NAVIGATING THE LONG ROAD OF MEDICARE SECONDARY PAYER COMPLIANCE

Amy E. Bilton, JD, MSCC, CMSP-F

Ms. Bilton is a shareholder, Medicare Secondary Payer professional, and workers' compensation defense trial attorney at the Chicago law firm of Nyhan, Bambrick, Kinzie & Lowry. She received her B.A. from the University of Michigan and J.D. from DePaul University College of Law. Her certifications include the Medicare Secondary Payer Consultant certification (MSCC) through the International Commission on Health Care Certification (ICHCC) and Certified Medicare Secondary Payer Professional Fellow (CMSP-F) certification.

Ms. Bilton is a frequent lecturer on workers' compensation and all aspects of Medicare Secondary Payer compliance. She is a board member and past president of the National Medicare Secondary Payer Network (formerly NAMSAP), for which she co-chairs the Annual Conference planning committee; chairperson of the MSCC board for the ICHCC; and instructor for the CMSP and CMSP-Fellow certifications.

She is also a member of the Chicago Bar Association, Illinois State Bar Association, and Illinois Workers' Compensation Lawyers Association. Ms. Bilton is also a Board member of Habitat for Humanity Chicago and co-chairs the Women Build sub-committee, which brings women together to fundraise and build affordable housing for other women and their families.

