WINTER 2020

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

Join Amy Bilton, Bill Delaney and Rasa Fumagalli on February 12, 2020 at 1:00 p.m. CST for a complimentary webinar on the "Highlights of the Revised WCMSA Reference Guide, Version 3.0." We will address the substantive changes in the Guide that may impact your MSP compliance decision making. These include the mandatory use of a new Consent to Release note which indicates that the Claimant approves of the submission packet beginning on April 1, 2020 as well as the expanded Amended Review period for older claims that didn't settle due to excessive CMS determinations. Register here.

Ask Amy / Amy Bilton

This Ask Amy topic comes from one of my workers' compensation cases. An MSA was priced by a vendor about 6-½ months ago. We have the updated medical records, which demonstrate the treatment regimen is the same as it has been for the last year: the Petitioner remains on the same medications and the treatment is consistently quarterly. We were trying to get the MSA submitted before the end of the year and had all of the necessary documents. We provided them to the vendor, only to receive a response that "the MSA is more than six months old, and we therefore will need to reprice it." We were offered the option of a rush repricing to submit before the end of the year, but of course, rush pricing is expensive. The question from the adjuster was: what is the statutory or legal basis for requiring an MSA to be repriced every six months?

The easy answer is this: there is none. A Medicare Set-Aside itself has no statutory or legal basis *per se*. MSAs were born of an internal CMS policy that was initially developed by CMS policy memos starting in 2001, and later incorporated into a Reference Guide for Workers' Compensation Medicare Set-Asides ("WCMSAs"). The current Reference Guide outlines items that are required for a CMS WCMSA submission, as well as a suggested format. There is no requirement or suggestion that MSAs be updated after six months.

MSAs should only need to be updated when they are no longer accurate. Circumstances meriting update include: changes in treatment utilization; changes in medication; changes to a state's fee schedule pricing; or change in life expectancy. For example, every January, Illinois sees a change to its Workers' Compensation Medical Fee Schedule, which should trigger a change to the WCMSA proposal. This would be true even if the WCMSA is less than six months old. For example, if it was prepared in late November, and then submitted in mid-February, the MSA proposal should be updated to reflect the new fee schedule pricing. Similarly, in the absence of

a rated age for life expectancy, a WCMSA proposal should be updated after a claimant's birthday, even if that birthday happened just a couple of months after the WCMSA was initially prepared.

My frustration in my workers' compensation defense case was with the vendor's apparent automatic policy of WCMSA repricing after six months, with charge and despite no change in any of the above circumstances, which is not based on any CMS policy and unnecessarily delayed our settlement. Ethically, I have concerns about this type of practice. Realistically, every case being submitted to CMS for approval should be re-reviewed and analyzed for any changes at the time of the submission to ensure that the product going to CMS is accurate. The False Claims Act requires submitters to be honest and truthful in their submissions, and to submit documentation that comports with the facts. This should be part of the submission process itself, every time, and should not require another line item charge. If, on the other hand, the insurance carrier has a contract with the vendor wherein updates are completed without charge within the first six months, exceptions should be made when the update will simply result in a delay in the resolution of the claim and not impact the submission figure.

Major changes to medical treatment or change in an individual's co-morbidities may significantly impact a WCMSA submission. However, it is this author's opinion that blanket repricing requirements (and fees) are not supported by the CMS guidelines, and are not in our clients' best interests.

As lawyers, we at NBKL have an ethical obligation to our clients to provide accurate, complete and well-reasoned legal advice and recommendations that are in the clients' best interest. Often, what is in our clients' best interests may not be in the firm's financial interest, but it is a choice we will make every time – to do the right thing by our clients.

If your contract with your MSA vendor has blanket and legally baseless and overbroad guidelines for when they "must" reprice your MSA, perhaps it is the time to look at renegotiating that contract. If nothing has changed, should you be charged and, if not, why does the insurance industry stand for it?

Unintended Medicare Consequences from Workers' Compensation Claim Handling / William Delaney

Medicare exposure can be significantly impacted by claim decisions made early in the handling of a workers' compensation case. Medicare is a secondary payer to an applicable workers' compensation insurance plan meaning that Medicare should not be paying for past and future treatment that is compensable under workers' compensation. If Medicare does pay for

treatment that should have been paid by a workers' compensation insurance plan, Medicare has a right to recover such conditional payments from the workers' compensation plan. Further, the workers' compensation plan is required to protect Medicare's future interests by not shifting the burden of related future medical payments to the Medicare system. Medical payments, reporting of diagnosis codes to the Centers for Medicare and Medicaid Services ("CMS") and denial letters, if handled properly, can substantially mitigate the indemnity and expenses associated with protecting Medicare interests.

