



The Medicare Conditional Payment Crisis:

The Darkness Before the Dawn

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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.

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 where 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 payment exposure. In addition, the FI will create a working file on the case which decreases the turn-around 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.

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