MEDICARE COMPLIANCE MANUAL

PUT AN END TO MEDICARE COMPLIANCE CHALLENGES

- Section 111 Reporting
- Medicare Lien Recovery
- Maintaining 100% Medicare Compliance as a Responsible Reporting Entity

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INTRODUCTION

Approximately 15-18% of the United States population is covered by Medicare.

Depending on your customer base, that means 15-18% of the Liability and No-Fault claims crossing the desks of P&C insurance claims adjusters every month are Medicare-related, and therefore require attention to Medicare compliance.

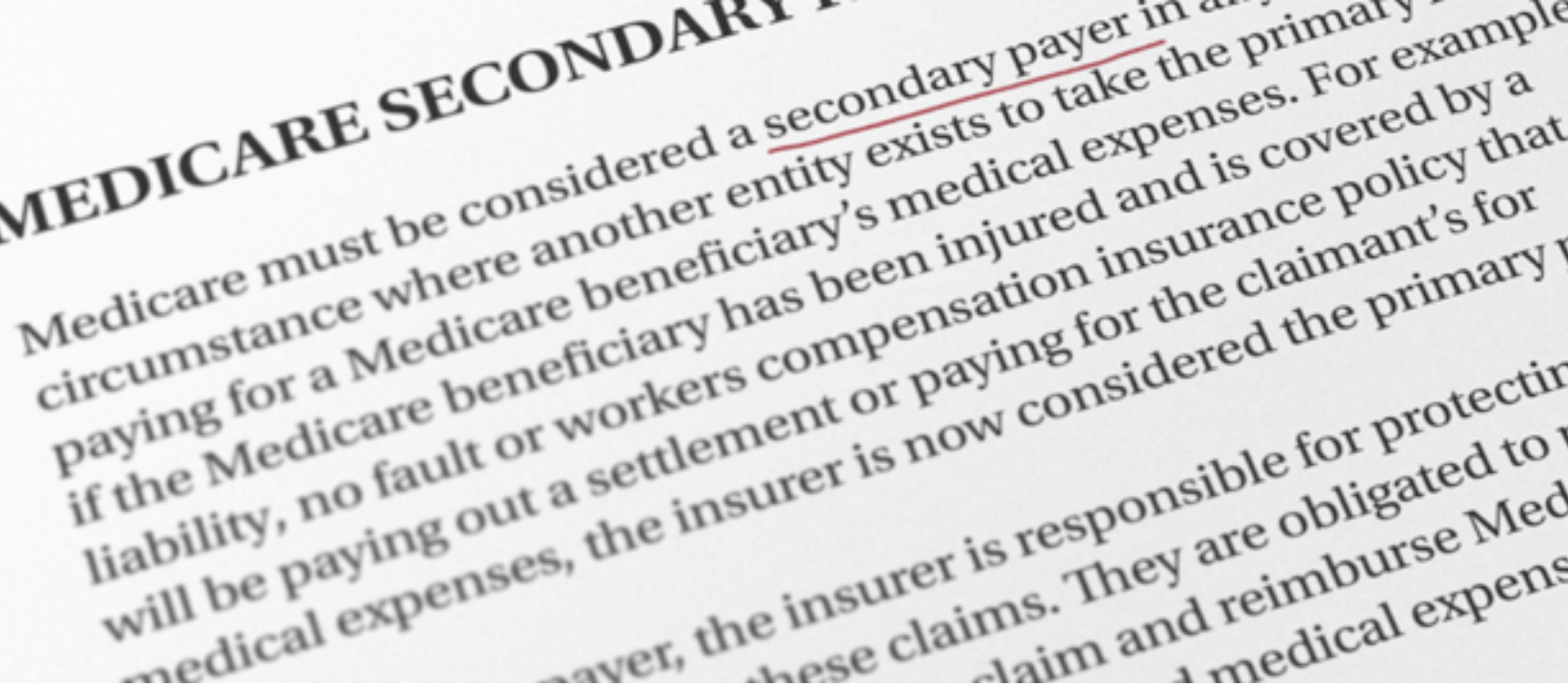
Whether your insurance company is small or large, this can amount to hundreds or even thousands of claims per year, potentially involving millions of dollars. However, it can also mean that claims adjusters only see a Medicare-related claim a few times each month, but are still expected to know and follow Medicare's procedures.

