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Beyond SMART, and what's on the horizon

By Ben Pugh

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) placed a new reporting duty on both group health entities and non-group health entities.
The SMART Act amended Section 111 to allow for conditional payment downloads from a website, provided for safe harbors for good faith reporting efforts and softened the penalty.

Regulations have been developed by CMS to implement the SMART Act and will likely take effect later in 2014 or early 2015. There are now at least two False Claims Act lawsuits brought by whistle blowers for reporting deficiencies.

It's important to realize that CMS acts through a disparate group of contractors. They are private companies who are awarded the contract for their specific function. The ones who are part of the triangle are the contractor for conditional payments (BCRC), the one which reviews and approves WCMSAs (the WCRC) and now the contractor which audits Section 111 reporting, the Medicare Secondary Payer Recovery Audit Contractor (MSPRAC).

All three are now operating under the same computer system and share data at a rapid pace. It's important to understand the role of each and how the primary plan and responsible reporting entity (RRE) must comply with all obligations imposed by each of these contractors.

Conditional Payments
Historically, any primary plan attempting to research and resolve conditional payments made by Medicare dealt with the Medicare Secondary Payer Recovery Contractor (MSPRC). This continues to be the case, although CMS has now combined the MSPRC with Coordination of Benefits (COB) to form the Benefits Coordination and Recovery Center (BCRC). The typical method is to obtain a letter of assignment (LOA) from the adjuster and send to the contractor. This will produce a claim payment summary form.

The form lists all the charges paid by Medicare on behalf of a beneficiary, both related and unrelated to the claim. The party resolving the conditional payments must, using ICD 9 codes, show which charges are not related and remove them from consideration. The BCRC will then resolve the related charges and await reimbursement.

Once a settlement, judgment, award or other payment is funded, the BCRC is provided notice and will send to the primary plan a final demand for payment letter. This letter will require the reimbursement of the conditional payments within 60 days or interest will accrue. The plan should issue a separate check to the BCRC and they will, in turn, issue a closure letter advising that the plan has complied with all CMS requirements for resolution of conditional payments. The closure letter will conclude any issues regarding conditional payments. The BCRC deals with claimants who chose to enroll in "traditional" Medicare, which is Part A (hospital), Part B (physician) and Part D (medication).

Medicare Advantage Plans (MAPs) are approved, for profit, group health plans which offer policies to Medicare beneficiaries. The MAPs operate under Part C and the enrollment period runs from October to December in each calendar year. These companies tend to offer better benefits which cover all areas of traditional Medicare, but the cost tends to be higher. Due to competition, the rates for the policies have declined and more claimants are opting for MAPs and the better choices of coverages. However, the MAPs tend to be more aggressive in pursuing their conditional payments and must be dealt with carefully. Currently, two courts of appeals of allowed MAPs the same rights as Medicare to pursue their conditional payments in court with double damages. This issue is in flux and will need to be decided by the U. S. Supreme Court. However, the MAPs do tend to offer a better discount off the related charges when resolving conditional payments.

SMART Act
The IVIG and Strengthening Medicare and Repaying the Taxpayer

INSIDE THIS ISSUE

Beyond smart *continued*

Act of 2012 ushered in a new era in Medicare compliance. The statute passed both houses of Congress in two weeks and was signed into law by President Obama on 1/13/13. The new legislation was designed to provide relief for primary plans and RREs from the current environment. The SMART Act contains five distinct sections that address problematic issues in MSP compliance.

Section 201
This section provides either party the opportunity to download from a website the pertinent conditional payment information in a timely manner. Although there are certain deadlines to me, the purpose behind the section is to improve the speed with which the parties can research and resolve conditional payments before settlement. Currently, CMS is seeking to push this implementation back to 2016, with resistance from the industry. We should know more in the coming months when the download will be available. Until then, the current method must be used. This involves securing a claim payment summary form from the BCRC, researching which charges are related to the claim based on the ICD 9 codes, resolving the related charges and then securing a final demand for payment letter when the case is settled. The BCRC will, in turn, provide a closure letter relieving the primary play of any additional responsibility for conditional payments. Federal jurisdiction is also created by this section for disputes over conditional payments.

Section 202
This section requires the Secretary of Health & Human Services to publish by 11/15 of each year a threshold amount which will allow a primary plan/RRE to avoid repaying conditional payments and reporting if the settlement is at that amount or lower. It applies only to physical trauma cases and not exposure or ingestion. Although it applies to liability cases, the Secretary is to report to Congress on both workers' compensation and no fault thresholds.

