FALL 2019

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

Join Paul Pasche and Rasa Fumagalli on Thursday, November 21, 2019 at 12:00 p.m. CST for a complimentary webinar on "Medicare Set-Aside Projections Trends." We will examine the pros and cons of the traditional CMS reviewed MSA, the Evidence Based MSA and the Compromise MSA. We will also discuss other factors that may play a role in selecting your best Medicare Secondary Payer compliance option in a case. Register here.

The Importance of Using Accurate Diagnosis Codes in Section 111 Reports / Joseph Gregorio

In 2015, CMS announced it would be requiring responsible reporting entities (RREs) to begin using ICD-10 diagnosis codes in Section 111 reports for accidents occurring on or after October 1, 2015. There are several benefits to using ICD-10 codes compared to ICD-9 codes, namely improved specificity and hierarchy of diagnoses. Although ICD-10 codes are required for accidents on or after October 1, 2015, RRE's may also use ICD-10 codes for reporting accidents before then, as long as all codes are reported as ICD-10.

Diagnosis codes in Section 111 reporting primarily serves two purposes:

1. It allows for the accurate coordination of benefits for claims submitted to Medicare for a claimant's treatment; and

2. It facilitates accurate identification of conditional payments related to a work injury.

These two purposes illustrate the importance of accurately reporting ICD codes.

In the first situation, when CMS receives claims for prospective treatment, it compares the diagnosis codes submitted in the request to those contained in the Section 111 report. If the codes for the requested treatment are similar to those in the Section 111 report, CMS may deny the prospective treatment. Thus, inaccurate reporting could result in unwarranted denial of treatment that has no relation to the work injuries, which could create unnecessary friction between the claims handler and the Claimant.

Reporting accurate and specific ICD codes also promotes effective and efficient conditional payment investigations. CMS does not just search for the specific ICD code; rather, it will include many similar codes that cover the same body parts or similar conditions. Therefore, reporting

codes for specific body parts can reduce the chance of CMS including unrelated claims in a conditional payment notice or demand.

When selecting which codes to report, RREs should avoid blindly reporting codes listed on EOBs or medical records, as providers may include conditions beyond those involved in the work accident. An example commonly seen is the inclusion of codes for unrelated hypertension or diabetes which appeared on the EOBs from the bills from the initial treatment. RREs should also periodically update their Section 111 reports to account for any new, updated or recently denied body parts or conditions.

Section 111 reports allow RREs to report up to 19 different diagnosis codes and one external cause of injury code. For catastrophic injuries or accidents involving multiple body parts, the RRE should include at least one diagnosis code per body part.

Specificity is key in reporting ICD codes. For example, if the accepted condition involves a left knee meniscal tear, RRE's should report a code like "M23307 – Other meniscus derangements, unspecified meniscus, left knee," rather than general or non-specific codes like "S8982XS – Other specified injuries of left lower leg, sequela." Reporting the latter could yield denial of treatment for conditions such as unrelated DVT or ankle conditions, and can lead to conditional payment recovery for those conditions, as well.

Of course, the level of specificity must be determined on a case-by-case basis and will vary depending on the circumstances of the claim and the injuries involved. However, with over 70,000 ICD-10 codes accepted by Section 111 reporting, RRE's should be able to find the right code for almost any work-related accident or injury. ICD-10 allows RRE's to be quite granular in identifying the nature, location, and status of the injury. For instance, "S0511X – Contusion of eyeball and orbital tissues, right eye, initial encounter," "S91152A – Open bite of left great toe without damage to nail, initial encounter," and "S30867A – Insect bite (nonvenomous) of anus, initial encounter," are all valid codes under Section 111.

There are also very specific "external cause of injury" codes that can cover nearly any situation. There is "W2202XD – Walked into lamppost, subsequent encounter," "V0490XA – Hit by a Mack Truck," "V00151A – Fall from heelies, initial encounter," and "W6101XA – Bitten by parrot, initial encounter". In the event "bitten by parrot" does not sufficiently capture the situation, there is also "W6112XD – Struck by macaw, subsequent encounter."

Finally, RRE's should confirm that the diagnosis codes are entered in the proper format, and not an excluded code. CMS publishes guidance materials detailing the requirements for reporting ICD codes under Section 111, as well as a list of valid codes.