These facts create an ongoing challenge for insurance companies that wish to avoid the steep penalties that come from failing to comply with Medicare regulations. Senior claims officers face the **following questions:**

1. What exactly is required for compliance for all the different types of claims my adjusters handle?
2. How can I guarantee the company remains 100% compliant when my adjusters see these claims infrequently and the rules are constantly changing?
3. Is there any way to guarantee 100% compliance without slowing down my adjusters or costing the company too much money?

The purpose of this manual is to simplify Medicare compliance and provide straightforward, answers to these questions.

To begin, we will discuss the importance of Medicare compliance for P&C insurers, then we'll cover the two basic elements of Medicare compliance, reporting and recovery.



WHAT IS MEDICARE COMPLIANCE?

In this context, Medicare Compliance refers to complying with Medicare regulations under the Medicare Secondary Payer (MSP) rules.

At their core, these rules boil down to **two basic facts:**

1. Medicare must be considered a secondary payer in any circumstance where another entity exists to take the primary role in paying for a Medicare beneficiary's medical expenses. For example, if the Medicare beneficiary has been injured and is covered by a Liability, No-Fault or Workers Compensation insurance policy that will be paying out a settlement or paying for the claimant's for medical expenses, the insurer is now considered the primary payer.

2. As the primary payer, the insurer is responsible for protecting Medicare's interests in these claims. They are obligated to properly report their involvement in the claim and reimburse Medicare for any conditional payments made toward medical expenses on the beneficiary's behalf.

To be considered 100% Medicare compliant, both the reporting and recovery aspects must be administered accurately on every single claim involving a Medicare beneficiary.

SECTION 111 REPORTING

As a Responsible Reporting Entity (RRE), any insurance company that assumes ongoing responsibility for medical expenses (ORM) for a Medicare beneficiary or awards a beneficiary any sort of financial settlement, is responsible to report the details of the claim to Medicare via the rules laid out in Section 111 of the Medicare Medicaid SCHIP Extension Act (MMSEA).

Section 111 reporting must be completed according to Medicare's strict regulations. These policies and procedures include rules on timing, formatting, and specific data elements, using ICD-10 codes and submission with an approved format. The intricacies of these regulations - many of which have changed in recent years, or could change at any time - make this seemingly simple requirement challenging for insurance companies.

The Reporting Process

Most RREs rely on an automated process for Section 111 Reporting that includes **four basic steps:**

1. Although not required, most companies run all of their claims through an automated query to identify Medicare beneficiaries on a monthly basis.
2. All claims involving Medicare beneficiaries are then further investigated to identify those involving ORM and those involving a final settlement or Total Payment Obligation to Claimant (TPOC).
3. All claims involving ORM require two reports: one report when the ORM is assumed and a second report when the ORM is terminated. While there are several reasons why ORM is terminated it is important to remember that Medicare has specific rules that must be followed.
4. A claim involving a TPOC must be reported once settlement is reached.

Altogether, each claim may involve several mandatory Section 111 reports. Each of these must be reported according to Medicare's strict formatting specifications and their timeframes. Automating this process is wise as it saves RREs time and manpower. However, if not done properly, in can leave the process open to potentially costly errors.

The Challenges with Reporting

The reporting process under Section 111 is highly detailed and must be done accurately or the RRE risks having reports rejected or delayed. Delayed reports can result in compliance flags.

While a proven automated process can help maintain compliance, there is no denying that details such as the exact dates of when ORM was assumed or terminated and the correct dollar amounts factored into the TPOC are all prone to human error upon entry. There is frequently debate and misunderstanding regarding Medicare's definitions and requirements. An automated reporting system can't catch errors made at the time of initial data entry.

An automated reporting system also won't be able to verify the validity of ICD-10 codes reported by claims adjusters. Failing to enter correct data can lead to under-reporting or over-reporting. Under-reporting can lead to compliance penalties. Over-reporting can result in thousands of dollars of unrelated medical claims being included in a Medicare lien.

