Shift Your MSP Compliance into High Gear

Don't let costly conditional payments leave you in the dust

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Navigating Medicare Secondary Payer (MSP) compliance is more challenging than ever. It's difficult enough for insurers to identify claims for which MSP compliance is even an issue. Add to that the changing policies of the Centers for Medicare and Medicaid Services (CMS), and it becomes nearly impossible to keep pace.

As a result, insurers are unknowingly—and frequently—paying more than they should for conditional payment liens. The Commercial Repayment Center (CRC), the CMS recovery enforcement arm, is shifting conditional payment demands into overdrive with rolling recovery and referring more claims to the Department of Treasury for collection. In 2017, Treasury referrals increased 55 percent.[1]

Insurers need a better strategy to get ahead of the demands and fuel an effective compliance program.

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Conditional payments are costlier than realized

The CRC shows no signs of slowing down its recovery of Medicare payments in ongoing responsibility for medicals (ORM) situations. In fact, it's putting its foot on the gas. In fiscal year 2017, the CRC returned more than $130 million to the Medicare trust fund.[2] That's nearly a $43 million increase from the previous fiscal year.

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While that figure should be a wake-up call to insurers, it's more alarming that many carriers don't realize how much they're wasting on conditional payments. Insurers often overpay for claims or pay without disputing because they don't have proper insights to contest a conditional payment notice (CPN) or demand.

Municipal self-insurer caught in the mire of ICD codes

A large municipal self-insured entity's Section 111 reporting got mired in over-inclusive ICD codes, causing almost $900,000 in exposure. The municipality suffered when the Treasury Offset Program (TOP) intercepted federal grant monies for vital city services. With ISO Claims Partners reporting for this entity and overseeing conditional payment mitigation, nearly $900,000 was mitigated—a 99 percent reduction.

Just because an insurer receives a demand letter doesn't mean the CRC is correct in issuing it. There are many instances where Medicare mistakenly attempts to recover charges that aren't related to a claim. Last year, the CRC refunded nearly $23 million in excess collections it had recovered.[3]

Unfortunately, many carriers consider conditional payments a cost of doing business. But have they really tracked how much it's actually costing their business?

Exposure reductions for national carrier

A national property/casualty carrier with significant workers' compensation business has been presented with more than $8 million in conditional payment exposure in 2018 to date. So far, ISO Claims Partners has been able to mitigate over $6 million of that amount—nearly 80 percent of the total exposure. More mitigation could come, as disputes and appeals are pending.

For example, some conditional payments may be for small amounts. But one insurer can have thousands of these "small" claims. And if they don't reimburse the payment within 60 days, interest accrues. If the process lags, it can end up in Treasury collections after 120 days.

These small claims can add up quickly and turn into major leakage, especially if the payments could have been disputed or reduced.

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$23M

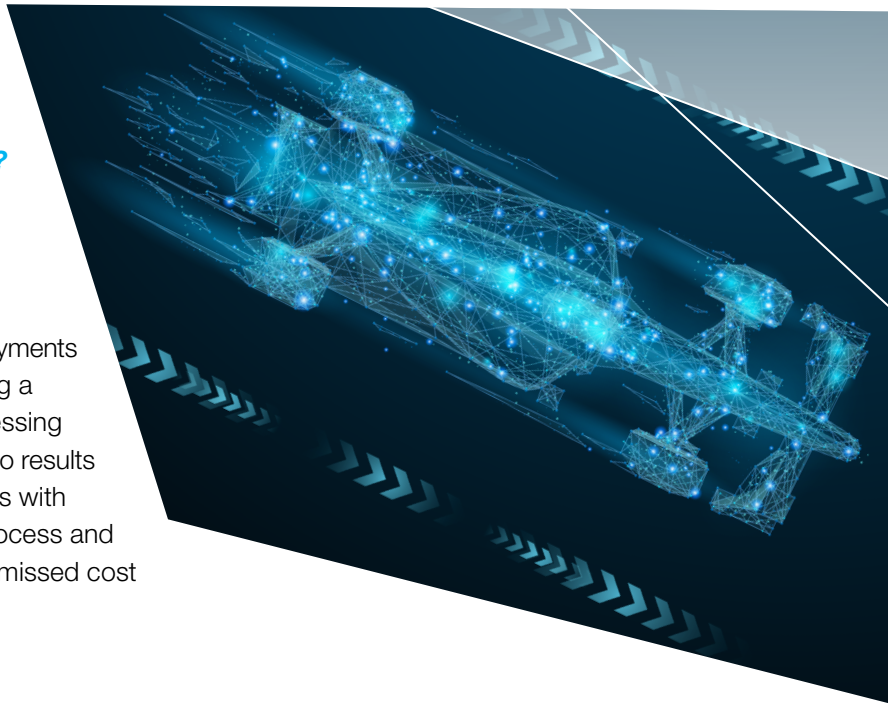
in excess collections in 2017.

Complexity makes it difficult to stay on track

Conditional payments are just one part of an increasingly complex MSP compliance landscape. As that landscape evolves, it's more difficult to stay up to speed. Consequently, missteps in compliance can be costly.

