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MSP Compliance
legislative, regulatory and administrative update

November 16, 2022

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Agenda

1. MSP regulatory updates
2. Case law
3. Industry updates
4. Fact patterns

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MSP regulatory updates

Civil Monetary Penalties
Final rule submitted for review
not yet published

Future Medical Proposed rule
Submitted but not published
Potentially related to liability MSAs

PAID Act
implemented December 2021

WCMSA Guide update
re: non-CMS-approved MSAs

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MSP regulatory updates

Case law updates

“Go Paperless”
CMS initiative

Presumption of COVID laws
impact on workers’ compensation MSAs

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Final rule on civil monetary penalties

February 18, 2020

Centers for Medicare and Medicaid Services (CMS) released proposed rule for imposing civil monetary penalties (CMP) related to Section 111 reporting failures by responsible reporting entities (RREs).

Possible CMPs when RREs:

1. Fail to register and report claims
2. Report data inconsistent with information already communicated to CMS
3. Report claims, but errors in Section 111 reporting exceed set tolerances

CMP can be up to **$1,000 per day**, up to **$365,000 per year** for ***each*** claim out of compliance

March 1, 2022

- CMS submitted final rule to OIRA for approval.
- Final Rule has not yet been published. CMS has until 2/18/2023 to finalize.
- Final Rule anticipated to be prospective, not retrospective.

Make sure all reportable claims are in compliance.

Possible CMP #1

RRE failure to register and report

- CMP up to $1,000 per day for non-compliance. Up to $365,000 per year.
- When RRE fails to report beneficiary beyond one year of settlement, judgment, award or other payment (TPOC).
- Likely will require “good faith efforts” to report showing efforts to obtain SSN or other information required.

Possible CMP #2

RRE reports inconsistent data communicated to CMS

- Purpose is for CMS recovery efforts to be based on accurate data. Civil monetary penalties could occur if CMS makes recovery effort and RRE indicates Section 111 information is incorrect.
- $1,000 penalty per day, per claim. Max penalty = $365,000 per year.

Example

- Section 111 is showing ORM = Yes; no termination date.
- CMS makes recovery effort for conditional payments, but ORM should have had a termination date entered.
- RRE failed to properly report ORM termination
- CMP would be up to $1,000 per calendar day

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Possible CMP #3

RRE Section 111 Reporting exceeds tolerance threshold

Proposed rules:

- Indicated CMP would be imposed if Section 111 reporting exceeded error tolerance threshold in 4 of 8 consecutive reporting periods
- 20% maximum error tolerance threshold (represents errors preventing ≥20% of beneficiary records from being processed)
- Tiered approach

1st	25% max penalty ($250) per individual per calendar day out of compliance for one quarter
2nd	50% max penalty ($500) per individual per calendar day for subsequent quarter out of compliance
3rd	75% if still out of compliance next quarter; 100% after that

Common threshold errors

- No ICD codes entered
- Invalid ICD codes entered
- Incorrect or no Social Security Number entered

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Proposed rule submitted on March 1, 2022, withdrawn on October 13, 2022

On March 1, 2022, the Final Rule on CMP was submitted to OIRA and CMS submitted a proposed rule regarding “Medicare Secondary Payer and Future Medicals”

On October 13, 2022, CMS withdrew the same rule.

Anticipated to potentially be regarding liability Medicare Set-Asides

What does this mean?

CMS has been working on a rule involving liability Medicare Set-Asides for years. The challenge is that liability and no-fault claims have a number of factors that make determining what amount would adequately take Medicare’s interests into account a difficult process.

Is the rule dead?

Yes. (For now.) It is always possible CMS will take another swing at this down the road.

Non-CMS-Approved MSAs

CMS views the MSA as an agreement between CMS and their Medicare Beneficiary. Medicare Beneficiaries are now required to sign a release form that is sent to CMS with the MSA stating they understand their obligations for the MSA.

- Various non-CMS-approved MSA products on the market.
- CMS has had a longstanding negative opinion of non-CMS-approved MSAs.
- It is through the submission process that the Common Working file is updated to reflect the settlement and the funds available to the beneficiary post settlement for CMS to coordinate benefits.

CMS updated WCMSA reference guide explicitly warning against non-CMS-approved MSA products:

4.3 The Use of Non-CMS-Approved Products to Address Future Medical Care

A number of industry products exist with the intent of indemnifying insurance carriers and CMS beneficiaries against future recovery for conditional payments made by CMS for settled injuries. Although not inclusive of all products covered under this section, these products are most commonly termed “evidence-based” or “non-submit.” 42 C.F.R. 411.46 specifically allows CMS to deny payment for treatment of work-related conditions if a settlement does not adequately protect the Medicare program’s interest. Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program’s interests are adequately protected. As such, CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement.

As a matter of policy and practice, CMS will deny payment for medical services related to the WC injuries or illness requiring attestation of appropriate exhaustion equal to the total settlement less procurement costs before CMS will resume primary payment obligation for settled injuries or illnesses. This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount.

