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# Best Practices for Medicare Secondary Payer Compliance – Industry Perspectives

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## I. Presentation of the Case Study.

Each of the Presenters, will comment on best practices from their perspective (Insurer, Insured/Self Insured, Third Party Administrator, & Medicare Secondary Payer vendor) within the Workers' Compensation Industry. The case study to be presented and discussed throughout the presentation involves a Worker that was injured in the course and scope of employment with Insured/Self-Insured Employer. Employer timely reported the injury to their Third Party Administrator (TPA) and a corresponding workers' compensation claim was then set-up. The TPA or the Employer may report the claim to the insurance carrier. The TPA has contacted Worker who has sought medical treatment from Employer's approved provider. The Worker has been off of work for more than the requisite waiting time period applicable to the jurisdiction. Worker has reached maximum medical improvement and desires to resolve his claim. What Medicare Secondary Payer steps, if any, must be considered by the Insured/Self-Insured, TPA, Insurer and Medicare Secondary Payer vendor? What are the applicable best practices for those considerations?

## II. Insured/Self-Insured (Employer) Perspective.

An important threshold issue when dealing with a Medicare beneficiary workers' compensation claimant, is understanding who would be the Responsible Reporting Entity that is responsible for data reporting purposes under the Medicare Secondary Payer Act. Compliance with the Medicare Secondary Payer Act comprises of 4 parts. Two of these compliance pieces are solely the responsibility of the Responsible Reporting Entity. They are: 1) Determination of Worker's Medicare status; and 2) Reporting data regarding medical responsibility, termination of that responsibility, along with any associated lump sum settlements for the purpose of releasing medicals. If not done correctly, the Responsible Reporting Entity is subject to fines of up to $1,000 per day per claim. The Insured/Self-Insured (Employer) wants to be clear whether or not this exposure is their concern.

The Employer determination is based on the type of risk transfer program in place applicable to the Worker's claim in the case study. Generally, if an insurance deductible covers the loss, then the Insurer is the Responsible Reporting Entity. If the Employer has a self-insured retention, then they would be the Responsible Reporting Entity, and would need to make certain that this exposure is appropriately managed. They could manage this exposure directly by either reporting the data directly to the Centers for Medicare & Medicaid Services or privately contract with an established Medicare Secondary Payer reporting agent. Alternatively, they could rely on the Third Party Administrator to manage the reporting.

What if the Employer is not the Responsible Reporting Entity, well they still need to be concerned as primary plans under the Medicare Secondary Payer law for conditional payments (reimbursement of past medical expense) and protecting Medicare's interest (a fund established to pay for future medical care related to the claim) at settlement. This is not the responsibility of the Responsible Reporting Entity and represents the two other compliance parts of the Medicare Secondary Payer Act. Because of this, the Employer must be aware of how the Responsible Reporting Entity identifies Medicare claimants and reports data to Medicare. If it is not done properly, then the Employer as the primary plan is still responsible to Medicare for conditional payments and protecting Medicare's interest. A best practice would be to periodically audit the Responsible Reporting Entity's practices on effectiveness of identification of Medicare status; timely reporting.

If a decision is made to settle, the Employer, as the primary plan is responsible to protect Medicare's interest. The settlement amount is important to determine how that obligation would be satisfied. Worker who has settled their claim with the Employer for more than $25,000 who is a Medicare beneficiary; or more than $250,000 if reasonably expected to be a Medicare beneficiary, should consider a Medicare Set Aside Allocation. However, a Medicare Set Aside Allocation is only helpful if approved by the Centers for Medicare & Medicaid Services review contractor. An important best practice is to measure number of Medicare Set Asides to approved Medicare Set Asides. To reduce costs, analyze reasons a Workers' Compensation Medicare Set Aside Allocation is completed but never submitted, and adopt protocols to minimize non-submissions.

Conditional Payments occur during the pendency of the Workers' Compensation claim. Worker in the case study may have visited with his personal physician and raised concerns about the work related injury. This provider may have translated those concerns into ICD-9 diagnosis codes that the Centers for Medicare & Medicaid Services would identify as related. When Worker's case is settled, these provider payments by the Centers for Medicare & Medicaid Services would be considered Conditional Payments and subject to recovery. The best practice to avoid Conditional Payment liability is to have a robust and proactive system in place to identify, dispute and pay Conditional Payments. The Centers for Medicare & Medicaid Services <u>always</u> pursues Conditional Payments, even more so, since the start of data reporting of the settlement. Compare this to cases involving Medicare Set Asides, there are very few on record, and none regarding the Centers for Medicare & Medicaid Services pursuit of inadequate Medicare Set Aside funding.

