Tower MSA PARTNERS
Technology Driven MSP Compliance

MSA – Don't make them harder than they have to be

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Learning Objectives

- Identifying Medicare eligible claimants
- Understanding CMS MSP Enforcement Mechanisms
- Investigating, Disputing and Resolving Medicare Conditional Payments
- Determining if and when an MSA is appropriate
- Criteria for Zero MSA
- Resolving MSA cost drivers

1981 Medicare Secondary Payer (MSP) Statute

- The MSP statute resides in the Omnibus Budget Reconciliation Act of 1981
- 42 CFR 411 is the Medicare Secondary Payer Regulation
- The MSP was passed to reduce federal spending by protecting Medicare as a "secondary payer" whenever a primary payer exists
- Carrier/TPA/Self-Insured = primary payers for injuries
- Centers for Medicare and Medicaid Services (CMS)
  - The federal agency that administers the Medicare programs
  - Began enforcing MSP Regulation in 2001 via "a memo"
- ***Intent: avoid shifting the burden of future medical expenses to Medicare***

Who qualifies for Medicare?

- Age – 65 or older,
- Disabled under SSDI and after 24 month waiting period; or,
- End-Stage Renal Disease/ALS

MSP Compliance Requires Three Major Focuses

- **The Past:**
  - Reimbursement of Conditional Payments (Medicare Lien)
- **The Present:**
  - Medicare Medicaid SCHIP Extension Act (MMSEA) (The Treasure Map)
- **The Future:**
  - Medicare Set Asides (MSA): Allocation of Money for future treatment

CMS MSP Enforcement Structure

6

Section 111 Mandatory Insurer Reporting

What is Mandatory Insurer Reporting?

- The purpose of Section 111 reporting is to enable CMS to pay appropriately for Medicare-covered items and services furnished to Medicare beneficiaries.
- Section 111 NGHP (Non-Group Health Plan) reporting of applicable liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim information helps CMS determine when other insurance coverage is primary to Medicare.

Mandatory Insurer Reporting allows Medicare to 'follow the money'……

When Should Data Be Reported?

- Reporting trigger events:
  - Accept Ongoing Responsibility for Medical (ORM)
  - Change to claim, injury or demographic information
  - Termination of ORM
  - Total Payment Obligation to Claimant (TPOC)

Why Section 111 Reporting Matters to You

- Information provided to CMS through ORM or TPOC will have an effect on conditional payment resolution process and WCMSA review process.
  - If an RRE has reported an ICD-9 /ICD-10 as part of ORM, any payments made by Medicare for such ICDs will be considered conditional payments.
  - Even if such codes were not related to the claim, CMS will seek reimbursement from either the primary payer or applicable plan pre-settlement, or from the beneficiary or his counsel post-settlement.
  - If an RRE reports ICD-9 or ICD-10 as part of ORM or TPOC, and an MSA is submitted to CMS for approval, such codes may be included in the MSA.
  - Even if such codes were not related to the claim, but were mistakenly reported, CMS may include such future treatment in the MSA.

Best Practices – Section 111 Reporting

- RREs can no longer look at Section 111 in isolation
  - Align S111 reporting with claims management execution
  - Report only accepted ICD10 codes
  - Modify ORM immediately when injuries / body parts are denied to remove denied ICD10 codes
  - Review edit / error reports and make corrections ASAP
  - Verify TPOCs are reported as soon as possible
  - Ensure Recovery Agent is aware of responsibility

Medicare's Past Interest - Conditional Payments

What Are Conditional Payments?

- *42 CFR §411.21* defines a conditional payment as a Medicare payment for services/treatment for which another payer is responsible or may have an obligation to pay.
- A primary payer must reimburse Medicare for conditional payments Medicare has been made when:
  - *Claim is settled*
  - *Indemnity is settled and medicals are left open,*
  - *RRE reports acceptance of ORM via MMSEA Section 111 Mandatory Insurer Reporting (MIR).*

When are conditional payments made?

