

THE MEDICARE SECONDARY PAYER ENHANCEMENT ACT OF 2010 (H.R. 4796) PROPOSES AMENDMENTS TO THE MEDICARE SECONDARY PAYER STATUTE

Major Changes Are Proposed to the Medicare Conditional Payment Process, Section 111 of the MMSEA & Other General MSP Compliance Matters

By: Mark Popolizio, J.D.

On March 9, 2010, the Medicare Secondary Payer Enhancement Act of 2010 (MSPEA) (H.R. 4796) was introduced into the United States House of Representatives by Patrick Murphy (D-PA) and Tim Murphy (R-PA). This legislation proposes major amendments to the Medicare Secondary Payer Statute (MSP).¹

The MSPEA (H.R. 4796) targets specific components of MSP compliance related to conditional payment reimbursement, Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) (Medicare's new "notice and reporting" statute), and other important aspects of MSP compliance.

A copy of the MSPEA (H.R. 4796) may be obtained at http://www.nquestbridgepointe.com/news/uploads/h_r__4796.pdf.

The introduction of the MSPEA (H.R. 4796) is largely credited to the efforts of the Medicare Advocacy Recovery Coalition (MARC) (www.marccoalition.com). MARC is a national industry group that has formed over the past two years to address various aspects of MSP compliance in the non-group health plan (NGHP) claims context. The group is comprised of a broad range of interests and sectors in the NGHP claims context.

It is important to keep in mind that the MSPEA (H.R. 4796) is *proposed* legislation. As such, the provisions discussed below have *not* been enacted into law as of this time. Furthermore, the MSPEA (H.R. 4796) is *unrelated* to the new "healthcare reform" legislation that was recently passed by the House and signed into law by

President Obama, which has been the subject of significant national debate and attention over the past year.

As with every bill introduced in Congress, it is unknown whether or not the MSPEA (H.R. 4796) will be formally passed and enacted into law. Likewise, it is important to remember that the bill's current provisions could be modified as the bill moves through the legislative process. Thus, the reader will need to monitor the status and progress of this bill to stay abreast of all pertinent developments.

The reader may keep track of the progress of this bill at <http://www.govtrack.us/congress/bill.xpd?bill=h111-4796>.

The purpose of this article is to provide the reader with an "informational overview" of the amendments contained in the MSPEA (H.R. 4796) by placing the proposals into proper focus in terms of how they relate to the specific area of MSP compliance addressed.

This analysis is divided into the following parts:

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PART I

Proposed Amendments to the Conditional Payment Process

The MSPEA (H.R. 4796) Proposes Two Methods to Calculate and Pay Conditional Payment Claims & Establishes Specific Timeframes for CMS to Respond

Conditional Payments – Brief Background

The MSPEA (H.R. 4796) proposes major changes to the current process with regard to calculating and paying conditional payment claims.

A complete examination of all aspects of the conditional payment process is outside the scope of this article. However, a brief *general* overview of the issue of conditional payment reimbursement is necessary to better understand the bill's specific target areas and the potential significance of the proposed amendments.

Under the MSP, Medicare may not make payments with respect to any item or service for which payment has been made, or can reasonably be expected to be made, “*under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability policy or plan (including a self insured plan) or under no fault insurance.*”² These forms of insurance are referred to as “primary plans” or “primary payers” under the MSP.³

However, Medicare may pay for medical treatment related to a claim in certain situations where the primary plan “*has not made, or cannot reasonably be expected to make payment,*” with such payments being “*conditioned on reimbursement*” to Medicare.⁴ Accordingly, a “conditional payment” can be defined as “*a Medicare payment for services for which another payer is responsible.*”⁵

Pursuant to 42 U.S.C. § 1395y (b)(2)(B)(ii), the Centers for Medicare and Medicaid Services (CMS) has a statutory right to seek reimbursement for conditional payments made by Medicare in relation to a claim. This section, in pertinent part, provides as follows:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter 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.⁶

In addition to the items referenced in 42 U.S.C. § 1395y (b)(2)(B)(ii), a “*settlement*” or “*contractual obligation*” demonstrate “responsibility” under the MSP.⁷

With respect to reimbursement, 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 Medicare’s claim may be reduced by “procurement costs” as outlined in the Code of Federal Regulations.⁹ If it is necessary for CMS to take legal action, Medicare may seek *twice the amount* of the Medicare primary payment against the responsible party.¹⁰

The MSP provides CMS with wide latitude in terms of who it may pursue for conditional payments, and how it may do so. For example, Medicare has a direct action against “*any and all entities that are or were required or 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

The above cited MSP sections set forth the bases and scope of CMS’ substantive rights for conditional payment reimbursement under the MSP.

