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**Conditional Payment Recovery Process**

**Introduction**
Any discussion regarding avoidance of issues concerning the Centers for Medicare and Medicaid (CMS) contractors and Treasury collection begins with understanding conditional payments made by traditional Medicare or a Medicare Advantage plan claimed by a Medicare beneficiary/claimant for injuries/illnesses that were incurred under a workers' compensation (WC), auto personal injury protection (PIP) or liability claims, premises liability or med pay claims, or medical malpractice claim. Conditional payments are defined under *42 U.S.C. §1395y (b)(2).* They arise when "payment has been made or can reasonably be expected to be made" by a primary plan. An exception to this occurs when payment is not reasonably expected to be made "promptly," or within 120 days of receipt of the claim by the primary payer. If Medicare then makes payments, there is a legal obligation to reimburse the Medicare Trust Fund.

**Medicare has a statutory right of recovery**
Since non group health plans (NGHP) reporting requirements were mandated by *Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)*, CMS and its Medicare Secondary Payer (MSP) contractors, as well as CMS' conditional payment recovery contractors are cross checking information already reported to CMS via Section 111 mandatory insurer reporting (MIR). As such, it is very important that the data fields that are electronically reported to CMS quarterly are correct and accurate. If not, conditional payment recovery becomes difficult and costly.

Because Medicare has a statutory right of recovery, workers' compensation insurers and self-insurers are primary payers to the Medicare program for Medicare beneficiaries' work-related illnesses or injuries. Medicare beneficiaries are required to apply for all applicable workers' compensation benefits and WC self-insured's or their third party claims administrators (TPAs) are to be billed first. If the item or service is reimbursable under Medicare rules, Medicare may pay conditionally, subject to later recovery if there is a subsequent settlement, judgment, award, or other payment, *42 C.F.R. § 411.21.*

Repayment is required [*42 U.S.C. 1395y(b)(2) (B)]* … if it is *demonstrated* that such primary plan has or had to make payment, accepted *responsibility* to pay, or released medical expenses in the settlement language to such item or service. *42 USC Section 1395y* indicates responsibility as a primary payer arises even if responsibility for the medical expense is contested. Primary payers always have the obligation to reimburse conditional payments.

**Primary payer responsibility is demonstrated** by an entry of a judgment, arbitration award, or by payment conditioned on a release or waiver of payment (settlement), even if liability or compensability is denied. When the total payment obligation to the claimant (TPOC) date and amount is reported to CMS via Section 111 mandatory insurer reporting (MIR), then a demand for conditional payments comes from CMS' Lead Contractor of the Benefits Coordination & Recovery Center (BCRC), formerly known as the MSPRC, if there is a settlement, judgment, award, or other payment.

Primary payer responsibility is also demonstrated when assumption of ongoing responsibility for medicals (ORM) as reported to CMS via Section 111 mandatory insurer reporting (MIR). This usually involves WC carriers and no-fault insurers. As of Oct. 5 2015, the Commercial Repayment Center (CRC) began sending out conditional payment notices (CPN) to insurers who have reported ORM to ascertain if repayment of conditional payment should be made.

In addition, the SMART Act, effective 7/10/2013, imposes a three (3) year statute of limitations on Medicare conditional payment recovery. Three (3) years from the date TPOC is received/acknowledged by CMS via Section 111 MIR. Not three years TPOC from the TPOC date reported and not three years from the prescribed quarterly reported date.

Over the past year, that ongoing responsibility for medicals (ORM) also "demonstrates responsibility" to pay and has triggered many more Conditional Payment Notices (CPN) that conditional payment recovery is anticipated and action must be taken within 30 days.

**Assumption of Ongoing Responsibility for Medicals (ORM) and Assignment of ICD codes**

Recall, that ORM refers to the responsible reporting entity (RRE)'s responsibility to pay on an ongoing basis for the injured party's (Medicare beneficiary's) medicals associated with the claim. The trigger for reporting ORM is the assumption or acceptance of ORM by the RRE, when the RRE has made a determination to assume responsibility for ORM, or is otherwise required to assume ORM. The trigger for reporting ORM is not when (or after) the first payment for medicals under ORM has actually been made. In other words, medical payments do not actually have to be paid for ORM reporting to be required and the dollar amounts for ORM are not reported, just the fact that ORM exists or existed.

