Reminger
ATTORNEYS AT LAW est. 1958

HISTORY AND HANDLING CASES IN LIGHT OF

THE MEDICARE SECONDARY PAYER ACT

This is intended as a thumbnail sketch of issues surrounding the Medicare Secondary Payer Act for our friends in the Long Term Care and Assisted Living Industry. Of course, it is not intended as specific legal advice or the creation of an attorney-client relationship. Please call one of us with questions.

I. HISTORY AND BACKGROUND

In 1965, Congress enacted Title XVIII of the Social Security Act that established the Medicare program. Thereafter, under Section 1862 of the Social Security Act, Medicare was positioned as a secondary payer to workers' compensation and group health plan payments. In 1980, the Medicare Secondary Payer Act was broadened to include automobile, liability and no fault insurance (including self insurance) as third-party payers.

While essentially being part of the personal injury landscape since 1980, enforcement in workers' compensation claims did not begin but has increased significantly since approximately 2002 with the publication of the first of twelve Policy Memos. These memos were issued by Centers for Medicare and Medicaid Services (CMS), the operational contractor of the Federal government charged with administering the Secondary Payer Act, and led to the development of Medicare Set Aside Agreements (MSA) and the process of protecting those who have settled workers' compensation claims from future Medicare liens. <u>While none of the Policy Memos specifically call for the same treatment of liability settlements, it is thought that with the 2007 enactment of the Medicare, Medicaid and SCHIP Extension Act that Medicare will begin enforcement on liability settlements</u>. Significantly, the Extension Act imposes new and strict Medicare secondary payer reporting requirements on group health plans and liability, workers' compensation and no fault insurance carriers. Originally planned for mandatory reporting as of July 1, 2009 the dates have been pushed back in accordance with the attached May 12, 2009 Policy Memo from the Office of Financial Management/Financial Services Group of CMS. The data assembled through the required reporting will be used to coordinate the payment of benefits and to insure protection of Medicare's interest.

Medicare's purpose is to provide medical care that is "…reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Under the Medicare Secondary Payer Act, Medicare payments "…shall not be made…with respect to any item or service to the extent that…payment has been made or can reasonably be expected to be made under workman's' compensation law or plan of the United States or a state or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." However, Medicare is permitted to make payment "…with respect to an item or service if a primary plan…has not made or cannot reasonably be expected to make payment with respect to such item or service promptly…" Where any such payment is made the payment "…shall be conditioned upon reimbursement to the appropriate trust fund in accordance…" with the Act.

Under these regulations, therefore, Medicare's right of recovery under the Medicare Secondary Payer Act is broken down into two parts:

(1) conditional payments: past payments for services provided for injuries covered by a workers' compensation or general liability plan;

(2) any future payments.

For conditional payments, Medicare may recover the full amount from the primary payer and from any entity who receives payments from the primary payer. This would include not only the workers' compensation or liability carrier, but also their agents to include their attorneys. The right of recovery is triggered when the payment is made by Medicare. Under the Medicare Secondary Payer Act, the right of recovery has priority over all other private, statutory or government liens or claims. Should Medicare's interest not be protected, the Medicare Secondary Payer Act provides double damages for the costs paid plus interest.

In assessing the exposure for the primary payer it will be necessary to determine not only the amount of the conditional payments made but to also assess the amount of future benefits to be paid so that a MSA can be provided for in the personal injury and/or workers' compensation settlement. Once the set aside amount has been approved Medicare will not pay for a covered service unless and until those dollars have been spent by the beneficiary.

Determining the amount of the conditional payments requires an initial contact with Medicare's Coordination of Benefits Contractor (COB) who, in turn, will assign the case to a Medicare Secondary Payer Recovery Contractor (MSPRC). This contractor will then develop the information on any conditional payments and pursue recovery of the same. Once advised of the amount of conditional payments made, attempts can be made to negotiate a lower repayment obligation.

For future medical benefits utilizing the services of an MSA allocator, life care planner or other actuary professional is advisable as Medicare's interest will be determined utilizing a matrix of ICD codes as applied to CPT codes for covered injuries. Utilizing a life care plan, however, is not recommended as the life care plan will often include costs that would not be covered by Medicare.

It is recommended that assembly of the conditional payment information and projection of the future Medicare costs be obtained before settlement negotiations are commenced. Due to the volume of requests made on the various contractors, it is recommended further that the process start earlier in the case and thereafter supplemented as the case's end approaches.

II. HANDLING MATTERS INVOLVING A MEDICARE/MEDICAID INTEREST

Once settlement is imminent or has been reached, the attorney's focus should be on:

(1) resolution of the conditional payment obligations;

(2) determining if Medicare approval of the set aside is required. That analysis is broken down as follows:

(a) Class 1 Settlements: (PRE-APPROVAL REQUIRED) The recipient is currently eligible for Medicare and the total uncommuted value of the settlement exceeds $25,000.00.;

(b) Class 2 Settlements: (PRE-APPROVAL REQUIRED) The recipient is "reasonably expected" to become eligible for Medicare within thirty (30) months of the settlement and the total uncommuted value of the settlement exceeds $250,000.00. For purposes of this class of settlements "reasonable expectation of Medicare eligibility within thirty (30) months" is defined as:

(i) age 62 ½
(ii) currently receiving Social Security Disability
(iii) has applied or plans to apply for SSD
(iv) is appealing a denial of Social Security disability
(v) has a diagnosis of end-stage renal disease or amyotrophic lateral sclerosis

(c) Class 3 Settlements: (PRE-APPROVAL NOT REQUIRED BUT RECOMMENDED) All others not contained in Class 1 or 2. Please note, even though pre-approval is not required, the settling of a

Class 3 case does not provide safe harbor for the parties. Similarly, voluntary submission of a Class 3 settlement is unlikely to gain Medicare action but utilizing an MSA provides the parties with an added layer of protection should Medicare later question the recipient's eligibility, the covered expenses or the contingent liability of the parties.