In relation thereto, issues are raised regarding current CMS practices with respect to (a) *obtaining and calculating the conditional payment “amount”* and (b) *available recourses to challenge a conditional payment claim*. The MSPEA (H.R. 4796) takes direct aim at these issues. In order to assess the potential impact of the proposed amendments in these areas, further overview of the current process is in order.

Under the current process, to obtain conditional payment information the parties must first notify Medicare of the claim by contacting the Coordination of Benefits Contractor (COBC).

[NOTE: It must be understood that the need to notify Medicare of the claim in order to address the conditional payment issue is *independent* of the electronic “notice

and reporting” process under Section 111 of the MMSEA – they are two separate processes, and two separate compliance obligations under the MSP. In this respect, the parties are *currently* obligated (and have been obligated for quite some time) to protect Medicare’s interests for conditional payments. Accordingly, the various timelines under Section 111 are inapplicable with regard to the longstanding and continuing obligation to address the conditional payment reimbursement issue. Thus, although the claim may not yet be reportable under Section 111, or may be exempted from reporting per a Section 111 reporting exception, the parties still have an obligation to address conditional payment reimbursement under the MSP].

Once notice is given to the COBC, the COBC alerts the Medicare Secondary Payer Contractor (MSPRC) of the claim. The MSPRC then issues a “Rights and Responsibilities Letter” to the claimant and other authorized parties on record advising of Medicare’s interests. Within 65 days from the date of the “Rights and Responsibilities Letter,” the MSPRC will then forward what is called a “Conditional Payment Letter (CPL)” to the claimant and other authorized parties on record.

The CPL is a significant document as it provides the parties with an *initial* listing of CMS’ alleged conditional payment amount related to the claim. Since conditional payments can continue to accrue as the case progresses, it is often necessary for the parties to request updated conditional payment information from the MSPRC during the course of the claim in order to properly assess potential exposure.

To learn more about the current process to obtain conditional payment information, the reader may wish to review a summary of same as contained in an educational flyer prepared by NuQuest/Bridge Pointe at http://www.nuquestbridgepointe.com/news/uploads/cms_conditional_payment_policy_changes.pdf. In addition, the reader may wish to review the MSPRC website at <http://www.msprc.info> and <http://www.msprc.info/forms/reporting%20a%20case.pdf>.

As part of the current process, the parties generally cannot obtain the “final amount” of CMS’ conditional payment claim until *after* the case has settled and the settlement document is forwarded to the MSPRC. At that point, the MSPRC issues a “final demand” for the conditional payment amount and typically demands full reimbursement of the claimed amount within 60 days. If the amount demanded is not paid within 60 days, interest is then assessed on the underlying amount.

The current process to obtain and calculate the conditional payment amount as described above presents a number of formidable challenges from a practical standpoint.

First, the process to obtain CMS’ claimed conditional payment amount can be quite time consuming. As outlined, obtaining the initial CPL can alone take a few months. Thereafter, if it is necessary to obtain updated conditional payment information (which is often the case as the claim matures), additional requests must be made to the MSPRC, and it could take another several months to obtain the updated figures from the MSPRC.

Second, the parties’ inability to obtain the “final” conditional payment amount *prior* to settlement causes considerable problems. In this regard, the parties are essentially placed in a position where they are settling the claim based upon an interim *estimate* of the conditional payment amount. Accordingly, there is potential “bounce” in this number as it is entirely possible that the “final” amount obtained from the MSPRC *post settlement* could be higher than the interim estimate. This could occur because additional medical treatment may have been rendered *after* the date the interim estimate was provided. Furthermore, since most medical providers have 15-27 months to submit their bills to Medicare for payment, there could very well be additional conditional payment amounts that had not yet hit CMS’ system at the time the interim estimate was rendered.

