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"Medical Cost Containment Solutions"

Medicare Secondary Payer Compliance - Creating Best Practice Management

Introductory Overview

Prepared for:

[redacted]

Monica Williams
Manager, MSP Compliance Department
Innovative Claims Strategies LLC
mwilliams@icstrategies.com

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Today's Agenda

- Medicare Secondary Payer (MSP)
- Section 111 Reporting
- Medicare Set Aside Criteria
- Liability & No-Fault MSA
- Conditional Payment Management
- Step by Step process for CRC closure
- Settlement Initiatives
- Post Settlement Professional Administration
- Current CMS Updates
- Questions & Answers

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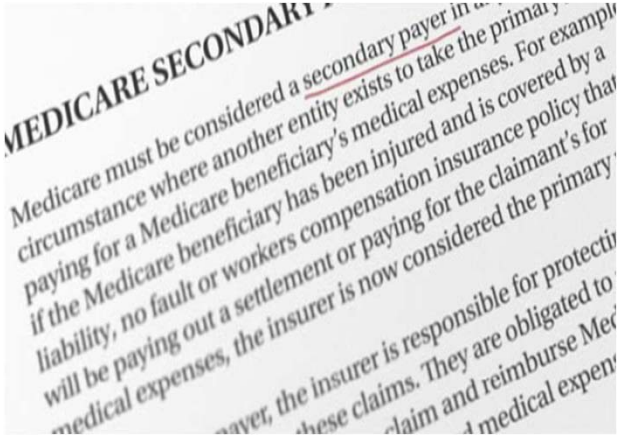
Medicare Secondary Payer – Compliance 101



As the primary payer, the insurer is responsible for protecting Medicare's interests in these claims.

They are obligated to properly report their involvement in the claim and reimburse Medicare for any conditional payments made toward medical expenses on the beneficiary's behalf

- Created in 1980 – Adopted in 1981
- Congress wanted to slow the rising cost of Medicare
- Primary Payers – Workers' Compensation, Liability and Auto No Fault
- Secondary Payer – Medicare
- ALL Settlements must "adequately consider" Medicare's interest, no shifting of Medicare to the primary payer (past & future medical care).
- Prohibits Medicare from making payments for covered medical items or services if payment has been made (past medical) or can be reasonably be expected to be made by another source (future medical bills)
- If no payer source is identified, Medicare will make conditional payment & Medicare may seek reimbursement once payment from another source becomes available

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Medicare Secondary Payer – Section 111 Reporting

As a Responsible Reporting Entity (RRE), any insurance company that assumes ongoing responsibility for medical expenses (ORM) for a Medicare beneficiary or awards a beneficiary any sort of financial settlement, is responsible to report the details of the claim to Medicare

- Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements with respect to Medicare beneficiaries
- MMSEA requires all primary payers to determine if claimant is entitled to Medicare. If so, primary payer must report to Medicare. Purpose is to track conditional payments
- Most RRE's rely on an automated process for Section 111 Reporting that includes four basic steps:
  - Although not required, most companies run all of their claims through an automated query to identify Medicare beneficiaries on a monthly basis
  - All claims involving Medicare beneficiaries are then further investigated to identify those involving ORM and those involving a final settlement or Total Payment Obligation to Claimant (TPOC).
  - All claims involving ORM require two reports: one report when the ORM is assumed and a second report when the ORM is terminated
  - A claim involving a TPOC must be reported once settlement is reached

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Medicare Secondary Payer – Section 111 Reporting Challenges

The reporting process under Section 111 is highly detailed and must be done accurately or the RRE risks having reports rejected or delayed. Delayed reports can result in compliance flags.

- While a proven automated process can help maintain compliance, there is no denying that details such as the exact dates of when ORM was assumed or terminated are all prone to human error upon entry
- An automated reporting system can't catch errors made at the time of initial data entry.
- An automated reporting system also won't be able to verify the validity of ICD-10 codes reported. Failing to enter correct data can lead to under-reporting or over-reporting
  - Under-reporting can lead to compliance penalties.
  - Over-reporting can result in thousands of dollars of unrelated medical claims being included in a Medicare lien.
- While automating the reporting process is the only realistic way for to keep up with Section 111 requirements, it can leave gaps

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Medicare Set Aside Criteria – Quick Reference Guide

As the name suggests, a Medicare Set-Aside (MSA) is a finite sum that is set aside by the primary payer, typically in a claim settlement, based on an estimate of future health care costs for a Medicare beneficiary due to a work-related or general liability injury, illness or disease.

