Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

FALL 2018

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

UR: What Is It Good For? / Julie Garrison

You may have asked that question lately. In the management of workers' compensation claims, Utilization Review (UR) provides a process whereby proposed treatment is assessed for medical necessity and reasonableness. In several states, the UR process is mandatory and employers or their claims administrators are required to have a UR program. Some states, like California's Independent Medical Review (IMR) process, allow for appeal of a UR determination, but a final UR/IMR determination is binding on the parties with regard to an injured worker's treatment.

UR determinations non-certifying or modifying requested medical items, services and prescription drugs are regularly relied upon to exclude or limit care. In the Workers' Compensation Medicare Set-Asides (WCMSA) context, the Medicare Secondary Payer Act cannot impose greater obligations on an employer than those that stem from the underlying state law that imposes the liability. Therefore, UR-excluded treatment for which an employer would not be liable under state law should be excluded in WCMSAs.

Consistent with this federal law mandate, the Centers for Medicare and Medicaid Services' (CMS) WCMSA Reference Guide provides the following: *"***State-Specific Statutes** *The CMS will recognize or honor any state-legislated, non-compensable medical services and will separately evaluate any special situations regarding WC cases. CMS will recognize WC state-specific statutes addressing the limits of future treatment regarding the length or nature of future treatment...."* (WCMSA Ref. Guide, 9.4.5 Medical Review Guidelines, v. 2.8).

Pursuant to these provisions, CMS' Workers' Compensation Review Contractor (WCRC) - the entity tasked with reviewing and approving WCMSA proposals – has in the past excluded both medical treatment and prescription drugs deemed not medically necessary pursuant to California's IMR process and other state UR provisions.

However, two recent events have changed the status of URs in WCMSAs. First, in July 2017, the WCMSA Reference Guide amended the above provision to require an "*alternative treatment plan"* by a claimant's treating physician for UR-denied care. (WCMSA Ref. Guide, 9.4.5 Medical Review Guidelines, v. 2.6). The Guidelines further state that failure to include an alternative plan will result in the requested treatment being included despite UR denials. Then, earlier this year, Capitol Bridge, LLC became the new WCRC contractor. Since Capitol Bridge took over review of WCMSA proposals, adherence to UR exclusions has been inconsistent at best. Approvals - both including and excluding UR-denied treatment including prescription medications - have issued.

A theory behind the changes is that a UR denial does not mean that a claimant has stopped treating or that the employer is not responsible for other treatment. Thus, more medically appropriate, or perhaps limited, treatment should be sought. Strategies to achieve such results include requesting a specific alternative plan from a treating physician and participation in physician peer review. Nevertheless, the NBKL MSA team continues to take the position in its submissions of WCMSA proposals and as a policy that deference should be given to state-legislated and binding UR/IMR determinations.

A timely and compelling example of the need for a consistent approach is seen in the WCRC's inclusion of prescription opioid drugs in WCMSAs. Despite UR/IMR denials citing inadequate monitoring and/or an absence of documented improvement in function and pain levels, opioids are included in WCMSAs for full life expectancies and often at levels in excess of daily morphine-equivalent dosages. Certainly, such allocations are contrary to public policy and measures aimed at combatting the opioid epidemic and even the federal government's own CDC guidelines. To that end, careful analysis of prescription patterns and allocation of previously used non-opioid drugs and non-medication modalities should be considered by submitters and reviewers.

The status of UR determinations in the WCMSA context dictates a case-by-case approach. Evidence-based medicine should be part of claims management long before submission of a future WCMSA care plan is proposed. Sometimes, it may be prudent to authorize certain medications or procedures rather than submit a request for treatment to UR and ultimately, risk inclusion of more costly or prolonged treatment. Non-submission programs for compromise settlements might be an option. So if you find yourself asking UR - what is it good for? – Our team of MSA attorneys can assist with strategies and recommendations. Assuredly, our answer will not be absolutely nothing!