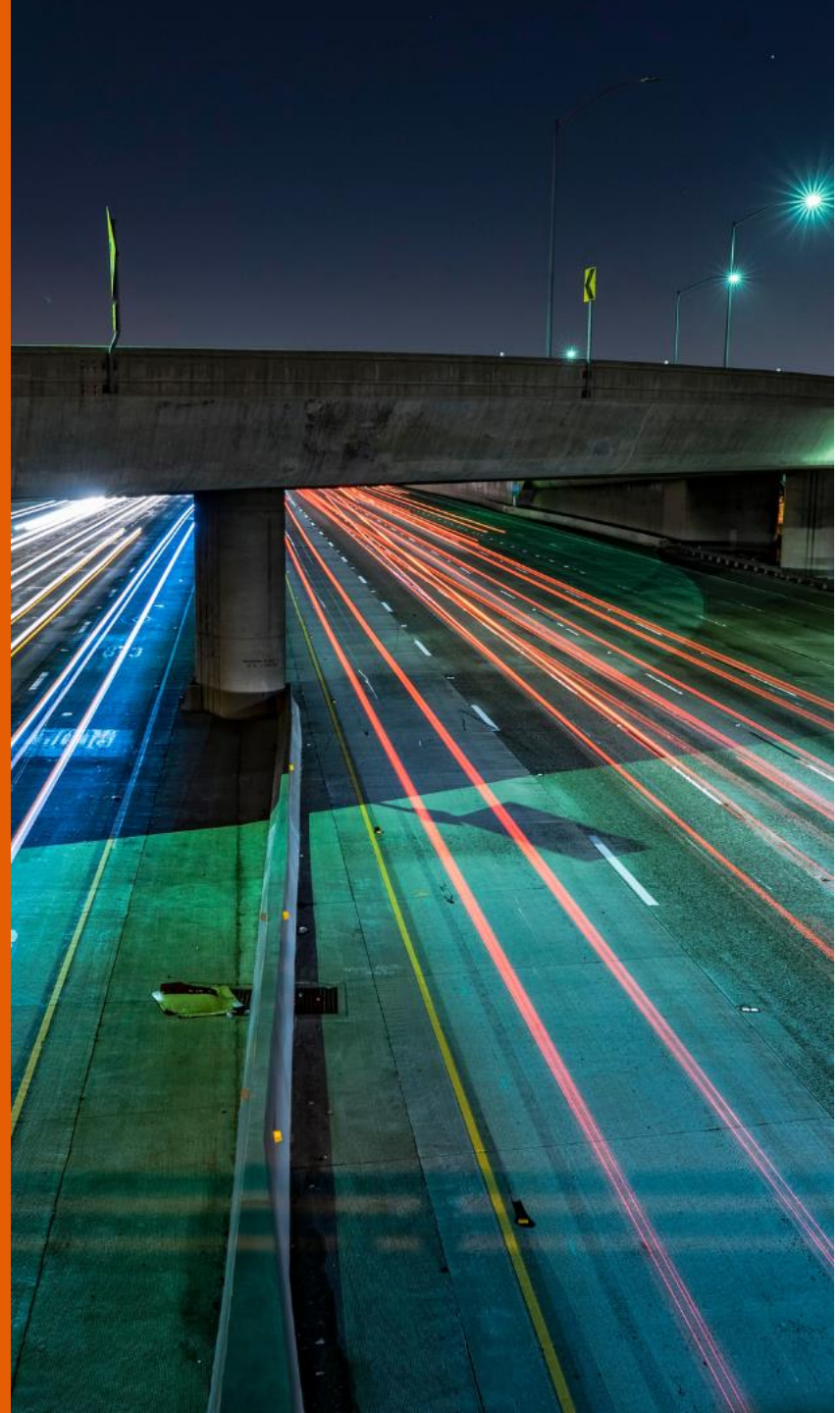
Jennifer M. Shymanski, JD, CMSP-F

Jennifer has been with the NuQuest (and formerly Protocols) since 2010. Prior to joining Protocols, she spent over ten years at a large national insurer working with both workers compensation and liability claims teams. Her focus is on assisting clients in designing and then implementing their Medicare Secondary Payer Compliance programs. Jennifer develops the training content and creates the education programs at NuQuest including their weekly educational webinar series “NuQuest Knowledge Series”. As part of the NuQuest Settlement Consultant Team, Jennifer uses her extensive claims and MSP experience to assist clients in reaching optimal outcomes for their claims resolution.

Jennifer holds a law degree from Northern Illinois University College of Law and a Bachelor of Arts in Political Science from the University of Wisconsin – Stevens Point. She is admitted to practice law in the State of Wisconsin. Jennifer is also an instructor for the Certified Medicare Secondary Payer (CMSP) and CMSP-Fellow designations. She is an Advisory Board member of The National Medicare Secondary Payer Network (MSPN formerly NAMSAP) and is a co-chair of their Webinar and Podcast Committees. Jennifer is also an adjunct instructor of Business Law at Northcentral Technical College in Wausau, Wisconsin.

Life in the Fast Lane or the Long and Winding Road?

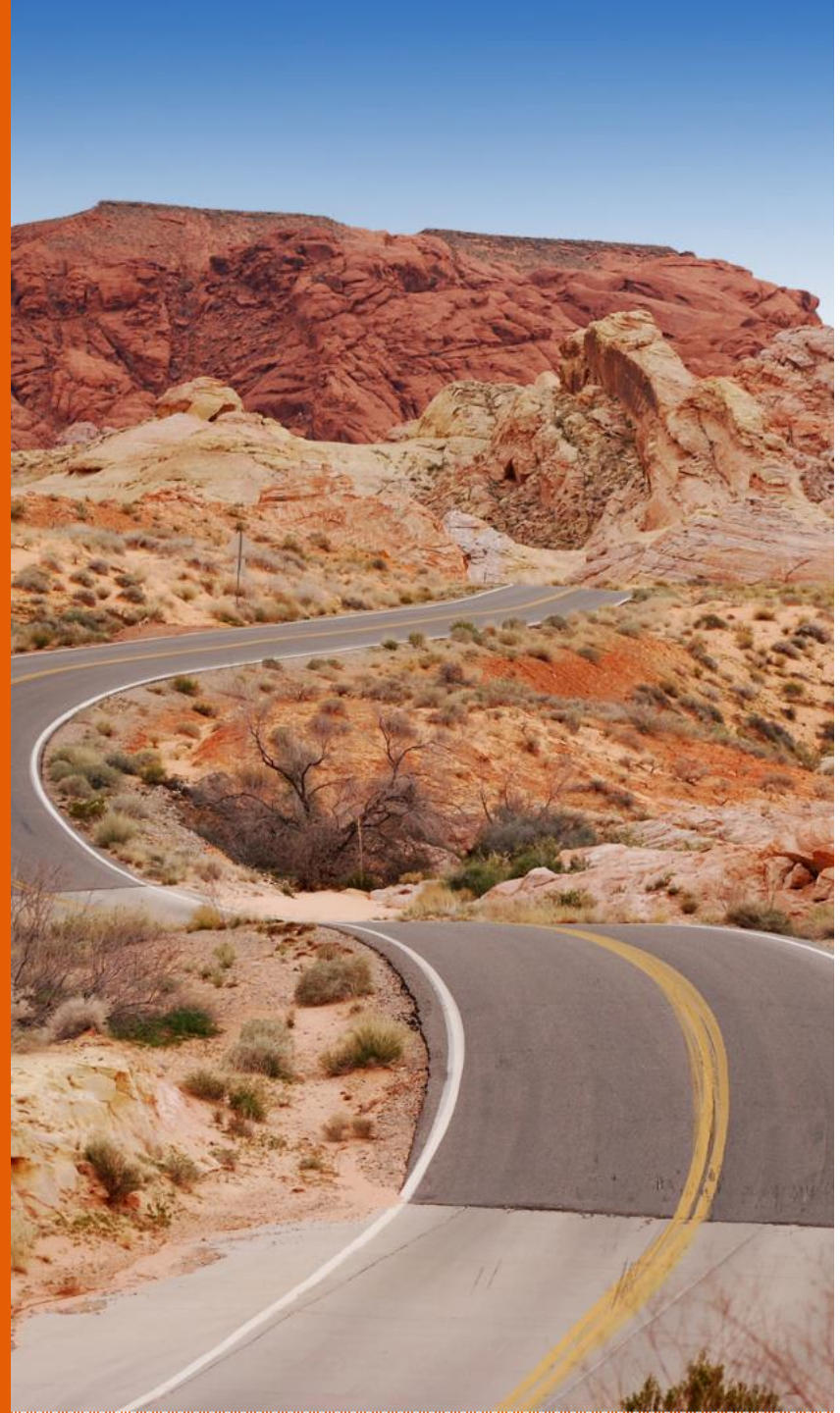
We will discuss what it takes to have a well-constructed allocation, the road rules for CMS submission and when (or if) you want to take the off ramp and opt out of submission.



