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Medicare Secondary Payer and Medical Providers: The Devil's in the Details

A new patient sits in your waiting room. They fill out your intake paperwork, your staff visits with them, your doctor diagnoses their condition and sets forth a course of action. Surgery, prescription medications, etc. At check out, the patient instructs the billing department to bill Medicare for the visit. Your staff does just that. Happens every day. Did you know that doing so might violate federal law?

Recent developments should give the medical community pause when deciding how to collect a bill incurred by a Medicare-enrolled patient. Though it has been common practice historically, Medicare will begin enforcing certain provisions of a thirty-six (36) year old law called the Medicare Secondary Payer (MSP) Act later this year. Medicare will no longer pay on claims as a matter of course under certain circumstances. Medical providers must understand the change and establish new protocols in order to minimize business disruptions and legal exposure under federal law. When it comes to dealing with Medicare, the devil's in the details.

On February 3, 2017, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9893. CR 9893 is a technical notice from CMS to the medical community. In it, CMS advises the medical community to expect more reimbursement claims to be rejected starting October 2, 2017 when a provider submits to Medicare for reimbursement. CMS shares the two (2) new rejection codes providers will see: N723 (Patient must use LMSA funds to pay for the medical service or item) and N724 (Patient must use NFMSA funds to pay for the medical service or item). When CMS rejects a reimbursement claim under one of those two codes, it directs the provider to seek reimbursement directly from the patient. Since Medicare is barred under US law to make payment when someone else has accepted responsibility for the bill, CMS advises the provider to collect from the responsible party: the patient.

CR 9893 may wreak havoc with medical provider billing departments nationwide. Starting October 2, 2017, offices will need to keep files open longer to seek repayment. Collection resources will need to be engaged to collect amounts owed. Payment cycles will be lengthened, adversely affecting a provider's cash flow. The trickle-down effect then hits other financial functions of the provider. Payroll and accounts payable are among the groups possibly affected if providers are not addressing the issue proactively.

While harmful, Medicare rejecting a reimbursement claim is not the medical community's worst case scenario. The worst-case scenario is Medicare instead paying the bill in error, realizing the mistake and then seeking reimbursement from the provider.

U.S. law provides Medicare a priority right of recovery for any conditional payment it makes. *42 U.S.C. § 1395y(b)(2)(B)(ii)*. A so-called conditional payment is the only exception to the broad prohibition under U.S. law for Medicare to pay a medical bill that is/was someone else's responsibility. When Medicare makes a conditional payment, it is made with the understanding that Medicare can seek repayment of that expense if another entity is or was responsible for it. Medicare interprets this law as providing a right of recovery against any entity that makes or receives payment. *42 C.F.R. § 411.24*.

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Under U.S. law, Medicare can seek reimbursement of a conditional payment from a medical provider. Lawyers for Medicare advise this when asked who is responsible for repayment in a situation such as the one described above. But there's more. Not only can Medicare recover the full amount of the payment from the provider, U.S. law grants Medicare the ability to recover twice the amount under the MSP Act's double damage provisions. *42 U.S.C. § 1395y(b)(2)(B)(iii)*. Under extreme circumstances, Medicare could also bring action under the federal False Claims Act (FCA) if it believes the provider is attempting to commit fraud against the Medicare program. *31 U.S.C. §§ 3729, et seq*.

The FCA, in my estimation, is Medicare's nuclear option. Each FCA violation carries with it a penalty of 10K to 21K which could be tripled. *31 U.S.C. § 3729(a)(1)(G).* And that is per occurrence. So, every time a bill is submitted to Medicare that Medicare pays and later realizes it should not have, the provider could be in line for a total penalty of 63K per occurrence. With increasing frequency, legal practitioners observe parties attempting to use the FCA. *See, for example, United States v. Wanaque Convalescent Center,* 2017 U.S. Dist. LEXIS 150566 (filed September 18, 2017) (where a plaintiff asserts recovery obligations under the MSP Act as justification for recovery under the FCA).

Given rapidly rising Medicare enrollment rates, longer life expectancies and the constant threat these days of the repeal/replacement of the Patient Protection and Affordable Care Act (aka Obamacare), the Medicare program is projected to go bankrupt within ten (10) years. Thinking Medicare would want to extend the life of the Medicare program by pushing the FCA button against providers is not inconceivable. In 2015, the U.S. Department of Justice used the FCA to collect over $1.9 billion from healthcare providers. The MSP Act and the FCA represent just another tool in Medicare's tool box to ensure the solvency of the Medicare program.

There's good news, though, for the medical community. You are in complete control of when to bill Medicare, up to 365 days of course. You can make sure CR 9893 and these MSA issues do not disrupt your practice and your business. In fact, Medicare recently issued an alert through its MLN Matters series titled "Accepting Payment from Patients with a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), a Liability Insurance Medicare Set-Aside Arrangement (LMSA), or a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17019.pdf.

With the benefit of Medicare's early warning, you can take steps now to avoid seeing rejection codes or billing yourself into an overpayment situation. Here are the steps this lawyer suggests:

1) Start Now – This seems simple, but time is of the essence. Don't wait to address this issue;
2) Decide How to Address – Review your current protocols. What needs to be changed in light of CR 9893?;
3) Document the Changes – Make sure a record is kept of what changes are made. Update your protocols; and

4) Seek Help (As Needed) – Make sure you pull in your legal and/or risk management departments when making these decisions. They may have dealt with these issues in the past or have an ad hoc way to handle currently. Ultimately, though, you may want advice from a lawyer well-versed in Medicare Secondary Payer law and MSA obligations. While the MSA business has boomed over the past ten (10) years, there are few lawyers whose legal practice focuses on MSAs. If you have questions about this, an MSA lawyer should be your first step.

MSAs and other reimbursement obligations under U.S. law are complex. On more than one occasion, courts have admitted that laws addressing Medicare and Medicaid difficult to comprehend.

> "There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase." *Rehab. Ass'n v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994).

CR 9893 and MSAs have the potential to wreak havoc with the business of your medical practice. Don't let that little devil do that. Understand the details of CR 9893, act now and call @MSA lawyer if needed.