Accounting for these contingencies raise additional practical challenges. For instance, issues are raised in terms of how best to ensure the availability of funds to pay off any additional amounts claimed by CMS *post settlement*, especially in light of the fact that CMS has the right to pursue *any* of the parties to the settlement to the extent the conditional payment claim is not properly satisfied. Compounding the problem further is the fact that it can take several months for the parties to receive the actual “final” amount from the MSPRC.¹⁴

Proposed Amendments

Against the above backdrop, the MSPEA (H.R. 4796) proposes the following amendments to the current process of determining and paying conditional payment claims:

Proposed Amendment #1 (“Final Demand” Method)

Obtaining a “Final Demand” from CMS PRIOR to Settlement, Judgment, Award or Other Payment

The MSPEA (H.R. 4796) would allow the parties to request a final demand from CMS *prior* to a settlement, judgment, award or other payment. In response, CMS would be required to provide the requested conditional payment amount within a specific period of time with failure to do so constituting a waiver of the conditional payment claim.

Specifically, the bill proposes that the claimant or applicable plan¹⁵ “*may at any time beginning 120 days prior to the reasonably expected date of such settlement, judgment, award or other payment*” submit a request for a “*recovery demand letter for reimbursement.*”¹⁶

Upon request for a “final demand,” CMS would have 60 days to provide the requested conditional payment amount. If CMS does *not* provide the final demand within 60 days, the bill proposes that “*the claimant, applicable plan, or an entity that receives payment from an applicable plan shall not be liable for and shall not be obligated to make such payment.*”¹⁷ (Emphasis Added).

If, on the other hand, CMS issues a “final demand” within the 60 day timeline, then the claimant or applicable plan “*not later than 60 days after receipt of such final demand*” would have two options: (a) *reimburse* Medicare in the amount identified in their final demand which “*shall satisfy any obligations of the claimant and the applicable plan*” regarding the conditional payment claim;¹⁸ or (b) *appeal* the asserted conditional payment amount.¹⁹

The bill proposes a \$30 fee per each recovery demand letter requested (this fee would not start until 90 days after enactment of the MSPEA (H.R. 4796) into law).²⁰ If this fee is not paid 30 days after it is due, it would be treated as a claim of the Federal Government subject to subchapter 37 of title 31 of the United States Code.²¹ This fee is subject to yearly revision for inflation.²²

Proposed Amendment #2 (“Good Faith” Method)

“Good Faith” Calculation & Payment of Conditional Payments

Alternatively, the MSPEA (H.R. 4796) would allow the parties to make a “good faith” estimate of the conditional payment amount and tender the amount directly to CMS, with the agency having a right to challenge same within a specific period of time.

Specifically, the bill proposes that during the 90 day period preceding the “*reasonably expected date of a settlement, judgment, award, or other payment,*” the claimant and applicable plan may:

- Calculate “*in good faith*” the amount of the reimbursement “*based upon billing data for such items and services provided;*” and
- Reimburse such amount in accordance with regulations as to be established by the Secretary of Health and Human Services.²³

As proposed, the corresponding payment “*shall satisfy any obligation of the claimant and the applicable plan*”²⁴ for conditional payments unless Medicare contests the adequacy of this payment “*during the 75 day period beginning on the date of such reimbursement is made*” by “*serving the claimant and applicable plan a final demand for the balance of the remaining amount so owed.*”²⁵

If CMS challenges the adequacy of the tendered payment, the claimant or applicable plan would then have two options: (a) *reimburse* Medicare for the balance of the conditional payments; or (b) *appeal* the balance amount through a formal appeals process with the claimant or applicable plan having the burden of proof to show that the reimbursement made was in fact correct.²⁶

The bill proposes a \$30 fee for payment submitted under this section (this fee would not start until 90 days after enactment of the MSPEA (H.R. 4796) into law).²⁷ However, payment of the fee under this section of the bill would *not* be required to the extent a party had paid the \$30 fee to obtain a “final demand” from CMS as discussed in the preceding section.²⁸ This fee is subject to yearly revision for inflation.²⁹

If the fee is not paid 30 days after it is due, it would be treated as a claim of the Federal Government subject to subchapter 37 of title 31 of the United States Code.³⁰

The MSPEA (H.R. 4796) Proposes Extended Right of Appeal

The MSPEA (H.R. 4796) also proposes an “extended” appeal right to afford additional parties formal appeals rights to challenge conditional payment claims through the administrative appeals process and the Federal court system.