While automating the reporting process is the only realistic way for P&C Insurance Carriers to keep up with Section 111 requirements, it can leave gaps that could end up costing a lot on the back end in inflated lien amounts and/or penalties for failure to properly report. These potential gaps must be identified and measures put in place to alleviate them. Under the Section 111 guidelines, the penalties associated with non-compliance are steep and can include heavy penalties and double damages for every claim reported incorrectly.

Despite its inherent complexity and the potential for inadvertent non-compliance due to human error and extensive automation, most RREs believe they do a fairly good job of reporting under Section 111. However, the second step needed to maintain compliance can often be the greatest challenge.

MSP RECOVERY

While many RRE's have a fairly reliable method for Section 111 Reporting, many fall short in their recovery obligations. The recovery side of Medicare compliance involves actually reimbursing Medicare for the conditional payments they've already made that are related to the claim.

The inherent time lapse between when an injury occurs and when the insurance claim is finalized and/or settled makes Medicare's involvement almost inevitable. The complexities in the reporting process described above, make recovery a confusing situation fraught with opportunities to fall out of compliance if an RRE isn't careful:

Different types of claims are handled by different Medicare contractors and the contractors have distinct and separate processes.

These contractors may or may not communicate with each other, and they may or may not utilize the information from your Section 111 report.

The charges on a Medicare Conditional Payment Letter may or may not be completely accurate.

Medicare's contractors may or may not be proactive in notifying RREs of existing liens, necessitating additional steps to ensure you remain in compliance.

And, to top it off, these rules are constantly in a state of flux and changes are not always communicated clearly or at all.

As a result, the recovery process has become a virtual minefield for P&C insurance companies wishing to remain compliant. And, similar to the reporting side, failure to comply with recovery requirements carries with it stiff fines and penalties.

Recovery for Liability Claims

Although the recovery process for Liability claims has gone through subtle changes, the process has remained relatively constant:

1. Because RREs are not obligated to report Liability claims until settlement, Medicare does not even know about the claim unless it is reported to the Recovery Contractor.

2. The RRE must then request a Conditional Payment Letter (CPL) from Medicare. Most RREs are under the impression that Medicare automatically generates CPLs. Remember, you are not reporting your Liability claim until you reach settlement, and thus Medicare does not know about the claim until AFTER settlement.

3. A CPL is NOT a bill. It is merely a snapshot of all medical expenses Medicare has already paid up to the date of the letter that they believe to be related to the claim. The amount you end up actually owing can fluctuate over time.

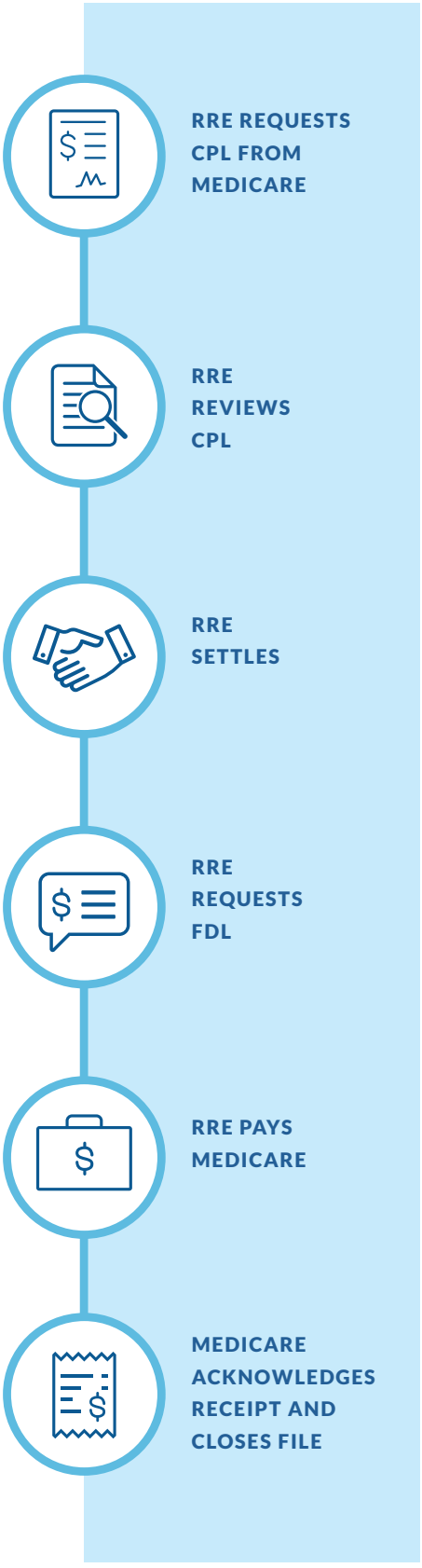
4. The RRE should review the CPL to confirm that the charges are related to the claim, and dispute any that are not. Because of Medicare's filtering system, we have seen them routinely overbill by more than 50%

