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ONE SOURCE FOR MEDICARE SECONDARY PAYER COMPLIANCE

2014 - A YEAR IN REVIEW

NuQuest/Bridge Pointe
MSP COMPLIANCE

As 2014 came to a close and we begin 2015, I have been reflecting on where NuQuest/ Bridge Pointe began as a company in 2001, how we have grown over the last 13 years and where we are going in 2015 and beyond.

NuQuest/Bridge Pointe was built on the pillars of quality, integrity, strong customer focus and innovation. Over the years, we have evolved from a MSA Company to a Medicare Compliance leader. We did this by developing strong partnerships with our customers; by developing innovative solutions; and most importantly by building a solid team of extremely talented professionals. As we continue to grow in 2015 by adding new customers, building stronger partnerships and continuing to focus on quality and customer service, we will continue to learn and to evolve as the industry dictates.

We have and will continue to be cutting-edge and provide our clients with innovative solutions to not only comply, but reduce their costs and exposure.

So as 2015 begins, I would like to share how extremely grateful we are for our customers and look forward to another successful year of partnership.

Thank you for your trust and Happy New Year!
Tracey Lazzopina, President

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MSP Compliance – 2014, a Year in Review

It will be nearly impossible to touch on every aspect of MSP Compliance in this short review, therefore our focus will be on some of the major changes and occurrences that impact your claim's settlement. Let us start with the Workers' Compensation Review Contractor (WCRC) and the Workers' Compensation Medicare Set Aside Portal (WCMSAP).

The new Workers Compensation Review Contractor (WCRC), Provider Resources, Inc., took over the responsibility of reviewing the MSA submissions and providing the individual Centers for Medicare and Medicaid (CMS) Regional Offices with recommendations for approval in July, 2012. In 2013, the industry experienced a shorter turnaround time for the review process and was provided with additional published resources to assist in understanding the process. It felt like CMS was finally taking the industry's concerns seriously; then came 2014.

CMS issued a new WCMSA Reference Guide on November 6, 2013, with an overview of the operating rules and WCRC review process. By January, 2014, concerns were growing over how the WCRC interpreted the guidelines. Inconsistent review practices were apparent and the number of development letters being issued was increasing. Development letters are what the WCRC and CMS call a request for additional records and information needed to complete their review. The WCRC will not complete the review until all requested documents are received. In January and February, 2014, the industry noticed an increase in development letters requesting non-industrial medical records. By March, 2014, 50% or more of submissions had an open request for additional records including non-industrial records pending. NuQuest approached the CMS Central Office and the WCRC – Provider Resources, Inc. regarding the development letters and our concerns with providing non-industrial records. In March, 2014, NuQuest contacted State Senators for assistance. After several communications and conference calls with

CMS and WCRC, CMS agreed in April, 2014 to change the verbiage in the WCMSA Reference guide and to provide the WCRC additional training.

As part of the new WCMSA Reference Guide, CMS issued guidelines of when a "re-review" of a CMS Approval could occur. A re-review can occur under the following circumstances:

1. You believe CMS' determination contains obvious mistakes (e.g. a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, that has already occurred); or

2. You believe you have additional evidence, not previously considered by CMS which was dated prior to the submission date of the original proposal and which warrants a change in CMS' determination.

On February 11, 2014, CMS announced their proposed expansion of the WCMSA re-review process which would allow for more opportunities to contest the CMS approved MSA amount. The expansion has yet to be put in place and the re-review process remains limited and subjective.

Similar to what we saw in 2012, CMS released mass approvals in May, 2014. MSA submissions that were affected by the previously mentioned development letters requesting non-industrial related records that had no bearing on the adequacy of the WCMSA proposal and were outside of the WCRC's scope of review, were approved as submitted. Additionally, CMS released a new WCMSA Reference Guide changing the verbiage that caused the development letters to be issued.

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Industry 1 and CMS 0?