This aspect of the proposed legislation addresses the issue of the recourses available to the parties to contest the claimed conditional payment amount when they believe Medicare’s claim is incorrect, inaccurate or otherwise includes inappropriate claims. A complete examination of all of the various recourses available to the parties is outside the scope of this article.

In general, under the current process the claimant or applicable plan (primary payer) can submit a request to the MSPRC for removal of those claims they believe should not be included as part of the conditional payment claim. If the MSPRC agrees to remove the requested claims, this usually extinguishes the issue. However, problems could arise in situations where the MSPRC *rejects* the request. This then raises the issue of what additional recourses a party may have to challenge the conditional payment claim.

Under the current process, the *claimant* may appeal the claim through an established administrative appeals process, and may file an action in Federal Court.³¹ Claimants also enjoy other potential methods to request a reduction of the conditional payment claim not available to primary payers, including, but not necessarily limited to, “economic hardship,” “equity and good conscience,” and for reasons “beyond the fault of the claimant.”³²

By contrast, CMS takes the position that when a conditional payment recovery demand letter is issued to a primary payer identifying said primary payer as the debtor, the primary payer has *no* formal administrative appeal rights under the MSP.³³

The MSPEA (H.R. 4796) now proposes to extend the “right of appeal and appeals process” regarding conditional payments to “the applicable plan involved, or an attorney, agent or third party administrator on behalf of such applicable plan.”³⁴

In pertinent part, as proposed, this right of review would be required to:

[I]nclude review through an administrative law judge and administrative review board, and access to judicial review in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District of Court for the District of Columbia.³⁵

PART II

Proposed Amendments to Section 111 of the MMSEA (Regarding Non-Group Health Plans)

The MSPEA (H.R. 4796) also proposes amendments to the penalty provision under Section 111 of the Medicare, Medicaid and SCHIP Extension Act (42 U.S.C. 1395y(b)(8)).

A complete examination of Section 111 is outside the scope of this article. However, in general, Section 111 is a “notice and reporting” statute which governs when a claim involving a Medicare beneficiary needs to be reported to CMS. Entities known as “Responsible Reporting Entities (RREs)” are required to put Medicare on notice of claims involving Medicare beneficiaries in accordance with two “reporting triggers” referred to as “TPOC – Total Payment Obligation to the Claimant” and/or “ORM – On Going Responsibility for Medicals.” When a trigger is met, the RRE must report the claim electronically to Medicare and submit certain required informational data.

Over the past year and a half, CMS has been releasing its Mandatory Insurer Reporting (MIR) guidelines to implement Section 111’s “notice and reporting” mandates. The MIR remains in a “work in progress” state in certain areas and CMS continues to release updates to its guidelines. At the time this article was drafted, official reporting under Section 111 is scheduled to commence January 1, 2011 in accordance with a RRE’s quarterly submission period.

However, it is important to understand that the January 1, 2011 date is simply the date when the *electronic reporting* aspect of Section 111 will commence, and *not* the date from which substantive obligations to report under Section 111 are determined. In this latter regard, whether or not a claim must be reported under Section 111 is measured by the applicable directives regarding TPOC and ORM, which by their definition require reporting on cases that *predate* January 1, 2011.

In general, TPOC reporting is triggered from an October 1, 2010 date; while ORM reporting is based off a January 1, 2010 date. Thus, the RRE will have cases that must be reported under Section 111 *prior* to January 1, 2011, but which will essentially remain in a “reporting holding pattern” until the RRE’s assigned quarterly submission date in the first quarter of 2011. Again, a full examination of Section 111 in general and TPOC/ORM in particular is beyond the scope of this article. The author will be releasing a comprehensive article on Section 111 in the near future to address CMS’ recent updates as a supplement to his numerous previous articles on the subject.

The penalty for non-compliance with Section 111 is steep. Per 42 U.S.C. 1395y(b)(8)(E), if the RRE fails to properly comply with Section 111, the RRE “*shall be subject to a civil money penalty of \$1,000 for each day of non-compliance with respect to each claimant.*” (Emphasis Added).

As of this time, the only written guidance released by CMS related to the “compliance” aspect of Section 111 is the agency’s February 24, 2010 “Alert.” A copy of said “Alert” can be obtained at <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPCComplianceAlert022410.pdf>.

Through this “Alert,” CMS has issued *general* statements with respect to how the agency is currently assessing RRE “compliance” with Section 111. However, at this time the agency has *not* issued any specific directives defining exactly how it intends to actually apply and enforce Section 111’s monetary penalty.