Non-CMS-Approved MSAs

What does CMS' recent update mean with respect to non-submit MSAs?

- The reality is CMS' recent update doesn't actually change anything, but puts CMS' previously unspoken opinion of non-submit MSAs in writing.
- CMS views MSAs it reviews and approves through the submission process as an agreement between CMS and the beneficiary.

What can CMS do if it feels a non-submit MSA doesn't adequately cover Medicare's interest?

- As a matter of policy and practice, Medicare may deny payment for medical services if its interests were not adequately considered in a non-submit MSA.
- As noted in the WCMSA update, CMS continues its position that if the non-submit MSA is insufficient, CMS may require a spend-down of up to the total settlement, less procurement costs.

Provide Accurate Information Directly (PAID) Act Implemented December 2021

CMS is required to provide information of any Medicare Advantage Plan (MAP) or Part D Prescription (PDP) plan the claimant has been enrolled in the past three years.

- No requirements on RRE, such as actually contacting the MAP or PDP
- However, still recommended that RRE reach out to verify if MAP and/or PDP has any conditional payments prior to settlement.
- Consequences include third party private cause of action for double damages.

PAID Act in Practice:

- Simplifies identifying MAP/PDP plans for RREs
- MAP/PDP plans may still be unresponsive
- Only one contact point for MAP/PDP plans provided by CMS
- Develop protocols for providing notice to MAP/PDP plans based on PAID Act data to minimize risk of private cause of action for double damages.

Case Law

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Case law updates

- Aetna Life Ins. Co. v. Big, 2022 I.S. App. LEXIS 29797 (October 26, 2022)
- MSP Recovery Claims, Series LLC et al., v. Nationwide Mutual Insurance Company, et al. (S.D. Ohio Mar. 28, 2022)

- The decisions held Medicare Advantage Organizations (MAOs) have a private right of action for double damages under 42 U.S.C. § 1395y(b)(3)(A).
- To date, the Second, Third and Eleventh Circuit Court of Appeals are the only appellate level courts that have, so far, found MAOs have a private right of action against primary payers.
- While the Sixth Circuit Court of Appeals has not specifically made any decisions on this subject as of yet, the *MSP Recovery Claims v. Nationwide Mutual Insurance Company* opinion shows a pattern of holdings at the District Court level to the effect of MAOs right of private cause of action.

MSPA Claims 1, LLC v. Tower Hill Prime Insurance Co.

11th Circuit Court of Appeals case where MSPA Claims was assignee of defunct MAO and sued Tower Hill for recovery of reimbursable payment under MSP Act.

- Facts: Claimant sustained dog bite injury and had a liability claim. MAO paid $8,146.09 in 2012. Tower Hill settled with claimant for $25,000 to release claim of liability in 2012. MSPA Claims learned of possibility of claim against Tower Hill in 2015 and issued a Notice of Lien letter.
- MSPA Claims filed suit against Tower Hill in 2018

Court had to decide

1. Does statute of limitations apply to private cause of action under §1395y(b)(3)(A)?
2. If so, what statute of limitations should apply?

Court held a four-year statute of limitations that was a "catch all" under 28 U.S.C. §1658(a) applied from **the date the MAO paid medical bills.**

This decision is limited to the 11th district, which includes FL, GA & AL. Possible other districts follow suit.

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Gallardo v. Marstiller – FL Medicaid Right to Seek Reimbursement

Ms. Gallardo suffered permanent disabilities from being hit by a truck when she was exiting a school bus. She sued multiple parties and settled for $800,000.

- Medicaid paid $862,688.77 and continued to pay for benefits.
- Florida Medicaid sought reimbursement of $300,000.

- Gallardo argued that the Medicaid Act's anti-lien provision (§1396p) does not permit Florida to seek reimbursement for settlement amounts representing future medical expenses.
- The Supreme Court disagreed and held the text of 42 U.S.C. §1396k(a)(1)(A) provided an anti-lien exception for medical care, past or future.
- Justice Thomas said, "the grant of 'any rights . . . to payment for medical care' most naturally covers not only rights to payment for past medical expenses, but also rights to payment for future medical expenses. §1396k(a)(1)(A); see *United States* v. *Gonzales*, 520 U. S. 1, 5.
- The relevant distinction is between 'medical and nonmedical expenses,' *Wos* v. *E. M. A.*, 568 U. S. 627, 641, not between 'past and future medical expenses'

Industry updates

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COVID-19 Impact on MSA

28 states
have extended workers' compensation coverage to include COVID-19 as a work-related illness.

11 states
have statutes creating a presumption of coverage for COVID-19.[1]
Depending on the state, the presumption could cover most workers or it could cover a specific class of workers.

When dealing with MSAs that involve a COVID-19 claim:

- Be aware of state workers' compensation laws that could impact the MSA allocation or potentially disqualify a zero-dollar MSA.
- It is likely CMS would require a court order to overcome a presumption of an occupational disease statute.
- In the Virginia example, while there was no statute in place when the insurer denied the COVID-19 claim, the Virginia statute retroactively applied to claims dating back to 2020.
- There are several states pending legislation on similar laws regarding presumption of occupational disease for COVID-19, which could impact future MSAs.

