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NuQuest

Settlement News

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NuQuest consolidates with Protocols

NuQuest and Protocols are recognized leaders in the MSP Compliance industry. As long-standing, strategic partners, we have mutually agreed to join forces and consolidate our complementary strengths, expertise and operations into one organization under the NuQuest brand.

"Our outstanding leadership team has done a fantastic job of building a solid and successful operation that provides superior services to our client partners. I want to take a moment and thank you for your continued loyalty as we have worked to become one. The integration of two companies is no easy task. Today we are both excited and proud to present our innovative suite of services, and enhanced logo and website which reflects upon the pillars of our past success as well as our vision for the future."

- Tracey Lazzopina, Chief Executive Officer

Our policies and procedures are fully aligned, creating a seamless MSP Compliance experience for you, our valued client. Today we stand as one unified company providing each of our client partners with greater value and expertise.

"We are pleased to combine our strengths to meet the demands of the marketplace. The integration of Protocols' historic leadership and legal expertise into NuQuest's industry-leading operation reinforces that we are fully committed to making NuQuest the most trusted and valued MSP Compliance company in our industry."

- Robert Sagrillo, President and Chief Legal Officer

This is an exciting time for our organization, teammates and client partners.

As we step into the New Year, we look forward to sharing our revolutionary new products and services that will forever transform our industry.

Join Us on April 25th! Conditional Payment Recovery Process Webinar with Rasa Fumagalli, J.D, MSCC

Join us on April 25th at 1:00 pm CST for a webinar **Register here** that will discuss the current conditional payment recovery process. The webinar will outline the various changes that came about as a result of the implementation of the Strengthening Medicare and Repaying Taxpayers Act of 2012. These changes include the three-year Statute of Limitations for conditional payment recovery, the establishment of recovery thresholds in liability cases, a new direct right of appeal for applicable plans, as well as the ability to secure final conditional payment information in certain settlements. We will also discuss the partial transition of recovery work from the Benefits Coordination and Recovery Center (BCRC) to the Commercial Recovery Center (CRC), as well as the initiation of conditional payment recovery in claims with Ongoing Responsibility for Medicals. Given the impact of these changes, it is important that all Medicare compliance programs account for them.

Rasa Fumagalli, J.D., MSCC

NuQuest Conditional Payment Department

The scope of conditional payment recovery has changed quite a bit since its inception. The Secondary Payer Compliance guidelines can not only include Medicare, but also Medicaid, Medicare Advantage Plans, and Government and Military Medical Plans. These agencies, now included in Secondary Payer Compliance, are creating subrogation departments or obtaining subrogation contractors to handle the task of recovery. Over the past year, NuQuest has

requested liens from agencies and subrogation contractors in all of these areas. We can help in identifying what is required, advise on the differences between a Medicare Advantage Plan and a Medicare Supplemental Plan, and negotiate with these agencies to have unrelated claims removed. In 2015, NuQuest recovered over $2,538,000 for our customers, representing unrelated claims listed on the conditional payment summary.

As of October 1, 2015, Medicare split their Medicare Secondary Payer Compliance unit into two separate agencies. The Benefits Coordination and Recovery Contractor (BCRC) handles all workers' compensation, liability and no-fault claims developed before October 1, 2015. The Commercial Repayment Center (CRC) handles recovery claims that are directed against the liability insurer, no-fault insurer or workers' compensation insurer that were developed after October 1, 2015. Needless to say, the transition process in dividing up the work between these two agencies has been a bumpy road. However, we believe that, as the dust settles, communication will improve between the two agencies and the conditional payment process from Medicare will be streamlined.

The Secondary Payer Recovery process and requirements are always in flux. NuQuest strives to stay on top of these changes, keep our customers informed and save our customers from paying for unrelated charges. Our Conditional Payment Coordinators have over nine years of combined experience in the area of Secondary Payer Recovery and Compliance. We are fully versed in authorization requirements and have the ability to procure the latest Conditional Payment information available on the MSPRP Web Portal.

