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IWCAC Annual Symposium

Medicare Secondary Payer Compliance: 2025 Updates

June 20, 2025

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Agenda

1. MSP – The Law
2. Section 111 Reporting
3. Conditional Payments
4. Future Considerations
5. Mitigation
6. Q&A

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MSP – The Law

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Recap: Medicare Secondary Payer Act

Main Components

- 42 U.S.C. 1395y(b)(2)
- Regulations begin at 42 C.F.R. 411

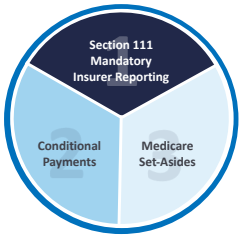
The Centers for Medicare & Medicaid (CMS) Publishes Guides:

Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide

- Current version: COBR-Q2-2025-v4.3
- April 7, 2025

MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting: Non-Group Health Plan (NGHP) User Guide

- Current version: COBR-Q2-2025-v8.0
- April 7, 2025



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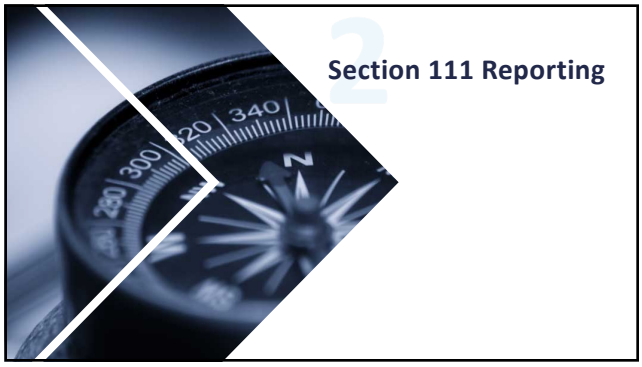

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Section 111 Mandatory Insurer Reporting

"The purpose of the Section 111 MSP reporting process is to enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries."

- NGHP User Guide version 8.0 released April 7, 2025

Why is it so important?

- **Conditional Payments** – CMS uses the information supplied (dates, ICD coding) as the basis of the conditional payment process
- **Medicare Beneficiaries** – incorrect/incomplete information may affect their treatment/billing
- **Civil Money Penalties** – untimely reporting may result in civil money penalties

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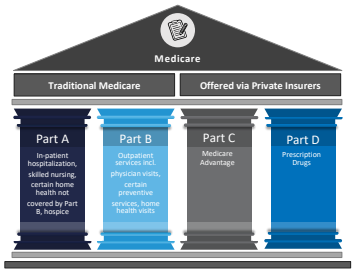
Query Response



If Claimant a Medicare beneficiary, Medicare will supply:

- Date Claimant gained Part A
- Date Claimant gained Part B
- 3 years of Part C and Part D information (if Claimant has C or D) up to 12 occurrences

The PAID Act required CMS to supply the additional query information.

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ORM Acceptance

Ongoing Responsibility for Medicals (ORM)

The RRE's responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with the claim

Most often applies to no-fault and workers' compensation (does not often occur in liability cases)

The trigger for reporting ORM is:

- the determination to assume ORM by the RRE—which is when the RRE learns, through normal due diligence, that the beneficiary has received (or is receiving) medical treatment related to the injury or illness sustained

Required reporting of ORM by the RRE does not necessarily require the RRE to have made payment for Medicare-covered items or services when the RRE assumed ORM, nor does a provider or supplier necessarily have to have submitted a claim for such items or services to the RRE for the RRE to assume ORM

The dollar amounts for ORM are not reported, just the fact that ORM exists or existed.

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ORM – Termination Options

OPTION 1

Where there is **no practical likelihood of associated future medical treatment**, an RRE may submit a termination date for ORM if it maintains a statement (hard copy or electronic) signed by the beneficiary's treating physician that no additional medical items and/or services associated with the claimed injuries will be required

OPTION 2

Where there is no practical likelihood of associated future medical treatment, which is reflected by meeting ALL of the following:

- No claims were paid with any diagnosis codes related to alleged ingestion, implantation, or exposure; and
- No claims were paid, for any medical item or service related to the case, within five (5) years of the date of service of any such claim; and
- Treatment did not include, nor were any claims paid related to, a medical implantation or prosthetic device; and
- The total amount paid by the insurer, for all medical claims related to the case, did not exceed $25,000.