5. Once the RRE settles, they must then request a Final Demand Letter (FDL) which serves as Medicare's official "bill" for payment.

6. Finally, the RRE is responsible to pay Medicare the amount owed within the appropriate time frame.

7. The RRE is not truly compliant until Medicare has acknowledged that they received the money and close their file.

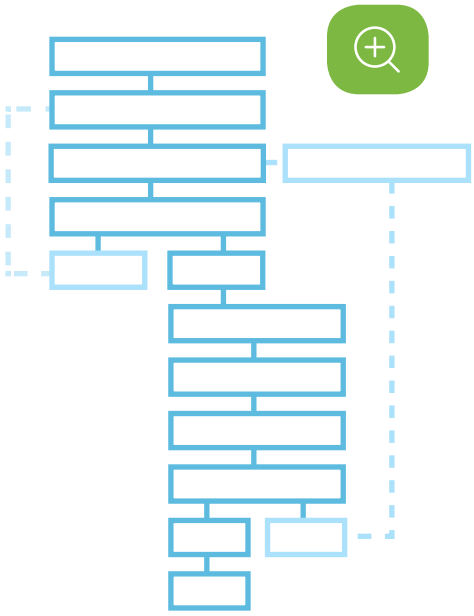
While this process has not changed much in the years it's been in place, many P&C insurance companies still struggle with its inherent pitfalls and complications, one of the most glaring of which is the fact that this process differs dramatically from how Medicare handles recovery of No-Fault claims.



Recovery for No-Fault Claims

The claim recovery process changed dramatically in late 2015 with the establishment of the Commercial Recovery Center (CRC). The CRC is charged with handling the recovery for all No-Fault and Workers Compensation claims on Medicare's behalf.

Unlike the Liability claim process described above, the No-Fault/Workers Compensation process is much more proactive in nature:



1. The RRE reports the assumption of ORM in connection with the No-Fault or Workers Compensation claim under Section 111 guidelines.

