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CMS Issues Updated Section 111 NGHP User Guide

On **January 5, 2015**, CMS issued an updated Section 111 NGHP User Guide (version 4.4). The new User Guide incorporates the previous Alerts on reporting partial SSNs. As we discussed previously, beginning January 5, 2015, where a NGHP RRE cannot obtain an individual's HICN or full SSN, the RRE may report the following data elements that will enable CMS to properly identify a Medicare beneficiary:

•Last five digits of SSN

Submit your files to us electronically by clicking [here.]

•First Initial

•Surname

•Date of Birth

•Gender

The new User Guide was also updated to show that for liability claims not involving ORM, RREs will receive the CJ07 error code for reporting liability TPOCs with TPOC dates on or after October 1, 2014, with a cumulative TPOC amount less than or equal to the current $1,000.00 threshold. Previously, RREs could optionally report below-threshold liability TPOCs with TPOC dates on or after October 1, 2014, if the cumulative TPOC amount was more than $300.00. CMS also included new tables in the section in the User Guide on the liability TPOC threshold (section 6.4.3). The new Table 6-5 shows liability TPOC reporting requirement for TPOC dates since October 1, 2011, along with information on optional reporting for below-threshold liability TPOCs with TPOC dates prior to October 1, 2014. The new Table 6-6 shows when RREs will receive the CJ07 error code for reporting below-threshold liability TPOCs.

CMS Releases Updated WCMSA User Guide and Self-Administration Toolkit

WCMSA User Guide

Version 2.3 of the Workers' Compensation Medicare Set-Aside (WCMSA) User Guide was released January 5, 2015. Importantly, language was added regarding hydrocodone compounds schedule change and the deadline for responding to development requests has been extended for cases submitted through the WCMSA Portal.

In Section 9.4.6.2, Pharmacy Guidelines and Conditions, language was added addressing the hydrocodone compound schedule change. The reclassification occurred in October 2014, changing these products from a C-III controlled substance to a C-II controlled substance. This is significant because C-IIs require a new prescription every thirty (30) days or less while C-IIIs only require new prescriptions after five refills or six months, whichever occurs first. Under the C-II regulations, a physician may issue up to three prescriptions in one visit which would allow the patient to receive a ninety (90)-day supply in one office visit. For WCMSAs submitted on or after January 1, 2015, a minimum of 4 healthcare provider visits per year must be allocated when schedule II controlled substances are used, unless the medical records document more frequent provider visits.

Additionally, the amount of time allowed for responding to development requests for cases submitted through the WCMSA portal was extended from ten (10) days to twenty (20) days. Once the time allowed has passed, CMS closes the file and treats the subsequent submission as a new case. See Sections 9.4.1 and 9.5.

Additional changes were made to clarify language found in previous versions. To view the updated WCMSA User Guide in its entirety and a list of all changes,click here.

Self Administration Toolkit

CMS also released a toolkit for the self-administration of Medicare Set-asides as a resource for claimants. The toolkit lays out the process and guidelines of self-administration, from the time the WCMSA account is first established through its exhaustion. It explains who claimants will work with to manage their account, discusses lump sum verses structured settlement accounts and even covers special circumstances, such as when a beneficiary's status changes. The full toolkit can be downloaded here.

District Court in the Fifth Circuit gives an MAO a Private Cause of Action against a Tort Settlement Beneficiary

In *Collins v. Wellcare Plans, Inc*., the plaintiff filed a declaratory action against Wellcare Plans, Inc. (Wellcare), a Medicare Advantage Organization (MAO), seeking a declaratory judgment that Wellcare is not entitled to subrogation or reimbursement from her tort settlement funds. The amount in dispute, and arguably paid by Wellcare, was held in trust by Plaintiff's attorney and not disbursed with the other settlement funds. Wellcare subsequently filed a counterclaim, asserting that it has a statutory right of reimbursement, which expressly pre-empts contrary state law, and sought summary judgment.