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

FALL 2018

The Yin and Yang of MSP Compliance in the Disputed Claim / Rasa Fumagalli

The Medicare Secondary Payer Act provides that Medicare is a Secondary Payer when a primary payer has responsibility for payment. Responsibility for payment may be "demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." 42 U.S.C. Section 1395y(b)(2)(B)(i). The underlying state Workers' Compensation Act however, governs the "responsibility for payment". Although the Medicare Secondary Payer Act is a federal law, several courts have confirmed that the "responsibility to make payment with respect to an item or service is generally a matter of state law." *CIGA v Burwell, 227 F. Supp.3d 1101,1113 (C.D.Cal 2017), Caldera v Ins. Co. of the State of Pennsylvania, 716 F.3d 861 (5th Cir.2013*).

Workers' Compensation cases generally fall into three categories: those that are fully accepted; those that are partially disputed and those that are completely denied. The characterization of the claim into one of these three categories will likely drive the Medicare Secondary Payer compliance strategy for the claim. Although a fully funded Medicare Set-Aside may be appropriate for the fully accepted category, it is a less than optimal solution in the partially disputed or completely denied category of claims. So how can one give Medicare's interests consideration when it comes to a disputed settlement? How do you balance the employer's position that the case is not compensable with Medicare's interest in being a Secondary Payer in a settlement?

There are several options available to the parties. If the parties choose to avail themselves of CMS' voluntary review process when the proposed settlement meets CMS' internal workload review threshold, the parties may ask CMS to find that it has no interest in the settlement. This is commonly referred to as a "zero dollar waiver MSA." Historically, CMS would find that Medicare had no interest in a disputed proposed settlement, when the employer/carrier had not paid for any medical and indemnity benefits in the denied claim and the settlement agreement had not been executed prior to CMS' determination in the matter.

Section 4.1.4 "Hearing on the merits of a Case" of the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide (Version 2.8, October 2018) was originally updated in 2017 to address disputed settlements. It states: "Because the CMS prices based upon what is claimed, released, or released in effect, the CMS must have documentation as to why disputed cases settle future medical costs for less than the recommended pricing. As a result, when a state WC judge or other binding party approves a WC settlement after a hearing on the merits, Medicare will generally accept the terms of the settlement, unless the settlement does not adequately address Medicare's interests. This shall include all denied liability cases, whether in part or in full. If Medicare's interests were not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the entire dollar amount of the entire WC settlement…" Given this updated provision, CMS may still grant a zero dollar waiver MSA in a proposed settlement when no medical or indemnity payments have been made and legal support for the denial is provided. If a full and final Court Order has been issued after a hearing on the merits, CMS will generally defer to the Court Order if the claim is submitted for review.

Since CMS review is purely voluntary, parties may "opt out" of it and instead choose to consider Medicare's interest based on the Medicare Secondary Payer (MSP) Act and supporting Regulations. 42 C.F.R. Section 411.46 states that " if a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment." This analysis also applies to a disputed settlement, or lump sum compromise settlement, as long as the settlement does not attempt to cost shift future injury related expenses to Medicare. Cost shifting occurs when parties attempt to maximize other damage elements in the settlement while minimizing the future medical damages to Medicare's detriment.

Parties should always have reasonable support for the amount of the disputed settlement that is being set aside to consider future injury related Medicare covered treatment. Because a Medicare Set-Aside is intended to prevent a future conditional payment by Medicare, it stands to reason that the formula outlined in 42 C.F.R. Section 411.47 for the apportionment of conditional payments in a lump-sum compromise settlement should apply to the apportionment of future medical as well. The formula looks to the ratio between the total potential trial exposure for both the accepted and denied conditions and the value of the MSA for both the accepted and denied conditions. The total potential trial exposure may include the value of the disputed temporary total disability benefit, disputed permanent disability, disputed medical bills, conditional payments, future Medicare covered and non-Medicare covered treatment for the accepted and disputed conditions. The ratio is then applied to the net settlement and determines the portion of the net settlement that should be "set-aside" to consider Medicare's interests in the disputed settlement. By applying this formula, the parties can objectively support the lack of any attempt to cost shift future injury related Medicare covered expenses to Medicare in the settlement.

