

PROTECTING MEDICARE'S INTERESTS FOR CONDITIONAL PAYMENTS: THE TIME IS NOW

New Amendments to the Code of Federal Regulations Affect Primary Payer Compliance

Just as the smoke is clearing from the recent passage of Senate Bill 2499, amendments were made in late February to key sections of the Code of Federal Regulations (CFR) affecting the *current* obligations of primary payers to protect Medicare's interests regarding conditional payments.¹ These amendments and discussion related thereto are outlined in the Federal Register referenced at 73 Fed. Reg. 9679 (February 22, 2008). The new amendments serve as another example of CMS' intent to more strictly enforce its rights against primary payers under the Medicare Secondary Payer Statute (MSP).²

These revisions to the CFR were announced as part of CMS' "final rule" in relation to Title III of the Medicare, Prescription Drug Improvement, and Modernization Act of 2003 (MMA).³ The amendments pertain to 42 C.F.R. § 411.22 and 42 C.F.R. §411.25. As stated in the preamble, these sections "*have been amended to further clarify the reimbursement and notice requirements of primary*

payers."⁴ The amended regulations become effective on March 24, 2008.⁵

With much of the industry still abuzz over the impact Senate Bill 2499 will have after it becomes effective on July 1, 2009; primary payers must not lose sight of the fact that they *currently* have a statutory obligation to reimburse Medicare for conditional payments. In this regard, the recently announced amendments to 42 C.F.R. § 411.22 and 42 C.F.R. §411.25 strike at the very heart of these *current* obligations and serve as a stark reminder that Medicare's interests must be protected.

This article addresses the substantive changes made to 42 C.F.R. § 411.22 and 42 C.F.R. §411.25 and presents a "nuts and bolts" outline of practical approaches for all primary payers to consider in meeting their *current* obligations under the MSP, as well as in preparation of the forthcoming requirements per Senate Bill 2499.

¹ As used in this article, "primary payer" relates to a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) and no fault insurance. See, 42 U.S.C. § 1395y(b)(2)(A) and 42 C.F.R. § 411.20 (a)(2). Under the MSP, this term includes, but is not limited to, insurers, self-insurers and third party administrators. 42 C.F.R. § 411.21. Group health plans are also covered under the MSP. The obligations of group health plans and other forms of insurance under the MSP are *not* included within the scope of this article. Generally stated, a "conditional payment" can be defined as a payment made by Medicare for which a primary payer has or had responsibility. See, 42 C.F.R. § 411.21.

² 42 U.S.C. § 1395y. Historically, Congress enacted the MSP in the 1980's in an effort to protect the financial integrity of the Medicare program. The MSP has been amended several times over the past 25 years to further solidify Medicare's rights. The most recent amendment is embodied in Senate Bill 2499 discussed herein.

³ In conjunction with the passage of the MMA back in 2003, CMS published an "interim final rule with comment period" on February 24, 2006 which made several amendments to the CFR to effectuate the provisions of the MMA. See, 71 Fed. Reg. 9466 (February 24, 2006). The now enacted "final rule" makes further clarifications and changes to the CFR as discussed herein.

⁴ 73 Fed. Reg. at 9683 (February 22, 2008). In addition to these sections, minor nomenclature changes were made to 42 C.F.R. § 411.45.

⁵ 73 Fed. Reg. at 9679 (February 22, 2008).

PART I:

Primary Payers Have an Obligation to Reimburse Medicare for Conditional Payments

Medicare's Right of "Reimbursement" and the Related Concept of "Notice"

Under the MSP, Medicare is considered as the secondary payer in the context of workers' compensation, liability (including self insurance) and no-fault claims.⁶ In this regard, primary payers are obligated to reimburse Medicare for conditional payments. Medicare's rights are set forth in 42 U.S.C. § 1395y(b)(2)(B)(ii) which states as follows:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund [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 (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

Additionally, under the CFR a primary payer's "responsibility" may also be demonstrated by a "settlement" or "contractual obligation."⁷ It is important to note that based on these sections CMS appears to have the right to claim conditional payment reimbursement in denied/disputed cases.

