Avoiding Treasury Collections in Injury-Related Cases

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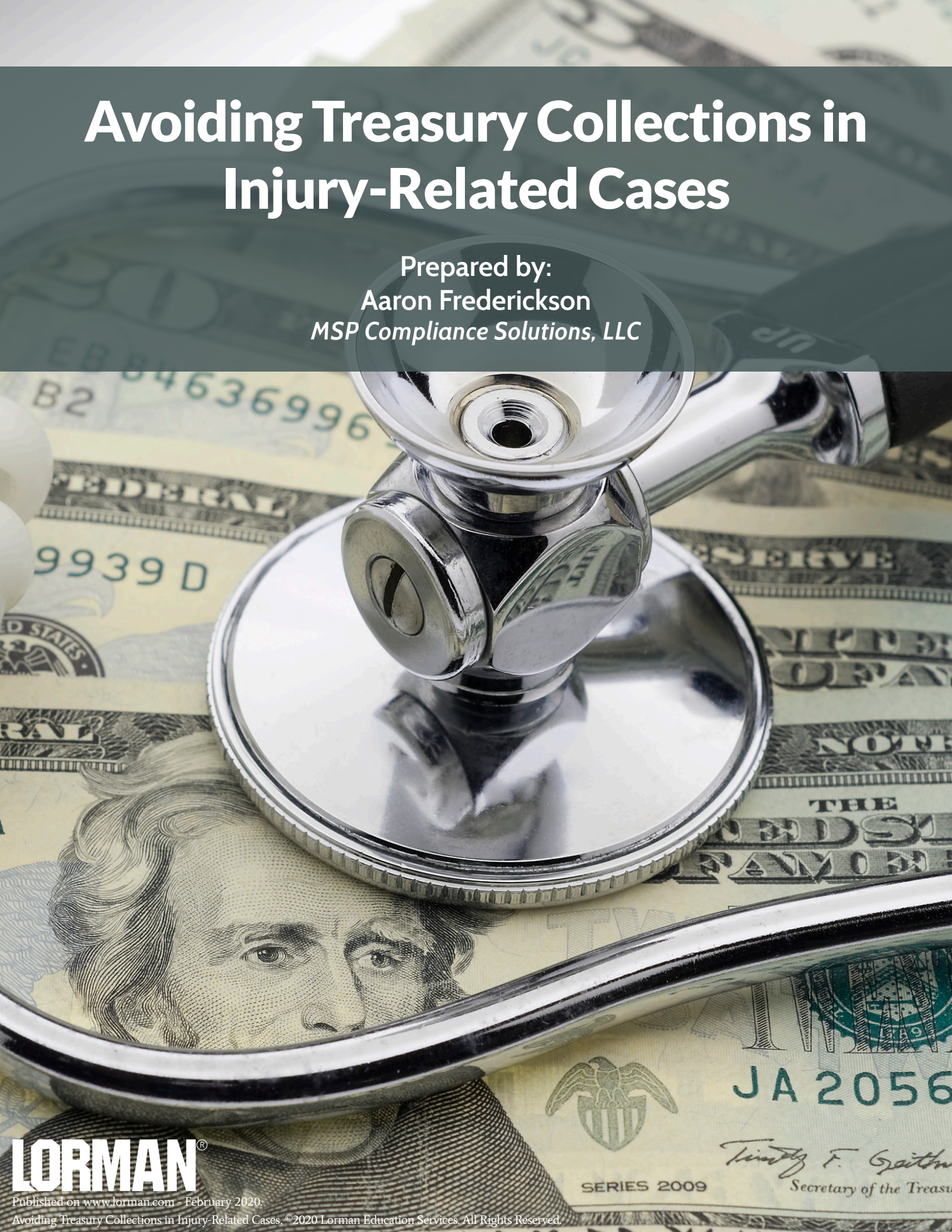

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Never Run Out of Time

Avoiding Treasury Collections in Injury-Related Cases

By Aaron Frederickson

The main function of an effective Medicare compliance program is to reduce future exposures and liabilities. An emerging trend in this area is the avoidance of conditional payment recovery referrals to the U.S. Treasury Department. These occur when formal collection processes fail to either identify or resolve conditional payment matters in personal injury and workers' compensation claims. Now is the time for attorneys and claims professionals to review their compliance programs and prevent future complications.

Understanding Conditional Payments

Any discussion regarding avoidance of Treasury collection actions starts with understanding conditional payments in injury claims. Conditional payments are defined under 42 U.S.C. §1395y (b)(2). They arise when "[p]ayment has been made or can reasonably be expected to be made" by a primary plan. An exception to this occurs when payment is not reasonably expected to be made "promptly," or within 120 days of receipt of the claim by the primary payer. If Medicare then makes payments, there is a legal obligation to reimburse the Medicare Trust Fund.

To put the legal definition of conditional payments in con-

text, they occur in injury-related claims in the following instances:

- A judgment or award of the claim.
- A payment conditioned upon the recipient's compromise, waiver, or release, regardless of liability (e.g., disputes regarding reasonableness or necessity, treatment parameters, etc.).
- By other means as defined by Section 1862 (b)(2) of the Social Security Act (e.g., incorrect billing by a medical provider or payments made based upon a mistake of fact).

Attorneys and interested stakeholders in injury-related litigation need to investigate conditional payments in all cases where the claimant is a Medicare beneficiary. Due to the fact that Medicare could mistakenly make a conditional payment, it is important to investigate this matter even on accepted claims. Failure to do so can result in a loss of reputation or clients, a malpractice action, a professional ethics complaint, or adverse legal action by the Centers for Medicare and Medicaid Services (CMS). There also is exposure to a private cause of action via the Medicare Secondary Payer Act.