Disputed settlements must also address Medicare's interest in the reimbursement of conditional payments. Interim conditional payments may be disputed with the Benefits Coordination & Recovery Center prior to settlement or after the final conditional payment figure is provided. Denied claims involving Medicare beneficiaries may also have conditional payment demands from Part C or Part D plans. Lastly, Section 111 reporting of the Total Payment Obligation to Claimant may also be required.

Medicare's interest in a disputed claim is not the same as that in an accepted claim. Contact our team of MSP compliance attorneys for assistance in choosing the best MSP compliance approach for your claim.

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

FALL 2018

Not So Fast MSPA Claims / Geraldine Balow

In response to the question whether the Medicare Secondary Payer statute preempted the state's automobile no fault law, the State of Florida Third District Court of Appeal responded with an emphatic No! *Ocean Harbor Cas In. v. MSPA Claims* (2018 Fla. App. LEXIS 13775) involved the intersection of the law of Florida class actions, Federal Medicare and Florida no-fault insurance. In *Ocean Harbor*, MSPA Claims 1 LLC ("MSPA) asserted it was an assignee of a defunct Medicare advantage organization ("MAO") and filed a class action seeking to represent other MAOs to prosecute a private cause of action for double damages under the Medicare Secondary Payer Act against Ocean Harbor Casualty Insurance Company, a Florida no-fault automobile insurer. MSPA sought reimbursement for the medical bills of Ocean Harbor's no-fault insureds which were paid by MSPA's alleged assignor under Medicare but which allegedly should have been paid by Ocean Harbor. The trial court certified the class and Ocean Harbor appealed. The Court acknowledged the nature of proof required under this private cause of action was at the heart of the class certification.

The complaint alleged Ocean Harbor failed to pay covered medical bills on behalf of certain insureds in violation of federal and state law. This failure caused MSPA's alleged assignor to make conditional payments under Medicare for those bills, thereby triggering a right to bring a private cause of action for double damages under 42 U.S.C. § 1395y(b)(3)(A). MSPA contended class action was appropriate because some or all of the 37 MAOs in Florida might be in a similar situation. Common issues will predominate, it asserted, because its right to payment from Ocean Harbor was "automatic." Proof of liability involved little more than establishing (1) its assignor made a payment under Medicare to an enrollee or his or her provider, (2) the enrollee was also insured by Ocean Harbor and (3) Ocean Harbor failed to pay or reimburse the payment. Any other issues as to liability were "waived" or could be ascertained based upon a "propietary algorithm" developed by MSPA's lead attorney and that class-wide damages could be derived from statistical models.

Ocean Harbor countered MSPA's characterization of its right to reimbursement as automatic and its reliance upon *Humana Med. Plan. Inc. v. W. Heritage Ins Co., 832 F.3d 1229, 1232 (11th Cir. 2016*) was misplaced. In that case, the private insurer's responsibility to pay medical bills was demonstrated by a pre-existing tort settlement in which coverage was admitted and the amount due held in trust. Here, in contrast, MSPA did not intend to demonstrate Ocean Harbor's responsibility to pay the medical bills at issue by pre-existing settlements reached by Ocean Harbor. Instead, MSPA intended to demonstrate Ocean Harbor's responsibility by other means, namely Ocean Harbor's obligations under Florida's no-fault statutes and its enrollees' no-fault policies with Ocean Harbor.