Allocations

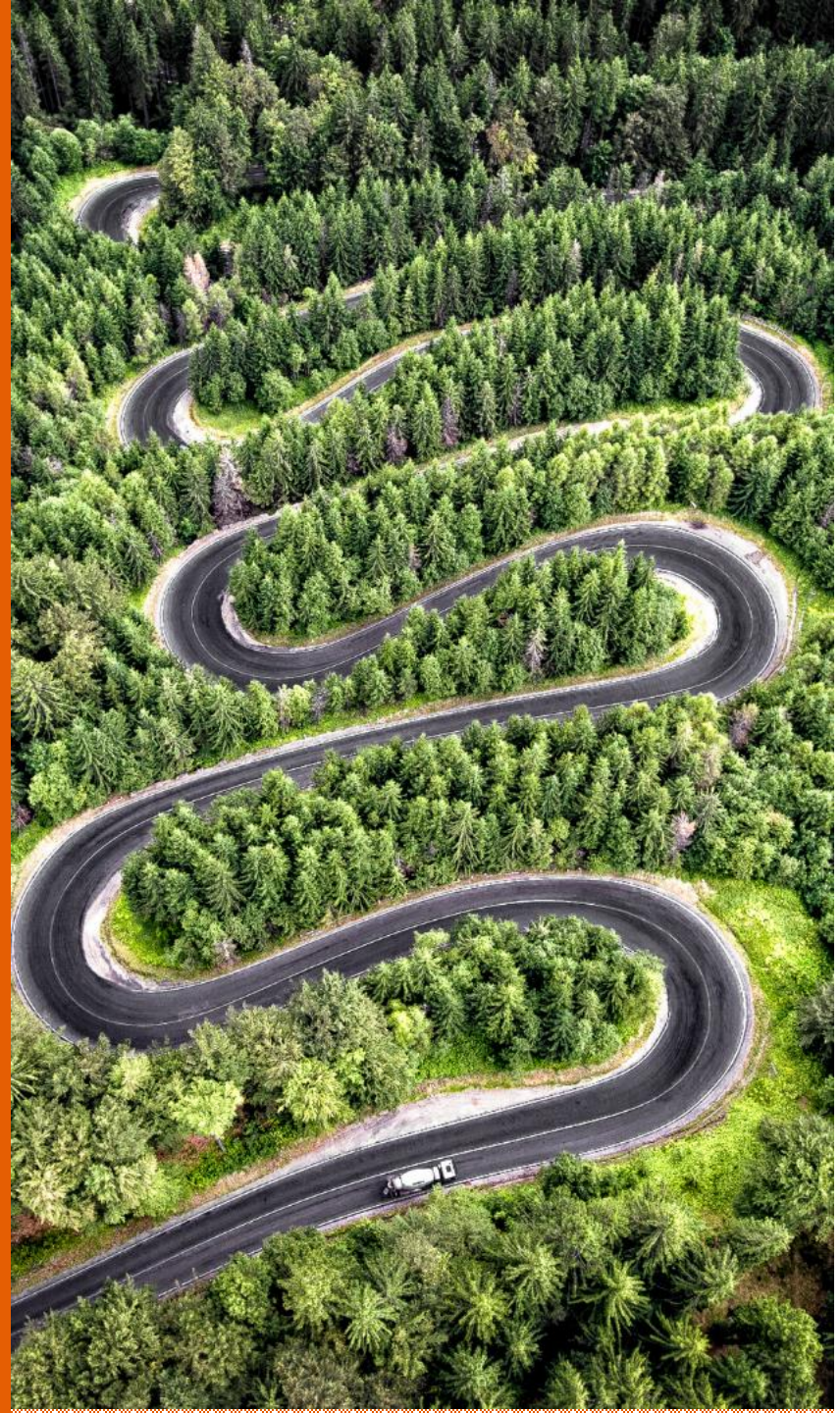
THINGS TO CONSIDER

- Timing of the MSA
- Claimant’s beneficiary status (Medicare and Social Security Disability)
- Insured/Self-Insured protocols
- Documentation



Allocations

- CMS allocates based on what the treating doctor(s) is/are recommending (not med legals)
- Body part/conditions
  - Consistent throughout the file – Reporting/CP/Allocation
  - Options for removing:
    - Medically – treater adopts changes
    - Legally – CMS defers to a ‘hearing on the merits’
- Zero (Waiver) Allocations



Allocations

PRICING

- Medical – state workers' compensation fee schedule (for states that have it) or full actual charges (WCMSA Reference Guide) /usual and customary
- Pharmacy – Red Book Drug Reference used to price according to Average Wholesale Price (AWP)

CMS Submission

- **Voluntary - WCMSA Reference Guide Section 1.0:**
  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 requests that you comply with CMS' established policies and procedures.

