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News and Alerts

Winter 2017

ALERT: District Court Finds CMS Erred in Requiring Carrier to Reimburse Entire Provider Charge Rather Than Just Related Portion

It is a familiar story for many insurance carriers and self-insured employers—Medicare has asserted a number of conditional payment claims which they indicate are related to an accident-related injury. Although the majority of the diagnosis codes associated with the charges are clearly unrelated to the injuries at issue, one code is related. Because of that one code, CMS assumes the entire charge is related to the accident and requests reimbursement for everything. In order to have it removed, CMS must be persuaded that the entire charge is for unrelated treatment, which is often a difficult to impossible task.

In a recent case, *Cali. Ins. Guar. Ass'n v. Burwell*, No. 2:15-cv-01113-ODW (FFMx), 2017 U.S. Dist. Ct. LEXIS 1681, the U.S. District Court of Central California addressed this exact problem and issued a ruling which could impact the way CMS handles this situation in the future. In this particular case, CMS (Defendant) paid medical benefits on the behalf of three individuals who were also covered under workers' compensation policies administered by the California Insurance Guaranty Association (CIGA) (Plaintiff). CMS sought reimbursement from CIGA for payments it had made on behalf of the three beneficiaries. In response to CMS' request for reimbursement, CIGA alleged that CMS determined the reimbursement responsibility of CIGA in a way that is contrary to the Medicare Secondary Payer Act (MSP) and resulted in a demand which was over-inclusive. CIGA requested that the court grant it partial summary judgment finding that the demands were over-inclusive and barring Defendant from reapplying this practice to demands issued to them in the future. Defendant, in response, argued in part that CIGA did not properly show that CMS' claims were over-inclusive and CMS' practice is based on a reasonable interpretation of the MSP. In reviewing the facts and the law, the Court rejected Defendant's argument and granted partial summary judgment to CIGA.

In all three demands issued by CMS in this case, the charges asserted contained at least one code related to the work injury; however, they also contained codes which were undeniably unrelated. The Court noted that both parties were in agreement on this point. The issue came down to whether CIGA provided enough evidence that the reimbursement requests were erroneous and...

Continued on page 2

Continued from page 1

... also turned on the proper interpretation of the MSP and implementing regulations. The Court first found that CIGA's prior disputes of the claims asserted, in which they identify all of the unrelated diagnosis codes, was sufficient to evidence that there was at least an argument that the charges were erroneously issued. The Court next reviewed the language in the MSP itself which indicates that "a primary plan...shall reimburse [Medicare] for any payment made...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." 42 U.S.C. §1395y(b)(2)(B)(ii). While the Defendant argued that an item or service refers to the entire medical treatment rendered by a provider, the Court found that interpretation to be unsupported. Reviewing regulations and the use of the terms "item and service" in other parts of the statute, the Court found that just because various medical treatments are lumped together in one charge does not mean that they are one "item or service". Rather, one provider charge can contain a number of items and services for which a carrier may only have partial primary payment responsibility.

This decision provides an excellent foundation for a more judicious and reasonable conditional payment claim reimbursement policy. We strongly support the Court's decision and will keep you posted regarding similar cases and any changes in CMS' policies resulting from the same.

CMS Alert—Beneficial Changes Expected For CMS Re-review Process

CMS recently issued an alert stating that it expects to expand the existing WCMSA re-review process. This potential expansion will include situations in which CMS has provided an approved amount, but settlement has not occurred and the medical care that supported the approved amount has substantially changed.

According to current CMS policy, a re-review is appropriate in the following situations: (1) you believe CMS' determination contains obvious mistakes; (2) you can provide additional documentation that justifies the original proposed amount; or (3) you have additional evidence, dated prior to the date of the original submission, that warrants a change in CMS' determination.

Noticeably absent from that list of options is the situation where CMS has provided an approved amount and the claimant's medical care changed substantially prior to settlement. Fortunately, according to the recent CMS alert, it appears that CMS has revisited its policy on re-review in that situation and is expected to make changes concerning the same in the coming year. This would be a very welcome, positive change that we have been encouraging CMS to explore for quite some time.

We are anxiously awaiting its implementation, as it will provide a direct and potentially invaluable benefit to our clients. As always, we will monitor this expansion closely and will keep you apprised of any new developments.