Overall, accurate reporting of diagnosis codes can help reduce the likelihood of two inconvenient situations that may arise when handling a workers' compensation claim involving a Medicare beneficiary. It can reduce the improper denial of treatment that is unrelated to the work injury, which will avoid calls from disgruntled claimants or their attorneys. It will also reduce the likelihood that non-industrial treatment is alleged as a conditional payment, saving claims handlers time and other resources in addressing conditional payments.

Dealing with Drugs in the Medicare Set-Aside / Rasa Fumagalli

The prescription component of a Medicare Set-Aside allocation may at times present an obstacle to the settlement of the claim. There are however certain steps which may be taken during the life of a claim to help ensure the lowest possible prescription allocation. This article will provide background on the drug pricing structure in the MSA and outlines best practices to follow for ensuring a favorable drug allocation.

Background

Average Wholesale Pricing (AWP) and Medicare Coverage of Drugs

The Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, Version 2.9 outlines the prescription drug review process used by CMS' Workers' Compensation Review Contractor (WCRC). Section 9.4.6.1 notes that all drug products are priced using average wholesale pricing (AWP), with generic drugs being priced at the lowest non-repackaged generic AWP. The WCRC prices for a generic drug unless a brand name drug is being filled or the claimant/claimant's attorney insists on a brand-name drug in writing. When a condition requires certain drugs, but the submitted proposal does not include drugs, the WCRC will include pricing for brand name medications.

By way of background, AWP is a measure for the pricing and reimbursement rates for prescription drugs that has been used by both the government and private payers for decades. It was originally created in 1969 as a reference price for examining California Medicaid claims. Most prescription drugs sold in the US have an AWP that is published in major drug compendium, such as Red Book. The AWP may be reported to the publisher directly by the manufacturer of the drug or it may be calculated by the publisher, based upon the manufacturer's mark-up for the drug. The mark-up is added to the Wholesale Acquisition Cost (WAC), or the list price for a drug sold by a manufacturer to a wholesaler. The list price excludes any rebates or discounts available to the wholesaler. The publisher then sells the published AWP list to the government, private insurers or other buyers of the prescription drugs that use it to establish reimbursement rates for the drugs. The price a consumer pays for a prescription from the pharmacy may vary greatly

from the retail price the pharmacy paid to acquire the drug given the complicated payment models used to determine the price of a drug.

The WCMSA Reference Guide further explains that the WCMSA includes drugs being used for a condition related to the workers' compensation injury which are covered by Medicare Parts D or B and which are being used for a medically accepted indication. The WCRC reviewers look to Medicare Part D and Part B guidance documents, current WCRC operating rules, the Part D formulary reference guide and recognized drug compendia. A drug is generally covered by Medicare Part D when it is being used for a "medically accepted indication." A medically accepted indication is any use for which the drug is approved by the FDA, or a use which is supported by one or more citations included or approved in the recognized compendia. The WCRC is currently using Micromedex's Drug Dex database and the American Hospital Formulary Service Drug Information data base as their recognized compendia.

Shaping a Favorable Drug Allocation

Establish a generic drug usage pattern

Generic drugs typically cost significantly less than brand name drugs. A comparison of the Red Book AWP for Pregabalin, the recent generic for Lyrica, and the brand name Lyrica provides a stark example of this. At this time, the lowest AWP non-repackaged per unit cost of Pregabalin 75 mg capsule is $0.92, while the brand name Lyrica 75 mg capsule is $9.36. This generic is therefore approximately 90% less than the cost of the brand name. Given the huge savings in the future prescription component of the MSA, it behooves the adjuster/attorney to be mindful of the availability of generic substitutes in a case.

Generic drug usage patterns may be established in several ways. The simplest of course would be to have the treating physician agree to change the brand name drug to the generic. Once this occurs, it is important to establish controls with the pharmacy to ensure that only the generic drug is dispensed. It may also be helpful to work with opposing counsel and the claimant to effectuate this change in connection with settlement discussions.

Consider and identify less expensive combinations to achieve the same drug dosage

Certain doses of drugs are associated with a much higher AWP per unit than slightly lower doses of the same drug. Since the slight change in the dose may not impact the symptom relief provided by the drug, treating physicians have been agreeable to make the change upon request.

An example of this may be seen in the AWP per unit for Morphine Sulfate CER 80mg and Morphine Sulfate CER 60 mg. According to Red Book, Morphine Sulfate CER 80mg has a per unit cost of $15.13, while the Morphine Sulfate CER 60 mg has a per unit cost of $11.36 per unit.