Medical Payments: The employer reports a workers' compensation claim that appears to be compensable as the employer does not question the accident. A claim file is opened. An emergency room bill from ABC Hospital for treatment on the accident date is submitted two weeks after the accident date. The bill is paid by a medical only claim handler based on the notes in the file stating the employer reported the claim was compensable. After a month-long investigation, it is determined the claim is actually not compensable. A denial letter is issued. No TTD has been paid. No other medical or pharmacy bills have been paid. The worker retains an attorney who files a workers' compensation claim. The worker has medical complications related to the alleged injury and as a result, is no longer able to work. The worker applies for and is awarded Social Security Disability (SSD) benefits. Two years after the SSD benefits start, the worker qualifies for Medicare. The workers' compensation case is still pending. The future medical is likely hundreds of thousands of dollars. The carrier is concerned about the pure exposure and wants to settle the case. The worker's attorney recognizes that liability is thin for the worker. The parties agree to settle the case for $50,000.00, which is 5% of the pure exposure for past and future benefits. The carrier refers the case to our office requesting we obtain a zero-dollar MSA approval from CMS given the case was denied.

We request and analyze the claim payment history and pharmacy benefit manager history. We find the payment to ABC Hospital for treatment on the date of the accident. Because of this one medical payment, the likelihood of CMS approving a zero-dollar MSA is significantly less than had there been no payment by the carrier of any medical bills or other benefits. Why? Because CMS takes the position that the payment of just one medical bill related to the work accident is evidence the carrier accepted the claim. While there are sometimes arguments to overcome CMS's default position, the need to make these arguments could have been avoided in this hypothetical if the emergency room bill had not been paid.

Because CMS will typically approve a zero-dollar MSA ("Legal Zero") proposal in a denied case when no benefits have been paid, it is critically important that no payments, inadvertent or otherwise, are made on a claim until there is reasonable certainty the claim is compensable.

The same care regarding payment for medical treatment needs to be taken when the claim involves an accepted body part and a denied body part. It is very important to take all necessary steps to avoid payment issuing for the denied condition. For example, if there is a bill for a doctor visit that includes treatment for the accepted body part and the denied body part, consideration can be given to issuing a letter to the medical provider stating the office visit bill is only being paid because there was treatment for the accepted condition. Provided there have been no payments made for the denied body part, CMS will typically allocate nothing for the denied body part in their MSA determination.

ICD Codes Reported to CMS: The ICD (International Classification of Diseases) Codes reported to CMS are used to determine what Medicare payments may be related to the work accident. CMS searches its database for Medicare payments with the same or similar reported ICD codes. As with the first medical payment on a claim, caution should be taken with the first report to CMS of the ICD Code(s) for the work injury. It is important to only report code(s) related to accepted body part(s)/condition(s). Additional codes can be added when it becomes clear that another body part/condition is related to the work injury. For example, what was originally thought to be a neck injury, can become a neck and shoulder injury. Report the neck injury when it is clear the neck is related, and later report the shoulder injury when it is clear the shoulder is related.

If there is any doubt as to the nature of the injury, the first reported code for an accepted body part/condition should be a general ICD Code. For a neck injury, consider reporting ICD 10 Code S13.4: Sprain of ligaments of cervical spine. If it becomes clear the work accident caused a herniated disc (*e.g.* IME doctor causally connects herniated disc), consideration can be given to adding a more detailed code such as M50.222: Other cervical disc displacement, at C5-6 level. While reported ICD codes can be removed, best practice is to try to avoid reporting unrelated ICD codes.

It is important not to report all ICD codes listed on a submitted medical bill as some of the codes may be for diseases or conditions that pre-existed or have no relationship to the work accident. Hospital bills typically include codes for the patient's chronic diseases and conditions, such as diabetes, hypertension or depression. If codes for non-work-injury diseases and conditions are reported to CMS, Medicare could seek reimbursement for payments that are clearly unrelated to the work accident. While it is typically not difficult to successfully dispute or appeal clearly unrelated conditional payments, the need to do so is avoided if only related diagnosis codes are reported to CMS.

Claim Denial Letters: Many workers' compensation claims are denied following the completion of an investigation. In most cases, a claim denial letter is issued by the claim handler to the claimant informing the claimant that after investigation, the claim has been denied. Often times, the denial letter will state the reason or reasons for the claim denial. For Medicare purposes, it is important to promptly issue a claim denial letter upon a determination that the claim in not compensable or a particular body part is denied. Later in the claim if Medicare issues arise, it is very helpful to have a denial letter issued shortly after the accident or the determination that a condition is not related to the accident when trying to persuade Medicare to waive reimbursement of conditional payments or approve a partial or complete Medicare Set Aside waiver.

Conclusion: Improper handling of medical payments, reporting of related diagnosis codes to CMS and claim denial letters could result in unnecessary claim expenses related to Medicare compliance and increased medical indemnity to Medicare. Proper handling of these claim tasks will help ensure that Medicare issues are handled efficiently, and Medicare's interests are not overprotected.