With respect to repayment, if CMS does not need to take legal action, the amount of recoverable conditional payments is the lesser of either the Medicare primary payment, or the amount of the full primary payment that the

primary payer is obligated to pay.⁸ If it is necessary for CMS to take legal action, Medicare can seek double damages.⁹ Medicare's claim may be reduced by procurement costs.¹⁰

Medicare is armed with broad enforcement rights under the MSP. Medicare has a direct right against all primary payers responsible for making payment¹¹ and any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer.¹² Medicare also has a subrogation right, as well as rights of joinder and intervention.¹³

Thus, primary payers clearly have an obligation to reimburse Medicare for conditional payments and that obligation exists currently. As noted, a "settlement" is one of the factors that establishes primary payer responsibility for conditional payment reimbursement. Given that a vast majority of cases settle, the MSP has significant applicability and needs to be considered as part of the settlement process.¹⁴

A companion consideration to Medicare's right of reimbursement involves the concept of "notice." *That is, when must a primary payer place Medicare on "notice" of a claim that could implicate their interests?* This is where 42 C.F.R. §411.25, and eventually Senate Bill 2499, enter the picture.

The current version of 42 C.F.R. §411.25(a) provides that *"if a primary payer learns that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary*

⁶ As noted, the MSP also applies in the group health context. This is a reminder that applicability of the MSP to group health claims is not included as part of this article.

⁷ 42 C.F.R. § 411.22 (b)(3).

⁸ 42 C.F.R. §411.24(c)(i)(ii).

⁹ 42 U.S.C. § 1395y (b)(2)(B)(ii), 42 CFR 411.24 (c)(2).

¹⁰ 42 C.F.R. §411.37.

¹¹ 42 U.S.C. § 1395y (b)(2)(B)(ii).

¹² 42 C.F.R. §411.24(g).

¹³ 42 C.F.R. §411.26.

¹⁴ It is important to note that other events aside from "settlements" can demonstrate primary payer responsibility. Specifically, a "judgment" or "contractual obligation" can establish responsibility on the primary payer. In addition, this responsibility could be established "by other means." It is unclear what may constitute a "contractual obligation" or what may fall under the concept of "by other means." Thus, determining exactly when "responsibility" of a primary payer is demonstrated in cases *not* involving settlements may pose difficulties. A discussion into these factors is beyond the scope of this article. Nonetheless, it is important to remember that a "settlement" is not the only factor that could establish primary payer responsibility. See, 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. § 411.22 (b)(3).

payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.” (Emphasis added).

Accordingly, a primary payer is currently obligated to place Medicare on “notice” when it “learns” that Medicare has made a payment which the primary payer either made itself or should have made. Obviously, what constitutes “learns” figures prominently in terms of determining the obligation. Apparently, CMS interprets “learns” to mean “is, or should be aware.”¹⁵ While this interpretation provides some guidance, the actual nature and extent of the obligations of primary payers under the “learns” standard is far from clear and, conceivably, could result in Medicare not being apprised of cases implicating their interests and placing primary payers at risk.

Now, 42 C.F.R. §411.25(a) has just been amended as follows:

If it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer had made or should have made primary payment, it must provide notice about primary payment responsibility and information about the underlying MSP situation to the entity or entities designated by CMS to receive and process that information. (Emphasis Added).

So, how does the amended version of 42 C.F.R. §411.25(a) change the picture?

The amended regulation indicates that “notice” must be provided when it is “demonstrated” that Medicare has made a payment which a primary payer has made or should have made. As will be noted, the amended regulation deleted the word “learns.” The term “demonstrate” under the amended section is not defined in the CFR. However, in discussing this amendment it was indicated that “*a demonstration of the primary payers responsibility includes a judgment, a payment conditioned upon the recipients compromise, waiver and release [whether or not there is a determination or admission of liability of*

*payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means].”*¹⁶

This language may sound familiar as it is essentially a key part of 42 U.S.C. § 1395y(b)(2)(B)(ii) which, as noted above, establishes Medicare’s *reimbursement* right. Assuming that this comment indicates CMS’ interpretational intent, it would appear that the obligation of “notice” under amended §411.25(a) would be based on the same factors that establish Medicare’s “reimbursement” right under the statute. In light of potential interpretational uncertainties, it may be prudent to play it safe and place Medicare on “notice” in accord with §411.25(a) as well as in other potential situations where the primary payer is, or could be considered primary.

Ok, so how will Senate Bill 2499 change the process?

Perhaps a helpful way to look at Senate Bill 2499 is to view it as the next step in CMS’ evolving process of establishing more strident requirements to increase primary payer compliance with the MSP.¹⁷ Thus, Senate Bill 2499 should not be interpreted as somehow suddenly “creating” an obligation on primary payers to protect Medicare’s reimbursement rights as of July 1, 2009. That right exists now and has for over 20 years.

