



Quarterly Newsletter

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NAMSAP is the only non-profit association exclusively addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. Through the voluntary efforts of our members, NAMSAP is a forum for the exchange of ideas and is a leading resource for information and news in this constantly evolving area of practice. The collective knowledge of our members and NAMSAP's resources will provide you with the ingredients essential to your success!

PRESIDENT'S LETTER

Greetings Fellow NAMSAP Members,

On behalf of the entire membership, I first want to extend my sincere thanks to past president Mike Westcott and outgoing board members Fran Provenzano and Mark Popolizio. They have worked tirelessly to improve our industry and their contribution to this trade organization has been invaluable. Also, I would like to thank all the committee chairs and committee members for their dedication and hard work.

I am honored and humbled to serve as president of NAMSAP this upcoming year. NAMSAP was formed in February of 2005 to educate its members and provide a voice for the then newly emerging Medicare Secondary Payer compliance industry. Both NAMSAP and the entire MSP compliance industry have come a long way since then; for example, NAMSAP has grown from around 25 members in to almost 600.

Our main focus and key strength, has always been, and will always be, providing quality education for our members. Last Fall we held our first Regional Mid-Year Workshop in Chicago and it was a huge success. Building on that success, we are very excited to announce our first ever "Take the Hill" Conference in Washington DC this fall, and also a Regional Conference in Miami this coming Winter. Our 2013 annual conference in Baltimore was spectacular. The 10th Annual Meeting and Educational Conference will be in Las Vegas, at the Vdara Hotel and Spa, May 8-9 2014. The participation of our members is critical to the overall success of NAMSAP, so we would encourage you all to join us in Las Vegas for what is shaping up to be our best annual conference ever.

We have seen a lot of change in our industry recently. The MMSEA Section 111 bill signed in 2007 is being implemented and in 2012, the SMART bill was signed into law. Courts are hearing cases on almost a weekly basis now. We even had the Hadden v. U.S. MSP case go all the way to the U.S. Supreme Court (however it was not heard). From Capitol Hill we have seen congressional hearings, a GAO report and a Congressional Research Service Report. From CMS we have seen MSA submission portals, new CMS contractors, a new WCMSA reference guide, a WCMSA Town Hall Meeting and an Advanced Notice of Public Rule Making. These changes have been challenging to say the least.

More change is coming. As we continue to advance our educational programs, it is critical for us, as the sole MSP trade organization, to also pull together and work hard to make our voices heard. My personal theme for this year is, "We must participate in shaping our future or someone else will".

This is an exciting year for NAMSAP. Challenges and opportunities lay ahead and we are prepared to meet them. Our new executive director, Kimberly LaBounty, and her staff at Apex Management are fantastic. Our committee chairs and committees are enthusiastic and engaged. Our board is prepared.

If you are a member of NAMSAP and have not been involved, now is the time to jump in and join us, either with your time or your financial support (or both) and help your industry trade organization meet the challenges ahead.

Sincerely,

Doug Shaw
President



CORNER

by Rochelle L. Lefler, JD,RN, LHRM

CASE LAW

Hello everyone. Once again it's that time of year where we have just had our annual conference, including a case law update. Our thanks to this year's legal panel, Donald Fernstrom, Michele Ready and Amy Bilton for providing an assortment of cases highlighting the various and challenging issues we face today as well as their legal expertise. For those of our members who could not attend the meeting, the following is a representative sampling of some of the cases presented.

This case is illustrative of what can occur when the parties are not in agreement as to the necessity of a liability msa. In **Early v. Carnival** (2013 U.S. Dist. LEXIS 16711, S.Dist. Fla, 2/7/13), a passenger alleged injuries as a passenger aboard a Carnival cruise ship. The terms of settlement were memorialized in a mediation agreement. As part of the terms of this agreement, the parties stipulated the court retained jurisdiction to enforce the terms of the settlement and further, they agreed to have the court determine the possible Medicare set aside, if any. The plaintiff filed a motion alleging that a LMSA was not necessary. The defendant's position was that it was legally required. It should be noted that the parties had not filed an executed "final settlement document" before the court but in essence were asking the court to determine one of the terms of settlement for future inclusion. The court held there was no settlement agreement and declined to "write in" terms for the parties. In analyzing prior cases dealing with LMSA issues, the court noted that this case somewhat differed. Typically, two scenarios arise, courts are called upon to determine MSA amounts when the parties have failed to obtain CMS approval (CMS has been notified of any hearing) or the courts determine whether a settlement agreement includes creation of an LMSA (final settlement documents seeking to be enforced). The case at bar did not involve a final settlement agreement and is representative of the courts not only declining to impose settlement terms but also to render advance opinions regarding application of the MSP statute. Although lack of guidance exists as to LMSA currently, the parties still need to deal with this issue at time of settlement.