Changing the form of the drug may also result in cost savings. By reviewing data from Red Book's AWP pricing, a case manager may be able to help identify drug doses that both benefit the claimant and mitigate against excessive drug projections in the MSA.

Determine if the drug is FDA approved or off label compendia approved for the injury related condition

Not all drugs being paid as part of the workers' compensation claim are covered by Medicare. It is important to obtain the medical reports that are generated in connection with the prescription to correlate the reason for the drug and the diagnosis. If the workers' compensation drug is not covered by Medicare, it may be funded outside of the MSA.

Investigate pre-injury usage of the drugs

Pre-injury medical and pharmacy records may at times provide information which may be used to support the exclusion of certain drugs in the MSA. For example, a review of the pharmacy and/or medical records may show a relevant pattern of current drug usage immediately before the injury. Don't neglect to apply the analysis used to defend the workers' compensation claim to the development of the MSA projections. The additional investigation and customization of arguments to limit the projections will oftentimes yield a far lower allocation than one which is driven by a "cookie-cutter," formulaic approach.

Explore alternative pain management approaches

Drugs are not the only way to manage pain. Alternative pain management approaches may include cognitive behavioral therapy, acupuncture, yoga and in some jurisdictions CBD oil and medicinal marijuana. Consideration of and implementation of these alternative therapies may result in significant cost savings down the road and yield a better outcome for the claimant.

Implement pharmacy controls to prevent inadvertent payment of drug for denied condition.

The defense strategy of a claim should also take Medicare Secondary Payer compliance strategy into account. If a condition is denied, it is important to avoid making payment for medication related to that condition. CMS reviewers look to payment histories to determine if a condition has truly been denied by the carrier. When certain conditions are accepted and others are denied, it is imperative that pharmacy controls are set up to prevent an inadvertent payment of a drug that is being used for a denied condition.

Conclusion

Excessive drug projections in an MSA may be prevented through strategic case management which considers potential Medicare Secondary Payer compliance issues during the life of the claim. By establishing a best practices format to follow, claims handlers/attorneys may help to ensure that the future drug projections are as low as possible under the circumstances.

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NAMSAP 2019: I'm All In / Julie Garrison

As a first-time NAMSAP (National Alliance of Medicare Set-Aside Professionals) annual conference attendee, I was able to meet, learn from, and network with many leaders and influencers in the Medicare Set-Asides (MSA) and Medicare Secondary Payer (MSP) compliance industry. NAMSAP is about collegiality among adversaries and competitors while its conference provided opportunities for policy discussion and problem solving. Our own NBKL MSA leader, Amy Bilton, is the current NAMSAP President and opened the September 18th & 19th Baltimore conference titled "All In."

In my opinion, there are two main takeaways from this year's conference. First, CMS is actively interested in feedback from and communication with MSP professionals and practitioners. Three Centers for Medicare and Medicaid Services' (CMS) representatives attended both days of the conference and managers with the recovery contractors – the Commercial Repayment Center and Benefits Coordination and Recovery Center – participated on individual session panels. John Albert, Senior Technical Advisor, Division of Medicare Secondary Payer Operations in the Office of Financial Management for CMS gave the keynote address, stressing CMS is interested in developing usable data. He commented that Section 111 mandatory reporting updates and clarifications are as important as the initial reporting. He announced upcoming changes to the Workers' Compensation MSA and MSP recovery portals and stated that electronic submission of annual attestations for MSA administration is coming. This ability will assist proper payment, document exhaustion of MSAs, and provide improved data for better allocations. Along with Steve Forry, the Division Director of Medicare Secondary Payer Program Operations, and John Jenkins, a Health Insurance Specialist in charge of the MSA review contract, all three engaged in Q&A sessions on many topics, acknowledging issues and concerns and offering solutions and assistance.

