



What Happens Once the Case Settles?

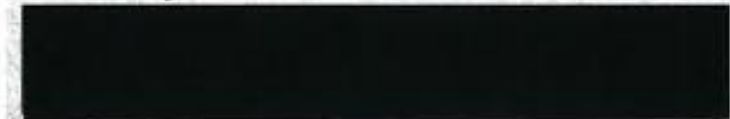
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Why Does It Matter?

What Are the Consequences?

January 02, 2018



290460
0003

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G0463-PO)	NO	\$229.00	\$0.00	\$0.00	\$229.00	E,F
Total for Claim		\$229.00	\$0.00	\$0.00	\$229.00	E,F,G

Notes for Claims Above

- E** Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies).
- F** Medicare does not pay for this item or service.
- G** The amount Medicare paid the provider for this claim is \$0.00.
- H** \$111.96 of this approved amount has been applied toward your deductible.
- I** This information is being sent to [Redacted] Send any questions regarding your benefits to them.

MSA Administration Responsibilities



- Establish a separate, interest-bearing bank account



- Identify if treatments are related to the injury and Medicare-covered and pay them in full



- Track all expenses and submit annual attestation and/or any other exhaustion reports

Do the injured individuals seek the treatment in the MSA?

Do they exhaust their funds?

The Treatment Plan Varies from the MSA

29% of provider bills
have ICD10 codes NOT on the MSA

32% of prescription drug fills
for drugs NOT on the MSA

Figures based on Ametros data as of 8/31/19.

Providers Do Not Bill at Fee Schedule

Average Bill Review Result:

Billed Amount: \$850

Fee Schedule Amount: \$368

Reduction %: 57%

Figures based on Ametros 2018-2019 data.

Provider: MEMORIAL HOSPITAL

Dates of Service: 06/28/17 - 06/28/17

Medicare #: XXXXX

Diagnosis Code(s):

TIN: XXXXXXXX

Treating Provider: MEMORIAL HOSPITAL

Rendering Zip: XXXX

Bill Type: APC Outpatient

NPI:

Z4589 Encounter for adjustment and management of implanted devices
 M545 Low back pain
 M791 Myalgia
 I10 Essential (primary) hypertension
 F17210 Nicotine dependence, cigarettes, uncomplicated

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Qualify Code
1	06/28/17	250	PHARMACY	15	\$399.45	\$0.00	\$0.00	\$19.97	\$379.48	DSPRS
2	06/28/17	272	MEDICAL/SURGICAL SUPPLIES: STERILE SUPPLIES	4	\$10514.00	\$0.00	\$0.00	\$525.70	\$9988.30	DSPRS
3	06/28/17	C1820 278	MEDICAL/SURGICAL SUPPLIES: OTHER IMPLANTS	1	\$102555.00	\$78,665.00	\$0.00	\$1194.50	\$22695.50	INV2
4	06/28/17	C1787 278	MEDICAL/SURGICAL SUPPLIES: OTHER IMPLANTS	1	\$8336.00	\$4,039.75	\$0.00	\$214.81	\$4081.44	INV2

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Qualify Code
Totals:				306	\$132,777.05	\$82,723.51	\$0.00	\$2,502.67	\$47,550.87	

Sample Bill from Ametros Member.