Cribb v. Sulzer Metco (2012 U.S. Dist. LEXIS 125729, E.D. NC, 9/5/1) involved an unopposed Motion for Court Approval of Settlement and Determination of Need for and Amount of Medicare Set Aside. Plaintiff, a Medicare beneficiary, was notified by CMS that his past conditional payment amount was \$608.09 which was paid out of the settlement proceeds. The parties obtained medical testimony regarding the provision of future medical care and allocated towards the MSA accordingly, namely \$4500.00. In approving the amount, the court specifically noted in its order that "Medicare does not currently require or approve Medicare Set Asides when personal injury lawsuits are settled. The court went on to state "Medicare does not currently have a policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of the future medical aspect of a liability settlement or recovery of future medical expenses incurred in liability cases." In essence, the parties sought court approval of their agreed upon LMSA making this case representative of the parties' quandary regarding protection of their clients in liability cases.

Sipler v. Trans Am Trucking, Inc (2012 U.S. Dist. LEXIS 109278 , D.N.J. 7/24/12) involved a Plaintiff who was injured while riding a bus that was struck by truck. The parties settled on the eve of trial for \$225,000 in exchange for a release of all claims arising out of the accident. No further terms were mentioned. However, upon receipt of the proposed release, Plaintiff's counsel argued there were several terms included which had never been agreed upon. Defense refused to omit the terms and so a motion to enforce settlement was filed by the Plaintiff. Under the proposed release, Plaintiff could not seek reimbursement from Medicare for claims arising out of his 2006 accident, his private health insurance would not pay claims arising out of the accident as it was pre-existing, and Medicare would not pay any future medicals arising out of the accident. Plaintiff's counsel argued, among other things, that there was no federal law requiring the establishment of a Medicare Set Aside nor did his client have to disqualify himself from the receipt of Medicare benefits. The court noted that the Plaintiff had recently become a Medicare beneficiary but that Medicare had not paid any medical bills in this matter. Coverage for medicals was provided initially by the automobile policy and then by group health. Thus Medicare was not a primary payer in this case. The court granted Plaintiff's motion and determined that to the extent Plaintiff 's medicals were covered by his group health as well as the settlement monies, Plaintiff could not seek payment from Medicare and that federal law did not require the establishment of a LMSA. Specifically, the court found LMSA's are a recommended method not a mandate. Further, although not all the terms or details of settlement had been discussed, there was enough "flesh" (substantive terms) in existence to enforce the settlement as originally proposed despite the fact one party did not wish to proceed. Moral of the story? Make sure you are clear on all the details of settlement or you may end up with enforcement of a settlement agreement that is too general in nature or lacking in important terms.

Robinson v. Land-O-Sun Dairies, LLC (2012 Phila. Ct. Common. Pl. LEXIS 324, 9/19/12) is a case regarding an automobile accident which was subsequently settled. Settlement documents were carefully crafted and included the following language " this settlement is predicated upon you providing me with up to date Medicare lien information along with lien information from any other provider ". The case settled in September, 2011 and a Motion For Failure to Deliver Settlement Funds was filed in November of that year. The Defense relied upon the yet unfilled term stated above as grounds for refusal to proffer the funds, arguing it was a material term to the settlement. The court issued a favorable ruling for defense and Plaintiffs appealed. After conducting an analysis of prior case law which the court found to be distinguishable, the appellate court upheld the original ruling, in essence relying on principles of contract law.

Our thanks to the legal panel for also providing us with a summary of highlights regarding the SMART ACT!