District Court Grants Motion to Dismiss After U.S. Argues that Court Lacks Jurisdiction Over Medicare Repayment Claim

In *Cheryl Nelson & Geico Gen. Ins. Co. v. Medi-Cal*, No. 1:16-cv-01328-LJO-BAM, 2016 U.S. Dist. Ct. LEXIS 153596 (E.D. Cal., November 4, 2016), the Plaintiffs (Geico General Insurance Company and Cheryl Nelson) brought an action for an interpleader of funds. The Plaintiffs intended on resolving competing claims by twelve entities against a \$100,000 motor vehicle accident insurance settlement which was to be paid to the injured party. Plaintiffs alleged that they were unable to determine the entities to which the settlement belonged and the proportions in which they were owed.

One of those entities, the United States (through the Medicare program), made conditional payments on behalf of the injured party totaling \$4,100. In response to its inclusion in the claim, the U.S. filed a motion to be dismissed from the action, arguing that the court lacked jurisdiction over its Medicare repayment claim and further arguing that sovereign immunity had not been waived. In making this argument, the U.S. contended that the Medicare Secondary Payer Act (MSPA) does not give the Medicare program a lien against the insurance proceeds such that sovereign immunity is waived. Further, they argued that the MSPA requires the exhaustion of administrative remedies before a claim can be subject to judicial review.

The Court considered the arguments of the U.S. separately, first finding that sovereign immunity had not been waived. As a rule, the U.S. is immune from suit

unless it has unequivocally expressed its waiver of sovereign immunity. The burden of proving that this immunity has been waived falls on the party seeking relief. In this case, the Plaintiffs did not even put forth an argument that the U.S. waived its sovereign immunity. While sovereign immunity is expressly waived under federal law in cases in which the U.S. claims a mortgage or lien, this law is not applicable in this case since the MSPA does not, by itself, establish a lien. Rather, the MSPA permits the U.S. to bring an action against a primary payer; it does not give the government a claim against property. The Plaintiffs also did not put forth an argument that they exhausted their administrative remedies under the Medicare Act. As a result, the court did not have subject-matter jurisdiction over the claim. The Court granted the Defendant's motion to dismiss on both grounds.

This case illustrates the unique hurdles that arise in cases involving Medicare. If you have questions regarding the administrative remedies available for claims arising under the MSPA, please contact us and we will be happy to help.



Recent Client Feedback

"You made this process so easy! And that made my job so much easier. I cannot tell you how happy I was with you and everyone I came in contact with at Carr Allison."

"I can't thank you or your firm enough for your extensive knowledge on the subject of Medicare."

US District Court Approves Split of Settlement Funds between CMS and TriCare

The case of *Geico Gen. Ins. Co. v. Dep't of the Navy Med. Care Recovery Unit*, No. 8:16CV58, 2016 U.S. Dist. LEXIS 141929 (D. Neb. Oct. 13, 2016) arose from a motor vehicle accident. June Shaw, an occupant of the vehicle was severely injured when the vehicle crashed. Ms. Shaw was both a Medicare and TriCare beneficiary.

Ms. Shaw received treatment on the condition that both Medicare and TriCare would be reimbursed for the payment of accident-related treatment after settlement. At that time, the \$100,000 policy limit proceeds were paid to the court for safekeeping. Geico, the plaintiff insurance carrier, filed an interpleader that allowed third parties to claim their interest in the settlement proceeds from Ms. Shaw's accident.

Both Medicare and the Department of the Navy, Medical Care Recovery Unit answered the interpleader and sought statutory reimbursement for funds paid on behalf of Ms. Shaw. The court determined that both parties had undisputed liens for treatment paid on Ms. Shaw's behalf. Medicare's lien alone, however, exceeded the policy limits. As a result, Medicare and Navy agreed to split the settlement proceeds on a pro rata basis. Per the agreement, Medicare took 93% of the proceeds and Navy the remaining 7%.

The court determined that both CMS and Navy had statutory rights to reimbursement from the interpleaded funds and approved the parties' agreement regarding the splitting of the proceeds.



Fighting for you — CMS Alert

CMS recently indicated that changes had been made to its review of MSA proposals involving denied injuries. These changes could have negatively impacted the amount required for Medicare Set-Asides involving denied injuries and greatly increased the difficulty involved in obtaining CMS approval of MSAs without funds for denied conditions.

CMS suggested that either a court ruling, following a hearing on the merits of the claim, addressing the compensability of the injuries or medical records from the treating physician, indicating that no future treatment of the denied injuries is needed on an industrial basis, would be required. It appeared that CMS would not treat a condition as denied without this documentation.