Recently the Secretary has published the threshold for this year. Currently, the reporting threshold for TPOC liability and workers' compensation is $2,000. This will drop to $1,000 for any physical trauma case on 10/1/14. However, for exposure and ingestion cases, it will drop to $3000.

Section 203
This section softened the original Section 111 penalty of $1,000 per day, per claim to "up to" $1,000 per day, per claim. The agency is to develop regulations for both the penalty criteria and safe harbors for good faith efforts in reporting. As discussed below, this has now been developed and prepared. However, Medicare does have discretion in the penalty format.

Section 204
This section compels CMS to allow reporting using something other than the full SSN. The concern was state law privacy claims and we have proposed using the last four digits of the SSN. On 9/10/14, CMS issued a alert advising that a RRE can use the last 5 digits of the SSN for reporting purposes.

Section 205
This section settled the dust over the applicable statute of limitations for both collecting conditional payments and pursuing reporting penalties. It became effective in 2013 and the limitation period is now three years from when the government knew, or should have know about the existence of a claim.

Implementing Regulations
CMS, by virtue of the SMART Act, has now developed regulations for both the penalty criteria and the safe harbors for good faith efforts in reporting. As of this writing, both are at the Office of Management and Budget awaiting "acceptance." Once accepted, a 60 day public comment period will occur before implementation. The new MSPRAC will then begin to audit Non-Group Health Plans and assess reporting penalties.

RAC Audits
The MSPRAC is charged with auditing both Section 111 reporting and MSAs. Any RRE who registered to report electronically consented to a audit. The MSPRAC will begin the penalty assessment once the regulations mentioned above are implemented. The MSPRAC has been auditing Group Health Plans for almost a year and a half and, presumably, is prepared to audit Non-Group Health Entities.

Recently the Office of Inspector General (OIG) announced a proposal for rulemaking for the enforcement of civil monetary penalties. While Section 111 was not addressed in the announcement, the prevailing thought is that OIG will collect the penalties if the MSPRAC is unable to do so. They have the backing of the Department of Treasury and the ability to garnish accounts. This could be very problematic with respect to small primary plans who have been assessed a large penalty.

Concluding Thoughts
We can expect the MSPRAC to be aggressive in pursuing reporting errors and assessing penalties. Now, with OIG involved, there will be a procedure in place to collect them. Most recently, seven U.S. Senators sent a letter to CMS pressuring them to quickly implement the SMART Act, including the penalties, in order for a smoother transition to the penalty phase. It remains to be seen when OMB will accept the regulations but all signs point to later in 2014 when this will occur.

We recommend a independent audit be performed on any RRE's historical reporting to determine if there is any system weakness that could expose them to costly penalties and unpaid conditional payments.

Ben Pugh is a partner at Franco Signor LLC.

President's Note

Managing pain medications

The National Safety Council reaches a surprising conclusion about opioid drugs in its recently released position paper titled *Evidence for the efficacy of pain medications*. The group says "the combination of over-the-counter pain medications ibuprofen and acetaminophen are more effective at treating acute pain than opioid painkillers."

Not everyone would agree with this statement but, nevertheless, there is broad consensus in the workers' compensation community that opioid drugs are overprescribed and not managed well at all. Hydrocodone, in particular, is notorious because of indiscriminate use. It is the most frequently prescribed opioid in the United States with nearly 137 million prescriptions dispensed in 2013. There are several hundred brand name and generic hydrocodone products on the market.

The U. S. Drug Enforcement Administration recently moved hydrocodone combination products from Schedule III to the more-restrictive Schedule II. The new regulation became effective October 5. Physicians can no longer call in prescriptions for drugs like Lortab and Vicodin, and patients are allowed only one 90-day prescription per doctor visit. Additionally, patients have to see a physician before they can obtain a refill.

How has the change affected your organization? Has it altered prescribing patterns? Please share your experiences with us, as this is a subject of widespread interest.

With very best wishes,
Jay Norris

OSHA toughens reporting requirements

Effective January 1, 2015 employers must notify OSHA promptly when an employee is killed on the job or suffers a work-related hospitalization, amputation, or loss of an eye.

Under the revised rule, employers will be required to notify OSHA of work-related fatalities within eight hours, and work-related in-patient hospitalizations, amputations or losses of an eye within 24 hours. Previously, OSHA's regulations required an employer to report only work-related fatalities and in-patient hospitalizations of three or more employees. Reporting single hospitalizations, amputations or loss of an eye was not required under the previous rule.