[1]See https://www.ncsl.org/research/labor-and-employment/covid-19-workers-compensation.aspx for list of states that have enacted COVID-19 statutes related to workers' compensation.

CMS Goes Paperless — Conditional Payments

"Go Paperless" provides Responsible Reporting Entities (RREs) the ability to receive Medicare correspondence digitally.

CMS indicated the initial opt-in or opt-out is done at either:

- Section 111 reporting process
- TIN Reference File Submission

  This option is only accessible to RREs or their recovery agent, and is not an option that beneficiaries or attorneys can unilaterally select.

With Go Paperless...

- The RRE can access correspondence and manage email notifications in Medicare Secondary Payer Recovery Portal (MSPRP).
- A designated Account Manager (AM) can maintain or update email addresses for the RRE, Account Designees (Ads) or additional people or distribution lists.
- It is the RRE's and AM's responsibility to regularly review correspondence.

Fact patterns

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Proposed Final Rule CMP Fact Pattern #1: Workers' Compensation

RRE's Section 111 reporting for claimant reflects the following information:

- ICD-10 code S33.5 (lumbar sprain)
- ORM = Yes, but no termination date entered
- TPOC = nothing entered

Scenario: The CRC issues a conditional payment to the RRE for $10,000 relating to lumbar spine treatment on 1/1/23. The RRE responds to the CRC by disputing the conditional payments for the following reasons:

1. The Section 111 reporting inadvertently had the wrong ICD for the accepted condition. The lumbar spine was not accepted, but this was instead a neck injury.
2. ORM should have a termination date, which the RRE failed to enter. All conditional payments fall after the ORM termination date, which was not entered in Section 111. The RRE also did not include a TPOC as the claim settled in this situation.

Potential consequences: $1,000 per day civil monetary penalties.

Proposed Final Rule CMP Fact Pattern #2: Workers' Compensation

RRE's Section 111 reporting for Claimant reflects the following information:

- ICD-10 code S33.5 (lumbar sprain)
- ORM = Yes and termination date of 1/1/22
- TPOC = $10,000
- No MSA obtained by parties or approved by CMS, claimant was Medicare beneficiary at time of settlement.

Scenario: The BCRC issues a conditional payment on 1/1/23 to the claimant for $10,000 relating to lumbar spine treatment. The claimant or his/her attorney responds that ICDs inaccurate and TPOC inaccurate.

Additional Facts:

1. Claim was accepted for lumbar spine, but denied for the right knee. The settlement closed future medical for the right knee as well as lumbar spine.
2. Total settlement was $100,000, not $10,000

Potential consequences: $1,000 per day civil monetary penalties.

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Proposed Final Rule CMP Fact Pattern #3: Workers' Compensation

RRE's Section 111 reporting for Claimant reflects the following information:

- ICD-10 codes: R69 (unspecified illness)
- SSN: No SSN entered
- Unable to transmit due to CMS errors

Scenario: Based on Section 111 reporting alone, this claim could be subject to civil monetary penalties if errors are not corrected. Errors include:

1. Invalid or missing ICD codes.
2. Invalid or missing SSN.

Potential consequences: $250 to **$1,000 per day civil monetary penalties.**

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Proposed Final Rule CMP Fact Pattern #3: Workers' Compensation

- "Maximum error tolerance threshold" = errors that prevent 20% or more of beneficiary's records from being processed.
- CMS will impose civil monetary penalties if the claim has errors in more than three quarterly reporting periods in a period of eight consecutive quarters.
- There is an opportunity to make corrections without consequence of civil monetary penalties.
- The claim needs to remain error free for remaining quarters in the eight-quarter period.

Sliding scale for claims with eligible civil monetary penalties.

Daily CMP amounts	Time frame	
$250	First quarter	
$500	Next quarter	
$750	Following quarter	
$1000	Following quarter	← Maximum amount

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Fact Pattern #4: Liability and No-Fault

RRE's Section 111 Reporting Information:

- Liability & No Fault (PIP/Med Pay claim) claims reported separately.
- Both claims have no ICD codes entered.
- Liability claim = ORM No; No Fault claim = ORM yes (no termination date)
- No TPOC for either claim
- No Fault Insurance Limit is not entered.

Scenario: RRE has a liability claim, which is denied at this time.

A personal injury protection policy covers up to $10,000.

Fact Pattern #4: Liability and No-Fault

Liability claim

- In general, the liability claim is reported correctly assuming the claim remains denied.
- No ICD codes would be reported at this time, and ORM = No is appropriate as well.
- If a settlement is reached for this claim, then the insurer would update with TPOC and ICD codes at the time of the court approved settlement.

No Fault/PIP claim

- If ORM = Yes, then ICD codes should be entered for the injuries accepted as part of the no fault claim. To omit ICD codes will result in CMS errors with Section 111 reporting.
- The No Fault Insurance Limit should be updated to $10,000.
- If the $10,000 limit has been reached, the date the policy limit was reached should also be updated.

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