July 2006

NAMSAP news

National Alliance of Medicare Set-Aside Professionals

The Medicare Conditional Payment Crisis: The Darkness before the Dawn

by Patty Meifert, RN, CRRN, CCM, CLCP, MSCC and Robert T. Lewis, Esquire

Medicare is a nationwide, Federal insurance program enacted in 1965 as Title XVIII of the Social Security Act ("the Act"; 42 U.S.C. § 301 et seq.) The Medicare program serves an estimated 42 million beneficiaries and processes in excess of one billion claims per year.

The Secretary of the Department of Health and Human Services (DHHS) is charged with the administrative responsibility for the Medicare program. In turn, the Secretary has delegated the program authority for Medicare to the Administrator of the Centers for Medicare & Medicaid Services (CMS).

The CMS administers the Medicare Program through significant reliance upon Medicare contractors. These Medicare contractors, known as "Fiscal Intermediaries" (FIs) and "carriers," are private entities that participate in the administration of the Medicare program under contracts or agreements entered into with CMS.

Currently, CMS has 46 FIs and carriers throughout the United States. In general, FIs perform bill processing and benefit payment functions for Medicare Part A and carriers perform similar functions for Medicare Part B. The CMS additionally has 4 Durable Medical Equipment Regional Carriers (DMERCS) who handle only Medicare Part B claims for durable medical equipment (DME), prosthetics, orthotics, and supplies in specified geographic regions of the United States.

In addition to general bill processing and payment functions, the FI's were tasked with identifying Medicare conditional payment claims (claims paid by Medicare conditioned on reimbursement if another primary payer was determined to be responsible), issuing recovery demand letters, processing waiver and appeal requests and many other functions related to the Medicare Secondary Payer Statute (MSP).

With Medicare's ever increasing enforcement of the MSP, the FI's were inadequately prepared to process the overwhelming number of requests to provide estimates of conditional payments claims to primary payers settling cases involving a Medicare beneficiary. As a result, primary payers were experiencing delays in FI response as long as 6-8 months. The Workers' Compensation (WC) insurance industry was particularly impacted by the extreme delays which in turn caused delays in finalizing WC settlements. WC carriers choosing to finalize settlements prior to obtaining conditional payment information risked unknown conditional payment exposure.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that CMS phase out these contractors, including the FI's, under Medicare Contracting Reform. Therefore, CMS must replace the current FI and carrier contractors with competitively-procured Medicare Administrative Contractors (MACs). CMS has between 2005 and 2011 to complete the transition of Medicare processing activities from the FIs and carriers to the MACs. To date, the CMS has awarded the contracts for the four MACs that will take over administration of Medicare claims from DMERCs. The newly titled DME MACs are scheduled to assume full responsibilities for the work on July 1, 2006. The other types of MAC contracts will be awarded on an ongoing basis.

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In addition to the above contracts, CMS is proposing to consolidate all of the functions related to Medicare Secondary Payer (MSP) recovery into one MSP recovery contract with full implementation by October 1, 2006. The goals of the consolidation are to increase administrative and operational efficiencies, maximize consistency of process, streamline recoveries, and enhance customer service. The selected MSP Recovery Contractor (MSPRC) will, under CMS's discretion, perform the MSP recovery functions currently performed by the Medicare claims processing contractors.

MSP recovery activities to be assumed by the new MSP recovery contractor include:

- identifying mistaken MSP payments for recovery;
- determining conditional payment amounts potentially subject to recovery;
- providing interim conditional payment amounts when a beneficiary's claim involving WC, no-fault insurance, or liability insurance (including self-insurance) is disputed;
- answering telephone inquiries and written correspondence;
- issuing recovery demand letters, where appropriate;
- making beneficiary waiver determinations pursuant to § 1870 of the Act when such requests are filed;
- answering alleged defenses to MSP debts;
- processing first level appeal requests from beneficiaries on beneficiary MSP debt;
- providing MSP litigation/negotiation support to CMS;
- performing activities related to the Debt Collection Improvement Act of 1996 (DCIA; Pub. L. 104-134), including referral of delinquent MSP debt to the Department of Treasury for cross-servicing activities, where appropriate (see C.3.3.4.15, DCIA Processes); and
- reporting financial activities including the establishment and tracking of all MSP debt.