Note: If, at any time, any of the parameters set forth above should no longer be applicable, the insurer must then update the ORM record to reflect that they, once again, have ongoing responsibility for medicals

OPTION 3

Where the insurer's responsibility for ORM has been terminated under applicable state law associated with the insurance contract

OPTION 4

Where the insurer's responsibility for ORM has been terminated per the terms of the pertinent insurance contract, such as maximum coverage benefits.

Source: NGHP User Guide version 8.0 released April 7, 2025

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Total Payment Obligation to Claimant (TPOC)

Refers to the dollar amount of a settlement, judgment, award, or other payment in addition to, or apart from, ORM. Generally, reflects a "one-time" or "lump sum" settlement, judgment, award, or other payment intended to resolve/partially resolve a claim."

TPOC CALCULATION

"The computation of the TPOC amount includes, but is not limited to:

- all Medicare covered
- and non-covered medical expenses related to the claim(s),
- indemnity (lost wages, property damages, etc.),
- attorney fees,
- set aside amount (if applicable),
- payout totals for all annuities rather than cost or present values,
- settlement advances,
- lien payments (including repayment of Medicare conditional payments),
- and amounts forgiven by the carrier/insurer."

TPOC DATE

The TPOC date is not necessarily the payment date or check issue date.

The TPOC date is the date the payment obligation was established.

- It is the date the obligation is signed if there is a written agreement, unless court approval is required.
- If court approval is required, it is the later of the date the obligation is signed or the date of court approval.

Source: NGHP User Guide version 8.0 released April 7, 2025

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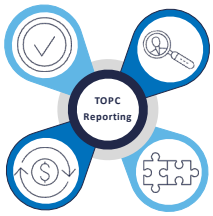
MSAs Reported as Part of TPOC

Effective April 2025 CMS expanded Section 111 Mandatory Insurer Reporting to capture the WCMSA information as part of the TPOC reporting.

Reporting for Medicare beneficiaries only

Only WorkComp claims



WC Reporting Threshold Remains: $750

Applies to all TPOCs: Includes both submitted and non-submit MSAs

NGHP User Guide version 8.0 released April 7, 2025

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What Is Being Collected?

CMS identified the following 7 fields to be added to the Claim Input File record layout:

Field Name	Description	Required
MSA Amount	Total MSA Amount	Yes, if WC and TPOC is reported
MSA Period	Period of coverage in years	Yes, if the MSA amount is greater than $0
Lump/Annuity Indicator	Is the settlement setup as a lump sum or a structured annuity?	Yes, if the MSA amount is greater than $0
Initial Deposit Amount	Initial amount deposited	Yes, if specified as a structured annuity
Anniversary (Annual) Deposit Amount	Amount deposited annually	Yes, if specified as a structured annuity
Case Control Number	ID from case that has been established with CMS	No
Professional Administrator EIN	Tax ID of the Professional Administrator if one exists	No

NGHP User Guide version 8.0 released April 7, 2025

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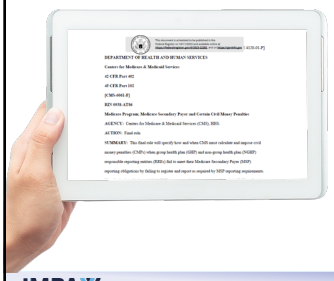
Civil Money Penalties– Final Rule



- Effective: December 11, 2023
- Applicable: October 10, 2024
- One year to report before Civil Money Penalties (CMPs) imposed

- Only for Untimely Reporting of ORM Acceptance and TPOC
- Audit Approach
- Appeals Process (Informal and Formal)
- Five-Year Statute of Limitations
- Safe Harbors
- Tiered Approach for NGHPs
- Prospective Only

42 CFR 402

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"Untimely" Reporting

ORM trigger - the determination to assume ORM by the RRE, which is when the RRE learns, through normal due diligence, that the beneficiary has received (or is receiving) medical treatment related to the injury or illness sustained

A **TPOC** generally reflects a "one-time" or "lump sum" settlement, judgment, award, or other payment intended to resolve or partially resolve a claim.

Timeliness is determined by comparing the date a record is submitted and accepted against the date CMS should have received the record.