An Update on Pharmacy Issues and MSAs

A Summary of the NAMSAP Pharmacy Panel from the Educational Conference

Prescription drugs often represent a primary component of a long-term medical treatment plan involving MSAs. When incorporating a prescription drug regimen into a lifetime treatment plan, issues with respect to efficacy and safety must be considered primary. However, when all else is equal, decisions must factor in cost. All too often clinicians focus on the benefits, but neglect the dark-side of drug therapy. It is estimated that prescription medications cause 140,000 to 180,000 deaths annually. If it were monitored as a cause of death, drug therapy would represent the third-leading cause of death in the U.S., well ahead of stroke, chronic lower respiratory diseases, and diabetes. Estimates have suggested that for every \$1 spent on purchasing prescription medications, as much as \$2 is spent managing the complications of medication therapy. Unfortunately the healthcare system is doing little to address preventable drug-related morbidity (or drug-induced disease) and mortality (or drug-related death). All too often the doctor diagnoses and prescribes, the pharmacist dispenses and after that patient care is left largely to chance.

Class of RX	RX Example	An Evidence-based Medicine Perspective
Opioids	Hydrocodone, Oxycodone, Morphine, OxyContin®, Opana ER®, Exalgo®, etc.	<ul style="list-style-type: none"> • CDC considers opioid use an “epidemic” and “public health crisis”. The U.S. only comprises 4.5% of the world population, yet consumes 80% of all opioids and 99% of all hydrocodone. • Practice guidelines generally recommend against the chronic use of opioids in non-cancer pain. • Highly limited data exists to support opioid use for >6 months. • If used chronically, a therapeutic response (i.e., improved function, reduced pain) should be documented. Dosing should be restricted to less than 120 mg of morphine equivalents/day generally. Weaning should be attempted at least annually. • Safety issues include CNS sedation, mental confusion, physical impairment, constipation, nausea, etc. Opioid-related mortality associated with increasing dose. • Red Flags: Use for >6 months; Total daily dose exceeds 120 mg of morphine equivalents/day; No/minimal changes in pain/function; Suspected abuse, overuse, misuse, or diversion.

Class of RX	RX Example	An Evidence-based Medicine Perspective
Skeletal Muscle Relaxants	Carisoprodol, Cyclobenzaprine, Metaxalone, Methocarbamol, etc.	<ul style="list-style-type: none"> • Only recommended for short-term therapy for acute conditions (<14 days of therapy). Not studied for chronic/lifetime therapy. • Most do not actually relax muscles, simply provide sedation. • Safety issues include CNS sedation, mental confusion, etc. • Red Flags: Use for >2 consecutive months.
NSAIDs	Naproxen, Ibuprofen, Meloxicam, Celebrex®, etc.	<ul style="list-style-type: none"> • Effective for acute therapy, but many safety risks associated with chronic and/or high-dose therapy. • Safety issues include toxicities involving the following: gastrointestinal (bleeding, nausea, etc), renal (kidney failure), and cardiovascular (heart attack, stroke, etc.) • Red Flags: Use for >6 months, high-dose therapy, and/or use in “at risk” patients (e.g., elderly, cardiovascular comorbidity).
Anti-convulsants	Gabapentin, Lyrica®, Topiramate, etc.	<ul style="list-style-type: none"> • Often used for neuropathic-related pain; however, effectiveness is often marginal. Only about 1 in 4 patients in clinical trials benefit to a greater extent than with placebo. • Safety issues include CNS sedation, peripheral edema, etc. • Red Flags: Use in the absence of neuropathic pain; Use of multiple anticonvulsants.

The MSA process represents a window of opportunity to foster medication changes that improve the medication regimen’s efficacy and/or safety profile, while reducing unnecessary cost. A Pharmacy Panel from the NAMSAP Annual Education Conference was convened to discuss pharmacy issues related to MSAs. Panelists included Dane Higgins, Mark Pew and Steve Miller. Various pharmacy issues were discussed and a summary of these topics is provided below.

