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Settlement News

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Join Us on January 31st! Medicare Advantage Webinar

Rasa Fumagalli, JD, MSCC

Join us on January 31st, 2017 at 1:30 (CST) **Register here** for a webinar that will recap some of the noteworthy MSP Private Cause of Action claims brought by Medicare Advantage Plans in 2016. We will also discuss best practices for addressing payments made by Medicare Advantage Plans when handling or settling your claims.

Rasa Fumagalli, JD, MSCC, NuQuest's Director of Compliance, holds a law degree from IIT's Chicago Kent College of Law with an undergraduate business degree from the University of Illinois. Prior to joining NuQuest, she spent over twenty years specializing in workers' compensation defense work in the Chicago area. Rasa utilizes her extensive experience in handling workers' compensation cases when consulting with clients about Medicare Secondary Payer (MSP) compliance issues. She is admitted to practice law in the State of Illinois and is an active member of the National Alliance for Medicare Set-Aside Professionals (NAMSAP) organization, serving on the Evidence-Based Medicine, Communications and Liability Committees.

Review of MSP Compliance

Patrick Czuprynski , JD, MSCC

The Medicare Secondary Payer Compliance industry had an eventful 2016. Between Commercial Recovery Center's (CRC) conditional payment recovery issues, CMS' change in its process and then unchanging the process, Medicare Advantage Organization case law and more, there has been plenty to keep everyone engaged throughout the entire year. With a transition of the government in 2017, we expect another year of excitement and high involvement.

Regarding conditional payments, the following highlights occurred in 2016:

- CRC's "grouper" includes diagnosis/charges for unrelated charges forcing applicable plans to appeal conditional payment notices and initial determinations on massive scale
- CRC's town hall presentation:
    - Importance of proper authorizations from both claimant and applicable plan
    - Process of transferring collection to BCRC and against the claimant and/or recipient without notice to the applicable plan
    - Intent to Refer to U.S. Department of Treasury correspondence process
- Regarding 2017, the CRC has advised plans to:
    - Provide the diagnosis codes reported to CRC and used in searching for conditional payments on their conditional payment repayment correspondences. This will allow the applicable plan to determine if the diagnosis and conditions have been correctly reported
    - Provide additional functions to the Medicare Secondary Payer Recovery Portal (MSPRP) allowing for upload of appeal of initial determination, viewing of account receivable information and downloading of redetermination

With respect to workers' compensation MSAs and liability MSAs:

- In reviewing workers' compensation MSAs, CMS without notice began requesting a court order demonstrating the non-compensability of a claim, in addition to proof of no payment, to approve a zero waiver request. This change by CMS was quickly retracted due to the huge response from the stakeholders in the industry
- CMS requests bids for MSA review contract that includes LMSAs
- 2017 Re-Review process for WCMSAs in specific circumstances where CMS already approved a MSA.
- 2017 Re-Review process incorporating utilization review

With respect to case law, the following provides highlights for the year:

- Oklahoma Supreme Court finds workers' compensation opt-out law unconstitutional - *Vasquez v. Dillard, Inc.*, 2016 OK 89 (Sept. 13, 2016)
- Medicare Advantage Organizations' big win in 11th Circuit of the United States Court of Appeal who upheld award of double damages against liability insurance carrier - Humana Medical Plan v Western Heritage Insurance Company case, No: 15-11436 (U.S.C.A. 11th Cir. 8/8/2016)
- Medicare Advantage Organization can collect against a claimant's attorney fees - Insurance Co. v Parris Blank, LLP, 3:16CV79HEH (E.D. Va.2016)
- Dr. Takemoto appeals the dismissal of his False Claims Act suit by the District Court (U.S.C.A. 2d Cir., *docket number* 16-365). Oral arguments are currently scheduled for 1/9/2017.
- Contract for No-Fault insurance demonstrates responsibility to reimburse Medicare Advantage Organizations - *MSP Recovery LLC v. Allstate Ins. Co.*, (U.S.C.A. 11th Cir. 2016) (*consolidated dockets:* 15-cv-21532-JLK, 15-cv-20213-UU, 15-cv-20208-UU, 15-cv-20616-FAM, 15-cv-21687-JLK, 15-cv-21504-JLK, 15-cv-20732-RNS)

Not every Medicare compliance event is reflected in this article, however, a few important items that should be kept in mind moving into 2017 are:

- CRC case closure letters may not be the end of the conditional payment collection process. BCRC may be attempting to collect from the claimant or a recipient of settlement funds. If BCRC cannot collect, they have a right to pursue collection against the associated workers' compensation, liability (including self-insured), or no-fault plan
- Medicare Advantage Organization's reimbursement rights must be taken seriously
- Contractors will be bidding to provide CMS liability MSA review

With the delay and difficulties the industry had with CRC and CMS' about face in its zero waiver procedure, 2017 looks to be a promising adventure with changes on the horizon that appear to be in the right direction.

We will keep you posted as more develops in 2017.

Medicaid in 2017

Rasa Fumagalli, JD, MSCC

The new administration has made the repeal of the Affordable Care Act (ACA) a priority item on their agenda. Under the ACA, many states had opted to expand Medicaid eligibility for certain individuals in order to provide insurance coverage. Although the transition to the new administration is still underway, a review of the backgrounds of Representative Tom Price, chosen as the Secretary of the Department of Health and Human Services (HHS), and Seema Verma, chosen as the Administrator of the Centers for Medicare and Medicaid Services (CMS), allows some insight into their views on federal funding for state Medicaid programs.