In this regard, use of the word “shall” in 42 U.S.C. § 1395y(b)(8)(E) has generated concern in some circles as in the context of legal statutory interpretation the word “shall” is generally interpreted to mean “must,” thereby imparting a mandatory or affirmative obligation to act. In accordance with this strict interpretation, concerns have arisen that this section as currently drafted will technically mean that CMS will be required to impose the penalty as a matter of law, *without* consideration of potential mitigating factors, such as a RRE that acts in good faith, or otherwise exhibits due diligence in complying with Section 111.

The MSPEA (H.R. 4796) proposes to amend Section 111’s penalty provision by replacing the phrase “shall be subject to a civil money penalty of \$1,000 for each day of non-compliance” with the phrase “may be subject to a civil penalty of up to \$1,000 for each day of non-compliance.”³⁶

This proposed revision would seemingly inject a discretionary component to Section 111’s penalty provision with respect to imposition of the penalty in the first instance (“*may be subject to*”), and in terms of the potential penalty that could be levied (“*up to \$1,000*”).

Furthermore, the bill proposes that certain “safe harbor” provisions be established under which a RRE would be considered to have properly complied with Section 111.³⁷ In this regard, the bill proposes that CMS solicit proposals from the industry as part of the process of establishing the applicable “safe harbors.”³⁸

PART III

Proposed Amendments – General

In addition to the amendments outlined above, the MSPEA (H.R. 4796) proposes the following revisions to the MSP:

The MSPEA (H.R. 4796) Proposes A MSP Monetary Threshold Exemption

The MSPEA (H.R. 4796) proposes that claims falling below a \$5,000 threshold would be exempted from the MSP.

Specifically, under the bill, “*any settlement, judgment, award or other payment by an applicable plan constituting a total payment obligation to a claimant of not more than \$5,000*” would be exempted from the MSP.³⁹

In addition, the bill states as follows:

Any settlement, judgment, award, or other payment by an applicable plan involving the ongoing responsibility for medical payments not otherwise addressed in sub clause (I), of not more than \$5,000 [would be exempted]. For purposes of this sub clause and with respect to a settlement, judgment, award, or other payment payments not otherwise addressed in sub clause (I) involving the ongoing responsibility for medical payments, such payment shall include only the cumulative value of the medical payments made and the purchase price of any annuity or similar instrument.⁴⁰

The above monetary threshold exception would “*apply with respect to payments made on or after 3 months after the date of the enactment [of the bill].*”⁴¹ The bill further provides that this threshold amount shall be adjusted annually based on the percentage increase in the Consumer Price Index (rounded to the nearest multiple of \$100).⁴²

The MSPEA (H.R. 4796) Proposes A 3 Year Statute of Limitations

The MSPEA (H.R. 4796) proposes that the following provision be added to 42 U.S.C. 1395y(b)(2)(B)(iii):

Every action brought by the United States or an officer or agency thereof ... shall be barred unless the complaint is filed not later than three years after the date of receipt of notice of a settlement or other payment giving rise to recovery of a payment made pursuant to paragraph (8).⁴³

The bill proposes that this amendment would become operative with respect to actions “*brought on or after 6 months after*” enactment of H.R. 4796.⁴⁴

The MSPEA (H.R. 4796) Proposes Discontinued Use of Social Security & Health Identification Numbers

The MSPEA (H.R. 4796) also proposes that CMS would have one year after the enactment of the bill to develop a

system for reporting under the MSP using identifying information for the claimant *other* than his/her social security or health identification claim number which are the current criteria being used.⁴⁵

Conclusion

As the foregoing illustrates, the MSPEA (H.R. 4796) proposes several major amendments to important aspects of MSP compliance. The amendments proposed in the bill address certain key provisions that have, or may

have, direct impact on a parties' obligation to comply with the provisions of the MSP.

As mentioned above, whether the MSPEA (H.R. 4796) is ultimately enacted into law in its current form, or passed in modified version, is unknown at this time. The bill remains in its nascent stages of the legislative process, and, as such, it will be necessary for the reader to follow the progress of this bill as it proceeds through Congress.

About the Author

Mark Popolizio, J.D. is the Vice President of Customer Relations for NuQuest/Bridge Pointe. Mark also served as Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) from 2006-2008 and remains active with NAMSAP concentrating on educational and legislative matters.

