



Financial Services Group

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APPEAL RIGHTS FOR APPLICABLE PLANS

Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation

Summary & Background

On February 27, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a final rule implementing certain provisions of the Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART ACT). This final rule establishes a formal appeals process for applicable plans in situations where the Secretary seeks Medicare Secondary Payer (MSP) recovery directly from an applicable plan. The rule is effective on April 28, 2015 and applies to demand letters issued on or after April 28, 2015.

Applicable plans include liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans. The SMART Act further requires that the Medicare beneficiary who received the items and/or services in question be notified of the applicable plan's intent to appeal. The final rule can be found at 80 FR 10611, February 27, 2015.

Overview

Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans. Medicare may make conditional payments, if payment for items or services has not been made promptly or cannot reasonably be expected to be made promptly by the applicable plan. The expectation is that these payments will be reimbursed to the appropriate Medicare Trust Fund if there is a settlement, judgment, award, or other payment (hereafter referred to as "settlement"). This includes situations where Ongoing Responsibility for Medicals (ORM) exists. Once there has been a settlement, Medicare pursues recovery of its conditional payments.

If an MSP recovery demand is issued to the beneficiary as the identified debtor, the beneficiary has formal administrative appeal and judicial review rights. Prior to this regulation, recovery demands issued to the applicable plan as the identified debtor had no formal administrative appeal rights or judicial review. CMS' recovery contractor addressed any dispute raised by the applicable plan, but prior to this final rule there was no multilevel formal appeal process for applicable plans.

The appeals process established in the final rule parallels the existing process for claims-based beneficiary and other appeals for both non-MSP and MSP, and is used for appeals involving both pre-payment denials as well as overpayments.

PROVISIONS OF THE FINAL RULE: Appeal Rights for Applicable Plans

Who does this regulation apply to? When is it effective?

“Applicable plan” means liability insurance (including self-insurance), no-fault insurance, and workers’ compensation laws or plans. The final rule is effective April 28, 2015. The formal appeals process applies to MSP recovery demand letters issued directly to applicable plans as the identified debtor on or after April 28, 2015. Please note that receipt of a courtesy copy (“cc”) of a MSP recovery demand letter by an applicable plan does not mean that the applicable plan has the ability to file an appeal..

What is the process?

The final rule establishes a formal multilevel appeal process for applicable plans where MSP recovery is pursued directly from the applicable plan. This process includes:

- An “initial determination” (the MSP recovery demand letter),
- A “redetermination” by the contractor issuing the recovery demand,
- A “reconsideration” by a Qualified Independent Contractor,
- A hearing by an administrative law judge (ALJ),
- A review by the Departmental Appeals Board’s Medicare Appeals Council, and
- Judicial review.

The MSP recovery demand letter and any subsequent appeal determination will specify any timeframe or other requirement to proceed to the next level of appeal.

Who can appeal?

The applicable plan is the only entity with appeal rights/party status when Medicare pursues recovery directly from the applicable plan. The beneficiary is not a party to applicable plan appeals. However, CMS is required to provide notice to the beneficiary of the applicable plan’s intent to appeal and will provide such notice if the applicable plan files a request for a redetermination.

What is required for proof of representation?

Proper proof of representation must be submitted in writing prior to or with a request for appeal in order for an attorney, agent or other entity to file an appeal on behalf of an applicable plan or act on behalf of an applicable plan with respect to an appeal that has been requested. Appeal requests without proper proof of representation will be dismissed. Proper proof of representation may be submitted with a request to vacate the dismissal, but the better course of action is to make sure that proper proof of representation has been submitted when requesting a redetermination. Separate proof of representation is required even where an applicable plan may have identified an agent for recovery correspondence as part of the Medicare, Medicaid & SCHIP Extension Act of 2007 Section 111 reporting process.

What can be appealed?

The applicable plan may appeal the amount of the debt and/or the existence of the debt. The regulation does not permit applicable plans to appeal the issue of who is the responsible party/correct debtor. Requests for appeal on the basis that the applicable plan is not the correct debtor will therefore be dismissed. Medicare’s decision regarding who or what entity it is pursuing recovery from is not subject to appeal.