Medicare has recommended MSA's as a reasonable means of protecting Medicare's interests for future medical expenses

Class I – Medicare Beneficiary

- A MSA arrangement and CMS approval is appropriate in all settlements involving Medicare Beneficiaries if the total settlement is greater than $25,000, regardless of the reason for Medicare eligibility

- CMS recommends a MSA for Medicare Beneficiaries if the total settlement is $25,000 or less, even though CMS will not review and pre-approve the MSA

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Medicare Set Aside Criteria – Quick Reference Guide

1. ***Whether the claimant has applied for Social Security Disability benefits***
2. ***Whether the claimant anticipates appealing a denial of SSD benefits***
3. ***Whether the claimant is in process of appealing and/or refiling for SSD benefits***
4. ***Whether the claimant is 62.5 years old***
5. ***Whether the claimant has End Stage Renal Disease***

Class II – **Reasonable Expectation** of Medicare Entitlement

- A MSA arrangement is appropriate if the claimant has a **reasonable expectation** of becoming a Medicare beneficiary within 30 months from the date of the settlement AND the total settlement is greater than $250,000

- If the claimant has a **reasonable expectation** of Medicare entitlement within 30 months and the total settlement amount is large enough but falls short of the CMS threshold, a MSA may be utilized to designate future medical expenses although CMS will not review and pre-approve the MSA

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Liability & No Fault MSA – Considerations

- The following analysis is recommended for all parties to a liability settlement:
  - Evaluate open cases for potential Medicare eligible clients
  - Audit the files at the onset of the intake process and group the cases into categories:
    - Nuisance value cases
    - Catastrophic cases
    - Settlement value groupings

- Identify health insurance coverage and disability benefits:
  - Medicaid cases, as well as dual eligible claimants (Medicaid/Medicare)
  - Other forms of health insurance – Private, ERISA, Tri-Care, VA Benefits, etc.
  - Medicare / Medicare Advantage beneficiaries
  - Determine Social Security disability status and eligibility.
    - A Social Security Consent for Release of Information form can be submitted to claimant's local Social Security office to verify eligibility. This form is also known as the Form SSA-3288

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Liability & No Fault MSA – Considerations

- Determine if future medicals are claimed: pleadings need to be analyzed to determine whether there is a claim for future medicals and pleadings should be amended if future medicals are not part of the claim.

- Take into consideration:
  - The nature of the injuries
  - The likelihood of future injury related medical care
  - The ability to secure a report from the treating physician stating that no future care is anticipated related to the accident
  - The existence of liens that need to be resolved
  - The potential settlement amounts
  - The policy limits
  - The defenses such as comparative fault or other

- Verify ICD-10 Codes at the onset of the file and update before submitting to CMS. Investigate Medicare Part C, Part D Coverage

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Medicare Secondary Payer Recovery – Conditional Payment

While many RRE's have a fairly reliable method for Section 111 Reporting, many fall short in their recovery obligations. The recovery side of Medicare compliance involves actually reimbursing Medicare for the conditional payments they've already made that are related to the claim.

Conditional Payment - CMS increases recovery efforts

- A conditional payment is a payment made by Medicare for services on behalf of a Medicare beneficiary when there is evidence that the primary plan does not pay promptly. These payments are referred to as conditional payments because the money must be repaid to Medicare when a settlement, judgment, award, or other payment is secured.
- After a conditional payment notice (CPN) or a conditional payment letter (CPL) has been issued, users may submit unlimited disputes any time prior to the case being demanded.
- Conditional payment letters are sent out 65 days after the Rights and Responsibilities letter is sent.
- Update conditional payment amount within 10 calendar days of Submitting Notice of Settlement
- Conditional Payment notice- You have 30 days to respond. If you agree with amount you can initiate the demand letter early

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Conditional Payment Management – Step by Step process to secure closure with CRC

The key is to send the final settlement documents to CMS to stop CP search and receive the Cease Recovery Letter. CMS does NOT have a time frame for generating the Cease or CMS closure letters. Reliance on the No Claim Found Letter and the Date of Settlement is imperative

