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2017's Medicare Conditional Payment Trilogy? *CIGA v. CMS*

Episode I

On January 5, 2017, the United States District Court for the Central District of California issued orders in the matter of *California Insurance Guarantee Association v. Burwell,* 2017 U.S. Dist. LEXIS 1681. This case involved Centers for Medicare & Medicaid Services ("CMS") asserting recovery against California Insurance Guarantee Association ("CIGA") for conditional payments made by Medicare in underlying actions for which CIGA was the primary payer. CIGA contended that CMS' recovery demand was over-inclusive and that CIGA was in fact not the primary payer for many of the claimed charges. CIGA moved for Summary Judgment, seeking judicial declaration regarding the conditional payments, as well as an injunction barring CMS from ever asserting recovery against CIGA that was contrary to the Medicare Secondary Payer ("MSP") statute and the associated regulations. CMS filed Motion to Dismiss.

The primary contention of CIGA's claim was that CMS was seeking recovery for payments made by CMS for care that CIGA was not the primary payer. For instance, in one of the underlying claims that CIGA had accepted primary payer responsibility for, they had limited their acceptance to back and leg injuries only. However, CMS sought recovery for charges associated with diagnosis codes wholly unrelated to the injuries CIGA was responsible for, such as hypertension or diabetes, as well as for codes associated with the accepted injuries. By failing to identify specific, claim-related care and apportion the charges by diagnosis code, CMS was in effect making CIGA the primary payer for injuries and conditions that they were not responsible for.

CMS' Motion to Dismiss asserted a variety of defenses, including that CMS had self-terminated their recovery efforts against CIGA, CIGA's failure to make a prima facie case that the demand was over-inclusive, that CMS practices were reasonable under the MSP and regulations, and that the injunction sought by CIGA directing CMS not to use certain practices to calculate their conditional payment demands was an impermissible programmatic attack on Medicare.

The MSP permits recovery by CMS from a primary plan for payments made by Medicare for any "item or service" that the primary plan had responsibility to make payment for. 42 U.S.C. § 1395y(b)(2)(B)(ii). CMS attempted to justify their practice of seeking reimbursement for all diagnoses codes associated with a charge by characterizing a charge containing multiple diagnosis codes as a single "item or service." Ultimately, the court found CMS' arguments unpersuasive and their interpretation of the MSP and accompanying regulations to be incorrect. In particular the court noted that the regulations promulgated by CMS under the MSP had already defined an "item or service" as "any item, device, medical supply or service provided to a patient (i) which is listed in an itemized claim for program payment or a request for payment . . ." 42 C.F.R. § 1003.101. Given the available regulatory definition, and a plain interpretation of the singular form words "item and service," the court found that CMS' broader characterization of "item or service" as any single line-item charge on the payment history was not correct. Partial Summary Judgment was granted to CIGA.

Episode II

Following CIGA's successful motion, the Court instructed the parties to submit a proposed schedule to adjudicate the remaining disputes, or alternatively submit a proposed judgment to the court. After failing to reach an agreement regarding the relief to which CIGA was entitled, the parties filed briefs with the Court to determine the issue. The

Court issued a decision on May 3, 2017. *California Insurance Guarantee Association v. Price,* 2017 U.S. Dist. LEXIS 67589.

The Court concluded that CIGA was entitled to an order vacating and setting aside the underlying reimbursement demands of CMS and a judicial declaration that CMS' interpretation of the Medicare Secondary Payer statute's conditional payment language is unlawful. However, the Court determined that injunctive relief prohibiting CMS from continuing its billing and reimbursement practices was not required.

With respect to vacating the underlying reimbursement demands of CMS, the Court found that even though CMS had voluntarily withdrawn their demand for payment in the underlying cases and represented a lack of intent to collect on the demands in the future, an order vacating and setting aside the demands was appropriate. The Court cited to prior filings of CMS that indicated a possibility that CMS may reassert new demands in the future and ordered that any future demand must consider some apportionment of their prior demand taking into account the portions disputed by CIGA.