Representative Price has staunchly opposed the ACA from early on and has proposed annual alternatives to it since 2009. His latest version of the "Empowering Patients First Act" H.R. 2300, introduced in May of 2015, shows his support for providing federal money to states to subsidize insurance for "high-risk populations". It also offers fixed tax credits regardless of income, so that people may buy their own insurance through private markets. Seema Verma is known for her work in designing Indiana's Medicaid model. A newer feature of this program provides that Indiana Medicaid enrollees may be denied all benefits for six months if they fail to make a monthly Medicaid premium payment. Price and Verma have been described by President-elect Trump as "the dream team that will transform our healthcare system for the benefit of all Americans."

Given the new administration's agenda and selection of Price and Verma, we would expect to see significant cuts in the federal government's contributions to state Medicaid programs. These cuts may result in an increase in an individual state's contributions to the program, along with a reduction in the benefits offered under the Medicaid program. Enhanced reimbursement efforts by the states to collect payment from other sources are also anticipated. Reimbursement efforts are required by federal law in exchange for the federal contributions to the states' Medicaid programs.

Whenever a Medicaid recipient receives medical assistance for an injury or condition for which a third party is liable, Medicaid has an enforceable right to recover the amount of the medical assistance paid by the State. Medicaid lien statutes vary from state to state. In a majority of states however, whenever Medicaid has furnished medical assistance for an injury or condition for which a third party is liable, the State has an automatic statutory lien for all medical assistance furnished to the Medicaid recipient. The Medicaid lien is against the judgment amount, award, or settlement in a claim or suit against the third party. In some states, the lien may be reduced to cover the attorney fees and costs of the plaintiff in procuring the judgment, award, or settlement.

In order to collect information about potential third-party recovery, states may have reporting requirements. The reporting will often be made through data exchange or intercept programs. Data exchange programs, such as the Public Assistance Reporting Information System (PARIS), match the Social Security Numbers of Medicaid recipients, or other information, against federal databases and participating states. Currently, 47 states participate in the PARIS program. Many states are considering adding workers' compensation as a program to be included in the PARIS match metrics. Medicaid intercept programs are also used by some states to intercept payments to claimants for reimbursement to a state's Medicaid program.

At this time, Medicaid's lien recovery is limited to that portion of a settlement or judgment that is for health care items or services. In other words, Medicaid may not assert its lien against other aspects of the underlying claim, e.g. lost wages and other nonmedical damages. As a result, settlement or judgment proceeds may be allocated among the various damage elements asserted in an underlying claim based on their relative value. **This will, however, change as of October 1, 2017, when Medicaid's lien may be asserted against all amounts paid to a claimant regardless of the character.** This change, which has been delayed several times, is due to the enactment of Section 202(b) of the Bipartisan Budget Act of 2013.

Given the lack of uniformity in the state Medicaid recovery rules, it is imperative that parties familiarize themselves with the relevant statutes in regards to reporting and repaying liens. We will keep you advised as new developments occur in the area of Medicaid.

Updates to CMS WC MSA Submissions Portal

The CMS WC MSA Submission portal has improved the submission process in many aspects. Some of those improvements are:

- Being able to upload materials directly to CMS therefore cutting out the mail time and the guess work in whether or not the materials were received/processed by the CMS contractor.
- The turnaround time to complete review of a WC MSA (with the proper materials) has greatly improved. It no longer takes several months to complete the review but on average a response is received in approximately 30 days if not sooner.
- Being able to check the submission status via the portal.
- Being able to obtain the CMS responses immediately versus having to wait for it to arrive in the mail.

However a down side to the current process is that we are no longer able to speak directly with the CMS reviewer to discuss any questions, concerns, or discrepancies regarding a development. We must explain the situation, questions or concerns with the call center. The call center will then reach out to the reviewer, via email, with our questions. This can cause calls back and forth. It creates a middle man to deliver the message and if the answer leads to other concerns, the call center must then email the reviewer again.

There also seems to be a disconnect between the call center and the review center. The call center will refer to the CMS policy to explain why something is needed stating that it is simply CMS policy. For example, when a reviewer requests additional current treatment records but we have already provided the last two years of treatment, the call center may only reply that it is CMS policy and will refer us to contact CMS regarding any policy issues.

However, when the call center is forced to look further into the file or reach out to the reviewer (through my questioning and prodding), the explanation for why they are requesting additional records could be because there are more current medical payments noted in the payment history, more current drugs noted in the pharmacy or the medical records, sent to CMS, indicate treatment with another provider but those records were not provided to us. This type of information is important to determine the proper steps in moving forward but it is not normally noted in the CMS development letters. This leads to the next issue.

The CMS development letters are sometimes vague and general. The letters may only state that current treatment records are needed, a complete payment history is needed, etc... This makes it difficult to determine the proper steps to move forward. Extra time must be spent to figure out what exactly the reviewer is asking for. What is missing from the records provided, are they requesting a complete payment history because medical payouts are missing or indemnity or is it because there are denied conditions and they need the entire payment history? There could be a number of possibilities which would help if the reviewers were specific and consistent. One reviewer may say the records provided are sufficient another reviewer may require additional information. This makes is hard to predict what CMS considers to be sufficient or what information they are looking for.

In situation where there are no current treatment records and no current medications but the last treatment records indicate further treatment is needed or the claimant was symptomatic, CMS may request further information to confirm the claimant has not gone outside of work comp. to treat for the injury. Generally CMS requires a statement from all treating physicians to state when the last two years of treatment for any reason occurred.

The treating physician must also state, in writing, the specific condition/injury the claimant was last treated for, and any related therapy. This type of request causes further delay as the carriers must obtain additional information from the claimant's physicians and/or contact the claimant and their attorney to determine if there are any treatments, for the injury, outside of the work comp. system.

Overall the current CMS WC MSA submission process has improved, although there is a new set of challenges, they seem to be improving.