CLM CLAIMS & LITIGATION MANAGEMENT ALLIANCE™

ADVANCING ETHICS, COOPERATION AND EDUCATION

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Roundtable 1: Thursday, April 10, 2014 (10:10 am – 11:10 am)

A Discussion of Medicare Conditional Payments, the Resultant Settlement Bottlenecks and Proposed Solutions

On November 19, 2013, CMS' Interim Final Rule related to the SMART Act's new expedited conditional payment process became effective. The Interim Final Rule, now codified at 42 C.F.R. 411.39, implements Section 201 of the SMART Act. Section 201 enables parties to obtain Medicare's "final" conditional payment amount prior to a settlement, judgment, award or other payment. These new regulations implement this expedited process through expanded use, and eventual increased functionality, of CMS' existing Medicare Secondary Payer Recovery Portal.

Section 201 also requires Medicare to promulgate regulations establishing a right of appeal and an appeals process with respect to any determination for which the Secretary is attempting to recover payment from an applicable plan (defined by the Medicare Secondary Payer Act as liability insurance, self-insurance, no-fault insurance or workers' compensation).

I. 42 C.F.R. 411.39

Excitement around the implementation of these new regulations has been building since the SMART Act was signed into law in January, 2013. 42 C.F.R. 411.39 sets forth the "new and improved" process to obtain Medicare's final conditional payment reimbursement demand **prior** to a settlement, judgment, award or other payment. The new regulations also detail a new process for disputing the amount of Medicare's asserted lien.

II. Roadblocks to Settlement Imposed by Medicare

Despite the changes promised by Section 201, Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 still imposes requirements upon claim handlers and defense counsel which present significant hurdles to settlement. We offer some practical guidance to achieving settlement in light of these requirements.

Our industry responsibilities stem from primary payor obligations prescribed through the passing of the Medicare, Medicaid and SCHIP Extension Act of 2007, which amended the Medicare Secondary Payer Act. The law extends to every property/casualty insurer and to all companies that self-insure risks involving bodily injury, inclusive of workers compensation, general liability, auto liability, professional liability and others as well as to captive insurers and risk pools. While the proposed changes under Section 201 are meant to ease the burden to settlement imposed by the existence Medicare liens, the practical situation facing claims professionals and defense counsel remains as problematic as ever.

a. Determining Beneficiary Status

While claim companies have different methods of reporting losses, either through vendors or through their current claim management systems, it is crucial to limit reporting errors by ensuring that accurate ICD-9 codes, dates of birth and Social Security numbers are entered and submitted. The earlier information is accepted by CMS the sooner you can confirm whether or not a person qualifies as a Medicare beneficiary. It is recommended that the claimant's middle initial be eliminated to reduce errors and it may be fruitful to conduct a preliminary search through ISO to identify if aliases and/or pre-existing or subsequent claims exist which may impact the level of responsibility for payments. As it can take up to 60 days for a response from Medicare as to its total payout, it is extremely important to make certain the claim is reported as soon as possible to prevent delays in the ultimate settlement of the claim.

To determine whether an injured party may have become a beneficiary during the course of a claim, or if a formal status response from Medicare has not yet been received, it can be fruitful to contact Medicare COBC (Coordination of Benefits Contractor), at 1-800-999-1118, well in advance of settlement to ensure that you will receive Medicare's final demand and to avoid any associated penalties when Medicare's interests are not protected. As qualified Medicare beneficiaries are not limited to age 65 years or older, and may include persons who have received more than 24 months of Social Security Disability Insurance (SSDI), people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant), or recipients of Medicaid, all parties for which an anticipated bodily injury, medical expense or PIP payment will be made should be reported. A follow-up call to CMS prior to settlement ensures that you can be certain of the injured party's status in the event they become a beneficiary during the course of a claim before formal confirmation from Medicare. Further, the monthly query process is not foolproof as gaps may exist between the date the information is input and the date on which a response is received from CMS.

