Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

Spring 2018

# Welcome to NBKL's "Medicare Secondary Payer Compliance Corner"

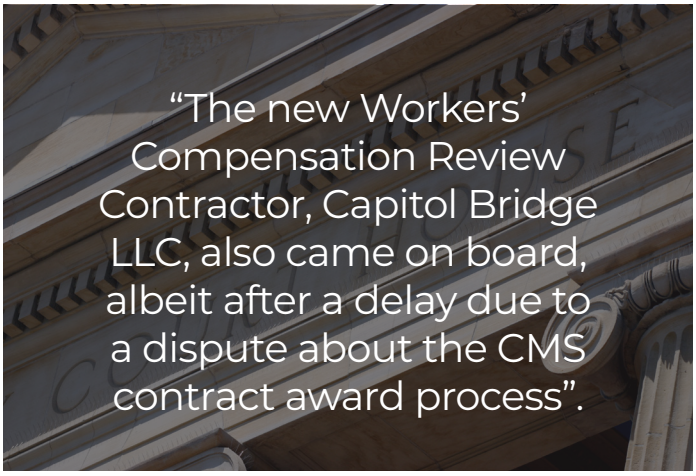
## New Contractors at CMS

The beginning of the year ushered in two new contractors at CMS. Performant Financial Group replaced CGI Federal as the Commercial Repayment Center (CRC) operating contractor for recovery involving Group Health and Non-Group Health Plans. The transition was completed on February 12, 2018. Although Performant has managed to avoid some of the issues that CGI faced during their transition, the learning curve has not yet disappeared.

The new Workers' Compensation Review Contractor, Capitol Bridge LLC, also came on board, albeit after a delay due to a dispute about the CMS contract award process. Capitol Bridge LLC assumed the work of the former contractor, Provider Resources, on March 18, 2018. During a transition webinar, Capitol Bridge reiterated its commitment to maintain timely turnarounds in processing files: determinations would be issued within 20 business days of a complete submission and development letters would be issued within 10 business days of receipt of the submission. The transition is still too recent to assess whether the commitment is being honored. The most recent version of the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, Version 2.7 (Q1-2018), includes the new Workers Compensation Review Contractor contact information. Their phone number is 1-833-295-3773.

## Know the difference between interim and final conditional payment figures

The failure to distinguish between an interim conditional payment letter and a final demand conditional payment letter wreaked havoc in a medical malpractice settlement. In Mayo v NYU Langone Med. Ctr, the Supreme Court of New York issued a slip opinion in a case involving the Plaintiff's motion to declare a partially executed settlement agreement in a medical malpractice claim null and void. (2018 N.Y. Misc. LEXIS 885*, 2018 NY Slip Op 30456(U)). By way of background, CMS sent out two different conditional payment letters during settlement negotiations. The initial January 15, 2015 CMS conditional payment letter identified $2,824.50 in payments, while the subsequent July 21, 2015 conditional payment letter showed a lower interim figure in the amount of $1,811.95. Both letters noted the amounts being claimed were interim figures and may be updated. The Plaintiff advised the court on January 5, 2016 that a settlement had been reached for $725,000 "inclusive of all liens..." On January 6, 2016, Plaintiff's counsel advised the defense counsel that the "final Medicare lien is $1,811.95." although defense counsel's settlement document of January 6, 2016 showed the Medicare "final" lien was $2,824.50. The settlement documents were signed by the Plaintiff and counsel on January 22, 2016.




On the same day, CMS sent a final demand letter seeking reimbursement of conditional payments in the amount of $145,764.08. Although the Plaintiff disputed this amount with CMS arguing that they had relied on the July 2015 letter that identified $1,811.95 in conditional payments, CMS upheld its determination seeking reimbursement of $145,764.08. The Qualified

Independent Contractor and Administrative Law Judge from the Office of Medicare Hearings and Appeals similarly found the plaintiff responsible for the $145,764.08 plus interest. The Plaintiff then filed Motion to declare the settlement contract null and void, arguing there was "no meeting of the minds."

The Plaintiff raised several arguments in support of its motion to declare the Settlement Agreement void. He argued in part, that the agreement had been entered into based on an erroneous assumption that the most Medicare would ever claim is $2,824.50. In addition, the language that was intended to release the defendant from "other liens and claims" would not prevent Medicare from enforcing its reimbursement rights against the Defendant's insurer. The lack of a signature by the Defendant was also raised. Defendant objected to the motion arguing that the Plaintiff's failure to investigate Medicare's lien was a unilateral mistake and should not void the agreement.