Prescription Drug Therapy and Chronic Pain

Pain management therapies often represent a primary component of the medical treatment plan involving MSAs. Prescription drugs commonly encountered in the management of pain include opioids, muscle relaxants, and others (see below). MSA projections often assume that these pain management therapies will be employed on a daily basis for 10, 20 or more years of remaining life. In reality, not only is this unlikely to transpire, evidence-based medicine suggests that such projections are clinically inappropriate

Inappropriate medication treatment plans involving these medications is unfortunately all too commonplace. The inappropriate use of these medications also often drives other unnecessary medication use. For example, OxyContin® and hydrocodone/APAP could be employed for pain, which could cause adverse events such as constipation, sedation, sexual dysfunction, etc. Ultimately, the patient could be prescribed other medications to treat the side effects of opioids, such as Provigil® for sedation, Amitiza® for constipation, and Viagra® for sexual dysfunction. Such inappropriate medication use often results in “polypharmacy”, or the use of too many medications. The Amrix® (cyclobenzaprine ER) MSA process represents a window of opportunity for targeted interventions to address these and other drug therapy issues that ultimately foster a safer, more effective and less expensive drug regimen.

High Cost / “Me Too” Medications

In the absence of major drug developments in recent years, many pharmaceutical companies have released high cost “me too” medications. A “me too” medication is a drug that is structurally and pharmacologically similar to currently marketed product. Differences are typically very minor and rarely result in any clinically significant therapeutic gain. However, these “me too” medications are brand-name drugs that demand a major price premium. Consider the following examples:

Class of RX	RX Example	An Evidence-based Medicine Perspective
Amrix® (cyclobenzaprine ER)	Once daily formulation of cyclobenzaprine (Flexeril®)	<ul style="list-style-type: none"> Amrix® 30 mg = \$23.96 Cyclobenzaprine 10 mg (#3) = \$3.27
Aplenzin® (bupropion hydrobromide)	No documented advantage for Aplenzin® over generic bupropion XL	<ul style="list-style-type: none"> Aplenzin® 348 mg = \$15.77 Bupropion XL 300 mg = \$4.76
Avinza® (morphine ER) and Kadian® (morphine ER)	Extended-release capsule formulations of morphine. Generic morphine ER tablets (MS Contin®) are available.	<ul style="list-style-type: none"> Avinza® 60 mg = \$11.21 Kadian® 60 mg = \$11.36 Morphine ER 60 mg = \$3.31
Conzip® (tramadol ER)	Once daily capsule containing tramadol (Ultram®).	<ul style="list-style-type: none"> ConZip® 200 mg = \$9.65 Tramadol ER 200 mg = \$6.01
Gralise® (gabapentin) and Horizant® (gabapentin)	Allow for less frequent dosing of gabapentin (generic Neurontin®)	<ul style="list-style-type: none"> Gralise® 600 mg = \$3.30 Horizant® 600 mg = \$4.57 Gabapentin 600 mg = \$2.28
Naprelan® (naproxen ER)	Once daily formulation of naproxen.	<ul style="list-style-type: none"> Naprelan® 500 mg = \$10.21 Naproxen DR 500 mg = \$1.21
Subsys® (fentanyl spray)	Sublingual spray formulation of fentanyl.	<ul style="list-style-type: none"> Subsys® 800 mcg = \$98.27 Fentanyl Lozenge 800 mcg = \$34.57
Zipsor® (diclofenac potassium)	25 mg capsule containing diclofenac potassium (numerous generics)	<ul style="list-style-type: none"> Zipsor® 25 mg = \$4.78 Diclofenac 50 mg = \$1.64

Recent FDA Actions

The FDA is requiring manufacturers of acetaminophen (Tylenol®) containing combinations to limit the amount of acetaminophen (or “APAP”) to 325 mg per tablet or less. This will affect many commonly employed opioids, including Lortab® (hydrocodone/APAP) and some formulations of Percocet® (oxycodone/APAP). Hydrocodone/APAP is the most prescribed drug in the U.S. with about 140 million prescriptions processed annually. Manufacturers will have until January 2014 to comply with this requirement.

The change is highly clinically appropriate. APAP is the leading cause of acute liver failure with about half of cases being accidental. APAP use results in 56,000 emergency department visits, 26,000 hospitalizations, and 450 deaths annually.