When encountering an injured party who does not have a Social Security number, make certain to send an Affidavit to the party (or his representative), testifying that the claimant does not have a Social Security number, within 30 days of receipt of the claim. Also include a cover letter explaining that failure to cooperate can result in a suspension of their Medicare benefits and their attorneys could be subject to collection proceedings.

b. Excluding Non-covered Expenses

In order to eliminate unrelated charges from inclusion in the Medicare lien, it is critical to enter accurate ICD-9 codes and to review the final list of medical payouts provided by the Medicare Secondary Payer Recovery Contractor in its Conditional Payment Letter. Oftentimes a claimant's attorney will attempt to negotiate a settlement off of the unscrutinized list of Medicare expenses. The list can include paid services which are unrelated to the claim and ultimately result in an inflated settlement demand by the claimant's attorney. Therefore, bill review is crucial to ascertain those charges for which you are ultimately responsible. Submit the reviewed medicals to the claimant's attorney prior to requesting a formal settlement demand. This will help elicit a demand in consideration of related damages only and will afford the attorney/injured party the opportunity to negotiate the lien down. Request a copy of Medicare's final demand letter with the negotiated lien so that the check sent to Medicare reflects the actual amount owed.

c. Future Treatment

The responsibility for future medical services can be capped through a signed Affidavit from the treating physicians which indicates that treatment for the alleged injury has been completed as of the date of the settlement. Once the Affidavit is obtained on settlements where future medical services will not be required, CMS will consider the amount of the settlement within the parameters specified by the physician as satisfying its lien. A copy of the Affidavit should be provided to the beneficiary and their representative and maintained in the claims file.

For settlements of $5,000 or less, the beneficiary can opt to resolve the claim by paying Medicare 25% of the total liability insurance (including self-insurance) settlement. This is referred to as the Fixed Percentage Option and

does not apply to no-fault insurance or workers' compensation settlements. A qualifying settlement must be for a physical trauma and not related to ingestion, exposure or medical implant. A formal request for the Fixed Percentage Option must be submitted prior to any settlement or payments associated with the incident and prior to receipt of Medicare's demand letter or other request for payment related to the incident. Model language to be utilized can be found in the Attorney and Medicare Beneficiary Tool Kits on the MSPRC website (www.msprc.info).

d. Avoiding Enforcement of Settlement Where Medicare Interest Not Satisfied

One of the most perplexing settlement bottlenecks occurs when courts fail to assist in the compliance of this federally mandated Act. Many claim professionals and defense counsel have faced a brick wall when dealing with claimants' attorneys who have previously agreed verbally to include Medicare's interests in the total agreed settlement and rebuke the commitment at the time of settlement. Instead they will utilize the courts to force the carrier or responsible payer to remit the payment, or suffer enforcement of interest relative to late payment, without Medicare's mandatory interests being contemplated. A pre-negotiation agreement, executed by plaintiff's counsel in advance of any settlement negotiations, can be used to address and avoid this situation, as such an agreement would constitute an acceptance with mutuality of obligation and constitute an enforceable contract that can be upheld by the courts. For those interested in utilizing this approach, please contact Christopher Fusco, Esq., of Callahan & Fusco, LLC, for a copy of a proposed Pre-Negotiation Agreement.

e. Potential Penalties

The penalties for noncompliance with the mandatory requirements of Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 are $1,000 per each day of noncompliance for each individual for whom information should have been reported. Therefore, although burdensome, claim professionals must ensure immediate and continued compliance. By following the practical solutions herein to some of the more common reporting and settlement-related challenges presented by Section 111, claim professionals can avoid significant penalties and promptly and efficiently resolve claims when they become ripe for settlement.

III. Pictures of the Past

These new regulations, theoretically, represent a tremendous improvement over the method parties used in the past to obtain information on Medicare payments. Before the passage of the SMART Act, parties were unable to obtain Medicare's final demand in advance of settlement. Therefore, parties to a settlement with a Medicare beneficiary were unable to ascertain the full amount of the Medicare lien until **after** the claim was settled, when a party would submit the Final Settlement Detail to Medicare in exchange for Medicare's Final Demand Letter.

The problems with this process were obvious; the primary payers to the settlement were unsure as to their ultimate liability for reimbursement to Medicare of Medicare's conditional payments, despite the fact settlement may have already been tendered. Issues of bad faith arose when a carrier refused to make payment until its receipt of Medicare's final demand. Litigation often resulted in these cases which would have been unnecessary had the carrier or other primary carrier been able to obtain this information in advance of settlement. Likewise, Medicare beneficiaries, who would also be liable for repayment in certain circumstances, could not obtain certainty as to the exact amount of their reimbursement obligations in advance of settlement. In some cases, this uncertainty resulted in a chilling effect on settlement- and cases that could have resolved peacefully and expeditiously were run off the rails by the parties' inability to obtain Medicare's final demand prior to settlement.

