

# NOVARE Newsletter

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## Articles:

- What's New with Mandatory Insurer Reporting?
- New MSPRC guidelines for obtaining conditional payments

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## What's New with Mandatory Insurer Reporting?

On the January 28, 2010 conference call, CMS stated, "Testing is underway." Here are the other highlights from that call:

- Recent alerts for the Non-GHP community included registration guidelines for foreign RREs and the addition of a document control number for query files.
- The "Representative TIN" (attorney information) will now be optional.
- CMS encouraged all RREs to stay in touch with their EDI representative.
- There is no exclusion for small employers.
- There are no "specific" record retention requirements for Section 111.
- If the claimant is not a Medicare beneficiary at TPOC, then there is no need to report. If there is ORM, then the case must be monitored.

- Issues still pending with CMS:
  - Risk Management write-offs
  - Clinical Trials
  - Periodic Payments
  - Mass Torts

The COB Secure Website is [www.section111.cms.hhs.gov](http://www.section111.cms.hhs.gov). Information on test beneficiary data, the GHP and Non-GHP User Guides, error codes, and insufficient ICD 9 codes can be found under the Reference Material section of this site.

**Please note: CMS announced on February 16, 2010 that they have postponed the date for the first claim input files from April 1, 2010 to January 1, 2011. The new User Guide will be posted during the week of February 22, 2010.**

## New MSPRC guidelines for conditional payment/liens

Before October 1, 2009, in order to get conditional payment information, carriers, vendors like Novare, or attorneys had to get a signed release from the claimant and send it with a letter to the MSPRC. Then, after 45 - 60 days, whoever requested the information was supposed to get it. Sixty days after the final settlement documents were received, the MSPRC sent out the final lien amount.

Now, the basic changes are as follows:

- If you a WC carrier, the process actually got easier. You no longer need consent from the claimant and when the injury is reported to the COBC, it is also automatically reported to the MSPRC. They begin to gather the conditional payment information, and should send it to the carrier and claimant with no other info needed. If no information is received, the carrier can request the information without a consent form. Settlement documents still have to go to the MSPRC. (Liability cases still need a consent to release)

- If you are an attorney, you now need to send "Proof of Representation" signed by the claimant, or send the attorney's retainer agreement with the client's signature in order to get the information.
- If you are a vendor, like Novare, we now also get a letter from the carrier on their letterhead stating that the vendor is acting on behalf of the carrier about the claim. This letter has to include the beneficiary/claimant information.

The MSPRC also changed the names of some of the letters that they send. For example, the initial letter is now called the "Rights and Responsibilities" letter. It used to be the "Right to Recovery" letter and now includes an educational brochure. It goes to the claimant and is copied to the carrier. The website [www.msprc.info](http://www.msprc.info) has all the information on the recovery process, including a copy of the presentation that was given on November 12, 2009.

CMS has stated that they are looking into planning a conference call on these issues in the near future.

## LEGAL BRIEFS

Several cases have affirmed the Centers of Medicare and Medicaid Services (CMS) are intent on ensuring Medicare Secondary Payer Compliance for all applicable parties. These Court decisions are evidence of the current challenges in settling claims when complying with the Medicare Secondary Payer statute. It is paramount these issues are resolved at the time of settlement. We believe the new aggressive approach Medicare is taking to seek recovery for conditional payments, and their requirements to allocate for future applicable medical exposure, confirms the necessity of partnering with champions in the Medicare Secondary Payer compliance arena. Novare offers a seamless solution to MSP compliance.