July 2014 – NuQuest participated in the Cold Water Challenge! Check out K:\ColdWater to see our Kip Daniels drenched in freezing water, all for a good cause! Personally, I love to see his surprised look when the cold water hits him.

July 2014, CMS released their "Crystal Ball" rationale – "reasonably probable and predictable". The rationale "reasonably probable and predictable" is used to justify the inclusion of future services and Part D drugs that are no longer being utilized and/or have not been prescribed for more than a year. An example is provided below.

The medical records (dated May 18, 2012 through March 20, 2014) and claim payment history (dated August 6, 2014) provided to CMS were current at the time the WCMSA was submitted to CMS on August 8, 2014. On March 20, 2014, the medical record documented that the claimant was stable and was advised to follow up as needed. There was no documentation of medication being prescribed or utilized. The pay history confirmed there were no follow up visits beyond 3/20/2014 and documented the last pharmacy date of service in 2010. CMS requested documentation from the claimant's personal physician and after many months; this was obtained and provided to CMS. These unrelated medical records provided an extensive list of the claimant's medications and CMS determined that 2 of these medications were for the work injuries. CMS therefore included hydrocodone/APAP and omeprazole in the Part D drug costs even though these records did not document who was prescribing these medications or why they were being prescribed. CMS noted that it was "reasonably probable and predictable" that these medications would be continued through life expectancy for the work-related condition.

Pharmacy continues to be a concern for the WC industry as a whole. In 2014, we have grown increasingly concerned with the overprescribing epidemic and abuse resulting in

In another case where the claimant's non-dominant hand was amputated, the medical records and prosthetic evaluation noted the prosthesis would be cosmetic and not functional. Even with these records, CMS included the hand prosthesis. Again, when a re-review was requested based on this mistake, CMS would not change their opinion. And in another case, CMS included shoe lifts. These would be covered only if they were being prescribed for diabetic foot disease. The industrial conditions in this case were low back pain and right knee pain. Therefore, shoe lifts would not be covered by Medicare in this situation.

We continue to shake our head and ask where this is going….

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2014 MSP Compliance Legal Highlights

Author: Rasa Fumagalli, J.D., MSCC

Senate Bill 2731

As of today's date, it has been referred to the Committee on Finance. The Bill provides for limited application of MSP laws to certain settlement agreements and presents qualified

Medicare Set-Aside arrangements as a means of satisfying MSP obligations. Section 1 of the Bill seeks to exclude workers' compensation plans as primary plans when the total settlement amounts are under $25,000.00 or any such greater amount as determined by the Secretary. Also excluded are workers' compensation settlements involving claimants who are not Medicare eligible at the time of settlement and are unlikely to become eligible within thirty months of the settlement. These thresholds and the definition of "likely to become eligible" are similar to those set out in CMS' workload review thresholds.

The Bill also seeks to allow for satisfaction of MSP requirements through use of "Qualified Medicare Set-Asides" (QMSAs) in workers' compensation settlement agreements. It notes that a QMSA "shall" satisfy the parties MSP obligations provided that it "reasonably takes into account" the parties' full payment obligations.

A second type of QMSA outlined in the Bill allows parties to a compromise settlement agreement to proportionally adjust the MSA amount of the agreement. The Bill states that the QMSA amount may be calculated by "applying a percentage reduction to the Medicare set-aside amount for the total settlement amount that could have been payable under the applicable workers' compensation law or similar plan involved had the denied, disputed, or contested portion of the claim not been subject to a compromise agreement".

Although the submission of the QMSA to the Secretary for review is optional, the Bill sets out a 60 day turn-around time for the Secretary to review the submission and notify the parties in writing of the adequacy of the QMSA. Should the Secretary fail to deliver the notice of the determination in a timely manner, the parties would have a right to an appeal to an Administrative Law Judge. Under the proposed Bill, the parties may elect to make direct payment of the QMSA to the Secretary. The services and items funded in the MSA should be based on the applicable workers' compensation fee schedule in effect as of the date of the agreement. Since there is no requirement that the QMSA be approved by the Secretary prior to the Secretary's acceptance of the direct payment, one may argue that upon receipt of the payment, the Secretary has "acquiesced" or agreed that the amount of the QMSA is reasonable.