Avoiding Medicare Secondary Payer Compliance Settlement Term Traps / Rasa Fumagalli

Medicare is a secondary payer when a primary payer is available and has a demonstrated responsibility to make payment. Under the Medicare Secondary Payer statute and regulations, a "primary plan's responsibility for payments may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver of release (whether or not there is 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.S. Section 1395 y(b)2 (B) (i). Given Medicare's potential interest in a settlement, a proactive approach to Medicare Secondary Payer compliance issues allows parties to take appropriate steps to mitigate Medicare's potential interest in the settlement. Similarly, reviewing and addressing interim conditional payments during the life of the claim may help to prevent any post settlement surprises.

Far too often Medicare's potential interest in the claim comes up as an afterthought once a settlement agreement has been reached. The dreaded call from Claimant's counsel usually goes like this: "Oh by the way, I just found out my client applied for Social Security Disability benefits and may be on Medicare," and is one most adjusters/defense attorneys have experienced. Parties who are caught off guard by Medicare's interest in the settlement or are unfamiliar with the nature of Medicare's interest in a settlement may unwittingly draft settlement terms that

can result in unintended consequences. A few of the more common scenarios involving settlement language provisions are addressed below.

> **Scenario One**: Settlement terms which keep medical rights open in the claim until CMS review is completed and the CMS determination is funded.

It is perfectly acceptable to settle indemnity benefits while keeping medical rights open until such time CMS review is secured and the CMS determination is funded. Before this type of settlement language is used however, the parties should first consider whether the settlement will actually meet CMS' internal workload review threshold. Currently, CMS is willing to review a settlement involving a Medicare beneficiary if the proposed settlement exceeds $25,000.00. If a Claimant has a reasonable expectation of Medicare entitlement within 30 months of settlement, CMS review is available provided the proposed settlement exceeds $250,000.00. Before using settlement language agreeing to or requiring CMS review prior to closing medical rights, it is imperative the parties consider whether CMS review is even available in the case. If it isn't, medical rights may never close in this case with this type of settlement language.

Similarly, settlement language requiring the employer or carrier to fund the CMS determination may inadvertently limit the employer/carrier's ability to seek a review of an unacceptable or error-filled CMS determination. More appropriate settlement terms would provide the employer/carrier with the right to: choose to fund the CMS determination; dispute the determination; seek re-review of errors made; seek amended review in the future; or keep medical rights open subject to the available defenses in the claim.

> **Scenario Two**: Ambiguous settlement terms which do not clearly specify whether the dollar amount of the settlement includes the amount of the Medicare Set Aside (MSA) or if the MSA amount is to be funded in addition to the settlement amount.

Ambiguous settlement terms involving an MSA were considered by the Appellate Court of Illinois, First District, Third Division in the case of *Paluch v UPS*. (2014 IL. App (1st) 130621) In the *Paluch* case, a dispute arose as to whether the settlement of $400,000.00 included the amount to be paid for an MSA annuity or if the MSA annuity was to be paid in addition to the $400,000.00. Although one section of the contract stated "Respondent agrees to pay and Petitioner agrees to accept $400,000.00 in a lump sum **plus** payment of a MSA in annuity form," other sections of the contract itemized the various damage elements to be paid which when added amounted to $400,000.00.

In examining the various provisions of the settlement contract, the Appellate Court remanded the claim for an evidentiary hearing on the settlement terms before the trial court since they were open to more than one interpretation. The decision correctly cautioned: "Sloppy, imprecise drafting can lead to legal wrangling." (Id at p139621). This caution should be heeded.

> **Scenario Three**: Failure to address the parties' obligations to reimburse conditional payments claimed by Medicare.

Many settlements involve disputed conditions. In light of this, settlement documents should clearly outline the parties' responsibilities when it comes to addressing conditional payment claims that may be made by both traditional Medicare, Medicare Part C and Part D plans. If the burden will be placed on the Petitioner, a clause requiring cooperation with the employer/carrier is critical since Medicare may technically seek reimbursement from the primary plan for pre-settlement payments.

> **Scenario Four**: Settlement terms that erroneously interpret Medicare Secondary Payer compliance obligations.

Alvarenga v Scope Industries (2016 Cal. Wrk. Comp. P.D. Lexis, ADJ8873556) addressed a situation involving a petition for reconsideration of an order approving a compromise and release. In granting the petition, the Workers' Compensation Appeal Board (WCAB) noted several issues with the settlement documents. Although the settlement terms stated that an MSA "must" be submitted and approved by CMS, the WCAB correctly pointed out that CMS does not require review and approval of an MSA. This, however, was not the basis for the decision since the parties correctly understood that CMS review is voluntary. The WCAB instead found that the Claimant was not adequately advised about the risks associated with not seeking CMS review. It also found that the amount of the settlement was inadequate since it was less than the CMS determined MSA and voided the settlement.