Challenges in Conditional Payment Resolution

Attorneys and members of the claims management team encounter many challenges in the area of conditional payment resolution and recovery. Some of the more common issues include:

- *Determining a claimant's Medicare status.* Often the wrong questions are asked or, in other cases, no questions are asked regarding a person's Medicare status. Medicare beneficiaries are confused about what benefits they receive (e.g., Medicaid, Medicare, Medicare Advantage Plans, private disability, etc.). Matters complicate this when the claimant is suffering from the effects of an injury-related claim.
- *Understanding the role of the Medicare recovery contractors.* Prior to October 2015, all conditional payment recovery processes were handled through the Benefits Coordination & Recovery Center (BCRC). Changes have taken place that shift some of the responsibilities to the newly formed Commercial Repayment Center (CRC).
- *Change in the timing of recovery efforts.* Prior to 2015, CMS generally waited until total payment obligation to claimant (TPOC) and reporting of an injury-related claim before commencing recovery efforts. This process has been radically altered, and now CMS has taken an interest in seeking repayment of conditional payments in instances where there is reported ongoing responsibility for medicals (ORM), per 42 C.F.R. §405.906.

Attorneys and members of the claims management team also are seeing challenges with the conditional payment resolution process under the institution of the new appeals process that has been in place since April 28, 2015. Under these new regulations, applicable plans have similar rights and responsibilities as claimants did in the past.

Under this framework, applicable plans can challenge only the existence of "debt" resulting from conditional payments. Parties must follow this process closely or be subject to referrals to the U.S. Department of Treasury:

1. Initial determination (demand letter).

A referral to the U.S. Treasury Department signifies that, somewhere along the line, a step was not followed and conditional payment is now debt.

2. Redetermination by the contractor issuing the demand letter—must be filed within 120 days from the date the notice of initial determination is received.
3. Reconsideration by a qualified independent contractor (QIC)—must be filed within 180 days from the date the notice of redetermination is received.
4. Hearing before an administrative law judge (ALJ)—must be filed within 60 days after receipt of notice from the QIC's reconsideration.
5. Review by the departmental appeals board's Medicare appeals council (MAC)—must be filed within 60 days of receipt of the ALJ's decision.
6. Judicial review in U.S District Court—must be filed within 60 days of the MAC's decision.

This is a significant change in CMS policy regarding conditional payment recovery.

Time is of the essence if you receive a collection letter seeking repayment on behalf of the Treasury Department.

Treasury Collection Referrals—Now What?

A referral to the U.S. Treasury Department signifies that, somewhere along the line, a step was not followed and conditional payment is now debt. Once the debt is deemed delinquent, CMS will transfer the matter for collections.

Prior to a referral for debt collection, several steps need to occur. The first part of the process is an attempt by the responsible CMS contractor to collect on the matter via the issuance of a demand letter for immediate payment. Once 60 days elapse and payment is not made, interest will accrue on all amounts payable to the date of the demand. This interest continues to accrue until the debtor makes full payment. During this timeframe, a notice of intent to refer to the Treasury Department will be issued to the responsible party. If payment is still not received, the matter will be referred for formal collections after 120 days in delinquency.

All collection actions originating from the Treasury Department are handled via a group of approved collection agencies. The companies include: The CBE Group Inc., ConServe Inc., Performant Corporation, and Pioneer Credit Recovery.

Time is of the essence if you receive a collection letter seeking repayment on behalf of the Treasury Department. Interest accumulates from the date the debtor initially received the demand letter. The details contained within the letter will provide information on whom to contact and steps that need to be taken in order to resolve the delinquent debt.

It is important to contact the agency in charge of the matter via telephone and obtain the following: information on how the debt occurred and a determination if the debt in question is related to a claim, including the injury and corresponding ICD-10 codes. Once a party obtains this information, it will be important to analyze how to resolve the problem. This can include discussions with an attorney specializing in debt collection matters.

Implementing Best Practices

Avoiding the receipt of Treasury Department referrals is a best practice for every Medicare compliance program. Part of every compliance program should include the implementation of The Office of the Inspector General, Department of Health and Human Services' *Core Elements of an Effective Compliance Program*. This includes implementation of the following steps:

- Identify Medicare beneficiaries or potential beneficiaries at the onset of every claim.
- Correctly place Medicare on notice through the Coordination of Benefits & Recovery (COB&R). This includes the reporting of the correct ICD-10 codes. The COB&R comprises all BCRC and CRC recovery activities and is the main conduit for conditional payment recovery matters.
- Communicate and cooperate with all interested parties and attorneys regarding conditional payment recovery activities during the life of an injury-related claim. This applies to matters whether or not they are in litigation.
- Verify the accuracy of all items listed on a conditional payment letter. Patience, persistence, and perseverance are required when dealing with these matters.
- Never assume that conditional payments are going to be resolved by someone else. Review all correspondence and respond accordingly. Failure to respond within specified timeframes can result in a referral to the Treasury Department for collections.

Sometimes matters slip through the cracks and conditional payments end up in collections. Be vigilant and act in a prompt manner. If a collection situation occurs, compliance program adjustments should include (1) identifying how the matter resulted in a referral for collections in order to stop future incidents, (2) education efforts and improvement of lines of communication, and (3) responding promptly to and resolving all collection matters. ■

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