The second takeaway was that MSP compliance parties and players share the same objective of considering Medicare's interests to protect the Medicare Trust Fund and should work together. Medicare Set-Asides and compliance and recovery measures are tools to meet the burden imposed by federal law and collaboration, and cooperation from all sides and interests can improve the system. That's what NAMSAP is all about. One area of ongoing concern is the resolution of conditional payment claims – those medical expenses paid by Medicare prior to the settlement of a workers' compensation or liability case. Conference participants cited duplicate claims and inadequate, or even non-existent, review of disputed conditional payment claims. Many raised the difficulty in resolving conditional payment claims after a settlement when CMS looks to the beneficiary for recovery, though an employer has accepted responsibility for related amounts. Conversely, CMS will often seek recovery from an employer despite a case being completely denied and disputed with no accepted responsibility for payment of medical

expenses. In the liability arena, additional conditional payment cases are opening despite notification to CMS of exhaustion of benefits. Attendees were encouraged to forward examples of individual problematic cases to CMS for direct assistance.

Other topics and highlights of the conference included the following:

- Opioid use in MSAs in on the decline. Since 2017, professional MSA administrators have noticed a general decrease in usage. CMS-approved MSA patterns also show downward changes in opioid allocations.

- Professional administrators report actual post-settlement care often differs from projected Set-Aside allocations. Medical advancements and newly developed drugs contribute to this status. While there are low MSA exhaustion rates, non-fee schedule billing and drug costs still lead to dissipation of MSAs and CMS does track full exhaustion of MSAs.

- Formal guidance for liability MSAs is still pending with compliance placed primarily on claimants/beneficiaries. Until then, a good faith approach based on all facts is the best practice.

- Non-submission, legal zero MSA criteria may become part of the WCMSA Reference Guide. Non-submission Evidence-Based MSAs are also gaining interest.

- Hearings on the Merits can have an impact in liability and high-exposure workers' compensation claims. Again, an adversarial but cooperative approach in presenting a complete record before a court/trier of fact is key to defining Medicare's proper interests.

- Primary payers are not using CMS' online payment system. Payer options like EFT or ACH transactions are under consideration.

- Medicare for All remains on the table. Senator Sanders' bill contains a reimbursement provision. Some panelists predict an expansion of Medicare to those 55 and older and including home health care under Medicare coverage.

I was proud to attend the NAMSAP conference with firm colleagues who have taken on officer and board positions and serve on several committees. Working closely with CMS and legislators on improvements; the collection, analysis and sharing of data and trends; developing procedures for liability MSAs; and addressing the opioid crisis are important and exciting objectives. I have

become better informed through participation in NAMSAP and am motivated to become more involved.

The Ticking Time Bomb in Your File Cabinet: CMS Referring Old Claims to Treasury / Paul Pasche

In what appears to be a trend lately, we are seeing more instances of cases where The Centers for Medicare and Medicaid Services (CMS) is referring older claims (often thought by the adjuster to have been closed long ago) to the United States Treasury for collection. Here are some tips for how to avoid having this happen, and for how to defend yourself once it does happen.

The Medicare Secondary Payer (MSP) statute (42 USC §1395y, et seq.) states that Medicare is secondary to other forms of insurance, including "Non-Group Health Plans" (NGHP), which include workers' compensation, liability, and no-fault insurance plans or self-insured plans. When Medicare conditionally pays medical bills it believes are the responsibility of an NGHP, the statute requires CMS to seek reimbursement of its payments. CMS will open a claim file and send notice to the NGHP. If the NGHP does not respond within a certain time, CMS will refer the case to the Treasury to collect the amount claimed. The Treasury has the power to "offset" the debt owed, meaning it can grab all or part of any pending payment from the US Government to the insurer or self-insured employer in order to repay the amount claimed by CMS. CMS most often learns of the existence of a primary payer NGHP through the mandatory insurer reporting program under Section 111 of the MMSEA[1], but the primary payer may also be identified by the beneficiary at the time of settlement. But if there is no final settlement, and the insurer closes its claim and releases its reserves, the "closed" file may eventually detonate when the Treasury gets involved.

How does this happen? A typical scenario involves a medical-only case, or a case where the claimant abandons his case after medical recovery is achieved. No final settlement is offered, and after a period of time the claim file is closed by the adjuster. Sometime later, maybe years later, CMS gets wind of the case and searches its records for conditional payments it made that are believed to be related to the injury involved in the claim. A reimbursement demand notice is sent to the insurer, but the insurer does not respond, perhaps because no active claims handler was assigned to the closed file, perhaps because the insurer moved after the file was closed, perhaps because the insurer misapprehended its duty to respond, or perhaps just due to the insurer's bad luck. A few months later, the insurer notices a payment it is expecting from a governmental entity has been cut short due to a deduction taken by the Treasury, but this deduction initially appears

[1] Section 111 of Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Public Law 110-173, is codified at 42 USC §1395y(b)7, et seq.

to have no immediate connection to Medicare or to an old claim. Eventually the deduction is traced back to the original claim and to the CMS reimbursement demand. The explosion has occurred, and the money is gone! What could have been done? What can be done?