While clinically supported, the FDA-required change will likely have unintended consequences that could increase pharmacy cost on MSAs. For example, a patient on generic hydrocodone/APAP 10/500 mg (Lortab®) #90 tablets per month would have a relatively inexpensive MSA cost of about \$500/year. If therapy were converted to generic hydrocodone/APAP 10/325 mg (Norco®) tablets, cost would be minimally affected. However, if use was converted to Vicodin HP® 10/300 mg tablets (a branded generic), cost would be increased to about \$3,000/year of therapy. Use of Xodol® 10/300 mg tablets would increase cost to about \$8,600/year of therapy. Over the course of a 20 or 30 year life expectancy, this FDA change could add hundreds of thousands of dollars in excess pharmacy cost on a single MSA.

Drugs and Aging/Beers Criteria

As we age, major physiological changes occur that affect how our bodies handle medications. The absorption of medications is slowed through the gastrointestinal system, the rate of elimination of medications via the kidneys and liver is slowed, and we become more sensitive to the effects of medications. Ultimately, this results in a medication regimen that may be considered clinically appropriate in a 40 or 50 year old, but potentially dangerous in an individual 60 or 70 years old.

The Beers Criteria is a list of Potentially Inappropriate Medications (PIMs) that are considered high-risk drugs in older individuals. The list of drugs is currently maintained by the American Geriatrics Society and is recognized by CMS, the National Committee for Quality Assurance, the Pharmacy Quality Alliance, and various other organizations. Despite the fact that the Beers Criteria has been in publication for over 20 years, these high-risk medications are commonly used in older individuals. Studies have found that 20% to 25% of seniors are prescribed one or more of these medications.

CMS has attempted to address the overuse of Beers medications by integrating use as a factor in the STAR quality rating system. Therefore, Medicare Part D plans now have reimbursement in the form of quality bonus payments tied to how well their plan controls the use of Beers drugs. While such performance incentives are not currently addressed within the MSA process, issues with respect to aging should be addressed when projecting a lifetime Rx treatment plan in the context of an MSA. Some of the commonly encountered Beers drugs are listed in the table below.

Class of RX	RX Example	An Evidence-based Medicine Perspective
Tertiary Amine Tricyclic Antidepressants (amitriptyline, doxepin, imipramine, etc)	Poorly tolerated due to sedation, confusion, delirium, constipation, dry mouth, orthostatic hypotension, etc.	Avoid in older individuals.
Antipsychotics (Abilify®, Seroquel®, Zyprexa®, etc)	Increased risk of weight gain, diabetes, stroke and death when used “off-label” in dementia.	Avoid use in dementia. Attempt to foster appropriate/reserved use in treatment-resistant depression.
Barbiturates (butalbital, phenobarbital, etc)	Risk of dependence, tolerance and overdose.	Avoid in older individuals. Now covered by CMS for epilepsy, cancer or chronic mental health conditions.
Benzodiazepines (alprazolam, diazepam, lorazepam, etc)	Risk of cognitive impairment, delirium, falls, fracture, etc.	Avoid in insomnia or agitation. May be appropriate in seizure disorder. Now covered by CMS.
Hypnotics (zolpidem, Lunesta®)	Minimal improvements in sleep. Risk of falls, fracture, delirium, etc.	Avoid chronic use (>90 days).
NSAIDs (diclofenac, ibuprofen, meloxicam, naproxen, etc)	Gastrointestinal, renal and cardiovascular risk.	Avoid chronic use, particularly in “at risk” patients. Use PPI co-therapy.
Muscle Relaxants (carisoprodol, cyclobenzaprine, metaxalone, etc)	Questionable efficacy with long-term use. Major safety concerns.	Avoid use for longer than 2 to 3 weeks.

Conclusion

While medications represent a primary component of a long-term medical treatment plan involving MSAs, drug therapy also represents one of the largest sources of MSA-related cost. In many instances, the lifetime projection for drug therapy can prohibit settlement efforts. However, the MSA process represents a window of opportunity to foster the development of a safe, effective and economical long-term medication treatment plan. The clinically trained Doctor of Pharmacy (Pharm.D.) represents an optimal agent of change within the MSA process. Practicing physicians find it difficult to keep up-to-date on the explosion of medical information involving drug therapy, which changes on a daily basis. Additionally, a physician's knowledge base on drug therapy often encompasses only a narrow range of drugs from their specialty. Doctors also rarely know what drugs actually cost. A Pharm. D. can collaborate with the physician to assist in the development of a drug therapy regimen that is safe, effective and economical. Issues within the context of this report and numerous other medication-related issues can be addressed in an effort to improve patient care while lowering MSA cost for payers.