14

- Improper billing by provider
- Denied claim by primary payer
- Other insurance presented by the claimant
- Improper Coordination of Benefits

Recovery Methods and Exposure

15

- Direct Recovery: Demand from CMS via Contractors
- Interest Accrual
- Referral to U.S. Department of Treasury
- Lawsuit for Double-Damages
- Private Cause of Action Lawsuit

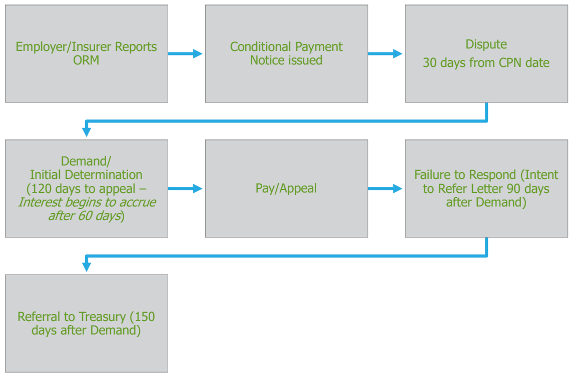
Commercial Repayment Center - CRC

16

- As of 10/5/2015, identifies and recovers conditional payments for all new* recovery cases where CMS pursues recovery directly from an applicable plan as the identified debtor. (Workers' compensation, liability and no-fault claims)
- CRC also oversees a separate Group Health Plan recovery program
- CRC contract currently held by CGI Federal

**Note on definition of "new"*

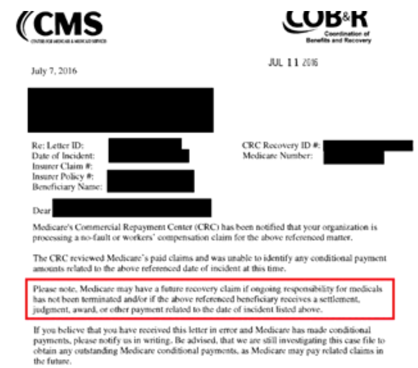
What is CRC's Recovery Process?



Examples of CP Correspondence: No-Claims Paid

- **No Claims Paid Letter:** From CRC - an indication that Medicare currently has not

18



July 7, 2016

JUL 11 2016

[redacted]

Re: Letter ID: [redacted]
Date of Incident: [redacted]
Insurer Claim #:
Insurer Policy #: [redacted]
Beneficiary Name: [redacted]

CRC Recovery ID #: [redacted]
Medicare Number: [redacted]

Dear [redacted]

Medicare's Commercial Repayment Center (CRC) has been notified that your organization is processing a no-fault or workers' compensation claim for the above referenced matter.

The CRC reviewed Medicare's paid claims and was unable to identify any conditional payment amounts related to the above referenced date of incident at this time.

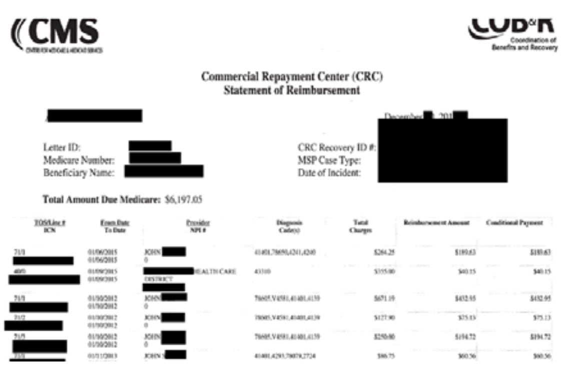
Please note, Medicare may have a future recovery claim if ongoing responsibility for medicals has not been terminated and/or if the above referenced beneficiary receives a settlement, judgment, award, or other payment related to the date of incident listed above.

If you believe that you have received this letter in error and Medicare has made conditional payments, please notify us in writing. Be advised, that we are still investigating this case file to obtain any outstanding Medicare conditional payments, as Medicare may pay related claims in the future.

Examples of Correspondence: CPN/SOR

- **Statement of Reimbursement(SOR):** From CRC – Lists contended conditional payments made by Medicare.