AWP is Not What is Actually Billed/Paid

Diltiazem 60MG

Redbook AWP = \$0.33

Avg. Paid = \$0.20

40%+ Less

Gabapentin 300MG

Redbook AWP = \$0.03

Lowest AWP ever filled = \$0.18

Most common AWP = \$1.34

Significant differences in AWP



Exhaustion Rates

4%

of members exhaust in a given year

17%

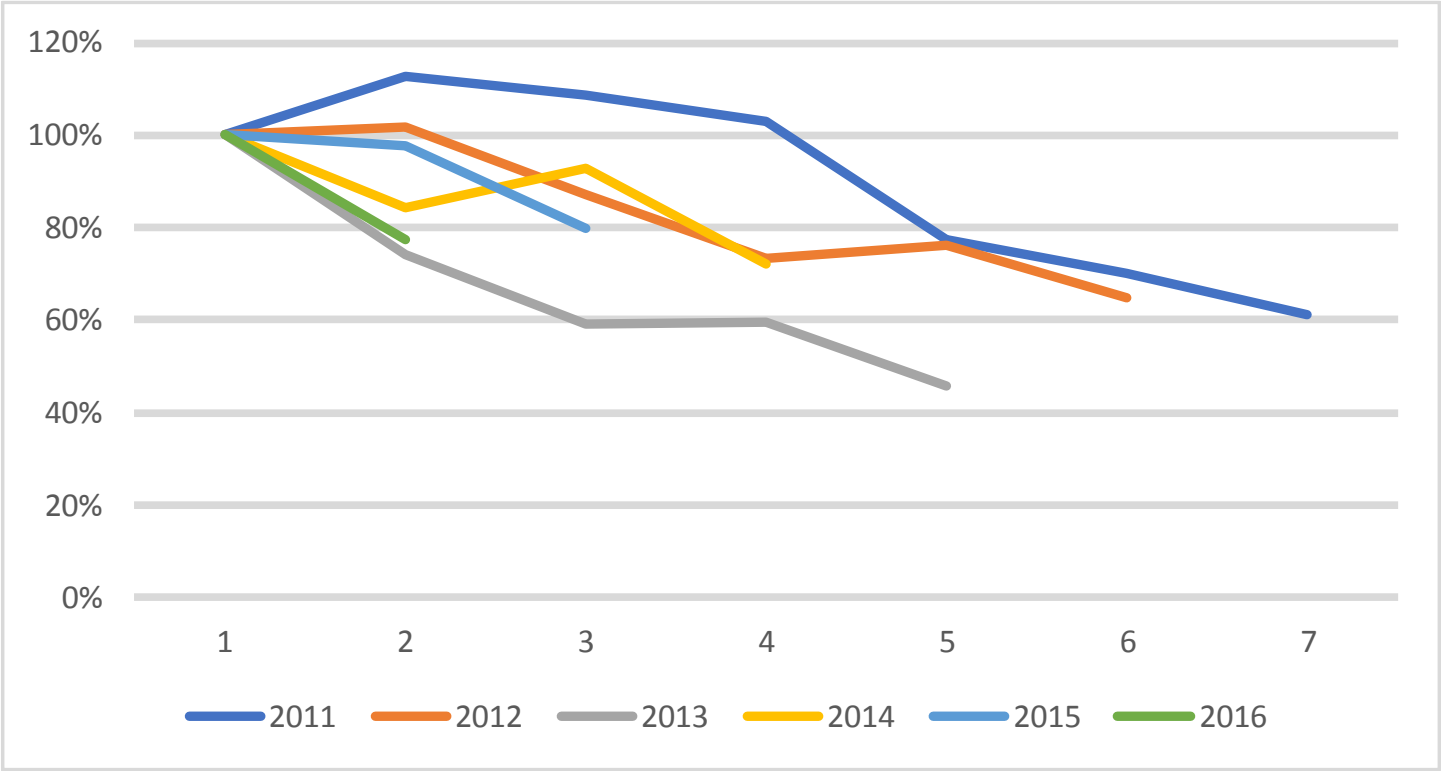
of members would exhaust
if they paid Billed Charges on provider bills