After noting an MAO's access to the private cause of action did not appear to be settled law in light of several forceful and reasoned dissents, the Court concluded it could not accept the argument that MSPA's reimbursement rights were "automatic" and not governed by Florida law relating to the recovery of benefits under a no fault insurance policy. It stated,

> "Contrary to MSPA's arguments, the Secondary Payer Act does not eliminate the terms and conditions of underlying state no fault law. Under the Secondary Payer Act, "Medicare does not pay until the beneficiary has exhausted his or her remedies under no-fault insurance."
>
> As this language indicates, the Secondary Payer Act does not supersede an existing State insurance policy; it merely requires the exhaustion of the benefits under that policy. Except for making Medicare the secondary payer and private insurance the primary payer, the Secondary Payer At "has never created or extended coverage; it has only dictated the order of payment when Medicare beneficiaries already have alternate sources of payment for health care.""

Thus, for each reimbursement it claims, MSPA must demonstrate not only did it make a proper conditional payment under Medicare, but also that Ocean Harbor was required to make the payment in the first place under Florida no-fault law. Therefore, MSPA's proof to establish liability would necessarily degenerate into a series of mini trials under Florida's no-fault law. The Court stated that an MAO must prove with evidence Ocean Harbor's valid insurance contracts actually rendered it responsibility for primary payment of each of the expenses it sought to recover.

Florida's no fault insurance is a system that involves each insurance company paying for the damage incurred by its customer regardless of who is at fault, but coverage is not without limitations. The Court noted Florida had gone to great lengths to craft a statutory structure that protected both the insured and insurer in a process that promotes accurate and expedited payments of medical bills and lost income to covered persons. Insured persons must provide reasonable proof of loss; an insurer may decline or reduce payment if the claim was unrelated, not medically necessary, unreasonable or the amount of the charge exceed statutory limits or schedules; coverage may be denied if the injuries were intentionally self-inflicted, incurred during the commission of a felony or while operating a vehicle without the owner's permission; the law requires a demand letter be sent to the insurer as a condition precedent to litigation; it allowed an insurer to decline to pay all or part of a claim subject to the insurer specifying in writing what and why it is declining to pay; is allows insurers to require written notice of a loss as soon as practicable; and also authorizes the insurer to obtain relevant medical records and even require a mental or physical examination by physicians; and it provides for civil actions for penalties against an insurer who fails to timely pay valid claims and against an insured who commits insurance fraud.

In short, payment under Florida no-fault law proceeds on a factually intensive bill-by-bill and case-by-case basis and an insurer's liability is far from "automatic." The Court concluded MSPA would have to prove Ocean Harbor was required to pay each particular bill it sought to recover and Ocean Harbor would be entitled to raise any appropriate defense under the statute and individual policies, effectively defeating the trial court's class certification because each "mini trial" would not necessarily involve the same questions or similar results:

> What matters to class certification…is not the raising of common 'questions' – even in droves – but, rather the capacity of a class-wide proceeding to generate common answers apt to drive the resolution of the litigation; and

> A class representative establishes predominance if he or she demonstrates a reasonable methodology for generalized proof of class-wide impact. A class representative accomplishes this if he or she, by proving his or her own individual case, necessarily proves the cases of the other class members.

Finally, the Court rejected MSPA's argument that Ocean Harbor had failed to exhaust available administrative remedies. It argued it had made an "organization determination" that Ocean Harbor had the responsibility to make payments and that Ocean Harbor could have challenged these determinations, as the Court was unable to find in the record examples of when and where MSPA made administratively appealable "organization determinations" that Ocean Harbor had the responsibility to make specified payment and it found nothing in the cited regulations that created a federal administrative remedy for a primary plan like Ocean Harbor to challenge such an "organization determination." The regulations cited by MSPA dealt only with claims by an enrollee against an MSA and while Congress created a "right of appeal" for secondary payer determinations relating to no fault insurance when it enacted the SMART Act, the administrative remedy was available only as to decisions made by the Secretary for which the Secretary is seeking to recover conditional payments from an applicable primary plan; in so doing, Congress specifically excluded MAOs.