Author:

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Vice President of Pharmacy Operations
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The Annual Meeting Subcommittee is already hard at work in the initial planning stages of the 2014 Annual Meeting. They are working very hard to build on the momentum gathered in Baltimore during the last meeting in April. The committee is working with the Board to help determine the city and venue, which will be announced.

A tremendous amount of resources go into the Annual Meeting planning process. While the committee has

enjoyed a few weeks off since Baltimore, it is never too early to start planning again. The dedication shown and time given by this fantastic committee is a key contributor to the success of the conferences. Keep an eye on your Inbox as information on the 10th NAMSAP Annual Meeting and Educational Conference will be coming soon!

Vdara Hotel & Spa

2600 W. Harmon Ave.
Las Vegas, NV 89158
www.vdara.com

Vdara is an All-Suites, Non-Gaming, Smoke-Free, Eco-Friendly hotel.

Room Rate:

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\$160.00 plus taxes

Friday, May 9th

\$184.00 plus taxes

Rate Includes:

- Internet Access in room and throughout the City Center Campus
- (2) bottles of water per day
- Local and 800 number phone calls
- Access to Vdara Fitness Center
- Daily newspaper from the front desk
- Daily turn-down service (upon request)



NAMSAP Annual Conference Presentation Summaries

ANPRM and You:

Panelist discussed the Advanced Notice of Public Rule Making (ANPRM) process. Last year CMS issued an ANPRM for liability MSA that set forth several options in liability cases. The Panel consisted of Mary ReKnack from the Defense Research Institute, Jason Lazarus from the American Association for Justice and the moderator was Robert Sangrillo. The panel went through the proposed options and discussed the pros and cons for both plaintiff and defense for each option. Both sides agreed that there needs to be clear guidance about compromised agreements and needs to differentiate the difference between liability settlements and workers compensation. Latent liability is also an issue that needs to be clarified. Some of the issues that were discussed included the effects of the MSP on settlements, more cases ending up going to trial, CMS insisting on full reimbursement of conditional payments while other liens can be compromised, liability including pain and suffering and loss of consortium, liability refusing medical payments, the need to come up with an easily applied apportionment tool, and the MSP can only enforce conditional payment and can only rely on language of the settlement for future payment of medicals. Both sides agree that the rules used for WCMSAs cannot be applied to liability cases.

A View From the Hill:

This session discussed the legislation process when a bill is at the hill for consideration. There are many ways to get bills to be considered. All bills are reviewed in a committee prior to being brought to the full house or senate. The best way to get your bills sponsored is to meet with the key people on the committees. Start with a congressperson from your State, meet with them in the district, ask to be put on their in-district committee, bring the CEO of the company to show you have support. Form a coalition that represents more than just one area of the county. Have the coalition develop a common white paper which presents why the issue is important and what you want done about it. Be as specific as possible but keep it simple and short. Stick to facts and stay away from emotions.

Legal Update and SMART Act Overview:

Panelists went through some recent cases that have been heard around the county. (see the legal corner in the newsletter for more information on cases).

Panelists also went through the SMART Act. See NAMSAP newsletter from [December 2012](#) for a detailed article by Roy Franco.

CMS Presentation:

Panelist and CMS representatives joined us for a discussion on recent events and topics. See separate in depth article in Newsletter.

CMS Pharmacy Trends – Part D changes on the Horizon:

Panelists discussed changes that are in the works with Part D. See detailed article in Newsletter for more details.

Data and Development Update:

Panelists and committee members presented some of the latest trends they are collecting on MSA submissions and CMS responses. See article in Newsletter for more details.

Medicare Advantage Plans “The Wild West of MSP Compliance”:

Panelists discussed what Medicare Advantage Plans are, rules that govern the interaction between the Medicare Secondary Payer statute and these plans, and practical problems and considerations when dealing with Medicare Advantage Plans. A large part of the discussion involved the fact that Medicare Advantage Plans have increased litigation and are starting to pursue recovery. Five of these cases (Care Choices HMO v. Engstrom, Nott v. Aetna U.S. Healthcare, Parra v. Pacificare, Humana v. Reale, and In re Avandia Products Liability) stated that Medicare

Advantage Plans have no private right of action, but instead have state court contract claims. The panel also discussed that within the last year, one Federal Court held that Medicare Advantage Plans do have a private right of action (In re Avandia Marketing, Sales Practices and Product Liability Litigation). Medicare also issued a memo in December of 2011 indicating that CMS supported MA plans having the same right to recovery as CMS. Recommendations from the panel included recognizing the issues in your jurisdiction and making solid risk management decisions.