The Court dismissed the plaintiff's claim for lack of jurisdiction. Plaintiff's argument requires an interpretation of the Medicare Act and therefore, arises under the Medicare Act. Thus, Plaintiff was required to exhaust the administrative remedies prior to seeking judicial review. Jurisdiction over the Defendant's counterclaim was proper; however, as MAOs are not required to exhaust the same administrative remedies.

In analyzing the defendant's claim, the court found that a cause of action existed under the MSP. The court relied on the Third Circuit's interpretation of the MSP in *In re Avandia Sales Practices, and Products Liability Litigation*, 685 F.3d (3rd Cir. 2012), which held that Medicare Advantage plans may assert a private cause of action against a "primary plan" under the MSP. In Avandia, the Third Circuit found that a plain reading of the statutory language provided such a cause of action, as the section of the MSP that references causes of action is broad and does not include exclusionary language that would preclude MAOs from recovering against primary plans. The Collins Court found that even if the language were vague, the result would be the same as an ambiguity would require Chevron deference be given to the Centers for Medicare & Medicaid Services, which has supported MAO's recovery rights in at least two memos.

After determining that MAOs have a cause of action under the MSP, the court then turned to the question of whether, in this case, Wellcare could bring a cause of action under this provision.

The Collins court first analyzed whether or not the tort settlement should be treated as a primary plan for purposes of Wellcare's recovery rights. The Collins court followed the reasoning of the Fourth Circuit in *Brown v. Thompson*, 374 F.3d 253 (4th Cir. 2004), that there is no real distinction between attempting to obtain reimbursement from a tortfeasor or his insurer and attempting to obtain reimbursement from a beneficiary whose settlement was funded by a tortfeasor or his insurer. In both instances, the money essentially flows from the same source: a tortfeasor or his insurer, both of which are considered "primary plans" under the MSP.

Once the court decided that the tort settlement should be treated as a primary plan, the court then addressed whether the Plaintiff's settlement satisfies the MSP's cause of action requirement that a plan fulfill both conditions denoted in § 1395y(b)(1) ("paragraph (1)") and (b)(2)(a) ("paragraph(2)(a)"). Paragraph (1) describes group health plans while paragraph (2)(a) notes that Medicare organizations should be secondary payers when making conditional payments. Although some courts have interpreted the private cause of action to strictly apply to Group Health Plans (GHPs), the Collins court refused to do so. Instead, it followed the Sixth Circuit's decision in Michigan Spine, which held that the MSP provides a private cause of action for primary plans other than GHPs. The court noted that to limit the MSP private cause of action to GHPs would only "eviscerate" the private cause of action for non-group health plans.

The court then addressed the plaintiff's arguments that Wellcare did not make a conditional payment because it did not actively seek out and identify a responsible party prior to making its payments. The court thoroughly disagreed and refused to place the burden of engaging in an active investigation on an MAO, as nothing in the statute supports such an interpretation. Moreover, in this case, Wellcare attempted to contact the plaintiff and her counsel for primary payer information and they failed to respond. As such, the court found that Wellcare did make a conditional payment in satisfaction of paragraph (2)(a).

Finally, the Court analyzed the double damages remedy of the private cause of action, which may be awarded when a primary plan fails to provide payment. The Court focused on the word "fail", noting that "[f]ailure connotes an active dereliction of duty, and the award of double damages is intended to have a punitive effect on plans who intentionally withhold payment." Because the plaintiff set aside the money into a trust and sought the court's direction, punishment was not justified in this case. The court distinguished the double damages remedy from the private cause of action recognized, and limited double damages to parties who evidence a "failure to provide payment."

This is the second court in the Fifth Circuit to follow the Third Circuit's decision in Avandia. Decisions like this one evidence that

Medicare Advantage Organizations continue to gain momentum and favor with courts when it comes to their recovery rights and from whom they are able to recover. We will be glad to help ensure that you are protected by confirming whether a claimant is enrolled in a Medicare Advantage Plan or Part D Prescription Drug Plan and assisting with resolution of any such lien.

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Register here today!

Happy New Year!

Carr Allison MSA would like to thank everyone for a great 2014!

We wish all our clients and friends continued success in 2015 and look forward to working with each of you soon!

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