- **Review Thresholds - WCMSA Reference Guide Section 8.1**
  The claimant is a Medicare beneficiary, and the total settlement amount is greater than$25,000.00; **or**

  The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00.

CMS Submission

WHAT IS NEEDED?

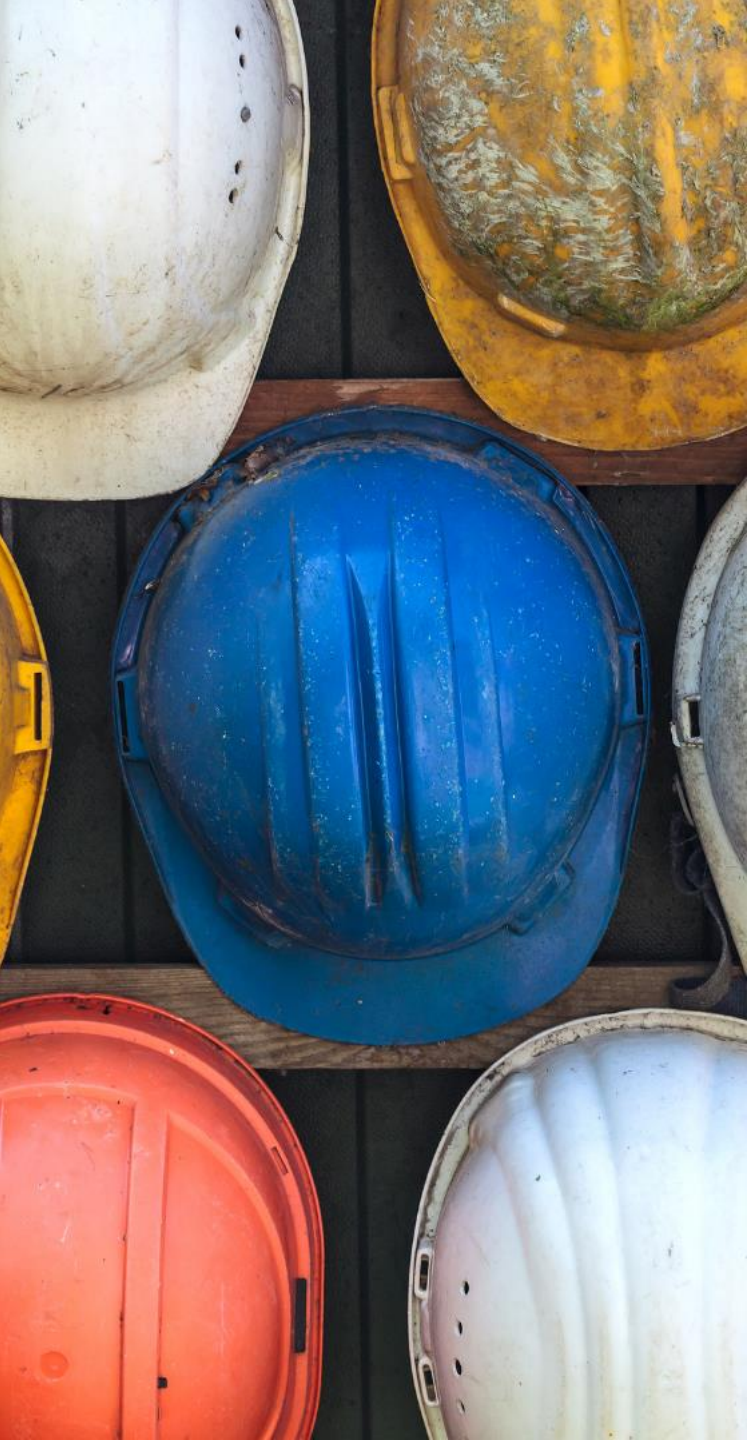
- Allocation
- Consent to Release
- Rated Ages
- Treatment records – last two years of treatment
- Payment history
- Prescription printout
- Funding
- Administration
- Proposed Settlement Amount
- Other information (denial letters, court rulings, state law)

Why Opt Out of Submissions?

- Based on records, CMS would include treatment that is not likely to occur and will be a bar to settlement (ex: treater is saying SCS is a possible, Claimant will not get)
- Documentation - unable to provide information that CMS is requesting
- Timing – can settle immediately if not submitting
- Allocation of dollars in settlement – can ‘free up’ funds for other parts of settlement

Construction Ahead

As we await the final rule for Civil Monetary Penalties, we will discuss the toll they may take on MSP compliance.