The last noteworthy section of the Bill discusses final workers' compensation settlement agreements. Court approved settlement agreements would be deemed "final and conclusive" as to any and all matters within the jurisdiction of the workers' compensation law. Specific examples of matters included: "any allocation of settlement funds, the projection of future indemnity or medical benefits that may be reasonably expected to be paid under the State's workers' compensation laws". This deference to the parties stipulations would clearly make the settlement process less burdensome as it concerns MSP compliance.

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Noteworthy Case Law

Cecelia Taransky vs Secretary of the United States Department of Health and Human Services (US DHHS); et al (2014 US. App. LEXIS 14408(3rd Cir.7-29-2014)

Cecelia Taransky vs Secretary of the United States Department of Health and Human Services (US DHHS); et al (2014 US. App. LEXIS 14408(3rd Cir.7-29-2014)

The Taransky vs Secretary US DHHS case discussed the degree of deference that CMS should give to a Court's allocation order. The appeal involved the interaction of the MSP Act with the New Jersey Collateral Source Statute (NJCSS). The NJCSS provides that a tort plaintiff cannot recover damages from a defendant when she has already received funding from a different source. Taransky claimed that reimbursement to CMS would be inequitable, since her settlement did not allow for any medical expenses. She also argued that a tortfeasor cannot be a "primary plan" from which the government may recover under the MSP.

By way of background, it is important to note that during settlement negotiations, Taransky's attorney sought conditional payment information from Medicare on several occasions. After settlement was reached, Taransky filed a motion with the New Jersey Superior Court requesting an apportionment of the settlement proceeds between the various damage elements. This motion was intended to allow Taransky to secure documentation relevant to "anticipated administrative proceedings with CMS". The New Jersey Court entered an order on November 20, 2009 finding that the settlement did not include any Medicare expenses.

Taransky disputed Medicare's conditional payment demand through CMS' administrative procedures. The Administrative Law Judge found against Taransky, ruling that the Government may be reimbursed from the proceeds of a tort settlement. He also refused to recognize the state court's allocation order because it was "not made on the merits".

The Appellate Court ruled against Taransky finding that the MSP Act authorizes the Government to seek reimbursement from her settlement. Neither the NJCSS nor the Superior Court's allocation order of the settlement prevented her from obtaining damages for medical expenses. The Government also did not need to recognize the allocation order because it was not on the merits. The Appellate Court noted that a court order is "on the merits" when it is delivered after the court has heard and evaluated the evidence and the parties' substantive arguments" Taransky's motion requesting apportionment of the settlement proceeds was not intended to resolve any issues in her suit. It was sought "only to the extent necessary to obtain specified documentation relevant to anticipated administrative proceedings with the federal Centers for Medicare and Medicaid Services". In light of this, the order in question was "the antithesis of one made on the merits".

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Estate of Clinton McDonald vs Indemnity Insurance decision, Civil Action No. 3:12-CV-577 United States District Court for the Western District of Kentucky, 2014 U.S. Dist LEXIS 121902

The Estate of McDonald case involved the " private cause of action" provision of the Medicare Secondary Payer Act (MSPA) 42 U.S.C. ss 1395 y(b)(3)(A). This provision establishes "a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)" 41 U.S.C. ss 1395y(b)(3)(A).

McDonald, a Medicare beneficiary, was injured in a motor vehicle accident on May 10, 2007 while working for O'Reilly Auto. McDonald died on November 5, 2007 allegedly from the injuries sustained in the accident. Between the accident and his death, Medicare paid $180,185.75 in injury related medical bills.