While the Court declined to grant declaratory relief to CIGA with respect to the prior reimbursement demands, noting this would be redundant in light of their decision to set aside the disputed portions of CMS' prior demand, relief was granted to CIGA with respect to CMS' interpretation of the MSP and with respect to prospective demands from CMS. The Court found CIGA provided evidence that CMS continued to demand conditional payments from them in other matters seeking reimbursement for charges containing diagnosis codes for which CIGA was not the primary payer determinative in their decision.

The Court's declaration stated that "item or service" used in the MSP statute as a matter of law did not equate to any medical items, devices, supplies, or services appearing as a single line-item charge on a payment summary form; that whether a particular line-item charge contains divisible items, devices, supplies, or services was a factual question to be resolved on a case-by-case basis; that if a line-item charge contains multiple diagnosis codes, including codes for which CIGA is responsible and codes for which they are not, CMS is not entitled to the full amount of the charge; and that CIGA does not have responsibility to make payments for an uncovered indivisible item, device, supply, or service appearing on the same line-item charge for which they do have responsibility to make payment.

However, as stated previously, the Court declined to provide CIGA with injunctive relief, as they determined that CIGA had not suffered an irreparable injury and that the remedies at law, including the judicial declaration, were adequate to compensate their injury and deter similar future conduct from CMS. Reluctant to grant CIGA a remedy in equity, the Court noted that CIGA's hardship of utilizing the available administrative appeals process for disputed reimbursement demands was proportionately less than the burden CMS would face if their administration of the MSP was burdened and disrupted by an injunction.

Episode III

In their brief outlining their proposed relief from the Court, CIGA requested that a trial be set in the event that their full payer for relief was not granted. As the court declined to extend injunctive relief, a trial was set for September 2017, with Court noting that their decision was in part based upon an insufficient factual record. In their order, the Court wrote that the summary judgment record lacked "meat on the bone" with respect to any factual evidence illustrating why or why not a single line-item charge represented a single "item or service." In particular, the Court pointed out that CIGA never produced any medical documentation that could shed light on what medical treatment was rendered at the time a line-item charge occurred. Stay tuned . . .

Review

Once the veil of the statutory and regulatory interpretation issues is brushed away, the overarching theme of this litigation (and MSP compliance as a whole) is clear; CMS cannot extend the scope of primary payer status beyond what the underlying statute that the claim is based on obligates a party to pay. In this case, CIGA was only responsible for the injuries that had been determined to be compensable under the state workers' compensation system and the court found that the MSP could not preempt state law with respect to primary payer status. It was for these reasons the court found that CIGA had no obligation to pay for the full line-item charges asserted by CMS and was only obligated to reimburse the Medicare trust for the conditional payments made by CMS for the specific claim-related care accepted by CIGA under the state workers' compensation system.

Legally, the case makes sense. An entity cannot be forced into the role of a primary payer simply by over-broad medical coding. Barring a total reversal at trial, the case puts a justified burden on CMS and their contractors to limit a recovery action against a payer to only those conditions and for those services where it has been established the payer is categorized as primary under the MSP.

Practically, if the Court finds in favor of CIGA at trial there is a benefit to the parties on both sides of the "v." Claimants would derive the same benefit as defendants in terms of any direct recovery actions by CMS against the Claimant being limited on to the conditions for which the Claimant has recovered monetarily. The Claimant would also gain a decreased threat of a loss or suspension of benefits based upon the non-payment of an erroneous lien. The case could also provide an unintended benefit to Claimants and Defendants alike by CMS also being limited in the treatment that the agency and their contractor can include in MSAs for post-settlement claim related care.

If CIGA prevails in this matter, the case will become the authority cited by all primary payers confronted with CMS reimbursement demands for conditional payments that the primary payer is not responsible for. We will continue to monitor the proceedings and hopefully will be reporting a favorable outcome for the MSP community in the coming months.

The Dickie, McCamey & Chilcote **Medicare Compliance Group** is available to help your organization with all aspects of MSP compliance. If you have any questions regarding the information outlined above or any other inquiries, please feel free to contact us.

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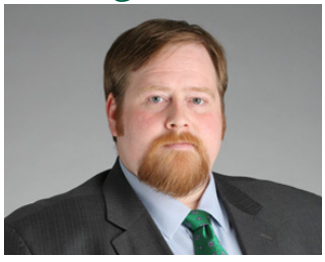

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