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Medicare Secondary Payer (MSP) Compliance Checklist

October 2023

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Agenda

1. What is MSP compliance
2. The core three MSP compliance areas
3. Risk of noncompliance
4. Checklist Part 1: Onset of the claim
5. Checklist Part 2: During the life of the claim
6. Checklist Part 3: At/After settlement or claim closure

What is MSP compliance

MSP Vocabulary and acronyms

- MSP = Medicare Secondary Payer
- RRE = Responsible Reporting Entity. This entity is typically the underling insurer. The RRE typically carries the most responsibility and risk with regard to MSP compliance.
- TPA = Third-party administrator
- CMS = Centers for Medicare and Medicaid Services
- MAP = Medicare Advantage Plan (Medicare Part C)
- PDP = Prescription Drug Plan (Medicare Part D)
- MSA = Medicare Set-Aside
- CRC = Commercial Repayment Center
- BCRC = Benefit Coordination & Recovery Center
- MIR = Mandatory Insurer Reporting (also referred to as Section 111 reporting)
- ORM = Ongoing responsibility for medicals
- TPOC = Total payment obligation to the claimant

Medicare Secondary Payer Act and other relevant law

- The Medicare Secondary Payer Act of 1980 *42 USC Section 1395y(b)(2)*
- Medicare Advantage statute (**Part C**) expressly acknowledges MA payments are "made secondary" *(42 U.S.C. §1395w-22(a)(4))*
- The Medicare Prescription, Improvement, and Modernization Act of 2003, *[Pub. L. No. 108-173], (42 U.S.C. §1395)* (**Part D**)
- **Section 111** of the Medicare, Medicaid, and SCHIP Extension Act of 2007 *(MMSEA), Pub. L. No. 110-173 (2007) (42 U.S.C. §1395y(b)(8))* (**MIR**)
- The *Strengthening Medicare and Repaying Taxpayers Act of 2012 (**SMART**) 42* U.S.C. *§1395t*
- The *Provide Accurate Information Directly (PAID) Act* 42 U.S.C. §1395y(b)(8)(G)
- MSP and Certain Civil Money Penalties Rule – Published October 11, 2023; Effective December 11, 2023 (https://www.federalregister.gov/documents/2023/10/11/2023-22282/medicare-program-medicare-secondary-payer-and-certain-civil-money-penalties)

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Non-Group Health Plan (NGHP) claims

Insurers are considered **primary payers** and obligated to reimburse Medicare. CMS recognizes three **non-group health plan (NGHP)** types of claims:

1. Workers' compensation
2. Liability
3. No-fault.

NGHPs include, but are not limited to:

- Auto insurers liability
- Homeowners insurers liability
- Commercial General Liability (CGL) Insurers-premises liability
- Professional Liability insurers-malpractice
- Self-insured entities
- MedPay
- Personal Injury Protection (PIP)

Areas of MSP compliance

Protection of Medicare's interest

Requirements of all parties involved in a settlement to assure Medicare's interest has been considered

Medicare is due protection in three areas:

These are three very different items, each with its own set of rules, policies and procedures.

Section 111 of MMSEA is Mandatory Insurer Reporting (MIR)

- **Mandatory Insurer reporting (MIR)** is required by insurers to report claim information for claimants who are currently Medicare eligible.
- **Responsible Reporting Entity (RRE):** It is the insuring company who bears the responsibility of MSP compliance. While the insurer may use a third-party administrator (TPA) to perform reporting requirement, the insurer is still the entity that will be held responsible for noncompliance.
- Medicare Query to determine eligibility – Medicare allows for its database to be queried to know if the claimant is a current Medicare beneficiary or will be one in the next 3 months.
  - **Big 5 to query include: SSN/MBI (at least last 5 of SSN), Date of Birth, First Name, Last Name & Gender**
- **MIR data** required and needed to transmit to CMS during prescribed quarterly reporting/submission time
- **Data fields** required for all claim types:
  - Same query data fields
  - Three claim types-workers' compensation, liability, and no-fault
- **Coordination of benefits (COB)** allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities
- **Failure to report timely can result in civil monetary penalties of up to $1,000 per day.**

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Conditional payments

Medicare (Part A and B), Medicare Advantage Plan (Part C), Prescription Drug Plan (Part D)