Civil Monetary Penalties

- CMS issued a proposed rule in 85 Fed. Reg. 8793, No. 32 (Feb 2020)
- Comment period ended April 2020
- CMS now has until February 2023 to issue the final rule
- Prospective - based on files submitted on or after effected date of the rule

Civil Monetary Penalties

FOCUS ON THREE ITEMS:

- Failure to Report
- Contradictory Response to Recovery Efforts
- Error Tolerances

Failure to Report

- Any NGHP beneficiary record within required timeframe
- No more than 1 year after the date of the settlement, judgment, award, or other payment (also referred to as the Total Payment Obligation to Claimant (TPOC)
- Penalties on a daily basis counted from the day after the last day of the RRE's reporting window where information should have been submitted
- Can demonstrates attempt to comply:
  - Communicate the need to the claimant at least twice by mail and once by other means?
  - Certifies no response was received
  - Documents these efforts in their system and the failure to obtain needed information to report.

Contradictory Response to Recovery Efforts

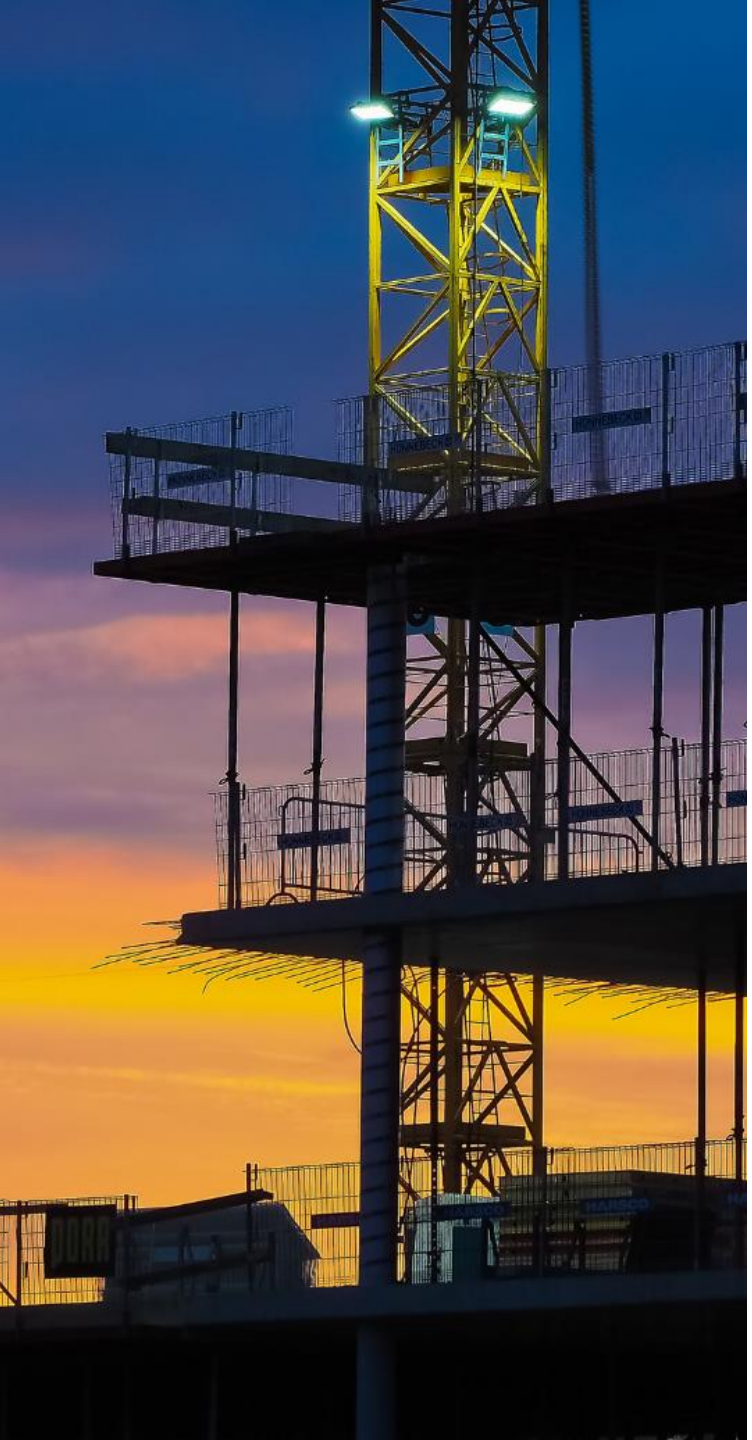
- NGHP's response to CMS recovery efforts contradicts the entity's section 111 of MMSEA

  Example: if an RRE reported and repeatedly affirmed ongoing primary payment responsibility for a given beneficiary, then responded to recovery efforts with the assertion that coverage for that beneficiary terminated 2 years prior to the issuance of the recovery demand letter.