Debra Torchia and Roma DeSanctis

2015 CMS Highlights

CMS started the year off with the issuance of a February 27, 2015, final rule establishing a right of appeal and formal Medicare Secondary Payer (MSP) appeal process for applicable plans. This process was mandated by Section 201 of the SMART Act. Applicable plans were defined as: liability insurance (including self-insurance), no-fault insurance, and workers' compensation plans. Implemented by CMS on April 28, 2015, applicable plans were given a multi-level appeal process for the resolution of conditional payment recovery demands issued directly to the plans. The appeal process includes: an 'initial determination" of the conditional payment demand, a "redetermination" by the contractor issuing the recovery demand, a "reconsideration" by a Qualified Independent Contractor, a hearing by an ALJ, a review by the Medicare Appeals Council, and judicial review.

Claims with a reported Ongoing Responsibility for Medicals (ORM) were also targeted by CMS for conditional payment recovery. This represented a significant departure from CMS' prior conditional payment recovery actions at the conclusion of a claim. In addition, CMS did away with a procurement cost reduction in their recovery demands issued directly to applicable plans.

On July 21, 2015, CMS rolled out its Multi-factor Authentication (MFA) services for use on the Medicare Secondary Payer Recovery Portal (MSPRP). This service allows non-beneficiary users to access conditional payment information that was previously unavailable through the portal. Access is available upon successful completion of the Identity Proofing and MFA process requirements.

On October 1, 2015, CMS converted to the ICD-10 diagnostic and procedure code system. The new coding system allows for greater specificity in the injury / condition descriptions. This improved data collection is expected to impact evidence-based

medicine research. It should also allow CMS to better target conditional payment recovery claims.

October also saw CMS' transition of a portion of the non-group health plan recovery workload to the Commercial Repayment Center (CRC). The CRC assumed responsibility for new recovery claims where CMS is pursuing recovery directly from the liability insurer, no-fault insurer or WC entity. Recovery actions directed towards the beneficiary would continue to be handled by the Benefits Coordination and Recovery Contractor (BCRC).

CMS advised in its CRC webinar and training materials that a Conditional Payment Notice (CPN) will be issued by the CRC to the applicable plan when it reports that it has ORM in the claim. Payments identified in the CPN may be disputed once within 30 days of the date of the CPN. Failure to dispute the CPN will trigger the issuance of a demand letter or initial determination. Once this letter is issued, administrative appeal rights will become available to the plan. A Conditional Payment Letter (CPL) is issued when a beneficiary or his representative self-reports the claim and the MSP occurrence was not otherwise reported by the applicable plan. Conditional payments noted in a CPL may be disputed at any time.

On October 19, 2015, CMS announced the 2015 recovery threshold for physical trauma-based liability insurance settlements, judgments, awards or other payments remained at $1,000.00 or less. This means that CMS will not seek recovery of conditional payments in these physical trauma-based liability settlements of $1,000.00 or less and that entities are not required to report these settlements.

CMS' implementation of the Smart Act changes continued in November 2015, when it announced that the Medicare Secondary Payer Recovery Portal (MSPRP) will provide

Final Conditional Payment process functionality by January 1, 2016. This new process will allow authorized MSPRP users to notify CMS within 120 days or less of an anticipated settlement and request that the case be a part of the Final CP process. This means that disputes regarding the conditional payment amount submitted through the MSPRP will be resolved within 11 business days of receipt of the dispute. In addition, the new process provides that the Final Conditional Payment Amount will be available on the MSPRP after all the disputes have been resolved and within three days of the settlement. This figure will remain the final figure as long as the case is settled within three calendar days of requesting the Final Conditional Payment Amount. The settlement information must also be submitted through the MSPRP within 30 calendar days of requesting the Final Conditional Payment Amount. The new Final CP process became available on December 21, 2015.

Michigan Circuit Court Private Cases of Action Opinion

By Rasa Fumagalli, J.D., MSCC

The recent Michigan Circuit Court opinion in the John F. Hull v Home Depot USA, Inc. case (CN. 15-148344-CZ (2/17/2016)) has raised several issues in the area of MSP compliance. The Court was asked to rule on motions for summary disposition of Hull's Private Cause of Action (PCA) case. Hull filed the action on August 3, 2015, seeking to recover double damages for Home Depot's failure to promptly reimburse Medicare and a Medicare Advantage Plan the sum of $42,233.16.