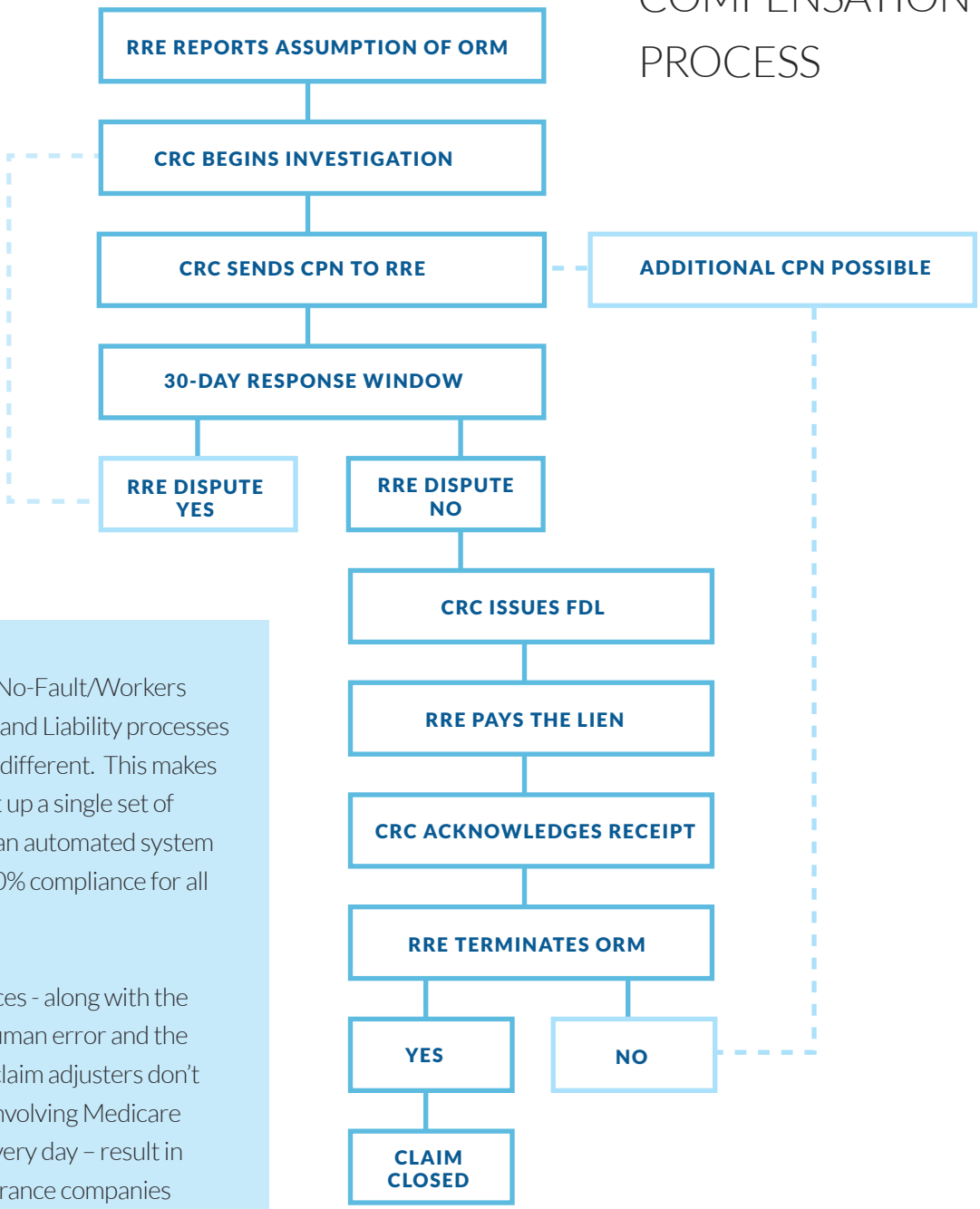
2. The department processing Section 111 reports communicates this information to the CRC and the CRC immediately begins an investigation to determine what Medicare has already paid on behalf of the claimant that could be related to the claim.

3. The CRC sends out a Conditional Payment Notice (CPN) to the RRE. While this notice is nearly identical to a traditional CPL, it differs in one very important aspect: it includes a tight 30-day response window during which the RRE must investigate and dispute any of the charges that are unrelated. At the end of that brief time period, if a dispute has not been submitted, the CRC will issue a FDL and the RRE is responsible to pay the lien.

4. Once the FDL is paid, the CRC will acknowledge receipt of payment.

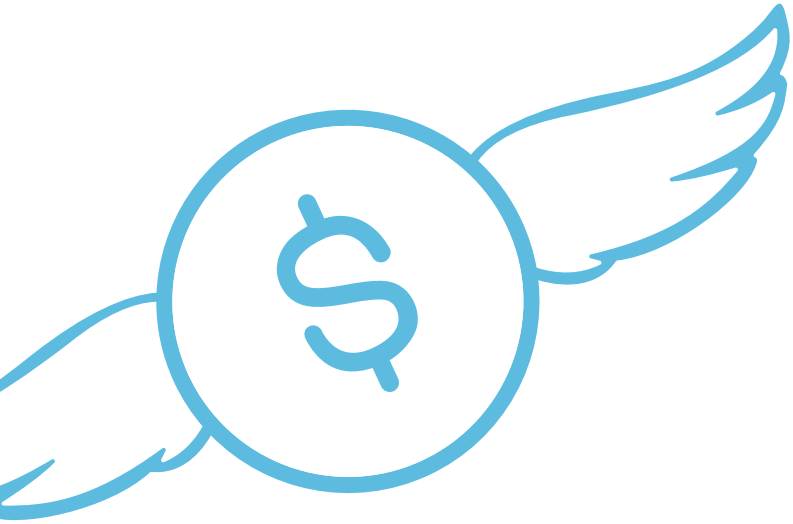
5. This claim will not close with Medicare until the RRE terminates ORM in Section 111. Until that time, it is possible for the RRE to receive additional CPNs if additional bills are paid by Medicare. Failure to properly terminate ORM can result in additional liens for the RRE and the termination of Medicare benefits for the claimant.