Medicare contracting reform and the consolidation of the MSP recovery functions may provide a glimmer of light at the end of a long dark tunnel but it is anticipated that the tunnel may get even darker in the months to come and primary payers may experience even greater delays in obtaining conditional payment estimates from the FI's. Since the FI's are aware of the consolidation efforts, staff reductions will certainly occur. One FI, Riverbend Governmental Benefits Administrator, reportedly plans to pull out all together.

What then can primary payers do to minimize potential exposure for Medicare conditional payments during this difficult period? First, identify claims involving Medicare beneficiaries as soon as possible in the course of claim management. Waiting until settlement to determine Medicare entitlement will result in significant delay. Medicare entitlement can be obtained from the Social Security Administration (SSA). In cases were the claimant is age 65 or older as well as cases where the claimant has been out of work for 30 months or longer, Medicare entitlement should be verified. If it is determined that the claimant is entitled to Medicare, details of the claim should be called to the Medicare Coordination of Benefits Contractor (COBC). If the case is a WC case, Medicare will flag its database and should deny Medicare payment for WC injury related claims. This should significantly reduce future conditional

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payment exposure. In addition, the FI will create a working file on the case which decreases the turnaround time for receiving conditional payment information. If a primary payer decides to finalize a settlement involving a Medicare beneficiary prior to obtaining Medicare conditional payment information, the parties should agree upon responsibility for payment of Medicare conditional payment claims.

Although settlement without confirmation of conditional payments allows for prompt resolution, it may generate significant problems post settlement. Many times the FI identifies Medicare payments that are not related to the underlying claim. Who will be responsible for challenging these payments? What if the claimant sought unauthorized treatment and those claims were picked up by Medicare? Under state law they may not be reimbursable, but who will challenge these claims post settlement? These and other issues must be carefully evaluated and it is recommended that you consult with someone familiar with these issues in order to ensure that the parties are properly protected. In some instances it would be advisable to "hold" funds by way of a formal custodial agreement or Trust in order to ensure that the conditional payment issue is satisfied post settlement.

Failure to properly consider these issues could result in significant exposure to all parties involved in the claim. While Medicare is reforming their practice it is incumbent upon the industry to do so as well. This will ensure timely and effective claim resolution. Early reporting and creative settlement strategies can make the difference between a case that settles and a case that lingers.

Patty Meifert is the Executive Vice President of NuQuest and Bridge Pointe specializing in Medicare Set-Aside (MSA) arrangements and professional administration services and MSA custodial accounts. Ms. Meifert is the founding President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) and can be reached at 866-858-7161.

Robert T. Lewis is an attorney with Capehart Scatchard specializing in Medicare Secondary Payer compliance. Mr. Lewis is the founding Vice President of NAMSAP and can be reached at 856-914-2064.

Everything You Need to Know to Register for a NAMSAP Webinar

If you have not yet participated in NAMSAP's monthly webinar series, here's how. You can check the list of topics that will be presented during the year on our website and decide which ones you would like to attend. Then you can register online at **www.namsap.org/calendar_webinars.html**. You will need to use a credit card to pay for the webinar. The Internet conferencing center, Genesys, will forward an email reminder to you with links to test your browser, join the meeting, and the phone number for the audio portion of the webinar. It's important to test your browser in advance to allow time for any updates that may need to be downloaded and installed. Also remember to disable all pop-up blockers because the slide portion of the webinar appears as a pop-up.

To join the meeting, click on the link in the email reminder or go to **www.genesys.com** and click on the "Participants Join" button. A browser test automatically runs to let you know everything is ready. If you need any technical support, you can call Genesys at 1-866-436-3797. You will then be prompted to enter your name and meeting number. The meeting number is the same for both the web portion and the audio portion; however the audio portion does not require any symbols before or after the number. You should then see a "Welcome to the Conferencing Center" screen. When the Moderator opens the meeting, the screen will show the slide presentation.