### US v. Harris

Claimant attorneys (and all parties) need to be aware they are not excluded from protecting Medicare's interest in their settlement processes. The United States demonstrated this active recovery process in the United States of America v. Paul Harris (2009). In this case, the Plaintiff attorney, Paul Harris, failed to protect Medicare's interest, and was personally sued by the United States. The U.S. filed a complaint against defendant (Paul Harris) for declaratory judgment and money damages owed to CMS by virtue of third-party payments made to a Medicare beneficiary. Mr. Harris submitted settlement documents to CMS on a liability settlement of \$25,000.00. CMS subsequently submitted a demand letter with their right of recovery (\$10,243.59). He did not respond nor did he pay CMS within the 60-day timeframe. The Court found in favor of the U.S. with a final judgment amount of \$15,578.38, plus interest at the rate of 0.49% per annum from the date of settlement. 42 C.F.R. 411.24 supported CMS' argument that they had a right to recover its payments from any entity including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that had received a primary payment. The Court was specific that Mr. Harris was individually liable for reimbursement to MC based on the above regulation because he was considered "an entity" that the Government may recover payment.

### US v. Stricker

The United States exercised their right to seek recovery of conditional payments from both the liability carrier and the plaintiff's counsel. In the U.S. Court action, United States of America v. James J. Stricker, et al, the U.S. based their right of recovery argument on the MSP statute. The defendant and carrier did not designate a particular dollar award to a specific plaintiff; hence there was no report to CMS of those plaintiffs who were Medicare beneficiaries, nor was there a component of the final settlement allocated for Conditional MC Lien resolution. The United States' position was they were entitled to reimbursement with the final settlement award monies in relation to the individual plaintiffs in the Suit that were eligible MC beneficiaries. Medicare argued they should have been considered Secondary Payer and reimbursed out of final settlement award. The U.S. went further to seek interest and penalty, and requested the defendants must submit notice of projected future Medicare-covered expenses for those MC beneficiaries pursuant to 42 C.F.R. 411.25. The Suit requested that all defendants must ensure appropriate payments are made to the U.S. prior to any final settlement payments. This case brings to light, the U.S. intent to precede against the liability carriers for both conditional and future payments for Medicare expenses. The final decision in this case is pending.

### Hadden v. US

The Federal Court decision to uphold the Center for Medicare and Medicaid Services' policy to not recognize comparative fault principles in negotiating conditional payments, unless allocation of fault was determined at trial is demonstrated in Hadden v. United States of America, 2009. Mr. Hadden sustained significant injuries when his person was struck by a vehicle that ran a stop sign. The final settlement amount in favor of Mr. Hadden was \$135,000.00. The medical expenses incurred prior to settlement were paid "conditionally" by Medicare [42 U.S.C. 1395y(b)(2)(B)(ii)]. Medicare had the right of recovery of these monies from the settlement prior to other providers or suppliers receiving payment. Medicare assessed conditional payments in the amount of \$62,338.07. Mr. Hadden submitted a request to CMS for a waiver of their full right of recovery based upon the argument of comparative fault; and suggested that CMS' right of recovery was 10% of the conditional payment amount. This request was based on the Plaintiff's ability to recover a percentage of damages caused by defendant under the State of Kentucky's application of a "pure comparative" negligence standard relative to any allocation of fault. CMS denied the request and Plaintiff appealed. The case was brought to the Federal Court where the Suit was dismissed

## Updated Drug Utilization Review savings:

The worker's compensation market is associated with disproportionately high pharmacy costs. In many cases, drug expenditures are unnecessarily inflated. Novare can help avoid or minimize the financial risk from pharmaceutical costs. Leveraging Novare's unique experience and knowledge of the pharmacy marketplace can translate into significant financial savings. Drug Utilization Review can save 20% to 40% or more on pharmacy cost projections.