19



Commercial Repayment Center (CRC)
Statement of Reimbursement

[redacted]

December [redacted], 201[redacted]

Letter ID: [redacted]
Medicare Number: [redacted]
Beneficiary Name: [redacted]

CRC Recovery ID #: [redacted]
MSP Case Type:
Date of Incident:

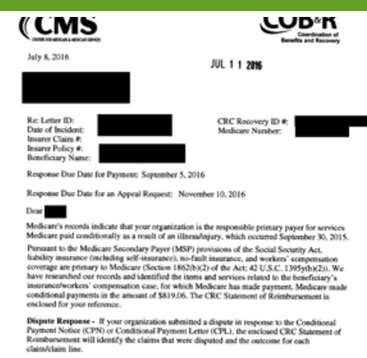
Total Amount Due Medicare: $6,197.05

TOS/Line # ICN	From Date To Date	Provider NPI #	Diagnosis Code(s)	Total Charges	Reimbursement Amount	Conditional Payment
71/1 [redacted]	01/06/2015 01/06/2015	JOHN [redacted] 0	41401,78650,4241,4240	$264.25	$189.63	$189.63
40/0 [redacted]	01/09/2015 01/09/2015	[redacted] HEALTH CARE DISTRICT [redacted]	43310	$355.00	$40.15	$40.15
71/1 [redacted]	01/10/2012 01/10/2012	JOHN [redacted] 0	78605,V4581,41401,4139	$671.19	$432.95	$432.95
71/2 [redacted]	01/10/2012 01/10/2012	JOHN [redacted] 0	78605,V4581,41401,4139	$127.90	$75.13	$75.13
71/3 [redacted]	01/10/2012 01/10/2012	JOHN [redacted] 0	78605,V4581,41401,4139	$250.00	$194.72	$194.72
71/1 [redacted]	01/11/2013	JOHN [redacted]	41401,4293,78079,2724	$86.75	$60.56	$60.56

Examples of Correspondence: Demand

- **Demand** – Request for repayment; 60 days to repay or interest may accrue; appeal rights.

20



July 8, 2016

JUL 11 2016

[redacted]

Re: Letter ID: [redacted]
Date of Incident:
Insurer Claim #:
Insurer Policy #: [redacted]
Beneficiary Name:

CRC Recovery ID #: [redacted]
Medicare Number:

Response Due Date for Payment: September 5, 2016

Response Due Date for an Appeal Request: November 10, 2016

Dear [redacted]

Medicare's records indicate that your organization is the responsible primary payer for services Medicare paid conditionally as a result of an illness/injury, which occurred September 30, 2015.

Pursuant to the Medicare Secondary Payer (MSP) provisions of the Social Security Act, liability insurance (including self-insurance), no-fault insurance, and workers' compensation coverage are primary to Medicare (Section 1862(b)(2) of the Act; 42 U.S.C. 1395y(b)(2)). We have researched our records and identified the items and services related to the beneficiary's insurance/workers' compensation case, for which Medicare has made payment. Medicare made conditional payments in the amount of $819.06. The CRC Statement of Reimbursement is enclosed for your reference.

Dispute Response - If your organization submitted a dispute in response to the Conditional Payment Notice (CPN) or Conditional Payment Letter (CPL), the enclosed CRC Statement of Reimbursement will identify the claims that were disputed and the outcome for each claim/claim line.

Payment - Please provide a check or money order made payable to **Medicare** in the amount of

Examples of Correspondence: ITR

- **Intent to Refer** – Delinquent demand – can come from CRC or BCRC.

