Inaction is not an option: Get a grip on MSP risk

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THE COST OF LETTING GO

Claim handlers are in a position where they can't let anything go. Every day, they must determine coverage, investigate and evaluate claims, identify potential fraud, confer with legal counsel, authorize payments, and negotiate settlements. They've got to make all the right moves, because missing a step isn't an option. If every task doesn't get done, the result could be increased delays, high claim costs, charges of bad faith, failure to uncover fraud or unfavorable settlements, or lost customers.

But getting on top of claims management has become more difficult. Now claim handlers must negotiate the intricacies of the Medicare Secondary Payer (MSP) Act. Complex and constantly evolving, the MSP Act presents numerous thorny challenges for the claims department.

While nearly all insurers are taking the steps to fulfill basic levels of MSP compliance obligations, many don't have the bandwidth to fully mitigate exposure. However, just as with all the claim handlers' other essential tasks, when it comes to MSP, inaction on any front is not an option. Insurers are missing opportunities to better protect their balance sheets from critical exposure risks, including: recovery of payments made by Medicare against insurers, the potential for $1,000 per claim/per day reporting violations, and exorbitant Medicare Set-Asides. In addition, lack of action in complying with MSP can add delays and costs and significantly increase exposure and risk.
BACKGROUND OF THE MSP ACT

To understand why inaction is not an option for MSP compliance, let’s first take a look at this federal law, which was created to preserve the fiscal integrity of the Medicare trust. The MSP Act effectively places Medicare in the position as the payer of last resort in all situations where there is, or where there could be, another entity or policy of insurance responsible for medical treatment for a Medicare beneficiary. In the non-group health plan context, the MSP Act is applicable to workers compensation, liability and first-party no-fault, and any self-insured situations.

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ARE YOU MAKING THE RIGHT MOVES TO COMPLY WITH SECTION 111?

The Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 required insurers and self-insureds to report electronically certain claims data pertaining to Medicare beneficiaries, including a claimant’s Medicare entitlement status, the insurer’s assumption of Ongoing Responsibility for Medicals (ORM), and a Total Payment Obligation to Claimant (TPOC) event (typically a settlement). Section 111 reporting allows Medicare to coordinate benefits and ascertain recovery opportunities. While we’ve seen many insurers be responsive to this part of MSP reporting, it’s always a good idea to look fully at your compliance program because potentially steep fines are associated with misreporting and noncompliance.
Are you doing everything you can to avoid:

- **Civil money penalty:** The MSP Act subjects insurance carriers and self-insureds that are Responsible Reporting Entities (RREs) to a potential civil money penalty of $1,000 per day/per claim for Section 111 reporting compliance failure.

- **Compromising conditional payments:** Now, more than ever, Medicare is relying on Section 111 data to initiate, coordinate, and effectuate conditional payment recovery. Medicare uses ICD codes, dates of injury, and various claim data points for this purpose. Therefore, it’s critical that insurance carriers and self-insureds do not fail to report accurate data.

- **Improper payments or denial of service:** Medicare is using Section 111 data to determine if Medicare should be making payments. Incorrect or inaccurate data may result in Medicare paying when they shouldn’t or denying treatment when they should pay.

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**DO YOU HAVE A FIRM FOOTING FOR CONDITIONAL PAYMENT COMPLIANCE?**

The MSP Act generally prohibits Medicare from making payment for treatment that is the responsibility of another primary payer. However, the legislation allows Medicare to make payments for medical expenses on the condition that those payments are reimbursed to Medicare should a primary payer’s responsibility be demonstrated. To properly execute on conditional payment compliance, parties need to coordinate securing conditional payment information, mitigating exposure, and ensuring that the case is resolved.

Claims organizations generally fall on a continuum of conditional payment compliance:

- **LESS RISK**
  - Partner with MSP vendor with programmatic approach or develop robust internal program
  - Ad hoc referrals for services to MSP vendor
  - Internal program that addresses some exposure

- **MORE RISK**
  - Let claimant or claimant’s attorney handle
  - Do nothing

Insurers that aspire to assume less MSP risk have built robust internal programs or partnered with compliance organizations to address all conditional payment exposure. At the other end of the spectrum are those that passively address only a small volume of conditional payment claims.
Organizations at the riskier end of the conditional payment spectrum face steep costs

- **Money**: Medicare will often attempt to effectuate recovery for purported conditional payments that the primary payer doesn’t owe, typically due to a mistaken recovery attempt for charges that aren’t causally related to the underlying claim.