Achieving Successful Outcomes in Lien Resolution:

This panel offered insight and suggestions for dealing with entities that seek recovery, but the panel focused primarily on Medicare recovery issues. Recommendations from the panel included starting the process early in settlement, always removing unrelated diagnoses from conditional payments, and clear correspondence with Medicare. Multiple questions from the audience were answered, including questions regarding recovery and zero dollar MSA's, difficulties in Medical Malpractice and Toxic Tort cases, and issues regarding disputed cases. The panel answered a number of individual audience member's questions with reference to this topic.

CMS speaks: A brief synopsis of the CMS panel at the NAMSAP conference

CMS representatives presented during the NAMSAP conference, including John Albert, Acting Director, Barbara Wright, Senior Technical Advisor, Cynthia Gross, Health Insurance Specialist, and Elizabeth Poole, Health Insurance Specialist. They discussed goals of standardized interface for all Medicare Secondary Payer issues, which included combining the MSPRC and COBC into one organization. They also mentioned their goal of transparency regarding Medicare Secondary Payer issues.

The Government Administrative Office (GAO) conducted a study between July 2011 and July 2012. The purpose of this study was to address systemic issues and to foster improvements. There were 9 stakeholders involved in the study (including NAMSAP). They issued a report regarding the MSP, and outlined additional steps to improve the effectiveness of the program. They had very specific action steps for non-group health but no specific recommendations for executive action related to the CMS process, other than timeliness of the reviews. Based on this data, actions taken by CMS included:

- Web redesign and restructure
- Recently published reference manual
- Backlog eliminated
- Improvement in turnaround time
- Use of evidence based guidelines
- 60-90 day notice prior to program change implementation
- Re-review via web portal



They went over in detail the revised web site, which was revised to make information easier to find. New tabs include "WCMSA web portal," "WCMSA arrangements," "Archive," "Memorandums," "WCMSA submission," and a "What's New" section. The web portal was also discussed, which they state has been successful to date, and a vast majority of submissions now come to them via the portal.

The new website's URL is: <http://www.cms.gov/Medicare/Coordination-of-Benefits/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSAP-Overview.html>

A discussion of the new contractor, Provider Resources, Inc., indicated that the contractor Statement of Work provided for 22 day turnaround time for "clean" submissions and an additional 17 days for cases that require development.

The memorandum page on the updated webpage now has the memos listed by subject and date, with more detailed information. CMS also published a reference manual in March of 2013 which puts all the memos in one place and has interpretive statements. This reference manual is very lengthy.

WCRC is now charged with conducting various educational activities. The goal is to have two educational activities per year. The first activity was the town hall held on 4/11/2013 which went over in detail many of the questions that were brought up. The transcript from the town hall meeting was not yet available.

The panelists, referring to the recent Town Hall conference, also noted that Medicare's goal is for transparency - stating that these sorts of meetings will happen twice yearly, and that they are also considering Twitter, Facebook, and YouTube. They also noted that posting of the latest transcripts was pending approval of the new CMS administrator.

Medicare also took limited, pre-submitted questions at the end of their presentation. They indicated that there is not one system for Reasonable and Customary pricing. They cannot comment on their position on professional administration. Redbook is used for AWP pricing.

Due to resource constraints they will not be able to re-review MSA proposals years after the original submission. However there is a formal re-review process. If the MSA is submitted via the portal it can be re-reviewed via the portal. In order for a WCMSA to be re-reviewed, new information must be presenting to support the issue, the information need to be specific, and the documentation must be provided to support the need for a re-review. This includes if there are state laws that affect the WCMSA. Again these issues need to be documented for the WCMSA to be re-reviewed. If the case does not settle, they will not re-review.

