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Recent Results:

- CMS approval of an $18,380 MSA reduced from $322,371 which was suggested by another vendor.

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Our Clients:

-"I cannot thank you enough for your extensive knowledge on the subject of Medicare."

-"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."

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May 2015 News and Alerts

Generic Drugs, Big Savings!

Recently, one of the most commonly prescribed opioids in workers' compensation cases, Oxycontin, has become available in generic form in the following dosages: 20 mg, 40 mg and 80 mg. By utilizing this drug in the generic form, the savings can be tremendous since the generic costs between $2.21 and $2.74 per pill less than the brand.

Another frequently prescribed drug in the workers' compensation arena is Nexium, which is often used to help prevent gastro-esophageal reflux due to the use of non-steroidal anti-inflammatory drugs (NSAIDs). Nexium's patent expired and the drug is now available in generic form. The cost of generic Nexium is $0.90 to $1.00 less per pill than the brand, depending on the dosage. Accordingly, use of the generic can save a substantial amount of money, particularly when priced over the remainder of a claimant's lifetime.

Need help determining if your claimant's drugs have a generic form? Contact us today!

CMS Update: Summary of Webinar on Applicable Plan Appeals

In case you missed the webinar on May 5, 2015, we have provided a summary below:

CMS held a webinar to discuss the new administrative appeals process for applicable plans. The new regulations establishing a formal right of appeal and an administrative appeals process for applicable plans went into effect on April 28, 2015, and will allow applicable plans to go through an administrative appeals process if CMS issues a formal demand for conditional payment claims naming the applicable plan as the debtor. The appeals process is

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only available for demands issued against an applicable plan on or after April 28, 2015.

CMS explained that the appeals process is only available after Medicare has issued an "initial determination" (i.e., a formal demand) and includes the following steps: (1) redetermination by the contractor that issued the demand letter; (2) reconsideration by a Medicare Qualified Independent Contractor; (3) hearing with an Administrative Law Judge; and (4) review by the Medicare Appeals Council. After an applicable plan has exhausted these steps, the plan may then seek judicial review. It is important to keep in mind that by not appealing conditional payment claims through the administrative appeals process within the appropriate time frames, applicable plans will lose the right to seek judicial review or otherwise appeal the amount owed.

CMS noted that the demand letter and any subsequent appeal determinations will specify any time frame or other requirements to proceed to the next level of appeal. CMS also reiterated that the beneficiary is not a party to applicable plan appeals but the beneficiary will receive notice of any appeal that is filed.

The applicable plan may designate a representative to handle the administrative appeals process on its behalf by providing a valid Proof of Representation form. CMS confirmed that appeal requests submitted by a representative without a proper Proof of Representation form will be dismissed. A request to vacate the dismissal may be submitted with a proper Proof of Representation form.

CMS discussed that the applicable plan may appeal the amount and/or existence of the debt. However, applicable plans cannot appeal Medicare's decision to seek reimbursement from the applicable plan rather than the beneficiary.

CMS announced significant policy changes in how they will issue demand letters to applicable plans. In the past, CMS has reduced demands for procurement costs (i.e., attorney's fees and costs). In the webinar, however, CMS stated that they would not apply the procurement cost reduction for demands issued against applicable plans. We asked CMS to explain this position, as 42 C.F.R. § 411.37(b) indicates that demands issued against primary payers should be reduced for procurement costs. CMS said that they did not want to give any reduction for applicable plans for opposing their recovery. However, CMS also said that they would review all questions submitted. We are hopeful that CMS will review 42 C.F.R. § 411.37(b) and agree that demands issued against applicable plans should be reduced for procurement costs. Because CMS will typically list the insurer/self-insured employer automatically as the debtor in workers' compensation cases, a refusal by CMS to recognize the procurement cost reduction will lead to a significant increase in demand amounts in workers' compensation cases. However, we have seen CMS apply the procurement cost reduction

in some demands issued after April 28, 2015, with the insurer listed as the debtor, and we are hopeful that this will continue.

CMS also indicated that in cases where CMS has agreed to a waiver or compromise of its recovery for the beneficiary, CMS may still pursue recovery from the applicable plan. In the past, if CMS agreed to a waiver or compromise request for the beneficiary, CMS would typically not pursue recovery against the primary payer. This change in policy would make it significantly more difficult to settle some cases in which Medicare has a substantial amount of conditional payment claims compared to the total settlement amount.

CMS also stated in the webinar that for claims involving ORM, CMS may periodically issue formal demands before there is a TPOC.

Typically, CMS has waited to seek recovery until there is a settlement, judgment, or award in the beneficiary's favor. Now, applicable plans that have reported ORM may start receiving demands prior to any settlement, judgment, or award.

Under 42 C.F.R. § 411.24(b), "CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan." It is important to note, however, that applicable plans should be able to appeal charges for which primary payment responsibility has not been demonstrated. If a claim has not resolved through settlement, judgment, or award, and an applicable plan would not otherwise be responsible under state law or the terms of the plan for the charges at issue, the plan could argue that CMS does not have a valid recovery claim since primary payment responsibilty has not been demonstrated.

Applicable plans will often have an MSA vendor handle the conditional payment claim research process when settlement is anticipated. However, if CMS starts issuing demand letters periodically when the applicable plan has reported ORM under Section 111, an MSA vendor may not be involved when the demand is issued and the applicable plan may not otherwise be actively looking for any conditional payment claim correspondence. Any demand that CMS issues against an applicable plan based on information that is reported under Section 111 should be sent to the address for the RRE that is reported on the TIN reference file. It is important for RREs to ensure that they have a process established for handling in a timely manner any demand letters that are sent to the address reported on the TIN reference file. Applicable plans have 120 days to file an appeal after receipt of an intial demand letter, and CMS assumes receipt of the demand letter within 5 days absent sufficient evidence to the contrary. Fortunately, beginning July 13, 2015, CMS will allow RREs to report recovery agent information on the TIN reference file, which should reduce concerns about any potential demands going unnoticed.

If you have any questions about the new appeals process, please feel free to contact one of our knowledgeable attorneys here. We will continue to keep you updated on any policy changes with CMS.

Additional Updates:

- Final Ruling: Conditional Payment Appeals Process for Applicable Plans
- 11th Circuit Court: Humana receives a Private Cause of Action under MSP

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