Prevention of this typical scenario is as straightforward as establishing an internal "bomb squad" within the insurer's organization. This squad of designated staff members can provide a double-check on Section 111 compliance, review of Open Debt reports, and performing immediate triage of any communications received from CMS on closed files. Each of these tasks protects the insurer or self-insured against the occurrence of ticking Treasury bombs.

We all know no case file is absolutely immune from a reimbursement claim by Medicare, but that does not mean that Medicare will necessarily prevail in the end. The first step of prevention is to maintain an accurate and timely Section 111 system. Most internal systems provide for reporting to CMS when a claim is accepted and the insurer has an "ongoing responsibility for medical" (ORM) or when the case completely settles. The complete settlement is reported to CMS in a Section 111 Total Payment Obligation to Claimant (TPOC) report. When ORM is terminated or a TPOC is established through settlement, the insurer can tick a box in its next Section 111 report to CMS, and this will normally prevent CMS from seeking any conditional payments made by it for services rendered after the date of settlement. At that point, the insurer can resolve any pre-settlement conditional payments prior to closing its file. Even when a case does not resolve with a final settlement document, the insurer can terminate ORM in its Section 111 report when something occurs that legally severs its liability. The most common example occurs when the statute of limitations expires on the underlying claim. Another frequent basis is the exhaustion of the insurance policy limits in a no-fault claim. Before "closing" a claim, the insurer's bomb squad should establish a protocol to make sure the ORM issue was addressed and properly reported under Section 111. The squad should also follow-up on any pre-closure conditional payments issues to make sure they are resolved before the claim file is officially closed. All evidence that supports the proper closure of the claim and any previous resolutions of any Medicare issues should be maintained in case of future involvement with CMS. This documentation should include evidence and analysis of relevant defenses like the statute of limitations, policy limits expirations, or any defense—including causation, employment relationship or the like—which led to the closure of the claim. The squad should also make sure CMS has updated contact information to reach the insurer in case any future communications are needed. Lastly, the squad should have a protocol for monitoring when claimants reach Medicare age (usually 65), and to double-check that the Medicare issues were properly resolved prior to claim closure.

The latest tool for an insurer's bomb squad is the new access that CMS allowed as of October 7, 2019, to the insurer's "Open Debt Report." This report lists all open conditional payments claims

CMS has asserted against that insurer or self-insured. The squad should check these reports on a regular basis to see if any closed files are listed among conditional payments claims. If so, appropriate remedial action can be taken before one of these potential bombs goes off.

Lastly, the squad should establish a procedure for receiving and responding to any communications from CMS on closed files. This could be as simple as designating a person (and at least one back-up) to immediately investigate any notices involving closed files. Even if the file was properly closed and the evidence is clear that CMS is not entitled to reimbursement, a timely response provides the only method to forestall further action by CMS or the Treasury. This is the time when the prior documentation may be critical to establish that CMS has no right to reimbursement. Defusing these bombs is a matter of timing. Each missed CMS deadline ticks the clock closer to a Treasury problem.

We at Nyhan Bambrick Kinzie & Lowry are prepared to assist with developing your company's bomb squad, as well as to assist with any conditional payments issues, and all other aspects of MSP compliance. Please contact a member of our MSP team with any questions you may have.

Answers by Amy / Amy Bilton

I received several calls in the last couple of months, mainly from Claimants' attorneys, asking if I know anything about "evidence-based MSAs." In my role as an officer for the National Alliance of Medicare Set-Aside Professionals (NAMSAP), and in working with clients all over the country, I had seen all varieties of MSA programs. The new, up and coming trend is toward Evidence-Based MSAs ("EBMSAs").

An EBMSA is a future medical allocation which uses evidence-based medicine guidelines in predicting post-settlement medical care for a settling Claimant or Plaintiff. Evidence-based studies serve as a roadmap in outlining the most efficacious treatment for claimant's condition. In general, EBMSAs are about 30% less expensive than the traditional, CMS-approved WCMSAs.