The Court's analysis mostly focused on whether there was a "meeting of the minds" in the material terms of the transaction, which would determine whether a contract exists. After considering the evidence and the more than $140,000 difference between the two Medicare conditional payment lien amounts, the Court found that the settlement agreement was the "product of a mutual mistake." The settlement agreement was vacated and the action restored to the trial calendar.

This case underscores the need for parties to understand the difference between the letters that are issued by the Commercial Repayment Center (CRC) and the Benefits Coordination and Recovery Center (BCRC). An interim Conditional Payment Letter will always contain an "interim" figure, which may be updated by Medicare at any time, before or after settlement. This letter is issued by the BCRC. A final recovery demand is generally only issued after the case is fully settled.

A Conditional Payment Notice (CPN) on the other hand is issued by the CRC in a worker's compensation claim after a Section 111 Ongoing Responsibility for Medicals (ORM) report. If the figure identified in the CPN is not disputed, an initial determination letter is issued seeking payment of the CPN amount. It is important to note that several different CPN letters may be issued and must be addressed during the life of the workers' compensation claim. A final sweep of Medicare's database is done after the case settles and the Section 111 report of the Total Payment Obligation to Claimant (TPOC) is made. This will result in Medicare providing a final conditional payment demand figure, or initial determination that must be either disputed or paid in a timely manner. We have noticed an increase in the Insurer Conditional Payment Letters being generated since the current CRC contractor, Performant Financial Group, assumed responsibility as the CRC operating contractor.

In order to secure a final recovery demand figure in a case approaching settlement, the parties must follow the specific process that is outlined in and available through the Medicare Secondary Payer Recovery Portal (MSPRP). The final conditional payment process can only be initiated when parties are within 120 calendar days of settlement and there is no ORM in the case. It is imperative that parties appreciate the distinctions in the various letters and figures in order to avoid challenges to the enforceability of settlement agreements.

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## Opioids, CMS and the MSA

The United States is in the midst of an opioid abuse epidemic. According to the Centers for Disease Control (CDC), over 42,000 deaths in 2016 were attributed to opioids, with an average of 115 Americans dying daily from an opioid overdose. The use of opioids for chronic pain conditions over the past 30 years has played a significant role in the development of the opioid abuse epidemic. Since evidence based medicine contradicts the use of opioids for chronic pain, the CDC has issued specific weaning and tapering recommendations to promote the safe discontinuation of opioids. In addition, various levels of the state and federal governments are working to pass legislation and find solutions to halt the epidemic. On January 2, 2018, the Centers for Medicare and Medicaid Services (CMS) issued a Medicare Advantage and Part D payment and policy update seeking to provide more oversight in their Part D plan programs to reduce the over use of opioids.

Given this background, CMS' current opioid projection policy in the area of the Workers' Compensation Medicare Set Aside review process is unconscionable. As most of our readers know, CMS' drug projection model includes monthly projections of opioids for life by extrapolating the last refills of the drugs in the claim over life expectancy. The California Workers' Compensation Institute (CWCI) issued a report entitled "Opioids in Workers' Compensation Medicare Set-Asides" in 2017 based on their review of approximately 8,000 CMS approved determinations. The study found that the cumulative morphine milligram equivalents in the CMS reviewed and approved WCMSA proposals were 45 times higher than that actually used in similar claims from a control group of closed cases without associated WCMSA proposals. Our firm's WCMSA submission data further shows that out of all the MSAs submitted by our firm (including MSAs prepared by other vendors), 70.9% of the MSAs that included any allocation for prescription medication included an opioid. Of those 70.9%, 73.8% also included another nervous system suppressant, such as a benzodiazepine, muscle relaxant or sedative. CMS' projection methodology in the WCMSA review process is clearly fueling the opioid epidemic by providing excessive funds for long term use of opioids. The National Alliance for Medicare Set-Aside Professionals (NAMSAP) is actively involved in seeking a policy change on this issue. Our firm remains committed to seeking change in CMS' projection methodology for opioids in MSAs. The time has come for CMS to stop burying its head in the sand on this important issue.


## About our MSP Compliance Services

The Medicare Secondary Payer Act and supporting Regulations are complex. Our team of thought leading experienced MSP compliance attorneys, all with workers' compensation defense backgrounds, is here to help you navigate the MSP compliance path. Our full range of MSP compliance services includes the following:

1. Medicare Set-Asides
2. CMS Submissions and Review
3. Amended Re-Review to CMS
4. Future Medical Allocations
5. Conditional Payment Negotiation
    a. Parts A & B
    b. Parts C & D
    c. Recovery of Overpayments to CMS
6. Liability Payment Compliance
7. Medicaid Lien Resolution
8. Assistance with the Development and Implementation of Internal MSP Compliance programs

Contact us for information regarding the above services. Additional services may also be available upon request.