It is also important to mention the associated delays inherent in this process. Even if both sides were working together to uncover what payments Medicare made on the claim, it would often take months to receive the PSF (Payment Summary Form) and associated CPL (Conditional Payment Letter). Many times the amount contained in Medicare's first asserted initial demand was incorrect and contained charges not associated with the specific claim. Several more months would pass as the parties corresponded back and forth with Medicare, via fax or regular mail, to correct the discrepancies in the Medicare "lien" and to obtain some visibility into what the parties' ultimate reimbursement obligation would look like. These delays were frustrating, particularly in situations where the parties desired to settle quickly- and were just trying to "do the right thing" by protecting Medicare's interests.

IV. New and Improved? Or Business As Usual?

So it appears at first blush the new regulations improve this process dramatically- now, according to 42 C.F.R. 411.39(c), the parties may obtain the final conditional payment demand in advance of settlement. In addition, 42 C.F.R. 411.39 (b) provides for enhanced functionality of the MSPRC web portal.

The new and improved process, as detailed in the regulations, sets forth the following procedure for obtaining Medicare's final conditional payment amount prior to settlement:

- **Medicare must be put on initial notice**: the beneficiary, beneficiary's attorney, or applicable plan (primary payer) must provide notice to Medicare of the impending settlement at least 185 days in advance of the settlement.
- **Medicare then has 65 days to post its initial claims compilation**: within 65 days of receipt of the initial notice, Medicare must post its payments made on the claim. (Medicare can extend the 65 days by an additional 30 days in certain circumstances).
- **After the posting of the initial claims compilation**: any time after Medicare's initial posting, the beneficiary, the beneficiary's attorney or the applicable plan, may notify Medicare once and only once the settlement is going to occur within 120 days.
- **This is the "Claims Refresh;" the parties request updated payment information via the web portal:** Medicare will provide the refresh within 5 days. (on or before 12/31/15)
- **After 1/1/16:** Beginning January 1, 2016, Medicare will provide an "uninitiated claims refresh via updated functionality of the web portal."

The regulations also provide a new way to dispute Medicare's conditional payment reimbursement demand. The beneficiary, his or her attorney or representative, may "once and only once" dispute Medicare's demand. All disputes are to be resolved with 11 business days of receipt of the dispute. If the dispute is fully resolved, and the beneficiary has obtained confirmation of a completed claims refresh, the beneficiary can then request a conditional payment summary. If the conditional payment summary is within three days of settlement, the summary becomes the final demand.

If the dispute is not resolved with Medicare, and the beneficiary is within 3 days of settlement, he or she may not request a final conditional payment amount.

Within 30 days of settlement, the beneficiary must provide Medicare with information about the settlement, including the date and total amount of the settlement. Failure to provide this information with 90 days of settlement renders the final conditional payment amount void.

Notice these provisions regarding the request for the final demand apply only to the Medicare beneficiary; so how do primary plans obtain the final demand in advance of settlement?

The regulations provide the applicable plan may also request the final demand in the manner outlined above as long as the plan is properly registered to access the web portal and has obtained from the beneficiary and provided to Medicare the proper release documentation- either a proof of representation or consent to release. The applicable plan may also obtain read only access with a consent to release.

Beginning January 1, 2016, the MSP web portal will include functionality to provide final MSP conditional summary forms and amounts.

V. The More Things Change, the More They Stay the Same

As of the date of the preparation of this handout, January 15, 2014, despite the fact, that by law, these new regulations changing the conditional payment process are effective, **nothing** has changed at Medicare. In other words- for all practical purposes, Medicare has not aligned its procedures to conform with the new regulations. Parties are still laboring under the process in existence pre-SMART Act (with the exception of the implementation and various improvements to the MSPRC web portal). When will this change? Perhaps by the time we are discussing this topic in April in Boca Raton- or perhaps not.

Practical Considerations

In the meantime, once Medicare does permit the parties to follow the new procedure, what are the practical implications raised by these regulations? For one, the upgrades to the web portal allowing all authorized users full visibility to conditional payment information is not expected to be completed until January 1, 2016. In other words, until January 1, 2016, anyone other than the beneficiary will need the actual conditional payment letter to see the diagnosis codes, provider names, dates of service, etc.- basically all of the information necessary to dispute the Medicare demand.