To join the audio portion of the meeting, dial in to

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the toll-free number listed in the email reminder. You will be prompted to enter the meeting number. You must be sure to enter the star sign before and after the number. If you encounter any technical problems while on the call, you can dial *10* to access technical support. Please be aware that everyone dialed into the audio portion of the meeting can hear you and any background noise at your location. If you do not have a mute button on your phone, you can dial *6* to mute. The Moderator does have mute control. When this feature is activated, everyone dialed in can hear the Presenter but not each other. This feature is deactivated at the end of the presentation for a question and answer session.

The process is really quite simple and once you attend one webinar, we're sure you'll enjoy this very convenient way to learn – no travel, no time away from your office and home – and a great way to keep up to date on these important professional topics! We hope to see your name on the registration list soon!

Home-Based Study Coursework for MSA Consultant Training

NAMSAP's MSA Consultant Training Program is approved by the Commission of Health Care Certification (CHCC) as meeting the educational requirements necessary to sit for the Medicare Set-Aside Consultant-Certified (MSCC) exam. The program provides 30 hours of education specific to Medicare Secondary Payer Compliance and consists of 10 courses including 9 (prerecorded) courses and a home-based practicum test.

To register for this home-based study coursework, visit the Education section at our website and select MSA Consultant Training. Courses can be purchased one at a time, or the entire program may be purchased. Once registration for the coursework is processed, an email is sent which includes the links to view and hear the courses as well as attachments of handouts for the courses. When the coursework is completed, answer the practicum questions and

Medicare Set-aside Webinar Series

NAMSAP's Webinar series provides timely information of special interest to professionals working within the MSA industry and those seeking to learn more about this evolving area of practice. Webinar sessions are presented in "real time" via the Internet. Participants view Webinar materials online while listening to the audio portion of the presentation via the telephone. Throughout the Webinar session, participants are encouraged to interact with other attendees and the presenter

Thursday July 13, 2006
Structured Funding of an MSA Account: Understanding Annuities, Rated Ages and CMS Requirements
Time: 1:00 pm
Facilitator: Michele Whitmore

Implementing tax exempt annuities known as "structures" in the funding of Medicare Set-Aside arrangements can enhance the outcome for all parties to the agreement. This course, presented by Michele Whitmore, will review the CMS criteria when annuities are used to fund MSA arrangements; define and discuss annuities in friendly terms for the non-financial professional and clarify age rating and life expectancy issues. How to properly engage the structure professional into the process will also be addressed.

Ms. Whitmore's national settlement and disability planning practice, Settlement Strategies, Inc., is devoted to advising legal professionals and their clients in the negotiations, design and funding of legal settlements to maintain the benefits provided by public and private assistance programs and to promote the proper application and safeguard the tax and financial remedies afforded recipients of tort recoveries.

Member Cost: $ 60
Non-Member Cost: $ 80

Monday August 14, 2006
Medicare Conditional Payments: Pre-settlement Negotiation to Post-settlement Appeal
Time: TBA
Facilitator: Mark Popolizio and Robert Lewis

Hold on a minute ... So, you protected Medicare's interests by including a MSA , but are you done? Have you considered Medicare conditional payments? Medicare conditional payments should be a major concern for everyone involved in the Medicare industry. However, all too often they are either overlooked or the parties fail to appreciate their potential impact. This program will focus on critical things you need to know and steps you can take to protect your client and yourself!

Mr. Lewis has a national practice focusing on Medicare compliance and claims impacted by the Medicare Secondary Payer Statute. He is a frequent lecturer and has written a number of articles addressing this emerging area of law. Mr. Lewis also represents employers, self-insured companies, and insurance

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submit the completed exam to the NAMSAP office. The exam answers and a certificate of course completion will then be mailed to the participant.

Participants who plan to sit for the MSCC exam must coordinate this through the CHCC. The CHCC may be contacted at 804-378-7273 or by email at **chcc1@aol.com**. General information regarding the MSCC exam is available on the CHCC website at **www.chcc1.com**.

Medicare Set-Aside Consultant Certified (MSCC) Criteria:

Training
The candidate must complete 30 hours of training related to MSP compliance that has been approved by the CHCC.

License Requirement
It is a requirement that the candidate has one of the licenses or certifications listed under Professional Experience, License /Certification Requirement and that the license or certification is current and the candidate is in good standing with his or her professional discipline.