To mitigate exposure, the Employer would consider in this case study professional administration which manages the Medicare Set Aside funds after a settlement is finalized. The funds are protected to pay for only medical items and services related to the resolved claim and to reduce provider charges to rates established by the Medicare Set Aside to preserve funding. Another best practice to protect the primary plan is including a reversionary interest with regard to any funds in the Medicare Set Aside account to revert back to the primary plan upon Worker's death.

There are no options to resolving conditional payment reimbursement claims. Unrelated payments to the Workers' Compensation claim can be disputed and remove, but if a conditional payment is related, the primary plan must pay it. In contrast, protecting Medicare's interest does have options. Approved Medicare Set Asides is only "recommended" by the Centers for Medicare & Medicaid Services. Best practices would include a periodic review with Medicare Secondary Payer vendors for other low risk alternatives that can adequately demonstrate Medicare's interest was protected.

## III. Third Party Administrator Perspective

The Third Party Administrator must be aware of who is the reporting agent for the Responsible Reporting Entity. This agent is responsible for collecting data to help determine Medicare status, and report ongoing medical responsibility information, as well as information about lump sum settlements. Generally, the Third Party Administrator is the reporting agent or manages the vendor that has reporting agent responsibilities. The Third Party Administrator in this situation must have best practices in place to adequately query Medicare, by having complete and accurate "Big Five" data – Worker's Social Security Number, Date of Birth, Last Name, First Name and Gender. Incomplete information would negate Worker's claim from being potentially reported. Complete information allows for prompt match by the Centers for Medicare & Medicaid Services and the opportunity to report ongoing responsible for medical and lump sum settlement data reporting. Best practices then requires prompt reporting of Ongoing Responsibility for Medical, Termination of that responsibility and information about lump sum settlements.

Ongoing Responsibility for Medicare occurs when there is a determination of responsibility to pay for medicals, and not the actual payment. Best practices require a consistent and clear process of when this responsibility is triggered for the Workers' Compensation claim. It cannot be a subjective in nature. Similarly, the termination of ongoing responsibility for medicals is not tied to the status of the claim. Termination can only occur if medical benefits are exhausted, the applicable jurisdiction workers' compensation act terminates medical benefits, a settlement occurs that releases medical responsibility or there is no settlement, and the treating doctor attests that no further treatment is reasonably expected related to the claim.

When a decision is made to resolve the claim with Worker, the Third Party Administrator must not only determine if a Medicare Set Aside is required, but also resolve conditional payments after a settlement is agreed to. Once a settlement is reached, the Third Party Administrator must submit information regarding the settlement that includes over 164 data fields to the Centers for Medicare & Medicaid

Services. Most of the information is typically found in a standard claim system. However, other fields aren't and best practices to promptly report the settlement date, settlement amount, injury codes, attorney information, and ongoing medical termination has to be manually entered by the adjuster, when the settlement occurs. The data entry cannot be automated, but best practices on reminding the adjuster is critical, as missing a reporting period can subject the Responsibility Reporting Entity to significant fines and penalties under the Medicare Secondary Payer law. The best practice is to trigger entry into the system of required data fields as soon as a settlement agreement is approved.

Even if the Third Party Administrator is not responsible for the reporting agent, their claim system populates data for the reporting agent. Consequently, whether or not they are the reporting agent, the Third Party Administrator must manage the accuracy of their claim data, and uploaded periodically to the reporting agent that is responsible.

## IV. The Insurance Company Perspective.

The Insurance Company must be clear on whether or not it is the Responsible Reporting Entity for Worker's claim. A deductible or no deductible insurance policy typically establishes the insurance company as the Responsible Reporting Entity. If the risk transfer program involves a self-insured retention, it is not for the retention amount. If the settlement amount of Worker's settlement exceeds the self-insured retention, then the insurance company must report what it pays out as a Responsible Reporting Entity. The Insurance Company must have best practices in place to monitor for these situations, and more importantly mirror the reporting data (except for its portion of the settlement amount) by their insured for its portion of the self-insured retention.