Example	Lifetime Pharmacy Cost Before the DUR	Lifetime Pharmacy Cost After DUR	Savings
Claimant 1	\$386,906.04	\$71,368.61	\$315,537.43
Claimant 2	\$550,035.29	\$252,670.58	\$297,364.71
Claimant 3	\$285,146.44	\$21,277.08	\$263,869.36
Claimant 4	\$229,416.49	\$45,768.53	\$183,647.96
Claimant 5	\$264,438.20	\$105,465.82	\$158,972.38
Claimant 6	\$152,193.22	\$1,945.52	\$150,247.70
Claimant 7	\$1,118,596.20	\$1,020,595.68	\$98,000.52
Claimant 8	\$128,429.54	\$43,454.00	\$84,975.54
Claimant 9	\$253,093.92	\$171,877.92	\$81,216.00
Claimant 10	\$94,395.84	\$36,650.88	\$57,744.96
Claimant 11	\$124,812.00	\$70,193.52	\$54,618.48
Claimant 12	\$84,689.54	\$30,333.30	\$54,356.24
Claimant 13	\$150,437.26	\$99,746.66	\$50,690.60
Claimant 14	\$90,117.00	\$42,592.08	\$47,524.92
Claimant 15	\$43,657.20	\$6,492.96	\$37,164.24
Claimant 16	\$50,536.00	\$16,644.00	\$33,892.00
Claimant 17	\$120,416.62	\$90,915.12	\$29,501.50
Claimant 18	\$65,829.36	\$37,323.36	\$28,506.00
Claimant 19	\$91,443.90	\$67,561.56	\$23,882.34
Claimant 20	\$48,361.00	\$25,641.12	\$22,719.88
Claimant 21	\$20,739.00	\$6,977.35	\$13,761.65

Total Savings:

\$2,088,194.41



# Your MSA questions answered....

## **My case is a liability case. Do I need an MSA?**

Answer: Pursuant to 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Third Party Liability proceeds are also primary to Medicare. CMS has stated repeatedly on conference calls, the CMS website, and by phone that while they do not have a formal review process for Set Asides in liability cases, that Medicare's interests must be reasonably considered in all cases.

CMS does not require approval of Liability MSAs, however:

- 1.) Medicare states that their interests must be met under MSP provision, and the only way that CMS has recognized doing that is with an MSA.
- 2.) Using an MSA for Medicare beneficiaries is the best way to guarantee no future problem with Medicare.
- 3.) There is no formal review process for liability MSAs, but the Dallas, Chicago, Philadelphia, and Seattle CMS Regional Offices are all currently reviewing liability cases.
- 4.) Because of the new Mandatory Insurer Reporting requirements, Medicare will know about liability and no-fault settlements, as well as worker's compensation claims.
- 5.) Most importantly, if Medicare's interests are not protected, the claimant/your client could lose Medicare benefits related to the injury.



## **The Second Medical Opinion and Independent Medical Examiner stated no surgery was necessary. Does it have to be included in the MSA?**

Answer: Yes, the surgery would have to be included in the MSA. CMS states that it is always their intention that the beneficiary or claimant receives the appropriate medical treatment as determined by his or her **treating physician**.

## **The claimant refuses surgery. Does it have to be included in the MSA?**

Answer: Yes, the surgery would have to be included in the MSA. CMS guidelines indicate that there "is no means by which a claimant can permanently waive his or her right to certain specific services related to a WC case and, thereby, reduce the amount of an MSA." This guidance is found in the 7/11/2005 memo, question 9.



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## Novare: Your MSP solution

Novare consistently provides solutions for Medicare Secondary Payer compliance with quality Medicare Set Aside reports and MMSEA reporting.

Our Medicare Set Aside reports are completed by nurses that are MSCC certified and are reviewed by our PharmD to assure the best prescription allocation costs for our clients.

Medicare Agent Reporting Services include up-front consultation to assist with registration, retrieving query files, importing files from the RRE, editing files for mandatory data elements, enabling interface to correct missing elements, transmitting the final report file to CMS, and sending Medicare's acknowledgement to the RRE.

### Novare Medicare Set Aside Service Commitment:

- MSCC Professional Nurses complete the MSA process to include on-going communication with the client to move the file to settlement
- PharmD reviews and prices all prescriptions using generics
- Novare MSA reports meet CMS requirements, resulting in high CMS Submission rate
- Turnaround time is 10 days
- All Medicare Set Aside reports are one flat rate with NO HIDDEN FEES and NO CHARGE FOR RUSH CASES

### *About Our Organization..*

Novare is committed to efficient and effective cost containment with a high responsibility to quality, service and local representation. Our services are uniquely customized to meet your specific needs.

Our staff is highly professional and among the most experienced in the industry. We gauge our success by our customers' satisfaction.