The Kentucky Workers' Compensation Board found that McDonald's death was related to the accident and ordered O'Reilly Auto's workers' compensation insurance carrier, Indemnity to pay for McDonald's medical expenses. Although an appeal was filed by the Estate, the Kentucky Board's subsequent March 9, 2010 Order did not impact its prior opinion on the medical expenses. There is no indication that Indemnity took any action in regards to Medicare's conditional payments after this Kentucky Board Order was entered.

The Estate filed a lawsuit on September 13, 2012 under the MSPA "private cause of action" provision seeking double recovery of the medical expenses given Indemnity's failure to reimburse Medicare. After the Estate filed its complaint, Indemnity received an interim conditional payment letter from MSPRC dated September 19, 2012. Medicare sought the sum of $181,326.38 in conditional payments. A Final Demand Letter was sent to Indemnity on October 25, 2012 seeking $184,514.24. Indemnity issued a check

to Medicare on December 11, 2012 that was acknowledged by Medicare on January 11, 2013.

Both Indemnity and the Estate filed multiple cross motions in the case seeking dismissal of the action and summary judgment. The US District Court for the Western District of Kentucky filed its Decision on September 2, 2014 finding that the Estate was entitled to receive double damages under the MSPA. It rejected Indemnity's "no harm; no foul" argument since it disregarded the two years between the Kentucky Board's Order for payment of the medical and the filing of the Estate's suit.

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Raymand Nawas vs State Farm Mutual Automobile Insurance Company
No. 13-11158, U.S. District Court for the Eastern district of Michigan, Southern Division, 2014 U.S. Dist. 128365

Raymond Nawas v. State Farm Mutual Automobile Insurance Co., decided by the US. District Court for the Eastern District of Michigan on September 15, 2014, primarily involved a claim for no fault insurance benefits. When the plaintiff's insurance company refused to pay medical bills he had incurred following a motor vehicle accident, Medicare conditionally paid them. The plaintiff then filed a multi-count complaint which was premised, in part, upon the Medicare Secondary Payer (MSP) Act which the defendant insurance company then sought to have dismissed. The defendant argued the plaintiff's claim was premature because a claim under the MSP Act cannot be pursued until the defendant's obligation to the plaintiff's underlying no-fault insurance claim has been established by a judicial determination or settlement. This argument was rejected and the plaintiff's claim under the MSP Act was allowed to proceed.

The District Court noted Medicare was at one time the primary payer of health costs for eligible individuals. However, rising health care costs led Congress to enact the MSP Act which designated "certain private entities – such as a group health plan, a worker's compensation plan or an automobile or liability insurance plan – as 'primary payers' that have the responsibility to pay for a person's medical treatment." Under the Act, if the primary payer has not paid for the rendered medical treatment or fails to make payment in a timely manner, then Medicare has the option of "conditionally" paying for covered medical services which have been or is reasonably expected to be paid by a primary payer. Medicare may then seek reimbursement of any conditional medical payments from the primary payer.

The District Court also noted the MSP Act created a private right of action, with double recovery, to encourage private parties who are aware of non-payment by primary plans to

bring actions to enforce Medicare's rights. This provision of the MSP Act was relied upon by the plaintiff in this case. He alleged since the defendant insurance company refused to pay his no-fault insurance claim, Medicare stepped in and made conditional payments to his medical providers and therefore he sought to recover from the defendant double the amount of the conditional payments.

The defendant's argument the claim was premature was based upon the interpretation of the MSP Act's "demonstrated responsibility" provision which states in pertinent part:

> "A primary plan…shall reimburse (Medicare) for any payment made by(Medicare)…with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver or release of payment for items or services included in a claim against the primary plan or the primary plan's insured…"

In support of its argument, the defendant relied upon Geer v. Amex Assurance Co. (09-11917, 2010 WL 2681160, E.D. Mich. July 6, 2010). The Geer court had accepted this argument and dismissed the MSP Act claim in the insurance context as the plaintiff had not yet "established" a claim against the defendant insurance company through a judgment, settlement or the like. In so doing, the Geer Court adopted the reasoning of Glover v. Liggett Group (459 F.3d 1304, 11th Cir. 2006), a case which arose in the context of a tort claim brought by a plaintiff against a cigarette manufacturer.