For the same reasons as the insured, the insurance company is equally concerned about who is the Responsible Reporting Entity. The Medicare Secondary Payer law obligates the Responsible Reporting Entity with the requirement to determine Medicare status and report ongoing medical responsibility and lump sum settlements that release medical benefits.

The Insurance Company as the Responsible Reporting Entity must have clear processes around on reporting Ongoing Responsibility for Medical. This requirement occurs when a determination has been made. A determination must be clear and objective. Subjective standards should not be used, as it leads to inconsistencies. Best practices would trigger Ongoing Responsibility in Worker's claim when Medicare status is identified and the claim is not controverted.

Similarly Ongoing Responsibility for Medical Termination Date must line up with the Centers for Medicare & Medicaid Services. Termination can only occur where: 1) Benefits are exhausted; 2) Benefits are terminated based on the applicable jurisdiction's workers' compensation law; 3) The treating Doctor attests that no further medical treatment is reasonably expected related to the claim; or 4) A settlement releasing medical benefits occurs. Ongoing Responsibility for Medical Termination cannot occur for any other reason and claim status is not germane to the

issue. Best Practices require strict application of Centers for Medicare & Medicaid Services rules to avoid False Claims Act fines or Medicare Secondary Payer penalties.

An important best practice to maintain Medicare Secondary Payer reporting accuracy is to audit the reporting agent. Verify all steps are being taken to promptly determine Medicare status and that reporting is accurate and timely. Medicare Secondary Payer reporting covers only two of the four compliance areas for Medicare. The Insurance Company is also responsible for conditional payments and protecting Medicare's interest to the extent the policy has paid. Even if the Employer/Insured/Self-Insured has paid the entire settlement, if the Insurance Company reports under the Medicare Secondary Payer law, it is potentially subject to a claim by the Centers for Medicare & Medicaid Services. A best practice by Insurance Companies is to make certain their insureds are managing Medicare Secondary Payer compliance for conditional payment reimbursement and protecting Medicare's interest consistent with the Centers for Medicare & Medicaid Services guidelines. To the extent alternatives are in place to established Centers for Medicare & Medicaid Services guidelines, must be vetted, as the Insurance Company retains the obligation under the Medicare Secondary Payer law.

In the case of Worker who wishes to settle, the Medicare Set Aside that is approved provides the most security from potential issues with the Centers for Medicare & Medicaid Services. This is a recommended Centers for Medicare & Medicaid Services, and best practices dictate that if any alternatives are developed that it be reviewed for maximum compliance.

## V. Medicare Secondary Payer Vendor.

The Vendor should be knowledgeable all aspects of the Medicare Secondary Payer law. Best practices require a periodic review of approved vendors to determine knowledge and expertise. The Vendor must use this knowledge in a manner that helps to close the claim. When a referral is made by the primary plan for Worker's case to develop a Medicare Set Aside to Vendor, best practices dictate: 1) An evaluation for the appropriateness of service; and 2) Collection of all relevant documents to secure a prompt approval of the Medicare Set Aside. These documents include, last 2 years of medical records from all treating providers; last 2 years of pharmacy records; applicable physician reports; life care plans; etc. Vendor as a best practice would have a complete listing of required documents. This expedites process.

Vendor should always share with referring party, opportunities to reduce Medicare Set Aside exposure values. This could be done through peer to peer review or pharmacy review. If the law of the jurisdiction permits, a decision to change treating regimen may be appropriate and also recommended.

An allocation with completed documentation should take no longer than 10 business days to prepare. Once prepared, it should be reviewed with the referring party. After this review, a follow-up plan should be implemented as the best protection for the primary plan and Responsible Reporting Entity is to submit an allocation for

approval. During the submission process Worker and Employer have agreed in principal to settle the claim, but do not execute or seek Board approval. The settlement is always conditioned upon an approved Medicare Set Aside to be a fair value, consistent with the submitted value. After approval, execute the settlement documents, if the approved Medicare Set Aside value is acceptable.

An important last step is to identify and secure conditional payments. The Centers for Medicare & Medicaid Services strongest claim under the Medicare Secondary Payer law is for recovery of conditional payments. The Vendor as a best practice should identify this issue, process and monitor for closure on behalf of the referring party.

**V.** Questions & Answers