- What is a conditional payment? Payments made by Medicare for treatment related to the auto, liability, no-fault, or work comp claim where the primary payer may have an obligation to make payment.
- Medicare may be due reimbursement from the primary payer. Responsibility for reimbursement can be demonstrated by acceptance of compensability, settlement, judgment, arbitration award, or other payment made pertaining to the claim
- CMS enforces coordination of benefits through the CRC/BCRC specific to Medicare conditional payments. There is a multi-tiered administrative and legal process for disputing/appealing conditional payments.
- Part C and Part D plans are third party payers that stand in the shoes of Medicare and require repayment of conditional payments just like Medicare. Part C&D plans usually don’t have a similar process for their liens and also have a right to a private cause of action for double damages.

Medicare Set-Aside

- A Medicare Set-Aside is an **allocation** to pay future related medical expenses otherwise reimbursable by Medicare for an injured party that would have been paid by Medicare had the injury/illness NOT been the responsibility of the **primary payer.**
- Any claimant who receives a settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's **future** interest with respect to related medical expenses
- The **purpose** of obtaining an MSA is to estimate as accurately as possible, the total cost that will be incurred for all future related medical expenses otherwise reimbursable by Medicare pertaining to the underlying claim
- MSA allocation includes line item medical and pharmacy needs projected over the life expectancy of the claimant
- An MSA allocation amount represents a portion of the total settlement amount that is designated to pay for all future related medical, surgical, and prescription expenses pertaining to the claim(s)

Why do you need to be concerned about MSP compliance?

Risk and consequences of noncompliance

Risk and consequences of noncompliance

- Civil money penalties up to $1,000 per day per claim will be assessed against insurers/RREs for failure to report or for untimely reporting to CMS.
  - Claims must be reported within one year of ORM acceptance, settlement, judgment award or other payment determination.
  - There is a tiered approach to the penalties which start at $250 per day after one year of noncompliance. The penalties go up to $1,000 per day if the claim is over three years out of compliance. The maximum penalty is $365,000 per year.
  - Penalties will begin to be imposed 10/11/2024.
- With regard to settlements, CMS can bring an action against any party to a settlement payment if Medicare's interest wasn't adequately considered. An example could be if the parties did not incorporate a MSA with the settlement and Medicare was paying for post-settlement treatment.
- Medicare could deny treatment to the beneficiary.
- CMS could require a spenddown of the entire settlement if it determined.

Risk of not resolving conditional payment issues

- Unresolved conditional payment demands will accrue interest. Interest rates vary, but have been around 10%.
- Failing to resolve matters at the BCRC/CRC level can result in conditional payments being referred to the Department of Treasury.
- The Medicare beneficiary could have Social Security benefits garnished.
- Treasury offsets are taken from Insurers/TPAs assets for debts owed to CMS
- Medicare beneficiaries, beneficiaries' estate, Part C Medicare Advantage Plans and Part D Prescription Drug Plans will file a private cause of action against the insurer/RRE seeking recovery, including double damages not to mention astronomical defense costs

MSP compliance Checklist Part 1:

At the onset of the claim

Actions needed at the onset of the claim

- Querying the claim
  - Obtain the big 5 (first name, last name, date of birth, gender, SSN/MBI) to query the claim
  - Missing information? Good faith effort to obtain – 2 attempts by mail + 1 by other means (example: phone call)
- Confirmed to be a Medicare beneficiary?
  - Ensure Section 111 reporting is accurate. Correct errors if any.
- Is the claim reportable?
  - If yes, ensure all information is provided to report claim.
- Assuming responsibility for future medical?
  - If yes, turn ORM indicator to Y (once turned to Y do not return to N or it will delete the claim from the Medicare System)
- ICD Codes
  - Ensure accuracy of ICD codes for conditions accepted for ORM
  - Denied conditions should not have ICD codes reported at this point.