The **date CMS should receive a record** is determined by the effective date of coverage or the date of settlement (or settlement funding date if the funding of the settlement is delayed) plus 1 year (365 days).

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Audit Approach

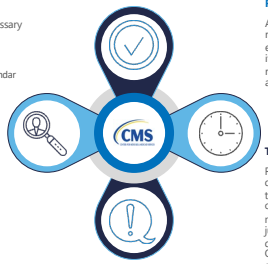
Evaluation

Based on time and resources necessary to evaluate, CMS will audit:

- 1,000 records per calendar year
- Across all RRE submissions
- Divided evenly among each calendar quarter (so, 250 individual beneficiary records per quarter)
- Proportionate number of GHP and NGHP

Noncompliance

Any time CMS identifies a new beneficiary record that was not reported to CMS timely.



Random Selection

At end of each quarter, CMS will randomly select records and analyze each selected record to determine if it is in compliance with the reporting requirements as required by statute and defined in final rule.

Timeliness

Reporting to CMS within one year of the date: GHP coverage became effective, the date a settlement, judgment, award, or other payment determination was made (or the funding of a settlement, judgment, award, or other payment, if delayed), or the date when an entity's Ongoing Responsibility for Medicals (ORM) became effective.

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Informal Appeals Process

Informal (that is, prior to formal enforcement actions) written "pre-notice" process.

Will allow the RRE the opportunity to present mitigating evidence for CMS review prior to the imposition of a CMP.

The RRE will have 30 calendar days to respond with mitigating information before the issuance of a formal written notice in accordance with 42 CFR 402.7

Impractical to regulate or enumerate all mitigation options

- They will leave the informal notice process open to any reasonable submission of mitigating factors
- So that they are free to entertain all such documentation without strict limits on what is, or is not, acceptable

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Formal Appeals Process

Formal Process
CMPs subject to formal appeals process in 42 CFR 402.19 and 42 CFR 1005

Written Notice
Formal written notice at time penalty is proposed

Request a Hearing
Right to request a hearing with ALJ (Administrative Law Judge) within 60 calendar days of receipt

Appeal Within 30 Days
Any party may appeal the initial decision of the ALJ to the DAB (Department Appeals Board) within 30 calendar days.

Binding Decision
DAB's decision becomes binding 60 calendar days following service of DAB's decision – unless there is a petition for judicial review

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Notification of CMPs

Account representative will receive notification of Civil Money Penalties

CMP correspondence will be mailed to the RREs Account Representative (AR) on record.

Contact your EDI Rep if you need to replace the AR and/or update associated contact info

Copies will be mailed to Account Manager

Account Manager can update contact information and RRE's account data through the COBSW.

Reporting Agents **will not** receive CMP correspondence

RREs are accountable if any correspondence is missed due to inaccurate/outdated contact information.

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Statute of Limitations

Five Years

Under 28 U.S.C. 2462, they will impose a CMP within 5 years from the date when the noncompliance occurred.

Why not three years? Based on 1862(b)(2)(B)(iii)

- CMS states that provision applies only to legal actions CMS may utilize for recovery of MSP debts
- Argues recovery of conditional payments may on face be similar to CMPs, but actually they are "unique and serve separate and distinct purposes"

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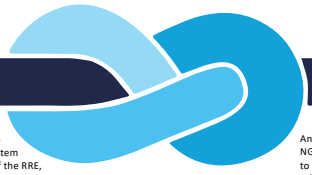
Safe Harbors



Technical or System Issue

Any untimely reporting that is the result of a technical or system issue outside of the control of the RRE, or that is the result of an error caused by CMS or one of its contractors would not be considered noncompliance for purposes of this rule.

Lack of Cooperation

Any untimely reporting by an NGHP that is the result of a failure to acquire all necessary reporting information due to a lack of cooperation by the beneficiary will not lead to a CMP provided that certain standards are met

Other situations may exist. RREs can utilize the informal or formal appeals process.

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Tiered Approach

Calculation of the Penalty

CMS will multiply the number of audited records found to be noncompliant by the number of days that each record was late (in excess of 365 days).