- **Time**: Conditional payment activities are time-consuming: registering a claim, following up with Medicare, reviewing claims, initiating a dispute or appeal. The federal government’s processes and timelines often impede time frames, causing delays and increased costs.

- **Interest accrual**: If Medicare issues a demand for repayment of conditional payments, a debtor has 60 days from the date of the demand to provide reimbursement to the program. Interest accrues on the debt from the date of initial demand and is assessed for each 30-day period that the debt remains unresolved.

- **Referral to Treasury for collection**: Medicare may refer the debt to the U.S. Department of the Treasury if the demand is not paid within 120 days. Once the matter is with the Treasury, interest will continue to accrue and collection efforts will begin, including the withholding of federal disbursement through the Treasury Offset Program (TOP).

- **Federal court lawsuit for double damages**: Medicare can refer a debt to the Department of Justice for legal action. If Medicare is successful in a suit, the program may require recovery of double damages against the defendant insurer.

- **Private cause of action**: Under the MSP statute, a provision exists for a “private cause of action” for double damages in situations where a primary plan fails to provide primary payment.

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**Getting tough with conditional payment compliance**

A client had a workers compensation claim with numerous denied components, but Medicare contended that many conditional payments were related. Medicare reported more than 59 separate unrelated ICD codes. The total unrelated and inappropriate conditional payments alleged exceeded $700,000 in Medicare exposure. ISO Claims Partners successfully disputed every single unrelated conditional payment down to $0, with a **total savings of $713,165.86**.
MEDICARE SET-ASIDES: DON’T LET THIS MAJOR COST DRIVER SLIP

Whenever parties are settling a workers compensation claim that includes future (postsettlement) medical expenses, Medicare’s interest must be protected by means of a Medicare Set-Aside (MSA). An MSA allocates money for anticipated postsettlement expenses otherwise covered by Medicare. Although implementing an MSA in a lump-sum workers compensation settlement has been standard practice since the early 2000s, current Medicare policy has made MSAs a significant cost driver in the resolution of workers compensation claims.

Are you letting MSAs get out of control by:

• **Not allocating accurately:** It’s critical when calculating for inclusion of services and prescription drugs that you aggressively mitigate the unnecessary addition of unreasonable or unnecessary elements. Although determining the lowest possible defensible and reasonable allocation amount can be a difficult task (given Medicare’s guidance), not advocating for accurate allocation can frequently result in increased costs.

• **Counter-highers:** A counter-higher occurs when an MSA is submitted to Medicare for review and Medicare determines that a higher amount should have been allocated. Counter-highers can be staggering, leading to derailed settlements and major delays.

• **Prescription drugs:** CMS’s prescribed methodology concerning prescription drugs typically involves allocating use for the life of the claimant. With this regimen, prescription drugs can become major cost drivers in an MSA. Many MSAs involve treatment of pain management through exorbitantly priced opioids. Unmitigated, these drugs result in skyrocketing MSA amounts that derail a settlement.

Taking strong action on MSAs

Medicare evaluated an MSA amount of $39,384 that ISO Claims Partners proposed on behalf of a client and issued a counter-higher for $538,233. CMS added treatment for injections (related to diabetes) and medication that would be used to treat the claimant’s hepatitis condition. We recommended submitting a reconsideration argument to CMS because the insurer denied the diabetic condition. Additionally, we reviewed current records, and it appeared that the injections were not successful. The adjuster confirmed that the medication for the hepatitis was a six-week program intended to cure the disease. CMS agreed with our reconsideration argument and reduced the set-aside from $538,233 to $91,835. As a result, ISO Claims Partners was successful in saving the client more than $445,000 on this claim.
GET ON THE RIGHT TRACK TO MANAGE SERIOUS MSP RISKS

For each part of the MSP Act, insurers can take powerful actions to ensure compliance while mitigating risk. Here are step-by-step approaches to defending your interest in each area.

