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Section 111 Bulletin: Updates on Medicare Recoupment from Casualty Insurers

September 18, 2017

The Centers for Medicare & Medicaid Services (CMS) has posted its 2016 annual report on mistaken and conditional payment recoveries by the Medicare Secondary Payer Commercial Repayment Center (CRC) from Group Health Plans and Non-Group Health Plans (NGHPs). NGHPs include liability and no-fault insurers, workers' compensation carriers, and self-insured entities. Somewhat surprisingly, recoveries dropped from a net return high of $125 million in 2015 to $88 million in 2016 (after deducting administrative costs), with 2016 collections comparing more favorably to the $59 million recovered from GHPs alone in the three quarters of 2014 in which the CRC operated. CMS attributed the 2017 decline to a falloff in recoveries from GHPs due to fewer (although unquantified) mistaken Medicare payments in the first instance. But as 2016 was the first year the CRC also sought reimbursement from NGHPs, many had expected recoveries to increase, especially as CMS's administrative costs appear to have declined.

For undisclosed reasons, the report does not break down recovery data between GHP and NGHP collections, and thus sheds little light on the overall efficacies of the Section 111 program other than an acknowledged $6.5 million uptick in "excess collections refunded" to GHPs and NGHPs. We are left wondering why data was withheld and if transparency will increase as the CRC gains more NGHP experience. You may read the two-page report (short compared to prior years) here. Prior year reports offered more data.

Below are updates addressing three related Section 111 developments affecting NGHP reimbursement obligations.

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CMS Recovery Practices Are Changing: Federal Court Lets Casualty Insurer Off the Section 111 Reimbursement Hook

CMS appears to be listening to casualty insurers that contest the overreach of Medicare reimbursement demands for payment of medical expenses not covered by their policies. That willingness to listen may be tied to two related decisions out of the U.S. District Court for the Central District of California that soundly rejected CMS's practice of seeking reimbursement from NGHPs under Section 111 of the Medicare & Medicaid SCHIP Extension Act for the *full amount* of a provider invoice where:

(i) the medical items or services reimbursed by both the casualty insurer and Medicare have corresponding dates of service, and

(ii) *at least one* coded item or service paid by Medicare is covered by the casualty policy or paid by the insurer.

See Cal. Ins. Guar. Ass'n (CIGA) v. Burwell, 227 F.Supp.3d 1101, 2017 WL 58821 (C.D. Cal. Jan. 5, 2017) and – F.Supp.3d –, 2017 WL 1737717 (C.D. Cal. May 3, 2017).

In *CIGA,* the California Insurance Guarantee Association sought judicial review of Medicare demands that CIGA pay full invoices of provider charges that included not only "items or services" related to a medical condition covered by a member insurer's policy, but also items or services indisputably lacking a covered diagnosis code. For example, one workers' compensation policy covered medical costs for leg and back injuries caused by a slip and fall accident but did not provide coverage for treatment of eczema and tobacco use for which CMS also sought full reimbursement.

As recounted by the court, CMS argued that (i) the term "item or service" – as used in the MSP statute and its regulations – "refers to whatever (and however many) medical treatment(s) a provider lumps into a single charge [or an invoice of itemized claims]," and (ii) "CIGA has a responsibility to make payment with respect to such item or service if the provider lists one or more diagnosis code(s) that are covered by the CIGA-administered policy." CMS explained that it is not uncommon for providers to list multiple diagnosis codes under a single charge and then not apportion the charge to individual codes.

In January, the court told CMS it was wrong on both counts and granted partial summary judgment to CIGA. The court stated "if a single charge contains multiple diagnosis codes—some of which relate to a medical condition covered by CIGA's policy and some of which do not—the presence of one covered code does not *ipso facto* make CIGA responsible for reimbursing the full amount of the charge." *CIGA,* 2017 WL 58821 at *10. Rather, CMS must consider on a case-by-case basis whether the charge can reasonably be apportioned between covered and uncovered codes. In other words, an insurer does not have a duty to make payment for an uncovered item or service just because it is lumped together by a provider with a covered item or service.