23%

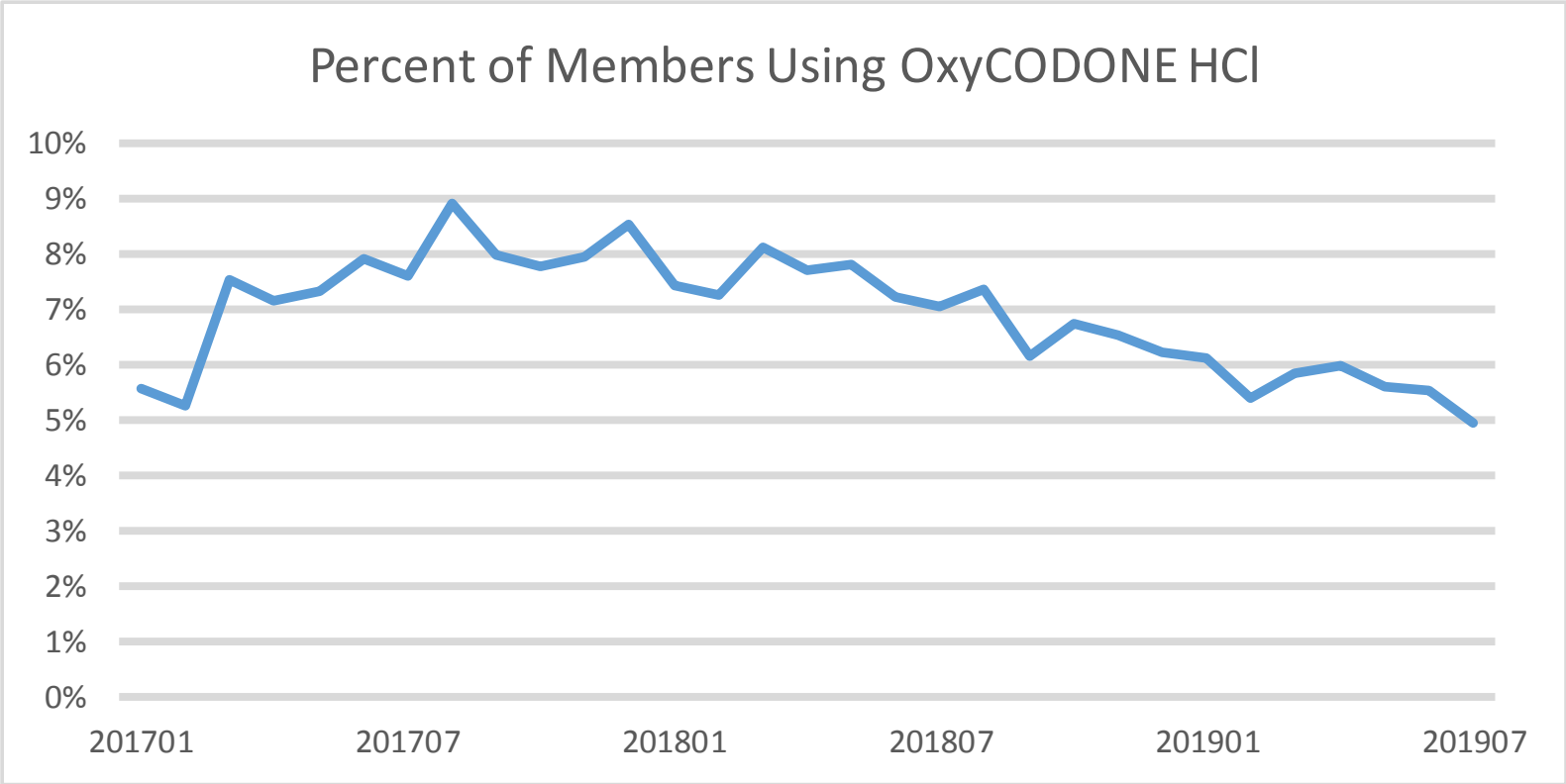
of members would exhaust
if they paid both Billed Charges and AWP

Estimates based on Ametros data.

Overall Treatment Frequency (all claims)