The current recommended process for resolving a matter where a Medicare interest exists is as follows:

(1) obtain the following three (3) releases:

(a) HIPAA compliant medical release;
(b) Social Security Release (attached);
(c) Consent to Release Medicare Information (attached).

(2) utilize Social Security Release to determine if recipient is receiving SSD, SSI, Medicare or Medicaid. Such information will automatically point to Class 1 settlement eligibility and provide the necessary information to assess Class 2 and/or Class 3 potential.

(3) Initiate contact with Coordination of Benefits Contractor to begin looking for conditional payment amounts owed. The Ohio region Coordination of Benefits Contractor is located at:

Medicare – Coordination of Benefits
MSP Claims Investigation Project
P.O. Box 33847
Detroit, MI 48232
(800) 999-1118

Response from your inquiry concerning conditional payment information will come from the Medicare Secondary Payer Recovery Contractor. The contact information for this contractor, depending on type of matter being resolved is as follows:

For liability or no fault recovery:

MSPRC Auto/Liability
P.O. Box 33828
Detroit, MI 48232-3828

For workers' compensation recovery:

MSPRC WC
P.O. Box 33831
Detroit, MI 48232-3831

(4) Undertake analysis of future liabilities utilizing a medical planning professional. The analysis should be based upon:

(a) the facts of the injury;
(b) the course of care with particular attention to the care provided two years prior to the settlement;
(c) the recipient's rated age;
(d) the corresponding CPT codes and costs to the ICD codes in dispute.

(5) Once set aside analysis is complete, determine settlement authority and/or settlement amount utilizing relevant considerations including, but not limited to:

(a) no fault liability considerations;
(b) future indemnity payments as required by no fault liability;
(c) disputed liability considerations;
(d) proximate cause issues;
(e) policy limits;
(f) comparative fault;
(g) damage caps.

(6) Determine method of funding future payment obligations. Funding methods may be:

(a) Medicare set aside trust;
(b) Medicare set aside custodial account;
(c) self-administered Medicare set aside agreement.

(7) Once all particulars have been resolved between the parties, including the resolution of conditional payments, settlement proposals should be forwarded to the Centers for Medicare and Medicaid Services (CMS) at the following address:

CMS
c/o Coordination of Benefits Contractor
Attn: Settlement Proposal
P.O. Box 33849
Detroit, MI 48232-5849

The submission of a settlement proposal is preferred in a CD-ROM media with all documents imaged in a .pdf format. Documents scanned to the CD-ROM should be named/coded in the following fashion:

05 – submitter letter or other summary documentation presenting the case
10 – consent form
15 – rated age information or life expectancy
20 – modified life care plan or MSA allocation report
25 – settlement agreement or proposed order
30 – MSA administrator documents (trust or custodial) or MSA agreement
35 – medical records for last two years
40 – payment history (workers' compensation claim)
45 – future treatment plan
50 – supplemental or additional information

(8) Upon receipt and review of the settlement proposal, CMS will either reject the proposal or approve it as written. Currently, there are no appeal rights to a CMS rejection but negotiation directly with the regional office is permitted.

(9) Once the final proposal has been approved, conditional payments should be satisfied and the MSA funded. Once the MSA is approved and funded, the only party who thereafter remains liable is the Medicare recipient. The Medicare recipient is obligated to spend down the allocated dollars before Medicare will pay for claim related treatment. Where Medicare determines that the beneficiary has inappropriately spent down the dollars, Medicare will require that the dollars be re-deposited into the set aside account and spent before Medicare benefits will be paid.

III. GOING FORWARD

Over the next year while the required reporting is being worked out it is expected that many clients will request liability cases be settled before a required report is mandated. Historically, while we have not seen Medicare attempt to enforce liens on workers' compensation cases that were settled prior to the 2002 enforcement effort, and

commentators expect the same with liability settlements, the lien remains nonetheless. It has been reported that the Dallas region contractor has begun to review liability set asides and that others are soon to follow suit even though guidelines have not been published on that process. Best practices, therefore, would seem to suggest that consideration be given to Medicare's interest and, where possible, a set aside be implemented. At the very least one should document efforts at protecting the Medicare lien as that information can be used at a later time to show that burden shifting has not taken place.

Currently there is a flood of vendors seeking to enter the MSA market. While preparing an MSA in a no-fault workers' compensation case with an obligation for lifetime medical can be handled by such a vendor, there are serious considerations that may prevent such vendors from handling these matters in liability cases. In addition to those mentioned in item (5) in section II above, unauthorized practice of law considerations may be the biggest obstacle faced by these vendors.

We are in the process of developing a Reminger practice group that will be available to assist you in handling these matters. As part of that process we will be working with third party sources to contract out the medical projections needed to complete the MSA if we cannot handle the same in house. Ultimately, the goal of this group will be to help you provide MSA services not only on the cases that we are actively handling but to perform the work for cases not assigned to us for defense.

Please contact any one of our team at 1-800-486-1311.

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