In its follow-on decision in May, the court held that CIGA was entitled to an order setting aside the Medicare reimbursement demands, as well as a declaration that CMS's "interpretation of the MSP statute with respect to reimbursement of conditional payments is unlawful." The court declined to go a step further "at this time"

and enjoin CMS from continuing its billing and reimbursement practices because the court was not certain it had a "complete understanding" of provider line-item charges, specifically whether HCPCS/CPT codes also appearing on a provider invoice might be used to determine whether one charge covered multiple items or services.

The *CIGA d*ecisions underscore the importance of reviewing CMS demand letters carefully. If CMS sweeps into a reimbursement request any diagnosis code not covered by the insurer's policy, the insurer should request that CMS apportion charges between covered and non-covered medical expenses. Since the *CIGA* decisions, Wiley Rein has found CMS receptive to apportionment.

Eleventh Circuit Extends Avandia and MSP Private Right of Action to Medicare Advantage Plan Assignees

Casualty plans have encountered far fewer reimbursement demands from Medicare Advantage (MA) Plans than from CMS, but that statistic may change if MA Plan assignees can make a lucrative business out of chasing conditional payments. The U.S. Court of Appeals for the Eleventh Circuit and the U.S. District Court for the Southern District of Florida have opened that door.

Many of our past Section 111 Bulletins have tackled some aspect of the MSP private right of action. In short, the MSP statute establishes a private cause of action for damages "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with [the MSP statute]." 42 U.S. C. § 1395y(b)(3)(A). The MSP statute defines a primary plan to include NGHPs, which include liability, no-fault, and workers' compensation insurers and self-insured entities. As first held by the U.S. Court of Appeals for the Third Circuit in *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353 (3d Cir. 2012) and subsequently by the Eleventh Circuit in *Humana Medical Plan, Inc. v. Western Heritage Ins. Co.*, No. 15-11436 (11th Cir. 2016), and a growing number of district courts in other circuits, an MA Plan may file a private right of action against an NGHP to recover payments the Plan made for a Medicare beneficiary's medical expenses before it learned of the NGHP's primary payer status. The MSP statute refers to these MA Plan payments as "conditional payments." Prior to *Avandia*, many in the industry argued only Medicare beneficiaries had standing to file a private right of action against an NGHP. (Read our prior Bulletin coverage here and here.)

In August 2016, the Eleventh Circuit extended standing to assignees of an MA Plan, holding that they can sue an NGHP for reimbursement of the MA Plan's conditional payments, without first obtaining a judgment that the NGHP has primary payment responsibility under the terms of its insurance policy. It is now sufficient in the Eleventh Circuit that the plaintiff assignee *allege only* the existence of the NGHP's contractual obligation to pay. *See MSP Recovery, LLC v. Allstate Insurance Co.*, 835 F.3d 1351, 1358 (11th Cir. 2016).

Earlier this year, in one of the seven cases remanded by the *Allstate* court, the Southern District of Florida held that one of the MA Plan's assignees, MSPA Claims 1, LLC, had standing to sue the defendant no-fault insurer for reimbursement of the MA Plan's conditional payments. *MSPA Claims 1, LLC v. Infinity Auto Insurance Co.*, 15-21504 (Mar. 9, 2017). The court also held that the plaintiff had adequately stated a claim under the MSP private cause of action. The no-fault insurer had argued that the plaintiff's case should be dismissed because the plaintiff had relied upon conclusions rather than facts and had failed to allege that the insurer was

responsible for paying the Medicare beneficiary's medical bills or had actual or constructive knowledge of the bills. But the court rejected this argument, citing to that portion of the Eleventh Circuit opinion that stated, "a contractual obligation may serve as sufficient demonstration of responsibility for payment to satisfy the condition precedent to suit under the MSP Act." 835 F.3d at 1361.