Actions needed at the onset of the claim *(continued)*

- Did Medicare provide contact information for a Medicare Advantage Plan (MAP) and/or Part D Plan (PDP)?
  - The PAID Act requires CMS to provide MAP/PDP contact information to you for any MAP/PDP that provided coverage in the past three years.
- Consider setting up a Recovery Agent as a back up
  - Both entities would receive letters regarding conditional payment actions
- Unsolicited Response Report

MSP compliance Checklist Part 2:

During the life of the claim

Actions needed during the life of the claim

Claims can evolve and insurers must remain compliant as changes occur

- Monitor claim for changes in accepted conditions to update ICD codes
  - New conditions accepted? Need to add to ICD codes reported.
- ORM: is Termination appropriate?
  - Does state law terminate ORM? Judicial decision?
  - Does insurance contract terminate ORM? Examples: No fault limits, maximum coverage, claims can only be made for “X” years from date of incident, etc…
  - Treating physician has indicated no further treatment.
  - No practical likelihood of future medical treatment. Must include all of:
    - No ingestion, implantation or exposure claim
    - No claims paid for medical in the past five years
    - No treatment paid related to medical implantation or prosthetic device
    - Total paid for medical claims by the insurer did not exceed $25,000

Actions needed during the life of the claim (continued)

Claims can evolve and insurers must remain compliant as changes occur

- Monitor to see if Medicare has made a conditional payment
  - Medicare eligible claimant is treating, but you aren't being billed = red flag.
- Review medical treatment regime for appropriate of care and cost drivers that might impact ability to obtain a reasonable MSA
- Keep up to date on MSP updates or changes to rules and regulations.
- If claim is not yet reportable, verify there have been no updates that would make the claim reportable. An example is an individual on an accepted work comp claim became age eligible for Medicare at 65 and subsequently became a Medicare beneficiary.
- Consider sending notices for and new MAP/PDP plans identified in Section 111 reporting.

MP Compliance Checklist Part 3:

Settlement/Claim closure and beyond

Actions needed at the time of settlement

- If closing out future medicals in settlement, consider a MSA.
  - Does claim fall within threshold for review? Total settlement over $25,000 for Medicare beneficiary or over $250,000 if reasonable expectation of becoming a Medicare beneficiary.
  - If not pursuing MSA or outside threshold for review, was Medicare's interest adequately considered?
- If obtaining MSA:
  - Mitigation efforts on MSA pain points? (i.e., medications, spinal cord stimulators, pain pumps, vague surgery recommendations)
  - ICDs in MSA match Section 111 reporting?
  - Funding? Self-administered vs professionally administered
  - Final conditional payment request performed?
  - Determine if MSA should be submitted to CMS.

Actions needed at the time of settlement *(continued)*

- CMS Submission:
  - Is it the right time to submit to CMS?
  - All documentation to submit? Last two years of treatment for the injury, personal treatment records if no recent injury treatment, last two years of medication invoices/pharmacy history, CMS release, etc…
- Were MAP/PDP interests resolved?
- Settlement documents should be consistent with your MSA submission.
  - Do settlement documents refer to MSA?
  - Do settlement documents discuss who is responsible for post-settlement conditional payments?
- Following finalization of settlement: have ICD codes released by settlement, ORM Termination Date and TPOC entered correctly?
- Was claim not previously reportable? A settlement likely makes the claim reportable if the claim was not previously reportable. For example, a denied work comp or liability claim may not be reportable until the point of settlement. Once the claim settles, the claim is now reportable to CMS since a payment was made with the settlement.

Key data drives in MSP compliance

	MEDICARECONNECT, SECTION 111 MANDATORY INSURER REPORTING	CONDITIONAL PAYMENTS	MEDICARE SET-ASIDES
RRE	**Responsible Reporting Entity,** The company Medicare has identified as the responsible party for this claim i.e., carrier or self-insured employer	**Responsible Reporting Entity,** will receive notification of demands and any unpaid demands will be taken in the form of Offset from the RRE	**Responsible Reporting Entity**, can be responsible for payments made by Medicare post settlement due to an underfunded MSA
ORM	**Ongoing Responsibility of Medical** notified Medicare of the RREs responsibility of the claimant's treatment related to the ICD codes reported and populating a termination date notifies Medicare when the RRE is no longer responsible for the treatment of the claimant	**Ongoing Responsibility of Medical** as long as ORM remains open the CRC will continue to seek reimbursement from the RRE	**Ongoing Responsibility of Medical** should terminate after the MSA allocation is approved and the claim has settled to terminated the RREs responsibility
ICD	**ICD** Codes reported to Medicare indicated the accepted injuries	**ICD** all codes reported will be included in the CRCs recovery efforts, even codes reported in error	MIR **ICD** codes should be consistent with the MSA allocated conditions unless carrier/TPA inadvertently paid for unrelated conditions which will be included by CMS in the MSA as a counter high.
TPOC	**Total Payment Obligation to Claimant** notifies Medicare of the complete sum of money paid to the claimant to settle claim	**Total Payment Obligation to Claimant** upon submission of the TPOC and the termination of ORM the debtor moves from the RRE to the claimant.	**Total Payment Obligation to Claimant** will include the amount of money designated in the MSA as part of the settlement funds
DOI	**Date of Injury** CMS Date of Injury is the date of the accident/incident or the date of first exposure	**Date of Injury** is used by Medicare to set up individual demands. For each date of injury there will be a separate recovery effort by the CRC and BCRC	A global settlement involving multiple **Date of Injuries** may be included within one MSA. Each DOI and ICDs reported via MIR must be consistent with MSA allocation