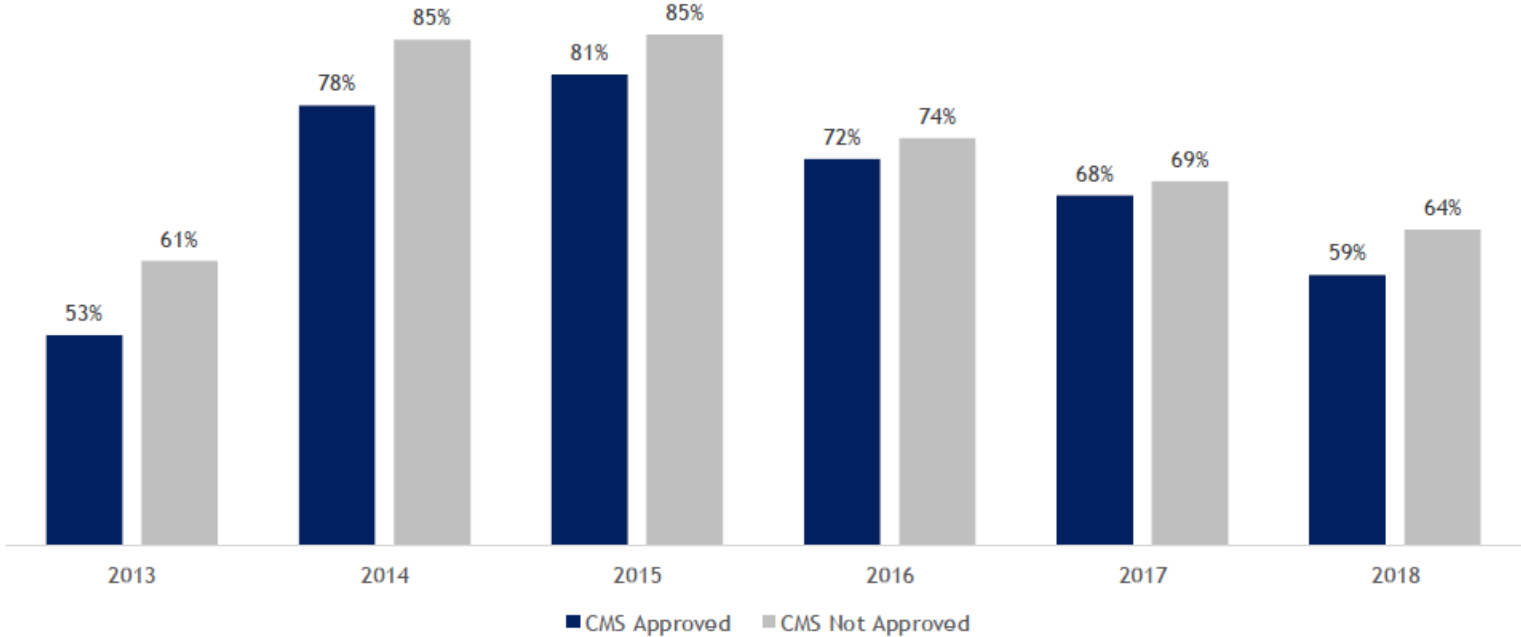
Opioid Usage Trends



Figures based on Ametros data.

Comparison of Non Submits

Actual Rx Spend by CMS Approval Status (as % of Expected Rx Spend)



Figures based on Ametros data. Non-submit information includes below threshold amounts.

MSP Continues After Settlement

Denials

Pre-Settlement Conditional Payments

Post-Settlement Conditional Payments (Advantage Plans)

Section 111 issues regarding what was reported

BCRC calling on exhaustions

RE: Member: [REDACTED]
Patient: [REDACTED]
Event No.: [REDACTED]
Injury Date [REDACTED]
Your Insured:
Your Claim/File No.: [REDACTED]
Benefits Provided Through: Humana

Dear Sir or Madam:

We provide Medicare Advantage coverage to the above-referenced member. We have been advised that our member may have a claim against no-fault, liability, or other insurance coverage and/or a third party for services or supplies related to the above-referenced loss.

Please note that the Plan is a Medicare Advantage Plan and, thus, is governed by the Medicare statutes and regulations. The same Medicare Secondary Payer priority rules apply as with traditional Medicare. We are entitled to be reimbursed when we have paid or provided benefits to our member due to an injury, illness or condition, and another party or insurance carrier is responsible for payment of the member's medical expenses or benefits. The pertinent provisions governing a Medicare plan's right of recovery can be found at 42 U.S.C. § 1395w-22 (a)(4), 42 U.S.C. § 1395y(b)(2)(B)(iii), and 42 C.F.R. 422.108. These provisions preempt state laws and regulations.

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Thank you!

Q&A

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