Senate Bill 2499 places an affirmative obligation on primary payers to (a) determine if the claimant is entitled to Medicare and (b) notify Medicare of said entitlement as specifically required. An important feature of the new legislation is the expressed requirement that primary payers determine a claimant’s Medicare status. This change is significant as this obligation is not technically required under the current statutory or regulatory framework. Specifically, primary payers must “*determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis.*”¹⁸ Based on the exact wording of this section, it appears that this obligation will extend to all cases, whether or not resolved.

¹⁵ See e.g., 73 Fed. Reg. at 9683 (February 22, 2008).

¹⁶ 73 Fed. Reg. at 9683 (February 22, 2008).

¹⁷ President Bush signed Senate Bill 2499 into law on December 29, 2007 which will make significant changes to the MSP effective July 1, 2009. The new legislation applies to workers’ compensation, liability insurance (including self-insurance), no-fault and group health insurance. It is important to note that the amendments and related requirements pertaining to group health carriers are addressed separately under the bill. See, Section 111(a)(7) of Senate Bill 2499. The requirements of Senate Bill 2499 as same pertain to group health insurance are not included as part of this article. Please note that the author provided an in depth analysis of Senate Bill 2499 in an article entitled *Just In Time For The NewYear... New Amendments To The Medicare Secondary Payer Statute*, NuQuest/Bridge Pointe “Settlement News,” January 2008. This article can be obtained by logging onto www.NOQP.com (select “Resource Library” and then choose “Newsletters”).

¹⁸ Section 111(a)(8)(A)(i).

If it is determined that the claimant is entitled to Medicare, then the primary payer must put Medicare on notice “*within a time specified by the Secretary after the claim is resolved through settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).*”¹⁹

Overall, Senate Bill 2499 further delineates the obligations and expectations of primary payers and establishes at least some semblance of a process to be followed (albeit a bit rudimentary at this point). Notwithstanding, key aspects of the notice and reporting obligations remain unknown at this time. For instance, under the legislative text the only known information required to be included in the “notice” to Medicare is the “identity of the claimant.”²⁰ It is unknown if CMS will require “notice” be provided only with respect to “resolved” cases (as would seem to be indicated by the legislative text) or if it will also require that notice be given regarding “unresolved” claims. Furthermore, the exact time period within which the required “notice” is to be given is unknown. Under the legislation, the Secretary of Health and Human Services is to provide this and other relevant information at a later date.

Perhaps the most significant feature of Senate Bill 2499 is the substantial civil penalty for non-compliance — \$1,000.00 per day, per claim which is in addition to any other penalties available at law.²¹

New Amendments Related to Making Payment – Primary Payers Must Make Proper Payment

The recently announced amendments also make significant changes regarding the obligations of primary payers in making the actual reimbursement payment to Medicare. Specifically, a new subsection was added to 42 C.F.R. §411.22 which reads as follows:

(c) The primary payer must make payment to either of the following:

(1) To the entity designated to receive payments if the demonstration of primary payer responsibilities is other than receipt of a recovery demand letter from CMS or designated contractor.

(2) As directed in a recovery demand letter.

The intent of this amendment appears to be to clarify that a primary payer “must” make payment to CMS as opposed to any other individual or entity.²² This interpretation would appear to be supported by the general comments discussed in the Federal Register regarding Medicare’s reimbursement rights under the MSP. Specifically, it is stated that “*This means that a primary payer may not extinguish its obligations under the MSP provisions by paying the Medicare beneficiary or the provider when it should have reimbursed the Medicare program. Primary payers are expected to reimburse CMS when it is demonstrated they have or had payment responsibility.*”²³

Accordingly, it appears that primary payers would place themselves at risk by providing reimbursement to anyone or any entity other than CMS. Thus, issuing the reimbursement to the claimant or the medical provider should be avoided.

Another important point was raised regarding CMS’ authority to pursue conditional payment reimbursement. Specifically, a commenter suggested that §411.22 could be interpreted to allow Medicare to seek its reimbursement from the provider *first*, before going to the primary payer. This interpretation was *rejected* and it was noted that the MSP “*gives Medicare the authority to recover from the party responsible for making primary payment; any entity that has received a primary payment from Medicare and a primary plan; and from providers, physicians, and other suppliers who fail to file a proper claim. Accordingly, it would be inappropriate to limit Medicare’s recovery options.*”²⁴

The above statement is important in that it reflects CMS’ apparent position that its authority under the MSP is not subject to any procedural priority considerations or limitations – it may proceed against the primary payer to obtain its reimbursement without first pursuing the provider (or other potential parties) to obtain reimbursement.