Prior to joining NuQuest, Mark practiced workers' compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included Medicare Set-Asides and Medicare Compliance. Mark is very active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations.

Mark has also published several articles on MSA/ Medicare issues. Mark can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.

SERVICE SPOTLIGHT

NuQuest/Bridge Pointe can assist you in meeting your obligations to determine a claimant's Medicare status in workers' compensation, liability and no-fault cases. Our Conditional Payment services provide tools and expertise to assist parties to a settlement with regard to consideration of Medicare's interests concerning injury related Medicare payments made prior to the settlement date, including the following:

Medicare Conditional Payment Identification Services

- Social Security and Medicare status determination
- Registered Nurse review of all medical records and identification of related diagnoses and ICD-9 codes
- Report of case demographics and related diagnoses to the Medicare Coordination of Benefits Contractor (COBC) along with a request for a Conditional Payment Worksheet outlining the details of Medicare's conditional payments, if any
- *This service is included at no additional cost as part of an MSA allocation service.*

Medicare Conditional Payment Claim Investigation Services

- Registered Nurse review of Medicare's Conditional Payment Worksheet and related medical records
- Submission of recommendations regarding the appropriateness of Medicare's claim and a request for removal of any inappropriate claims to the MSP Recovery Contractor.
- Revised conditional payment worksheet sent to the customer upon receipt from Medicare

Professional Services

Allocation Services

MSA I

Includes MSA allocation, Social Security and Medicare status determination, Reporting to COBC to initiate Medicare conditional payment claim identification process, determination of rated age life expectancy, and recommendations for frequency and amounts of periodic payments when a structured settlement is being utilized.

MSA II

Includes all aspects of MSA I above plus a detailed projection of non-Medicare allowable costs to provide a total cost projection.

MCP with Free MSA

Apportions both Medicare allowable and non-Medicare allowable future injury related medical costs. Costs are calculated at WC reimbursement rates or rates actually paid, when available, over the rated age life expectancy. Utilize to set reserves, obtain settlement authority or as a settlement tool now, and receive a free MSA allocation within one year of the MCP report completion date, if needed.

Low Dollar Settlement MSA

MSA allocation for total settlements of \$25,000 or less. Does not include Social Security and Medicare status determination, COBC reporting or conditional payment inquiry.

Submission of MSA to CMS for Approval

Includes submission of MSA allocation and supporting documents to CMS and ongoing communication with CMS throughout the review process.

Submission of \$0 Allocation to CMS for Approval

Includes preparation of submission document and supporting attachments requesting approval of a \$0 MSA allocation in disputed/denied cases, Social Security and Medicare Status determination, Medicare conditional payment claim identification and ongoing communication with CMS throughout the review process.

Administration Services

We will meet or improve upon any major competitor's fees for administration

MSA Self Administration Support Services

Services are provided for 1, 3 or 5 years and provide instructions, forms, contacts and other resources necessary for self administration of an MSA account. Includes professional support via our toll-free Help Line for the duration of the service selected. Available in English or Spanish.

MSA Custodial Account Administration

Professional administration complies with CMS administration requirements for the life of an MSA account. Includes preparation of individualized Custodial Agreement.

Medical Custodial Account Administration

Professional administrator provides services to protect, conserve or extend settlement dollars post settlement through network access, discount pharmacy program, care coordination, bill review and payment. May be used in conjunction with an MSA account or stand alone.

Additional Services

Social Security & Medicare Status Determination only

Medicare Conditional Payment Identification

Provides Social Security and Medicare status determination, reporting to Medicare and an estimate of Medicare conditional payments

Medicare Conditional Payment Claim Investigation

Includes a review of Medicare's claim and requests removal of inappropriate claims.