**Section 111 reporting**

- **Identify errors**: Conduct an audit or analysis of prior reporting errors and determine the root cause to ensure compliance going forward.

- **Accuracy**: The goal should be 100 percent error-free reporting. Ensure proper format and correct data values.

- **Monitoring**: To report consistently and properly, continuous monitoring with internal reporting capabilities (for visibility) and compliance flags and alerts should be implemented.

**Conditional payment compliance**

- **Don’t delay**: There’s nothing worse than finding out on the courthouse steps that a claimant is entitled to Medicare. The sooner the conditional payment process is initiated, the better positioned the claim will be for resolution. So identify the claimant’s Medicare status as soon as possible.

- **Identify**: It’s critical to ensure at the start that the claim is properly registered with the applicable Medicare contractor and that conditional payment correspondence is generated and obtained. Without these actions, subsequent steps cannot be taken to mitigate risk and exposure.

- **Analyze**: Many times, Medicare will incorrectly assert conditional payment responsibility for claims that should not be recoverable. It’s important to scrutinize the applicable listing of Medicare conditional payments and thoroughly analyze whether Medicare is indeed the secondary payer.

- **Dispute/appeal**: Following an analysis, it’s important to move forward quickly when engaging the applicable MSP contractor in a dispute or appeal to eliminate unrelated or unwarranted conditional payments.

- **Finalize**: When a claim reaches resolution—whether by way of settlement or termination of Ongoing Responsibility for Medicals—it’s critical to obtain a final demand or case-closure letter from the applicable contractor so there is no exposure beyond the life of the claim.

- **Execute programmatically**: If you’re properly executing on only 50 percent of your claims, you’re still at risk for the other 50 percent. A solid conditional payment compliance program focuses on 100 percent of claims with potential risk and is actionable for every claim.
Medicare Set-Asides

- **Use a holistic approach:** By implementing a medical/legal approach and looking at every aspect of a claim for reduction, MSA costs can be greatly mitigated. It’s also vital to keep on top of CMS’s constantly changing cost requirements and trends.

- **Stand up to Medicare:** Many insurers wrongly believe that if Medicare issues a counter-higer they have no recourse. The fact is that requesting CMS to reduce unwarranted treatment or prescription drugs can effectively lower the cost of the MSA.

- **Address cost drivers:** Instead of assuming that you’ll be saddled with a particular expensive prescription drug or procedure, analyze and attempt to mitigate these cost drivers before they make their way into an MSA.

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GET A GRIP: ISO CLAIMS PARTNERS CAN HELP

It’s clear that MSP compliance can inadvertently put insurers at risk for numerous unnecessary exposures. And it’s equally clear there are many steps insurers can take to vastly strengthen their MSP risk mitigation efforts. If you choose not to go it alone, ISO Claims Partners provides a full spectrum of MSP compliance products and services to ensure complete conformity, reduce costs, and improve claims outcomes.

- **Seamless Section 111 reporting:** ISO Claims Partners’ MSP Navigator™ is the industry’s premier Section 111 reporting platform. Its seamless integration, compliance flags, and smart prompts ensure accurate and error-free reporting.

- **Integrated Conditional Payment Compliance:** ISO Claims Partners offers CP Link, our programmatic approach to addressing conditional payment compliance that integrates directly with your Section 111 reporting data. CP Link ensures that all exposure is addressed and gets ahead of the compliance process at the earliest point in time possible. We also offer ad hoc conditional payment services for identification, analysis, and disputes or appeals on a claim-by-claim basis.

- **Accurate and Economical MSAs:** Our suite of MSA services will provide the most cost-effective compliance vehicles available. Our proven approach to allocating—by identifying and mitigating cost drivers, using data and analytics, and advocating with Medicare—will result in accurate and economical MSAs to enable settlement and improve claim outcomes.
MSP compliance is a risky proposition; one wrong step can send claims severity tumbling out of control. Taking action and proactively defending your company’s interests can put your company on the right path to reducing potential risks—and improving outcomes.