¹⁹ Section 111(a)(8)(C).

²⁰ Section 111(a)(8)(B)(ii).

²¹ Section 111(a)(8)(E)(i).

²² With regard to the actual application of this section in practice, CMS stated that it “*will provide notice as to where and in what format the repayment should be made.*” This will hopefully provide further practical guidance to primary payers. 73 Fed. Reg. at 9682 (February 22, 2008).

²³ 73 Fed. Reg. at 9680 (February 22, 2008).

²⁴ 73 Fed. Reg. at 9682 (February 22, 2008).

PART II:

The Time Is Now For Primary Payers To Develop Work Flow and Processes to Protect Medicare's Interests For Conditional Payments

Under the MSP, the obligations of primary payers to protect Medicare's interests are well established. Admittedly, the MSP is far from perfect from an interpretational standpoint on some of the finer points of application. However, it is important not to lose sight of the forest for the trees. At the end of the day, it is clear that primary payers must protect Medicare's interests with regard to conditional payments – and that obligation exists today. Failure to do so could result in significant financial consequences, which will be augmented significantly once Senate Bill 2499 becomes effective.

Accordingly, it is incumbent upon all primary payers to develop and implement workflows and related processes as part of their claims handling to assure that Medicare's interests are adequately protected. The time is now for primary payers to roll up their sleeves and tackle this important area.

Since 2001, NuQuest/Bridge Pointe (“NuQuest”) has led the way nationally in helping primary payers develop necessary workflow and processes to address the issue of conditional payment identification and reimbursement. The increasing importance of this issue demands nothing less than the proven competence and experience NuQuest offers.

NuQuest has a host of services to assist primary payers from Social Security & Medicare Status Determination, to Medicare Conditional Payment Identification, to Medicare Conditional Payment Claim Investigation. Through our experience, NuQuest is uniquely qualified to partner with all primary payers in developing their required work processes to meet the increasing obligations under the MSP. NuQuest stands ready to help you get this job done.

In this regard, all primary payers should consider implementation of the following practical approaches:

Identify Cases That Involve Medicare Beneficiaries

There are certain factual “red flags” that may indicate Medicare entitlement including:

- Claimant's Age. Claimants who are 65 or older are likely Medicare entitled based on their age.
- Claimant has not worked for 30 months or more as a result of his injury related disability. This could suggest the claimant may be entitled to Medicare based on disability.
- Claimant has been receiving SSD for 24 months. As noted above, a claimant will become Medicare entitled as part of his/her SSD award. In most cases, a claimant becomes entitled to Medicare after receiving SSD for 24 months. However, it is important to keep in mind that in certain situations a claimant's SSD award and corresponding Medicare benefits could be awarded retroactively.

NuQuest's “Social Security & Medicare Status Determination” service is specifically designed to determine social security and Medicare status.

Reporting & Conditional Payment Identification

If it is determined that the claimant is a Medicare beneficiary, then the following activities should be undertaken:

- (a) Report the case to the Medicare Coordination of Benefits Contractor (COBC)
- (b) Request a conditional payment estimate from the Medicare Secondary Payer Recovery Contractor (MSPRC).

There are several advantages to reporting the case up to the COBC as soon as it is determined that the claimant is a Medicare beneficiary and obtaining a conditional payment estimate. These advantages include:

- Medicare will “flag” its database related to the reported accident related injuries. This will help reduce/eliminate future conditional payment accrual.
- Obtaining conditional payment estimates during the course of the claim (as opposed to waiting until the time of settlement) allows the time necessary to investigate and request removal of inappropriate claims. In turn, this helps accurately quantify exposure for reserve setting and settlement authority.

- As outlined in Part I above, failure to report may result in significant civil penalties under Senate Bill 2499 beginning July 1, 2009.

NuQuest's "Medicare Reporting & Conditional Payment Identification" service addresses all these areas.

Conditional Payment Claim Investigation

The conditional payment estimates received from the MSPRC must be scrutinized carefully to assure that inappropriate claims are identified and removed. This can be a very tedious and involved process. Notwithstanding, this is an extremely important task to avoid providing reimbursement for non-claim related services.

NuQuest's "Conditional Payment Claim Investigation" service helps primary payers in this important area. NuQuest has a dedicated unit uniquely experienced in dealing with Medicare in this respect.

NuQuest continues to monitor all major events and announcements in this area, including the forthcoming information expected to be provided in relation to Senate Bill 2499 in order to assure that work flows and processes comport with all necessary requirements.