The product will then be multiplied by the appropriate penalty amount:

- $250, as adjusted annually under 45 CFR part 102, for each calendar day of noncompliance, where the record was reported 1 year or more, but less than 2 years after, the required reporting date;
- **$500**, as adjusted annually under 45 CFR part 102, for each calendar day of noncompliance, where the record was reported **2 years or more, but less than 3 years after**, the required reporting date; or
- **$1,000**, as adjusted annually under 45 CFR part 102, for each calendar day of noncompliance, where the record was reported **3 years or more after the required reporting date**

The **total penalty** for any one instance of noncompliance by an NGHP RRE for a given record identified by CMS will be **no greater than $365,000** (as adjusted annually under 45 CFR part 102).

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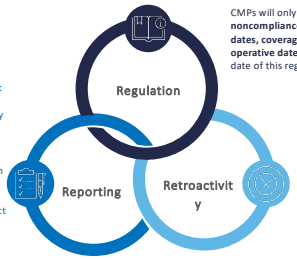
Prospective Only



CMPs will only be imposed on instances of **noncompliance based on those settlement dates, coverage effective dates, or other operative dates** that occur after the effective date of this regulation

The **one-year period to report** the required information before CMPs would potentially be imposed would begin on the latter of the rule effective date or the settlement or coverage effective dates which an RRE is required to report in accordance with sections 1862(b)(7) and (b)(8) of the Act

There will be **no instances** of inadvertent or de facto retroactivity of CMPs

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3 Conditional Payments

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Appeals Process

1 - **Conditional Payment Letter** or Conditional Payment Notice – this is not a bill, do not send payment

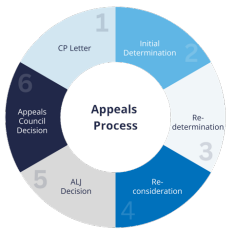
2 - **Initial Determination** – 120 days from receipt to appeal

3 - **Redetermination** by initiating contractor (BCRC or CRC) – 180 days from receipt to appeal

4 - **Reconsideration** by a Qualified Independent Contractor (QIC) – 60 days to appeal. Evidence not submitted to QIC may be disqualified from review by ALJ in further appeal

5 - **Administrative Law Judge Decision** – 60 days to appeal

6 - **Medicare Appeals Council Decision** – 60 days to appeal



If deadline is missed, there likely are still options: Request for Extension or Request for Reopen Negotiations BCRC vs. CRC

*CMS presumes receipt within five days of issuance: rebuttable

42 CFR 411

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Parts A/B: Collection Process

Referral to U.S. Treasury

- CMS presumes receipt within **five days of issuance**.
  - Rebuttal
- Unless appeal is pending or payment is received, Medicare usually refers debt to the U.S. Treasury **180 days from the initial determination**.
- If the deadline is missed, there are likely **still options**:
  - Request for Extension
  - Request to Reopen
    - Within one year of the initial determination or redetermination for any reason
    - Within four years from date of initial determination or redetermination for good cause
    - At any time to correct a clerical error with respect to an unfavorable initial determination

42 CFR 405.980(c)

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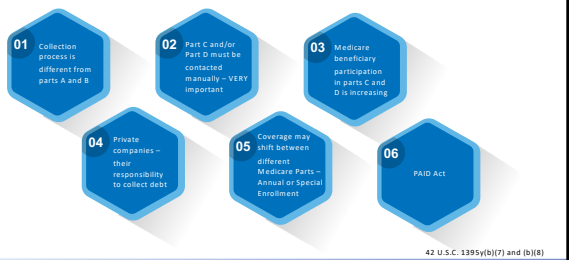
Parts C and D – Overview and Protocols

Medicare Advantage Plans and Medicare Drug Plans



42 U.S.C. 1395y(b)(7) and (b)(8)

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4 Future Considerations

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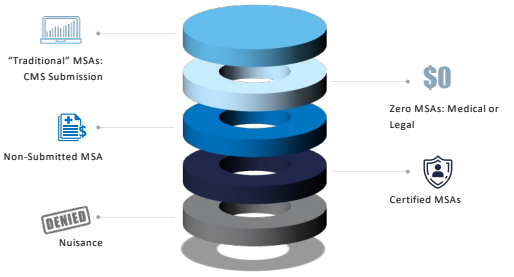
Allocation Options



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CMS Review Options

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New: Zero Dollar MSAs/Future Waivers – Change Coming in July 2025

Section 4.2 - Indications That Medicare's Interests Are Protected

Section 4 of the Workers' Compensation Medicare Set-Aside (WCMSA) Reference Guide v4.2 states that a WCMSA is not necessary under the following conditions because when they are true, they indicate that Medicare's interests are already protected:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement); **and**

b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment.