21

Re: Past-Due debt owed CMS as of January 20, 2015:
Date debt became past-due:
Date of Demand letter previously sent:
Case Identification Numbers:
Taxpayer Identification Number (TIN):
Beneficiary Name:
Medicare Number:
Date of Incident:
Insurer Policy Number:
Insurer Claim Number:

[redacted]

Dear [redacted]

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED DEBT COLLECTION CENTER

Initial Determination Letter from CRC

- Initial Determination or Demand Letter advises debtor (applicable plan in this case) of the amount owed to Medicare and requests reimbursement within 60 days. A courtesy copy is sent to the plan's recovery agent, the beneficiary and the beneficiary's attorney or other representative. The demand letter includes the following:
  - The beneficiary's name and HICN;
  - Date of accident/incident;
  - A claims listing of all related claims paid by Medicare for which Medicare is seeking reimbursement from the plan;
  - The total demand amount (amount of money owed) and information on administrative appeal rights.
- Options: Pay or Appeal. *Do not ignore.*

Bases for Disputing or appealing

23

- Policy limits exhaustion (No-fault)
- Causation
  - Treatment is unrelated to the claimed injury
  - Judicial decision has found the treatment unrelated or not reasonable or necessary.
  - Statutory process has found the treatment to not be reasonable or necessary.
  - Case has been completely denied.
- Important, with a CPN there is only 30 days from the date on the Notice to submit a dispute.

Appeals Process

1. Redetermination – Must be requested within 120 days of the Initial Determination (Appeal handled by the Commercial Repayment Center)
2. Reconsideration – Must be requested within 180 days of receipt of the Redetermination (Appeal handled by Qualified Independent Contractor)
3. Administrative Law Judge (ALJ) hearing – Must be requested within 60 days of receipt of Reconsideration determination
4. Departmental Appeals Board (DAB) – Must be requested within 60 days of ALJ decision
5. Federal Court Review – Must be filed within 60 days of DAB decision

Payment to CRC + Interest Accrual

- **Confirmation Letter:** If the CRC receives payment in full, it will issue a letter stating that the specified debt has been resolved. The letter will also note that new cases may be created if the applicable plan maintains ORM or the CRC receives information on additional items or services paid by Medicare during the period of ORM.
- **Interest:** Interest on the debt accrues from date of the demand letter and, if the debt is not resolved within 60 days, is assessed for each 30 day period the debt remains unresolved.
- **Recovery put on hold pending appeal:** If plan requests an appeal, the debt will not be referred to the Department of Treasury while the appeal is being processed, but interest will continue to accrue.
- **Pay while on appeal:** The applicable plan may choose to pay the demand amount while appealing to avoid the accrual and assessment of interest.
- *Interest calculator available on CMS website*

Treasury Department Debt Collection Activities

26

- Internal
  - Demand Letters
  - Telephone calls
  - Treasury Offset Program (TOP)
  - Administrative wage garnishment
  - Credit bureau reporting
- External
  - Private Collection Agencies (PCAs)

Best Practices - Conditional Payments

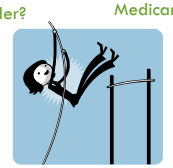
- Update claim ICD-9 / ICD-10 codes immediately when denials occur.
- Make certain all claims are reported to BCRC.
- Treat CP Letters & CP Notices the same. Dispute immediately…. Don't wait for Demand/Initial Determination Letter.
- Identify unauthorized treatment / unrelated illnesses & injuries.
- Accept only compensable injury(ies).
- Exclude pre-existing / co-morbid conditions.
- Determine if claimant claimed that injury exacerbated or aggravated the condition.
- Determine whether claimant alleged that injury or condition was caused or worsened as a result of the accident/incident/exposure.
- Determine obviously unrelated conditional payments and compare to what is contained in the medical records.
- Review settlement language to see what injuries, if any, were specifically released or whether release is a general release of any and all injuries.

Protecting Medicare's Future Interest - WCMSA

Do you need an MSA to settle your WC claim – Key Considerations

Is medical being settled? → Has claimant applied for Social Security Disability or 62 ½ or older? → Is claimant otherwise Medicare eligible? →

Settlement Amount? →



Above or below CMS MSA Review Thresholds?