This is yet another example of a Medicare Advantage Plan's continued attempt to avail itself of the private cause of action provisions of the Medicare Secondary Payer Act and in this particular case an attempt to tap into the primary plan's resources before liability for medical expenses was even established using not real evidence but an algorithm and statistical models. Even if not successful in this case, it shows these MAOs are determined to achieve on par status with Medicare. We encourage all our clients to exercise due diligence in determining if their claimants were at any time during the pendency of their claims covered by Part C or Part D Plans and whether any payments were made under those plans. If so, it is prudent to address and resolve any potential reimbursement claims at the time of the settlement in order to avoid any potential litigation as well as the possibility of double damages as it is inevitable that at some time a MAO's access to the private cause of action will become settled law.

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

FALL 2018

NAMSAP's October 2018 Annual Conference / Rasa Fumagalli

I recently attended the annual NAMSAP (National Alliance of Medicare Set-Aside Professionals) Conference along with Amy Bilton and Bill Delaney. The Conference's agency keynote speaker was Jacqueline Cipa, the Deputy Director, Division of Medicare Secondary Payer Program Operations from CMS. Ms. Cipa discussed the Medicare Secondary Payer recovery process and answered questions from the audience on related topics. This was followed by a lively discussion between Amy Bilton and Rear Admiral Pamela Schweitzer, former Chief Pharmacy Officer of the U. S. Public Health Service on the opioid epidemic, opioid projection methodology in the WCMSA and potential solutions. Ted Doyle of Performant Financial, the Commercial Repayment Center (CRC) contractor, and his colleagues also joined the conference via Skype for a Question and Answer session. He and his team shared information on their recent transition to the CRC position as well as appropriate methods for escalating issues in cases. CMS' presence and participation in the annual Conference suggests a willingness to improve communication and foster greater cooperation between the various stakeholders in the MSP compliance arena.

Other highlights of the Conference included panel discussions on the liability MSA, Special Needs Trusts, Medicaid, conditional payment recovery dispute strategies, Medicare Advantage Plan reimbursements, as well as MSA cost Mitigation strategies. Speakers also engaged the audience in discussions of the new Workers' Compensation Review Contractor, trend spotting and data analysis.

The Nyhan Bambrick Kinzie & Lowry team of MSP compliance attorneys is actively involved in NAMSAP, serving on the Executive Board, the Board of Directors and Advisory Committee. We also participate in the Communications, Data Development, Evidence Based Medicine, and Liability committees. Through our work with NAMSAP, we are at the forefront of efforts to improve the MSP compliance process. Additional information regarding the Conference is available upon request.

Nyhan Bambrick Kinzie & Lowry
Trusted Attorneys. Trusted Advisors.
FALL 2018

Answers by Amy / Amy Bilton

Question: *How much does the Medicare Secondary Payer program really impact the Medicare program? Does it really make it more likely that Medicare will be around when I am old enough to qualify for this entitlement program?*

CMS' most recent Financial Report claimed the Medicare Secondary Payer (MSP) program saved the Medicare Trust Funds approximately $8.5 billion in fiscal year (FY) 2017.[1] While the FY 2017 annual report has already been published, the FY 2017 Medicare and Medicaid Integrity report is not yet available. Hence, many of the figures below should be used as "ballpark" figures rather than actual FY 2017 savings to the Medicare program.

The Medicare Secondary Payer program has three main components: Mandatory insurer (Section 111) reporting; conditional payment recovery; and Medicare Set-Asides. Section 111 insurer reporting ensures Medicare is able to identify situations where another, primary payer exists. Medicare denies payments for medical bills related to those claims, hence translating into pure savings to the Medicare program. Conditional payment recovery involves identification of payments Medicare already made and seeking reimbursement for said payments. Medicare Set-Asides (MSAs) are financial agreements where a portion of a settlement is allocated for future medical expenses. Theoretically, once such settlement funds are allocated, Medicare should deny payment until said funds are exhausted. Formal MSA approval by CMS is offered for workers' compensation claims meeting certain thresholds, and CMS only tracks savings from CMS-approved MSAs.