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'Medical' Zero vs. a 'Legal' Zero

Medical Zero

- Based on the treating records
- What if the record is "gray"?
- Submission to CMS only until July 2025. How to handle after that?

"Legal" Zeros / Zero Dollar Waiver

- Denied cases
- Claimant may still be treating for the conditions
- Submission to CMS only until July 2025. How to handle after that?

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Zero Dollar MSAs / Future "Legal" Waivers

Changes Coming in July 2025

As indicated in Section 4.2, these conditions may be demonstrated through one of the following:

The individual's treating physician documents in medical records that to a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury or illness; or

The workers' compensation insurer or self-insured employer denied responsibility for benefits under the state workers' compensation law and the insurer or self-insured employer has made no payments for medical treatment or indemnity (except for investigational purposes) prior to settlement, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future or past medical or pharmacy services as a condition of settlement; or

A Court/Commission/Board of competent jurisdiction has determined, by a ruling on the merits, that the workers' compensation insurer or self-insured employer does not owe any additional medical or indemnity benefits, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services; or

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Zero Dollar MSAs / Future "Legal" Waivers

Changes Coming in July 2025

CMS Ending Review

Criteria

- Workers' compensation claim was denied by the insurer/self-insured employer within the state statutory timeframe allowed to pay without prejudice (if allowed in that state) during investigation period
- Benefits are not actively being paid
- Settlement agreement does not allocate certain amounts for specific future medical services

Effective July 17, 2025, CMS will no longer accept or review WCMSA proposals with a zero-dollar ($0) allocation. Entities should consider the criteria provided above in determining whether a zero-dollar WCMSA allocation is appropriate and maintain documentation to support that allocation.

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Re-Review and Amended Review

Re-Review

- Mathematical error
- Missing documentation
- Submission Errors

Amended Review

- The request must result in a 10% or $10,000 change (whichever is **greater**) in CMS' previously approved amount (cannot just switch to generic submission)
- Records from the time of previous submission to new submission
- All information is needed at the time of submission (no development letters)

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Strategy and Initial Intake Considerations

1. Understand that advances will negate the ability to secure waiver for denied claim from CMS
2. Use state law defenses early on in claim
3. Pay attention to Ongoing Responsibility for Medical (ORM) reporting under Section 111. CMS will 'connect' the ICD-10 codes supplied for the ORM to the conditional payments and future medical
4. Clarify conditions in the claim: alleged / denied / unrelated
5. Implement safeguards to prevent future issues with MSA
   - Flag denied drugs with PBM to prevent inadvertent pay
   - Flag denied diagnosis codes
   - Request itemized billing
   - Inform treaters of scope of care and authorized conditions

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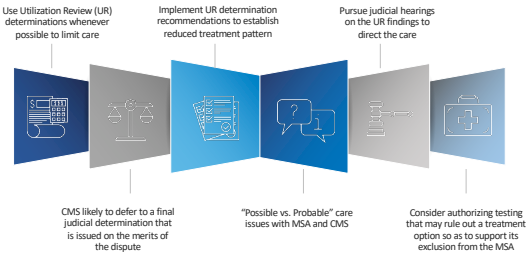
Medical Management



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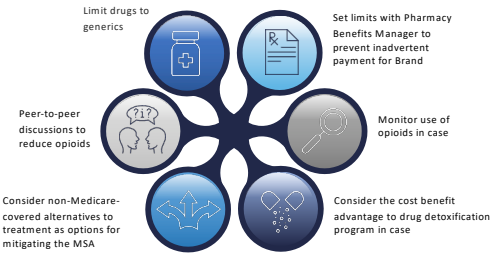
Pharmacy Management



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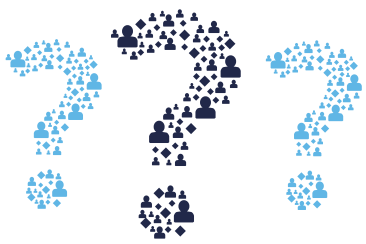
Q&A



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