Conclusion

Medicare Secondary Payer compliance settlement terms should be carefully drafted to meet the specifics of each settlement. Boiler plate terms can oftentimes result in unintended consequences when it comes to Medicare issues, particularly when drafted by individuals who do not thoroughly understand the intricacies of the Medicare Secondary Payer Act, MSAs or Medicare conditional payments. Should you wish assistance, our MSP compliance team is available to review your proposed contracts or draft the appropriate terms for your case. Let us know how we may help you.

Section 111 – Strategic Compliance Improves Outcomes / Paul Pasche

By now, most of our readers are familiar with the Mandatory Insurer Reporting statute, commonly called "Section 111 Reporting," because it originated in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. As it applies to the insurance claims and defense industry, Section 111 mandates that insurers or self-insured entities, and sometimes third-party administrators, report to Medicare when the entity learns a claimant is a Medicare beneficiary. While Section 111 applies to standard health insurance, it also applies to "non-group health plans," or NGHPs, a group that includes workers' compensation, liability, and no-fault coverage plans. For NGHPs, any claim with a total payment obligation to the claimant (TPOC) value over $750 is subject to Section 111 reporting. However, "ongoing responsibility for medicals," or ORM does not need to be reported when medical expenses paid directly to the providers do not exceed $750 and the claimant lost seven days of work or less. The purpose of the reporting is to prevent Medicare money from being spent on treatment where a primary insurance plan should be responsible, by providing to the Medicare program the data it needs to identify such claims and treatments. Over the years, the Section 111 program has evolved to its present-day online reporting system, and last fall the Centers for Medicare and Medicaid Services (CMS) updated its policy manual to provide a system for escalating unresolved issues, as well as an updated paperwork reduction disclosure. With potential penalties of $1,000 per day for non-compliance with the statute, most entities are more than happy to comply. CMS also continues to keep stakeholders awaiting guidance on its pending proposed rules on penalties for civil liability insurers non-compliance with reporting, and these are now expected to be announced later in 2020. However, there can be other consequences resulting from how the entity complies, as well as how CMS works with the data it receives from mandatory reporting. These consequences can be avoided or mitigated by approaching Section 111 with strategic planning for each case.

Probably the two most critical data items involved in Section 111 reporting are the diagnosis coding and the period of dates when the entity has ORM. As practitioners well know, the use of diagnosis codes is quite divergent between health care providers, insurers, state workers' compensation agencies, courts, and CMS itself. Therefore, it becomes critical in Section 111 reporting to make certain the codes being reported are correct and are limited to the injuries covered by the entity's claim. It also remains important to frequently re-check the reported codes as the claim investigation proceeds and as the claimant's condition evolves during the pendency of the claim. Misstated diagnosis codes can result in CMS seeking reimbursement for medical treatment wholly unrelated to the claim or can cause CMS to deny coverage when the claimant needs care for an unrelated condition. Understating or omitting diagnosis codes can result in delays or errors when it comes to the time of closing out conditional payments reimbursement

to CMS. Similarly, the reporting and updating of ORM status should be as accurate as possible and must be consistent with any trial awards or settlement documents. If a settlement or award closes future medical rights before the claim is resolved, the ORM should be reported as closed. Care should also be had for fully disputed and denied claims. In most instances, if there is a legal defense to liability, then ORM is never triggered. In other words, if there is no liability, there is no “responsibility for medicals” and thus there is no need for an ORM report.

Once the TPOC amount is finalized and ORM is closed, the TPOC should also be reported, even if the ORM closure happened earlier. If the case subsequently settles on a disputed basis for less than or equal to $750, there is no need to make a TPOC report since it is less than the TPOC reporting threshold. These kinds of cases include absolute defenses to liability, such as where there is no coverage (e.g., the claimant was not an employee, or the claimant is not covered by the terms of the applicable liability policy) or where the statute of limitations has expired. They can also include factual defenses like causation. In some cases, the ORM and TPOC (if any) may need to be closed at the same time.

The point of accurate reporting is to ensure CMS adjusts its records to properly account for potential conditional payments, but also to enable the claimant to access his or her Medicare benefits for treatment no longer covered under the claim. Given all the potential scenarios in a particular claim, Section 111 reporting should never be a rote or automated process. The unique circumstances of each case should be considered, and regular updating should conform the reporting to the changing facts as the case progresses. We at NBKL can assist in developing a customized strategy for Section 111 compliance to ensure that exposure for conditional payments is minimized and that the claimant’s access to Medicare benefits is maximized on a case-by-case basis.

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.