In Nawas, the Court went on to state, "Having considered the reasoning of these cases, the Court concludes that defendant's argument is not well-taken. First, the Sixth Circuit disavowed the position taken by the Eleventh Circuit in Glover and limited this argument to tortfeasor liability only. The Sixth Circuit had also previously conducted an extensive analysis of the MSP Act's "demonstrated responsibility" provision in the Bio-Medical

Applications v. Central States case, 656 F.3d 277 (6th Cir. 2011) and held that the "demonstrated responsibility" language does not prohibit or delay direct actions against insurance companies by policy holders seeking to enforce Medicare's Secondary Payer Act rights."

The Court further explained that it believed Congress had added the "demonstrated responsibility" provision as a condition precedent to and limiting principle only for tortfeasor liability under the Act, noting the Medicare Modernization Act made no other major changes to the MSP Act. Therefore, there was no reason to believe that Congress intended to affect the liability of primary plans other than tortfeasors, that is, traditional primary plans like private insurers. It went on, "Moreover, the concept of demonstrated responsibility makes sense only in the context of tort (where no evidence of responsibility exists until it is adjudicated), rather than in the context of an insurance contract (where insurers assume the responsibility of payment for enumerated contingencies). The Court concluded the "demonstrated responsibility" provision limits only lawsuits brought against tortfeasors, not lawsuits brought against private insurers.

Accordingly, the defendant's motion to dismiss the plaintiff's claim was denied, thereby allowing the matter to proceed toward a determination on the merits of the underlying case as well as leaving intact State Farm's exposure for double damages should it ultimately not prevail in the case.

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Humana Insurance Company vs Farmers Texas County Mutual Insurance Company and Mid-Century Insurance Company of Texas Cause No. 13-CV-611-LY, U. S. District Court for the Western District of Texas, Austin Division (filed September 24, 2014)

The question presented in Humana Insurance Company v. Farmers Texas County Mutual Insurance Company and Mid-Century Insurance Company of Texas included, among other things, whether MAOs, such as Humana, may pursue a private cause of action under 42 U.S.C. § 1395y(b).

Humana made conditional payments for medical treatment its MAO enrollees received due to injuries sustained in separate motor vehicle accidents. The six enrollees were, at the time of their accidents, insured by Farmers. Humana sought reimbursement from Farmers and filed suit when Farmers refused to reimburse Humana, contending it had a right of recovery under the Medicare Secondary Payer Act (MSP).

On February 26, 2014, the United States Magistrate Judge issued a Report and Recommendation recommending that the court grant the motion to dismiss Humana's federal claims asserting it has a private cause of action under the MSP. Humana's objections and Farmer's response were filed. The United States District Court for the Western District of Texas reviewed the entire case de novo and on September 24, 2014 published its opinion.

In its opinion, the court noted the plain language of the MSP establishes two separate causes of action against noncompliant primary plans: (1) a federal cause of action and (2) a private cause of action with no particular plaintiff specified.

As the Fifth Circuit had not addressed the issue presented here, the court relied on In re Avandia Mktg., 685 F.3d 353 (3d Cir. 2012), which held that the text of § 1395y(b)(3)

(A) "unambiguously provides Humana with a private cause of action." Id. at 365. The Third Circuit found that any private plaintiff may bring an action for damages where a primary plan fails to appropriately reimburse a secondary payer for conditional payments made as this provision's broad scope placed no limitations on which entity may file suit for reimbursement and double damages. The court found this analysis persuasive enough to reject the magistrate judge's recommendation to grant Farmers' motion to dismiss Humana's cause of action for double damages under § 1395y(b)(3)(A).