All employers covered by the Occupational Safety and Health Act, even those who are exempt from maintaining injury and illness records, are required to comply with OSHA's new severe-injury and illness reporting requirements. To assist employers in fulfilling these requirements, OSHA is developing a web portal for employers to report incidents electronically, in addition to the phone-reporting options.

"Hospitalizations and amputations are sentinel events, indicating that serious hazards are likely to be present at a workplace and that an intervention is warranted to protect the other workers at the establishment," said Dr. David Michaels, assistant secretary of labor for occupational safety and health.

OSHA reports nationwide 4,405 workers were killed on the job in 2013. According to the South Carolina Department of Labor, Licensing and Regulation, there were a total of 72 occupational deaths in South Carolina in 2013. Most of the deaths were attributed to transportation incidents (27), violence (14), and falls, slips, trips (13). LLR administers the state's OSHA program.

Business Insurance notes workplace fatalities in the U.S. peaked in 1994, when there were 6,632 deaths. Transportation accidents have been the number one cause of workplace deaths for at least 10 years, accounting for two in five deaths in 2013.

Separately, OSHA released its list of the ten most-frequently cited safety violations for fiscal 2014. The list below shows the number of citations:

1. Fall protection (1926.501) – 6,143
2. Hazard Communication (1910.1200) – 5,161
3. Scaffolding (1926.451) – 4,029
4. Respiratory Protection (1910.134) – 3,223
5. Lockout/Tagout (1910.147) – 2,704
6. Powered Industrial Trucks (1910.178) – 2,662
7. Electrical – Wiring Methods (1910.305) – 2,490
8. Ladders (1926.1053) – 2,448
9. Machine Guarding (1910.212) – 2,200
10. Electrical – General Requirements (1910.303) – 2,056

coming up

March 25-27, 2015.
Annual Conference, NC Association of Self-Insurers. **Holiday Inn Resort, Wrightsville Beach**

April 15-17, 2015
Members-Only Forum, SC Self-Insurers' Association. **Litchfield Beach & Golf Resort**

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At the NC Industrial Commission

By Bruce Hamilton, partner Teague Campbell Dennis & Gorham

New terms limits

The North Carolina General Assembly included a provision in the budget establishing six year terms with a maximum of two terms for Deputy Commissioners. The seven Deputy Commissioners with the least time of service will have their current terms expire February 1, 2015, the seven deputies with the next least time of service will have their terms expire August 1, 2015 and the terms of the remaining Deputy Commissioners will expire February 1, 2016.

Based on recent legislation, it appears the Chairman of the Commission now has the power to hire Deputy Commissioners and that a Deputy Commissioner may only be removed from office for a violation of a judicial standard of conduct. The Deputy Commissioners will be given a six-year term, but most will be limited to no more than 12 years of service at maximum. Those Deputy Commissioners who have worked less than two years are eligible for two additional six-year terms.

New Medical Motion Procedures

On July 22, 2014, Governor Pat McCory signed Senate Bill 794 into law, which, among other things, changed N.C.G.S. §97-25 to clarify and modify existing procedures for expedited and emergency medical motions. Changes to the statute do not impact a party's ability to file a medical motion with either the Executive Secretary's Office or at the Deputy Commissioner level, and parties can still appeal adverse rulings to either the Chief Deputy Commissioner or Full Commission.

One of the key features of the new § 97-25 is that it mandates that orders entered by the Executive Secretary's office or a Deputy Commissioner are not automatically stayed on appeal or on a motion for reconsideration. In order to obtain a stay, the appealing party must file a motion to stay which may be allowed, in the Commission's discretion, upon consideration of factors set forth in 97-25(f)(4).

Also, emergency medical motions must be decided by the Chief Deputy Commissioner within 5 days and parties are now provided with the option to appeal an administrative ruling on an emergency medical motion and receive an expedited formal hearing before a Deputy Commissioner.

Timelines imposed on the Commission for hearing and ruling on medical motions are now addressed specifically by the new statute, including requiring ruling on medical motions filed with the Executive Secretary within 30 days; ruling on expedited motions filed with the Chief Deputy Commissioner within 60 days, which leaves a very limited time for taking any allowed deposition testimony; and requiring a decision by the Full Commission on medical motion appeals within 60 days.