It has not been all smooth sailing for this assignee. Just late last month the Southern District of Florida dismissed MSPA Claims 1's case against another insurer due to the assignee's failure to properly establish its assignment from the MA Plan. *MSPA Claims 1, LLC v. First Acceptance Ins. Co.,* Case No. 16-20314-CIV (S.D. Fla. Aug. 24, 2017). The court scrutinized the purported assignment in detail and then emphasized that it was "critical" to the court's decision that standing be established at the time the suit is first filed. It was only through motions litigation that the Court had learned that MSPA Claims 1 was actually the second assignee of the MSP rights and had not alleged (and could not establish) that the MA Plan had given its required approval of the second assignment before suit commenced.

It now appears well-settled in the Eleventh Circuit that an MA Plan can assign its right to reimbursement under the MSP statute and thereby confer a private right of action upon its assignee. Assignees will be motivated to purse these rights outside the Southern District of Florida, and the Eleventh Circuit's decision and reasoning in *MSP Recovery, LLC* may prove to be persuasive elsewhere, particularly in the Third Circuit, which gave us the *Avandia* decision.

SPARC Act Earns Additional GOP Co-Sponsors While Congressional Health Policy Staffers Focus on ACA Reform and Urgent Public Health Legislation

U.S. Representatives Tim Murphy (R-PA) and Ron Kind (D-WI) recently welcomed four new Republican co-sponsors to their bill proposing the Secondary Payer Advancement, Rationalization, and Clarification Act (SPARC Act). We previously covered the introduction of the bill and its provisions in our *May* and *June 2017 Section 111 Bulletins*. In summary, the SPARC Act professes to amend Title XVII of the Social Security Act to clarify recovery rights concerning secondary claims responsibility under Medicare Part D. Medicare Part D provides prescription drug benefits to Medicare beneficiaries. Reps. Patrick Meehan (R-PA), David Rouzer (R-NC), Harold "Hal" Rogers (R-KY), and Steve Chabot (R-OH) officially put their support behind the legislation this summer, bringing the total number of SPARC Act sponsors to six. Reps. Rogers, Meehan, and Chabot are not currently serving on committees with jurisdiction over the SPARC Act, but Rep. Meehan sits on the House Committee on Ways & Means and could champion the Act in that Committee when the time comes.

Until recently, the debate over reforming the Patient Protection and Affordable Care Act (ACA) precluded serious consideration of the SPARC Act and other pressing health care issues. For example, Congress must reauthorize the Children's Health Insurance Program (CHIP) by the end of September. The program is authorized through 2019, however, funding is set to expire on September 30, 2017, at which point the federal government will stop making certain CHIP payments to states. In addition, the national opioid overdose epidemic is dominating public health debates, and Congress appears poised to pass legislation to address this crisis. In fact, Rep. Murphy has taken a leading role in this effort by introducing H.R. 3545, The Overdose Prevention and Patient Safety Act, on July 28, 2017. This bill would amend the Public Health Service Act to

ensure doctors have better access to a patient's addiction treatment record. Because of the legislative work needed on ACA reform, CHIP reauthorization, the opioid addiction crisis, and other competing health policy priorities, we believe the SPARC Act is unlikely to receive significant attention from lawmakers in 2017.

We expect the Subcommittee on Health of the Committee on Energy & Commerce to address the questions on consistency and clarity that we raised in our May 2017 Section 111 Bulletin, if and when the Subcommittee has the capacity and impetus to consider the legislation.

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Our Section 111 Practice Group sends periodic Section 111 Bulletins to our clients addressing notable Section 111 and other Medicare Secondary Payer (MSP) developments, including coverage of CMS's Section 111 Town Hall Teleconferences. We maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please contact us if you wish further information on any MSP topic. You may access our Section 111 webpage and other Section 111 Bulletins and articles we have published here, and sign up here to join our Section 111 Bulletin mailing list.

We would welcome the opportunity to assist in auditing or updating your Section 111 practices. Please contact Kathryn Bucher at 202.719.7530 or kbucher@wiley.law.