Conditional Payments: Section 1893(h) of the Social Security Act allows Medicare to enter into contracts with recovery audit contractors (RAC Auditors) to identify and recover conditional payments. Subsection (8) also requires CMS to provide Congress with annual reports on the comparative performance of such contractors and savings to the program. In FY 2017, the Commercial Repayment Center (CRC) identified $560.06 million in mistaken payments and recaptured $160.78 million of those payments.[1] After program expenses and auditor fees, Medicare netted $131.78 million in recovery in FY 2017 from the conditional payment recovery program.[1] This is an increase from the $88.35 million returned in FY 2016.[1] It should be noted that the CRC handled both group health plan and non-group health plan cases with ongoing responsibility for medical payments during that year, so these numbers include all of those collections.

As of February 12, 2018, the CRC contract is currently held by Performant Recovery, Inc. Therefore, the above numbers are reflective of the recoveries of the former CRC contractor. Our experience is that Performant's efforts have been more efficient, so fiscal year 2018's recovery figures should hopefully improve.

---

[1] CMS Financial Report FY 2017, published November 3, 2017, publication number 909418, inventory control number 952017, page 18. Found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2017_CMS_Financial_Report.pdf

[1] Department of Health and Human Services Agency Financial Report, FY 2017, page 220. Found at: https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf

[1] *Id*. at 223.

[1] The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2017, Report to Congress, March, 2018, at 2. Found at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/The-Medicare-Secondary-Payer-Commercial-Repayment-Center-in-Fiscal-Year-2017.pdf

Medicare Set-Asides: As mentioned above, the MSP program saved the Medicare Trust Funds approximately $8.5 billion in FY 2017. While the Social Security Act mandates that CMS report the performance of its conditional payment recovery contractors to Congress, there is no similar requirement for either Medicare Set-Asides or Section 111 reporting. The last data on the cost-avoidant savings stemming from MSAs which I was able to find came from CMS' Annual Financial Report from FY 2012, when CMS approved workers' compensation MSA amounts totaling approximately $1.52 billion.[1]

Section 111 Reporting/Denial of Payment: Just as with Medicare Set-Asides, the last data I was able to find on Medicare savings from Section 111 reporting came from CMS' Annual Financial Report from FY 2012. In that year, CMS reported cost-avoidant savings from Section 111 reporting at over $7 billion per year in FY 2011 and FY 2012, up from $6.5 billion in FY 2007.[1]

In 2017, Medicare benefit payments totaled $702 billion, with net spending of $591 billion.[1] This constitutes 15% of the Federal budget.[1] The $8.5 million in savings offered by the MSP program represent only a small part, less than 1.5%, of what Medicare spends in a year. While those of us in injury-related litigation jobs find the MSP program to be complex, onerous and sometimes poorly executed, it does tack on about 6 days to Medicare's liquidity, but is only a drop in the bucket. With Medicare Part A insolvency predicted for the year 2026, those 6 days per year will not do much to keep Medicare around for most of us.

With that noted, and not to leave you on a down note, Medicare is constantly making changes to improve the liquidity of the Medicare Trust Funds. With greater enrollment in Medicare Advantage Plans, coverage changes, introduction of the quality payment program, actions to reduce identity theft, and improved MSP actions likely on the horizon, Medicare (or its equivalent) will almost certainly be around longer than 2026. We may see changes from the Division of MSP Program Operations at CMS in the near future to improve the solvency of the Funds, including: tracking of MSAs which were not approved by CMS, a liability MSA review process, improved efficiencies in data exchange, and more.

[1] CMS Financial report, FY 2012, page 23. Found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2012_CMS_Financial_Report.pdf
[1] *Id.*
[1] KFF analysis of federal spending from the Congressional Budget Office, found at https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/
[1] *Id*.

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

FALL 2018

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
9. Complex and Legacy Claim resolution

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