As we know, the WCMSA approval process has an associated Reference Guide which explains how imaging, medications and other services will be projected over the lifetime of a Claimant. Even beyond that, CMS generally projects services at the same dosage, frequency or schedule as has been utilized over the last two years.

The concern about CMS-approved WCMSAs is that, once the case settles, the medical service utilization will go down and the WCMSA will be overfunded. EBMSAs look to avoid that overfunding and be more in line with reality.

Employers have been using EBMSAs for quite some time. These are not submitted to CMS, but most EBMSA programs annuitize the future medical funds and provide professional administration, which hopefully safeguard the funds from inappropriate expenditures and realize discounts to ensure the funds are sufficient to cover Petitioner's lifetime medical needs.

Some ask: Why would anyone non-submit an MSA at all? Isn't CMS approval the only way to get a "guarantee" that CMS will pick up post-settlement benefits once the MSA is properly exhausted? CMS' stated policy is that once they approve the WCMSA, and it is funded, CMS will pick up benefits for the Medicare beneficiary after demonstration of proper exhaustion of the funds. However, both parties in a settlement are able to re-review a WCMSA at any time prior to uploading finalized, approved settlement contracts, which means the Claimant can re-review the WCMSA just as easily as the employer/insurer. This can lead to a second approval letter being generated, which can be higher than the original negotiated/submitted amount. This can wreak havoc around settlement time. Employers have criticized this process, taking the position that a WCMSA provides no protection if the Claimant can ask for a re-review to have the number changed at any point, even post-settlement.

Downsides to EBMSAs are that CMS generally does not acknowledge them as a cap on post-settlement medical, or at least that is their stated position. CMS claims it will offset the entire amount of a workers' compensation settlement from a beneficiary's medical benefits where the MSA has not been submitted to CMS for approval. Even if settlement documents are forwarded to CMS, they currently have no process to track non-submitted EBMSAs. This can lead to a potential denial of benefits for a beneficiary with a non-submitted EBMSA. With that noted, the beneficiary has the full appeals process available to appeal the denial of services under the usual Medicare appeals process, and anecdotally we have heard CMS does reinstate benefits once a beneficiary demonstrates their EBMSA has been properly exhausted. With that noted, this is by no means published policy, nor is this a guarantee that CMS will continue to act in such a way.

In all, there are pros and cons to each option. Sometimes only an EBMSA can get a case settled, whereas other times Claimants' attorneys require submission to settle a case. These are always negotiable terms between the parties since CMS approval is optional.

Our duties under the Medicare Secondary Payer Act are to avoid shifting medical costs that should be borne by insurance or self-insurance onto the Medicare program. There is no legal or procedural requirement that CMS approve a workers' compensation MSA, and there is no way for CMS to currently approve a liability MSA. Companies should develop best practices for their MSA submission, or non-submission, programs, and stick to that process in all of their cases to avoid the appearance of just picking and choosing where an EBMSA will save money.

If you are interested in more information about non-submit programs and how to implement them, or need any assistance with those programs or CMS submissions, the attorneys at Nyhan, Bambrick, Kinzie & Lowry are excited to assist.

Our MSP Compliance Services

Our dedicated team diligently and efficiently streamlines and navigates the Medicare Secondary Payer (MSP) landscape for our clients. The attorneys, nurses, and paraprofessionals at NBKL guide you through the entire process from initial investigation through post-settlement. Our team's vast experience in workers' compensation defense, personal injury claims and MSP compliance makes us industry leaders in partnering with clients to achieve optimal claim resolutions while meeting all MSP requirements.

Services We Provide:

- Medicare Set-Asides ("MSA") (traditional and non-submit) including:
  - Legal Zero MSAs
  - Evidence Based Medicine MSAs
  - Future Medical Allocations/Life Care Plans
  - Advice and Recommendations to Mitigate MSA exposure
  - Analysis and Mitigation of competitor's MSA proposals
- Medicare Parts A & B Conditional Payment Analysis, Negotiation and Resolution
- Medicare Advantage Plan (Part C) and Prescription Drug Plan (Part D) Lien Investigation, Negotiation and Resolution
- Medicaid Lien Negotiation and Resolution
- Settlement Contract drafting to protect against past and future Medicare exposure
- Settlement Consulting on all aspects of MSP Compliance in Workers' Compensation and Liability cases
- Design and Implementation of MSP Compliance Programs

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