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Michigan Spine and Brain Surgeons PLLC vs State Farm Mutual Automobile Insurance Company case, US Court of Appeals for the Sixth Circuit, 758 F. 3d 787; 2014 U.S. App. LEXIS 13499, 2014 FED App. 0154P (6th Circ) (Decided 7/16/2014)

The Michigan Spine and Brain Surgeons PLLC vs State Farm case addresses the Michigan Spine Group's right to bring a private cause of action against State Farm under the MSP Act . State Farm's insured, Jean Warner, allegedly sustained injuries in an automobile accident on October 26, 2010. Ms. Warner received treatment from the Michigan Spine Group. State Farm refused to pay the Group's bill that amounted to approximately $26,000.00 stating that Ms. Warner's treatment was due to a pre-existing condition.

Michigan Spine Group subsequently submitted their bill to Medicare, which made a conditional payment in the area of $5,000.00. Ms. Warner became Medicare eligible in 2000.

Michigan Spine Group sued State Farm in state court alleging that payment of the medical benefits should have been made under Michigan's No-Fault Act. It also claimed damages under the Medicare Secondary Payer (MSP) Act's private cause of action provision that allows claims against primary plans that fail to pay owed medical expenses. State Farm removed the action to federal court and filed a motion to dismiss the MSP Act claim. The district court granted the motion to dismiss and remanded the action to state court.

The issue on appeal was whether a health care provider may bring the Medicare Secondary Payer Act's private cause of action against a non-group health plan that denies coverage for a reason besides Medicare eligibility.

The Sixth Circuit Court of Appeals in deciding that the Michigan Spine Group may pursue a private cause of action claim reviewed the language of the MSP private cause of action provision. It noted that paragraph one and the first three subparagraphs of paragraph one, prevent group health plans from "taking into account" that an individual is entitled to Medicare benefits due to being at least 65 years old, disabled or diagnosed with end-stage renal disease when denying coverage. 42 U.S.C. sections 1395 y(b)(1). Paragraph two was also reviewed and noted to indicate that only primary plans that are group health plans need abide by the group health plan requirements in paragraph one. Subparagraph (3)(A), the private cause of action, however seemed to apply to all primary plans, group and non-group health plans. Since Congress added the private cause of action language to the MSP Act in order to "preserve the fiscal integrity of the Medicare system", this Court held that the Medicare eligibility requirement in paragraph one only applied to group health plans and not to non-group health plans. In light of this, the Michigan Spine Group was able to pursue a private cause of action against State Farm.

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McCarroll vs Livingston Parish Council and Louisiana Workers' Compensation Corporation (LWCC), Court of Appeals of Louisiana, 1st Circuit (2014 La. App. LEXIS 2570)

The McCarroll case decided on October 27, 2014 highlights the importance of proper timing of medical treatment in a case close to settlement. In this case, Mr. McCarroll injured his cervical spine in a work related accident on December 22, 2003. A cervical fusion was recommended and declined in July of 2008. The parties reached a settlement agreement in early January of 2009 which included an MSA. The MSA included a projection for the cervical spine surgery and amounted to $98,684.00. CMS reviewed and approved the MSA on February 2, 2009. Mr. McCarroll's attorney subsequently negotiated an additional $5,000.00 for his settlement for non-Medicare covered expenses.

Mr. McCarroll underwent cervical spine surgery on February 16, 2009. The surgery was not approved by LWCC due to the pending settlement. Mr. McCarroll proceeded with the surgery based on his belief that it would be covered by Medicare. The settlement agreement was signed by Mr. McCarroll on March 2, 2009 and approved by the Office of Workers' Compensation (OWC) on March 9, 2009.

Mr. McCarroll filed a Petition to Enforce Settlement with the OWC on March 10, 2011. He sought payment of the medical expenses associated with the cervical fusion since they had been denied by Medicare and by LWCC. The matter was tried on April 24, 2013. The issue was whether LWCC was responsible for the medical bills pertaining to treatment after February 10, 2009 but before March 9, 2009. The OWC determined that there was no meeting of the minds and vacated the settlement approved by the OWC on March 9, 2009. The Court of Appeal affirmed the OWC decision. It noted that all the parties believed that the MSA amount could be used to pay for Mr. McCarroll's surgery. Since Mr. McCarroll was unable to use the MSA to pay for the surgery and Medicare would

not pay for the additional costs, this misunderstanding was sufficient to set aside the settlement approval.

