interests”

CMS’ 9/30/11 LMSA Memo

Purpose:

The purpose of this memorandum is to provide information regarding proposed Liability Medicare Set Aside amounts related to liability insurance (including self-insurance) settlements, judgments, awards, or other payments (“settlements”).

Announced Policy (Part I):

Where the beneficiary’s treating physician certifies in writing that treatment for the alleged injury ... related to the settlement has been completed as of the date of the settlement, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular “settlement,” satisfied.

If the beneficiary receives additional “settlements” related to the underlying injury or illness, he/she must obtain a separate certification for those additional “settlements.”
Liability Cases & “Future Interests”

Announced Policy (Part II):  

When the treating physician makes such certification, there is no need for the beneficiary to submit the certification or a proposed L-MSA amount for review.

CMS will not provide the settling parties with confirmation that Medicare’s interest with respect to future medicals for that “settlement” has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician’s certification.

The above referenced guidance and procedure is effective upon publication of this memorandum.
Part V:
SMART Act Changes
## SMART Act Changes

### Dissecting the SMART Act

**What are the changes?**

| **1. Required use of SSNs and HICNs for Section 111 reporting purposes to be eliminated.** | **CMS has 18 months to do so**  
**But, CMS can ask for time extensions**  
**Issue, impact, and considerations** |
|---|---|
| **2. Modifies Section 111’s penalty and requires CMS to solicit proposals to establish Section 111 penalty provisions.** | **Softens Penalty:** “Shall” to “May”  
**Formal penalty provisions to be established:**  
o Proposed Rule/Comment Process  
Must include safe harbor “for good faith efforts to identify a beneficiary…” |
## SMART Act Changes (cont.)

### Dissecting the SMART Act

**What are the changes?**

| 3. Sets a single monetary compliance threshold for certain claims starting in 2014. OOPS! Missed deadline! | • A yearly single monetary compliance threshold figure for:  
  - Liability TPOC reporting; and  
  - Conditional payments pertaining to “alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases).”  
  • Must be set and adjusted no later than November 15th each year, beginning in 2014. |

---

---

---
**Dissecting the SMART Act**

**What are the changes?**

<table>
<thead>
<tr>
<th>4. Parties can obtain Medicare’s “final” conditional payment figure prior to a settlement, judgement, award or other payment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- New CP portal is to be used (claimant’s consent required)</td>
</tr>
<tr>
<td>- CMS to post CP information w/in certain time periods</td>
</tr>
<tr>
<td>- Posted info must meet certain specificity requirements</td>
</tr>
</tbody>
</table>
SMART Act Changes (cont.)

Dissecting the SMART Act
What are the changes?

5. Extends formal appeal rights to primary payers and other parties to challenge conditional payment determinations.

- CMS must create regulations establishing a “right of appeal and appeals process with respect to any determination under this subsection for a payment made under this title for an item or service for which [Medicare] is seeking to recover conditional payments…”

- Applies to applicable plans that are also considered “primary payers” under the MSP, as well as to an attorney, agent, or TPA on behalf such plans.

- The claimant must be notified of the “intent to appeal such determination.”
Dissecting the SMART Act
What are the changes?

SMART Act changes...

An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award or other payment made pursuant to [Section 111] relating to such payment owed. (Emphasis Added)

Effective date:
This amendment “shall apply with respect to actions brought and penalties sought on or after 6 months after the date of the enactment of this Act.”

- Issues, impact and considerations...
Thank You!