- Penalty would be calculated based on the number of calendar days that the entity failed to appropriately report updates to beneficiary records

Error Tolerances

- Exceed error tolerance thresholds 4 out of 8 consecutive reporting periods
- Initial and maximum error tolerance threshold would be 20 percent (representing errors that prevent 20 percent or more of the beneficiary records from being processed)
- Only considering significant errors
- Assessed each calendar day of noncompliance for each individual for which the required information should have been submitted



Statute of Limitations

- Penalties may only be imposed within 5 years from the date that non-compliance was identified by CMS
- If an RRE fails to report any beneficiary record as required beginning in 2023, and CMS identifies this non-compliance in 2024 but fails to act until 2030, then no CMP would be imposed.

Appeals

- Separate appeal process from conditional payments
- ALJ - Department Appeals Board
- Requires representation by attorney
- Appeal to Departmental Appeals Board (DAB) Administrative Law Judge
- Appeal process governed by 42 CFR Part 1005
- Procedure Rules listed on CMS' website
- Can self-represent, but if representation is sought, attorney representation only.

Poll Question

IN THE PROPOSED CIVIL MONETARY PENALTIES RULE, WHAT IS THE PROPOSED ERROR THRESHOLD WHICH WOULD TRIGGER THE PENALTIES?

a) 10%

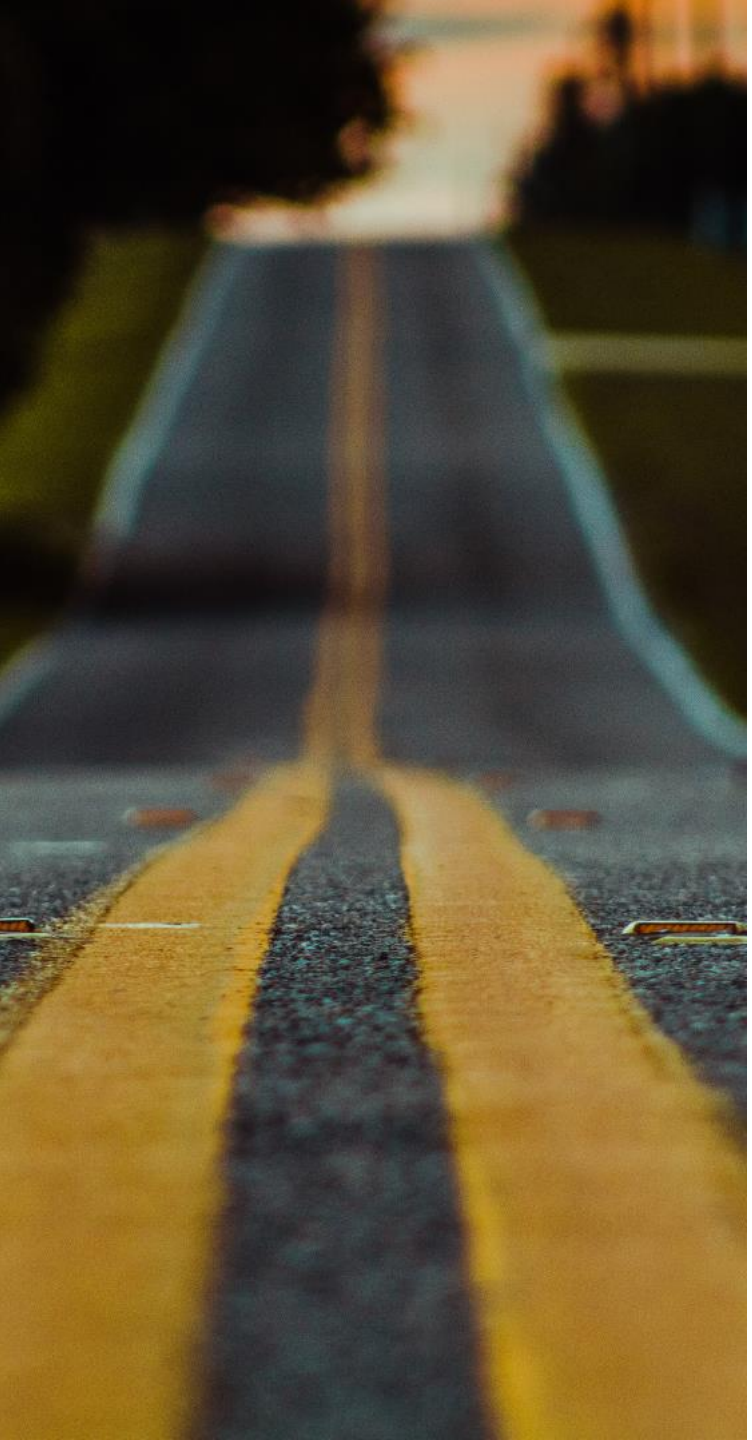
b) 20%

c) 15%

d) 5%

Road-Abouts of Conditional Payments

We will discuss the lien process and how to detour around the off-roading referrals to Treasury. And we will discuss the upcoming MAP changes.