Section 111 MIR is required for workers' compensation ORM that existed or exists on or after January 1, 2010 with the following exception:

a) The claim is for "medicals only;
b) The associated "lost time" is no more than the number of days permitted by the applicable workers' compensation law for "medicals only" (or 7 calendar days if applicable law has no such limit);
c) All payment(s) has/have been made directly to the medical provider; AND
d) Total payment for medicals does not exceed $750.00

In addition, it is critical to report ORM claims with information regarding the cause and nature of the illness, injury or incident associated with the claim. This is reported to CMS via ICD 10 codes. Medicare uses the information submitted in the Alleged Cause of Injury, Incident or Illness (Field 15) and the ICD Diagnosis Codes (starting in Field 18) to determine what specific medical services claims, if submitted to Medicare, should be paid first by the RRE and considered only for secondary payment by Medicare. The ICD-9/ICD-10 codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying injury, incident or illness claim reported by the RRE.

While ICD-9 causation codes (E-codes) are not required via MIR, if correctly reported, may help in limiting the items and services added to the conditional payment itemization. ICD-10 Z codes may also give you clues to causation. The CMS conditional payment recovery contractors will list both ICD-9 or ICD-10 codes as they apply on the date of service billed.

Each ICD under each date of service involving a health care provider must be looked up to determine the code description and whether a conditional payment related to the underlying claim. Initially if you deem your claim compensable involving an employee who alleged an injury/illness that arose out of or in the course of employment, carefully select the ICD code(s) that best describes the injury/illness. Avoid using ICD codes for degenerative or chronic conditions if the injury/illness is acute. Do not report ICD codes for which you do not intend to assume ongoing responsibility for medicals (ORM) otherwise known as compensability. Do not report ICD codes or assume ORM for a totally denied claim in which you have made no indemnity or medical payment.

The ORM information is shared within CMS involving all MSP contractors and the ORM and ICD reported leads to the items and services included in the Conditional Payment Statement of Reimbursement (SOR) and Payment Summary. The Common Working File (CWF) is a Medicare application that maintains all Medicare beneficiary information and claim transactions. The CWF receives information regarding claims reported with ORM so that this information can be used by other Medicare contractors (COB, CRC, BCRC, and WCRC) for claims processing. This ensures Medicare remains secondary when appropriate, and informs Medicare to seek reimbursement of conditional when payments have been made that are the responsibility of the primary payer or applicable plan.

**Arguments and Defenses for Disputing and Appealing Unrelated Conditional Payments**
CMS routinely holds primary payers responsible for the entirety of any bill for medical treatment or services which contains at least one related diagnosis code subject to an MSP exclusion, regardless of what treatment was actually rendered during the appointment or what was the chief complaint or reason for the provider encounter.

Physician offices list all possible ICD related codes associated with a patient on the evaluation & management reimbursement code because it has a higher reimbursement rate if the provider can justify that consideration of the co-morbidities made the diagnosis and treatment plan more complicated or time consuming.

In a recent but non-precedent setting case, *CALIFORNIA INSURANCE GUARANTEE ASSOCIATION v. BURWELL, et al. (UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, January 5, 2017, appealed in 2017 and pending),* the decision stated that a physician's decision to co-mingle visits, bundle, or over-code its bills does not legally render a primary payer responsible for unrelated medical services. The opinion stated that CMS's interpretation of the MSP and the relevant regulations are contrary to the underlying state WC law, not automatically subject to federal preemption, and not entitled to CMS deference. The court stated that CMS may be unintentionally acknowledging that payments made by CMS in workers' compensation claims are not made conditionally, but apparently by mistake. In addition, the Court ruled that the CMS practice of seeking full reimbursement of a medical provider's single charge, even where some unsegregated (bundled) portion of that charge relates to services *not* covered by a workers compensation plan, was improper under the Medicare Secondary Payer Statute (MSP) and its supporting regulations.