Rush Referral (MSA allocation in 1 - 5 business days)

Updating an MSA or MCP

Endnotes

- ¹ The Medicare Secondary Payer Statute (MSP) is codified at 42 U.S.C. § 1395y, et. seq. In addition, pertinent provisions related to MSP compliance are contained in Subparts B, C and D of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 411.20 through 411.50, et. seq.)
- ² 42 U.S.C. § 1395y (b)(2)(A)(ii); *See also*, 42 C.F.R. § 411.20(a)(i).
- ³ As noted, under the MSP the term “primary plan” includes a “workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no-fault insurance.” Under the MSP, an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. It should also be noted that this statutory provision also applies to a group health plan or large group health plan with said plans not addressed as part of this article. *See also*, 42 C.F.R. § 411.21 (definition of “plan”); and 42 C.F.R. § 411.50(b) (definition of “liability insurance” and “liability insurance payment”).
- ⁴ 42 U.S.C. § 1395y (b)(2)(B)(i); *See also*, 42 C.F.R. § § 411.21 and 411.52.
- ⁵ *See*, 42 C.F.R. § 411.21.
- ⁶ 42 U.S.C. § 1395y (b)(2)(B)(ii).
- ⁷ 42 C.F.R. § 411.22(a)(3).
- ⁸ 42 C.F.R. § 411.24(c)(i)(ii).
- ⁹ 42 C.F.R. § 411.37.
- ¹⁰ 42 U.S.C. § 1395y (b)(2)(B)(iii), 42 C.F.R. § 411.24(c)(2).
- ¹¹ 42 U.S.C. § 1395y (b)(2)(B)(iii).
- ¹² 42 C.F.R. § 411.24(g).
- ¹³ 42 C.F.R. § 411.26.
- ¹⁴ The reader may wish to review an interesting article highlighting this problem entitled *Medicare Won’t Let Clients Repay Government Lawyers Say*. This article may be obtained from the MARC website: www.marccoalition.com, select “Press Room.”
- ¹⁵ “Applicable Plan” under the MSP is defined to mean the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement: (i) liability insurance (including self-insurance), (ii) no fault insurance, and (iii) workers’ compensation laws or plans. 42 U.S.C. 1395y(b)(8)(F).
- ¹⁶ H.R. 4796 § 2 (a) (1) (viii) (I).
- ¹⁷ H.R. 4796 § 2 (a) (1) (II).
- ¹⁸ H.R. 4796 § 2 (1) (viii) (I).
- ¹⁹ H.R. 4796 § 2 (1) (viii) (II)(ix).
- ²⁰ H.R. 4796 § 7 (9) (A) (ii).
- ²¹ H.R. 4796 § 7 (9) (C).
- ²² H.R. 4796 § 7 (9) (B).
- ²³ H.R. 4796 § 2 (a) (1)(vii)(I)9(aa),(bb).

- ²⁴ H.R. 4796 § 2 (a) (1)(vii)(I)(bb).
- ²⁵ H.R. 4796 § 2 (a) (1) (II).
- ²⁶ H.R. 4796 § 2 (a) (1) (II).
- ²⁷ H.R. 4796 § 7 (9) (A) (i).
- ²⁸ H.R. 4796 § 7 (9) (A) (ii).
- ²⁹ H.R. 4796 § 7 (9) (B).
- ³⁰ H.R. 4796 § 7 (9) (C).
- ³¹ *See e.g.*, 42 C.F.R. § 405.900.
- ³² *See e.g.*, 42 U.S.C. 1395y(b)(2)(B)(v); 42 U.S.C. § 1395gg, 42 U.S.C. § 404(b), 31 U.S.C. § 3711 and 20 C.F.R. § 404.506. This is not an exhaustive list of all possible recourses to request a reduction of the conditional payment claim as this particular issue is beyond the scope of this article. As such, to fully examine this area the reader needs to review the United States Codes, Code of Federal Regulations, case law decisions and any CMS policy statements. The reader may also wish to consult MSPRC's website www.MSPRC.info.
- ³³ *See e.g.*, October 6, 2008 letter from CMS to NuQuest/Bridge Pointe, citing 42 C.F.R. § 405.926.
- ³⁴ H.R. 4796 § 2 (a)(II)(ix)
- ³⁵ H.R. 4796 § 2 (a)(II)(ix).
- ³⁶ H.R. 4796 § 4 (1).
- ³⁷ H.R. 4796 § 4 (2).
- ³⁸ H.R. 4796 § 4 (2).
- ³⁹ H.R. 4796 § 3 (a) (2) (II) (aa).
- ⁴⁰ H.R. 4796 § 3 (a) (2) (II) (bb).
- ⁴¹ H.R. 4796 § 3 (b).
- ⁴² H.R. 4796 § 3 (a) (2) (II) (bb).
- ⁴³ H.R. 4796 § 6 (a).
- ⁴⁴ H.R. 4796 § 6 (b).
- ⁴⁵ H.R. 4796 § 5.