Traditional Medicare or Medicare Advantage?

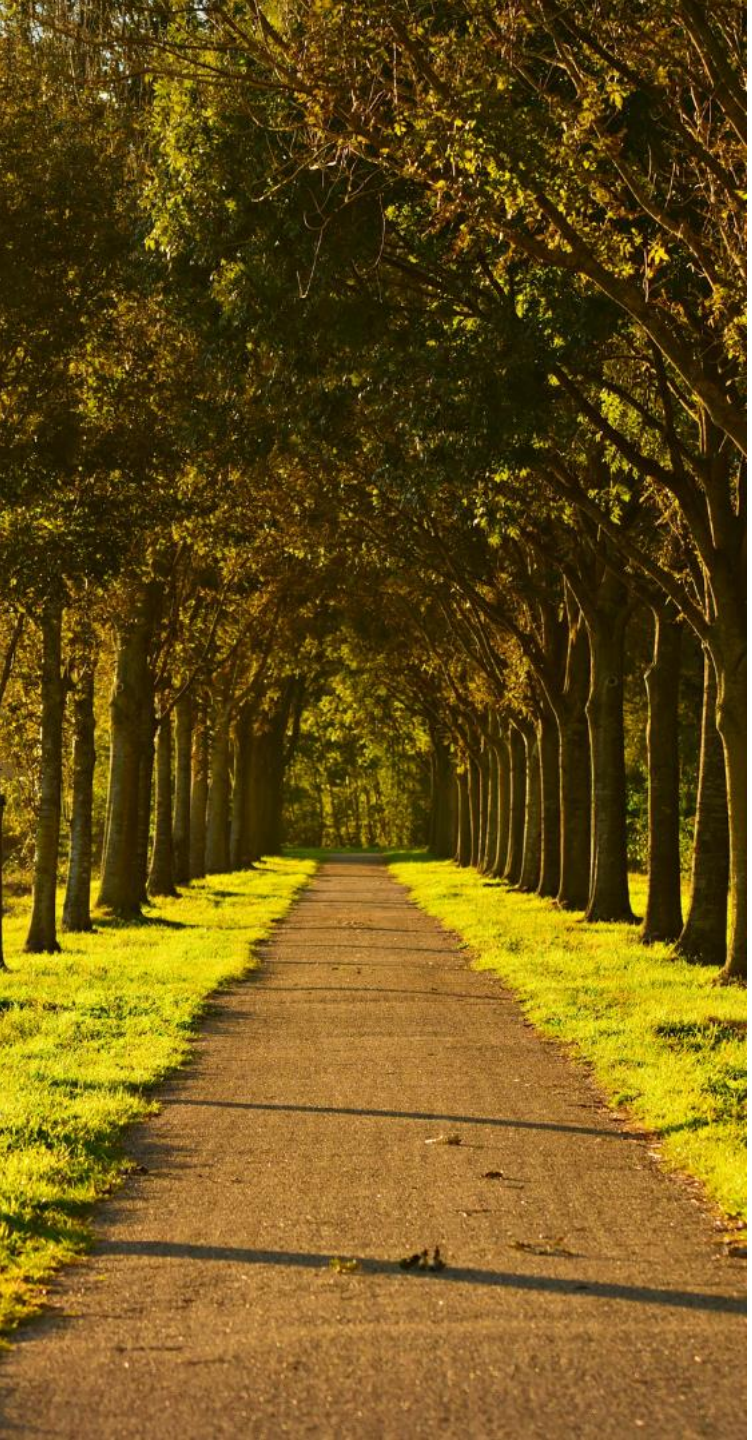
- Traditional Medicare (Parts A & B)
- Medicare Advantage (Part C)
- Prescription Drug Program (Part D)
- Each has a right to recovery of conditional payments
- There are different recovery processes for Traditional and Non-Traditional Medicare

Traditional Medicare

CONDITIONAL PAYMENT PROCESS

Traditional Medicare (Parts A & B)

- Portal access to conditional payments
- Letters also sent, including:
  - Conditional Payment Letter (CPL)
  - Conditional Payment Notice (CPN)
  - Demand
  - Intent to Refer (to the US Treasury for collection)
- Disputes to CPL, CPN and demand can be lodged via portal, mail or fax
- Timeframes to dispute charges on CPN (30 days) and demand



Traditional Medicare

CONDITIONAL PAYMENT PROCESS

- **Formal appeals process**
  - Redetermination (CRC & BCRC)
  - Reconsideration (QIC)
  - Administrative Hearing (ALJ)
  - Review by Medicare Appeals Council (MAC)
  - Judicial Review (Federal Court)
- **Statute of Limitations** – 3 years from date of notice of settlement, judgment, award or payment