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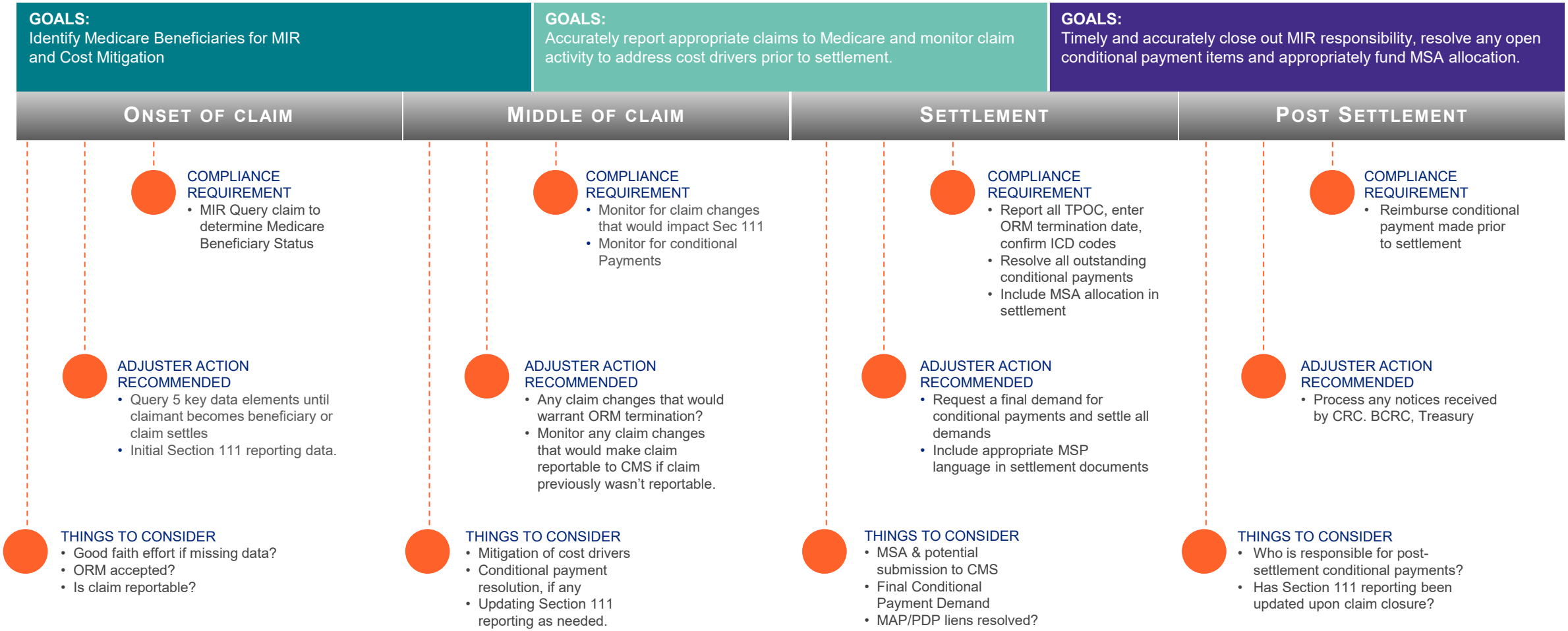
MSP compliance through the life of the claim



Questions?

To everyone involved …

It is a pleasure to work with you.

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