- On all CP requests, once file is set up, CRC has **45 days to develop**
- CRC sends out a **No Claim Found** letter if the CP is $0.00
- If there are Conditional Payments, CRC sends out the **CP Letter** for dispute or payment
- Upon receipt of the **No Claim Found** letter, settlement process should begin
- CRC will continue scanning the system for Conditional Payments
- The completed settlement documents should be sent to CMS to establish the **Term date** as the date of settlement
- CRC will stop scanning for Conditional Payments and work towards closing the file
- If additional Conditional Payments are found between the time of settlement and closure, CRC will forward the CP Letter for review
- Send a letter to CMS stating the claim has settled and the settlement documents have been previously forwarded. Attach the settlement document to the letter and CMS will proceed to send a **Cease Recovery Letter**
- CRC will send back the CP Letters to the BCRC to address with the beneficiary for payment since they would have received settlement funds

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Settlement Initiative & Post Settlement

- ICS in partnership with Ametros is changing the way individuals navigate healthcare by providing them with Post Settlement medical management tools for their settlement funds
- By utilizing our integrated services, we can help:
  - Unlock more Settlements
  - Increase efficiency and success rate of the Settlement Process
  - Ensure MSP Compliance with Medicare
  - Provide support to injured parties for the life of their medical treatment

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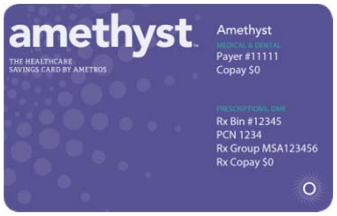
Settlement Initiative & Post Settlement – Best Practice Solutions

Professional Administration

CareGuard is designed to benefit injured parties after they settle their medical by providing savings, support and security.



Self Administration Tool

Amethyst is an innovative solution to help injured parties achieve healthcare savings from their settlement while receiving self-administration support.

Post-Settlement Pricing

CareQuote provides quotes for prescriptions, home healthcare, skilled facility, and durable medical equipment services.

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Medicare Secondary Payer – Updates

- Further clarified expectations of hearing on the Merits
- Updated defined requirements for Spinal Cord Stimulator Pricing
- Clarified total settlement calculations guidelines
- Added ICD-10 examples to Sample Cover Letter
- Clarified change of submitter requirements
- Clarified jurisdictional verification
- Updated Re-review policy
- Added required resubmission recommendation
- Updated Off Label Medication requirements
- More and more Providers will be confirming if there is a MSA in place to cover the medical expenses


Any Questions?

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Corporate Overview

Leading provider of strategic claims solutions—content, technology, and services—to the Property & Casualty industry

- National provider of medical cost containment solutions through a unique business model that delivers innovative, integrated, and flexible services focused to improve healthcare management and costs
- Long history providing customized Integrated Cost Containment Service programs specifically to the Workers' Compensation, Auto, Liability and Disability markets with demonstrated result and unparalleled services
- Customer / Service Centric Culture
- Medical & Disability services applying "Best Practice" techniques
- Documented Savings & Results
- Comprehensive, innovative, and flexible technology solutions
- We create branded business models, not commodities

Corporate Facts:

Founded:
2006

Headquarters:
Piscataway NJ

Ownership:
Privately Held

Mission Statement

"Our principle objective is to deliver innovative, integrated, and flexible medical cost containment services to our clients that result in outstanding program outcomes"

- Kay R. Estes, President/CEO

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Our Core Competencies

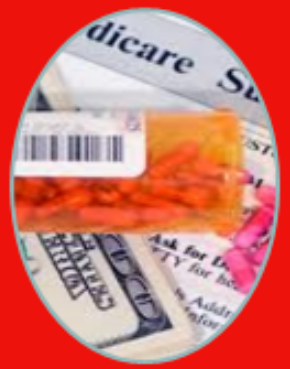
24/7 Call Center

Nurse Care Mgt with Return-To- Work Focus

Prospective Concurrent Retro UR Programs

Medical Bill Review with PPO ICING

Out of Network Signed Agreement IRON



MSP Compliance

Our Best Practice Technology creates Integrated Cost Containment Service Model

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Our Vision

"Every once in a while the unexpected arrives, a company that rises to the medical challenges of a new day"