Although not primary legal authority, *CIGA v. Burwell* should be used to challenge bundled conditional payments in over-inclusive CMS demands. Use the California Insurance Guarantee Association (CIGA) challenge that CMS's conditional payment claim for certain charges unrelated to the underlying workers compensation claim for which it was not responsible under California WC law, the law that controls the claim and creates MSP rights.

Cite *42 C.F.R. 1003.101* that defines this phrase as *"[a]ny item, device, medical supply or service provided to a patient (i) which is listed in an itemized claim for program payment or a request for payment…."* The court, contrary to CMS' position, concluded the phrase does not refer to multiple treatments just because they appear under one charge—noting the singular form of the phrase. The court stated that whether a WC payer has a "responsibility to make payment" for an "item or service" is a matter of state law and concluded that CMS calculates reimbursement demands contrary to any statute, regulation, or policy manual.

In addition to ORM assumption, ICD codes reported, a frequent error that complicates conditional payment recovery is the failure to properly terminate and report to CMS the ORM termination date. ORM may end when:

a) an authorized treating physician indicates no further medical care related to the claim is needed or anticipated
b) there is a judicial determination that medical care related to the claimed accident or injury is no longer necessary. There must be a hearing on the merits, not just an agreement or stipulation by the parties
c) the statute of limitations (SOL) has expired
d) the Medicare beneficiary deceased
e) or the RRE otherwise no longer has ORM responsibility

When ORM ends, the RRE reports an ORM termination date via Section 111 mandatory insurer reporting (MIR). ORM Termination Date signals to Medicare the last date on which the RRE had ongoing responsibility for medical care associated with the claim. Any payments made by Medicare thereafter are to be considered primary, or Medicare's responsibility.

**Pre-Settlement the Commercial Repayment Center (CRC) issues the Conditional Payment Notice (CPN) if the RRE has assumed and reported ORM**

Pre-Settlement Commercial Repayment Center Conditional Payments Resolution begins with a CRC Conditional Payment Notice (CPN). As of October 2015, if the RRE has accepted ORM, the Commercial Repayment Center (CRC) will identify conditional payments related to the claim made by Medicare. A Conditional Payment Notice (CPN) will then be issued to the applicable plan and its Recovery Agent as documented in the RRE tax identification number (TIN) file. If the applicable plan's primary payment responsibility does not terminate and the CRC identifies additional conditional payments, further CPNs may be issued for these additional conditional payments.

**CPN-CRC Dispute**

Applicable plans have the opportunity to dispute medical claims identified on the CPN before a formal request for repayment, or demand, is issued. Applicable plans have only 30 days from the date of the CPN to dispute whether the payments included in the CPN are related to the claim and owed to Medicare. If the applicable plan believes that any claims included in the CPN should be removed, documentation supporting that position must be sent to the CRC. If the applicable plan does not

respond within 30 days, CRC will assume such charges are related to the claim and will forward a demand letter.

**CRC Demand-Initial Determination**

If one or more conditional payments remain following the dispute response period, a demand letter, or initial determination, is issued. This is the CRC's first request for payment. The applicable plan will have 60 days within which to make payment without being charged any interest. Payments made after the 60 days will be charged interest from the date of the demand/determination letter. If the applicable plan disagrees with the CRC's demand/determination, an appeal may be filed. Once the demand is issued, recovery agents will need to submit signed letter of authority (LOA) to continue working with the CRC on behalf of the applicable plan.

**CRC Appeals Process**

Applicable plans may pay/appeal the amount or existence of the debt, in part or in full. Applicable plans have an opportunity to initiate the formal appeal process by requesting a redetermination. The request for redetermination must be filed within 120 days of the date of the demand/determination. If dissatisfied with the CRC's redetermination, applicable plans may request reconsideration within 180 days of the date of the redetermination. Formal appeals process available thereafter also includes a request for a hearing by an Administrative Law Judge, request for review by the Medicare Appeals Council, and United States federal court action.