The difficulties faced by the parties in the McCarroll case may have been avoided by finalizing the CMS WCMSA determination prior to Mr. McCarroll's surgery. Had the surgery taken place after the settlement and CMS WCMSA were finalized, it would have been properly characterized as "future" medical treatment. This case further highlights the need for parties to engage in comprehensive discussions about future care during settlement negotiations.

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Section 111 Update

Author: Iliana A Gallegos,

On October 6, 2014, the Centers for Medicare & Medicaid Services (CMS) revised the MMSEA Section 111 NGHP User Guide. Of note, version 4.3 of User Guide was updated to reflect the delay of ICD-10 diagnosis code implementation from October 2014 to 2015, pursuant to the Protecting Access to Medicare Act of 2014 signed into law on April 1, 2014. CMS further clarified that when implemented, RREs will no longer be allowed to report ICD-10 "Z" codes, which represents the reason(s) for an encounter.

As the Department of Health & Human Services adopted a policy treating same-sex marriages on the same terms as opposite-sex marriages, any same-sex marriage legally entered into in a U.S. jurisdiction that recognizes the marriage will be recognized. Effective January 1, 2015, the following rules will apply with respect to the term "spouse" under the MSP Working Aged provisions, which include both opposite-sex and same-sex marriages:

- If an individual is entitled to Medicare as a spouse based on the Social Security Administration's rules, that individual is a "spouse" for purposes of the MSP Working Aged provisions.
- If a marriage is valid in the jurisdiction in which it was performed, both parties to the marriage are "spouses" for purposes of the MSP Working Aged provisions.
- Where an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in question. If such an individual is reported as a "spouse" pursuant to MMSEA Section 111, Medicare will pay accordingly and pursue recovery, if applicable.

Additional revisions included the following:

- Change Request (CR) 12178: Missing excluded ICD-10 codes added to Appendix J, Chapter V.
- CR 12590: For ICD-10 changes, field numbering/layout discrepancies were corrected in Table A2 (Claim Input File Supplementary Information), Chapter V.
- CR 12170: Two threshold error checks for the Claim Input File were implemented in July 2011. These errors are related to the dollar values reported for both the cumulative TPOC amounts and the No-Fault Insurance Limit (Chapter IV).
- CR 12636: The Appendix L alerts table has been removed and replaced with links to the Section 111 web site, which posts all current alerts and stores all archived alerts (Chapter V).
- CR 12829: Updated CS field numbers in Table F-4 (Claim Response File Error Code Resolution Table) to accommodate ICD-10 revisions (Chapter V).

On October 27, 2014, CMS issued a Technical Alert titled Response File Naming Convention Change for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Worker's Compensation. Effective April 6, 2015, the naming convention used for the Claim Response, TIN Response and Query Response Files will be modified.

On November 12, 2014, a Technical Alert titled Option for Responsible Reporting Entities (RREs) to Submit Recovery Agent Information for MSP Recovery Related. Some NGHP RREs use a separate agent to assist with tasks related to MSP recovery demands. The current Section 111 file layouts, however, do not accommodate separate name and address fields for this purpose. As a workaround, RREs were allowed to submit Third Party Administration information in existing Section 111 TIN Reference File fields or Direct Data Entry fields. Effective July 13, 2015, CMS will be implementing a permanent solution for RREs to submit their recovery agent information in designated fields on the TIN Reference File and Direct Data Entry claim submissions. The submission of recovery agent information will continue to be an option, and the current workaround for

recovery agent information will continue to be an option, and the current workaround for submission of a Third Party Administrator Address should no longer be used. RREs are encouraged to use the new reporting methodology as both the RRE and recovery agent will be copied on recovery correspondence.