**In regards to Claims Adjusters, licensing requirements vary by state. In some States, claims adjusters employed by insurance companies can work under the company license and need not become licensed themselves. Adjusters will need to provide proof the appropriate State-defined requirements are met.*

Professional Experience
A minimum of 12 months of acceptable full time employment within the past 3 years in any of the following industry disciplines. Acceptable employment means that the candidate is working within the Workers' Compensation or Liability insurance industry.

- Insurance Claims Adjusters
  License/Certification Requirement:
  **see license requirement*

carriers in workers' compensation defense matters in New Jersey. Prior to moving to New Jersey, he handled workers' compensation and liability defense matters in North Carolina.

Mr. Popolizio practices law in Florida and is based in Miami. He is also licensed in Connecticut. Mr. Popolizio's practice areas include Medicare compliance and workers' compensation defense. He is a regularly featured speaker and presenter on Medicare related matters, including Medicare Set-Asides. Mr. Popolizio represents numerous employers, carriers and self insureds.

Member Cost: $ 60
Non-Member Cost: $ 80

Wednesday September 13, 2006
The Impact of the 2006 Deficit Reduction Act Amendment on Settlements Involving Medicaid Beneficiaries
Time: 3:00 pm
Facilitator: Tim Nay

Deficit Reduction Act of 2006 (DRA) introduced several changes to Medicaid's Spousal Impoverishment Provision when signed by the President on February 8, 2006. Join Tim Nay on Wednesday September 13, 2006 at 3:00 P.M. E.D.T. in discussing how Medicaid fits into MSA practice and the ramifications of DRA in advocating for injured clients.

Tim Nay has combined decades of clinical social work experience and legal expertise to develop an insightful, innovative and people-friendly approach to assisting our clients. He is the founding President of the National Academy of Elder Law Attorneys and was recognized in 1992 as a Fellow of the Academy. Tim is a past President of the Oregon Gerontological Association, past Chair and founding member of the Elder Law Section of the Oregon State Bar and the immediate past President of the Oregon Chapter of the Alzheimer's Association. He is Chair, Amicus Brief Committee-National Academy of Elder Law Attorneys (2003-2004) and also a member of the Medicaid Task Force-National Academy of Elder Law Attorneys (2003-present). He is a founding member and current secretary of the National Alliance of Medicare Set Aside Professionals. Tim is a member of the Oregon State and Washington State Bar Associations.

Member Cost: $ 60
Non-Member Cost: $ 80

Tuesday October 31, 2006
How to Properly Administer a MSA Allocation
Time: 1:00 pm EST
Facilitator: Robert D. Barson

Whether you opt for professional or self administration of an MSA Allocation, Medicare's requirements are exactly the same! This presentation will address account requirements for administration

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- Attorneys
  License/Certification Requirement:
  License to practice law

- Life Care Planners
  License/Certification Requirement:
  Certified Life Care Planner (CLCP) or
  Certified Nurse Life Care Planner (CNLCP)

- Case Managers
  License/Certification Requirement:
  Certified Case Manager (CCM)

- Disability Management Professionals
  License/Certification Requirement:
  Certified Disability Management Specialist (CDMS) or
  Certified Disability Examiner (CDE)

- Rehabilitation Specialists
  License/Certification Requirement:
  Certified Rehabilitation Counselor (CRC), Certified Rehabilitation Registered Nurse (CRRN)

- Nurses
  License/Certification Requirement:
  Registered Nurse (RN) or Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN)

Application
Completion and approval of the Medicare Set-Aside Consultant Certified application to sit for the MSCC exam by the CHCC.

Exam
Completion of the Medicare Set-Aside Consultant Certified exam administered by the CHCC with a passing score.

Peer review
Completion of a Medicare Set-Aside Submission Proposal with a successful review by a CHCC MSCC Commissioner. The review fee is $200.00.

Maintenance
Documentation of 20 clock hours of approved education every three years.

of an MSA allocation; allowable versus non-allowable expenses; how the new Part D prescription drug coverage affects administration of an MSA allocation; the duties and obligations of the account administrator; the challenges of self administration; and the differences between self administration and professional administration.