**Referral to US Treasury and US Justice**

Interest accrues monthly from the date of the demand/determination letter and is assessed if the debt is not resolved within 60 days. Even if a timely request for redetermination is filed, interest will continue to accrue on a monthly basis. If no appeal is filed, and the debt continues to be unresolved for 120 days, the CRC will issue a Notice of Intent to Refer (NITR) letter informing the applicable plan of next steps should the debt remain unpaid, including referral to the United States Department of Treasury (DOT) for collection.

Often one of four DOT collections contractors will reach out to the applicable plan to collect the debt. If the debt remains unpaid, DOT may refer debt to IRS for payment. IRS has authority to intercept or offset any payments owed to the debtor in collection of amount due to DOT once the debt is considered delinquent (60 days) under the Debt Collection Improvement Act of 1996 when they are unaware of an appeal pending review.

**Pre-settlement Benefits Coordination Recovery Center (BCRC) Conditional Payments Resolution**

Claimant/claimant's counsel, as well as Defendant/Employer/Carrier/TPA can call in or fax information about the claim. After the BCRC becomes aware of a claim, an MSP occurrence is posted, and the Benefits Coordination Recovery Center (BCRC) sends the beneficiary a Rights and Responsibilities (RAR) letter. The RAR letter explains what happens after a Medicare beneficiary files an insurance or workers' compensation claim, what information the BCRC needs, and what information the Medicare beneficiary can expect from the BCRC. The attorney/representative/agent will receive a copy of the RAR from the BCRC if they have submitted a Consent to Release form. With that form on file, the attorney/representative/agent will also be sent a copy of the Conditional Payment Letter (CPL). Within 65 days of the issuance of the RAR Letter, the BCRC will send the CPL and Payment Summary Form (PSF). The PSF lists all items or services that Medicare has paid conditionally which the BCRC has identified as being related to the pending claim. The CPL explains how to dispute any unrelated claims

and includes the BCRC's best estimate, as of the date the letter is issued, of the amount Medicare should be reimbursed (i.e., the interim total conditional payment amount).

**BCRC Dispute Pre-settlement by Requesting an Insurer Conditional Payment Letter**
If beneficiary/representative/agent believes that any claims included on CPL/PSF should be removed from Medicare's interim conditional payment amount, beneficiary/representative/agent may dispute any unrelated payments by providing supporting documentation to the BCRC. Any individual/entity representing the beneficiary in such a dispute will need to provide an Appointment of Representative form signed by the Medicare beneficiary. The BCRC will adjust the conditional payment amount to account for any claims it agrees are not related to what has been claimed/released. If BCRC determines that the documentation provided at the time of the dispute is not sufficient, the dispute will be denied. Pre-settlement, one may continue to dispute payments until settlement, judgment, award, or payment.

**Post Settlement BCRC Appeal of demand-initial determination**
When there is a settlement, judgment, award, or other payment, the beneficiary/representative/agent should notify the BCRC. The information sent to the BCRC must clearly identify: 1) date of settlement, 2) settlement amount, and 3) amount of any attorney's fees and other procurement costs borne by the beneficiary. The BCRC will identify any new, related claims that have been paid since the last time the CPL was issued up to and including the settlement/judgment/award date. BCRC will issue a recovery demand letter advising the Medicare beneficiary of the amount of money owed to the Medicare program. Interest on BCRC's determination or demand accrues from the date of the demand letter, but is only assessed if the debt is not repaid or otherwise resolved within 60 days of the recovery demand letter. Interest is due and payable for each full 30-day period the debt remains unresolved.

Unless successfully challenged, the only way to avoid interest is to repay the demanded amount within the specified time frame and if you still disagree, request waiver/appeal. If the waiver/appeal is granted, the payer will receive a refund. The beneficiary/representative/agent has the right to appeal Medicare's demand if they disagree that any of the claims paid by Medicare are not owed back to Medicare.
The appeal (Redetermination) must be filed no later than 120 days from the date of BCRC's determination. The next appeal (Reconsideration) must be filed no later than 180 days from the date of the Redetermination. The third level of appeal (Hearing by ALJ) must be filed within 60 days from the date of the Reconsideration. The next appeal (MAC) must be filed within 60 days from the date of the ALJ's decision. The final level of appeal to the United States District Court (USDC) must be filed within 60 days from date of MAC's decision.