NO-FAULT/ WORKERS COMPENSATION PROCESS



Obviously, the No-Fault/Workers Compensation and Liability processes are completely different. This makes it difficult to set up a single set of procedures or an automated system to maintain 100% compliance for all types of claims.

These differences - along with the possibility of human error and the fact that most claim adjusters don't handle claims involving Medicare beneficiaries every day – result in many P&C insurance companies remaining exposed to potentially costly non-compliance penalties despite their best efforts.



1. The settlement amount might be inadequate to appropriately reimburse Medicare and meet the claimant's needs. At the end of the day, Medicare will collect their money. The claimant could end up being short changed or the Insurance Company might have to come out of pocket additional funds including going above policy limits.

2. The adjuster may overestimate the lien amount and settle for more than necessary.

The Challenges with Recovery

In the case of Liability claims, the timing of the reporting process puts RREs at an automatic disadvantage.

While they need to be aware of the amount of any liens Medicare will impose on them prior to determining a final settlement amount, Medicare does not accept their Section 111 report and does not generate a FDL for the claim until settlement is complete.

The result of this Catch-22 is often a settlement based only on a guess at what Medicare may have paid or, worse yet, a settlement that fails to consider Medicare at all. What are the potential consequences?

In both cases, the end result for the insurance company is higher paid costs for the claim and higher reserves across the board. While higher costs for one claim may not sound alarming, multiply that times hundreds or thousands of claims per year and it really starts adding up.

The bottom line is that there are two different recovery contractors with two completely different documentation requirements, addresses, telephone numbers, fax numbers and processes that can lead to confusion, wasted time, and even errors resulting in inadvertent non-compliance.

Considering that claims adjusters do not deal with Medicare-related claims every day and all of the complexities involved, it's not hard to understand why mistakes are made all the time. Considering how often small changes in procedures and regulations occur, it's clear why insurance companies find it almost impossible to keep every adjuster up-to-date, much less ensure 100% compliance.

Fortunately, an expert partner in the Medicare compliance space can alleviate all these complications, mitigate your risk and GUARANTEE 100% COMPLIANCE.

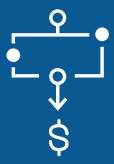
HOW FLAGSHIP SERVICES GROUP CAN HELP

At Flagship Services Group, MSP compliance is our specialty. It's all we do, all day, every day, so our compliance specialists are experts in the true sense of the word.

If you have any questions about the information in this guide, or if you know where your compliance program could use support, please **contact us** to discuss options.

FLAGSHIP® SERVICES GROUP

Our approach is comprehensive - from cradle to grave - taking the headache of maintaining compliance out of your adjusters' hands and walking each Medicare-related claim through the right process, on the right schedule, every time.



Along the way, our specialists review each and every charge noted by Medicare to verify that it is related to the claim. This ensures that Medicare is accurately reimbursed everything they are rightfully owed, but not a penny more.

In the case of Liability claims, we can obtain multiple CPLs prior to settlement, allowing your adjusters to settle on a figure that's just right to protect Medicare's interests and satisfy the claimant. In the case of No-Fault and Workers Compensation claims, address all CPNs and FDLs within Medicare's strict guidelines to alleviate overpayment or penalties and interest.

Finally, Flagship can do all this with speed and efficiency, and at an incredibly reasonable rate. The end result in most cases is zero net cost: Flagship's fees are far less than the amount clients save. As a Medicare compliance partner, the team at Flagship works hard to protect your financial assets.