We immediately contacted CMS and challenged this unreasonable change in policy which occurred with no forewarning and could have negatively impacted our clients. CMS has now issued an alert confirming that its former policies will remain in place and any changes to its policies in the future will be published prior to taking effect. At Carr Allison Medicare Compliance Group, we're fighting for you.

Changes to Section 111 TPOC Reporting Thresholds

On December 12, 2016, CMS issued an Alert regarding changes in the Section 111 TPOC reporting threshold for liability, no-fault and workers' compensation claims. The Alert provides:

- **Liability Insurance:** The mandatory reporting threshold for liability insurance (including self-insurance) Total Payment Obligation to the Claimant (TPOC) Amounts dated January 1, 2017 or after is changing from \$1000 to \$750. If the most recent TPOC Date is on or after January 1, 2017, and the cumulative TPOC Amount is greater than \$750, the TPOC(s) must be reported.
- **No-Fault Insurance:** The mandatory reporting threshold for no-fault insurance TPOC Amounts dated October 1, 2016 or after changed from \$0 to \$750. If the most recent TPOC Date is on or after October 1, 2016, and the cumulative TPOC Amount is greater than \$750, the TPOC(s) must be reported.
- **Workers' Compensation:** The mandatory reporting threshold for workers' compensation TPOC Amounts dated October 1, 2016 or after changed from \$300 to \$750. If the most recent TPOC Date is on or after October 1, 2016, and the cumulative TPOC Amount is greater than \$750, the TPOC(s) must be reported.
- **Reporting of cumulative TPOC Amounts at or below the required reporting threshold will be accepted but are not required.** As of January 1, 2017, the CJ07 error code logic will be updated to no longer reject TPOC amounts less than the required reporting thresholds. Until that time, workers' compensation TPOCs of less than or equal to \$300 and liability TPOCs of less than or equal to \$1000 will be rejected unless reported with ORM. After January 1, 2017, the CJ07 error will only be returned for a liability, workers' compensation, or no-fault claim report where the ORM Indicator is set to "N" and the cumulative TPOC Amount is zero.

On January 3, 2017, CMS issued an updated Section 111 NGHP User Guide (version 5.2) incorporating the changes to the TPOC reporting thresholds. The User Guide was also updated to reflect that the CJ07 error code will only be returned if the ORM Indicator is set to "N" and the cumulative TPOC amount is \$0.00.

The Alert is available at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/New-Downloads/Technical-Alert-Change-in-TPOC-Reporting-Threshold-Change.pdf>. The updated User Guide is available at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html>.

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Results

Obtained ZERO conditional payment claim formal demand after convincing CMS to withdraw charges of \$49,957.

Received CMS approval of a ZERO MSA in a denied case.

Received CMS approval of \$66,099 MSA. CMS excluded funds for two prescription medications based on IMR Final Determination argument we presented. Client Savings = \$35,784

Disputed \$61,661 in conditional payment claims, which CMS reduced to ZERO. Client savings= \$66,661

Disputed \$22,966 in conditional payment claims asserted by CMS based on a pre-existing neck condition. CMS reduced the lien to \$305. Client Savings = \$22,661

Disputed \$112,175 in conditional payment claims asserted by CMS based on a pre-existing back condition, including a surgery performed after the date of accident. Provided substantiating documentation that surgery was recommended before the accident at issue. CMS reduced the lien to \$506. Client Savings = \$111,669

Received CMS approval of MSA without bilateral total knee replacement revisions that fell in the next-to-last and last year of life expectancy. Client Savings = \$71,430

Negotiated with CMS to reduce a lien in the amount of \$285,798 to \$50,484. Client savings = \$235,314

Our Services

*Workers' Compensation
Medicare Set-aside
Allocations*

Liability Settlement Allocations

*Conditional Payment
Claim Resolution*

Medicare Advantage Plan Solutions

Prescription Drug Plan Negotiation

Section 111 Reporting Services

Policy & Procedure Guides

Client Education Courses

Pharmacist Prescription Reviews

Required statement from the AL State Bar: No representation is made that the quality of legal services to be performed is greater than the quality of legal services provided by other lawyers. Any recoveries and testimonials are not an indication of future results. Every case is different, and regardless of what friends, family, or other individuals may say about what a case is worth, each case must be evaluated on its own facts and circumstances as they apply to the law. The valuation of a case depends on the facts, the injuries, the jurisdiction, the venue, the witnesses, the parties, and the testimony, among other factors.