A flow chart diagramming the approaches and processes discussed immediately above is provided on the following page.

Conclusion

The significance of the CFR amendments and those contained in Senate Bill 2499 should not be underestimated or ignored by primary payers. They represent the latest in Medicare's loud and steady march over the past several years to foster increased primary payer compliance with the MSP. The obligation of primary payers to protect Medicare's interests is clear. The time is now for all primary payers to make sure that they have established the necessary internal procedures to meet their obligations under the MSP. In closing, perhaps a pertinent question for all primary payers to consider is: "*Can we afford to put off until tomorrow that which is actually required today?*"

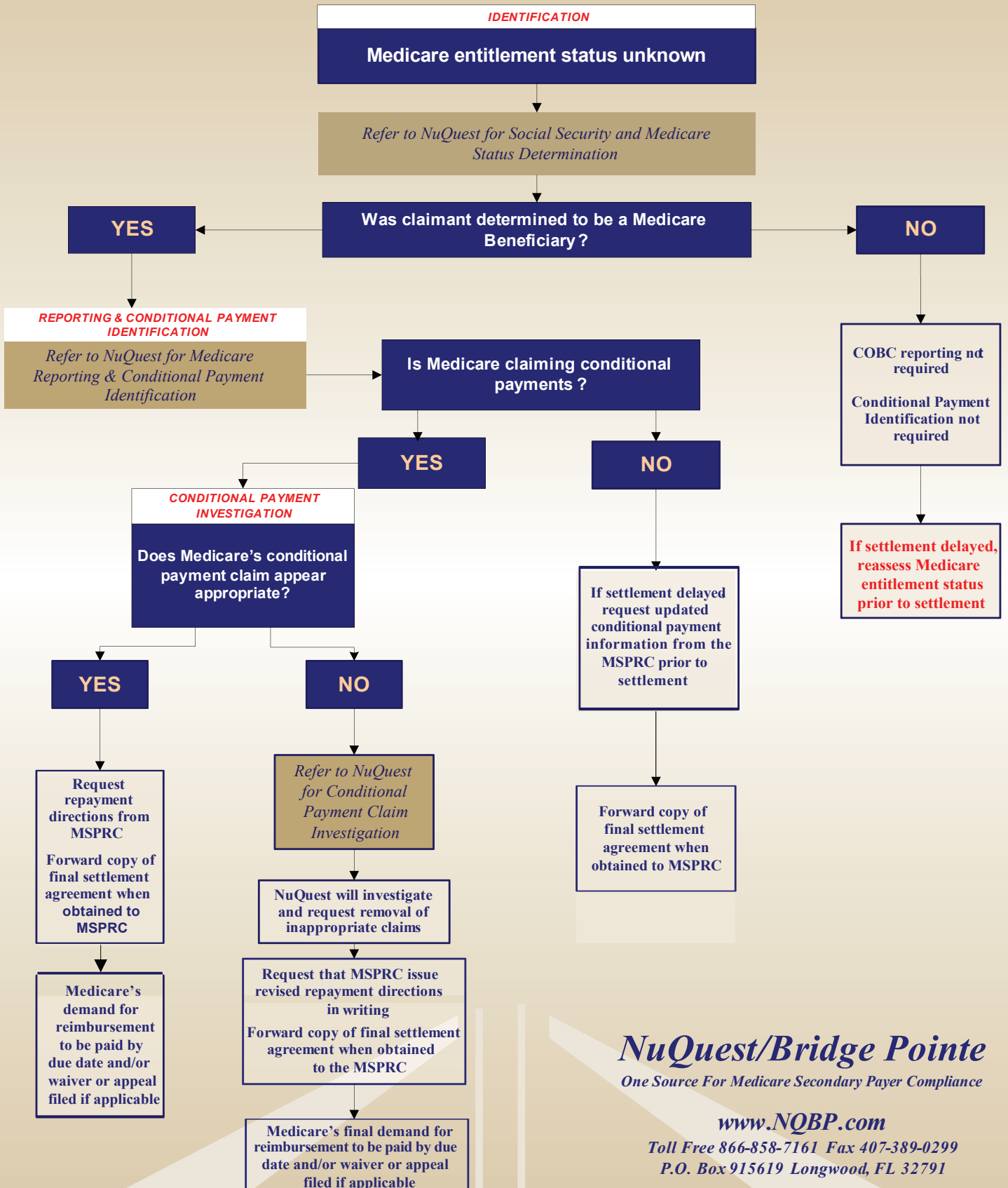
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