Mr. Barson is Chief Executive Officer of Medivest Benefit Advisors, Inc. and is a nationally recognized expert in MSA allocation administration. Medivest prepares MSA allocations, administers Medicare Set-Aside and Medical Custodial Accounts, and provides creative settlement solutions for workers' compensation and general liability cases. Since the company's inception in 1996, Medivest has settled cases totaling nearly $1 billion, which has resulted in over $250 million in case administration.

Member Cost: $ 60
Non-Member Cost: $ 80

Thursday November 9, 2006
Considering Medicare's Interests in Liability Cases
Time: 2:00 pm EST
Facilitator: Barbara Fairchild

When and how to consider Medicare's interests in a liability settlement, judgement or award continues to be a hot topic of conversation. There has been rumor that CMS will require Medicare Set-Aside Arrangements in liability settlements involving Medicare beneficiaries. To date, CMS has no formal policy to address how to consider Medicare's interest in liability cases. CMS indicates that they are working on a memorandum to answer frequently asked questions about liabilty cases, and there is a great deal of speculation regarding what it will contain. In the interim, this presentation will offer some practical approaches for considering Medicare's interests in liability cases until CMS renders a formal policy decision.

Barbara Fairchild has 22 combined years of experience in business, sales, marketing, insurance, catastrophic case management, utilization review and critical care nursing. Barbara currently holds the position of National Sales Manager for NuQuest/Bridge Pointe, a national provider of Medicare Set-Aside Allocation and Professional Administration services. Barbara also serves as membership chairman for the National Alliance of Medicare Set-Aside Professionals (NAMSAP).

Member Cost: $ 60
Non-Member Cost: $ 80

CMS Revises Review Threshold

by John Barringer

On April 25, 2006, the Center for Medicare and Medicaid Services (CMS) issued a Policy Memorandum raising from $10,000 to $25,000 the "low-dollar" threshold of review for Medicare beneficiaries entering settlement agreements that close future medical benefits. This change means that the protection offered by CMS "approval" is not available for worker's compensation set aside arrangements ("WCMSAs") in cases where the total settlement is $25,000 or less.

Effective April 25, 2006, CMS now states that they will only review new WCMSAs for Medicare beneficiaries where the total settlement is greater than $25,000. This modifies the Answer to Question 2 of CMS's July 11, 2005 Memorandum where it established a $10,000 review threshold. While this policy change will not affect most Medicare beneficiaries who are closing future medicals as part of their worker's compensation settlement, the change confirms that CMS is receiving an ever-increasing amount of WCMSA submissions. Moreover, this revision indicates that CMS is unable to return timely responses to WCMSA proposals unless its internal workload thresholds are changed.

The CMS Policy Memorandum does not effect a change in the law. CMS stresses that this new policy is a "**workload review threshold**", not a substantive dollar or "safe harbor" threshold. Thus, even though CMS approval is not required, Medicare beneficiaries must still consider Medicare's interests in all worker's compensation cases and ensure that Medicare is secondary to Workers' comp in any such case. Thus, even if the Medicare beneficiary's total settlement amount is less than $25,000, any settlement order outlining a worker's compensation award should be carefully crafted to ensure that Medicare's interests have been protected.

In addition, the Memorandum clarifies how to compute a total settlement amount. The total settlement includes, but is not limited to, "wages, attorneys' fees, all future medical expenses (including prescription drugs), and repayment of any medical conditional payments." CMS further instructs that payout totals for all annuities purchased to fund the above-listed expenses should be used rather than costs or present value of any annuity. Thus, whenever there is a difference between the amount of the annuity purchase price and the anticipated total payout (as is most always the case), MSA allocators must use the total payout figure rather than the actual purchase price (or present value) of the annuity.

CMS also advises that when drafting a WCMSA proposal on a claim that has already been partially settled, the previous settlement amount must also be included in computing the total settlement amount.

Finally, it should be noted that the workload review thresholds that are presently in place are always subject to change. CMS suggests that "claimants, employers, carriers and their representatives should regularly monitor its website at **www.cms.hhs.gov/WorkersCompAgencyServices** for changes. Above all, CMS's most recent Memorandum serves to reiterate that its interests must be protected. If one fails to keep oneself apprised of CMS's policies, it may only be to their peril.

John Barringer is a principal with Manier & Herod. He primarily practices in the areas of Workers' Compensation and Criminal law. Mr. Barringer can be reached at 615-742-9345

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