Also, as indicated earlier, do the regulations actually impose more restrictions on Workers' Compensation and No Fault plans? The regulations seem to say that all primary payers will need either a proof of representation or consent to release to access the web portal. Currently, Workers' Compensation and No Fault primary payers may directly access the portal provided they have the correct case identification number- no release is required. So is this a step backwards for Workers' Compensation and No Fault carriers?

It is also important to note the parties must still notify Medicare manually, either by phone, fax or mail, of the existence of the claim. The new regulations require parties to have notified Medicare of the existence of the claim at least 185 days prior to settlement in order to obtain conditional payment amounts in advance of settlement; this means in liability claims, the parties must still notify Medicare manually. It is also recommended that in workers' compensation and no-fault claims parties notify Medicare manually because it is not clear that a Section 111 ORM reporting will create a conditional payment lead.

Finally, will the parties really only be able to dispute Medicare's conditional payments using this new process "once and only once??" For example, the parties may successful complete their dispute of Medicare's conditional payments, yet fail to settle their case within the allotted time frame, are the parties prohibited from disputing any erroneous payments Medicare may make on the claim in the future? This is yet to be seen, but the implications are troubling.

VI. Primary Payer Appeal Rights

On December 27, 2013, Medicare published a proposed rule extending formal administrative appeal rights to applicable plans. The proposed rule would implement provisions of the SMART Act which require Medicare to provide a right of appeal process for applicable plans (liability insurance (including self-insurance), no-fault insurance and workers' compensation) when Medicare pursues a Medicare Secondary Payer (MSP) recovery claim directly from the plan.

Currently, if the MSP recovery demand is issued to the beneficiary as the debtor, the beneficiary has formal administrative appeal rights and final judicial review. The applicable plan, however, does not enjoy formal appeal rights. Medicare's contractor will address any dispute raised by the applicable plan as to the amount and charges contained on the recovery demand, but there is no multilevel formal appeal process.

The proposed regulations outline the following new procedure. When Medicare pursues recovery directly from the applicable plan, (in other words, when Medicare attempts to collect against the primary plan versus the Medicare beneficiary), the plan may participate in Medicare's existing administrative review process contained in subpart I of CFR Part 405. This review process consists of five steps: Redetermination by the MSPRC, Reconsideration by a Qualified Independent Contractor (QIC), a hearing before an administrative law judge, review by the Medicare Appeals Council (MAC); and once these levels have been exhausted, federal district court review.

VII. Haro v. Sebelius

On May 9, 2011, the United States District Court, D. Arizona enjoined Medicare from demanding reimbursement for conditional payments before the resolution of an appeal regarding the amount of the conditional payment (MSP) demand. *Haro v. Sebelius*, 789 F. Supp. 1179, 1197 (2011). The court also held Medicare's demand that

attorneys withhold liability proceeds from clients pending payment of amounts claimed by Medicare as MSP reimbursement exceeds its authority under the Medicare statute; consequently, the court enjoined Medicare from demanding attorneys withhold liability proceeds from their clients pending payment of disputed MSP reimbursement claims. *Id.*

Medicare appealed the district court decision to the Ninth Circuit, and on September 4, 2013, the Ninth Circuit reversed the district court and vacated the injunctions entered by the district court. *Haro v. Sebelius*, 729 F.3d 993 (2013). The court also remanded the case to the district court for consideration of the appellees' due process claim.

On January 2, 2014, the court concluded the district court lacked subject matter jurisdiction pursuant to 42 U.S.C. section 405 (g); therefore, the court denied Medicare's petition for panel rehearing and rehearing en banc by the Ninth Circuit.

This decision underscores the importance of the early determination of the parties' full exposure for Medicare reimbursement demands in advance of settlement; no longer are attorneys in the Ninth Circuit "protected" from Medicare collection claims in the event they decide to distribute settlement proceeds in advance of the final determination of the Medicare lien. In addition, it appears from the latest *Haro* ruling that the filing of an appeal or waiver request of Medicare's reimbursement demand will NOT toll the assessment of interest and penalties by the federal government if the Medicare lien is not satisfied within 60 days of Medicare's final demand.

It will be interesting to see how this ruling will be impacted by the ultimate adoption by Medicare of the new conditional payment regulations effectuated by the SMART Act. Since the parties, under the new regulations, will be able to obtain Medicare's final demand in advance of settlement, many of the challenges detailed by *Haro* may in large part become obsolete.