To avoid these issues and mitigate costs, insurers must ask themselves tough questions:

Where does my exposure come from?
How do I identify it?
How do I determine what I owe?
How do I contest it?



Traditionally, insurers handled conditional payments as an independent compliance point, taking a claim-by-claim approach. Not only is addressing claims separately time-consuming, but it also results in compliance gaps, such as missing claims with Medicare beneficiaries, inconsistency in process and execution, lack of visibility into claims, and missed cost mitigation opportunities.

Programmatic approach wins big

A national property/casualty carrier with significant workers' comp business began a programmatic approach in mid-June 2018 with nearly 1,500 referrals. By mid-August, the insurer had obtained conditional payment correspondence on 400 claims. Estimated savings are expected to be almost $300,000—a nearly 90 percent anticipated reduction in total exposure.

Closing these gaps requires a more holistic approach, particularly connecting Section 111 reporting to conditional payments.

Section 111 data drives compliance

Section 111 data and conditional payments are already inextricably connected. Medicare uses Section 111 reporting—which identifies Medicare beneficiaries—to initiate the conditional payment recovery process.

For example, the Section 111 query process notifies the carrier or self-insured of claims in which conditional payments may exist. The ORM report gives the CRC the data it needs to generate a CPN or demand before settlement, and the TPOC (total payment obligation to client) report provides notice of settlement, which gives Medicare the opportunity to seek final recovery.

Insurers are already reporting this mandatory data for Medicare to seek recovery for conditional payments. It makes sense for carriers to leverage this data to identify conditional payments early or spot errors that would trigger a CPN.

Minimizing leakage from conditional payments starts with accurate Section 111 reporting. It's important to pay close attention to key data fields that trigger conditional payments, in particular the query, ORM indicator, assumption of ORM, ORM termination dates, ICD codes, and date of incident (DOI). Accurate reporting in these areas not only eliminates exposure, it also preserves administrative resources needed to manage conditional payments down the road.

A strong and thorough Section 111 reporting program leads to more effective disputes and appeals. When disputing a CPN, pay close attention to items such as the Payment Summary Form (PSF), which indicates related treatment, as well as ICD codes that the CRC contends are causally related.

Ensuring accurate Section 111 reporting, analyzing claims, and disputing conditional payments are all part of a holistic program that can reduce costs and improve compliance. For optimal efficiency, insurers should infuse automation into the program as well.

Jump-start your compliance program

Conditional payments don't have to put your compliance program in the pits. With the right strategy and automated tools, you can reduce costs, mitigate exposure, and achieve full compliance.

CP Link® is ISO Claims Partners' automated solution that leverages Section 111 data to drive the conditional payment process proactively. The tool integrates with Section 111 reporting systems to create a comprehensive compliance program.

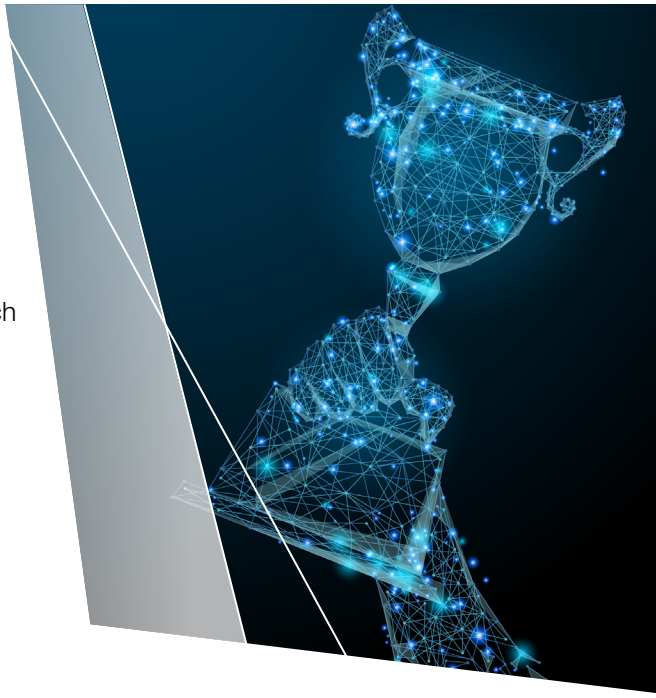
ISO Claim Partners
helped clients save

$60M

on conditional payments
in 2017.

Whether it's disputing CPN or handling Treasury collections, ISO Claims Partners can help. Our full spectrum of products and services helped clients save $60 million on conditional payments in 2017. In fact, our efforts result in payment reductions 98 percent of the time. We also helped clients save an average of 86 percent on Treasury Department requests.

It's time to stop paying more than you owe for conditional payments. Improve your claim outcomes with the right approach and the right partner in compliance.



Endnotes

1. Figures based on ISO Claims Partners' client data
2. http://img.en25.com/Web/ISO/%7b6cbd4e13-5526-4a09-a55c-dda47d688cca%7d_The-Medicare-Secondary-Payer-Commercial-Repayment-Center-in-Fiscal-Year-2017.pdf
3. http://img.en25.com/Web/ISO/%7b6cbd4e13-5526-4a09-a55c-dda47d688cca%7d_The-Medicare-Secondary-Payer-Commercial-Repayment-Center-in-Fiscal-Year-2017.pdf

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