A review of the timeline of the events in the underlying claim is important in understanding the case. Hull submitted a workers' compensation claim in September of 2011 for an alleged knee injury at work in April of 2010. The claim was denied by Home Depot. It went to trial several years later in March 2015. On May 5, 2015, the Workers'

Compensation Magistrate Castora signed an Opinion and Order finding that Home Depot was responsible for paying medical expenses. The Order was mailed to the parties on June 1, 2015. Home Depot filed a Claim for Review of the Order on June 26, 2015. Subsequently, on August 3, 2015, Hull filed a PCA suit seeking double damages for Home Depot's failure to reimburse the Medicare Trust Fund. Home Depot sent a letter withdrawing its Claim for Review on August 13, 2015. The Michigan Compensation Appellate Commission issued an order granting the withdrawal on August 28, 2015. Home Depot paid Medicare $6,813.83 and Blue Cross Blue Shield $35,419.33 on September 10, 2015.

Home Depot raised several arguments in support of its motion to dismiss Hull's PCA suit. The first argument focused on Home Depot's payment of the amounts owed to Medicare and Blue Shield. In rejecting this argument, the Court noted that the Plaintiff, Hull, had not been paid.

Home Depot's second argument focused on the lack of "demonstrated" responsibility prior to Hull's filing of the PCA suit citing the Glover v Ligget Group case (459 F3d 1304 (CA 11, 2006)). In Glover , the Eleventh Circuit held that "an alleged tortfeasor's responsibility for payment of a Medicare beneficiary's medical costs must be demonstrated *before* an MSP private cause of action for failure to reimburse Medicare can correctly be brought under section 1395y(b)(3)(A)." "459 F3d at 1309." Home Depot claimed that the filing of the PCA, while its appeal of the underlying workers' compensation award was pending, was premature.

The Michigan Court was not persuaded by this argument, noting that the Glover holding was limited to claims against tortfeasors. It also noted that this interpretation was supported by the Michigan Court of Appeals in the unpublished opinion in the Holmes v Farm Bureau Gen Ins Co case(May 19, 2015, Docket No. 320723). In Holmes, the Court of Appeals found that contract-based actions involving health plans did not require the

"demonstrated responsibility" discussed in the Glover case involving a tortfeasor. Home Depot's argument that it was a "tortfeasor" was deemed "wholly without merit" since the claim was a workers' compensation claim and not a tort action. The Court also pointed out in a footnote, that there had been a determination by the initial Magistrate that Home Depot was liable for the bills in the workers' compensation claim. Since Home Depot did not cite any support for the argument that a determination is only effective after all appeals are exhausted, this position was not addressed by the Court.

Home Depot's last argument, that its payment of Medicare after receipt of the dismissal of the Claim for Review order supports the dismissal of the PCA, was similarly rejected. The Michigan Court, in citing the Estate of McDonald v Indemnity Ins Co of North America, 46 F Supp 3d 712 (WD KY, 2014), noted that "Once a private cause of action claim has been lodged against a defendant, a defendant cannot escape the double damages provided for in that provision by paying single damages to Medicare."
In denying Home Depot's motion to dismiss the PCA, the Court specifically noted that Home Depot's denial of the Plaintiff's medical expenses for nearly five years forced Medicare to pay them. It was only after the PCA was filed that payment was finally made. Judge McMillen granted Hull's counter motion for summary disposition and awarded him the sum of $42,233.16 as a reward for his efforts in prompting Home Depot's reimbursement of conditional payments to the Medicare Trust Fund.

The Hull Court's decision raises several issues. Its comparison of a workers' compensation policy to a no-fault insurance policy fails to consider that some workers' compensation claims are not compensable. If the claim is not compensable, the employer is not liable for the medical bills paid by Medicare. This distinction removes it from a "contract-based action involving a health plan". In addition, the Court's dismissal of Home Depot's argument that the Magistrate's decision was not final, since an appeal had been filed, flies in the face of general appellate theory. We will continue to monitor the PCA case law and keep you advised of further developments.

Expectations for 2016

As we begin 2016, we expect CMS' new final conditional payment recovery process to assist in expediting the settlement process for cases involving Medicare beneficiaries. We anticipate future litigation to arise regarding the definition of the "settlement date". This year is also likely to see greater efforts by states to collect Medicaid liens from settlements. Greater uniformity among the state third-party recovery processes would be welcome and is being sought by various groups.

We look forward to serving your Medicare / Medicaid Secondary Payer compliance needs in 2016.