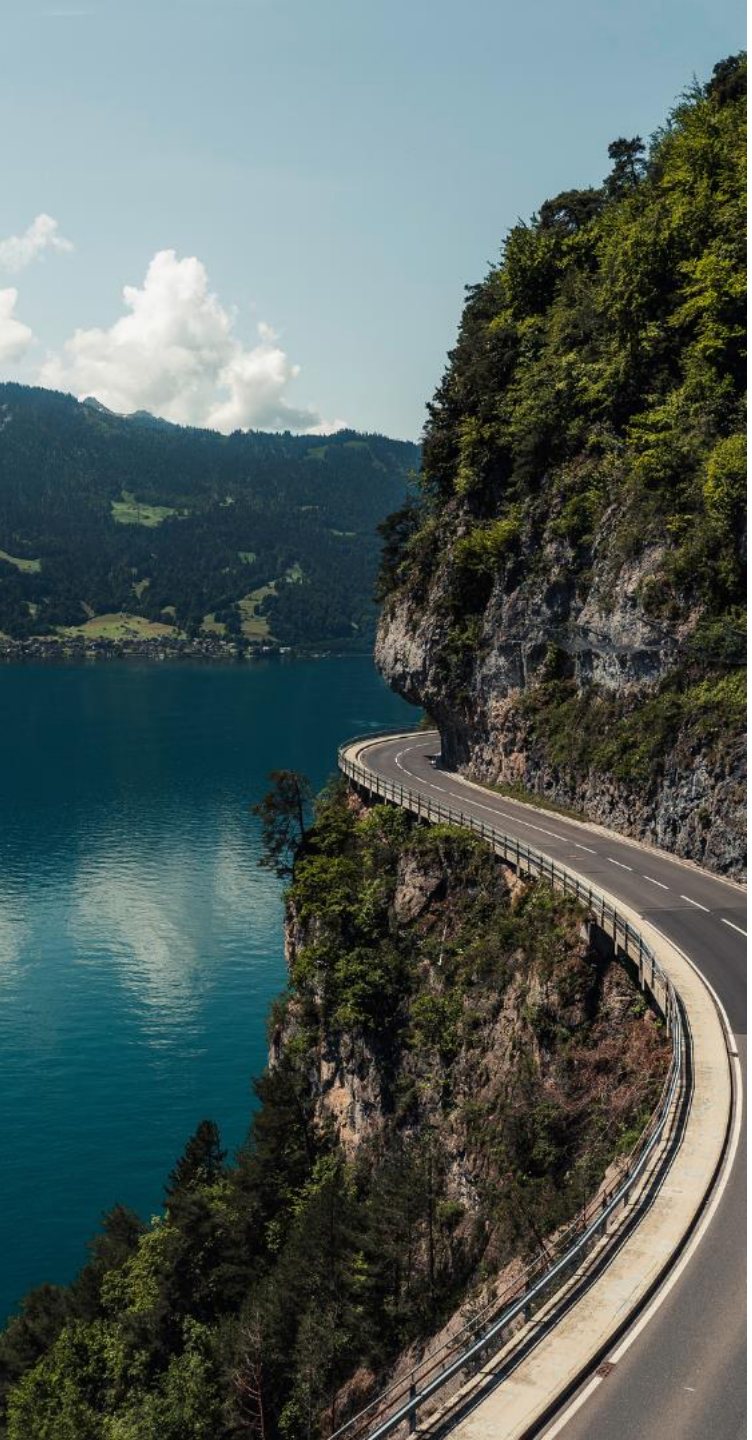
Part C & D Plans

CONDITIONAL PAYMENT PROCESS

- Identify the plan (coming soon through the Medicare query function)
- Alert plan of the claim
- Request itemization of payments
- Lodge disputes (no formal process like traditional Medicare)
- Pay

BE AWARE:

- Statute of Limitations is unclear – cases split
- Most of the current MSP litigation is for these claims!



Practical Concerns

CONDITIONAL PAYMENT PROCESS

- Interplay with Section 111 reporting
  - Adding body parts to a settlement/release will impact conditional payment recovery efforts
  - Codes reported under Section 111 will create a denial of Medicare coverage for the same and similar body parts and conditions
- Multi-year litigation – Beneficiary can change plans annually, including Part C and D plans, meaning multiple plans may need to be contacted for reimbursement
- Part C plans
  - No single system for reimbursement; every plan has their own procedures
  - Historically difficult to identify, leaving potential for future recovery claims well after the claim file is closed
  - No clear statute of limitations

Poll Question

WHAT IS THE STATUTE OF LIMITATIONS FOR TRADITIONAL MEDICARE (PARTS A & B) RECOVERY?

a) 3 years from the date of loss/accident/last exposure

b) 3 years from the date the medical service was paid by Medicare

c) 3 years from the date Medicare was given notice of the payment, settlement, judgment or award

d) There is no clear statute of limitations for traditional Medicare conditional payments


Thank You!