CMS Submission and Review Thresholds

- Why seek CMS approval?
  - The 'certainty' associated with CMS's approval of amount

"If the parties to a WC settlement do not receive CMS approval, CMS is not bound by the amount stipulated by the parties, and it may refuse to pay for claim-related medical expenses, even if the services would have normally been covered by Medicare" ***(WCMSA Reference Guide version 2.5, April 2016)***

- CMS review thresholds
  - Claimant is a Medicare beneficiary and total settlement amount is greater than **$25,000.00;** or
  - Claimant has a reasonable expectation of Medicare enrollment within 30 months of settlement date and anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than **$250,000.00**
- *What if settlement is below review thresholds?*

Documents required for MSA Completion and Submission

- **Documents required to complete MSA Report**
  - Completed referral form (online, faxed or mailed)
  - Medical records and Rx histories for the last 2 years.
  - Payment history for the last 2 years
  - Claimant's Medicare or Social Security Disability status (if available or we will investigate)
  - Any court orders or judicial determinations
- **If submission to CMS is requested:**
  - Executed Consent to Release form
  - Method of funding: Lump or Annuity
  - Method of administering: Self or Professional
  - Estimated settlement amount
  - Draft or final settlement documents

MSA Preparation & Mitigation Strategies

Zero MSAs

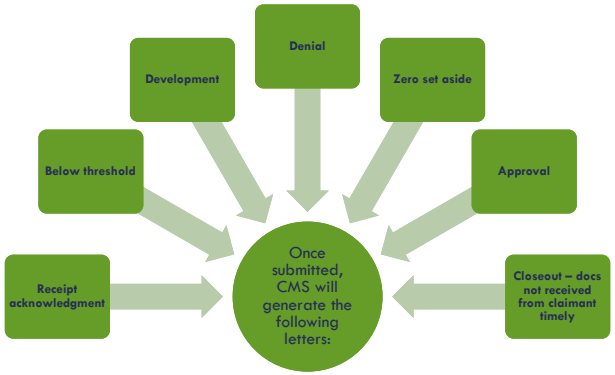
- **Zero MSA – Claim denial:** Claim denied in entirety and no medical/indemnity payments or settlements
- **Zero MSA – Medical basis:** Treating physician opines in writing that future care is not required for WC injury
- **Zero MSA – Judicial decision:** Judicial decision or court order based on merits of the case, outlines insurer has no responsibility for future medical care on accepted body part

Best Practice – Identify Obstacles Before MSA

- Index early / often – Intervene – don't wait for MSA
  - Identify / address denied body parts – remove unrelated ICD-10 codes
  - Address spinal cord stimulator (SCS) recommendations[1]
    - Used only as late/last resort for chronic, intractable pain
    - All other pharma, surgical, medical, psychological – failed
    - Claimant must be screened– Psych / Neuro evaluation
    - Must prove demonstrable pain relief - trial
  - Address surgical recommendations
    - Leverage state jurisdictional options to challenge necessity
  - Pharmacy – Identify PBM triggers
    - Challenge compound topical medications
    - Identify multiple prescribers
    - Morphine equivalent dosage - > 90 MG
    - Challenge inappropriate treatment via jurisdictional options
    - Block discontinued medications when changes are made

[1]Medicare National Coverage Determination (NCD)-Electrical Nerve Stim (160.7)

CMS Review Potential Outcomes



CMS WCMSA Re-Reviews

- When to consider re-review
  - If you think CMS has made obvious mistakes
    - Math errors
    - Fee schedule errors
  - You have additional evidence, not previously considered by CMS which was ***dated prior to the submission.***
  - **New policy:** MSA was submitted to CMS in the past one to four years and a new MSA would result in a change to the prior MSA approval of $10,000 or 10%, whichever is greater.

Best Practices - Protecting Medicare's & Your Interests

- Start with the right physician – Identify doctors who deliver the best outcomes - don't settle.
- Report only covered ICD codes (S111) / remove denied body parts ASAP.
- Be proactive to address CP Letters / CP Notices – Send to Tower ASAP.
- Be proactive to address surgical, SCS, injection recommendations immediately - don't wait for MSA.
- Leverage state jurisdictional options to enforce compliance.
- Be aware of gaps in treatment – CP exposure
- Obtain written agreement & track progress – remain treatment modification.
- Ensure that you obtain CMS accepted language to document change
- Report ORM termination / TPOC ASAP.

Questions?

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