**BCRC Referral to US Treasury and US Justice**
If a debt remains outstanding more than 60 calendar days after the demand letter date, it will be considered delinquent. The debtor is notified of delinquency through a Notice of Intent to Refer letter (NITR) to the Department of Treasury (DOT) Offset Program for further collection activities. CMS may also refer debts to the Department of Justice (DOJ) for legal action if it determines that the required payment or a properly documented defense has not been provided.

The NITR provides 60 calendar days for a response to be sent to the BCRC before the debt is referred to DOT. Interest accrues from the date of the demand letter or "initial determination: and is assessed for each 30 day period for which the debt remains unresolved. Interest continues to accrue and it is assessed monthly while a debt is under appeal. Interest is recalculated and refunded if the appellant is

successful on appeal. If you are only challenging part of the demand, consider payment of the amount you aren't challenging. Then, interest will only accrue and be assessed on the amount being challenged.

**Identified debtor**

Where there is a settlement, judgment, award, or other payment, CMS may recover from the primary payer, the Medicare beneficiary, or any other entity receiving payment from the primary payer. In general, where the primary payer has ongoing responsibility for medicals (ORM), CMS pursues recovery from the primary payer. For ORM, there may be multiple recovery efforts by the CRC to account for the period of ORM reported and assumed. In general, where there is Total Payment Obligation to the Claimant (TPOC) settlement, judgment, award, or other payment, CMS pursues recovery from the Medicare beneficiary. In some cases, there may be a combination, a recovery related to the ORM from the primary payer and a recovery from the Medicare beneficiary's TPOC

**Applicable Plan/RRE/ Insurer/Self-Insurer as the Identified Debtor**

When the applicable plan/RRE/ insurer/self-insurer is the identified debtor, only the applicable plan is a party to the appeal. *42 CFR 405.906*. The Medicare beneficiary will receive a notice that the applicable plan has filed an appeal, but the beneficiary is not a party and does not participate in the appeal. *42 CFR 405.947 and 405.906*

**Strategies to Challenge Conditional Payments**

A. Look up each ICD code description listed in the BCRC's Payment Summary or CRC's Summary of Reimbursement

B. Determine whether conditional payments are related to compensable body parts accepted. Revisit as often as necessary

C. Seek to remove unrelated conditional payments

D. Ascertain if a CMS approved WCMSA will help with Conditional Payments disputes

E. Is there a statute of limitation defense arguments in reducing conditional payments

F. Frame your defenses and arguments and communicate them simply, using only relevant conditional payment issues.

G. Determine what supporting documents are needed to support your defenses or arguments:

    i) Copies of pleadings/demands, amended pleadings/demands that show what injuries were claimed and alleged or have been rescinded

    ii) Copy of CMS approved zero MSA, if applicable, to show Medicare has already reviewed the case and deemed Medicare's interest has been adequately considered.

    iii) Relevant medical records that support certain ICD code descriptions are unrelated comorbid conditions, pre-existing conditions, or injuries/illness not claimed, alleged, or "in effect" released.

    iv) Recent retroactive ORM termination date reported

    v) Recent retroactive ICD code corrections made based upon IME, medical records, judicial ruling

vi) WC statutes that show statute of limitations or other relevant statutes

H. Prepare well in advance and take the lead to determine:

i) Who obtains and negotiates CP recoveries allegedly owed

ii) Who will reimburse Medicare the conditional payments already made

iii) Whether the conditional payments be paid within or in additional to the total settlement amount

iv) If specific settlement language is needed, prepare and have it at the mediation for mediator to include.