The panel reviewed in detail the web portal and submission questions. The message was that if there is a rationale for items to be included or excluded from the WCMSA, this needs to be clearly stated in the MSA so that the reviewers can understand the rationale. If body parts are denied or if care is denied by the WC insurance carrier, this needs to be clear in the submission or they will include it. Also the reporting entity needs to be accurate with the data they submit especially with denied claims.

The panel also indicated that if the submission does not include CPT codes then they will use the codes that they feel are appropriate. This may account for some of the discrepancies come from. They do not have one specific source for pricing but will look at what is submitted with the MSA and at the payment record.

Overall, this panel appeared to be a success, with a number of the pre-submitted Medicare Secondary Payer questions answered by Medicare and a clear attempt to reach out to the NAMSAP community. They appeared engaged and eager to answer questions that involved improvement of the Medicare Secondary Payer Process.



NAMSAP Committee News

Data and Development Committee

The Data and Development Committee continues tracking medications and began tracking procedures February 2013. The extrapolated data reveals a consistency in medication pricing throughout the regions with occasional pricing errors by the WCRC, as well as the vendor submitters. Currently, the most frequently seen medications include: Cymbalta, Gabapentin, Hydrocodone Bitartrate/Acetaminophen, Oxycodone HCL / Oxycontin®, Tramadol Hydrochloride / Ultram ER®, Zolpidem / Ambien®.

While the most frequently excluded medications include: Flector disc 1.3%, Lyrica, Nystop Powder, Pennsaid Topical Drop Incorrect pricing by vendors was at 44% with the inclusion of an incorrect medication or an incorrect NDC or use of an expired NDC; vendor did not price the lowest generic. Incorrect or inconsistent pricing by the WCRC was identified at 34%, with either a different drug being priced or the lowest generic was not used. The counter higher/lower ratio is approximately 29.8%.

Medication Pricing: Pricing is AWP at time of review by WCRC. Example: Meloxicam 15 mg CMS Unit Cost \$4.25 in 2013 first quarter; in 2012 was \$0.15 – this manufacturer stopped making the drug. In second quarter 2013 the price was again reduced to \$0.16

The top 5 drugs being prescribed “off label” include: LIDODERM, LYRICA, GABAPENTIN, CYMBALTA and FENTANYL.

When WCRC errors in calculation or incorrect NDC were identified and challenged, the outcome was generally positive.

In the initial tracking of procedures, unanticipated significant changes in pricing of procedures were identified. We are now tracking the following: Fusion – Cervical - \$32,546.48; Fusion – Lumbar - \$45,062.37; Knee – Arthroplasty - \$26,297.78 to \$31,015.31; Shoulder – Arthroplasty - \$17,915.91 to \$25,411.29; Shoulder – Arthroscopy - \$5,286.46 to \$6,149.44.

We will continue to monitor for consistency in CPT codes by the submitted vendor and response by the WCRC. This will be of significant importance with the pricing of future MSAs.

We look forward to the NAMSAP community’s greater participation in our venture, as our findings will be of greater value to the entire MSA community through a larger pool of data to be evaluated.

Please understand that all data is completely anonymous with no identifying information on the claimant or the submitter.

Please keep in mind; our committee was formed to track trends both of our vendor industry and the CMS responses. In tracking of these trends, our goal is for the Alliance members to have access to information in order to produce a more reliable MSA document, while monitoring the CMS/WCRC trends. The data from this committee is intended to be disseminated, **as an internal document only**, throughout the member Alliance. It was never the intention to have this information used as a personal marketing tool by any individual member organization. **Neither the DDC committee nor NAMSAP are to be held liable for the accuracy of the information contained within our document, as this information is gathered from many sources and is not independently verified.**

Education Committee

The Education Committee would like to welcome a new member, Kathy Otte from Allsup where she has responsibilities in assisting clients with Medicare Compliance. We look forward to working with Kathy and utilizing her talents and ideas on the committee.

While the Education Committee has been catching their breath after considerable effort assisting Tom Matson and , Gary Patureau and all the others who spent so much time and effort making the annual conference a success, Shawn Deane, Sub Committee Chair for Webinars has been hard at work scheduling Webinars for the membership. The most recent was one on Social Security Disability on June 5. Webinars are set for July and August as well, Structures and Custodial Administration July 25 and the role of Rated Ages in the MSA August 13. Shawn and his committee plans to hold Webinars on a monthly basis through November this year.

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