**Consequences for failure to Report Properly and Reimburse CMS**

A. Fines up to $1,000 per day per claim if not reported properly via Section 111 mandatory insurer reporting (MIR).

B. Potential private cause of action (PCOA) suit filed against the employer and insurer by Medicare and/or the Medicare beneficiary and/or the health care provider that includes double damages, not to mention 6 figure defense costs

C. Potential for False Claim Act (FCA) lawsuit filed against the employer and insurer for submitting false information in reporting your settlement to Medicare

D. CMS may refuse to recognize settlement

E. Medicare may refuse future benefits to claimant

F. A public relations nightmare

G. Potential loss of clients and business

**Claims Best Practices as it pertains to Conditional Payments-Check List**

A. Don't assume that conditional payments are a problem for just the claimant or the claimant's attorney. In reality, Medicare can recover its payments from "any entity, including a beneficiary, provider, supplier, physician, attorney, State agency, or private insurer…" *42 CFR 411.24(g).*

B. Determine early if Medicare believes there are related conditional payments owed as soon as you have completed a query to determine whether claimant is Medicare eligible or a Medicare beneficiary

C. Conditional payment amounts *should be* resolved at the time of the settlement, judgment, or award.

D. Conditional payment amounts must be searched for, obtained, reviewed for relatedness, completeness, and accuracy to include charges billed and paid, diagnosis and procedural billing codes (ICD).

E. Know the difference between disputing conditional payment owed pre-settlement and appealing the initial determination/demand

F. Date stamp all documents received from the CRC or BCRC. Set diary dates to be sure specific deadlines are met well in advance especially if an MSP vendor is counting on you to provide supporting documentation in order for them to act on your behalf

G. Reconcile and use correct BCRC Case ID Numbers or CRC Recovery ID Numbers with Medicare Identifier Number, Industry Date of Incident, CMS Date of Incident to avoid many different conditional payment letters pertaining to the same claim.

H. Use the correct terminology when disputing conditional payments and when appealing conditional payments or the communication to the BCRC may get misrouted

I. If the initial determination/demand, ascertain whether who is the addressee (debtor) or whether the claimant/Medicare beneficiary is the addressee.

J. If no proof of representation (POR) or consent to release (CTR) is on file with the CRC or BCRC, you may not receive an initial determination/demand if recovery is directed to the Medicare beneficiary.

K. Conditional payment repayment terms and conditions must be included in settlement negotiations.

L. Whenever possible write two separate checks, one to claimant and claimant's attorney and the other to the BCRC/CRC.

M. Confirm the CPs have been fully satisfied from BCRC/CRC before closing your claim file.

N. Document in claim file the basis of your decisions and actions and include supporting documentation in the event you are later challenged.

O. Set diary date 3 years from date ORM was terminated and TPOC was reported since statute of limitations for CMS recovery expires then.

P. Don't rely on defense counsel to know all MSP compliance issues.

Q. Become an expert in MSP compliance issues. They are an integral part of claims handling that are here to stay.

**Reality Check**

A. You waited until the MSA was done and a settlement amount was agreed upon before checking to see if there were any conditional payments owed to Medicare

B. The amount of conditional payments owed exceeded your reserves or settlement authority

C. You check for conditional payments with the BCRC/CRC and there were none but your claimant has a Medicare Advantage plan. Two years later you are sued to recovery conditional payments owed plus double damages.

D. Two years after settlement you receive notice that the conditional payment debt has been sent to the Department of Treasury to collect

E. One year after settlement you receive suit papers showing that you have been sued by HHS Secretary and/or the Medicare beneficiary for conditional payments not repaid claiming double damages. Defense counsel retained to defend charges $750/hour.

F. Unrepresented claimant contacts you six months after settlement to tell you that Medicare has refused to pay for her lumbar fusion recently recommended. ORM date was not terminated after settlement and still shows that RRE has accepted ongoing responsibility for medicals via Section 111 MIR

G. ORM ICD injury/diagnosis codes are inconsistent with MSA compensable codes

H. Settlement language did not address who would repay conditional payments

I. Settlement language did not include a waiver of a private cause of action

J. Settlement language stated that Medicare beneficiary would repay conditional payments from the settlement proceeds but did not and claimant has since died.